Division of Energy Employees Occupational Illness Compensation (DEEOIC)

Office of Workers' Compensation Programs

EEOICPA Procedure Manual

Transmittals

RELEASE – REVISION TO PART 0 OVERVIEW, FEDERAL (EEOICPA) PROCEDURE MANUAL

EEOICPA TRANSMITTAL NO. 09-01 November, 2008

EXPLANATION OF MATERIAL TRANSMITTED:

This material is issued as procedural guidance to update and revise the text of each Chapter within the Energy Employees Occupational Illness Compensation Program Act (EEOICPA) PM Part 0 Overview, which includes the following Chapters: 0-0100 Introduction; 0-0200 General Provisions of EEOICPA; 0-0300 Customer Service; 0-0400 Program Directives; and 0-0500 Definitions.

The revision of PM Part 0 incorporates the consolidation of updated information and guidance as it pertains to the Program's administration of Part B and Part E of the EEOICPA.

Rachel P. Leiton

Rachel P. Leiton

Director, Division of

Energy Employees Occupational Illness Compensation

FILING INSTRUCTIONS:

Insert New Pages

Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages
0	Outline	i	0	Outline	i
0	0100	i-6, Exhibit 1	0	0100	i-10, Exhibit 1
0	0200	i-4	0	0200	i-4
0	0300	i-3	0	0400	i-3

0	0400	i-3	0	0300	i-5
0	0500	i-12	0	0500	i-16, Exhibits 1-2
E	E-100	i-5	0	0500	i-16, Exhibits 1-2

File this transmittal behind EEOICPA Transmittal 06-10 in the front of the Federal (EEOICPA) Procedure Manual.

Distribution: List No. 3: All DEEOIC Employees

List No. 6: Regional Directors, District Directors, Assistant District Directors, National Office Staff, and Resource Center

RELEASE – REVISION TO PART 1 MAIL AND FILES, FEDERAL (EEOICPA) PROCEDURE MANUAL

EEOICPA TRANSMITTAL NO. 09-02 April 2009

EXPLANATION OF MATERIAL TRANSMITTED:

This material is issued as procedural guidance to update and revise the text of EEOICPA PART B Procedure Manual (PM) Part 1 Mail and Files, which includes the following Chapters: 1-0100 Introduction; 1-0200 Processing Mail; 1-0300 Case Creation; 1-0400 Case Maintenance; and 1-0500 Transfers and Loans.

The revision provides a unified PM Part 1 which incorporates the consolidation of updated information and guidance as it pertains to the Program's administration of Part B and Part E of the EEOICPA. This material is to be filed in the new Unified Procedure Manual binder.

Rachel P. Leiton

Rachel P. Leiton

Director, Division of

Energy Employees Occupational Illness Compensation

FILING INSTRUCTIONS:

File this transmittal behind Part 0 in the front of the new Unified Federal (EEOICPA) Procedure Manual.

Distribution: List No. 3: All DEEOIC Employees

List No. 6: Regional Directors, District Directors, Assistant District Directors, National Office Staff, and Resource Center Staff.

RELEASE – TRANSMISSION OF REVISED MATERIAL TO BE INCORPORATED INTO

THE FEDERAL (EEOICPA) PROCEDURE MANUAL: CHAPTER 2-1100 ELIGIBILITY REQUIREMENTS FOR CERTAIN URANIUM WORKERS.

EEOICPA TRANSMITTAL NO.09-03 May, 2009

EXPLANATION OF MATERIAL TRANSMITTED:

This material is issued as procedural guidance to update and revise the Chapter on Eligibility Requirements for Certain Uranium Workers. This material is transmitted for use in accordance with the existing Federal (EEOICPA) Procedure Manual (PM) and replaces Chapters 2-0900 and E-700. This material is to be placed in the new unified PM binder.

PM Chapter 2-1100 Eligibility Requirements for Certain Uranium Workers is being revised and updated for use as procedural guidance to:

· Combine administration of Parts B and E for uranium claims filed under the EEOICPA.

· Define the Radiation Exposure Compensation Act (RECA) and the role the law plays in developing and adjudicating claims under the EEOICPA.

· Explain how the Division of Energy Employees Occupational Illness Compensation (DEEOIC) identifies a uranium worker claim.

· Explain how DEEOIC communicates with Department of Justice (DOJ) and the role DOJ plays in case file development.

· Explain how evidence is weighed and developed for covered employment and to provide an explanation of the role of the Site Exposure Matrices (SEM) in causation and employment development.

· Explain how RECA Section 4 claims are identified.

· Explain how DEEOIC evaluates RECA Section 4 claims and the instances where a RECA Section 4 claimant might be eligible for benefits under the EEOICPA.

Rachel P. Leiton

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Director, Division of

Energy Employees Occupational Illness Compensation

FILING INSTRUCTIONS:

File this transmittal behind Part 1 in the front of the new u/-+ied Federal (EEOICPA) Procedure Manual.

Distribution: List No. 3: All DEEOIC Employees

List No. 6: Regional Directors, District Directors, Assistant District Directors, National Office Staff, and Resource Center Staff.

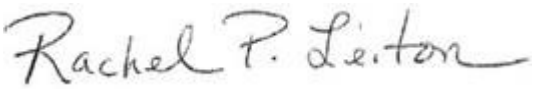
RELEASE – PART 2-1300 Impairment Ratings, FEDERAL (EEOICPA) PROCEDURE MANUAL

EEOICPA TRANSMITTAL NO. 09-04 May, 2009

EXPLANATION OF MATERIAL TRANSMITTED:

This material is issued as procedural guidance to update, revise and replace the text of EEOICPA Part E Procedure Manual (PM) E-900 Impairment Ratings. This material is to be placed in the new Unified PM binder and is intended to stand as policy guidance for both Parts of the EEOICPA.

- This material streamlines the impairment rating process and eliminates the two option process originally implemented at the inception of Part E.
- This material is designed to expedite the impairment rating process and improve customer service.
- This material provides detailed guidance regarding the handling of new claims for impairment and evaluating metastatic bone cancer claims.
- This material provides new letters for use by Claims Examiners (CEs) in developing impairment claims.



Rachel P. Leiton

Director, Division of

Energy Employees Occupational Illness Compensation

FILING INSTRUCTIONS:

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Distribution: List No. 3: All DEEOIC Employees

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RELEASE – PART 2-1400 WAGE-LOSS DETERMINATIONS, FEDERAL (EEOICPA) PROCEDURE MANUAL

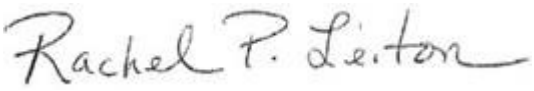
EEOICPA TRANSMITTAL NO. 09-05 July, 2009

EXPLANATION OF MATERIAL TRANSMITTED:

This material is issued as procedural guidance to update, revise and replace the text of EEOICPA Part E Procedure Manual (PM) E-800 Wage-

Loss Determinations. This material is to be placed in the new Unified PM binder and is intended to stand as policy guidance for both Parts of the EEOICPA.

- This material streamlines the wage-loss determination process by conferring authority to obtain Social Security wage and earning data from the Social Security Administration to the District Offices.
- This material explains the role of the Resource Centers in educating and soliciting wage-loss claims from claimants.
- This material provides new letters for use by Claims Examiners (CEs) in developing wage-loss claims. It also simplifies the Wage-Loss Worksheets in calculating the Average Annual Wage and determining the percentage of wage-loss and award amount.
- This material explains the Wage-Loss Calculator in ECMS and its preferred role in calculating wage-loss benefits.



Rachel P. Leiton

Director, Division of

Energy Employees Occupational Illness Compensation

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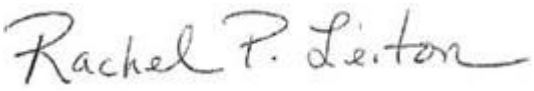
RELEASE – TRANSMISSION OF REVISED MATERIAL TO BE INCORPORATED INTO THE FEDERAL (EEOICPA) PROCEDURE MANUAL: CHAPTER 2-0400 REPRESENTATIVE SERVICES.

EEOICPA TRANSMITTAL NO.09-06 August, 2009

EXPLANATION OF MATERIAL TRANSMITTED:

- This material is to be transmitted for placement in the new Unified Procedure Manual(PM) binder.
- This material fully replaces Chapter 2-1200 Representative Services.
- This material incorporates the consolidation of updated information and guidance as it pertains to the Program's

administration of Parts B and E of the EEOICPA.



Rachel P. Leiton

Director, Division of

Energy Employees Occupational Illness Compensation

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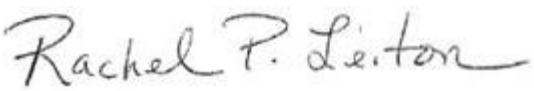
RELEASE – TRANSMISSION OF REVISED MATERIAL TO BE INCORPORATED INTO THE FEDERAL (EEOICPA) PROCEDURE MANUAL: 2-1200 ESTABLISHING SURVIVORSHIP

EEOICPA TRANSMITTAL NO. 09-07 August, 2009

EXPLANATION OF MATERIAL TRANSMITTED:

PM Chapter 2-1200 has been revised to:

- Be placed in the new Unified Procedure Manual binder, replacing chapters 2-0200 and E-600.
- Merge both Parts B and E of the EEOICPA regarding survivorship into this chapter.
- Incorporate new policy into existing sections of this chapter. Of particular note, section 5(c) provides the definition of a "child" as it applies to both Parts B and E of the EEOICPA.
- Added section 10 (Survivor Compensation, Part E)
- Added section 11 (Maximum Aggregate Compensation, Part E)
- Added section 12 (Alternative to Filing a Survivor Claim, Part E)
- Revised Exhibit 1 to include Part E policy.



Rachel P. Leiton

Director, Division of

Energy Employees Occupational Illness Compensation

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RELEASE – TRANSMISSION OF REVISED MATERIAL TO BE INCORPORATED INTO THE FEDERAL (EEOICPA) PROCEDURE MANUAL: CHAPTER 3-0500 COORDINATING STATE WORKERS' COMPENSATION BENEFITS.

EEOICPA TRANSMITTAL NO.09-08 August, 2009

EXPLANATION OF MATERIAL TRANSMITTED:

- This material is to be transmitted for placement in the new Unified Procedure Manual(PM) binder.
- This material incorporates updated information and guidance for handling claims in which the claimant had filed a state workers' compensation claim and its effect on Part E benefits.
- This material provides updated guidance on obtaining signed response (affidavit) regarding a state workers' compensation claim, lawsuit and fraud.
- This material clarifies when coordination is not required and includes a Do Not Coordinate Table for easy reference.
- This material incorporates updated procedures on tracking surplus due to coordination of benefits.

Rachel P. Leiton

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Director, Division of

Energy Employees Occupational Illness Compensation

FILING INSTRUCTIONS:

File this transmittal behind Part 2 of the new Unified Federal (EEOICPA) Procedure Manual.

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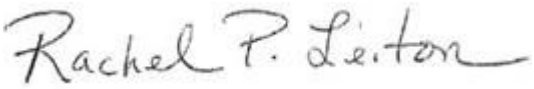
RELEASE – PART 3-0700 Post-Award Administration, FEDERAL (EEOICPA) PROCEDURE MANUAL

EEOICPA TRANSMITTAL NO. 09-09 September, 2009

EXPLANATION OF MATERIAL TRANSMITTED:

This material is issued as procedural guidance to update, revise and replace the text of EEOICPA Part E Procedure Manual (PM) E-1000 State Workers' Compensation. This material is to be placed in the new Unified PM binder and is intended to stand as policy guidance for both Parts of the EEOICPA.

- This material provides instructions to Claims Examiners (CEs) for use in Part E cases that have been approved for benefits.
- This material describes the actions taken by the National Office (NO) to ensure that payment of medical benefits to covered Part E employees is fully coordinated with any state workers' compensation benefits received by those employees or their survivors.



Rachel P. Leiton

Director, Division of

Energy Employees Occupational Illness Compensation

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RELEASE – TRANSMISSION OF REVISED MATERIAL TO BE INCORPORATED INTO THE FEDERAL (EEOICPA) PROCEDURE MANUAL: CHAPTER 3-0400 TORT ACTION AND ELECTION OF REMEDIES.

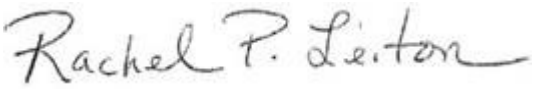
EEOICPA TRANSMITTAL NO.09-10 September, 2009

EXPLANATION OF MATERIAL TRANSMITTED:

- This material is to be transmitted for placement in the new Unified Procedure Manual(PM) binder.
- This material incorporates updated information and guidance for handling claims in which the claimant has filed a tort lawsuit.

It provides guidance to determine if election of remedies or tort offset is required due to a tort lawsuit.

- This material provides updated guidance on obtaining a signed response (affidavit) regarding a lawsuit, state workers' compensation claim, and fraud.
- This material incorporates updated procedures on tracking surplus due to a tort offset.



Rachel P. Leiton

Director, Division of

Energy Employees Occupational Illness Compensation

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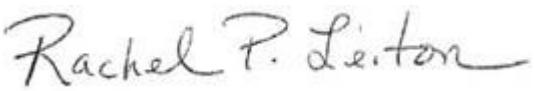
RELEASE – PARTS 3-0800 Overpayment Process AND 3-0900 Debt Liquidation, FEDERAL (EEOICPA) PROCEDURE MANUAL

EEOICPA TRANSMITTAL NO. 10-01 October, 2009

EXPLANATION OF MATERIAL TRANSMITTED:

This material is issued as procedural guidance to be included in the Federal (EEOICPA) Procedure Manual. This material is to be placed in the new Unified PM binder and is intended to stand as policy guidance for both Parts of the EEOICPA.

- This material describes functions that are solely the responsibility of the National Office (NO) for identifying and resolving overpayments, including steps necessary for recovery of debt.



Rachel P. Leiton

Director, Division of

Energy Employees Occupational Illness Compensation

FILING INSTRUCTIONS:

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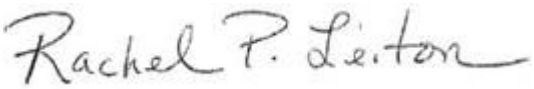
RELEASE – TRANSMISSION OF REVISED MATERIAL TO BE INCORPORATED INTO THE FEDERAL (EEOICPA) PROCEDURE MANUAL: CHAPTER 2-1600 RECOMMENDED DECISIONS, CHAPTER 2-1700 FAB REVIEW PROCESS, CHAPTER 2-1800 FAB DECISIONS, AND CHAPTER 2-1900 REOPENING PROCESS.

EEOICPA TRANSMITTAL NO.10-02 October, 2009

EXPLANATION OF MATERIAL TRANSMITTED:

- These four chapters are transmitted for placement in the new Unified Procedure Manual(PM) binder. These chapters consist of the consolidation of updated information and guidance as it pertains to the Program's administration of Parts B and E of the EEOICPA.
- New chapter 2-1600 replaces Part B chapter 2-1100, new chapters 2-1700 and 2-1800 replace Part B chapter 2-1300 and Part E chapter E-1100, and new chapter 2-1900 replaces Part B chapter 2-1400.
- These chapters incorporate changes that have arisen since last publication of the PM, including the following:
  - Chapter 2-1600 has been revised to clearly instruct claims staff to issue recommended decisions to all parties of a claim.
  - Chapter 2-1800 instructs FAB staff to issue Final decisions to all parties to a claim.
  - Chapter 2-1900 instructs claims staff to issue reopening decisions to all parties to a claim.
  - Chapter 2-1900 incorporates procedures from Bulletin 09-01, delegating authority to District Directors to reopen certain claims.



Rachel P. Leiton

Director, Division of

Energy Employees Occupational Illness Compensation

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File this transmittal behind Part 1 in the front of the new Unified Federal (EEOICPA) Procedure Manual.

Distribution: List No. 3: All DEEOIC Employees

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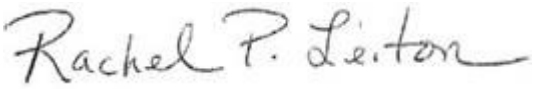
RELEASE – PART 3-0600 Compensation Payments, FEDERAL (EEOICPA) PROCEDURE MANUAL

EEOICPA TRANSMITTAL NO. 10-04 October, 2009

EXPLANATION OF MATERIAL TRANSMITTED:

This material is issued as procedural guidance to be included in the Federal (EEOICPA) Procedure Manual. This material is to be placed in the new Unified PM binder and is intended to stand as policy guidance for both Parts of the EEOICPA.

- This material provides instructions to claims staff in the district offices and FAB on processing compensation payments, and defines the roles of the various staff involved in the payment process.



Rachel P. Leiton

Director, Division of

Energy Employees Occupational Illness Compensation

FILING INSTRUCTIONS:

File this transmittal behind Part 2 in the front of the new Unified Federal (EEOICPA) Procedure Manual.

Distribution: List No. 3: All DEEOIC Employees

List No. 6: Regional Directors, District Directors, Assistant District Directors, National Office Staff, and Resource Center Staff.

RELEASE – TRANSMISSION OF REVISED MATERIAL TO BE INCORPORATED INTO THE FEDERAL (EEOICPA) PROCEDURE MANUAL: CHAPTER 2-1000 NON-CANCEROUS CONDITIONS.

EEOICPA TRANSMITTAL NO. 10-05 October 2009

EXPLANATION OF MATERIAL TRANSMITTED:

This material is issued as procedural guidance to update, revise and replace portions of the text of EEOICPA Part E Procedure Manual (PM) E-500 Evidentiary Requirements for Causation, and 2-0700 Eligibility Criteria for Beryllium Illness and 2-0800 Eligibility Criteria for Silicosis in their entirety. This material is to be placed in the new Unified PM binder and is intended to stand as policy guidance for both Parts of the EEOICPA.

- This material revises the requirements for demonstrating Chronic Beryllium Disease, and clarifies that satisfaction of either the pre-1993 or post-1993 is sufficient to allow for a diagnosis of CBD under the EEOICPA.

Rachel P. Leiton

Rachel P. Leiton

Director, Division of

Energy Employees Occupational Illness Compensation

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FILING INSTRUCTIONS:

Insert New Pages

Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages
E	500	55-73	2	1000	i-32
Exhibits 1-2			Exhibits 1-2		
2	700	i-11			
2	800	i-1			

Replace Federal (EEOICPA) Procedure Manual Chapters E-500, 2-0700, and 2-0800 with this transmittal and Chapter 2-1000.

Distribution: List No. 3: All DEEOIC Employees

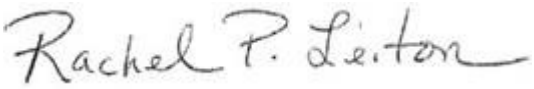
List No. 6: Regional Directors, District Directors, Assistant District Directors, National Office Staff, and Resource Center Staff.

RELEASE – TRANSMISSION OF REVISED MATERIAL TO BE INCORPORATED INTO THE FEDERAL (EEOICPA) PROCEDURE MANUAL: CHAPTER 2-2000 ECMS – GENERAL, and CHAPTER 2-2100 ECMS - DECISIONS.

EEOICPA TRANSMITTAL NO. 10-06 November, 2009

EXPLANATION OF MATERIAL TRANSMITTED:

This material is issued as procedural guidance to update, revise and replace the text of EEOICPA Part B Procedure Manual (PM) 2-1500 Energy Case Management System in its entirety, and all portions of the Part E PM relating to ECMS coding. This material is to be placed in the new Unified PM binder and is intended to stand as policy guidance for both Parts of the EEOICPA.



Rachel P. Leiton

Director, Division of

Energy Employees Occupational Illness Compensation

Replace Federal (EEOICPA) Procedure Manual Chapter 2-1500, and portions of the Part E Procedure Manual with this transmittal and Chapters 2-2000 and 2-2100.

Distribution: List No. 3: All DEEOIC Employees

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RELEASE – TRANSMISSION OF REVISED MATERIAL TO BE INCORPORATED INTO THE FEDERAL (EEOICPA) PROCEDURE MANUAL: CHAPTER 2-0100 INTRODUCTION, CHAPTER 2-0200 RESOURCE CENTERS, CHAPTER 2-0300 INITIAL DEVELOPMENT, CHAPTER 2-0500 COVERED EMPLOYMENT, CHAPTER 2-0600 SEC STATUS, CHAPTER 2-0700 TOXIC SUBSTANCE EXPOSURE, CHAPTER 2-0800 WEIGHING MEDICAL EVIDENCE, CHAPTER 2-0900 CANCER AND RADIATION, CHAPTER 2-1500 CONSEQUENTIAL ILNNESSES, CHAPTER 3-0100 INTRODUCTION, CHAPTER 3-0200 MEDICAL BILL PROCESS, AND CHAPTER 3-0300 ANCILLARY MEDICAL SERVICES.

EEOICPA TRANSMITTAL NO.10-07 January, 2010

EXPLANATION OF MATERIAL TRANSMITTED:

These twelve chapters are transmitted for placement in the new Unified Procedure Manual(PM) binder. These chapters consist of the consolidation of updated information and guidance as it pertains to the Program's administration of Parts B and E of the EEOICPA. This is the final transmittal accompanying the release of the Unified Procedure Manual. All prior released chapters should now be associated with this publication in the Unified binder to serve as the official DEEOIC Procedure Manual, and all older Part B and E versions should be discarded.

New chapter 2-0100 replaces Part E chapter E-100.

New chapter 2-0200 replaces Part E chapter E-400.

- Chapter 2-0200 establishes guidelines for Resource Center use of ECMS, and provides guidance for Resource Center outreach to

solicit impairment claims.

New chapter 2-0300 replaces Part B chapter 2-0100 and Part E chapter E-300.

- Chapter 2-0300 discusses the role of the Resource Centers in gathering claimant information for initial development, and establishes procedures for developing the claims of terminally ill claimants.

New chapter 2-0500 replaces Part B chapter 2-0400 and Part E chapter E-400.

- Chapter 2-0500 consolidates previous guidance for obtaining employment verification from four separate lists into a unified resource for employment verification known as the Employment Process Overview Document. Chapter 2-0500 also incorporates procedures from the following:
  - Bulletin 02-18: Use of ORISE database.
  - Bulletin 03-21: Coverage of Uniformed Members of the military.
  - Bulletin 03-26: Government Agency Employment.
  - Bulletin 03-27: Establishing covered subcontractor employment.
  - Bulletin 03-28: EEOICPA coverage of the citizens of the Marshall Islands.
  - Bulletin 06-09: Center to Protect Workers' Rights (CPWR) and its predecessor of the same name Bulletin number 04-09.
  - Bulletin 09-02: Subcontractor database for verification of contractual relationship at covered facilities.
  - Bulletin 09-10: Processing Social Security Administration Form SSA-581.

New chapter 2-0600 replaces parts of Part B chapter 2-0500 and 2-0600.

- Chapter 2-0600 incorporates existing procedures for handling SEC claims. This includes a listing of the specified cancers, instructions on calculating 250 work days, and roles of the claims staff including Branch of Policy, Regulations and Procedures in handling SEC claims.

New chapter 2-0700 replaces parts of Part E chapter E-400.

- Chapter 2-0700 includes information about the Site Exposure Matrices (SEM), and qualifies that under no circumstances is a claim for benefits denied solely due to a lack of information contained in SEM.

New chapter 2-0800 replaces Part B chapter 2-0300 and parts of Part E chapter E-500.

- Chapter 2-0800 has been revised to include an exhibit of a Statement of Accepted Facts (SOAF) and includes the general requirements for a proper Statement of Accepted Facts. The Chapter also instructs claim staff to use ACS web portal to select a second opinion physician.
    - Chapter 2-0800 includes revised ECMS coding to ensure prompt payment of medical bills from District Medical Consultants (DMC), second and referee physicians. This chapter includes an exhibit of approved ICD-9 codes and corresponding Procedure Codes, and has revised the Medical Consultant Referral Form to include more medical specialties.

New chapter 2-0900 replaces Part B chapter 2-0600.

· The revision of PM Chapter 2-0900 includes guidance on establishing causation for cancer under Part E.

- The chapter also explains how a case "pended" or "pulled" by NIOSH during the dose reconstruction affects the dose reconstruction process and the procedures to resolve a case in "pulled" status.
- Chapter 2-0900 includes detailed explanations of when rework of dose reconstruction is required and provides specific examples.
- Chapter 2-0900 includes procedures for requesting a rework of dose reconstruction.

