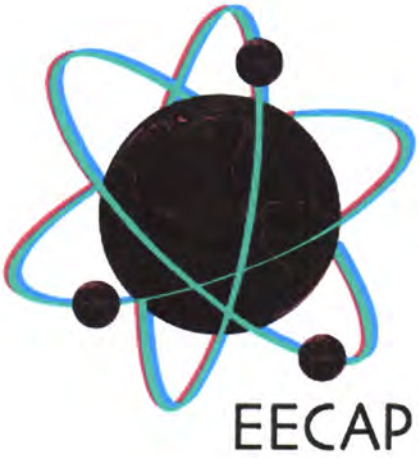
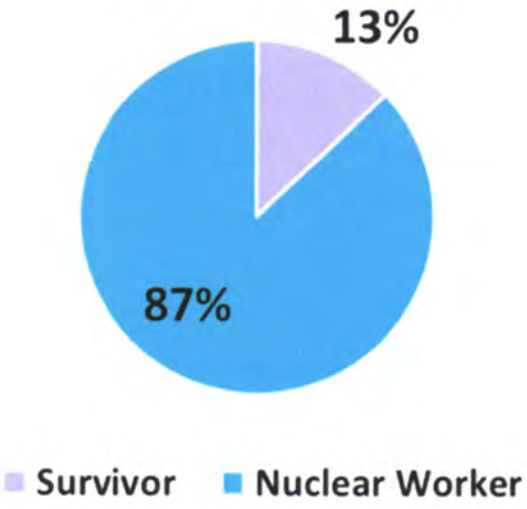
Interim Report on EEOICPA Medical Benefits Survey

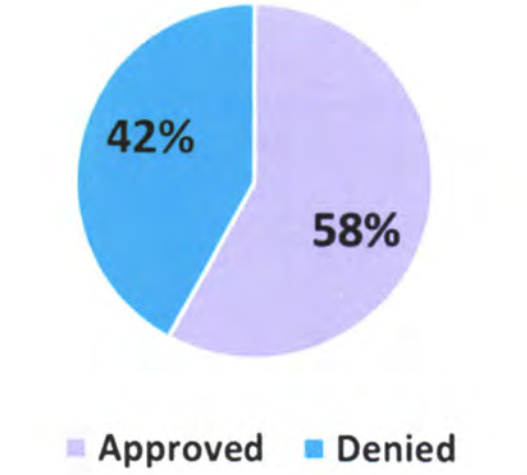


Thanks to Cold War Patriots for Outreach

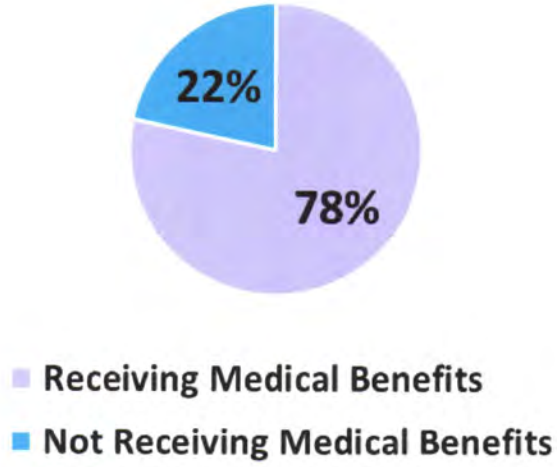
767 Survivor and Nuclear Workers with Claims Filed Completed the Survey



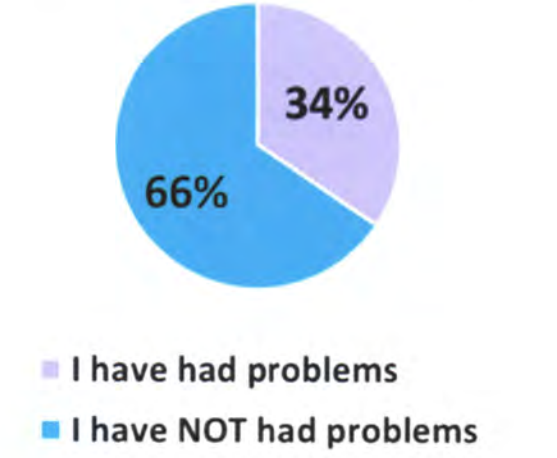
Percentage of Survivors and Workers with Approved Claims



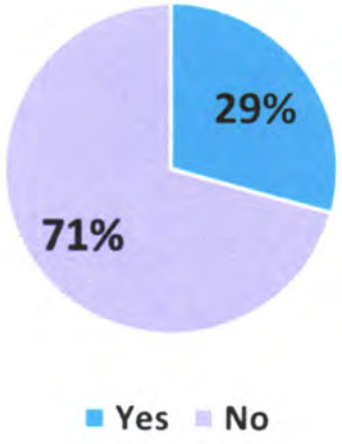
Percentage of 412 Workers with Approved Claims Receiving Medical Benefits



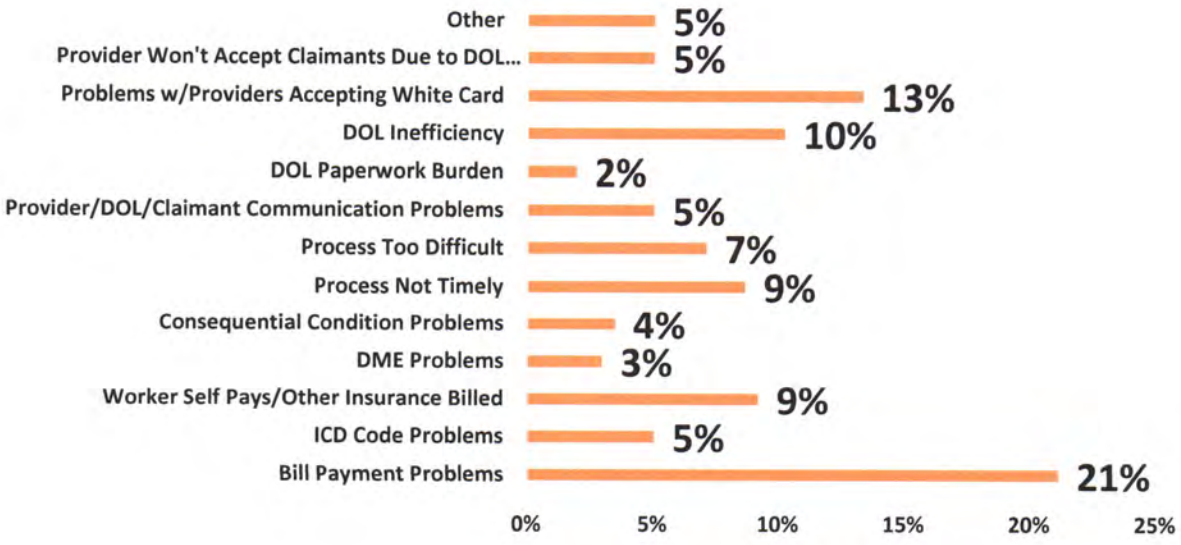
Percentage of Workers Who Have Problems using Their Medical Benefits



Were Your Medical Benefit Problems resolved Satisfactorily?



Problems Claimants report using Their EEOICPA Medical Benefits



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Problems with using EEOICPA Medical Benefits as Reported by Claimants

1. A bill for a CT scan of lungs ordered by Pulmonologist in 2015 still has not been paid. Patient asked for hospital to refile with corrected code per white card, however it has not been paid as of this date. Patient received bill again today for over $3,000.00.
2. Dental work is supposed to be covered because of immune suppressant medication. The dental office cannot get the claim paid because of "Technical" problems. I paid the charges which had accumulated to over $500. I am now trying to get reimbursement with the help of the Oak Ridge Office.
3. As the AR for a claimant, the wife received a hospital bill for $45,000 months after the passing of her husband (from the approved brain cancer) who had the Part E white card. I had to get John Vance involved and it was determined that the bill should have been paid already. I am unsure if it has been resolved since I have not heard back from her.
4. At first they would only pay a small amount of my medical bills. It has changed so now they cover all medical bills.
5. billing issues
6. Doctor Bill,s are question after seeing docturs on follow-up and differance things , such as Byops .
7. DOL rejected MRI for my back. Looks like hospital used the wrong billing code. Need to have my doctor send a letter to DOL saying that not only is my neck covered but the rest of my back.
8. Dr and lab charges were denied
9. During a recent impairment evaluation I had to have a new PFT test and so far DOLI has not paid the bill. Maybe because of my coverage being expressed in ICD 9 codes not the current ICD 10 codes.
10. EEOICPA would not pay for oxygen concentrator even though I had an approved condition of hypoxemia.This happened in 2014 and took approximately one year to resolve. As a result of not having oxygen, I had a stroke. EEOICPA approved the stroke conditions in 2015.

