AR-1

Accountability Review Findings

Dates of Review: July 15, 2013 – July 19, 2013

Office Reviewed: Seattle District Office

Reviewing Office: Branch of Policy, Regulations and Procedures

Review Period: June 1, 2012 – May 31, 2013

Standard:	Category #: 1 Category Name: Part B Initial Claims

Sample Size (total # of indicators in the element that were reviewed):	579
Number of cases reviewed:	46
Number of errors in element:	12
Acceptable rating:	85%
Rating for review:	98%

Describe Findings:

Overall, the Part B initial claims were well developed by the district office. The district office consistently and quickly reviewed cancer claims for potential SEC inclusion. Reviewers found cases where development letters were sent to claimants advising why their claims were not being considered for SEC inclusion. While this was not done consistently, AR team found this to be a good practice, especially in cases where claims involving a specified cancer and SEC work location were identified, but did not have the required 250 work days.

The majority of the development letters were very thorough when advising claimants of the deficiencies in the claim; and advising them of the documentation needed to establish their claims under the Act. However, the AR team found initial development letters in some situations to be somewhat complex, which could prove to be overwhelming to claimants. Some development letters could have been tailored to more closely address the evidentiary deficiency. In some cases, the development letters included information not pertinent to the file; or discussed duplicative information. Also, the development letters should refrain from stating that a particular illness is a "covered" occupational illness under Part B of the Act. While the AR team understood what this statement is attempting to convey (i.e. the condition is claimable), the claimant could interpret this

statement to mean that their claimed condition is being accepted. Also, in some cases, 2nd request development letters were just a resubmission of the original letter. This also could be confusing and frustrating for claimants, especially if some of the originally requested documentation had been submitted.

The reviewers found the recommended decisions to be well written overall. The Seattle district office did a good job of remembering their audience when writing decisions; making sure the decisions used language that was easy to understand. The introductory paragraphs and cover letters accurately described what was being accepted, denied or deferred. The statement of cases accurately described relevant v. irrelevant case evidence; and generally were written in a concise and logical order. The reviewers found the explanation of findings in some situations to simply be a regurgitation of the statement of case; instead of providing a narrative that clearly and accurately communicated the interpretative analysis of the findings of the writer. The conclusions of law generally included a clear and concise statement of claim acceptance, denial or deferral.

For the most part, the reviewed cases were free from errors that could result in an incorrect conclusion. However, the following errors were found:

- [redacted] It appears the claim was denied due to insufficient evidence establishing a diagnosis of cancer. The file did contain a death certificate, which listed liver cancer as a cause of death. There is no explanation of why the death certificate was not used as proof of diagnosis. If death certificate had been used, the case should have been developed for Hanford SEC inclusion or NIOSH review. Also, the reviewer found that there was no development action to the National Cancer Registry initiated, which could have been beneficial in obtaining medical evidence.

- [redacted] The claimed conditions were colon cancer, secondary melanoma of the bowel, BCC of the nape of neck, BCC or SCC of right ear, SCC of the left clavicle. By letter dated 12/12/12, the claimant's attorney withdrew the claims for skin cancers in order to expedite the recommended decision for colon cancer and inclusion into the SEC class. The statement of case clearly states that the attorney withdrew all claimed conditions (except colon cancer), which is not the case. Therefore, the claimed condition of secondary melanoma of the bowel still needs to be addressed.

- [redacted] This is a survivor claim involving two children of the employee. On the EE-2's, both claimants identified several deceased children of the employee. The district office developed the claim appropriately and obtained death certificates for all of the decedents. However, the recommended decision is silent on this matter. The recommended decision should have included the development of all potential survivors explaining why these two are the sole remaining eligible survivors of the employee. Also, the explanation of findings state that the medical evidence of record establishes a diagnosis of cancer. This is not a correct statement, as there was no medical documentation submitted with the initial filing. The district office used the death certificate to establish a cancer diagnosis.

- [redacted] While not identified as errors in this category, the reviewer found issues in the Part E development of this claim. The recommended decision did not address AWE eligibility or advise claimant why Part E did not apply in this case. The reviewer noted that this should have been a partial acceptance/partial denial recommendation.