New chapter 2-1500 replaces Part B chapter 2-1000.

- Chapter 2-1500 clarifies the circumstances by which an illness will become compensable as a consequential illness of an accepted condition.

New chapter 3-0100 contains entirely new material.

New chapter 3-0200 replaces parts of Part B chapter 3-0100.

- Chapter 3-0200 consolidates guidance on payment for non-standard medical treatments and explains the procedure for approving organ transplants, and experimental medical procedures, among others.

New chapter 3-0300 replaces parts of Part B chapter 3-0100.

- Chapter 3-0300 incorporates guidance relating to approval of in-home health care services for claimants requiring such services.

Rachel P. Leitor

Rachel P. Leiton

Director, Division of

Energy Employees Occupational Illness Compensation

FILING INSTRUCTIONS:

File this transmittal behind EEOICPA Transmittal 10-06 in the front of the new Unified Federal (EEOICPA) Procedure Manual.

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

EEOICPA TRANSMITTAL NO.10-08 July 2010

EXPLANATION OF MATERIAL TRANSMITTED:

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

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

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

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

Rachel P. Leiton

Rachel P. Leiton

Director, Division of

Energy Employees Occupational Illness Compensation

FILING INSTRUCTIONS:

Remove Old Page			Insert New Pages		
Part	Chapter	Page	Part	Chapter	Page

2	2-2100	i,52-62	2	2-2100	i,52-79

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

File this transmittal behind EEOICPA Transmittal 10-07 in the front of the new Unified Federal (EEOICPA) Procedure Manual.

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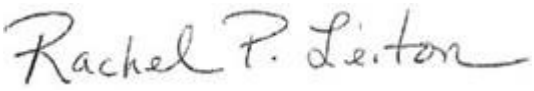
RELEASE – REVISION TO Chapter 2-1200 Establishing Survivorship, FEDERAL (EEOICPA) PROCEDURE MANUAL

EEOICPA TRANSMITTAL NO.10-09 August 2010

EXPLANATION OF MATERIAL TRANSMITTED:

This material is issued as procedural guidance to update, revise and replace the text of EEOICPA Unified Procedure Manual (PM) 2-1200 Establishing Survivorship.

- The material updates the chapter by providing further clarity on all aspects of establishing a survivorship claim.
- This material provides new guidance on identifying and establishing common-law marriage.
- This material updates the definition of a biological child.



Rachel P. Leiton

Director, Division of

Energy Employees Occupational Illness Compensation

FILING INSTRUCTIONS:

Replace the entire EEOICPA Unified PM Chapter 2-1200.

File this transmittal behind EEOICPA Transmittal 09-07 in the front of the Federal (EEOICPA) Procedure Manual.

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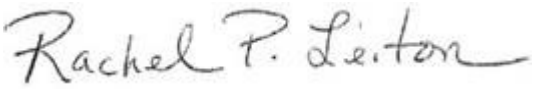
RELEASE – REVISION TO Chapter 2-2000 Energy Case Management System-General, FEDERAL (EEOICPA) PROCEDURE MANUAL

EEOICPA TRANSMITTAL NO. 11-01 April 2011

EXPLANATION OF MATERIAL TRANSMITTED:

This material is issued as procedural guidance to update, revise and replace the text of EEOICPA Unified Procedure Manual (PM) 2-2000 Energy Case Management System-General.

- This material serves to notify ECMS users that the SEC Desc field no longer needs to be completed.
- This material addresses the new SEC acceptance coding scheme, which encompasses the deactivation of the "SE" code and the activation of the "SER" and "SEF" codes and associated reason codes.
- This material updates the worksite/employment verification guidance
- This material clarifies the use of the "NI" code in ECMS E.
- This material updates the instruction regarding use of the WS code and removes the email related codes associated with the "DO" code.
- This material gives additional instruction on the use of the "IC" and "NIM" codes when impairment is claimed prematurely.
- This material adds the reason code "E12" to the "DO" claim status code to correspond to when the EN/EE-12 is sent.
- This material adds the reason code "E10" to the "DO" claim status code to correspond to when the EN/EE-10 is sent.



Rachel P. Leiton

Director, Division of

Energy Employees Occupational Illness Compensation

FILING INSTRUCTIONS:

Replace the entire EEOICPA Unified PM Chapter 2-2000.

File this transmittal behind EEOICPA Transmittal XX-XX in the front of the Federal (EEOICPA) Procedure Manual.

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RELEASE – TRANSMISSION OF REVISED MATERIAL TO BE INCORPORATED INTO THE FEDERAL (EEOICPA) PROCEDURE MANUAL: CHAPTER 2-1600 RECOMMENDED DECISIONS.

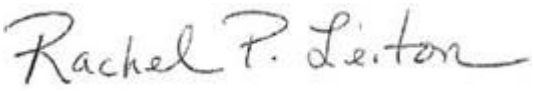
EEOICPA TRANSMITTAL NO. 11-02 May 2011

EXPLANATION OF MATERIAL TRANSMITTED:

This material is issued as procedural guidance to update, revise and replace the text of EEOICPA Procedure Manual (PM) Chapter 2-1600, Recommended Decisions.

Incorporates changes that have arisen since last publication of PM Chapter 2-1600, Recommended Decisions; including the following:

- This material clarifies the administrative closure procedures.
- This material has been revised to clarify the handling of claims involving non-filing survivors and non-responsive claimants
- Provides additional guidance on the issuance of multiple claimant Recommended Decisions
- Updates instructions regarding the content and format of a Recommended Decision; eliminating the "Findings of Fact" section and replacing it with "Explanation of Findings"
- Gives additional instruction on issuance of Letter Decisions
- Provides guidance in certain special circumstances; such as issuing Recommended Decisions:
  - When aggregate lump-sum compensation has been attained
  - When an employee dies prior to claim adjudication
  - Addressing prior overpayments



Rachel P. Leiton

Director, Division of

Energy Employees Occupational Illness Compensation

FILING INSTRUCTIONS:

File this transmittal behind Part 1 in the front of the new Unified Federal (EEOICPA) Procedure Manual.

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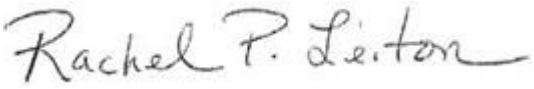
RELEASE – TRANSMISSION OF REVISED MATERIAL TO BE INCORPORATED INTO THE FEDERAL (EEOICPA) PROCEDURE MANUAL: CHAPTER 2-1000 ELIGIBILITY REQUIREMENTS FOR NON-CANCEROUS CONDITIONS.

EEOICPA TRANSMITTAL NO. 11-04 July 2011

EXPLANATION OF MATERIAL TRANSMITTED:

This material is issued as procedural guidance to update the text of Unified Procedure Manual (PM) 2-1000 Eligibility Criteria for Non-Cancerous Conditions.

- This material replaces chapter 2-1000 of the EEOICPA Procedure Manual. The new section should be filed behind PM chapter 2-0900. New text in the chapter outlines eligibility requirements to compensate claims for hearing loss based on toxic substance exposure.



Rachel P. Leiton

Director, Division of

Energy Employees Occupational Illness Compensation

FILING INSTRUCTIONS:

Insert New Pages

Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages
2	1000	TOC	2	1000	TOC
	1-32			1-34	
	Exhibit 1			Exhibit 1	
	Exhibit 2			Exhibit 2	

File this transmittal behind EEOICPA Transmittal 11-01 in the front of the Federal (EEOICPA) Procedure Manual.

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RELEASE – TRANSMISSION OF REVISED MATERIAL TO BE INCORPORATED INTO THE FEDERAL (EEOICPA) PROCEDURE MANUAL: CHAPTER 3-0900 DEBT LIQUIDATION

EEOICPA TRANSMITTAL NO.11-06 September 2011

EXPLANATION OF MATERIAL TRANSMITTED:

This material is issued to update, revise and replace Chapter 3-0900 Debt Liquidation as follows:

· Paragraph 4, Assessment of Charges, subparagraph c, Interest is revised as follows:

c. Interest. Interest is assessed at the rate in effect on the date of the final decision (unless the claimant has defaulted on a previous agreement). The rate of interest assessed shall be the rate of the current value of funds to the United States Treasury as published in the Federal Register. The Treasury Current Value of Funds Rate is posted on the U.S. Treasury website at: http://www.fms.treas.gov/cvfr/index.html.

- Exhibits 1 and 2, second and third demand letters, are revised as follows:

· The P.O. Box for remitting payments is revised to:

U.S. Dept. of Labor

DEEOIC

P.O. Box 77247

Washington, DC 20013

· The following "Notice to Customers Making Payment By Check" has been added to the end of the demand letters following the signature block:

Notice to Customers Making Payment by Check

When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction. When we use information from your check to make an electronic fund transfer, funds may be withdrawn from your account as soon as the same day we receive your payment.

***Privacy Act* – A Privacy Act Statement required by 5 U.S.C. § 552a(e)(3) stating our authority for soliciting and collecting the information from your check, and explaining the purposes and routine uses which will be made of your check information, is available on internet site at: https://www.pccotc.gov/pccotc/index.htm , or call toll free at 1-866-945-7920 to obtain a copy by mail. Furnishing the check information is voluntary, but a decision not to do so may require you to make payment by some other method.**

Rachel P. Leiton

Director, Division of

Energy Employees Occupational Illness Compensation

FILING INSTRUCTIONS:

Replace the entire EEOICPA Unified PM Chapter 3-0900 Debt Liquidation.

File this transmittal sheet behind Part 3 in the front of the Unified Federal (EEOICPA) Procedure Manual.

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RELEASE – TRANSMISSION OF REVISED MATERIAL TO BE INCORPORATED INTO THE FEDERAL (EEOICPA) PROCEDURE MANUAL: CHAPTER 2-1900 REOPENING PROCESS.

EEOICPA TRANSMITTAL NO. 12-01 April 2012

EXPLANATION OF MATERIAL TRANSMITTED:

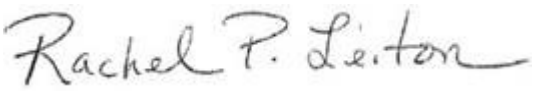
This material is issued as procedural guidance to update, revise and replace the text of EEOICPA Procedure Manual (PM) Chapter 2-1900, Reopening Process.

This version removes content from the previous version of this Chapter which was not relevant to the reopening process; including the following:

- Section 5, District Director Communications About a FAB Decision.

Also incorporates changes that have arisen since last publication of Chapter 2-1900, Reopening Process; to include:

- Provides additional guidance on referral for Reopening action
- Revised to clarify the handling of claimant's non-specific correspondence, and insufficient evidence for reopening.
- Expands description of a Director's Order and its components
- Gives additional information regarding the content of a Denial of Reopening Request.



Rachel P. Leiton

Director, Division of

Energy Employees Occupational Illness Compensation

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File this transmittal behind Part 1 in the front of the new Unified Federal (EEOICPA) Procedure Manual.

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RELEASE – TRANSMISSION OF REVISED MATERIAL TO BE INCORPORATED INTO THE FEDERAL (EEOICPA) PROCEDURE MANUAL: CHAPTER 0-0100, Introduction.

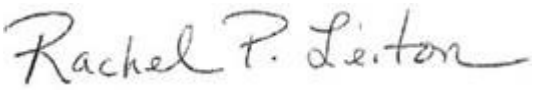
EEOICPA TRANSMITTAL NO. 12-02 March 2012

EXPLANATION OF MATERIAL TRANSMITTED:

This material is issued as procedural guidance to update, revise and replace the text of EEOICPA Procedure Manual (PM) Chapter 0-0100, Introduction.

Incorporates changes that have arisen since last publication of PM Chapter 0-0100, Introduction; including the following:

- This material outlines the updated Office of Workers' Compensation Programs (OWCP) organizational structure.
- Updates DEEOIC personnel and office location changes.
- Provides greater detail regarding the responsibilities of the Policies, Regulations and Procedures Unit.



Rachel P. Leiton

Director, Division of

Energy Employees Occupational Illness Compensation

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FILING INSTRUCTIONS:

File this transmittal behind Part 1 in the front of the new Unified Federal (EEOICPA) Procedure Manual.

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RELEASE – TRANSMISSION OF REVISED MATERIAL TO BE INCORPORATED INTO THE FEDERAL (EEOICPA) PROCEDURE MANUAL: CHAPTER 2-1700, FAB Review Process.

EEOICPA TRANSMITTAL NO. 13-01 December 2012

EXPLANATION OF MATERIAL TRANSMITTED:

This material is issued as procedural guidance to update, revise and replace the text of EEOICPA Procedure Manual (PM) Chapter 2-1700, FAB Review Process. This version includes content previously part of Chapter 2-1800, FAB Decisions, including the following:

- Section 6, Objections and Review of the Written Record
- Section 7, Hearing Requests
- Section 8, Conduct of the Hearing
- Section 9, Post Hearing Actions

Additionally, the following exhibits have been removed from the previous version of Chapter 2-1700, FAB Review Process:

· Sample Cover Letter, Partial Acceptance/Partial Denial Recommended Decision

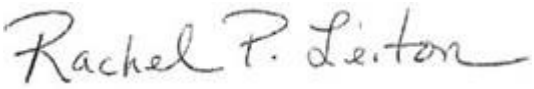
· Sample Waiver, Partial Acceptance/Partial Denial Recommended Decision

They have been replaced by the following exhibits:

- Exhibit 1, Sample Acknowledgement Letter, Review of the Written Record
- Exhibit 2, Sample Acknowledgement Letter, Hearing
- Exhibit 3, Sample Hearing Notice to Claimant Who Filed an Objection
- Exhibit 4, Sample Hearing Notice to Claimant Who Did Not File an Objection
- Exhibit 5, Waiver of Rights to Confidentiality
- Exhibit 6, Waiver of Rights to Confidentiality (Media)
- Exhibit 7, Sample hearing Script

Finally, this version also incorporates changes that have arisen since last publication of Chapter 2-1700, FAB Review Process, to include:

- Provides additional guidance on handling of Recommended Decisions, Final Decisions and Remand Orders returned by the Postal Service.
- Outlines handling of claims of non-responsive claimants
- Gives additional information regarding steps taken By FAB after new medical evidence is received.



Rachel P. Leiton

Director, Division of

Energy Employees Occupational Illness Compensation

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File this transmittal behind Part 1 in the front of the new Unified Federal (EEOICPA) Procedure Manual.

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PM Part 0 – Overview

0-0100 Introduction

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6 Jurisdiction	9	04/12	12-02
Exhibits			
1 Jurisdictional Map and DEEOIC District Office Addresses. .		04/12	12-02

1. Purpose and Scope. This chapter provides an overview of the Energy Employees Occupational Illness Compensation Program Act (EEOICPA) and the structure of the Division of Energy Employees Occupational Illness Compensation (DEEOIC). It also addresses the relationships between DEEOIC and the Office of Workers' Compensation Programs (OWCP), the various components of the DEEOIC, and training for DEEOIC employees.

2. The EEOICPA. The EEOICPA, as amended, 42 U.S.C. § 7384 *et seq.*, was enacted as Title XXXVI of the Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001, Public Law 106-398. The Act as amended has two parts, Part B and Part E. On October 28, 2004, the President signed into law an amendment that repealed Part D of the EEOICPA and created a new program called Part E. The amendment gives the Department of Labor the responsibility for administering this new program.

The amendment grants covered Department of Energy (DOE) contractor employees compensation based on the level of their impairment and/or wage-loss, if they develop an illness as a result of exposure to a toxic substance at a DOE facility. Medical benefits will also be available to qualifying employees for treatment and care of the accepted covered illness. Eligible survivors may receive compensation, if the employee’s death was aggravated, contributed to,

or caused by the covered illness.

a. Part B. The purpose of Part B is to provide a lump sum payment of $150,000 and medical benefits as compensation to covered employees suffering from occupational illnesses incurred as a result of their exposure to radiation, beryllium, or silica while in the performance of duty for the DOE and certain of its vendors, contractors and subcontractors.

The legislation also provides for the payment of compensation to certain survivors of these covered employees, as well as for payment of a smaller lump sum of $50,000 to individuals or their survivors who were determined to be eligible for compensation under Section 5 of the Radiation Exposure Compensation Act (RECA). Compensation for individuals with beryllium sensitivity is limited to medical monitoring and medical benefits.

b. Part E. The purpose of Part E is to provide variable amounts of compensation to DOE contractor employees or to their survivor(s) where it is at least as likely as not that exposure to a toxic substance while employed at a covered facility was a significant factor in aggravating, contributing to or causing the employee's illness or death. Variable amounts of compensation up to an aggregate total of $250,000 (for the employee and any survivors) are determined based on causation, wage-loss, and impairment.

3. Organization. This paragraph describes the structure and authority of the National, Regional, and District Offices (DOs). OWCP has six divisions, of which DEEOIC is one. (The others are the Division of Federal Employees' Compensation; the Division of Longshore and Harbor Workers' Compensation; the Division of Coal Mine Workers' Compensation; the Division of Planning, Policy, and Standards; and the Division of Technology and Standards (DTS).

a. Regional Director. OWCP Programs, in each of its six regions, are administered by a Regional Director (RD), who reports to the Director for OWCP.

b. District Director. DEEOIC has four DOs, which are located in Jacksonville, Florida; Cleveland, Ohio; Denver, Colorado; and Seattle, Washington. Each DO is managed by a District Director (DD), who reports to the RD. (Exhibit 1 contains a list of addresses, telephone numbers, and fax numbers for the DOs.)

4. Responsibilities. This paragraph describes the roles of the various components within the DEEOIC.

a. District Offices. Within each DO there are a variety of roles:

(1) Claims Functions. Supervisory Claims Examiners manage units of Senior Claims Examiners, Journey Level Claims Examiners and Claims Examiners (CEs). Staff in these units adjudicate claims, authorize compensation and medical benefits, respond to inquiries from interested parties, and maintain case files.

(2) Fiscal Operations. Fiscal Officers (FOs) are designated for each DO. The primary responsibility of these individuals is to ensure the integrity of the compensation payment process. The FO is also responsible for monitoring financial management records and serves as the DO point of contact for medical billing issues.

(3) Medical Referrals. DEEOIC uses the services of a contractor to assist in obtaining medical opinions on a range of issues including causation, impairment, wage-loss, etc. The contractor is also responsible for the scheduling of second opinion medical examinations. Within each DO, a designated District Medical Scheduler is responsible for coordinating case referrals with the contractor.

(4) Mail and File. Personnel in this area open, sort and place mail, compile case files, retire case records according to established schedules, and transfer case files in and out of the DO.

(5) Contact and Technical Assistance. Customer Service Representatives are responsible for answering phones, referring calls within the DO and responding to general inquiries. Technical assistants are responsible for providing technical guidance and assistance to DO personnel and maintaining liaison with organizations outside the DO.

b. National Office (NO). The Director of DEEOIC has final authority to manage and administer the program. With the exception of the FAB Chief, who reports directly to the Director, the Deputy Director supervises the DEEOIC Branch Chiefs and serves as the Acting Director in the Director's absence. Under the immediate jurisdiction of the Director and Deputy Director are the:

(1) Policy Branch. Personnel in the Policy Branch consist of the Policy, Regulations and Procedures Unit (PRPU), Secondary Claims Examiner (CE2) Unit, and the Medical, Health & Science Unit (MHSU).

(a) The Policy, Regulations and Procedures Unit (PRPU) develops program policies and procedures to carry out the functions of the DEEOIC. In particular, PRPU staff:

(i) Prepare and maintain the program’s Procedure Manual and issue program Bulletins or Circulars, which entail significant coordination with the Office of the Solicitor for the Department of Labor, especially with regard to statutory and regulatory changes;

(ii) Conduct accountability reviews;

(iii) Participate in the development of training

materials;

(iv) Handle functions relating to employment verification and records, including the tracking of covered time frames for employment;

(v) Review memoranda to the Director submitted by the Final Adjudication Branch (FAB) and DO requesting the reopening of a claim or the vacating of a FAB decision based upon new and/or relevant evidence, by reviewing the case record and making a determination whether a reopening of the claim or the vacating of a FAB decision is warranted. The Director or the appropriately designated authority issues a denial letter to the party requesting the reopening; or a Director's Order to the FAB or DO, setting the FAB decision or FAB Remand Order aside and outlining the course of action required to resolve the issue(s).

(vi) Issue decisions regarding overpayments.

(b) The Secondary Claims Examiner (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 recommended decision (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 been taken and what future actions are required to address any outstanding issues; and

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

(c) The Medical, Health & Science Unit (MHSU) consists of a Medical Director, Health Physicists, Industrial Hygienists, Epidemiologist/Toxicologist, and support personnel. The MHSU function includes the following:

(i) Review, research and respond to case referrals from the FAB, DOs and PRPU. Serve as the DEEOIC technical experts on medical, radiological, and toxicological causation and

exposure issues; and

(ii) Serve as the liaison between the National Institute for Occupational Safety and Health (NIOSH) and DEEOIC on all dose reconstruction related issues.

(2) Branch of Outreach and Technical Assistance (BOTA). Personnel in the BOTA are responsible for technical assistance and outreach activities, including developing informational materials and maintaining the Web page. In particular, BOTA staff:

(a) Develop and conduct training for DEEOIC staff;

(b) Manage the program's priority correspondence activity, including Freedom of Information Act (FOIA) requests; preparing responses for the Secretary of Labor; Office of Congressional and Intergovernmental Affairs; OWCP Director, and the Director of the DEEOIC;

(c) Facilitate development of comprehensive outreach plans; including local outreach by Resource Centers; monitor and approve outreach expenses, and conduct and arrange outreach events; and

(d) Promote and maintain cooperative relations with individuals and groups having EEOICPA interests through technical assistance and public relations activities.

(3) Branch of Automated Data Processing Systems (BAS). Members of this Branch provide data processing and payment systems support services for the DEEOIC. In particular, the Branch is responsible for:

(a) Developing and maintaining activities related to ECS;

(b) Providing statistical reports and data;

(c) Providing overall computer services;

(d) Overseeing medical and compensation system issues; and

(e) Coordinating activities of the bill processing agent.

(4) Management Unit. Members of this unit support the efficient operations of the DEEOIC by providing the following functions:

(a) Oversee DEEOIC budget and ensure that budget limitations are not exceeded;

(b) Monitor and manage personnel and

procurement actions; and

(c) Provide administrative support to the Director and the Deputy Director.

c. Final Adjudication Branch (FAB). Personnel in this Branch are responsible for issuing all final decisions under the EEOICPA, except for decisions on overpayments. The FAB also processes all objections by holding oral hearings or reviewing the written record. FAB representatives issue final decisions that affirm, remand, or reverse recommended decisions issued by the DEEOIC DOs.

A FAB Office is located in Washington, D.C., and a FAB unit is co-located with, but independent from, each of the four DOs. The manager of each FAB DO reports to the FAB Chief. (Exhibit 1 contains a list of addresses, telephone numbers, and fax numbers for the FABs.)

5. Training. This paragraph describes the information new employees need and addresses the kinds of training OWCP provides to its employees.

a. Orientation. The RD and/or DD provide orientation for all new employees in their respective DOs. This orientation includes the following topics:

(1) Organization of the DO, the Regional Office, and OWCP.

(2) Mission and objectives of the DEEOIC;

(3) General description of duties;

(4) Staffing pattern, chain of command;

(5) Floor plan/physical layout of office, unit locations, emergency procedures, office security, etc.;

(6) Mail handling, paper and case flow;

(7) Working hours, breaks, lunch hour, sick and annual leave arrangements, flextime, telephone use, overtime authorization, etc.;

(8) Introduction to staff;

(9) Reference materials; and

(10) Role of partner agencies, e.g. National Institute for Occupational Safety and Health (NIOSH), Department of Energy (DOE), Department of Justice (DOJ), Resource Centers, etc.

b. Courses. Three formal training courses have been developed for the DEEIOC staff. These include:

(1) All Staff Members Orientation. This is a course designed by each DO to explain the basic concepts of the EEOICPA.

(2) Claims Examiner Course. CEs, Journey level CEs,

Senior CEs, Supervisors, and FAB Representatives take this course.

It is delivered in a classroom or through self-instructional format. A resource person is available to respond to questions if the self-instructional format is used.

The course, which requires about two weeks to complete, is designed to explain the claims adjudication process and to develop case management skills.