11. Getting medical providers to PROPERLY fill out reimbursement forms to the full satisfaction of the EEOICPA is sometimes next to impossible and fraught with error. I have had claims returned many times for insufficient information. I have had claims denied due to paperwork errors.
12. Had difficulty getting another code approved; because of this, had to make some payments out-of-pocket. The code was finally approved.
13. Hospitals are up to speed on billing three possible insurances, this first, then medicare or the medicare supplement
14. I had a cat scan on my chest that was refused
15. I tried to use it once and no luck. I will try again.
16. It is difficult to find doctors that will bill the DOL. Also, I have had a travel claim denied.
17. It is difficult to get the charges Right on DOL card charges, The Drs. go ahead and charge to my personal insurance in spite of me trying to tell them to charge to DOL.
18. Long delays on payment, if paid at all. I am waiting for medical benefits on skin cancer benefits. My DR. said skin cancer was caused from my stem cell transplant. DOL will make a decision in a year or two. Most hospitals don't want to wait that long for payment. I also had to contact DOL in Washington DC in 2013 to get an ok for a stem cell transplant. The Jacksonville dropped the ball on it. Before I have anything done associated with the transplant the Jacksonville office say's they have to approve it. If it was life or death the still want to approve it.
19. Most doctors and doctor office workers do not know what the card is or how to process it. Furthermore, If the visit is not correctly documented by the office for the covered condition it is easy to get confused with other conditions when visiting the same doctor. At which point point the payment will be refused and create administration nightmares for the patient as their responsibility.
20. MY DERMOTOLIGIST REFUSED TO SEND ANY MORE CLAIMS FOR MY SKIN CANCER TREATMENTS BECAUSE OR SLOW PAYMENTS.
21. New prescription wasn't initially covered so to obsolete drug list. Forces me to finback through Jacksonville twice to get it straightened out.
22. Providers were denied payments without explainations.
23. repayment for out of pocket expenses.
24. Required labs payments have been turned down due to wrong codes being used on the lab orders from the doctor. This has only been happening in the last year or so since the new cards have been issued after new codes were implemented.
25. Several issues with physician filing to my Medicare and BC/BS because their billing is not done "in-house". Trouble with codes. Was out of town in Virginia and had to go to emergency room twice while I was there. Out of state hospitals and billing companies do not understand the card, not a member so this wound up being billed to my Medicare and BC/BS for most of the bills, E/R, X-ray, Doctor, Etc.

26. Some laboratory test have not been paid.
27. The medical billing service sends the bills to the wrong department on the DOL. The bills are then denied. It has taken much personal effort to correct this issue.
28. The process is very cumbersome. Everything is done by mail and very, very slow. Claims take way too long to process and after two months we have still not received reimbursement. Would love to have direct deposit.
29. THEY ARE NOT PAYING FOR A COVERED MEDICATION. THEY HAVE NOT PROVIDED INSTRUCTIONS FOR FILLING OUT THEIR EXPENSE REIMBURSEMENT FORM. IF AN EXPENSE REIMBURSEMENT FORM IS NOT FILLED OUT CORRECTLY, I AM NOT NOTIFIED THAT THERE IS A PROBLEM. THEY JUST DON'T PAY ME. INSTEAD OF RESOLVING MY PROBLEM THEY TELL ME I NEED TO CALL SOMEONE ELSE. MY EXPECTATION IS THAT MY CASE MANAGER SHOULD RESOLVE MY PROBLEM!!!
30. they take the card and theb they bill medicare no matter how many times i try to use the card
31. Too much back and forth needless paperwork. Too many delays in responses to get anything done. Not enough working with medical providers for their payments, leaving them to illegally bill and collect monies from my health insurance (that I provided them during a surgery years before)...still not straightened out.
32. Took a year before benefits were paid without me having to use my private health insurance and my Medicare. Still waiting to have the last bit of reimbursement repaid to me.
33. Took nearly a year before I could use EEOICPA medical to pay for my Chemo treatments. I had to use my own Medicare and BlueCross Blue Shield health insurance. It's taken nearly 6 months after EEOICPA kicked in for me to be reimbursed (still waiting for the last $300). Also, I needed extensive help filling out the paperwork to get reimbursed. Without that help, I would have given up on getting reimbursement. The process is just too difficult to do, especially for anyone who is already sick.
34. trouble getting prescriptions, not everybody will except my white card,
35. I have skin cancers. Many of the lesions require analysis. If one is determined to no be cancer than thw physician to pay for that treatment. While I have medicare and some cost for the noncancer lesion are paid, I am still responsible for any co pay and a doctors visit cost.
36. It has been difficult for some of the companies and the doctors that provide services to bill the Department of Labor so that their claims are paid so if they aren't paid by the Department of Labor because the dr. Doesn't jump through the hoops then I'm responsible for it or they bill my other insurances.

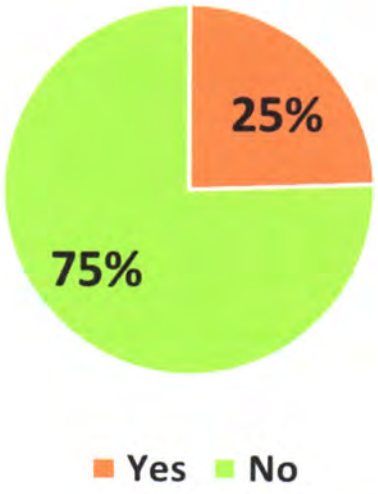
37. None of my Drs accept the White Card and don't intend to because the reimbursement is not enough money. We were told the reimbursement would be comparable to Medicare.....it isn't by any means. The reimbursement is horrible. Also, even though my medical claims adjuster in Denver, David White, has approved all my previous medical claims and forwarded the APPROVED claims, when the claims get to the Xerox Company (I may have their name wrong, I don't have those papers with me) they DENY COVERAGE! They don't have all the supporting documents and evidently don't research alternative/complementary solutions that my improve my APPROVED consequential illnesses. How can they deny a claim, when the medical claims adjuster has approved the claim??? Who do we, as claimants, go to to question or at least explain the claims. Someone is dropping the ball and we aren't getting all our benefits. I can be reached at 806-433-1862 if you would like to discuss any of this.
38. Not covering some medications for my approved condition
39. Payments not forthcoming to psychologists accepted condition nervous/anxiety.
40. Slow in getting some bills resolved.
41. No providers in area. Paid for my $5000+ EEOICPA related services and only received partial refund. Requested participation by facility; they declined. Requested balance from claims examiner and ACS per remittance advice. Declined.
42. At this time it costs more time and energy to file than the benefits pay. I am luckier than others. As i wind down, i will total up my annual costs and re-evaluate.
43. Been trying to get a portable light weight oxygen concentrator - have had problems getting it.
44. cancers
45. Consequential illnesses--the process is not client friendly to work Thur.
46. Doctors do not want anything to do with taking this insurance if it is not a local doctor that sees a lot of people with this card and understands what it is. I also have medicare so they bill them instead.
47. Doctors have problems filing paperwork with DOL
48. Doctors refuse to write letter stating consequential condition for their diagnosis simple because they see eeoicpa as another world of gov paperwork red tape...accused me of just wanting a gov hand out...i just quit going to drs...would rather go ahead and die than be labled a thief. Need a communications path to drs.
49. Doctors see that it as another Gov hand out and more paperwork for their staff then they see not writing the letter confirming the consaquential association as a way to avoid all the red tape of getting their money from the gov. More than one doc accused me of just wanting a hand out...i have just given up and stoped going to dr...would rather go ahead and die than be labled a thief.