- [redacted] Initial development letter provided information for cancer claims. However, cancer was not a claimed condition in this case.

- [redacted] A 6/15/12 development letter says there is no medical evidence to document an asthma or COPD diagnosis, but goes on to describe establishing medical evidence involving cancer, which the claimant never claimed.

- [redacted] The 6/15/12 development has entire section discussing inclusion into the SEC, but the claimed employment at Hanford didn't begin until 2001, which is well past the Hanford SEC timeframes.

Improvements Since Last Accountability Review:

Other Significant Findings:

REVIEWER(s):	DATE:
Tonya Fields, Tina Smith, Catherine Carter, Janie Hogan, Evelyn Yates, Tony Schwiefert, Quanah Jackson, John Vance	7/18/13

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Accountability Review Findings

Dates of Review: July 16, 2013 – July 19, 2013

Office Reviewed: Seattle District Office

Reviewing Office: Policy Regulations and Procedures

Review Period: June 1, 2012 – May 31, 2013

Standard:	Category #: 2 Category Name: Part E - Causation Claims

Sample Size (total # of indicators in the element that were reviewed):	490
Number of cases reviewed:	44
Number of errors in element:	63
Acceptable rating:	85%
Rating for review:	86%

Describe Findings:

Overall, the findings of the Accountability Review found that Claims Examiners conducted good development and analysis of causation. Development letters provided good information regarding what evidence was needed to resolve causation issues and recommended decisions were well written.

Some of the information provided in the development letters was not always relevant to Part E. Letters will include information that explains Part B requirements and discuss claims for cancer when the case is only a Part E claim and no cancers or Part B conditions have been claimed. Some recommended decisions ([redacted]) are still using an exhaustive list of conclusions of law instead of making a clear and concise statement regarding what is accepted and/or denied. One recommended decision ([redacted]) provided information that was not relevant to the outcome of the case. Case was being accepted based on a POC over 50%, however; there was discussion of SEC and how the case did not meet the criteria.

Not all program resources are being explored before making a causation determination. Even though a case may be unlikely to be compensable, all evidence sources should be utilized to explain

a negative determination. In case ([redacted]) DAR was not requested and in case ([redacted]) DAR was requested but not obtained before making the determination. The recommended decisions leave the impression that we are relying on SEM to make our determinations when SEM is just part of the analysis. The recommended decisions explain and go into detail the use and results of SEM but do not explain the use and/or results of the OHQ or DAR. There are times when the exposure evidence is contradictory from what is established by SEM and from the information provided in the OHQ or DAR records and there is no attempt to resolve the discrepancy through further development. In one case ([redacted]) the employee provided information in the OHQ regarding his work around burning yard waste, disassembly of computers, and delivering sheet rock but there was no further investigation as to the report exposures. In one case ([redacted]), the exposures were derived from SEM but the evidence in the DAR was contradictory as it stated the employee was not exposed to some of the toxins listed.

SEM searches are not always appropriately filtered. SEM is run on condition but not always filtered correctly on job categories or filtered further in accordance with policy. An exhaustive list is often provided to the CMC when referring for a medical opinion on causation. In case ([redacted]) it is not clear how the labor category of technician was chosen for the SEM search because the title does not seem to align with the DOE reported job categories.

Cases involving asthma ([redacted]) were not developed in accordance with appropriate policy. There is no additional development to determine the type of asthma that has been diagnosed to determine the most appropriate SEM search. SEM searches are not further filtered based on building and cross referenced to further narrow the list of numerous substances that could be listed for these conditions.

In several cases, the CMC made the exposure determination and offered opinions based on their own assessments of the level of exposure or lack thereof. There was no attempt to clarify the level of exposure so an accurate medical opinion could be obtained. In case ([redacted]) the Claims Examiner made a finding that the employee was exposed to cement and the CMC opined that the exposure would have been low and there was further development to resolve the discrepancy. In case ([redacted]) the CMC made his opinion based on his assumption that the employee had significant exposure to the toxins listed in the SOAF.