(3) Secondary Training. Additional training is provided to all claims personnel to address developing needs of the program (e.g., complex medical terminology/issues, facilities lists, additions to the Special Exposure Cohort (SEC), precedent-setting decisions, Resource Centers). This training may include advanced CE and FAB training. In addition, training in ECS is available.

6. Jurisdiction. This paragraph describes the jurisdiction of the four DEEOIC DOs. The DO that handles a claim is determined by where the employee last worked as a covered employee. A DO acquires jurisdiction if the last covered facility is/was located within the geographical area it serves. (Exhibit 1 contains a DEEOIC DO Jurisdictional Map.)

a. Survivor Claims. This rule applies to claims from survivors as well as those brought by the employee.

b. Uranium Workers. Normally, all claims for uranium workers (or their survivors) who may have been awarded benefits under Section 5 of the Radiation Exposure Compensation Act (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).

Exhibit 1: Jurisdictional Map and DEEOIC District Office Addresses

0-0200 General Provisions of EEOICPA

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1. Purpose and Scope. This chapter summarizes the

provisions and requirements of the Energy Employees Occupational Illness Compensation Program Act (EEOICPA or Act) and addresses its coverage.

2. Provisions of EEOICPA.

a. Requirements for Part B Eligibility. A covered employee must satisfy criteria of eligibility for at least one of the following compensable categories under Part B:

(1) Beryllium sensitivity or chronic beryllium disease resulting from exposure to beryllium in the performance of duty.

(2) A specified cancer if the employee was a member of the Special Exposure Cohort (SEC).

(3) A non-specified cancer if the employee incurred a cancer that is at least as likely as not related to radiation exposure from employment at a covered facility.

(4) Chronic silicosis resulting from exposure to silica from covered employment at a Department of Energy (DOE) facility in Nevada or Alaska, aggregating at least 250 work days during the mining of tunnels for tests or experiments related to atomic weapons.

(5) The U.S. Attorney General has determined entitlement to an award of $100,000 under Section 5 of the Radiation Exposure Compensation Act (RECA).

b. Requirements for Part E Eligibility. A covered employee must establish that it is at least as likely as not that exposure to a toxic substance while employed at a DOE facility by a DOE contractor or subcontractor was a significant factor in aggravating, contributing to or causing the employee's illness or death.

c. Medical Care. An employee who meets the statutory conditions of coverage is entitled to medical care consisting of services, appliances, and supplies prescribed or recommended by a qualified physician considered likely to cure, give relief, or reduce the degree or the period of that condition. Provider charges associated with the treatment of an accepted medical condition are paid from the compensation fund and are subject to a fee schedule.

d. Monetary Compensation under Part B. An eligible employee or survivor is entitled to receive a lump sum payment of $150,000, if found eligible under Part B of the EEOICPA. An eligible uranium worker or survivor is eligible for a lump sum payment of $50,000.

e. Monetary Compensation under Part E. Maximum compensation up to $250,000 is determined based on causation, wage loss, and impairment.

(1) Employee Benefits: Covered employee is eligible for compensation up to $250,000 based on wage loss and/or

impairment.

(a) Wage loss is based on the number of calendar years that the employee was unable to work or sustained a reduction in wages as a result of the covered illness. Wage loss compensation is payable for qualifying years of lost wages occurring prior to the employee's normal Social Security retirement age, determined by the employee's date of birth.

(b) Impairment is a loss, loss of use, or derangement of any body part, organ system or organ functionality as it affects the whole body, as a result of the covered illness. An impairment rating is performed once the employee has reached Maximum Medical Improvement (MMI) (i.e., the covered illness is stabilized and is unlikely to improve with or without additional medical treatment).

(2) Survivor Benefits: The survivor is eligible for compensation in the amount of up to $125,000 if the covered illness aggravated, contributed to, or caused the employee's death.

(a) Wage Loss: The survivor may be entitled up to an additional $25,000 or $50,000 depending upon the amount of calendar years over 10 years that the deceased covered employee experienced compensable wage loss prior to his or her normal Social Security retirement age.

(b) Impairment: In general, the survivor is not entitled to impairment benefits under Part E.

f. Survivor Eligibility under Part B. In the event of the death of an eligible employee, the Act provides for the disbursement of compensation in order of precedence and in proportion to the number of eligible survivors. The order of precedence is spouse, child, parent, grandchild, then grandparent.

g. Survivor Eligibility under Part E. The only survivors eligible for benefits are the spouse, or children of the covered employee who are under the age of 18 years at the time of the employee's death, or under the age of 23 years and a full time student at the time of the employee's death, or any age and incapable of self-support at the time of the employee's death. In limited circumstances, a spouse may elect to receive the compensation to which an employee would have been eligible prior to death.

h. Third Party Liability. With the exceptions listed below, where an employee's compensable illness or death results from circumstances creating a legal liability on some party other than the United States, the cost of compensation and other benefits paid by the OWCP must be offset to reflect any settlement obtained. Exceptions

include the following:

(1) Workers compensation benefits are not offset under Part B; and

(2) Insurance policy payments made to an employee or eligible surviving beneficiary, where the employee or eligible surviving beneficiary has purchased the policy, are not offset.

i. Coordination of Benefits with State Workers' Compensation (SWC). When a claimant has received benefits from a state workers' compensation program for the same covered illness(es) to which he or she is to be awarded compensation under Part E, this requires a reduction in the award. Exceptions to this reduction include the following:

(1) Medical and vocational rehabilitation benefits received from SWC for the same covered illness(es) are not included in the reduction;

(2) The claimant has received SWC benefits for both a covered and a non-covered illness as a result of the same-work related incident; these benefits also will not be included in the reduction; and

(3) Reasonable costs in obtaining SWC benefits incurred by the claimant, such as but not limited to attorney's fees and specific itemized costs of suits, are not included in the reduction.

0-0300 Customer Service

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1. Purpose and Scope. This chapter describes the commitment of the Division of Energy Employees Occupational Illness Compensation (DEEOIC) to serving its internal and external customers with excellence.

a. Internal Customers. These include but are not limited to National Office staff, District Office staff, and Resource Center employees.

b. External Customers. These include but are not limited to claimants, authorized representatives, attorneys, advocacy groups, congressional officials, contractors, and other external agents who have a vested interest in the claims process.

2. DEEOIC Standards for Customer Service. The highest level of customer service is expected in all dealings with individuals conducting business with and within the DEEOIC. All staff are expected to be courteous, professional, flexible, honest and helpful. The program's Operational Plan includes standards for the performance, responsiveness and timeliness of customer service. DEEOIC's Customer Service Goals include the following:

a. Customers. DEEOIC customers are satisfied with our services;

b. Services. DEEOIC services are delivered to customers in a timely and accurate manner; and

c. Planning and Development. Customer needs are integrated into program planning and product development.

3. Telephone Communications. DEEOIC staff talk to claimants, authorized representatives, health care providers, employer organizations, resource center personnel, governmental organizations, and others on a daily basis.

a. Telephone Skills. Effective telephone skills are one of the keys to providing accurate, courteous, and timely information to callers. These skills include but are not limited to the following:

(1) Answer the telephone promptly;

(2) Identify the caller's needs;

(3) Handle inquiries in a professional and pleasant (non-defensive) manner;

(4) Provide prompt, informative responses;

(5) Keep conversations brief but provide accurate, courteous, and timely information; and

(6) Give callers an accurate estimate of when a return call will be attempted, if necessary.

b. Inquiries Directed to Resource Centers. Resource Centers (RCs) are situated in key geographic locations throughout the United States to provide assistance and information to the DEEOIC claimant community and other interested parties. The RCs play a limited but valuable role in the claims process and their duties include the following:

(1) Provide information on claims process and program

procedures to the DEEOIC claimant community;

(2) Assist claimants in the completion of the necessary claim forms;

(3) Take initial employment verification steps for all new EEOICPA claims filed with the RC;

(4) Conduct occupational history development for certain employees; and

(5) Provide case-specific information and clarification to claimants and authorized representatives.

(6) Educate and assist the claimants regarding impairment and wage loss benefits on cases with positive causation determinations.

(7) Conduct medical provider outreach to assist in medical bill payment enrollment and resolve billing issues.

(8) Provide medical bill payment assistance to claimants.

(9) For more information about the RCs, see EEOICPA PM 2-0200.

c. Telephone Management System (TMS). The TMS feature in the Energy Case Management System (ECMS) allows the ECMS user to memorialize telephone conversations, place and obtain telephone messages within the system. TMS also provides a mechanism by which incoming and outgoing telephone contact on a given case file is tracked and maintained.

(1) The person who answers the phone must create the phone record in ECMS, unless the call is immediately transferred to another person *and* that person picks up the phone and speaks with the caller. The second person then becomes responsible for creating the phone message record in ECMS/TMS.

(a) In the first circumstance, the first person must record the incoming call by recording the caller's name, return phone number, the reason for the call, mark that the call has not been completed, and assign an ECMS user to return the phone call in ECMS/TMS for that specific case record.

(b) In the second circumstance, where the call is transferred to another person who picks up the phone and speaks with the caller, that second person is to create the automated ECMS/TMS phone message record providing a brief description of the phone call discussion and that it was completed.

(2) The person transferring the call must ensure that the call is picked up so that the caller is not inadvertently

dropped or transferred to a voicemail message.

(3) Callers may be transferred to voicemail only with the caller's explicit knowledge and consent.

(4) Rules describing the types of calls that must be entered and tracked in ECMS/TMS are described in EEOICPA PM 2-2000.

4. Written Communications. DEEOIC staff must use good writing skills in all correspondence. Letters must be clear, concise, instructional, accurate, and tailored. Specific skills include:

a. Considering the Reader. Use language that the reader can understand and customize the correspondence accordingly, specifically for that reader. Avoid using abbreviations in the body of the correspondence, unless they have been written out at the beginning of the correspondence;

b. Checking for Errors. Review correspondence before issuance to eliminate grammatical, spelling, template or other technical errors;

c. Choosing the Mode of Expression. Use natural and non-adversarial wording. To the extent possible, write politely, conversationally and employ commonly used words;

d. Making Documents Visually Appealing. Present text in a way that highlights the main points to be communicated. Use bullets or numbered lists when providing instructions or identifying deficiencies. Avoid lengthy narrative explanations or too much usage of underlining or bolding of the text in the correspondence; and

e. Tailoring the Letter to the Issue at Hand. Do not use lengthy, "laundry list" template letters when only certain information is being requested or provided. Identify what evidence has been submitted and the additional information that is needed in order to proceed with the adjudication of the claim in a timely manner.

0-0400 Program Directives

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1. Purpose and Scope. This chapter describes the communications and directives system used by the Division of Energy Employees

Occupational Illness Compensation (DEEOIC). It focuses on the structure of the Procedure Manual governing claims under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA or Act), and addresses its relationship to the Program's other written directives.

2. Directives. The publications relating to the EEOICPA include both external and internal releases, as follows:

a. External Directives. These may consist of either legal or informational releases.

(1) The *Federal Register* contains "Notices" and "Rules" pertaining to new or revised policy.

(a) "Notices" in the *Federal Register* advise the public of proposed changes and invite comments on them.

(b) "Rules" in the *Federal Register* state the regulations adopted by the program.

(2) Pamphlets and notices inform the public of the availability of EEOICPA benefits.

b. Internal Directives. There are three categories of directives; they are permanent (unless superseded), time-limited, and informational.

(1) Permanent directives include the following:

(a) EEOICPA Procedure Manual (PM), which is updated by transmittals.

(b) Other guides, including the DOL Correspondence Guide (DLMS Handbook 1-2); the GPO Style Manual; Program Memoranda; and the Energy Case Management System (ECMS) Users Manual which provides users and operators of the ECMS with guidelines for interacting with the system.

(2) Time-limited directives are issued as Bulletins. They may involve changes to procedures, special reports, or pilot programs. A Bulletin is effective until it is superseded by the PM or an updated Bulletin.

(3) Informational directives are issued as Circulars and do not require specific action. They are used to meet the following objectives:

(a) To announce personnel changes, upcoming events or activities, or other items of informational value;

(b) To call attention to standing instructions or performance standards that may require compliance or improvement;

(c) To announce proposed plans or anticipated program

changes; or

(d) To inform District Offices (DOs) of the activities and interests of the National Office.

3. Procedure Manual. The EEOICPA PM is accessible to all interested parties within and outside of the DEEOIC.

a. Part 0, Overview. This part provides an introduction to the EEOICPA, the program that administers it, and the directives issued to implement it. This section also provides employees with general information about program operations and the organizational structure of OWCP.

b. Part 1, Mail and Files. This part addresses the jurisdiction over cases and the movement of mail and case files within the DO. It also discusses how to create, maintain, transfer and retire case files.

c. Part 2, Claims. This part establishes policies, guidelines and procedures for developing, adjudicating and managing claims under the EEOICPA.

d. Part 3, Fiscal. This part establishes policies, guidelines and procedures for all fiscal issues.

4. Maintenance and Revision. EEOICPA Transmittals update the EEOICPA PM and are to be filed and cited in the following manner:

a. Filing Instructions. The PM is subdivided into and maintained in separate volumes or binders by part, chapter, and paragraph. For each transmittal:

(1) Remove and destroy any material identified as superseded or obsolete.

(2) File the new material in accordance with the instructions contained in the transmittal.

(3) File the transmittal behind the latest "Checklist" of all PM pages currently in effect. It is located in front of the PM.

b. Citations to the PM. The EEOICPA PM has four parts, as described in paragraph 3 above. Each part consists of several chapters, which in turn are divided into paragraphs, subparagraphs, and sometimes sub-subparagraphs. Chapters and paragraphs should be cited as follows:

Citation to a part of the PM: Federal (EEOICPA) PM Part 1

Citation to a chapter: Federal (EEOICPA) PM 1-100

Citation to a paragraph: Federal (EEOICPA) PM 1-100.1

Citation to a subparagraph: Federal (EEOICPA) PM 1-100.1a

Citation to a sub-subparagraph: Federal (EEOICPA) PM 1-100.1a(1)

0-0500 Definitions

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1. Purpose and Scope. The purpose of this chapter is to define the most commonly used terms in the administration of the Energy Employees Occupational Illness Compensation Program Act (EEOICPA). The chapter also identifies the abbreviations and acronyms for those terms (Exhibit 1) and provides a listing of the forms used in the program (Exhibit 2).

2. Definitions. This section defines the principal terms used in the Energy Employees Occupational Illness Compensation Program Act (EEOICPA) Procedure Manual (PM).

a. Act or EEOICPA means the Energy Employees Occupational Illness Compensation Program Act of 2000, as amended, 42 U.S.C. § 7384 *et seq*.

b. Atomic Weapon means any device utilizing atomic energy, exclusive of the means for transporting or propelling the device (where such means is a separable and divisible part of the device), the principal purpose of which is for use as, or for development of, a weapon, a weapon prototype, or a weapon test device.

c. Atomic Weapons Employee means:

(1) An individual employed by an atomic weapons employer (AWE) during a period when the employer was processing or producing, for the use by the United States, material that emitted radiation and was used in the production of an atomic weapon, excluding uranium mining and milling; or

(2) An individual employed:

(a) At a facility that the National Institute for Occupational Safety and Health (NIOSH), in its report dated November 2002 and titled "Report on Residual Radioactive and Beryllium Contamination at Atomic Weapons Employer Facilities and Beryllium Vendor Facilities," or any update, indicated had a potential for significant residual contamination outside of the

period described in subparagraph (1) of this definition;

(b) By an atomic weapons employer or subsequent owner or operator of a facility referenced in subparagraph (1) of this definition; and

(c) During a period reported by NIOSH, in its report dated November 2002 and titled "Report on Residual Radioactive and Beryllium Contamination at Atomic Weapons Employer Facilities and Beryllium Vendor Facilities," or any update to that report, to have a potential for significant residual radioactive contamination. This will be identified on the Department of Energy (DOE) facility database as the "residual contamination" period.

d. Atomic Weapons Employer (AWE) means any entity, other than the United States, that:

(1) Processed or produced, for use by the United States, material that emitted radiation and was used in the production of an atomic weapon, excluding uranium mining and milling; and

(2) The Secretary of Energy has designated as an AWE for purposes of the Act.

e. AWE Facility means a facility, owned by an AWE, that is or was used to process or produce, for use by the United States, material that emitted radiation and was used in the production of an atomic weapon, excluding uranium mining or milling.

f. Attorney General means the Attorney General of the United States or the United States Department of Justice (DOJ).

g. Average Annual Wage (AAW) means four times the average quarterly wages of a covered Part E employee for the 12 quarters preceding the quarter during which the employee first experienced wage loss due to exposure to a toxic substance at a DOE facility or RECA section 5 facility, excluding any quarters during which the employee was unemployed.

Being "retired" is not equivalent to being "unemployed"; therefore, quarters during which an employee had no wages because of retirement will be included in the AAW calculation.

h. Benefit or Compensation means the money the United States Department of Labor (DOL) pays to or on behalf of either a covered employee under Part B, or a covered DOE contractor employee under Part E, from the Energy Employees Occupational Illness Compensation Fund. These terms may also include any other amount paid out of the Fund for medical benefits including but not limited to medical treatment, monitoring, examinations, services, appliances and supplies.

i. Beryllium Sensitization or Sensitivity means that the individual is sensitized to beryllium as demonstrated by any of the following:

(1) An abnormal beryllium lymphocyte proliferation test (LPT) or an abnormal lymphocyte transformation test (LTT) on either blood or lung lavage cells as interpreted by a medical doctor, for Part B and Part E claims;

(2) A positive physician panel determination as specified in section 7385s-4(b), for Part E claims only; or

(3) A determination that it is at least as likely as not that exposure to beryllium at a DOE facility or a RECA section 5 facility was a significant factor in aggravating, contributing to, or causing the beryllium sensitization or sensitivity; and it is at least as likely as not that the exposure to beryllium was related to employment at a DOE facility or a RECA section 5 facility as specified in sections 7385s-4(c) and 7385s-5(a), for Part E claims only.

j. Beryllium Vendor means any of the corporations and named predecessor corporations designated as beryllium vendors in section 7384l(6)(A)-(I) of the EEOICPA, and also those facilities designated as beryllium vendors in the list published in the *Federal Register* by the Department of Energy.

k. Bioassay means the determination of the kind, quantity, concentration, or the location of radioactive material in the human body, whether by direct measurement or by analysis, and the evaluation of radioactive material excreted, eliminated, or removed from the body.

l. Chronic silicosis means a non-malignant lung disease as demonstrated by any of the following:

(1) The initial occupational exposure to silica dust preceded the onset of silicosis by at least 10 years and a written diagnosis of silicosis is made by a medical doctor and is accompanied by:

(a) A chest radiograph, interpreted by an individual certified by the National Institute for Occupational Safety and Health as a B reader, classifying the existence of pneumoconiosis of category 1/0 or higher;

(b) Results from a computer assisted tomograph or other imaging technique that are consistent with silicosis; or

(c) Lung biopsy findings consistent with silicosis.

This evidence holds true for Part B and Part E claims;

(2) A positive physician panel determination as specified in section 7385s-4(b), for Part E claims only; or

(3) A determination that it is at least as likely as not

that exposure to silica at a DOE facility or a RECA section 5 facility was a significant factor in aggravating, contributing to, or causing the chronic silicosis; and it is at least as likely as not that the exposure to silica was related to employment at a DOE facility or a RECA section 5 facility as specified in sections 7385s-4(c) and 7385s-5(a), for Part E claims only.

m. Claim means a written assertion to OWCP of an individual's entitlement to benefits under the EEOICPA, submitted in a manner authorized by the Act.

n. Claimant means an individual claiming compensation under the Act.

o. Compensation Fund or Fund means the fund established on the books of the Department of the Treasury for payment of benefits and compensation under the EEOICPA.

p. A consequential injury is any injury, illness, or impairment sustained by a covered employee as a result of an occupational illness, or sustained by a covered DOE contractor employee as a result of a covered illness.

q. Contemporaneous record means any document created at or around the time of the event that is recorded in the document.

r. Coordination of Benefits with State Workers' Compensation (SWC) is to be determined when a claimant has received benefits from a SWC program for the same covered illness(es) to which he or she is to be awarded compensation under Part E, resulting in a possible reduction in the Part E award.

s. Covered child means, under Part E, a biological child, a stepchild who lived in a recognized parent-child relationship, or a legally adopted child of a covered DOE contractor employee, who at the time of the employee's death:

(1) Had not attained the age of 18 years;

(2) Had not attained the age of 23 years and was a full-time student who had been continuously enrolled as a full-time student in one or more educational institutions since attaining the age of 18 years; or

(3) Had been incapable of self-support at any age.

This term should only be used in reference to claims under Part E.

t. Covered DOE contractor employee means, under Part E, a Department of Energy contractor or subcontractor employee, or a RECA section 5 uranium worker who has been determined by OWCP to have contracted a covered illness through exposure to a toxic substance at a Department of Energy facility or a RECA section 5 facility, as

appropriate. This term should only be used in reference to claims under Part E.

u. Covered employee means, under Part B, a covered beryllium employee, a covered employee with cancer, a covered employee with chronic silicosis, or a covered uranium employee. This term should only be used in reference to claims under Part B.

v. Covered illness means, under Part E, an illness or death resulting from exposure to a toxic substance from employment at a DOE facility or a RECA section 5 facility. This term should only be used in reference to claims under Part E.

w. Covered uranium employee means, under Part B, an individual who has been determined by the Department of Justice to be entitled to an award under section 5 of RECA, whether or not the individual was the employee or the deceased employee's survivor.

x. Department means the United States Department of Labor (DOL).

y. Department of Energy (DOE) includes the predecessor agencies of the DOE, such as the Atomic Energy Commission and the Manhattan Engineering District.

z. Department of Energy (DOE) contractor employee means any of the following:

(1) An individual who is or was in residence at a DOE facility as a researcher for one or more periods aggregating at least 24 months; or

(2) An individual who is or was employed at a DOE facility by:

(a) An entity that contracted with the DOE to provide management and operation, management and integration, or environmental remediation at the facility; or

(b) A contractor or subcontractor that provided services, including construction and maintenance, at the facility.

aa. Department of Energy facility means any building, structure, or premise, including the grounds upon which such building, structure, or premise is located:

(1) In which operations are, or have been, conducted by, or on behalf of, the DOE (except for buildings, structures, premises, grounds, or operations covered by Executive Order 12344, dated February 1, 1982, pertaining to the Naval Nuclear Propulsion Program); and

(2) With regard to which the DOE has or had:

(a) A proprietary interest; or

(b) Entered into a contract with an entity to provide management and operation, management and integration,

environmental remediation services, construction, or maintenance services.

bb. Disability means that OWCP has determined entitlement to payment of Part B benefits for the covered occupational illness of chronic beryllium disease, cancer or chronic silicosis. This term should only be used in reference to a claimant entitled to benefits under Part B.

cc. Dose reconstructions (DRs) are used to estimate the radiation doses to which individual workers or groups of workers have been exposed, particularly when radiation monitoring is unavailable, incomplete, or of poor quality. Then methods are applied to translate exposure to radiation into quantified radiation doses at the specific organs or tissues relevant to the types of cancer occurring among the workers.

dd. Durable medical equipment (DME) means the appliances that a qualified physician prescribes or recommends for a covered occupational illness or a covered illness which OWCP considers necessary to treat the illness. Examples of DMEs include walkers, wheelchairs, or hospital beds.

ee. Equivalent dose means the absorbed dose in a tissue or organ multiplied by a radiation weighting factor to account for differences in the effectiveness of the radiation in inducing cancer.

ff. External dose means the portion of the equivalent dose that is received from radiation sources outside of the body.

gg. The Freedom of Information Act (FOIA) means the law that generally provides for public access to documents maintained by the government. It requires the government to release those documents upon request, unless the request or documents fall within one of nine exceptions listed in the law.