50. DOL acts as though my beryllium problem will go away and I won't need my medical equipment any longer..... When I file for Impairment update , instead of sending all the paper work, they send one item at a time, then when it is sent back via London, KY ... that group looses some of the paper work which you then have to replace for DOL. which takes much longer than their 30 day turn around time they give me to respond for each item... It takes months to complete the Impairment process....
51. DOl is to complex takes at times three or four times to get a a question resolved.
52. Dr. office will not bill DOL
53. Drs refuse to show consequential connection due to fear of gettiing mired in red tape andnot getting paid
54. hearing loss
55. I ALSO HAVE A CLAIM IN FOR ASBESTOSIS AND COPD FOR A YEAR WITH NO RESULTS OR DECISION ON CLAIM
56. I don't know what doctor bills are covered. Is it just for cancer treatment, or anything else? What about dental? eye exams? I need to also file for reimbursement for travel and accommodations for my cancer checups in Houston, TX.
57. I have been fighting for oxygen and a CPAP and have been fighting for two years
58. I have had to go to Final Determination for any consequential condition related condition
59. I now live in the state of Texas. There is no doctor that's close to me they will except my card.
60. I receive pharmacy benefits for consequential conditions that are not approved yet. But I cannot get the consequential co donations approved.
61. I was approved for the Medical Benifts Program for cancer. I provide all the necessary forms to my detmatologest which she filed and was approved. However the following year the process proved to be to time consuming for my dermatologist, so we worked out a deal where I only pay a co-pay for her services and she dumped the goverment program.
62. It is hard to find providers
63. It is very difficult to get providers to use the medical card. They prefer to file Medicare or other.
64. it seems like there is only one doctor who who is approved to authorized coverage
65. I've sent multiple letters all the way to ombudsman.
66. Kaiser seems to have a problem accepting the card, sometimes it's in the system other times it's not
67. Lack of providers registered with the EEOICP program and glitches with standard health insurance who think it's "workers comp". Of course, that is in the name. This has had no effect on my health.

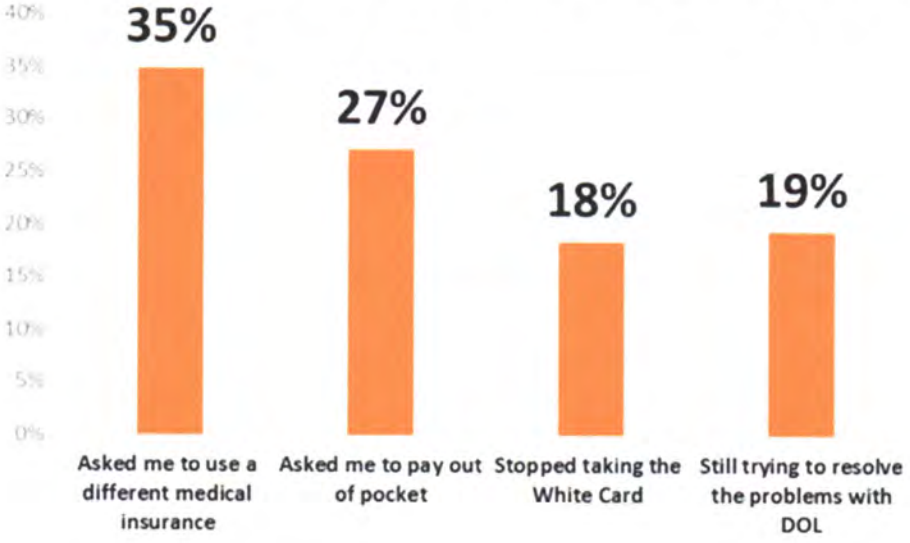
68. Lincare having trouble getting ICD-9 thru
69. Lincare having trouble getting the consentrator and C-pac approved.for ICD-9
70. Most Dr's will not accept the benefits card
71. My Dermatologist dropped me from the Program. I called DOL and they said that was their prerogative. I didn't know they had that option.
72. no one in Florida where I am located will honor
73. No one will take because they think it's WORKMAN comp
74. nobody seems to understand the program from the doctors to the pharmacy.
75. ON a visit to Vanderbilt hospital in Nashville TN. they refused to honor my medical card. After I got back home I called the DOL office in Oak Ridge TN. and they called Vanderbilt and got the ploblem resolved.
76. Skin Cancer, Restrictive Lung Disease, Small Airways Disease and COPD including emphasema
77. Some doctors refuse to take DOL insurance
78. Some dr will not accept the eeoicp card
79. Some medical organizations refuse to recognize, or don't want to recognize, EEOICPA/DOL medical benefits OR their billing departments don't know how to handle it. The solution is easy. Just find a medical organization that accepts it and go with them. That's what I did!
80. The benefits didn't start when my husband was diagnosed with brain cancer, and I was his 24-hr caregiver. They started after I had the first opportunity to file.
81. The biggest problem is recognition and acceptance of the white card. Most providers will not file on the card. Instead they rely on gap insurance if you have it, or they will request that you personally file on the white card for reimbursement.I
82. The Doctor prescribed safety shoes for my neuropathy as I have lost feeling in my feet. unfortunately, the shoes are also used for diabetics and are identified as such. Diabetics get neuropathy. The evaluators denied the claim saying that diabetic treatment was not covered. After 10-12 months they finally were satisfied that the shoes were covered and that all necessary paper work had been correctly submitted.
83. there is no guideline as to what is covered.
84. They started out saying that Melanoma was not a skin cancer, my Dermatologist said "WHAT?" Later they decided that it was a skin cancer so I re-applied even though the time ws over but I included a letter saying that I was trying again because they changed their minds and that worked.
85. They wanted the same information sent in more than once
86. Unable to find a doctor or pharmacy that will accept the ID card.
87. UNCLEAR BENEFITS

88. When I presented my DOL card to a local endocrinologist, at first, when he saw it, his office manager said that he would not see me, even though I was a former patient, and was not making a DOJ claim with him for that visit. Eventually, I spoke with the doctor himself, and he agreed to see me because I was a former patient.
89. Clarity...I'm told one thing by one representative something else by another
90. I have moved from St. Pete Beach, FL to Savannah, TN, and the medical people here have never heard of Oak Ridge, Tn, or ORNL, or Beryllium. It is very difficult for me to try to explain the medical benefit to them. They take one look at the white card and say "we don't take Workers comp.". Therefore, I think there should be more info on the card, or some form of information.
91. It's too complicated. Providers don't want to use it.
92. Massage therapy limited to 60 visits even though they allow 2 visits a week.Has to be approved every 8 weeks takes ce over a month to approve with delays treatment.Ridiculous way to do recert when it is the same written order from doctor
93. Very hard for pharmacy to communicate with DOL medical benefit staff.
94. Kidney disease
95. i can't get a doctor to accept it because of having to sign up and all the paper work.

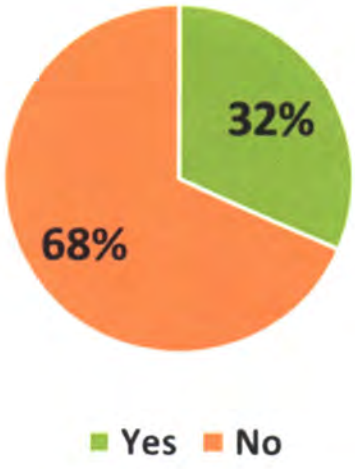
Has Your Doctor reported Problems to You with using EEOICPA Medical Benefits?