Improvements Since Last Accountability Review:

Other Significant Findings:

There is no exposure analysis being performed regarding nature, extent, and duration. Any toxin listed in SEM is being taken as confirmed exposure and being sent the CMC for opinion. The CMC will at times make a determination as to extent and duration. While it was determined that this was not an error for the AR, it is clearly an issue for further discussion.

REVIEWER(s):	DATE:
Tonya Fields, Tina Smith, Catherine Carter, Janie Hogan, Evelyn Yates, Tony Schwiefert, Quanah Jackson, John Vance	July 16-18, 2013

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Accountability Review Findings

Dates of Review: 06.16.2013 to 06.19.2013

Office Reviewed: SEATTLE

Reviewing Office: Branch of Policy, Regulations and Procedures

Review Period: 06.01.2012 to 05.31.2013

Standard:	Category #: 3 Category Name: Part E - Impairment Claims

Sample Size (total # of indicators in the element that were reviewed):	423
Number of cases reviewed:	39
Number of errors in element:	3
Acceptable rating:	85%
Rating for review:	99%

Describe Findings:

In summary, the 2013 AR for the Seattle District Office regarding review of Category 3 *Impairment Claims* shows extremely good performance with regard to development and decision writing. There were few errors found during the review/

Reviewers found that in one of the Recommended Decisions ([redacted]), "increased" impairment evaluations need to be emphasized in the Recommended Decision cover letter and Recommended Decision introductory paragraph itself. The Claims Examiner needed to make a distinction between the case being an initial impairment evaluation and "increased" impairment evaluation. In this case, it was a claim for increased impairment claimed by the employee.

Of the cases reviewed, one case ([redacted]) summary for the Statement of the Case cited the incorrect initial date of acceptance of medical conditions under B/E. The Claims Examiner needs to carefully review dates contained within the Recommended Decision to ensure that the correct date of claim acceptance is noted in additional Recommended Decisions.

Additionally, in another case reviewed; the District Office noted in the Statement of the Case ([redacted]) findings that "no evidence of impairment" was found. However, this was an incorrect statement as the evidence of record actually found "no increased impairment".

Improvements Since Last Accountability Review:

Other Significant Findings:

Anonymous Customer survey sentence should be on Recommended Decision cover letter and not on within the Conclusions of Law. "Please review the enclosed Notice of Recommended Decision and Claimant Rights..." should also be removed from Conclusions of Law.

REVIEWER(s):	DATE:
Tonya Fields, Tina Smith, Catherine Carter, Janie Hogan, Evelyn Yates, Tony Schwiefert, Quanah Jackson, John Vance	

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Accountability Review Findings

Dates of Review: July 15-19, 2013

Office Reviewed: Seattle District Office

Reviewing Office: Policy and Regulations Branch

Review Period: June 1, 2012-May 31, 2013

Standard:	Category #: 4 Category Name: Part E - Wage Loss Claims

Sample Size (total # of indicators in the element that were reviewed):	370
Number of cases reviewed:	33
Number of errors in element:	13
Acceptable rating:	85%
Rating for review:	96%

Describe Findings:

The overall review of the findings for wage loss shows the claims examiners are developing the cases timely and they are thoroughly reviewing the medical and employment evidence in determining if loss wages is warranted.

The overall review on the recommended decisions for wage loss shows the claims examiners are writing in a clear and concise manner so that the reader can easily interpret the information. The decisions are well written in a logical order and the claim examiners are thoroughly notating the calculations used in arriving at the award amount.

It is important to note that it is not to be assumed that loss wages will be awarded each subsequent year after the initial loss wage acceptance. Each year of loss wages should be determined based on the employment and medical evidence for the year claimed. The evidence must clearly show a causal link between the accepted illness and the periods of wage loss claimed. The evidence must be of probative value. The claims examiner should review the evidence to determine if the employee's condition has improve which may require a new medical evaluation as it relates to wage

loss. The claims examiner must communicate to the employee/claimant the necessary medical and employment evidence needed to establish a wage loss claim.