The FOIA also requires the publication of indexes of specified agency documents and records; provides time limitations for responding to requests; establishes a system of penalties for non-compliance with the time limitations; requires identification of persons responsible for granting or denying requests; provides for court review of denials, including classified materials; and provides for the levying of charges for searching and copying requested materials.

hh. Gaseous diffusion means a uranium enrichment process based on the difference in rates at which uranium isotopes in the form of gaseous uranium hexafluoride diffuse through a porous barrier.

ii. Impairment means a loss, loss of use, or derangement of any body part, organ system or organ functionality as it affects the whole body, as a result of the covered illness. An impairment rating is performed once the employee has reached Maximum Medical Improvement (MMI) or is terminal. [see paragraph(ll) below]. This term should only be used in reference to claims under Part E.

jj. Incapable of self support means the inability to obtain or retain employment, or engage in self-employment that provides a sustained living wage as a consequence of a physical or mental condition, illness or disease.

kk. Internal dose means the portion of the equivalent dose that is received from radioactive materials taken into the body.

ll. Maximum Medical Improvement (MMI) is when the covered illness is stabilized and is unlikely to improve with or without additional medical treatment.

mm. Occupational illness means, under Part B, a covered beryllium illness, cancer sustained in the performance of duty, specified cancer, chronic silicosis, or an illness for which DOJ has awarded compensation under section 5 of RECA. This term should only be used in reference to an individual(s) entitled to benefits under Part B.

nn. Offset is a reduction of the claimant's benefits under the Act. This is required if the claimant receives funds pursuant to a final judgment or settlement for the same accepted exposure that led to the accepted covered illness. Benefits that are excluded from an offset include:

(1) Workers' compensation benefits;

(2) Insurance policies; and

(3) A claim for loss of consortium filed by an individual other than the covered Part B or Part E employee.

oo. OWCP Medical Fee Schedule is a schedule of maximum allowable fees as determined by OWCP for the payment of medical and other health services furnished by physicians, hospitals, and other providers for an accepted occupational illness(es) and an accepted covered illness(es). The payment of fee for such service shall not exceed the maximum allowable charge with the exception of the following:

(1) Does not apply to charges for services provided in nursing homes; this does not include those charges for treatment furnished by a physician or other medical professionals in a nursing home; or

(2) Does not apply to charges for appliances, supplies, services or treatment furnished by medical facilities of the U.S. Public Health Service or the Departments of the Army, Navy, Air Force and Veterans Affairs.

pp. Physician includes surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors, and osteopathic practitioners within the scope of their practice as defined by state law.

The term "physician" includes chiropractors only to the extent that

their reimbursable services are limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by x-ray to exist.

qq. The Privacy Act means the statute governing a citizen's right to confidentiality of personal information, including financial and medical history, in records filed in a system of records under the individual's own name. This law sets forth the government's responsibility to properly maintain and restrict access to these records.

rr. Probability of causation (PoC) means the probability or likelihood that a cancer was caused by radiation exposure incurred by a covered employee in the performance of duty. In statistical terms, it is the cancer risk attributable to radiation exposure divided by the sum of the baseline cancer risk (the risk to the general population) plus the cancer risk attributable to the radiation exposure. Other terms for this concept include "assigned share" and "attributable risk percent."

ss. Radiation means:

(1) Ionizing radiation in the form of alpha particles, beta particles, neutrons, gamma rays, X-rays, or accelerated ions or subatomic particles from accelerator machines.

(2) Non ionizing radiation in the form of radio-frequency radiation, microwaves, visible light, and infrared or ultraviolet light radiation. This term should only be used in reference to claims under Part E.

tt. RECA means the Radiation Exposure Compensation Act of 1990, as amended, 42 U.S.C. § 2210 *note*. RECA is a federal statute implemented by Department of Justice that provides monetary compensation to individuals who contracted certain cancers and a number of other specified diseases as a result of defined on-site/downwind exposure to radiation released during above-ground nuclear weapons tests or as a result of their exposure to radiation during employment as uranium miners, millers, or ore transporters.

(1) Section 4 of RECA provides benefits for individuals with cancer who were either proximate to atomic tests at the Nevada Test Site (downwinder) or participated at the site of an atmospheric atomic weapon test (onsite participant).

(2) Section 5 of RECA provides benefits for individuals who have contracted a covered illness through exposure to a toxic substance during covered employment at a section 5 facility as a uranium miner, uranium mill worker, or as a uranium ore transporter.

uu. Specified Cancers are listed in Section 30.5(ff) of the regulations. An employee must be diagnosed with one of these

specific types of cancer to be considered eligible for benefits as a member of the Special Exposure Cohort (SEC). The list of specified cancers, which is derived from section 4(b)(2) of the RECA Amendments of 2000, is as follows:

(1) Primary or secondary lung cancer (other than a diagnosis of in situ lung cancer that is discovered during or after a post-mortem exam). Cancer of the pleura is also excluded;

(2) Primary or secondary bone cancer which also includes the following:

(a) Chondrosarcoma of the Cricoid Cartilage of the Larynx;

(b) Myelofibrosis with Myeloid Metaplasia;

(c) Myelodysplastic Syndromes;

(d) Polycythemia vera with leukocytosis and thrombocytosis; or

(e) Polycythemia rubra vera, also known as:

(i) Polycythemia vera;

(ii) P. vera;

(iii) Primary polycythemia;

(iv) Proliferative polycythemia;

(v) Spent-phase polycythemia; or

(vi) Primary erythremia.

(3) Primary or secondary renal cancers;

(4) Leukemia (other than chronic lymphocytic leukemia), only if onset occurred more than two years after initial occupational exposure;

(5) The following diseases, provided onset was at least five years after first occupational exposure:

(a) Multiple myeloma;

(b) Lymphomas (other than Hodgkin's disease);

(c) Primary cancer of the:

(i) Thyroid;

(ii) Male or female breast;

(iii) Esophagus;

(iv) Stomach;

(v) Pharynx (tonsil cancer is a cancer of the pharynx and is therefore included);

(vi) Small intestine;

(vii) Pancreas;

(viii) Bile ducts;

(ix) Gall bladder;

(x) Salivary gland;

(xi) Urinary bladder (due to biological and etiological similarities, Ureter cancer and Urethral cancer are included);

(xii) Brain (which consists of the cerebrum, cerebellum, brain stem, and diencephalon and *excludes* intracranial endocrine glands and other parts of the central nervous system);

(xiii) Colon (due to anatomical similarities, Rectal cancer is included);

(xiv) Ovary; or

(xv) Liver (except if cirrhosis or hepatitis B is indicated).

A Carcinoid tumor of the organs listed above may be considered as a specified cancer.

The specified diseases in this section mean the physiological condition or conditions that are recognized by the National Cancer Institute under those names or nomenclature, or under any previously accepted or commonly used names or nomenclature.

vv. Spouse of a covered employee or covered DOE contractor employee means a wife or husband of that employee who was married to that individual for at least one year immediately before the death of that individual.

ww. Survivor means:

(1) For claims under Part B, a surviving spouse, child, parent, grandchild and grandparent of a deceased covered employee; or

(2) For claims under Part E, a surviving spouse and covered child of a deceased covered DOE contractor employee.

xx. Time of injury means:

(1) In regard to a claim arising out of exposure to beryllium or silica, the last date on which a covered Part B employee was exposed to such substance in the performance of duty as specified in sections 7384n(a) or 7384r(c); or

(2) In regard to a claim arising out of exposure to radiation under Part B, the last date on which a covered Part B employee was exposed to radiation in the performance of duty as specified in section 7384n(b); or

In the case of a member of the Special Exposure Cohort under Part B, the last date on which the member of the

Special Exposure Cohort was employed at the DOE facility or the atomic weapons employer facility at which the member was exposed to radiation; or

(3) In regard to a claim arising out of exposure to a toxic substance under Part E, the last date on which a covered Part E employee was employed at the DOE facility or RECA section 5 facility, as appropriate, at which the exposure took place.

yy. Toxic substance means any material that has the potential to cause illness or death because of its radioactive, chemical, or biological nature.

zz. Uncertainty distribution is a statistical term meaning a range of discrete or continuous values arrayed around a central estimate, where each value is assigned a probability of being correct.

aaa. Wage loss is based on the number of calendar years that the covered DOE contractor employee was unable to work or sustained a reduction in wages as a result of the covered illness. Wage loss compensation is payable for the years of lost wages occurring prior to the covered DOE contractor employee's normal Social Security retirement age, as determined by his or her date of birth. This term should only be used in reference to claims under Part E.

bbb. Workday means a single workshift, whether or not it occurred on more than one calendar day.

ccc. Worst-case assumption is a term used to describe a type of assumption used in certain instances for certain dose reconstructions. It assigns the highest reasonably possible value to a radiation dose of a covered employee based on reliable science, documented experience, and relevant data.

Exhibit 1: Abbreviations

Exhibit 2: Forms

PM Part 1 – Mail and Files

Part 1

- **1-0100 Introduction**

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1. Purpose and Scope. This part of the Energy Employees Occupational Illness Compensation Program Act (EEOICPA) Procedure Manual (PM) addresses the processing and movement of mail and case files within the Division of Energy Employees Occupational Illness Compensation (DEEOIC) and the handling of documentation within the District Office (DO), the Secondary Claims Examiner (CE2) Unit, the Final Adjudication Branch (FAB), and the National Office (NO). It also discusses how to create case files, maintain case files, and assign docket numbers to case files referred to FAB.

2. Responsibilities. Effective handling of mail and files is a responsibility for all DEEOIC staff.

a. Mail and File (M&F) Staff. M&F Staff process mail, create and maintain physical case files, pull and deliver case files within a DEEOIC Office, and loan or transfer case files to other DEEOIC Offices.

b. Automated Systems Support Staff. Systems support staff create and transfer case files in the automated system, enter data, key location changes, assign docket numbers, and produce reports to support case processing.

c. Claims Examiners (CE), CE2, FAB Representatives, and NO Representatives. Personnel in the claims processing units key location and status changes in the Energy Case Management System (ECMS). These staff members are responsible for ensuring that case files are forwarded to the appropriate locations within their respective offices. Only files with pending action are kept at the physical location of the applicable CE, CE2, FAB Representative, or NO Representative.

3. Contents of Part 1. The chapters and their subjects are:

a. Chapter 1-0200, Processing Mail. This chapter describes the kinds of mail which the DOs, CE2 Units, FABs, and NO receive and how to handle each kind, including priority correspondence. It also addresses sorting, recording, and searching for mail, safeguarding Personally Identifiable Information (PII), processing outgoing mail, and the proper handling of returned mail.

b. Chapter 1-0300, Case Creation. This chapter describes the contents of new cases and additional new claims, and how to create them as physical files and as electronic records in ECMS. Duplicate cases, withdrawn claims, and the deletion of claims from ECMS are also discussed. How to determine a new claim's file date and received date, along with the proper handling of additional new claims received during different stages of the claims process are also described. This chapter also discusses the role of Resource Centers in assisting the claimant with the filing of a claim.

c. Chapter 1-0400, Case Maintenance. This chapter describes how to maintain case files. It includes procedures for dividing file material, reconstructing, and repairing damaged folders. It also addresses the FAB docketing process and changes made in ECMS, including a change of address.

d. Chapter 1-0500, Transfers and Loans. This chapter describes how to send case files between the various offices within the DEEOIC on either a temporary or permanent basis and how to refer case records to the National Institute for Occupational Safety and Health (NIOSH) or to a medical or scientific specialist in NO.

4. Automated Systems Support. The work of the M&F Staff is closely tied to the automated systems support functions within the DO, CE2 Unit, FAB, and the NO and some of those functions are referenced in the chapters that follow. Specific instructions for using the automated system are set forth in the Energy Case Management System (ECMS) Users Manuals and related policy will be found in EEOICPA PM 2-2000 and 2-2100.

1-0200 Processing Mail

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1. Purpose and Scope. This chapter identifies the different kinds of mail received in a Division of Energy Employees Occupational Illness Compensation (DEEOIC) Office and describes the procedures for processing them. Instructions are provided on how to sort, open, and date-stamp incoming mail. In addition, procedures for searching cases for mail association, processing outgoing mail, and handling returned mail are provided. Guidance is also provided for the handling of priority correspondence, including requests under the Freedom of Information Act (FOIA) and the Privacy Act, and the safeguarding of Personally Identifiable Information (PII) in the disclosure of claim records.

2. Mail and File (M&F) Staff. These individuals process mail received in the District Office (DO), Secondary Claims Examiner (CE2) Unit, Final Adjudication Branch (FAB), and the National Office (NO). They open and date-stamp incoming mail and then use the **"Inquiry"** option in the Energy Case Management System (ECMS) to obtain file numbers and case locations. They also determine the responsible Claims Examiner (CE), CE2, FAB Representative, or NO Representative, key case locations, and place incoming mail in the responsible staff member's mailbox. These individuals are also responsible for processing outgoing mail.

3. Types of Mail. Most mail received by a DEEOIC Office is through the U.S. Postal Service (USPS). However, some mail is received by private overnight mail service, facsimile transmission (fax), electronic mail (e-mail), or by hand. Mail is grouped as follows:

a. Priority Correspondence. The Department of Labor (DOL) considers mail to and from the following parties as priority correspondence:

(1) The President and White House Staff;

(2) The Vice President and members of the Vice President's staff;

(3) The President Pro Tempore of the Senate;

(4) The Speaker of the House of Representatives;

(5) Other Members of Congress;

(6) Members of the Cabinet;

(7) Heads of independent Federal establishments;

(8) Governors of States;

(9) Foreign government officials (e.g., Prime Ministers, Cabinet-level officers, Ambassadors, etc.);

(10) Directors/Managers of employee organizations;

(11) Directors/Managers of national and international labor organizations;

(12) Members of the press; and

(13) Requestors of data under the Freedom of Information Act (FOIA) and the Privacy Act.

b. Primary Claim Forms. These documents, which contain information on new claims, include:

(1) EE-1, Claim for Benefits under the EEOICPA;

(2) EE-2, Claim for Survivor Benefits under the EEOICPA; and

(3) Any letter or document containing "words of claim" under the EEOICPA. "Words of claim" simply means that the individual is requesting benefits under the EEOICPA.

c. Bills. Form OWCP-1500 is used to bill the Office of Workers' Compensation Programs (OWCP) for medical services and supplies. Hospital bills are submitted on the Form OWCP-04. Form EE-915 is used for employee reimbursement of out-of-pocket medical expenses. Form OWCP-957 is used for employee reimbursement of medical travel expenses.

d. Routine Mail. This mail, which is screened by designated DEEOIC staff, includes:

(1) Documents from claimants and their authorized representatives, such as: medical records; employment records; exposure records; birth, marriage, and death certificates; school records; affidavits; address changes; waivers; and requests for an oral hearing, a review of the written record, a reconsideration, or a reopening;

(2) Documents from the Department of Energy (DOE), contractors, and/or subcontractors;

(3) Information from other agencies, such as the Department of Health and Human Services (HHS), National Institute for Occupational Safety and Health (NIOSH), Social Security Administration (SSA), and the Department of Justice (DOJ);

(4) Medical reports from attending physicians;

(5) Mail from contractual sources, including reports from The Center to Protect Workers' Rights (CPWR), District Medical Consultants (DMCs), and second opinion and referee specialists;

(6) Occupational/Exposure reports from Industrial Hygienists (IHs) and Toxicologists (TXs);

(7) Requests for information from other Federal, state, and local government agencies; and

(8) Case-specific documents forwarded from other offices within DEEOIC, including the Resource Centers (RC), for file association.

e. Other Mail. This includes mail which does not concern specific claims.

4. Initial Sort. The M&F Clerk(s) separates certain envelopes from the rest of the incoming mail, as follows:

a. Mail for Delivery Without Opening. This mail includes:

(1) Certified mail which requires the M&F Clerk to sign a receipt;

(2) Mail for the Director, Regional Director, Branch Chiefs, District Director, or the administrative staff, who consist of the Administrative Officer, Management Officer, and the secretaries who conduct business on behalf of the NO, Regional Office, FAB, or the DO;

(3) Material from the NO; and

(4) Mail marked "Do Not Open in Mail Room" or the like (at the discretion of the DO, FAB, Regional Office, or NO).

b. Mail for a Third Party Outside of OWCP. If the third party is located in the same building, the mail is delivered to him or her. If not, it is returned to the sender unopened.

5. Opening and Date-Stamping Mail.

a. Opening Mail. The M&F Clerk must:

(1) Check the contents inside of each envelope carefully to ensure that all contents are removed. If the contents include a Form EE-1 or EE-2, correspondence with words expressing the desire to file a claim, a waiver, or a request for an oral hearing, a review of the written record, a reconsideration, or a reopening, the envelope is kept and attached to the document; and

(2) Circle the file number.

b. Date-Stamping Mail. The date stamp prints the location of the receiving DEEOIC Office and the year, month, day, and time of receipt. The date stamp is either an ink stamp or a perforated stamp. All incoming mail is date-stamped before leaving the Mail Room. The M&F Clerk date-stamps each item of mail on the front of the item. If a piece of mail consists of multiple pages, each page is date-stamped individually. The date stamp reflects the

actual date that the incoming mail is received in a DEEOIC Office, and not necessarily when it is reviewed by a DEEOIC staff member.

(1) If an ink stamp is used, the stamp is not placed over any writing.

6. Identifying Case Locations. The M&F Clerk identifies which case each piece of mail belongs to and its location prior to associating

the mail with the case.

a. Unnumbered Mail. If the mail does not contain a file number, the M&F Clerk finds the number by entering the claimant's name in the "**View Case**" function under the "**Inquiry**" option in ECMS.

(1) If a match is found, the M&F Clerk notates the file number, current location code, and the assigned CE, CE2, FAB Representative, or NO Representative in the upper right corner. The mail is then placed in the appropriate location to be sorted and forwarded to the assigned DEEOIC staff member.

(2) If a match is not found, the M&F Clerk writes "NID" (not in database) in the upper right corner and gives it to the appropriate Supervisory CE or Manager, who decides whether to create a case, route the mail within the respective DEEOIC Office without having to create a case, or return it to the sender.

b. Numbered Mail. If the mail contains a file number, the M&F Clerk uses the "**View Case**" function under the "**Inquiry**" option in ECMS to obtain the current location code and the assigned CE, CE2, FAB Representative, or NO Representative. He or she notates that information on the upper right corner.

(1) If an error message appears when the file number is entered, the M&F Clerk enters the claimant's name in the "**View Case**" function under the "**Inquiry**" option in ECMS to verify that the mail contains the correct file number. If it does not, the M&F Clerk notates the correct number in the upper right corner on the piece of mail.

(2) If the correct file number cannot be identified, the M&F Clerk gives the mail to the appropriate DEEOIC staff member (See paragraph 6a(2) above).

c. Mail for Other DEEOIC Offices. Mail sent to other DEEOIC Offices, including mail for cases that have been loaned or transferred, is date-stamped, collected, and forwarded to the appropriate DEEOIC Office, as identified in ECMS, on a daily basis by the USPS or by private overnight mail service.

7. Handling of Mail. After checking the mail for its file number and location, the M&F Clerk handles it according to type.

a. Groups of Mail. The M&F Clerk sorts the mail into the following groups:

(1) Priority correspondence, along with the case file, is hand carried to the person designated to handle priority correspondence in the DEEOIC Office;

(2) Primary claim forms require creation of a new case unless a case has already been created and coded (See EEOICPA PM 1-0300). The M&F Clerk then keys the case in ECMS and delivers it to the assigned CE, CE2, FAB

Representative, or NO Representative;

(3) Bills including, but not limited to, medical services/testing, medical supplies, medical travel expenses, home and automobile modifications, spa/gym membership, and impairment rating reports (performed by the claimant's chosen physician) for the accepted condition(s) are forwarded to the assigned CE, CE2, FAB Representative, or NO Representative who then forwards them to the Bill Processing Agent (BPA) on behalf of the claimant.

Bills for copying medical records for a claimed condition(s) are forwarded to the assigned CE, CE2, FAB Representative, or NO Representative who then forwards them to the BPA on behalf of the claimant.

Bills for medical reports from DMCs are first routed to the District Medical Scheduler, for tracking purposes, who then forwards to the assigned CE, CE2, FAB Representative, or NO Representative for review and coding in ECMS.

In those cases where there is an offset/surplus, it is especially important for DEEOIC staff to review incoming bills (excluding those for impairment ratings or from DMCs) and then forward to the Fiscal Officer for tracking purposes;

(4) Routine mail is sorted by assigned CE, CE2, FAB Representative, or NO Representative and delivered to each respective unit. However, the following kinds of mail are delivered directly to the Fiscal Officer, at the DO's discretion:

(a) Requests for action when a check was lost or an electronic funds transfer (EFT) was not received; and

(b) Transactions or other documents from the Department of the Treasury; and

(5) Other mail is handled as follows:

(a) General inquiries include questions about OWCP's practices and requests for technical assistance. Letters in this category are routed accordingly at the discretion of the applicable DO, FAB, or NO; and

(b) Interoffice memorandums are routed according to the party addressed.

b. Sorting and Associating Mail. Mail screened by the M&F Clerk is sorted each day and associated with the case files.

(1) When mail is placed in the assigned DEEOIC staff member's mailbox, the case file remains where it is, or is retrieved and given to the person working at that location, according to specific procedures established in each DO,

FAB, and in NO.

(2) The M&F Clerk does not remove a case file from its location (other than from the File Room) without notifying the DEEOIC staff member responsible for it. The M&F Clerk enters a location code change in the "**Case Update**" screen of ECMS for any case that is moved (See EEOICPA PM 1-0500 Exhibit 2).

8. Responding to Priority Correspondence. Priority correspondence generally pertains to the request of information and/or status on a claim from the claimant or an authorized third party. Consequently, priority correspondence is very delicate in nature and highly time sensitive, which requires careful attention in its review and response. Actions pertaining to the receipt of and response to priority correspondence must be properly tracked.

Of the priority correspondence listed in paragraph 3a above, the more common ones encountered during the claim adjudication process are Freedom of Information Act (FOIA) requests, Privacy Act requests, and Congressional Inquiries. These requests are submitted in writing and signed by the claimant or authorized representative. In instances where a third party makes the request, a waiver signed by the claimant or authorized representative must be included.

a. Freedom of Information Act. Freedom of Information Act (FOIA) requests allow third parties to request and gain access to existing Federal Government information, as outlined under 5 U.S.C. §552. FOIA requests are very important, as they involve the disclosure of specific documentation pertaining to the DEEOIC and/or its claimants.

FOIA requests are highly time sensitive and require careful attention. Each DEEOIC Office needs to have a FOIA coordinator to effectively facilitate the identification and processing of FOIA requests. The request itself contains such verbiage that includes "request for records" and/or the acronym "FOIA". Exhibit 1 is the FOIA Process Flow chart which identifies the steps to take in order to accurately and expeditiously process a FOIA request that is received in a DEEOIC Office.

b. Privacy Act. The Privacy Act of 1974, 5 U.S.C. §552a, applies to an individual seeking information about him or herself. The law provides an individual the right to access records that are maintained in federal "systems of records" (e.g., claim files) and are retrievable by his or her name or other personal identifier.

Examples of Privacy Act requests received by DEEOIC include requests for a copy of an entire case file or a specific document from the case file (e.g., a DMC report, SSA records). Privacy Act requests are submitted by claimants, authorized representatives, or third parties.

c. Congressional Inquiries. On behalf of their constituents,

written inquiries are made by Congressional Offices pertaining to a claimant's DEEOIC claim. These inquiries are reviewed and responded to in a written letter to the requesting Congressional Office within a timely manner.

9. Personally Identifiable Information (PII). Personally Identifiable Information (PII) is defined as information that can be used to distinguish or trace an individual's identity, such as his or her name, Social Security Number (SSN), or biometric records, alone, or when combined with other personal or identifying information that is linked or linkable to a specific individual, such as a date and place of birth or mother's maiden name.

During the claim adjudication process, the DEEOIC collects, maintains, and shares a large amount of data. It is of utmost importance that all DEEOIC staff maintains the integrity of the privacy of the claim records and safeguard the PII contained within the documents from unauthorized and improper disclosure. In addition, DEEOIC staff need to exercise care and vigilance in the daily operations of accessing, processing, transporting, and storing of sensitive data on end-user computing devices and portable media. All DEEOIC staff must ensure that information provided to the recipient (e.g., development letters, Recommended Decisions, Final Decisions, Director's Orders, copies of records) is accurate and pertains to that recipient (does not contain another individual's PII).

a. Protected PII. Protected PII is information, which if disclosed, can result in harm to the individual whose name or identity is linked to that information. Examples of Protected PII include, but are not limited to, the following: SSN; credit card number; bank account number; residential address; residential or personal telephone number; biometric identifier (e.g., image, fingerprint, iris); date of birth; place of birth; mother's maiden name; criminal records; medical records; and financial records.

b. Non-Sensitive PII. Non-sensitive PII is information, which if disclosed, cannot reasonably be expected to result in personal harm to the individual the information is linked to. Examples of non-sensitive PII that can become Protected PII if linked with other Protected PII include the following: first/last name; e-mail address; business address; business telephone; and general education credentials.

c. Categories of PII that Indirectly Identify an Individual.