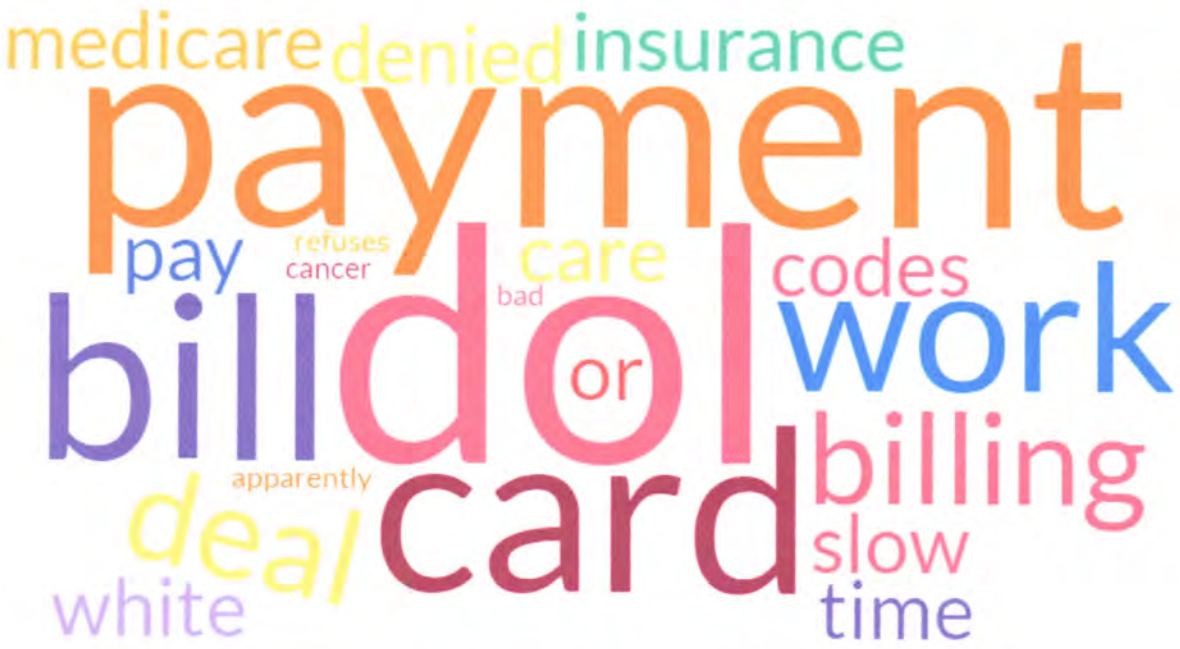
Because of Problems with DOL My Doctor

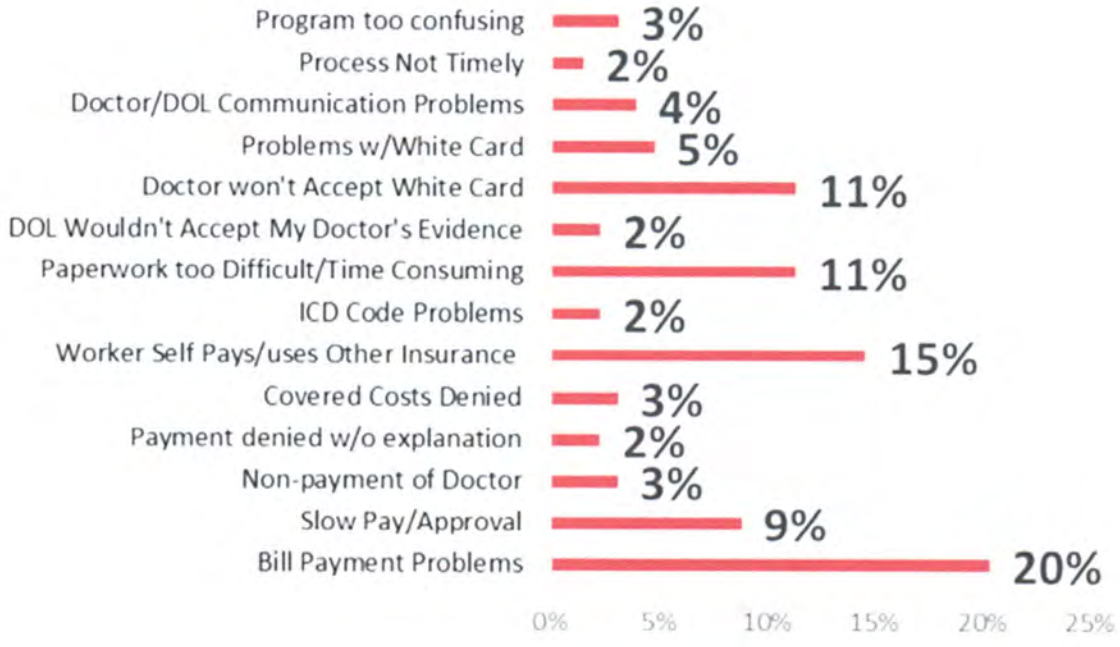


My Doctors' Problems have been Resolved to Their Satisfaction



Problems Claimants report Their Doctors have using EEOICPA Medical Benefits





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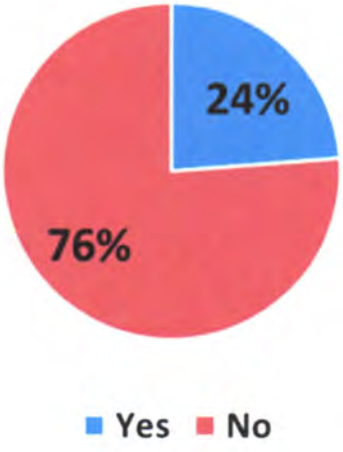
Problems Claimants report Their Doctors have with using EEOICPA Medical Benefits

1. After making calls for about a hour.
2. As noted before the forms required are too time consuming for her practice to participate in the program.
3. Being able to document issues to the requirements set by EEOC
4. Billing
5. Billing was not clear until the Dotor called DOL.
6. codes covered
7. Dental work is supposed to be covered because of immune suppressant medication. The dental office cannot get the claim paid because of "Technical" problems. I paid the charges which had accumulated to over $500. I am now trying to get reimbursement with the help of the Oak Ridge Office.
8. DOL DENIED PAYMENT WITHOUT AN EXPLANATION.
9. don't know
10. Don't know the DOL codes
11. For a cat-scan a few years ago, it was necessary for me to call both the hospital and DOE to see what was needed to honor the card. It was simply a billing code but the hospital had chosen not to peruse it or ask what they needed to do. They instead chose to bill me.
12. His expertise has been questioned more than once. One diagnosis has been in work for over one year and is still not settled. It was denied and was reopened over a year ago.
13. I do not know specifics, but apparently they were bad enough that he did not want to accept new patients.
14. i don't know realy know they seem like they just don't want to deal with it
15. I have tried 2 times to get some charges corrected and have not been able to correct charges
16. I recently went to my primary care doctor for chest congestion to get some medicine and his office did not bill the visit correctly and instead billed my Humana/Medicare insurance.and billed me for the copay.

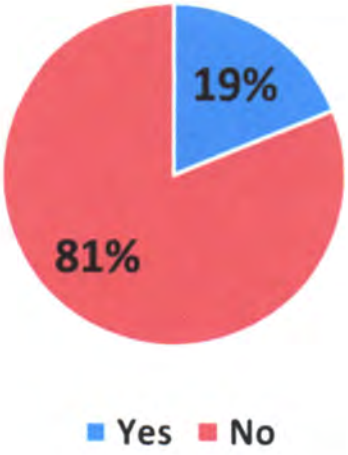
17. I was denied coverage for Part E type coverage.
18. If I wasn't willing to pay the bill because they had not received payment for months ago, then only way I could not pay was for them to file with Medicare and BC/BS
19. It takes too long to receive payment. The card states that it is workmanship comp and some of my doctors don't want to deal with it
20. It was billing problem at the Hospital, they did not, after instructions from me, bill the right insurance.
21. Just gives up and turns claim over to collections
22. Just refuses to fight the beaurocratic red tape...to get their money
23. Lack of payment. With no feedback as to why caused Dr to not accept DOL PATIENT INSURANCE.
24. Most doctors and doctor office workers do not know what the card is or how to process it. Furthermore, If the visit is not correctly documented by the office for the covered condition it is easy to get confused with other conditions when visiting the same doctor. At which point point the payment will be refused and create administration nightmares for the patient as their responsibility.
25. multiple filings to get paid by Zerox
26. my doctors office doesn't accept my white card,the office changes my doctor without notifying me.
27. Not familiar with this program if out of town specialist. If the doctor does not practice in an area where there is a lot of use they do not want to deal with signing up for this.
28. One doctor gave up and said he refuses to work with the DOL. The second doctor is always getting requests for medical information. They have all of my records but they question why he prescribed the care he did.
29. Paperwork to eeoicpa satisfaction
30. She didn't know what DOL was! Or CBD. She insists on using Medicare when EEOICPA is my primary, and she uses COPD instead of CBD.
31. SLOW PAYMENT FOR SKIN CANCER TREATMENTS
32. SLOW PAYMENTS
33. still trying
34. Stopped taking workers covered by the EEOICPA program
35. The icd codes don't work all the time
36. THEY DID NOT REIMBURSE THE DR AND DID NOT TELL HIM WHY. THE DR THEN SENT THE BILL TO ME AND I HAD TO RESOLVE THE PROBLEM.
37. Trying to work the system... Finally charge to other insurance.. Causing sick worker more problems.
38. Two of my doctors will not accept the white card any more because of all the extra paper work that is envolved
39. Unsure of problem, they prefer not to deal with the DOL.
40. very slow to pay