Some specific AR findings include:

[redacted]- the claims examiner used medical evidence from 2008 coupled with the fact that the claimant is still receiving ongoing treatment for the accepted illness and accepted the case. There was no referral to a Contract Medical Specialist (CMC) or a letter to the treating physician asking to clarify the link between the employees accepted illness and loss wages for 2012 calendar year.

[redacted]- the claims examiner had no specific evidence to support the request for wage loss benefits, the authorized representative stated they had no evidence to submit regarding loss wages, the records showed the employee was diagnosed the first quarter of 1971 and he still earned wages the second and third quarter of that same year. A referral was made to the CMC based on speculation and hear say from the employee's daughter. The CMC contributed loss wages to the accepted illness but no rationalized opinion was provided on the evidence used to reach that conclusion.

Improvements Since Last Accountability Review:

Other Significant Findings:

REVIEWER(s):	DATE:
Tonya Fields, Tina Smith, Catherine Carter, Janie Hogan, Evelyn Yates, Tony Schwiefert, Quanah Jackson, John Vance	07/18/2013

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Accountability Review Findings

Dates of Review: July 15-19, 2013

Office Reviewed: Seattle District Office

Reviewing Office: Branch of Policy Regulations and Procedures

Review Period: June 1, 2012 – May 31, 2013

Standard:	Category #: 5 Category Name: Payment Processing

Sample Size (total # of indicators in the element that were reviewed):	361
Number of cases reviewed:	60
Number of errors in element:	13
Acceptable rating:	85%
Rating for review:	96%

Describe Findings:

Overall the Seattle District Office did a good job with processing their payments accurately. Specifically, the AR Team did not find any errors in the completion of the Payment Transaction Form (PTF).

The most significant trend noted by the AR Team for this category was that memos were not placed in the file when clarification was needed. Whenever there's a discrepancy with an EN-20, especially if one is being replaced by another, there needs to be a memo in the file documenting the chronology of events that has taken place in order to process the corrected EN-20.

The AR Team found that half the errors for this category pertained to the phone number on the EN-20 not matching the phone number in ECS. Although the problem was possibly rectified, a memo to file should be used when the phone numbers do not match.

The AR Team also found a couple of errors in this category pertaining to the AOP received date on the EN-20 not matching the AOP received date in ECS. Specifically an EN-20 for file number 462-38-7950 was received on 6/28/12 and again on 7/5/12 (there was not a letter in the file explaining

why a 2nd EN-20 was requested), the AOP date in ECS was 7/9/12 (the date the District Office received verification from the bank that the account information was correct on the EN-20 that was received on 6/28/12) Although there was a memo in the file explaining that there was a problem with the account number on the EN-20 received on 7/5/12, and stated that the EN-20 received on 6/28/12 banking account information is correct, the memo did not explain why the EN-20 dated 6/28/12 was not originally used. In this instance a letter should have been sent to the claimant and placed in file explaining why a new EN-20 was needed. Also the memo on file should clearly address all the deficiencies noting why there were multiple EN-20's.

For file number [redacted], the AR Team noted that upon receipt of the EN-20 there was a phone message in the file to the claimant's bank, indicating that the account number was incorrect. The District Office received a new a new EN-20, however, there was not a phone message in the file verifying the claimant's account information based on the new EN-20.

Improvements Since Last Accountability Review:

Other Significant Findings:

REVIEWER(s):	DATE:
Tonya Fields, Tina Smith, Catherine Carter, Janie Hogan, Evelyn Yates, Tony Schwiefert, Quanah Jackson, John Vance	July 16-18, 2013

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Accountability Review Findings

Dates of Review: July 15, 2013- July 19, 2013

Office Reviewed: Seattle District Office

Reviewing Office: Branch of Policy, Regulations, and Procedures

Review Period: June 1, 2012- May 31, 2013

Standard:	Category #: 6 Category Name: Reopening Requests

Sample Size (total # of indicators in the element that were reviewed):	119
Number of cases reviewed:	20
Number of errors in element:	10
Acceptable rating:	85%
Rating for review:	91