(1) Any information where it is reasonably foreseeable that the information can be linked with other information to identify an individual;

(2) Documentation not containing a name or SSN but containing a place of birth and mother's maiden name, which when taken together, can identify a specific individual;

and

(3) Documentation containing the name or names of other individuals (e.g., names of co-workers).

d. Information Pertaining to Deceased Individuals. An individual's right to privacy ends upon his or her death. Therefore, a deceased person's name, address, or SSN is not PII; however, documentation referring to a deceased person can contain PII regarding living relatives, authorized representatives, or work associates. As such, the DEEOIC staff member must be cognizant and cautious about the information pertaining to living individuals in the deceased employee's case record.

e. Information Pertaining to Living Individuals. All DEEOIC staff must prevent the unauthorized release of PII contained in paper records, CDs, electronic records (e.g., e-mails), or any other material for any living individual. This includes materials received from NIOSH, DOE (e.g., Document Acquisition Request (DAR) records), CPWR, corporate verifiers, RCs, unions, or any other source.

(1) CDs from NIOSH and DOE often contain PII on other individuals. The DEEOIC staff member must thoroughly review all the documents on the CD before releasing the information. If a document contains PII on an individual other than the claimant, the DEEOIC staff member prints the document and redacts the other individual's PII by concealing the information with a black marker, opaque tape, or other method that completely removes the PII. The DEEOIC staff member then makes a photocopy of the newly redacted record to ensure that the redacted information cannot be detected from the document(s).

DEEOIC staff identify CDs (which remains in the case file) that contain PII on other individuals by placing a label on it that states the following:

NOTICE DEEOIC EMPLOYEE:

This CD and/or printed documents from the CD, **includes confidential information on workers other than this employee.** This information must be carefully reviewed and redacted before any release of the information from the CD, whether by electronic or printed version, pursuant to the Privacy Act. Monetary fines may be imposed on an individual government employee for release of confidential information or personally identifiable information.

(2) All DEEOIC staff must comply with all prescribed OWCP directives concerning the use of e-mails containing PII.

(a) E-mails sent from one DEEOIC employee to another DOL employee through the Employment Standards Administration (ESA) wide-area network (WAN) are

considered secure. E-mails to and from contractors who use the ESA network (ESA owned and properly configured equipment, including remote laptops that access the ESA WAN) are also considered secure. Central Bill Process (CBP) "threads" provided through the BPA's secured website conform to this policy, as they are also secured within an accredited network.

DEEOIC staff are permitted to list the employee's name and file number in the body of an e-mail message. However, the employee's name (non-sensitive PII) combined with the file number (Protected PII) is not permitted to be listed in the subject portion of the e-mail (can only list one or the other).

(b) E-mails between DEEOIC employees and parties outside of the ESA network (e.g., RCs, corporate verifiers, NIOSH, DOE) are not secured. As a result, DEEOIC staff are not permitted to disclose any Protected PII in any part of the e-mail message and the attachments must be password protected or encrypted. Therefore an e-mail message can contain the last name and last four digits of an individual's SSN in the text of the message, as long as the remainder of the SSN, full name, or other PII is not listed anywhere in the e-mail message. As such, DEEOIC staff must either fax or mail development letters to corporate verifiers.

(c) DEEOIC staff are permitted to receive e-mails that contain PII in the message from a party outside of the ESA network. Case specific e-mails received from an outside party containing Protected PII are printed and placed in the case file. However, DEEOIC staff must not confirm the existence of cases for specific claimants to members of the public who are not a party to the cases. DEEOIC staff are only permitted to reply with an acknowledgement e-mail, removing any personal identifiers from the sender's message and also advising the sender (e.g., claimants, physicians, Congressional Offices) that DEEOIC does not conduct claims communication over e-mail, but by telephone or letter instead, as the e-mail cannot be considered secured.

In addition, DEEOIC staff remove Protected PII in e-mail message chains and attachments prior to forwarding them outside of the ESA network. However, if it is not possible to alter or redact the document or e-mail, or if it is necessary that the attachment or e-mail includes both the claimant's name and file number or SSN, then the DEEOIC staff member faxes or

sends the document via mail or courier to the appropriate party. Packages containing extracts of multiple Protected PII records (e.g. to CPWR, DOE, RCs) sent via courier need to be tracked (e.g., by Registered Mail, Return Receipt, Fed Ex).

(d) E-mail messages with the BPA concerning claimants are to only include the claimant's CBP Member ID (from the CBP claimant eligibility file). Claimant names are not included in the e-mail message, unless they are provided in an encrypted attachment.

f. Handling the Signed Written Request for Copy of Case. Upon receiving a signed written request from a claimant or authorized representative for a copy of the case file, the assigned CE, CE2, FAB Representative, or NO Representative takes the following actions for the release of records in a paper format:

(1) Completes the Data Release Form (See Exhibit 2) by listing the employee's name, file number, name of the assigned CE, date of the request to copy the file, name of the requestor for the file copy, and to whom the file copy is to be sent to;

(2) Copies the case file and reviews each page of the copied documents for any PII that does not belong to the requestor;

(3) Redacts any PII found, not belonging to the requestor, to thoroughly conceal the PII. Once completed, the assigned CE, CE2, FAB Representative, or NO Representative lists his or her name as the Initial Reviewer, the date in which the Initial Review was completed, and signs his or her name with the date at the bottom of the form;

(4) Copies the redacted documentation and combines that with the remainder of the copied documentation that did not require redaction;

(5) Forwards the photocopies, the case file, and the signed Data Release Form to his or her Senior CE, Supervisory CE, or FAB Hearing Representative (the Final Reviewer) to ensure the documents are appropriately redacted; and

(6) Mails the documentation to the requestor, once the second level of verification has been completed with the Final Reviewer listing his or her name, signing, and dating the Data Release Form. The original copy of the Data Release Form is filed down on the spindle in the original case file.

g. Protected PII and Portable Media.

(1) DEEOIC staff only store Protected PII on portable

media when absolutely necessary, as determined by DEEOIC. Protected PII on portable media devices including laptops issued by DOL must be protected with encryption. All removable storage media, such as flash drives, CDs, DVDs, writable optical media, and external hard drives that store Protected PII, must be encrypted.

All reasonable measures are taken to ensure that portable media containing Protected PII are stored inside a safe or in a secured, locked cabinet, room, or area during periods when the media is not in transit or in active use.

(a) DOE and NIOSH submit CDs containing claimant PII to DEEOIC in accordance with DOE and HHS policies. Both DOE and NIOSH have assured DEEOIC that these policies address the sensitivity of the materials, and provide adequate protection of claimant PII.

(2) Delivery of portable media containing Protected PII including CDs, DVDs, or other writable media is done through the USPS or another DOL authorized delivery service with the ability to track pickup, receipt, transfer, and delivery. The portable media needs to be encrypted according to DOL standards and then double-wrapped in an opaque package or container that is sufficiently sealed to prevent inadvertent opening or signs of tampering. The decryption key is not included in the same package as the portable media, but instead sent in a separate package.

h. Disposal of Documents and Electronic Media Containing Protected PII. Documents and electronic media containing PII are not discarded in wastebaskets, but instead discarded in recycle bins picked up for shredding or burning.

i. Improper Release of Protected PII. If Protected PII is improperly released as a result of the inadvertent mailing of a case record copy to an incorrect individual or the documentation sent to the correct individual contains Protected PII of another person that was not redacted, a DEEOIC staff member must take the following actions:

(1) Contacts the individual via telephone and registered mail to request the return of the document. The DEEOIC staff member provides a self-addressed, stamped envelope for the return of the material directly to the DEEOIC Office;

(2) Immediately notifies his or her management who in turn notifies the Regional Director, who complies with established Departmental reporting requirements documenting the type of PII disclosure, the circumstances surrounding the disclosure and how it was discovered, the appropriate actions taken to recover the PII document in question, and

the disposition of the recovery effort; and

(3) Tracks each PII recapture request within the Regional or FAB Office.

(a) If the recapture of the PII documentation is successful, the incident becomes closed with the incident record filed and maintained in OWCP.

(b) If the third party in possession of the improperly released documentation refuses to return it, the DEEOIC staff member reports the situation through his or her management, through the Regional Director, to the NO who provides guidance on determining what actions need to be taken.

10. Outgoing Mail. Outgoing mail is processed as follows:

a. Envelopes. All envelopes show the addressee's full mailing address, including the ZIP code. If the addressee provides a P.O. Box and a street address, both are listed on the envelope. Some post offices require a further separation of local mail, and such requirements are honored.

b. Heavy Envelopes and Packages. Such parcels are securely wrapped with heavy-duty plastic tape. Likewise, boxes of case files are packed securely.

c. Postage. A postage meter is used to affix postage. Airmail letters for overseas delivery are bundled separately from regular mail.

d. Registered and Certified Mail. These types of mail are processed according to USPS regulations and specific procedures established in each DO, FAB, and in NO.

e. Overnight Express Mail. The services of the designated contractor are used at the discretion of the DO, FAB, or NO.

11. Returned Mail. At any point during the processing of a claim, there are instances when a DEEOIC Office mails correspondence to the claimant or authorized representative and it gets returned to the DEEOIC Office by the USPS. The effective handling of claims depends heavily on ensuring that the claimant and authorized representative receive the correspondence sent by a DEEOIC Office. Therefore it is important that a DEEOIC Office has the claimant’s and authorized representative’s current mailing address and phone number(s) and if not, then to make sufficient attempts to find/obtain that information, prior to administratively closing the claim. The returned mail is filed down on the spindle and retained in the case file.

a. Inaccurate Mailing Address. On occasion, printing errors occur in which the claimant’s or authorized representative’s mailing address on correspondence contains a typo, is transposed, or is incomplete. When this occurs, the USPS returns the correspondence as

returned mail. The assigned CE, CE2, FAB Representative, or NO Representative reviews the mailing address on the correspondence and compares it to the mailing address on the claim form, ECMS and/or signed authorized representative letter to determine if a typo (e.g., N**Y** vs. N**M**) or transposition (e.g., 32**10** vs. 32**01**) was made, or part of the address was missing (e.g., left out the ZIP code). If this is the case, then the assigned CE, CE2, FAB Representative, or NO Representative resends the correspondence with a corrected version of the mailing address and updated/current date. In addition, since the returned mail was as a result of a DEEOIC Office's action, the "**Claim Status Dt**" (of that specific claim status code) is updated under the "**Claim Status History**" section in the "**Claim Update**" screen of ECMS with the date of the resent correspondence.

b. Mailing Address Not Fully Visible in Window Envelop. The USPS returns mail when the mailing address is not fully visible in the window envelope. In this instance the assigned CE, CE2, FAB Representative, or NO Representative either resends the correspondence (with an updated/current date) in another window envelope ensuring that the correspondence is folded in such a way that the mailing address is fully visible or encloses the correspondence in an envelope with the address printed on the outside. The assigned CE, CE2, FAB Representative, or NO Representative must also ensure that the mailing address is correct and error free prior to resending the correspondence. In addition, since the returned mail was as a result of a DEEOIC Office's action, the "**Claim Status Dt**" (of that specific claim status code) is updated under the "**Claim Status History**" section in the "**Claim Update**" screen of ECMS with the date of the resent correspondence.

c. Forwarding Address. Sometimes claimants or authorized representatives notify the USPS but not a DEEOIC Office of a temporary or permanent change of address. When this happens and a DEEOIC Office receives returned mail, the USPS affixes a label on the returned mail/envelop with the forwarding address. The assigned CE, CE2, FAB Representative, or NO Representative resends the correspondence to the forwarding address and encloses a request letter to the claimant or authorized representative requesting a signed letter providing his or her current mailing address and phone number(s), which is updated in ECMS and in the case file (See EEOICPA PM 1-0400). Since the returned mail was not as a result of a DEEOIC Office's action, the date of the correspondence and claim status code in ECMS does not change (does not get updated in ECMS with the current date).

d. Unknown Address. When mail is returned, without a forwarding address provided by the USPS, printing error, or not being fully visible in a window envelope, the assigned CE, CE2, FAB Representative, or NO Representative takes the following actions to determine the mailing address for the claimant or authorized

representative:

(1) Check the Social Security Death Index Interactive Search website at http://ssdi.rootsweb.ancestry.com/cgi-bin/ssdi.cgi to determine if the claimant or authorized representative is deceased or not. A print out of the search is made and filed down on the spindle in the case file;

(2) Call the claimant or the authorized representative, explain the situation about the returned mail, request the current mailing address over the phone, and advise that he or she must provide a signed letter with the updated address. The assigned CE, CE2, FAB Representative, or NO Representative follows up the phone call with a written letter memorializing the phone conversation and requesting a signed letter with the updated address to be submitted to the DEEOIC Office.

When the case file contains multiple claimants, the assigned CE, CE2, FAB Representative, or NO Representative contacts the other claimant(s) to see if they have any contact information on the claimant or authorized representative;

(3) Review the case file in its entirety to determine if any new/different contact information for the claimant or authorized representative exists in any of the evidence;

(4) Contact the RC to see if they have contact information on the claimant or authorized representative;

(5) Send a letter to the USPS Postmaster to inquire about the current mailing address for the claimant or authorized representative. The letter includes the name (non-sensitive PII) and last known address of the claimant or authorized representative (not considered as Protected PII because evidence in the file, via the returned mail, shows that the address is no longer linked to his or her identity)(See paragraph 9 above).

The letter is addressed to the Postmaster at the city, state, and five digit ZIP code of the claimant's or authorized representative's last known address. After the five digit ZIP code, a dash is followed by "9998". This alerts the Postmaster to determine the local post office that last provided mail delivery service to the claimant or authorized representative.

The assigned CE, CE2, FAB Representative, or NO Representative provides his or her name, phone number, fax number, and mailing address in the letter for the USPS Postmaster to contact with the response (See Exhibit 3 for a sample letter). For contact information (e.g., phone number, fax

number) on the claimant's or authorized representative's local post office(s), the assigned CE, CE2, FAB Representative, or NO Representative goes to the website at http://www.usps.com/ and picks the option "Locate a Post Office".

e. Administrative Closure of Claim. Once the assigned CE, CE2, FAB Representative, or NO Representative has exhausted all efforts and is unable to obtain the current mailing address for the claimant or authorized representative, the claim is in a posture for an administrative closure. The assigned CE, CE2, FAB Representative, or NO Representative prepares a memorandum, for his or her Supervisory CE's or Manager's review and signature, stating how the claim is being administratively closed because of returned mail and outlining the actions/attempts taken to obtain the current mailing address. The signed memorandum is filed down on the spindle and retained in the case file. The Supervisory CE or Manager enters **"C2-Admin Closure"** under the **"Claim Status History"** section in the **"Claim Update"** screen of ECMS. The **"Claim Status Dt"** is the date of the signed memorandum.

Exhibit 1: FOIA Process Flow

Exhibit 2: Data Release Form

Exhibit 3: USPS Postmaster Address Request Letter

1-0300 Case Creation

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1. Purpose and Scope. This chapter describes the contents of new cases, the basis for creating them, and the procedures for determining whether a new claim is considered as filed under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA) Part B, Part E, or both. Guidance is also provided on the proper handling of additional new claims received during different stages of the claims process.

This chapter also describes the role of the Resource Center (RC), the District Office (DO), and the Secondary Claims Examiner (CE2) Unit in the case creation process. How to create the physical files and, in general, how to create the electronic records in the Energy Case Management System (ECMS) are also covered in this chapter. And lastly, the process for handling withdrawn claims, duplicate cases, and the deletion of claims from ECMS is also discussed.

2. New Cases. A new case usually consists of a Claim for Benefits, Form EE-1 or EE 2, with the accompanying Form EE 3, Employment History for a Claim Under the EEOICPA.

a. Written Notice. A new case is created based on signed written communication from the claimant, claimant's authorized representative, or a person acting on behalf of the claimant (e.g., a relative, guardian). Any one of the following documents is considered a request for benefits:

(1) Form EE-1, Employee's Claim for Benefits;

(2) Form EE-2, Survivor's Claim for Benefits; or

(3) Any letter or document containing "words of claim" under the EEOICPA. "Words of claim" simply means that the individual is

requesting benefits under the EEOICPA.

b. Resource Center. Each RC receives new Claims for Benefits, Forms EE 1 and EE 2, and provides assistance to claimants in the filing of their claims. The RC date-stamps the claim forms upon receipt into their office. In instances when the claimant mails the claim form to the RC, the postmarked envelope is kept and attached to the claim form.

(1) Initial Employment Verification. As needed, RC staff assist the claimant in completing the Form EE-3, Employment History for a Claim Under the EEOICPA. For all new non-Radiation Exposure Compensation Act (RECA) claims filed at the RC, the RC staff conduct initial employment verification by using the "**Search Orise Data**" function under the "**Inquiry**" option in ECMS, sending a Department of Energy (DOE) Employment Verification Request, Form EE-5, or by sending a request to a corporate verifier, as appropriate.

(2) Occupational History Development. RC staff also conduct occupational history development on most claims filed under Part E. This generally involves conducting an Occupational History Interview.

(3) Time Frames. Within seven calendar days after receipt of a claim, the RC staff complete all possible initial employment verification and occupational history development.

After taking the actions listed above, the RC then prepares a memorandum to the DO or CE2 Unit outlining their involvement with the claim. The RC also forwards a checklist to the DO or CE2 Unit, which identifies their completed actions on the claim. All claim forms, employment verification, occupational history development, and associated documentation are included in the package referred to the DO or CE2 Unit.

c. New Cases Received Directly in the DO or CE2 Unit. The DOs and CE2 Units generally receive new claims directly from the RC after they have conducted the initial development steps outlined above. However, sometimes new claims are received directly in the DO or CE2 Unit from the claimant, authorized representative, or a person acting on behalf of the claimant. Such cases are immediately created and the employment verification is conducted by the DO or CE2 Unit. However, the RC conducts Occupational History Questionnaires (OHQs) on those cases, when requested by the DO or CE2 Unit.

Claim forms received directly from the RC or from the claimant are date-stamped upon receipt in the DO or CE2 Unit and the postmarked envelope from the claimant is kept and attached to the claim form.

(1) New Cases Received Directly in the National Office

(NO). There are instances when claimants submit their claims to the NO instead of the RC, DO, or the CE2 Unit. When this occurs, the claim form(s) and any attached documentation are date-stamped by the NO and forwarded to the appropriate DO or CE2 Unit for case create (as discussed in this chapter) and processing, in accordance with jurisdiction (See EEOICPA PM 0-0100). The DO or CE2 Unit also date-stamps the forms upon receipt into their office from NO.

d. Electronic Applications. A claimant or third party has the option of accessing and completing a claim form electronically on the Department of Labor Website at www.dol.gov/owcp/energy/regs/compliance/claimsforms.htm When a claim form is submitted electronically, it is automatically sent via e-mail to the DEEOIC Form Mailbox at DEEOIC-FormsReceipt@dol.gov. A claimant or third party, who has questions or technical problems, requests assistance via the DEEOIC Assistance Mailbox at DEEOIC-FormsAssistance@dol.gov. The Branch of Outreach and Technical Assistance (BOTA) manages and responds to all e mails submitted to both mailboxes on a daily basis.

(1) When claim forms are received in the DEEOIC Form Mailbox, BOTA reviews them to determine the DO or CE2 Unit to assign the claim to for processing in accordance with jurisdiction (See EEOICPA PM 0-0100). Once this has been determined, a BOTA staff member forwards the electronic file via e-mail to the persons designated in the DO or CE2 Unit as the Point of Contact (POC) and backup.

(a) When the POC receives the e-mail, he or she prints the e-mail and the attached claim form(s) and takes them immediately to the mailroom to be processed and created, according to the procedures outlined in this chapter.

(b) The e-mail from BOTA is treated as a postmarked envelope and filed down, along with the claim form(s), on the spindle in the case file.

(c) If the POC is out of the office, the designated backup processes the claim form(s).

3. Creating Physical Cases. Case files are constructed from letter-size (8 1/2" x 11"), half-cut Kraft folders. Each of the four terminal digits of the file number (i.e., the last four digits of the employee's Social Security Number (SSN)) appears on a brightly-colored background label and is affixed to the outside edge of the folder. The employee's name and the file number are written either on the bottom right hand portion or sideways along the right side on the front of the folder.

a. Forms. New cases normally contain the following forms which are

filed down, starting from the bottom, on a spindle:

(1) Forms EE-1, EE-2, and/or document containing "words or claim" is filed down on the bottom of the spindle;

(2) Form EE-3 is filed on top of the Forms EE-1, EE-2, and/or document containing "words or claim"; and

(3) If a claim form (Forms EE-1/EE-2/document containing "words of claim") for benefits already exists, the new claim form is placed directly after (i.e., on top of) the existing claim form(s).

b. Documents. Medical reports, letters, and other documents are filed down in chronological order on the spindle (or on several spindles, if needed due to size). The date of a document is the date it was received (date-stamped) in the DEEOIC Office.

From the bottom to the top, the oldest documents are on the bottom and the newly received documents are on the top. However, documents that still require action (e.g., the payment certification form) are not placed on the spindle until the action is completed. Instead, they are clipped to the front of the case folder or inside on the left hand side of the file jacket.

c. Voluminous Records. When a great number of documents are received from a single source (e.g., hospital records, prior Part D records, or records from a Document Acquisition Request), they are placed on a separate spindle, as long as the records are clearly identified as belonging to a single identifiable source (See also EEOICPA PM 1-0400).

4. Case Create Worksheet. Once the Mail and File (M&F) staff construct a physical file for the new case (See paragraph 3 above), but before the Case Create Clerk (CCC) creates the new case in ECMS, a DEEOIC employee with experience in claims processing (hereafter referred to as "designated employee"), as designated by the District Director (DD) or the CE2 Unit Supervisory CE, reviews the claim to determine whether it is entered in ECMS as a Part B claim, a Part E claim, or both.

The designated employee reviews the available claim information about the medical condition(s) and employment claimed. Once the designated employee makes a determination as to the ECMS system(s) the claim is to be created in, he or she completes the Case Create Worksheet (See Exhibit 1), prints and signs his or her name ("Reviewer"), dates the worksheet, attaches it to the front of the folder, and forwards the case to the CCC for case creation.

a. Part B Medical Condition. If a claim identifies a Part B medical condition, the Part B medical condition is specified on the worksheet for entry in both ECMS B and ECMS E.

b. Part E Medical Condition. If a claim identifies a Part E

covered illness only, the condition is specified for entry in ECMS E only.

c. Consideration of Employment. In addition to considering the claimed medical condition(s), the designated employee considers the claimed employment when determining whether the case is created in ECMS B, ECMS E, or both.

(1) For claims filed at the RC, the RC verifies employment through the Oak Ridge Institute for Science and Education (ORISE) in ECMS (as described in paragraph 2 above) or clarifies the nature of the claimed employment. Any attached employment verification documents and/or medical evidence, in conjunction with the claim forms, are reviewed by the designated employee to determine whether the claim belongs in ECMS B, ECMS E, or both.

(2) If a claim identifies employment as a federal employee at a DOE facility and a Part B medical condition, the Part B medical condition is specified on the worksheet for entry in ECMS B only, because a DOE federal employee is not a covered DOE contractor employee under Part E.

(3) If a claim identifies employment at an Atomic Weapons Employer (AWE) or a Beryllium (BE) Vendor and a Part B medical condition, the Part B medical condition is specified on the worksheet for entry in ECMS B only, because employment at an AWE or BE Vendor is not covered employment under Part E. The exception to this is if it is indicated that the employee worked at an AWE or BE Vendor that was designated as a DOE facility for remediation.

(a) If appropriate, the assigned CE or CE2 of the case (not the designated employee) conducts additional employment development to determine if the latter situation holds true. If the latter does hold true, the assigned CE or CE2 prepares a memorandum and forwards it, along with the case file, to his or her Supervisory CE for signature requesting from the Chief of Operations that the claim be created in ECMS E. Once approved, the assigned CE or CE2 forwards the case file and signed memorandum to the CCC for case creation in ECMS E.