41. wasn't sure what the card was, and how to process the claim
42. When provides care he often doesn't get paid. When he writes reports for DOL he doesn't get paid.
43. Wouldn't pay the bills.
44. Apparently they have to fill out some paperwork or go online and do something in order for the Department of Labor to even accept a bill from them so then if I've already had a service the doctor hasn't filled out the information then they can't bill the Department of Labor and I'm responsible for the bill the doctors seem to be a little bit resistant anymore because it's becoming a little more difficult for them to bill and I'm just worried that at some point in time they don't want to see me because they don't want to bill the Department of Labor.
45. Approval still pending
46. As noted before the forms required are too time consuming for her practice to participate in the program.
47. Delays in getting approved for treatment then change of rules and regulations
48. She didn't know what DOL was! Or CBD. She insists on using Medicare when EEOICPA is my primary, and she uses COPD instead of CBD.
49. Payment for MRI cancer delayed
50. Very poor payment for claims. So bad they have no intention of offering services using the White Card!!
51. I personly had to go to agent t get problem resolved.
52. he ordered hearing aids for me in april 2016 and still hasn't heard from them and this is oct. 2016.

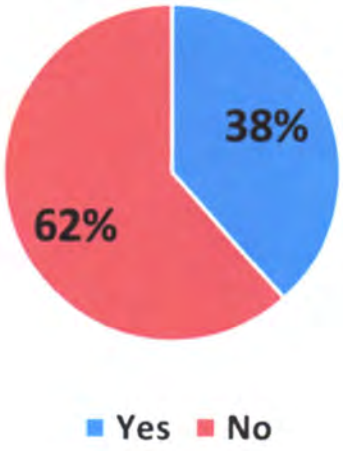
Do You receive Home Health Care as Part of Your Medical Benefits?



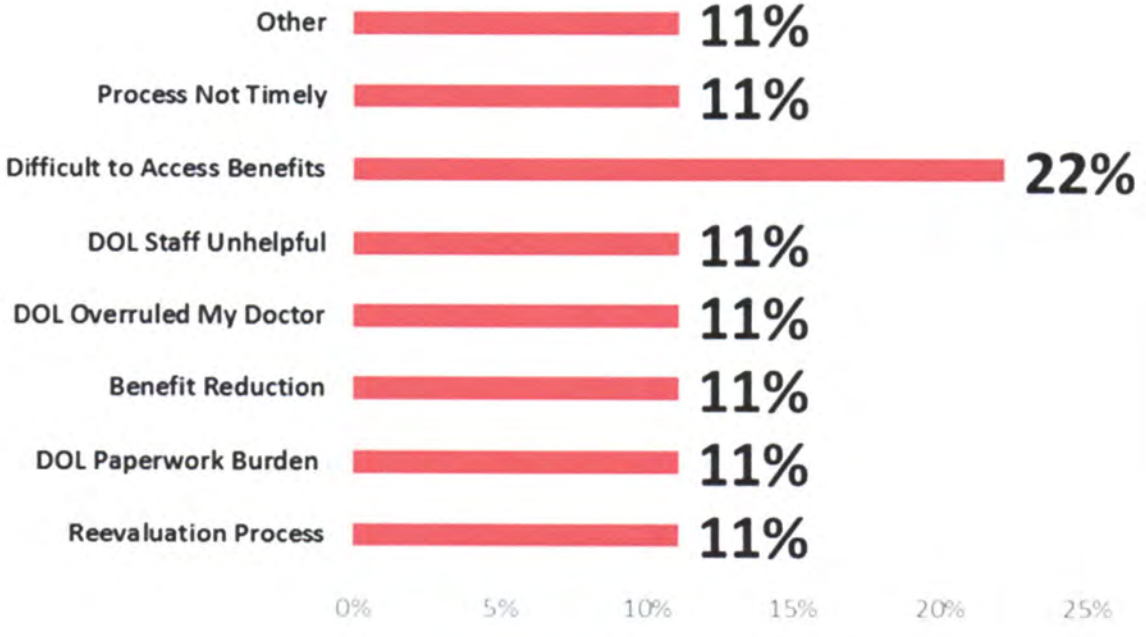
Have You had Problems using Your Home Health Care Medical Benefits?



Have Your Home Health Care Problems been resolved to Your Satisfaction?



Problems Claimants Report Using their Home Health Care Medical Benefits



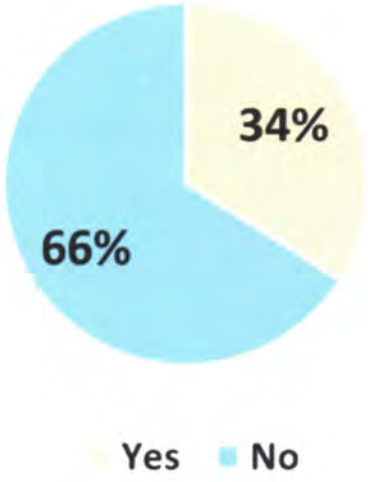
EECAP

Problems Claimants report using Their Home Health Care Medical Benefits

1. Approving 24 hour care seven days a week and then not approving it for the next approval period just because patient was not utilizing the entire time approved. Patient situation may require 24 hour care one week and then not the next week but may need 24 hour care again in two weeks. Patient should have flexibility to utilize care as needed once it is approved. Even expedited approval for emergencies takes too long to be effective when an unstable patient takes a turn for the worse.
2. DOL decreased home health benefits twice. DOL sent patient for re-evaluation 2 hrs. away from home to a doctor of their choosing. This was done before benefits could be restored. DOL then said their chosen doctor did not submit the required documentation, therefore they fired him. Then due to that issue, DOL sent patient to another doctor of their choice, who was not a pulmonologist, to do the patient's re-evaluation. Due to this doctor's recommendations, the patient's health benefits were greatly decreased. This was unacceptable and patient requested an appeal. Patient sent a very informative letter stating the facts of the home health issues to the DOL Claim Manager and the issues were resolved favorably. Even though the results were favorable to patient in that home health benefits were restored, having to go through this difficult process put a strain on the patient's health.
3. Getting medical equipment needed and a walker additional hours
4. I was placed on oxygen use, DOL Refused to provide a back-up system should the power fail.
5. The amount of approved care has gone down drastically while my symptoms have gotten worse. How does that make sense.
6. There have been requests for some durable equipment that has been questioned and has not yet been resolved. This has been in process since June of 2015.
7. We have a visiting nurse so in order to retain the nurse every few months our doctor has to re-assure DOL that we are still sick with Beryllium illness... It is also hard to impossible to get other items added to the white card that are caused by the Beryllium in the lungs even when your doctors state the added illness is due to having Beryllium in the lungs.... Our case workers are more

involved in trying to be a detriment to to us than they are trying to help us as the system was set up to do....
8. Xxxx!!!:?????!!!!.
9. They cut out the massage I use to receive for Neuropathy which help tremendously
10. ignorant unresponsive staff. Need for multiple requests for the same issues.
11. Seems like DOL drags their feet on some things. For example, getting me CNA's 1 or twice per week. Only have 2 in the last 18 months for 3 total visits. Also getting more difficult to to get other things approved. Claims examiners taking longer and longer to review things.

