ABTSWH Case or Data Request #1

Q1: What is timeliness of claims involving impairment evaluation over the past three years? Please provide the counts by year, by residence state of claimant, and by consulting impairment MD.

A: The question is unclear and it will require clarification. Timeliness can be measured in many different ways using different end points throughout the claim adjudication process. What two end points are you asking about?

Q2 - What is the overall timeliness of claims evaluations over the past two years?

A: The question is unclear and it will require clarification. What specifically is meant by "claims evaluations," and again, what two end points are you asking about?

Q3: What is the count and trend in the number of medical providers who accept the EEOICP benefit medical card in DOE communities over the past 3 years? Are there any common reasons why some have dropped out of the program over that past three years?

A: DEEOIC maintains an inventory of medical providers enrolled with the program that may receive payment for accepted illness treatment costs. DEEOIC does not record data relating to reasons for medical provider participation or lack of participation.

Q4: How many claimant occupational health interviews have contractor and Federal IH's done over the past two years?

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Q5: Is a more detailed role of the EEOICP Medical Director in the program being added to the Procedure Manual?

A: DEEOIC clarified the role of the DEEOIC Medical Officer in Federal (EEOICPA) Procedure Manual (PM) Version 5.1, Chapter 29 – Ancillary Medical Benefits. Per PM Chapter 29.5f, the Medical Officer will assist with reviews of organ transplant and experimental treatment requests.

Q6: Has any attempt been made to aggregate data from past claim decisions to ensure consistency in decision-making in future claims? For example, one could look at decisions on Beryllium sensitivity or COPD claims for different job titles to see if variation exists in claims outcomes for the same job titles?

A: No. DEEOIC adjudicates claims using case-specific data available for review. Since no two claims are identical, data aggregation of this type is neither possible nor statistically valid.

Q7: What are the current or future changes in occupational medicine at EEOICP?

A: The question is unclear and it will require clarification.

Q8. For what % of claims do the CMC's and IH's recommend denial?

A: None. DEEOIC Industrial Hygienists and Contract Medical Consultants only provide professional advice that a Claims Examiner weighs in adjudicating a claim. IH's and CMC's do not recommend that claims be denied.

Q9: For what % of claims do the CMC's and IH's find minimal exposure. This should be provided for each individual CMC and IH (protecting confidentiality).

A: DEEOIC does not record this type of data during claim adjudication.

ABTSWH Case or Data Request #2

Q1: What is the National Office's Medical Director's role in claims evaluation? Is the entirety of his role described in the EEOICP Procedure Manual?

A: See response to Q5 from ABTSWH Case or Data Request #1.

Q2: What procedures does the Medical Director follow?

A: It is not clear what this question refers to with regard to the particular function(s) of the DEEOIC Medical Officer.

Q3: How does the Medical Director communicate his input into the claims evaluation process?

A: When DEEOIC requests a case-specific review from the Medical Officer, the Medical Officer will communicate a response in writing. DEEOIC will then upload that written response into OIS for it to become part of the permanent case record.

Q4: What triggers a review of an impairment claim by the Medical Director?

A: With the update to Version 5.1 of DEEOIC Procedure Manual, if a need arises for a review of an impairment claim, the Claims Examiner may refer the matter to a Contract Medical Consultant for an opinion. However, a claimant's chosen physician is the first point of contact with regard to any deficiency of an impairment rating clarification.

Q5: How many remands of impairment claims have occurred? How many of such remands have involved Dr. Lewis versus other impairment MD evaluations?

A: DEEOIC requires clarification of the temporal parameters for the first question. For the second question, DEEOIC cannot track impairment remands by the name of the physician involved.

Q6: What constitutes a "significant exposure" as viewed by the claims examiners, IHs and CMCs in claims evaluation? What evidence is used to make this judgment? What combination of evidence is considered sufficient to say that an exposure is significant?

A: PM Chapter 15.11 discusses the ways that exposure can by characterized by DEEOIC IHs. DEEOIC IHs use their professional judgment to assess the available claim data when they characterize employee exposures to chemical or biological toxins.

Q7: The statute cites that an exposure has to be a "significant factor" in causing contributing to or aggravating a condition. How do "significant factor" and "significant exposure" relate, if at all?

A: They are distinct factors and have no relation at all. A qualified physician must apply their professional judgment to ascertain whether a reported toxic substance exposure, at whatever reported level, was at least as likely as not a “significant” factor in causing, contributing to or aggravating a diagnosed illness.

Q8: Do industrial hygienists (contractor and federal) use certain combination of frequency, intensity, and duration to arrive at a decision about significance of exposure?

A: Yes. DEEOIC IHs characterize exposure using various descriptors applied normally in the field of Industrial Hygiene including those relating to frequency, intensity, and duration.

Q9: Are bystander exposures included in determining whether exposure is significant? How do claims examiners, His and CMCs identify bystander exposures and include them in their assessment for claims evaluations? An example is security guards.

A: DEEOIC IH assessments include an evaluation of any available monitoring data from the case file when characterizing the extent of toxic substance exposure.

Q10: Has the newly revised OHQ provided additional detail that has improved determination of "significance" of exposure?

A: While the intent of the revisions to the OHQ was to enhance the collection of information about an employee's toxic substance exposure, DEEOIC does not assess how reported information affects claim outcomes.

Q11: What is the maximum amount of time that the Board can get to review anticipated PM changes before they are published?

A: 10 days

Q12: How often and what is the process for the PM to be checked for conflicting policies?

A: DEEOIC normally publishes two updates to its Procedure Manual each year. Each update communicates new staff guidance or provides clarification of existing procedures.

Q13: Is there a matrix for matching codes to ICD9 and ICD10 to SEC cancers?

A: Yes

Q14: Please provide a listing of ICD10 codes accepted in adjudicating non-cancerous beryllium-related health effects claims for Part B versus Part E.

A: The specific parameters of this question are unclear and will require clarification.

Q15: Are there specific instances of individuals who worked at facilities but were not considered employees due to their status as students, interns, or summer workers, and subsequently submitted claims? How were these handled? Note we are not requesting information on individuals.

Yes. Those claims were denied, as required under the terms of the statute.

Q16: Can treating physicians use the "target organ" list in the NIOSH Pocket Guide as an authoritative source in reports to DOL?

DEEOIC does not provide guidance on the reference material that a physician may or may not choose to apply professionally in the assessment of claims. However, the concept of a "target organ" is only relevant when NIOSH is performing a radiation dose reconstruction in a claim where the only diagnosed cancer is secondary, not when a treating physician is providing a diagnosis.

Q17: Could claims examiners' first inquiry with attending physicians be given a specific window of time for a response, and if they do not respond within that time, move the claim forward to the CMC?

PM Chapter 16.5d provides staff guidance that a period of 30 days is appropriate to allow for a physician to respond to written inquiries. A CE may grant additional time for a physician to respond to development requests when necessary.