(4) If a claim identifies a Part E medical condition and employment at an AWE or a BE Vendor with no indication of the site being designated as a DOE facility for remediation, the Part E medical condition is specified on the worksheet for entry in ECMS B only, because to establish covered employment under Part E, the employee had to have been a DOE contractor employee.

Example 1: If only Part B medical conditions are checked

on the claim form (e.g., Chronic Beryllium Disease, Beryllium Sensitivity, Chronic Silicosis, or Cancer) and DOE contractor employment is claimed, the designated employee checks Box 1a of the worksheet for data entry into both ECMS B and ECMS E.

Example 2: Some AWE and BE Vendor facilities are designated as DOE facilities during periods of remediation. If the claimant from Example 1 instead claims employment with an AWE or BE Vendor during a period of remediation or identifies the AWE or BE Vendor as a DOE facility on the Form EE-3, the designated employee checks Box 1a of the worksheet for data entry into both ECMS Part B and Part E. Additional development by the assigned CE or CE2 is required to establish covered employment under Part E.

Example 3: To establish covered employment under Part E, the employee had to have been a DOE contractor employee. If the claimant from Example 1 claims only employment as a DOE federal employee, the designated employee checks Box 2 of the worksheet for data entry into ECMS B only.

Example 4: If a non-Part B medical condition (e.g., asbestosis) and DOE contractor employment are claimed, the designated employee checks Box 3 of the worksheet for data entry into ECMS E only.

Example 5: To establish covered employment under Part E, the employee had to have been a DOE contractor employee. If the claimant claims diabetes (a non-Part B medical condition) and employment with an AWE or BE Vendor during a period in which remediation did not occur or does not identify the AWE or BE Vendor as a DOE facility on the Form EE-3, the designated employee checks Box 2 of the worksheet for data entry into ECMS B only.

Example 6: If an employee claims prostate cancer and DOE contractor employment, the designated employee checks Box 1a of the worksheet for data entry into both ECMS B and ECMS E. If the same employee claims both prostate cancer and asbestosis, the designated employee checks Box 1b of the worksheet for data entry into both ECMS B and ECMS E. In the space provided, the prostate cancer is identified as a Part B and Part E condition, while asbestosis is identified as a Part E condition only.

Example 7: If a claimant identifies chronic silicosis on the Form EE-2, the designated employee checks Box 1a of the worksheet for data entry into both ECMS B and ECMS E, if and only if the claimant claims employment in underground tunnels in Nevada or Amchitka Island, Alaska. If the claimant indicates another location, the designated

employee checks Box 3 of the worksheet for data entry into ECMS E only.

Example 8: For all new RECA 5 claims, the designated employee checks Box 1a of the worksheet, and the medical conditions are entered in both ECMS B and ECMS E.

5. Creating Cases in Energy Case Management System (ECMS). The CCC creates new cases and adds them to the automated system. Any claim submitted by way of Forms EE-1, EE-2, or written document containing "words of claim" is created in ECMS. The CCC reviews the claim forms (EE 1/2 and EE 3) and the Case Create Worksheet prior to case creation in ECMS.

a. Social Security Number (SSN). The database record for each case normally contains the employee's SSN as the file number. If the employee's nine digit SSN is not listed on the claim form, a nine digit dummy SSN is used. Therefore, new cases are created and numbered in ECMS by using the employee's nine digit SSN or a nine digit dummy SSN, as appropriate.

(1) Creating Dummy SSN. The computer system assigns a dummy SSN when the claimant does not supply a SSN (the first three characters will be "000"). The CCC tabs through the SSN field and enters the claimant's last name, first name, and middle initial. The computer prompts **"OK to create case file number."** When the CCC enters **"yes,"** the computer system then generates a dummy SSN.

b. When the Case Does Not Exist In ECMS. If the employee's SSN does not already exist in ECMS B or ECMS E (i.e., a new case that does not exist in ECMS at all) then the case is created by using the "**Add Case**" function under the "**Function**" option in ECMS and numbered using the employee's nine digit SSN or a nine digit dummy SSN.

c. When the Case Already Exists in ECMS. If the employee's SSN already exists in ECMS B only, a new claim is added to ECMS E through the "**Open Case**" function under the "**File**" option. Conversely, if the employee's SSN already exists in ECMS E only, a new claim is added to ECMS B through the "**Open Case**" function under the "**File**" option.

The "**Add Case**" function under the "**Function**" option in ECMS is not used for this purpose.

d. Shared Data. For the most part, ECMS B and ECMS E function the same way and allow for independent data entry into either system. Most information on the first ECMS screen ("**Case Update**" screen) is shared between ECMS B and ECMS E. Except for the "**Claims**" section at the bottom of the screen, information in the "**Case Update**" screen automatically transfers between the two systems without having to enter duplicate data into ECMS B and ECMS E.

The CCC enters information into the following shared fields/sections in EC

(1) CE

(2) CE Assign Dt

(3) Dist Office

(4) Location

(5) Location Assign Dt

(6) Employee Name and Address

(7) Employee Census Information

(8) Employee Dependents

(9) Employment Classifications

(10) Work Sites

Phone messages and call-ups are also shared between ECMS B and ECMS E, but are not entered during case creation.

e. ECMS Entry. For case creation, the following ECMS data entry rules apply:

(1) Worksite information is shared between ECMS B and ECMS E and can be viewed from either system. The CCC enters the worksite information in the "**Case Update**" screen in either ECMS B or ECMS E. In each line item of the "**Work Site**" section, the first column ("**Pt Source**") indicates "**B**" or "**E**". If a "**B**" is shown, the employment information was entered in ECMS B and is automatically shared with ECMS E. Conversely, if an "**E**" is shown, the employment information was entered in ECMS E and is automatically shared with ECMS B.

Since the employment is developed simultaneously for the Part B and Part E portions of the claim, the point of entry is from either system. However, if a DEEOIC employee wants to update employment information, it is only done in the ECMS Part identified in the "**Pt Source**" column;

(a) For Part B only cases, all worksite information (claimed/verified/non-verified) is entered directly into ECMS B. If the worksite is not specifically identified in the ECMS "**Worksite Desc Search**" table field, the information is listed in the "**Note**" field.

(i) The only exception is for RECA claims, where worksite data does not need to be entered into ECMS B. The reason for this is that the worksite data is adjudicated by the Department of Justice, as determined under RECA section 5.

(b) For Part E only cases, including RECA cases, all worksite information (claimed/verified/non-verified) is entered directly into ECMS E. If the worksite is not specifically identified in the ECMS "**Worksite Desc**

Search" table field, the information is listed in the "**Note**" field. If multiple mines/mills are listed in the Form EE-3, they are entered in the "**Note**" field.

(2) The file date is the earliest of either the postmark date on the envelope, the facsimile date on the transmittance (fax), or the received date stamp date from any RC or DEEOIC Office on the signed claim form or document containing "words of claim" (but not earlier than July 31, 2001 for Part B and not earlier than October 30, 2000 for Part E). The postmarked envelope is kept with the claim form and filed down on the spindle in the case file. The CCC enters the earliest discernable date as the claim's file date in the "**Filed Dt**" field, under the "**Claim Information**" section, in the "**Claim Update**" screen of the applicable ECMS system(s);

(a) For a claim form transmitted electronically (e-mail), the file date is the date the claimant electronically sent the claim form to the DEEOIC-Form Receipt Mailbox (i.e, the date on the sent line of the claimant's e-mail). This is the same date that the e-mail is received in the DEEOIC-Form Receipt Mailbox.

(3) The received date is the date in which any DEEOIC Office (DO, CE2 Unit, Final Adjudication Branch (FAB), or NO) receives a claim form or document containing "words of claim," as identified by the DEEOIC Office's received date stamp date. The CCC enters the earliest discernable date as the claim's received date in the "**Rcvd Dt**" field, under the "**Claim Information**" section, in the "**Claim Update**" screen of the applicable ECMS system(s);

(a) When a claim is received electronically, the date on the sent line of the claimant's e-mail is the received date. The DEEOIC Office does not use the date in which the POC received the e-mail from BOTA. The file date and received date of the electronically submitted claim form are the same.

(4) The signature date is the date in which the claimant, claimant's authorized representative, or a person acting on behalf of the claimant (e.g., a relative, guardian) signs the Forms EE-1, EE-2, or document containing "words of claim." The CCC enters this date as the claim's signature date in the "**Signature Dt**" field, under the "**Claim Information**" section, in the "**Claim Update**" screen of the applicable ECMS system(s);

(5) The medical conditions are entered under the "**Medical Conditions**" section in the "**Claim Update**" screen of the applicable ECMS system(s), as identified in the completed Case Create Worksheet; and

(6) The CCC also enters data under the "**Other Claim Factors**" and the "**SECs**" sections (both containing drop down menus) in the "**Claim Update**" screen of the applicable ECMS system(s), as identified on the Form EE-1 or EE-2. In addition, the CCC enters data under the "**Payees**" section in the "**Payee Update**" screen of the applicable ECMS system(s), as identified on the Form EE-1 or EE-2.

f. Multiple Claimants. There are cases which contain multiple claimants, where one claimant files for a medical condition that is approved under Parts B and E (e.g., stomach cancer) and the other claimant files for a medical condition that is approved under Part E (e.g., asbestosis). As long as eligibility has been established and there is an approved condition, a new claim is created in the other ECMS system for each eligible claimant, as appropriate, even when the claimant did not file a claim under that Part. As long as there is an open (active) claim for that claimant, there is no need to request an additional claim for the approved condition, which was already claimed by another claimant in that same case.

g. Case Create Worksheet. Once the case is created in ECMS, the CCC prints and signs his or her name ("Case Creator") and dates the worksheet, and then attaches it to the front of the case jacket.

h. After Case Creation. When a batch of cases has been created, the CCC notates on the front of each case file jacket the location for it to be sent within the DEEOIC Office and also enters the appropriate assigned CE and the Case Location Code under the "**Case Information**" section in the "**Case Update**" screen of ECMS (See EEOICPA PM 1-0400 and 1-0500 Exhibit 2). The CCC then forwards the cases to a Workers' Compensation Assistant/Customer Service Representative to send an acknowledgement letter to the claimant (See Exhibit 2).

6. Duplicate Cases. The automated system checks for duplicate cases. Sometimes, duplicate cases are created when an incorrect SSN is used. If this happens, the DD, ADD, Chief of Operations, or the CE2 Unit Supervisory CE is responsible for ensuring that both case files are merged appropriately and that all the ECMS coding in the case record to be deleted is entered in the correct case record prior to deletion. The DD, ADD, Chief of Operations, or the CE2 Unit Supervisory CE must obtain authorization from NO to delete the duplicate case record from ECMS. The DD, ADD, Chief of Operations, or the CE2 Unit Supervisory CE prepares a memorandum to the Branch Chief of the Automated Data Processing Systems and the Branch Chief of Policy, requesting the authority to merge/resolve the two cases in ECMS and that the payment records for compensation and medical bills be reconciled.

When there is a duplicate case, the case deleted is usually the one with the most recent "**Rcvd Dt**" in ECMS. However, if all compensation and bill payments were made in the later case, then the earlier case is deleted. All the documents from both case files are retained to

show the date of first filing and the adjudicatory actions taken thereafter. The following steps are taken after the duplicate record is deleted from the automated system:

a. Notation on Case Jacket. The M&F Clerk writes "Duplicate of 000-00-0000" (the file number of the other case) on the outside of the duplicate case file jacket;

b. Forms. In the upper right corner, the M&F Clerk re-numbers all documents with the file number of the case that is retained. These documents are then combined with the retained case file; and

c. Advising the Claimant. The assigned CE or CE2 advises the claimant by letter that the duplicate case was created in error and that only the file number of the retained case is to be used. However, if the claimant was never notified of the duplicate number, there is no need to send the letter.

7. Claims Examiner Review. Upon receipt of a new case, but prior to initial development and adjudication, the assigned CE or CE2 reviews the claim forms, any attached employment and/or medical evidence assembled at the RC, the employment verification and occupational history development conducted by the RC, the Case Create Worksheet, and ECMS to ensure the claim was entered in the correct ECMS system(s) and that the claim information was entered correctly. After this review is complete, the assigned CE or CE2 attaches the Case Create Worksheet to the inside cover on the left side of the case jacket, and files down all associated claim file documents on the spindle in chronological order in the case file.

a. Claim Entry into ECMS. The assigned CE or CE2 must ensure that the claim is entered in the correct ECMS system(s). If a claim is created in the wrong ECMS system, certain steps are followed to delete the incorrect entry (See paragraph 12 below). If a claim was not created in one of the ECMS systems but needs to be, the assigned CE or CE2 returns the claim to the CCC for case creation (See paragraph 5 above).

b. Verification of Claimant/Employee Information. The assigned CE or CE2 confirms that the claimant/employee information is correct in ECMS. The assigned CE or CE2 checks the last name, first name, and middle initial of the employee/claimant in ECMS for accuracy. The full middle name does not appear in ECMS unless the claim form is signed with the complete middle name. The assigned CE or CE2 checks the gender, date of birth, and date of death (when applicable) in ECMS for accuracy. The address and phone number of the claimant/employee are also checked for accuracy.

c. Medical Conditions. The assigned CE or CE2 must ensure that the medical conditions are entered in the correct ECMS system(s). If a medical condition is incorrectly entered, or not entered at all, the assigned CE or CE2 updates the medical information in the correct ECMS system(s).

d. Initial Handling Conducted by the RC. The assigned CE or CE2 reviews the employment verification and occupational history development materials provided by the RC. The assigned CE or CE2 enters the claim status codes under the "**Claim Status History**" section in the "**Claim Update**" screen of ECMS, for each claimant, as appropriate, to reflect the actions taken by the RC.

(1) The assigned CE or CE2 enters the "**OR – ORISE Employment Evidence Received**", "**ES – Employment Verification Sent to DOE**", and/or "**CS – Request for Corporate Verification**" claim status code(s), as appropriate. The "**Claim Status Dt**" is the date in which the action was taken by the RC, as identified in their memorandum to the DO or CE2 Unit.

If the assigned CE or CE2 enters an "**ES**," he or she also enters the appropriate reason code from the drop-down menu. The drop down reason code indicates the specific DOE Operations Center the Form EE-5 was sent to (e.g., "**AL5 – Albuquerque Operations Office (EE-5)**").

(2) If the employee's OHQ has been completed, the assigned CE or CE2 enters the "**DO – Development-Other**" claim status code and selects the reason code "**OH - Occupational History.**" The "**Claim Status Dt**" for the "**DO/OH**" code is the date the occupational history interview was completed, as reported in the RC memorandum to the DO or CE2 Unit.

(a) If a deficiency is identified or an additional interview is deemed necessary, the DO or CE2 Unit returns part of the package back to the RC. The assigned CE or CE2 does not enter the "**DO/OH**" code in ECMS because the OHQ is not yet complete. Instead, the assigned CE or CE2 enters the "**RC – Resource Center**" code and the drop down reason code "**RK - Rework**" or "**FW - Follow up**", respectively, as appropriate. The "**Claim Status Dt**" is the date of the memorandum from the DO or CE2 Unit to the RC outlining the rework or follow-up task, as appropriate.

(b) Upon return from the RC, the assigned CE or CE2 enters the "**DO/OH**" code in ECMS to correspond with the date on which the rework or follow-up occupational history development action occurred, as reported in another RC memorandum to the DO or CE2 Unit.

(3) If the claim requires additional follow up action by the RC or development by the assigned CE or CE2, the assigned CE or CE2 enters a call up in ECMS notes, as a reminder. The assigned CE or CE2 reviews the initial submission (and all subsequent submissions from the RC) and assigns additional tasks to the RC as necessary.

e. Missing Information. If a claim form or document with "words of claim" is missing vital information (e.g., a diagnosed condition, RECA information), the assigned CE or CE2 requests the omitted information from the claimant. The assigned CE or CE2 lists the information that is required and explains the reason the request is being made.

8. Claims for New Medical Conditions or New Survivors Before a Recommended Decision. When a claimant submits a claim form for an additional covered occupational illness under Part B or a covered illness under Part E prior to the issuance of a Recommended Decision, the new filed claim is recorded in ECMS by updating the "**Medical Conditions**" section in the "**Claim Update**" screen. When an additional survivor submits a claim for survivor benefits under Parts B and/or E prior to the issuance of a Recommended Decision, the new filed claim is created in ECMS and reviewed, as discussed in paragraphs 4, 5, and 7 above.

a. Medical Evidence Only. If the claimant submits medical evidence for an unclaimed condition (i.e., medical evidence indicating the presence of a covered occupational illness or covered illness) without a claim form or document with "words of claim" for the covered condition, then the DO or CE2 Unit contacts the claimant by telephone to explain the situation and sends a letter (with an attached claim form) asking the claimant to submit a new claim form.

(1) The DO or CE2 Unit only requests a new claim form and develops the evidence further, if it is apparent that eligibility is likely.

(2) The letter addresses the receipt of the new evidence and explains the need for a Form EE-1 or EE-2 to establish a new claim. A claim form is not requested, however, when it is unlikely that the new medical evidence establishes a covered medical condition (e.g., evidence of a recurrence of a previously reported cancer or evidence of a noise-induced hearing loss).

b. Medical Evidence and "Words of Claim". A new claim form is not required if the claimant provides medical evidence of a new condition along with a signed written statement that he or she wants the medical condition to be considered (or other "words of claim"). The assigned CE or CE2 develops and adjudicates the new claimed condition accordingly.

c. Survivorship Evidence Only. If a new survivor submits survivorship evidence (e.g., birth certificate, marriage certificate, school records) without a claim form, then the DO or CE2 Unit contacts the claimant by telephone to explain the situation and sends a letter (with an attached claim form) asking the claimant to submit a claim form.

(1) The DO or CE2 Unit only requests a claim form and

develops the evidence further if it is apparent that eligibility is likely.

(2) The letter addresses the receipt of the new evidence and explains the need for a Form EE-2 to establish a new claim.

9. New Claims Received in the DO During Case Review by FAB or NO. There are instances when an already created case file is under review with FAB (e.g., a review of the Recommended Decision) or NO (e.g., Reopening Request, policy question), and a claimant files a new medical condition or a new survivor files a claim. The DO date-stamps the claim form(s) and any attached documentation upon receipt into their office.

a. Case Review by FAB. Sometimes instead of the claim form(s) being sent to the FAB (or CE2 Unit), it is inadvertently sent to the DO who issued the Recommended Decision. In order to promote efficiency, the DO's M&F Clerk sends an e-mail, with an attached scanned/imaged copy of the claim form(s) and any received documents, to the designated CE2 in the appropriate local FAB or to the NO CE2 Unit Supervisory CE, if the case is at the NO FAB.

The request advises the CE2 that the attached new claim is being forwarded for case creation and appropriate development. In the body (not the subject line) of the e-mail, the M&F Clerk lists the employee's name, the claimant's name (if different from the employee's name), file number, the assigned FAB Representative, and the received date of the new claim. The DD, FAB Branch Chief, and Chief of Operations are also included in a carbon copy of the e-mail. This is followed up with the DO mailing (or hand delivering if located in the same building) the original claim form(s) and attached documents to the CE2.

(1) Once the CE2 receives the e-mail from the M&F Clerk, the CE2 prints the attachments, date-stamps the documents, and advises the assigned FAB Representative to assign the case to him or her in ECMS.

(2) The FAB Representative assigns the case to the appropriate CE2 through the "**Open Case**" function under the "**File**" option in ECMS. The FAB Representative then selects the appropriate CE2 in the drop down menu of the "**CE2**" field under the "**FAB Co-located Development**" section in the "**Case Update**" screen of ECMS. Once the FAB Representative selects the appropriate CE2, he or she tabs over to the "**CE Assign Dt**" field, which automatically populates with the current date and time (this field can be manually inputted if needed).

In addition, the FAB Representative keys the case file to the appropriate CE2 by entering the appropriate ECMS Case Location Code in the "**Location**" field (See EEOICPA PM 1-

0500 Exhibit 2), tabs over to the "**Location Assign Dt**" field, which automatically populates with the current date and time (this field can be manually inputted if needed), and then clicks on the "**Save**" button. The FAB Representative then advises the CE2 that the case has been assigned to him or her in ECMS.

Both the FAB Representative and the CE2 are able to make entries into ECMS without having to transfer the case back and forth in the system.

(3) For a new claimed medical condition, the CE2 enters the medical condition in the appropriate ECMS system(s), as discussed in paragraphs 4 and 5 above.

(4) For a claim filed by a new survivor, the designated employee within the CE2 Unit completes the Case Create Worksheet (as described in paragraph 4 above) and forwards it, along with the claim form and any attached documentation, to the CCC to create the case in ECMS (See paragraph 5 above).

(5) Once the CCC creates the case in ECMS, the claim documentation is returned to the CE2 who then reviews that information, in addition to the evidence in the case file, and develops the claim as appropriate.

(6) Prior to the FAB transferring a case out of their office that the CE2 is assigned to in ECMS, the FAB Representative or the M&F Clerk clicks on the "**Unassign CE2**" button in the "**Case Update**" screen.

b. Case Review by NO. When the DO receives a new claim on a case that is under review by the NO (e.g., Reopening Request, policy question), the M&F Clerk must advise the DD who in turn contacts the Unit Chief for Policies, Regulations and Procedures in NO to determine how to effectively handle the incoming claim. This is determined on a case by case basis.

10. Claims for New Medical Conditions After a Final Decision. A claim form is required when a Final Decision has been issued and a claimant submits evidence of a new occupational illness under Part B or a covered illness under Part E. A claimed medical condition is new only if it was not previously addressed in a Final Decision. A new claim form is not needed for consequential conditions. However, a signed written request to claim a consequential condition is required.

a. ECMS Entry. The newly filed claim is recorded by the assigned CE or CE2 with the entry of the claim status code "**RD- Reopened - Development Resumed**" under the "**Claim Status History**" section in the "**Claim Update**" screen of ECMS B, ECMS E, or both, as appropriate. The received date stamp, facsimile transmittance date (fax), or postmark date (whichever is the earliest discernable date) is entered

as the "**Claim Status Dt**" in ECMS.

b. No Claim Form Received. If the claimant only submits medical evidence for a new condition (e.g., medical evidence indicating the presence of an occupational illness or covered illness), then the DO or CE2 Unit sends a letter requesting that the claimant submit a new claim form. Before the letter is sent, the assigned CE or CE2 initiates a phone call with the claimant to explain the situation and determine the claimant's intention to pursue a new claim.

(1) The DO or CE2 Unit requests a new claim form and develops the evidence further, only if it appears that coverage is likely.

(2) The letter addresses the receipt of the new evidence and explains the need for a Form EE-1 or EE-2 to establish the new claim. If it is unlikely, however, that the new medical evidence establishes a new covered medical condition, a claim form is not requested.

c. Words of Claim. If a claimant submits a new claim form for a new condition or a signed written statement that he or she wants the medical condition to be considered (or other "words of claim"), the assigned CE or CE2 develops and adjudicates the new claim, regardless of whether or not it is likely that the condition is covered under the EEOICPA.

11. Withdrawal of a Claim. A claimant is able to withdraw his or her claim for benefits for any claimed condition(s), including wage loss or impairment, prior to the issuance of a Final Decision for the requested benefit(s). All requests to withdraw a claim for benefits must be in writing, signed by either the claimant or his or her authorized representative, and specific in reference to what part(s) of the claim is to be withdrawn. The assigned CE or CE2 codes the withdrawal request appropriately under the "**Claim Status History**" section in the "**Claim Update**" screen of ECMS system(s), with the "**Claim Status Dt**" being the earliest discernable received date of the withdrawal request letter

12. Deleting a Claim from ECMS. If the assigned CE or CE2 determines that a claim (for deleting a case, follow the instructions in paragraph 6) was created in the wrong ECMS system or needs to be added to an ECMS system, the claim is returned to case create. The assigned CE or CE2 writes a memo, in which his or her Supervisory CE reviews and signs, advising the Chief of Operations to delete or add a claim in a specific ECMS system.

If a claim is added to an ECMS system, the memo provides the name of the claimant, the file number, the file date, the applicable ECMS system, and refers to the claim form for any additional information for the CCC to enter into ECMS.

If a claim needs to be deleted in ECMS, the memo provides the name of the claimant, the file number, and the applicable ECMS system.