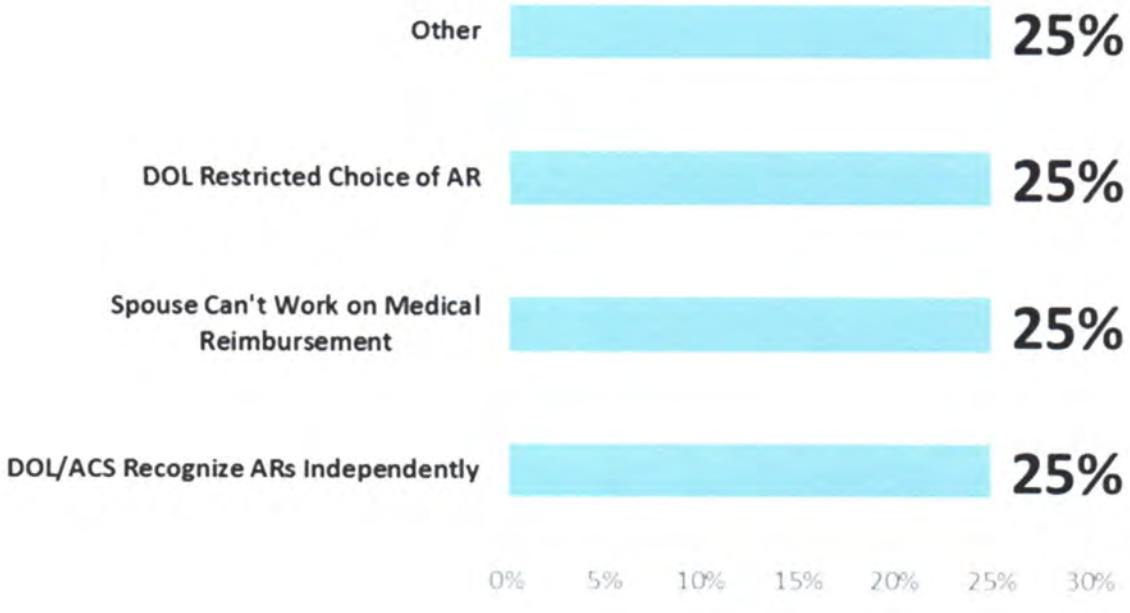
Do You have an Authorized Representative?

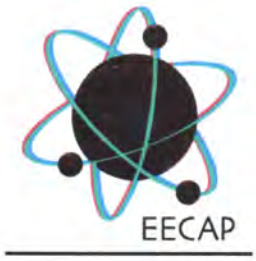


Who did You Choose as Your Authorized Representative?

Have Your Problems with Your Authorized Representative been Resolved Satisfactorily?

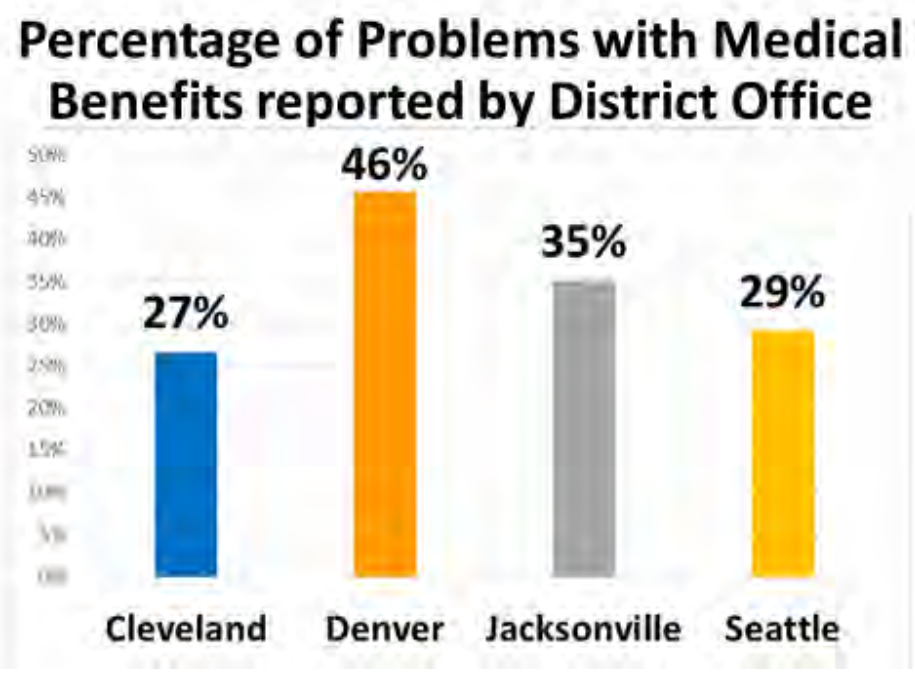
Problems Claimants report with Authorized Representatives in Regards to Medical Benefits

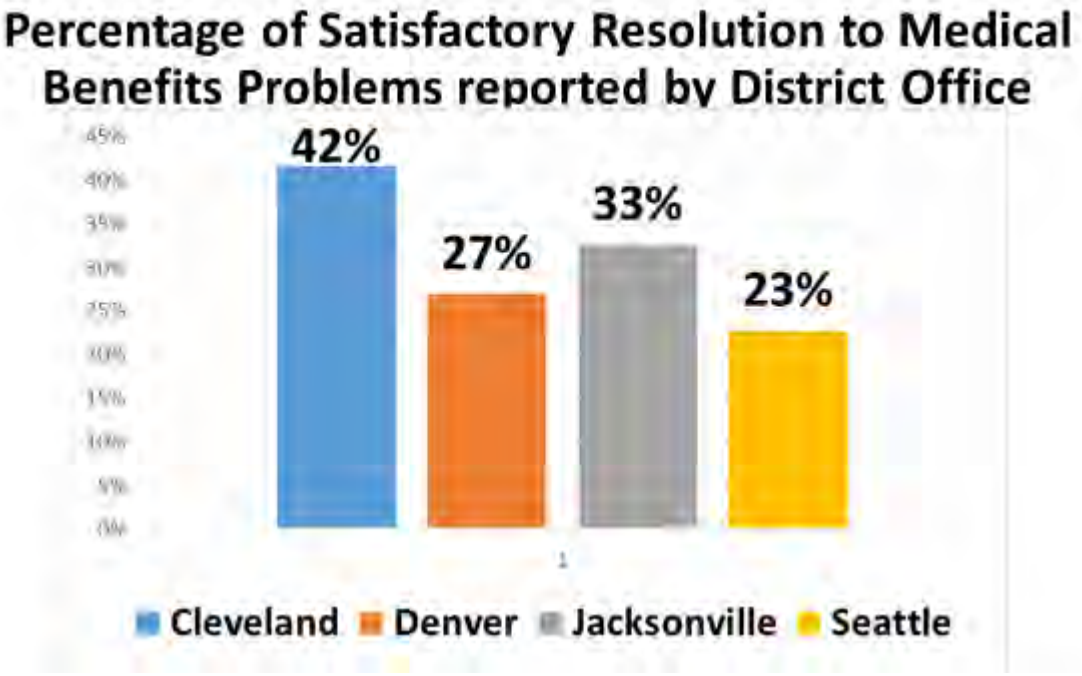




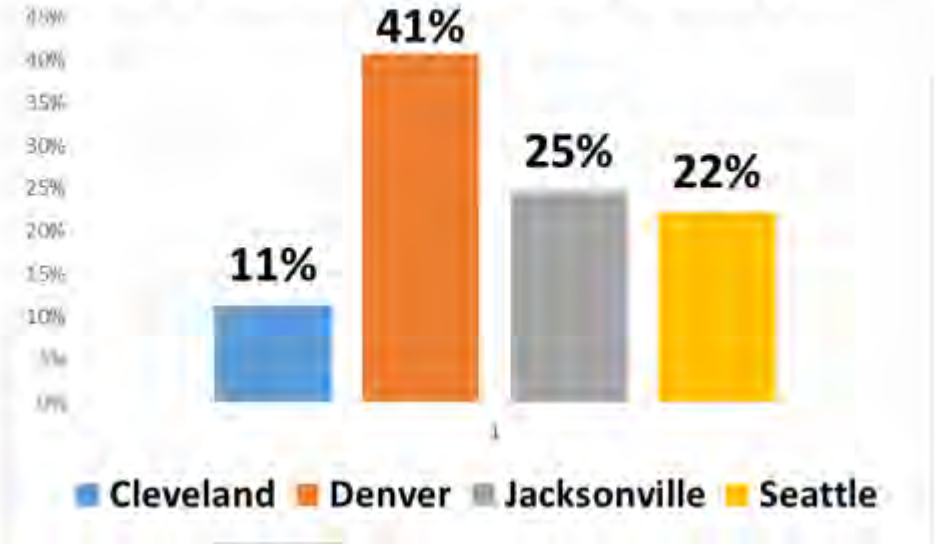
Problems Claimants report with Authorized Representative and EEOICPA Medical Benefits