Describe Findings:

For this category, the Accountability Review team reviewed cases with reopening requests received by and resolved by the district office within the AR period. In general, responses to reopening requests, whether as Director's Orders or Denials of Reopening Request, were found to be good work products and decision outcomes were appropriate based materials submitted and circumstances of the respective cases. The most significant trend noted was that Director's Orders and Denials of Reopening Request sometimes lacked a good explanation of the rationale used to explain the applicable outcome, whether to reopen the claim or deny the reopening request. Of the reopening request indicators that were found to be in error, the review team noted the following:

- [redacted] The Director's Order was found to be undated and unsigned, and, thus, the reviewer was unable to conclude that the Director's Order had actually been issued.
- [redacted] The Director's Order was not addressed to all the applicable claimants, as one claimant of a multiple claimant case submitted new evidence that would allow compensation to be paid, and, thus, per program policy, each claimant should have been party to the Director's Order.

- [redacted] The cover sheet of the Director's Order did not make clear on what basis the claim was being reopened; the same Director's Order contained insufficient rationale for the reopening and the evidence used for the reopening was of questionable probative value to support the reopening of the claim.
- [redacted] The Director's Order was found to have insufficient rationale to explain why the claim should be reopened; the explanation provided just says new evidence has been submitted for the different skin cancers, but doesn't provide any specifics. It does not refer to what evidence justifies the reopening.
- [redacted] The Director's Order has a single one sentence line that says that new evidence was received that warrants reopening. No discussion is provided for the justification of why the evidence is sufficient to vacate the prior final decision.
- [redacted] The Director's Order was found to have insufficient rationale to explain why the claim should be reopened; the Director's Order should have contained a brief discussion of the new evidence and how that evidence overcame the reason for the prior denial of CBD under Part B.

Improvements Since Last Accountability Review:

Other Significant Findings:

Cover letters of cases reviewed sometimes lacked the appropriate language regarding delegation of reopening authority; that the Director of DEEOIC has given the District Directors the ability to reopen cases in limited circumstances. Cover letters should include language to that effect moving forward.

Often, claimants are not specific in their reopening requests as to which claim elements they are requesting to be reopened. In the cases reviewed, the Seattle DO exercised good judgment in scrutinizing the specific language of the requests and applying the requests to the appropriate conditions and Part types.

REVIEWER(s):	DATE:
Tonya Fields, Tina Smith, Catherine Carter, Janie Hogan, Evelyn Yates, Tony Schwiefert, Quanah Jackson, John Vance	

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Accountability Review Findings

Dates of Review: 7/15/2013-7/19/13

Office Reviewed: Seattle District Office

Reviewing Office: Branch of Policy Regulations and Procedures

Review Period: 6/1/2012 – 5/31/2013

Standard:	Category #: 7 Category Name: In-Home Health Care Requests

Sample Size (total # of indicators in the element that were reviewed):	123
Number of cases reviewed:	35
Number of errors in element:	5
Acceptable rating:	85%
Rating for review:	96%

Describe Findings:

Overall, the review indicated compliance with all procedures with few exceptions. In general Home Health Care (HHC) authorization requests were addressed in a timely and accurate manner, with all applicable development letters and HHC approval/denial letters documented in the case file. Of the cases that were found to be in error, the reviewers noted the following:

- [redacted] The development letters and decision letter to support the HHC denial were not located in the case file.
- [redacted] The file showed that the Home Health Care was approved based on the examination report and request from a Physician's Assistant (PA). In a phone call to the PA provider the Claims Examiner noted that a PA is not allowable without an exception. There was no explanation of an exception provided in the case file, however the HHC was approved. Weeks later a physician submitted a request for the same time period verifying the need for HHC.

Improvements Since Last Accountability Review:

Other Significant Findings:

Notable was the response to an acceptance and communication from the Final Adjudication Branch (FAB) that an imminently terminal employee was in immediate need of care. Upon receipt of this information the District Office approved HHC. In addition, the employee quickly received an award for impairment compensation

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