The CCC initials and dates the memo once the claim has been deleted or added to an ECMS system. The memo is filed down on the spindle in chronological order within the case file and returned to the assigned CE or CE2.

Example: If a claim is for Part E only (e.g., asbestosis), but was entered in ECMS B and E, the B claim needs to be deleted. The CCC deletes the claim information, not case information, in the incorrect version of ECMS.

Exhibit 1: Case Create Worksheet

Exhibit 2: Letter of Acknowledgement

1-0400 Case Maintenance

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1. Purpose and Scope. This chapter describes how case files are transferred between locations within the Division of Energy Employees Occupational Illness Compensation (DEEOIC), filed, and maintained (including dividing a file's contents, repairing damaged folders, and reconstructing lost case files).

The chapter also describes how to update, correct, and adjust the electronic files in the Energy Case Management System (ECMS). Finally, the chapter addresses how the Final Adjudication Branch (FAB) assigns docket numbers to case files referred for their consideration and issuance of a Final Decision or other order.

2. Case Movement. Each DEEOIC staff member is responsible for

ensuring that cases are delivered to their appropriate locations. The new location code is notated on the front of the case file jacket and entered in the "**Case Update**" screen of ECMS before the file is moved.

a. Location Changes. As cases are moved to different locations within a DEEOIC Office, their location codes are changed in ECMS. Each location in a DEEOIC Office has its own location code, for example, "**FIL**" for the File Room, "**CCJ**" for a specific Claims Examiner (CE), "**FO1**" for the Fiscal Officer, and "**DMC**" for the District Medical Consultant (See EEOICPA PM 1-0500 Exhibit 1).

b. Notations on Case Jackets. When ECMS coding is completed, the DEEOIC staff member lists the new location code on the grid sheet on the front of each folder of the case file, dates each folder, and initials each folder. The DEEOIC staff member then hand carries the file to its next location or places the folder in the appropriate pick-up area for routing to the next location.

c. Replacement Grid Sheets. When the jacket has been completely filled, it is copied and the copy is placed on the inside cover of the left side of the case file. A gummed grid sheet with spaces to enter new routing locations is then placed on the front cover of the case file.

3. Filing Cases. Open cases (i.e., those cases needing further action) and closed cases are housed either in the File Room or in other locations throughout the DEEOIC Office.

a. Method of Filing. Most case folders are kept in the file room on open shelves.

(1) The 2x2 terminal digit system is used by the DEEOIC. The folders are grouped together and filed using the last four digits of the file number (hereafter referred to as "terminal digits").

The files are first grouped together in numerical order by the last two terminal digits (from XX00 to XX99). The first two terminal digits of a file determine the order of files with the same final two digits (00XX to 99XX). For example, files with the terminal digits 0034, 0234, 1001, 1034, 1234, 2001, and 3489 are filed as follows:

Ending with 01: 1001, 2001

Ending with 34: 0034, 0234, 1034, 1234

Ending with 89: 3489

(2) The outside edge of each folder is labeled with the last four digits of the claimant's file number_(terminal digits). Each digit has a distinct, brightly-colored background, allowing searchers to locate, retrieve and/or file the folders with greater ease and accuracy.

b. Cases Sent to the File Room. Case folders are not returned to the File Room unless:

(1) The File Room is the last location notated on the case folder along with the date transferred and the initials of the DEEOIC staff member initiating the move;

(2) ECMS is accurately coded to show the File Room ("**FIL**") as the last location; and

(3) Any loose documents or mail are filed down on the spindle in the folder, unless notated with the phrase "drop file," the date the document was drop filed, and the initials of the DEEOIC staff member who had requested the mail to be drop filed.

c. Cases Outside of the File Room. When case files are located at a DEEOIC staff member's work station or some other location, they need to be organized so they can be quickly located. When files are separated into different piles for effective case management (e.g., under development, awaiting a Recommended Decision), the DEEOIC staff member arranges each pile of cases in 2x2 terminal digit file number order.

d. Misfiled Cases. If a case is coded "**FIL**" in ECMS, but is not located in the File Room, a special search is required. This special search includes searching throughout the File Room (sometimes cases get misfiled on the shelves), on DEEOIC staff members' workstations, the DEEOIC Office as a whole, and even other DEEOIC Offices. If the special search is unsuccessful, then DEEOIC staff must reconstruct the file (See paragraph 7 below).

4. Dividing Cases. When the contents of a case file become too thick to be contained in one folder, they are divided. Mail and File (M&F) staff divide files on their own when deemed appropriate, or at the request of a DEEOIC staff member. The M&F Clerk takes the following actions when dividing a case file:

a. Prepare a New Folder.

(1) The M&F Clerk makes a duplicate folder with the same file number (See EEOICPA PM 1-0300 paragraph 3). The M&F Clerk writes the letter "A" at the bottom of the front cover of the original case file. The M&F Clerk then writes the letter "B" at the bottom of the front cover of the overflow folder.

(2) On the bottom of the front cover of each folder, the M&F Clerk writes "This case is divided into A and B parts"; and

b. Dividing the File. The M&F Clerk divides the contents of the file at a logical point, considering the size of each part and the content and receipt date of the documentation.

(1) The M&F Clerk skims through the case file records and determines a cutoff date for the Part A folder.

(2) The M&F Clerk places all correspondence and other documents received before the cutoff date in the Part A folder. All correspondence and documents received after the cutoff date are placed in the Part B folder. The M&F clerk files down Forms EE 1/2, EE 3, and copies of claim forms under Part E (formerly Part D) on the spindle in the Part B folder. Documents regarding any actions still pending and documents showing compensation paid are also kept in the Part B (active) folder.

(3) If it becomes necessary to divide the case more than once, the new overflow folders are labeled "AA", "AAA", etc.

(4) Part B is always the active folder and contains the most recent documents, the original Forms EE-1/2, Department of Energy (DOE) claim forms (formerly Part D), documents containing words of claim for benefits under the EEOICPA, Employment History Form EE-3, any documentation showing compensation paid, and all documents requiring further action.

(5) When voluminous records are received from a single source (e.g., hospital records, prior Part D records, responses to Document Acquisition Requests) resulting in the case to be divided, they are filed down on a separate spindle, as long as the records are clearly identified as belonging to a single identifiable source.

5. Multiple Survivors. When the case file has multiple survivors, the Form EE-2 for the first survivor is on the bottom. The Form EE-2 for the second survivor is just above the first, and so forth, as reflected in ECMS under the "**Claims**" section in the "**Case Update**" screen. The correspondence, medical evidence, employment evidence, and other documents are placed on top of the claim and employment history forms (on the spindle), in chronological order of date received in the case file and are not divided by survivor.

6. Repairing Cases. The M&F Clerk or other DEEOIC staff member designated by the District Director (DD), FAB Manager, or Policy Branch Chief, repairs the case folders and their contents that have become worn or unreadable due to wear and tear.

a. Loose Documents. The M&F Clerk or other designated DEEOIC staff member repairs or strengthens documents that have torn loose from the spindle by using a gummed or self-adhesive reinforcement, transparent tape, or other method approved by the DD, FAB Manager, or Policy Branch Chief.

b. Damaged Documents. If torn or damaged documents cannot be mended, and there is the potential for further damage to occur, the M&F Clerk or other designated DEEOIC staff member photocopies the documents so that the file contains a readable copy. To protect from

further damage, the torn or damaged documents are placed in a protective sleeve or envelope and placed in the case file.

7. Reconstructing Cases. When a case is lost and every effort to locate it within that DEEOIC Office and the other DEEOIC Offices is unsuccessful, the DEEOIC staff must reconstruct the case file. A Supervisory CE or Manager prepares a memorandum for the signature of the DD, FAB Branch Chief, or Policy Branch Chief, explaining the loss of the file and the necessary preparation of a new case jacket. The assigned CE, Secondary Claims Examiner (CE2), FAB Representative, or National Office (NO) Representative then requests duplicates of all documents in the lost file.

a. Memorandum and New Case Jacket. The Supervisory CE or Manager prepares and signs a memorandum describing the effort(s) taken to locate the original file and that a duplicate case jacket is necessary. Once approved and signed by the DD, FAB Branch Chief, or Policy Branch Chief, the memo is then forwarded to the Case Create Clerk, who creates a new case jacket (See EEOICPA PM 1-0300 paragraph 3) with the memo placed inside and returns it to the assigned CE, CE2, FAB Representative, or NO Representative.

b. Requests for Records. The assigned CE, CE2, FAB Representative, or NO Representative prepares correspondence to all the claimants and authorized representatives associated with the case requesting a copy of any documents pertinent to the case file. The assigned CE, CE2, FAB Representative, or NO Representative also requests duplicate documents from medical providers, the National Institute for Occupational Safety and Health (NIOSH), DOE, and any other identifiable source (e.g., Center to Protect Workers' Rights (CPWR), Social Security Administration (SSA), Resource Center (RC)). The memo and the letters requesting the documentation are filed down on the spindle in the new case folder.

c. Electronic Records. If electronic copies of documents (e.g., development letters, Recommended Decisions, Final Decisions) or claim related e-mails from external customers (e.g., the claimant, RC, DOE, corporate verifiers, Congressional Offices, NIOSH), that were in the case file have been maintained by the assigned CE, CE2, FAB Representative, or NO Representative, they are to be copied and placed in chronological order in the file by when they were originally created.

d. Recovery of Original File. If the lost case file is found, the assigned CE, CE2, FAB Representative, or NO Representative incorporates all original and unduplicated material into a single case jacket and discards the duplicate case information and case file jacket in a recycle bin for shredding.

8. Updating, Correcting, and Adjusting the ECMS Database. Changes to ECMS are sometimes needed due to errors in data entry or updated changes to the claimant's address, etc.

a. Corrections to Data Elements. It is each DEEOIC staff member's responsibility to safeguard the integrity of the data in ECMS. Stakeholders and interested parties (e.g., DEEOIC Offices, Congressional Offices, the Ombudsman Office) are provided with performance reports compiled from ECMS data. Therefore it is especially important to ensure that the data entered in ECMS is correct and up to date. These elements include all name fields, claimed illness information, claimed employment data, date of birth, date of death, and SSN.

b. Change of Address. All requests for change of address are submitted in writing by the claimant, authorized representative, or approved Power of Attorney. All such changes are referred to the individual designated as the Payee Change Assistant (PCA). The PCA (or a designee who does not have the authority to enter payments in ECMS) makes changes to names and addresses in ECMS. Any change of address needs to be approved by the assigned CE, CE2, FAB Representative, or NO Representative prior to any changes in ECMS. Attached, as Exhibit 1, is the form used to document changes of name, address, and/or telephone number by all DEEOIC Offices.

(1) The request for a new address must contain an acceptable signature on the document. The claimant's signature, an authorized representative's signature, or the approved Power of Attorney's signature is acceptable.

(2) If a written document contains a claimant's new address, the assigned DEEOIC staff member calls and confirms with the claimant, authorized representative, or the approved Power of Attorney whether the change is temporary or permanent. The call is then documented in the ECMS Telephone Management System (TMS), with a printed copy placed in the case file.

(3) A faxed request to change a claimant's address or phone number is acceptable, as long as it contains the signature of the claimant, authorized representative, or the approved Power of Attorney requesting the change.

(4) For payment purposes only, a "Payment Only" address is documented and signed by the claimant or approved Power of Attorney on the original EN-20 form. Faxes are not acceptable.

9. FAB Docketing. A unique docket number is assigned under Part B and Part E, as applicable, to each claimant involved in the FAB review process. The assignment of a docket number allows FAB to track individual claimants who filed under Part B and/or Part E and to protect their privacy.

a. Docket Number Assignment. Any case that is forwarded to FAB for issuance of a Final Decision or other order has a docket number assigned to each claimant identified in the Recommended Decision

under Parts B and E of the Act, as applicable. The docket number(s) assigned is generated randomly by ECMS within each local FAB Office. The docket number is a numerical prefix followed by the year in which the docket number is assigned. Once a docket number is assigned to a claimant (a separate docket number for Part B and Part E, as applicable), that document number remains the same, is always used to identify the claimant in future Final Decisions or other orders, and does not change.

b. Registering Docket Numbers in ECMS. Upon receipt of a Recommended Decision, a FAB Representative enters "**FD – FAB Received Recommended Decision**" under the "**Claim Status History**" section in the "**Claim Update**" screen of ECMS. An "**FD**" status code is entered for each claimant in ECMS who receives a Recommended Decision. The entry of the "**FD**" status code in ECMS is what generates the random assignment of the docket number.

c. Duplicate Numbers. The individual entering the docket number must ensure that he or she does not re-enter a new docket number for a claimant who has already been assigned a docket number under that Part of the Act. If this occurs, the file is referred to the local FAB Manager to have the second docket number removed from ECMS.

Exhibit 1: ECMS Change Form

1-0500 Transfers and Loans

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1. Purpose and Scope. This chapter describes the procedures for sending physical case files and electronic case records between the various offices within the Division of Energy Employees Occupational Illness Compensation (DEEOIC), including the District Office (DO), the Secondary Claims Examiner (CE2) Unit, the Final Adjudication Branch (FAB), and the National Office (NO). It also describes the procedures for sending the contents of a case file to the National Institute for Occupational Safety and Health (NIOSH) and to a medical or scientific specialist in NO.

2. Responsibilities. Mail and File (M&F) staff process all physical case files transferred temporarily or permanently among the DEEOIC Offices. The Chief of Operations, Supervisory CE, Assistant District Director (ADD), District Director (DD), FAB Manager, NO Representative, M&F Clerk, or designee transfers electronic records in the Energy Case Management System (ECMS) and notates the front of the case file jacket, accordingly, on all case files transferred temporarily or permanently.

3. Electronic Transfer of Case Records in ECMS. The electronic transfer of a case record in ECMS involves taking the following actions in the "**Case Update**" screen: enter the appropriate DEEOIC Office's transferred out location code in the "**Location**" field (See Exhibit 1); click the "**Save**" button; click on the "**Transfer Case**" button; pick the appropriate DEEOIC Office in the "**District Office**" drop down menu field under the "**Transfer To**" section; and then click on the "**Transfer Case**" button.

The electronic transfer of a case record in ECMS can be done in either ECMS system (ECMS B or ECMS E), and results in the transfer of the case record in both ECMS systems simultaneously.

a. Electronic Transfer to a CE2 Unit. The local CE2 Unit and the NO CE2 Unit are not listed in the "**District Office**" drop down menu field under the "**Transfer To**" section of ECMS. Instead, the designee must transfer the electronic case record to the appropriate FAB Office in which the CE2 Unit resides with.

(1) Once electronically transferred to the appropriate FAB Office, a FAB Representative selects the appropriate CE2 in the drop down menu of the "**CE2**" field under the "**FAB Co-located Development**" section in the "**Case Update**" screen of ECMS. Once the FAB Representative selects the appropriate CE2, he or she tabs over to the "**CE Assign Dt**" field, which automatically populates with the current date and time (this field can be manually inputted if needed).

In addition, the FAB Representative keys the case file to the CE2 by entering the appropriate ECMS Case Location Code in the "**Location**" field (See Exhibit 1), tabs over to the "**Location Assign Dt**" field, which automatically populates

with the current date and time (this field can be manually inputted if needed), and then clicks the "**Save**" button.

Both the FAB Representative and the CE2 are able to make entries into ECMS without having to transfer the case in the system.

4. Temporary Transfers (Loans). Case files are temporarily transferred between DEEOIC Offices for a variety of reasons, including the review of a Recommended Decision (RD), a Final Decision (FD), a remand order, a request for reconsideration, a request for reopening, a DO or CE2 Unit pending action, a medical or scientific referral, or for a policy issue. Whenever a case file is transferred, it is sent in its entirety to the designated location. It is of utmost importance that if a case is misrouted to a DEEOIC Office from another DEEOIC Office, that it be transferred immediately to the appropriate DEEOIC Office.

a. Procedures Before the Loan.

(1) The Claims Examiner (CE), CE2, FAB Representative, or NO Representative completes all applicable items listed on the case transfer sheet (see Exhibit 2) and attaches it to the outside of the case jacket. This sheet identifies the case, the DEEOIC Office the case is transferred to and from, and the reason for the transfer.

(2) If the CE, CE2, or NO Representative is transferring a case file, the following boxes in the **Reason for DO's/CE2 Unit's/NO's Transfer** field is checked, as appropriate:

(a) To the FAB, select the option **FAB Review** and any of the following options below, as appropriate:

(i) For an RD, select the option **Recommended Decision**; or

(ii) For a request for reconsideration, select the option **Reconsideration.**

(b) To and from the NO, select the option, **Policy/Procedure** and any of the following options below, as appropriate:

(i) For a request to reopen, select the option **Reopen.** For the return response to a reopening request, select the option **Reopen** and briefly explain whether the reopening was granted or denied in the **Comments/Other** field;

(ii) For a submission of a remand challenge, select the option **Remand Challenge.** For the return response to a remand challenge, select the option **Remand Challenge** and briefly explain whether the remand challenge was granted or denied in the **Comments/Other** field;

(iii) For a policy issue (e.g., stepchildren, incapable of self-support, employment verification), select the option **Policy Question** and briefly explain the request in the **Comments/Other** field. For the return response to a policy issue, select the option **Policy Question** and include a brief explanation in the **Comments/Other** field. This form does not replace the WS/WR form;

(iv) For a review by the Office of the Solicitor (e.g., power of attorney, filed court documentation), select the option **Solicitor** and include a brief explanation in the **Comments/Other** field. For the return response from the Solicitor, select the option **Solicitor** and include a brief explanation in the **Comments/Other** field; or

(v) For a medical or scientific review, including a referral to the **Medical Director**, **Industrial Hygienist** (IH), **Toxicologist** (TX), or the **Health Physicist**, select the specific type of review, as appropriate. For the reviewer's return response, select the type of review provided and include a brief explanation in the **Comments/Other** field, as appropriate.

(3) If the FAB Representative is transferring a case file, the following boxes in the **Reason for FAB's Transfer** field is checked, as appropriate:

(a) To the DO or CE2 Unit, in which the FAB vacates the RD and issues a remand order, select the option **Remand**;

(b) To the DO or the CE2 Unit, in which the FAB reverses the RD, select the option **Reversal**;

(c) To the DO or CE2 Unit, in which the FAB affirms the RD, select the option **Affirmation**;

(d) To the NO, select any of the following below, as appropriate:

(i) For a request to reopen, select the option **Reope**

(ii) For a policy issue (e.g., stepchildren, incapable of self-support), select the option **Policy Question** and briefly explain the request in the **Comments/Other** field. This form does not replace the WS/WR form;

(iii) For a review by the Office of the Solicitor

(e.g., filed court documentation), select the option **Solicitor** and include a brief explanation in the **Comments/Other** field; or

(iv) For a medical or scientific review, including a referral to the **Medical Director**, **Industrial Hygienist** (IH), **Toxicologist** (TX), or the **Health Physicist**, select the specific type of review, as appropriate.

(e) At the time of mailing the FD, the FAB Representative selects the option **Send Copy of Final Decision to** with either **NIOSH**, **DOJ (RECA)**, and/or **RC** (with the specific RC name/location listed) marked, as appropriate.

(4) The CE, CE2, or FAB Representative checks the following boxes, as appropriate, when rendering an RD or FD, respectively:

(a) The type of RD or FD submitted (Part B and/or Part E); and

(b) The status of the RD or FD under that Part(s) (Accept, Deny, and/or Defer)

The FAB Representative notates the **ECMS Final Decision Coding** under **Part B** and/or **Part E** and also the amount of any compensation approved (**AOP Amount**) under **Part B** and/or **Part E** in that field.

For any issue not specified above, include a brief explanation in the **Comments/Other** field.

(5) The Chief of Operations, FAB Manager, NO Unit Chief for Policies, Regulations and Procedures, DD, ADD, Supervisory CE, Senior Claims Examiner, or designee determines whether the case is in a posture for transfer to another DEEOIC Office (e.g., the DO issued an RD that needs to be sent to FAB for processing of the FD), and if so, then ensures that:

(a) Within reason, all pending actions have been taken and all correspondence answered;

(b) Mail is filed down on the spindle in order of date receipt; and

(c) The case file jacket is in good condition.

(6) The initiator and the authorizing signatory both sign and date the completed case transfer sheet (sometimes this is the same person). The NO Unit Chief for Policies, Regulations and Procedures, DD, and FAB Manager designate the authorizing signatory within their respective office.

All cases sent to the NO require the authorization of the

DD, ADD, Supervisory CE, FAB Manager, or designee. The NO Unit Chief for Policies, Regulations and Procedures or designee authorizes case transfers from the NO.

(7) The Chief of Operations, FAB Manager, NO Unit Chief for Policies, Regulations and Procedures, DD, ADD, Supervisory CE, M&F Clerk, or designee changes the location on the front of the case file jacket and in ECMS to reflect the physical and electronic transfer of the case to another DEEOIC Office (See paragraph 3 above).

The location of individual case files is tracked in ECMS through specific codes. ECMS Case Location Codes are identified in Exhibit 1.

Maintaining accurate case location information in ECMS is essential. Each time a file is physically transferred from one location to another within a DEEOIC Office or from one DEEOIC Office to another, ECMS must be updated to show the current location of the case file and the date in which the change in location was made. This is also notated on the front of the case file jacket.

(8) M&F staff mail the case file, either by the designated express mail service or through the United States Postal Service (USPS).

b. Procedures After the Loan.

(1) Upon receipt of the transferred case, the receiving office files the case transfer sheet down onto the spindle in the case file and takes the action reflected on the case transfer sheet.

(2) The receipt of individual case files is tracked in ECMS through specific codes. When a physical case file arrives in the DEEOIC Office, M&F staff date-stamp the case transfer sheet and deliver the case to the M&F Clerk who enters the appropriate receiving/transferring in office and location codes in the "**Dist Office**" and "**Location**" fields, respectively, in the "**Case Update**" screen of ECMS (See Exhibit 1).

The M&F Clerk also assigns the case in the "**CE**" field (See Exhibit 1). The dates of the change in location and CE assignment are recorded in ECMS by tabbing over to the "**Location Assign Dt**" and "**CE Assign Dt**" fields, respectively, which automatically populates with the current date and time (these fields can be manually inputted if needed). The location codes are also notated on the front of the case file jacket.

(3) Any mail received for a case which is loaned or temporarily transferred is forwarded to the appropriate DEEOIC Office that has the case file.

c. Cases with Partial FDs for Compensation. There are instances when FAB issues a partial FD allowing for the payment of benefits to a claimant while another portion of the RD is held in abeyance as a result of the pending expiration of the claimant's 60 day allotted time frame to file objections, or the consideration of objections or a request for a hearing already filed in reference to the pending portion of the RD. To ensure the timely processing of compensating the claim by the DO and the timely review of the pending portion of the RD by FAB, the following must be completed:

(1) The FAB Representative attaches a removable red label to the lower right corner on the front of the case file jacket with the following information:

(a) List the date of issuance of the pending RD and whether it pertains to Part B and/or Part E;

(b) List the FAB Office the case needs to be returned to;

(c) List the name of the FAB CE or FAB Hearing Representative to whom the case is assigned; and

(d) List a "no later than" date by which the case needs to be returned to FAB, in order to ensure timely review.

(2) The FAB Representative also attaches on the front of the case file jacket a case transfer sheet (see Exhibit 2) printed on red paper, with all applicable items completed.

(3) The assigned FAB CE or FAB Hearing Representative puts a call up note for the case in his or her Outlook calendar.

(a) The local FAB employees notify their Manager at least ten days before the due date, if the case has not been returned by the DO. The Manager contacts the DO to have the case transferred back to his or her office.

(b) The NO FAB employees notify the Operations Specialist and their Manager at least ten days before the due date, if the case has not been returned by the DO. The Operations Specialist or the Manager contacts the DO to have the case transferred back to the NO FAB.

(4) Once the DO has processed the claimant's payment, the Chief of Operations, DD, Supervisory CE, Fiscal Officer, or designee attaches on the front of the case file jacket a case transfer sheet (see Exhibit 2) printed on plain white paper, with all applicable items completed, including in the **Comments/Other** field the name of the assigned FAB CE or FAB Hearing Representative to whose attention the case is

to be given, identifying the claimant's payment has been processed, and that the case is returned back to FAB for their review of the pending portion of the RD.

5. Permanent Transfers. Case files are permanently transferred between the DOs due to jurisdiction, based upon the employee's last verified covered employment. There are instances when changes in jurisdiction go into effect in order to balance the case/workload among the DOs.