1. DOL WOULD REFER HER TO AS AND ACS WOULD NOT RECOGNIZE HER AS MY REPRESENTATIVE.
2. Since we already have an authorized representative from the claims process, DOL will not allow anybody else (spouse) deal with them on any reimbursement claims.
3. the home health aide company has someone that has helped in that past they have been told they can no longer do this because of "conflict of interest"
4. NO ONE

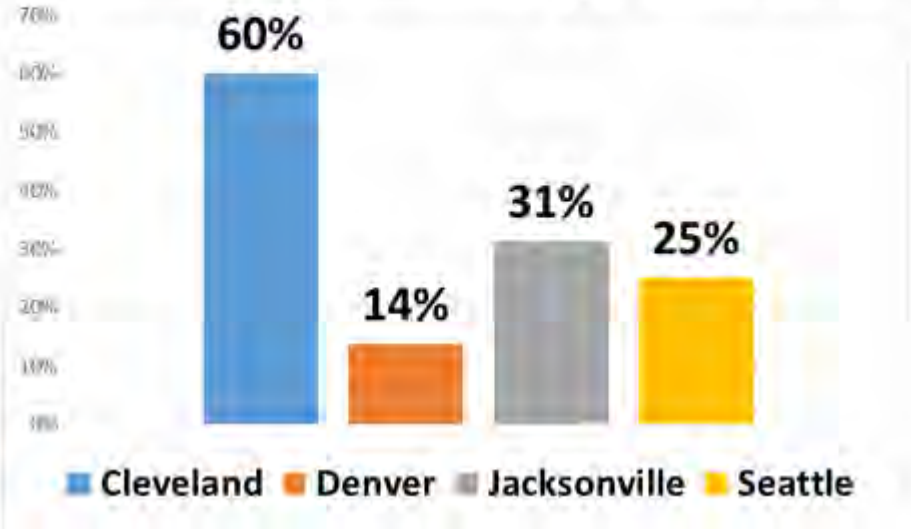

Percentage of Problems with Medical Benefits reported by District Office
46%
35%
29%
27%
Cleveland
Denver
Jacksonville
Seattle

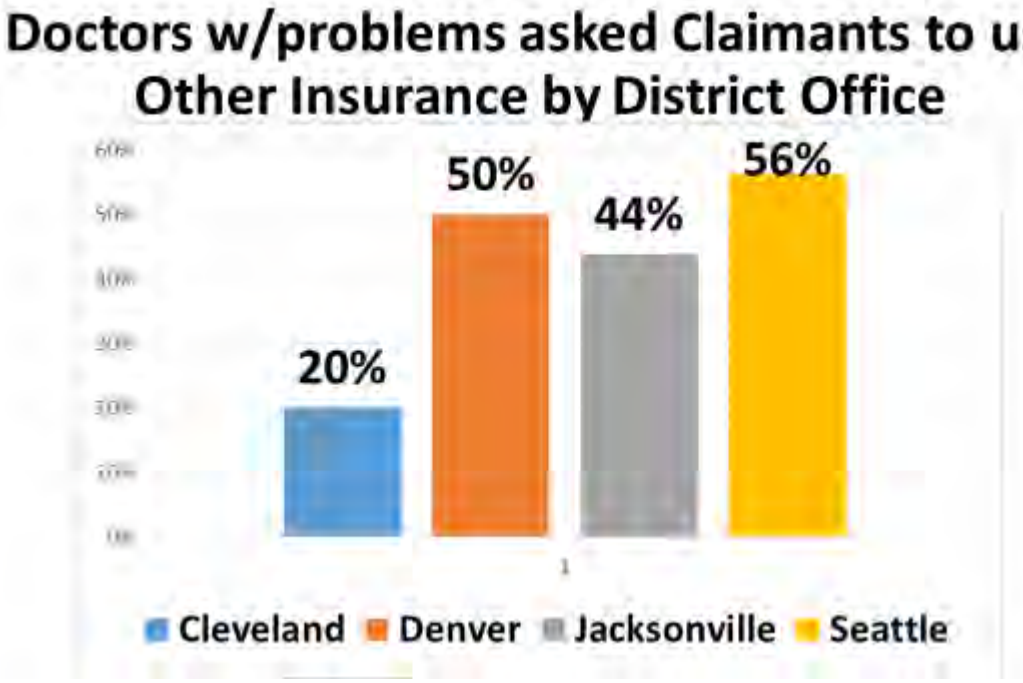

Percentage of Satisfactory Resolution to Medical Benefits Problems reported by District Office
42%
27%
33%
23%
Cleveland
Denver
Jacksonville
Seattle

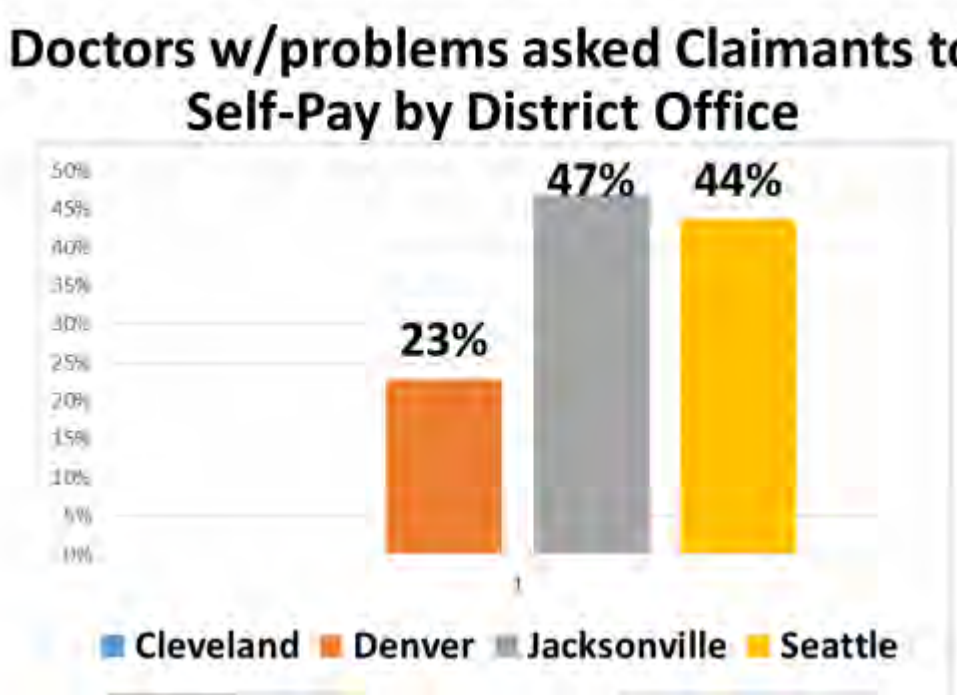
Percentage of Doctors reporting Problems to Claimants by District Office



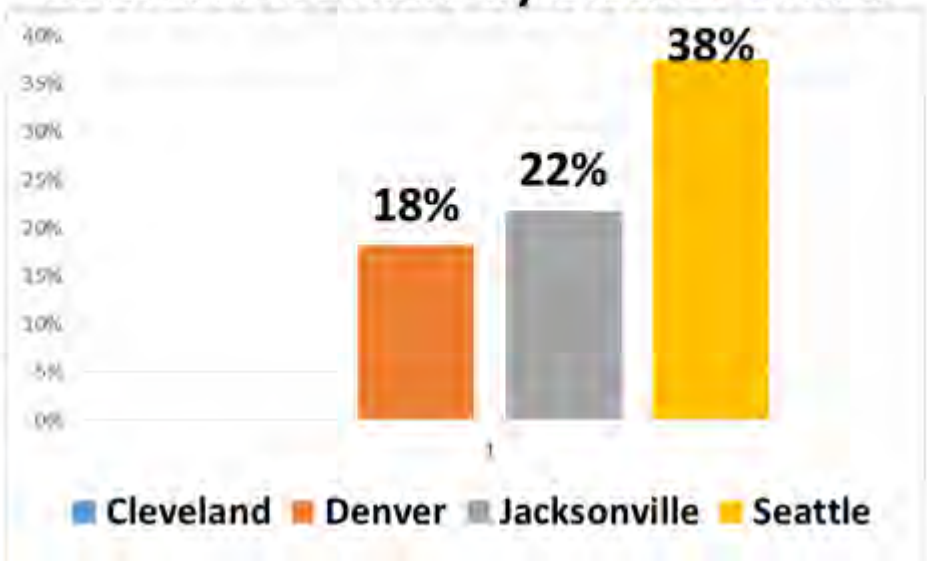
Percentage of Doctors reporting Satisfactory Resolution to Problems by District Office



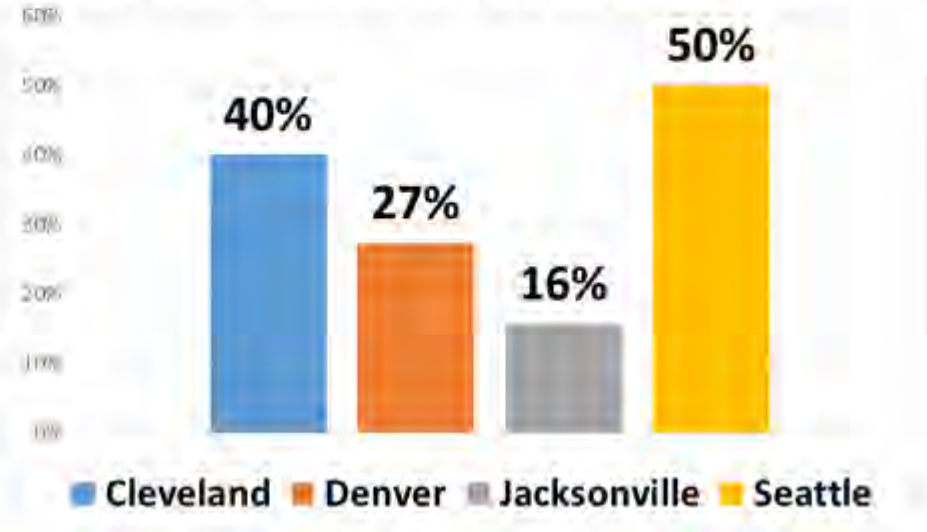

Doctors w/problems asked Claimants to use Other Insurance by District Office
20%
50%
44%
56%
Cleveland
Denver
Jacksonville
Seattle

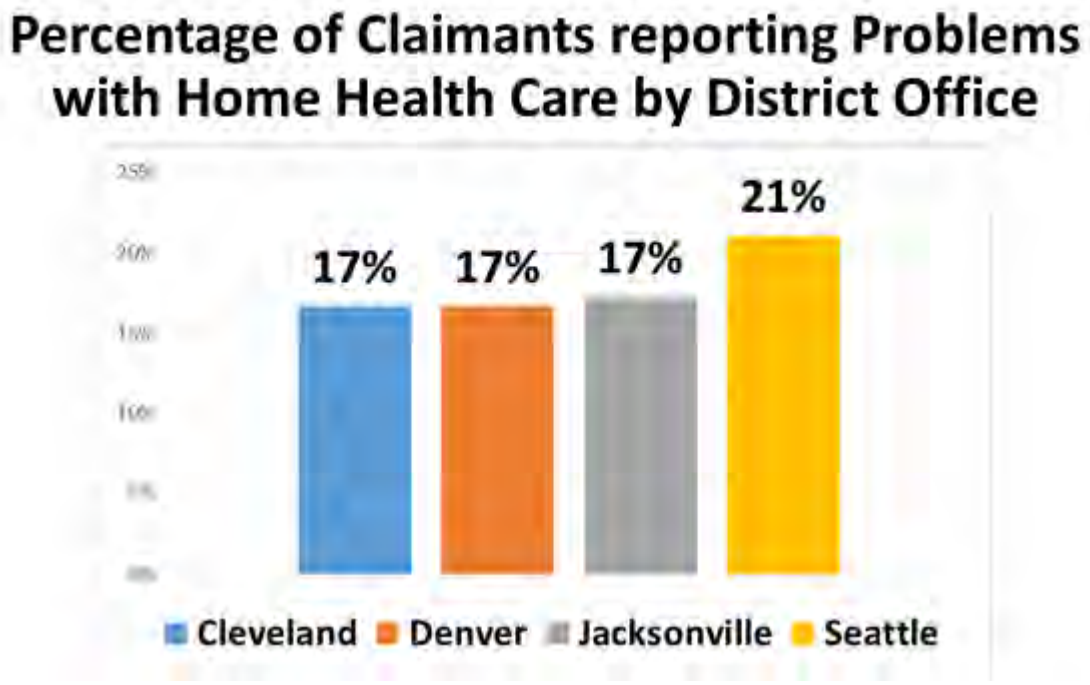

Doctors w/problems asked Claimants to Self-Pay by District Office
23%
47%
44%
Cleveland
Denver
Jacksonville
Seattle

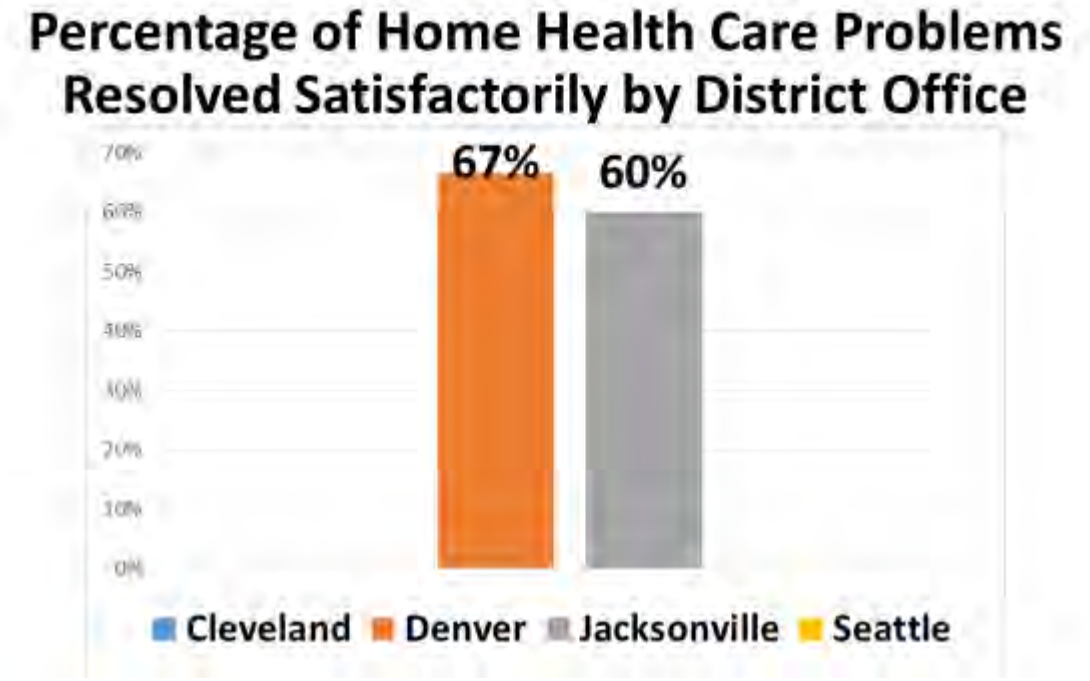
Doctors w/problems Who Stopped taking EEOICPA Workers by District Office



Doctors w/problems Who are Still working with DOL to Resolve Problems by District Office







When no bar is shown the percentage is zero.