In reference to Radiation Exposure Compensation Act (RECA) claims, all RECA Section 5 claims are handled in the Denver DO and are transferred there accordingly. All Section 4 RECA claims are transferred to the DO which has jurisdiction, based upon the employee's last covered employer. It is of utmost importance that if a case is misrouted to a DEEOIC Office from another DEEOIC Office, that it immediately be transferred to the appropriate DEEOIC Office.

a. Procedures for Permanent Transfers. After determining that a case needs to be transferred, the following actions are taken by DEEOIC staff:

(1) Prepare a transfer letter for the DD, ADD, Supervisory CE, or designee's signature notifying the claimant and other interested parties (e.g., Resource Center, authorized representative) of the transfer and the contact address and phone number of the other DEEOIC Office;

(2) Prepare a case transfer sheet (see Exhibit 2) for the DD, ADD, Supervisory CE, or designee's signature (as discussed in paragraph 4 above) which is then attached to the front of the case file jacket;

(3) The DD, ADD, Supervisory CE, or designee ensures the case is in a posture for permanent transfer (e.g., all pending actions have been taken, correspondence has been answered, mail has been filed down on the spindle, and the case file jacket is in good condition). The DD, ADD, Supervisory CE, or designee then authorizes the transfer and signs the notification of transfer letter and the case transfer sheet;

(4) The Chief of Operations, DD, ADD, Supervisory CE, M&F Clerk, or designee transfers the electronic case record by keying the appropriate location code and DEEOIC Office in ECMS (See paragraph 3 above);

(5) The physical case file is sent either through a designated express mail service or through the USPS;

(6) Permanent case transfers need to occur within 20 days of the date of the last pending action taken;

(7) If mail is received for the transferred case, the mail is forwarded to the responsible DEEOIC Office that has the

case file.

b. Delays in Permanent Transfers. In some instances, a case file reviewed for permanent transfer by the originating DO, is in a posture for an RD and needs to be sent to FAB for processing of the FD. In this instance, the originating DO prepares and issues the RD and transfers the case to FAB.

After taking all appropriate actions, FAB transfers the case back to the originating DO, which is the office that issued the RD.

(1) If there are no remand actions to be taken, the originating DO proceeds with the permanent transfer of the case to the DO which holds jurisdiction.

(a) The only exception to this is when FAB has determined that the claim is to be compensated. FAB proceeds with the permanent transfer of the case to the DO which holds jurisdiction (and not to the DO which issued the RD) to ensure timely payment of the claim.

(2) If there are remand actions to be taken, the originating DO completes the actions stipulated in the remand order, reissues the RD, and transfers the case to FAB. This also holds true when there is a change in jurisdiction while the case is at FAB for review. Ultimately, the case file is transferred to the originating DO for the completion of the actions stipulated in the remand order and reissuance of the RD.

c. Receipt of File. When a physical case file arrives in the DEEOIC Office, M&F staff date-stamp the case transfer sheet and deliver the case to the M&F Clerk who enters the appropriate receiving/transferring in office and location codes in the "**Dist Office**" and "**Location**" fields, respectively, in the "**Case Update**" screen of ECMS (See Exhibit 1).

The M&F Clerk also assigns the case in the "**CE**" field. (See Exhibit 1). The dates of the change in location and CE assignment are recorded in ECMS by tabbing over to the "**Location Assign Dt**" and "**CE Assign Dt**" fields, respectively, which automatically populates with the current date and time (these fields can be manually inputted if needed). The location codes are also notated on the front of the case file jacket.

6. Referring Case Records to NIOSH. As part of the dose reconstruction process, NIOSH reviews the employee's medical and employment records. The entire case file is copied and forwarded to NIOSH. This is done with the utmost attention as all DEEOIC staff members must ensure that Personally Identifiable Information (PII) is safeguarded (See EEOICPA PM 1-0200). The original case file remains in the DO or NO CE2 Unit.

a. Case Records. On a summary sheet, the DO or NO CE2 Unit

prepares a list of the case files contained in the shipping package. The summary sheet clearly identifies the cases referred to NIOSH for dose reconstruction. The DO or NO CE2 Unit maintains a copy of the express mail shipping slip along with the summary sheet.

b. Shipping Packages. The DO or NO CE2 Unit uses large express mail boxes when possible, as the boxes are traceable. A copy of the summary sheet, listing the case files being transferred, is inserted in each shipping package.

c. Shipping Address. Boxes are sent to:

National Institute for Occupational Safety and Health

Office of Compensation Analysis and Support

4676 Columbia Parkway

MS C45

Cincinnati, OH 45226

d. Schedule. Each DO (together with their local CE2 Unit) must send cases on designated days based on the following weekly schedule:

Tuesday:	Jacksonville	(Wednesday NIOSH receipt)
Wednesday:	Cleveland	(Thursday NIOSH receipt)
Thursday:	Denver	(Friday NIOSH receipt)
Friday:	Seattle	(Monday NIOSH receipt)

Due to the volume of referrals generated, the NO CE2 Unit does not have a designated day to send their cases to NIOSH. Instead, the NO CE2 Unit sends their cases on an as needed basis.

e. Coordination with NIOSH. Each week, the DO or NO CE2 Unit sends an e-mail to *ocas@cdc.gov* which lists the express mail tracking number for each box shipped. If a shipment was not sent that week or was sent late, NIOSH must be informed. This notification assists NIOSH with inventory control.

f. NIOSH Point-of-Contact Phone Numbers.

Cleveland DO	513-533-8423
Denver DO	513-533-8426
Seattle DO	513-533-8424
Jacksonville DO	513-533-8425
NO CE2 Unit	513-533-8565

7. Referring Cases to Medical or Scientific Specialists in NO. When a case file is referred for a review by a Medical Director, Industrial Hygienist, Toxicologist, or a Health Physicist, the case file or the medical records from the case file are copied and sent to the appropriate specialist in NO.

Exhibit 1: ECMS Case Location Codes

Exhibit 2: DEEOIC Case Transfer Sheet

PM Part 2 – Claims

2-0100 Introduction

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1. Purpose and Scope. Part 2 outlines the policies, guidelines and procedures for developing, adjudicating and managing claims under the EEOICPA.

This chapter describes the structure of EEOICPA PM Part 2 and the responsibilities of the Claims Examiner (CE) in administering the EEOICPA. The reference materials listed at the end of this chapter are available to staff in each District Office (DO), Final Adjudication Branch (FAB) and National Office.

2. Structure of Part 2.

a. General Topics. The chapters in this section address intake of information at Resource Centers (2-0200) and initial development by CEs (2-0300). PM 2-0400 addresses services provided by representatives.

b. Employment and Exposure. The chapters in this section address the aspects of employment that must be established for coverage under the EEOICPA. They include covered employment (2-0500), Special Exposure Cohort status (2-0600), and toxic substance exposure (2-0700).

c. Eligibility. The first three chapters in this section address the medical aspects of entitlement. They include a chapter on developing and weighing medical evidence (2-0800), a chapter describing the criteria for cancer and radiation claims (2-0900), and a chapter describing the criteria for non-cancerous conditions (2-1000).

The last two chapters in this group address entitlement under the Radiation Exposure Compensation Act (RECA) (2-1100) and requirements

for establishing survivorship (2-1200).

d. Entitlement. These chapters address ratings for permanent impairment (2-1300), computing compensation payments for wage-loss (2-1400), and consequential injuries (2-1500).

e. Decisions and Hearings. This section provides guidance on writing recommended decisions (2-1600), and is followed by two chapters about the work of the FAB. The first (2-1700) addresses the procedures used by FAB, while the second (2-1800) focuses on the decisions FAB issues. The final chapter in this group (2-1900) discusses reopening claims.

f. Codes. The last two chapters in Part 2 address coding under the Energy Case Management System (ECMS). PM 2-2000 describes the codes used in overall case processing, while PM 2-2100 describes the codes used to track decisions made within the Program.

3. Responsibilities of Claims Examiners. The CE develops and adjudicates claims, provides courteous and timely responses to requests for information, initiates compensation payments and monitors assigned caseloads.

a. Processing Claims. The CE is expected to exercise keen judgment, derived from experience, background, and acquired knowledge, tempered with compassion and common sense. This involves the ability to assess evidence, identify pertinent issues, and make well-rationalized judgments. Each case stands on its own merits and must be impartially judged based on the facts established in the case file. The decision cannot be based on conjecture, speculation, or unwarranted presumption.

4. Reference Materials for Claims Examiners. Each DO has resources containing the following items including, but not limited to:

a. Energy Employees Occupational Illness Compensation Program Act (EEOICPA) of 2000, as amended, 42 U.S.C. § 7384 *et seq*.

b. 20 CFR Parts 1 and 30 (Regulations) – Claims for Compensation Under the Energy Employees Occupational Illness Compensation Program Act, issued December 29, 2006.

c. Executive Order 13179, signed December 29, 2006.

d. EEOICPA Procedure Manual.

e. EEOICPA Bulletins, Circulars, Transmittals, and Program Memoranda. The Policy Branch issues these documents.

f. Dorland's Illustrated Medical Dictionary, W.B. Saunders Co.

g. Guides to the Evaluation of Permanent Impairment, 5th Edition, American Medical Association.

h. Current edition of The Merck Manual, Merck & Co.

i. Current directory of the American Medical Association for each state within the DO's jurisdiction.

j. Current ICD-9 coding manual.

k. NIOSH regulations on dose reconstruction and probability of causation (42 CFR Parts 81 and 82, Guidelines for Determining the Probability of Causation and Methods for Radiation Dose Reconstruction Under the Employees Occupational Illness Compensation Program Act of 2000; Final Rules).

l. The most recent DO accountability review report.

m. Road map or atlas covering the DO's geographical jurisdiction.

n. The Federal Register publications listing covered facilities.

o. Resource Center procedure manual.

p. User's Guide for the Interactive RadioEpidemiological Program (NIOSH-IREP).

q. Directory of Department of Energy records, contacts, and description of Department of Energy facilities.

r. Shared Drive maintained by the National Office.

2-0200 Resource Centers

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1. Purpose and Scope. This chapter describes the policies and procedures governing the Division of Energy Employees Occupational Illness Compensation (DEEOIC) Resource Centers (RCs).

2. Resource Center Functions. The RCs are situated in key geographic locations throughout the United States to provide assistance and information to the EEOICPA claimant community and other interested parties. The RCs gather substantial information and documentation, but they do not perform adjudicatory functions. The RCs provide claim development support and program outreach as well as initial claim intake.

The District Office (DO) retains all adjudicatory and most additional development functions. The RCs perform only certain initial development and limited follow-up tasks as specifically outlined in these procedures. The RCs are staffed and managed by contractor staff. Each RC has a manager, and each manager reports to the RC Contractor Project Manager, who in turn, reports to the DEEOIC RC Coordinator located at the National Office (NO). The RC Coordinator is responsible for supervising the activities of all RC staff, nationwide.

The RC role as it pertains to initial employment verification and occupational history development includes the following:

a. Claim Intake. Most new Forms EE-1/2 are filed directly with the RC located in the geographical area where the claimant(s) reside. Forms EE-1/2 received directly in the DO undergo employment verification at the DO and such claims are referred to the RC only if the DO determines that an Occupational History Questionnaire (OHQ) is required.

Regardless of place of receipt, the date of filing for a claim is the earliest discernible date stamp or postmark of a claim form or words of claim. Words of claim are any written statements received without a claim form that indicate a claimant’s intention to seek benefits under the EEOICPA.

Whether filing by telephone or in person, RC staff relays information about the program to the claimant. The RC explains the eligibility requirements, asks about conditions that the claimant has developed,

and begins the process of gathering information for use in adjudication.

(1) Filing by Telephone. When a claimant files a claim telephonically with RCs but then either refuses or fails to sign an actual claim form, the RCs must proceed as follows:

(a) Two weeks after the call, the RC telephones the claimant, informing him or her that the claim form must be signed to complete the filing process, and then recording the contact in the Telephone Management System (TMS) Energy Case Management System.

(b) Two weeks after that initial follow-up call, the RC sends the claimant a letter telling him or her that the unsigned claim form will be forwarded to the DO assigned to adjudicate the claim, and places a copy of the letter in the case file, but that the DO Claims Examiner (CE) will administratively close the claim because of the lack of a signed claim form.

(c) The RC then prepares a memo to the file documenting the times, dates, and manner of the efforts made to get the form signed, and of the warning that the claim will be closed administratively.

b. Claim Status. Claim status requests regarding initial employment verification or occupational history development fall within the purview of the RC staff, who also field other claim status requests to assist claimants with general questions not requiring DO or Final Adjudication Branch (FAB) involvement.

The RC staff member reviews ECMS status codes and answers claimant inquiries, memorializing such activities into the TMS or Notes screen. If the claim status request is beyond the scope of the RC staff to address, the RC staff member determines the case file location in ECMS and directs the caller to the proper CE or FAB Hearing Representative (HR).

Inquiries received from a claimant or authorized representative seeking claim statuses are referred to the adjudicatory DO CE or the FAB HR as necessary. When referring a claimant or authorized representative to a DO or FAB, the RC provides the claimant/authorized representative with the toll-free number to the DO or FAB. All RC Managers have full read only access to ECMS in order to better assist claimants with inquiries. Any inquiries that cannot be addressed by the RC staff/Manager go to the CE or FAB HR, as appropriate.

c. Program Information. If a potential claimant calls for information and/or guidance and no claim is on file, the RC staff member informs the potential claimant of filing requirements and available benefits. No referral to a DO or FAB is necessary. As no

claim exists in the system, a note memorializing the telephone conversation is not entered into ECMS.

Where a current claimant contacts the RC for guidance about the claims process (e.g., confirmation that a claim exists, questions about submitting new evidence or a new claim for benefits), the RC can provide guidance to the claimant as needed without referral to the DO or FAB. A TMS memorializing the telephone conversation is entered into ECMS

Also, RC staff may assist claimants in understanding the information being sought in DO development letters, explain the means by which such information may be obtained, and assist claimants in obtaining evidence. The RCs also assist claimants with medical bills/documentation and enroll/educate medical providers to join and navigate the automated medical bill pay system. A TMS memorializing the telephone conversation is entered into ECMS.

d. Initial Employment Verification. The RCs take initial employment verification steps for all new claims (Part B, E, and B/E) filed with the RC that are not covered under the Radiation Exposure Compensation Act (RECA). The DO conducts initial employment verification on claims filed directly with the DO (see section 5 below).

(1) Form EE-3 is the principal source for claimed employment information. However, if a claim is filed without a Form EE-3, the RC does not solicit it from the claimant. Rather, all claim materials are forwarded to the DO, where initial employment verification occurs.

(2) The RC uses DEEOIC tools, including procedures, bulletins, and employment verification updates and is given access to the DEEOIC Shared Drive to view these materials. The RC conducts initial employment verification on claims submitted by DOE contractor/subcontractor, Atomic Weapons Employer (AWE), and Beryllium Vendor (BV) employees for use in the adjudication of claims filed under EEOICPA.

e. Occupational History Questionnaire. RCs conduct occupational history development on all new Part E claims and some previously filed Part D/E claims, as discussed in section 6 below.

3. ECMS Usage in the Resource Centers. ECMS access is granted to the RCs to record claimant interaction and obtain claim status updates. Such interaction is recorded in ECMS Notes or ECMS TMS. RCs cannot input ECMS case status codes. Specific technical guidance regarding ECMS is provided in the ECMS User's Reference Guide.

Some RC activity occurs prior to case creation in the DO, and ECMS data input is unavailable. RCs make ECMS entries only on created cases. Where the case is not yet created, the RC maintains a written account of all claim-related activity, including the date on which such activity took place. All pre-case create actions at the RC are

recorded in the RC memorandum to the DO discussed in section 5 below.

a. ECMS Notes. The ECMS Notes field is used for all face-to-face contact with a claimant on a created case. For example, ECMS notes are used when a claimant appears at the RC to submit evidence or claim forms, to make an inquiry or raise a concern, or to complete the OHQ interview if the interview is done in person.

The RC staff member records the claimant's visit in the notes field in ECMS, providing a synopsis of the conversation and a description of any evidence or new claim filed during the visit. The Notes entry outlines the interaction with the claimant, including instructions or guidance the RC provides to the claimant. The RC discusses only information on a specific claim with the claimant in question. Once a note is placed in the system, a hard copy is printed and forwarded to the appropriate DO or FAB for association with the case file.

When creating an ECMS notes entry, the RC selects 'R - RESOURCE CENTER USE ONLY' entry in the "Note Type" section in the upper left hand box of the screen.

b. TMS. The TMS feature in ECMS allows RC staff members to memorialize telephone conversations and to access telephone messages for calls received in the RC. TMS provides a mechanism to track and maintain telephone contacts on given case files.

RC staff members receive incoming telephone calls, return calls and place calls to claimants and others regarding questions and concerns arising out of the claims process.

(1) RCs receive various kinds of direct calls. Generally, incoming calls are from claimants (or their authorized representatives) seeking claim status or guidance, or from potential claimants seeking program information and guidance regarding the claims process.

(2) A RC staff member returns a telephone call received in the RC within two business days of receipt regardless of the issue at hand. All calls related to claims in ECMS are logged into the TMS and must be returned accordingly.

(3) Outgoing calls are those generated from the RC for a purpose other than returning a telephone call. The DO may request RC assistance in obtaining evidence from a claimant or conducting some additional follow-up on a case file. Many RC outgoing calls are generated in the course of conducting employment verification and occupational history development, and are memorialized in ECMS only on created cases.

c. Calls from Claimants. Each telephone call to or from a claimant must be accurately entered into ECMS in accordance with the specific instructions contained in the ECMS User's Reference Guide and ECMS PM Chapter. If RC staff members conduct OHQ interviews (see below) by telephone, the OHQ interview must be memorialized in TMS in the same

manner as the in-person interview.

The RC staff member handling the telephone call outlines the content of the discussion, the claimant request, if any, the guidance or solution offered, and the outcome of the call or resolution of the issue at hand. Entry of quality data is of the utmost importance, and the RC staff member strives to ensure accuracy and specificity of data input when telephone contact is noted in TMS.

As with ECMS notes, the RC prints a TMS record once completed. The printed TMS record is forwarded to the appropriate DO for association with the case file.

d. ECMS Entries. The RC ECMS user may change ECMS entries placed into the system by RC staff as needed to correct errors, or at the request of the RC manager upon his or her final review of claim file material before it is forwarded to the DO. However, the RC cannot delete ECMS entries, so RC staff and managers must ensure that the data entered into ECMS is of high quality and free of errors prior to saving the entries into the system.

Once an ECMS record is input at the RC level, only NO DEEOIC staff may remove it. No capability to add or alter ECMS claim status codes has been granted to the RCs, and all coding operations related to RC activity on a case (aside from activities related to input in TMS or ECMS Notes) are entered at the DO to correspond with the date of the activity, as noted on the RC memorandum that accompanies case file materials to the DO.

e. ECMS Security. Security measures govern access to the system due to the sensitive nature of the records available in ECMS and other claim file documents (e.g., employment history, payment information, disease history, Social Security Numbers, and addresses).

When a RC staff member is hired, and ECMS access is required for that individual, access must be granted. Conversely, when an RC staff member’s employment is terminated, that person’s ECMS access must be disabled.

(1) To give a new RC staff member ECMS access, the RC manager prepares a memorandum to the RC Contract Project Manager requesting such access and providing all pertinent employee information. The RC Contract Project Manager sends a memorandum to the DEEOIC RC Coordinator at NO, who reviews the request and advises Energy Technical Support of the need to grant access to an incoming RC employee.

(2) Upon termination or resignation of an employee, the RC Manager prepares a memorandum to the RC Contract Project Manager. The memorandum provides the former employee’s name, title, employee number, and all other necessary information, including the date of the employee’s termination or resignation. The memorandum requests that

the former employee's access to ECMS be terminated on a specified date (i.e., date of termination or resignation).

(3) The RC Contract Project Manager then prepares a memorandum notifying the DEEOIC RC Coordinator advising of the RC former employee's scheduled departure. The DEEOIC RC Coordinator advises Energy Technical Support of the need to delete ECMS access to the outgoing RC former employee upon receipt of such notification.

4. Security, Privacy, Conflicts of Interest.

a. RC Staff Member with Interest in a Claim. A RC staff member may be a party to a claim under the EEOICPA or may have a personal or familial interest in the outcome of a claim.

(1) Resource Centers must avoid conflicts of interest in processing claims and should avoid even the appearance of impropriety in their work. Their staffs must work without any bias or influence that would affect their ability to render impartial service to the government in carrying out their duties.

Therefore, Resource Center staff cannot process claims or conduct either employment verifications or occupational histories for immediate family members (defined as spouses, children, siblings, grandparents, parents, or first or second cousins) or for any other individuals with whom they would have so close a relationship as to affect their judgment.

In such cases, the RC notifies the DEEOIC RC Coordinator at NO in writing via e-mail memorandum and refers those cases to the nearest alternate RC. After the conflict review process is completed, the RC manager prepares a memorandum to the alternate RC manager asking that the occupational history development or other task(s) be conducted and forwarded to the next nearest DO that does not have jurisdiction over the RC in question.

The RC assigned this development action has 14 calendar days upon the receipt of the assignment to complete all these activities and to report to the DO.

(2) When a RC staff member has a claim of his or her own, or when the situation meets the definition of a conflict of interest due to a relationship as defined above, the DO case file in question is transferred to the nearest DO for handling.

For instance, a claim involving an RC staff member working at an RC within the jurisdiction of the Denver DO is transferred to the Seattle DO for handling, and vice versa. Claims involving a staff member working at an RC within the jurisdiction of the Cleveland DO are transferred

to the Jacksonville DO, and vice versa.

b. Security and Individual Privacy Concerns. When interacting with claimants and other interested parties (e.g., authorized representatives) RC staff must remain aware of individual privacy concerns and maintain compliance with Privacy Act mandates. Except as discussed below, RC staff members may not provide information about an individual claim for benefits, or any other personal information, to anyone other than the identified claimant or his or her authorized representative.

(1) For RC staff to release any information regarding a specific claim or claimant to an alleged authorized representative of that claimant, an authorization form signed by the claimant must be in the case file appointing such individual as the claimant's authorized representative regarding his or her claim for benefits under the EEOICPA.

A claimant may authorize other third parties to receive claims information, but may not authorize multiple authorized representatives.

(2) Where information is sought that exceeds the RC's ability to assist the claimant or authorized representative (e.g., specific development questions regarding the relationship between toxic substances and illness), the RC staff refers the matter to the proper DO CE or FAB HR, denoted in ECMS as the primary CE.

c. Multiple Worksites. In all instances involving multiple worksites, the RC closest to the residence of the claimant(s) performs the required development tasks. For instance, if employment is claimed at all three Gaseous Diffusion Plants, and the employee/claimant(s) reside in the Paducah, Kentucky area, the Paducah RC handles all required tasks with assistance from the other RCs as needed.

d. Multiple Claimant Locations. If claimants reside in different states and the claim as a whole can be better served by utilizing more than one RC, a RC will be assigned based upon the geographical locations of the claimants. In such cases the RC forwards documentation to the adjudicatory DO.

5. Employment Verification. Detailed guidance on Employment Verification is found in the PM Chapter covering this subject. Below is an overview of those employment verification tasks with associated resource center tasks.

a. Review of ECMS. When the RC is taking a claim and reviewing it for initial action (employment verification or OHQ), the RC reviews ECMS to determine whether a claim already exists in ECMS. If so, the RC contacts the adjudicatory DO CE for guidance as to whether employment or occupational history development is required. If documentation is present in the existing claim file to either confirm

employment or document workplace exposure, the DO advises the RC accordingly and no action is needed by the RC. This is a case-by-case decision made by the DO.

b. Review of Case File. Upon receipt of a new claim, the RC staff member reviews the Forms EE-1/2, EE-3, and EE-4 and the DOE covered facility website to determine the type of facility claimed (e.g., DOE, BV, or AWE). The DOE website lists all major covered facilities, applicable time frames, a description of the site operations, and in certain instances, the names of the major contractors working at those facilities. This review also helps to determine the need for an OHQ, as AWE, BV and DOE (including DOE predecessor agency) federal employment is not covered under Part E and no interview is required.

c. Determining Appropriate Subpart. The claim may be filed under Part B, Part E, or both, depending upon the illness claimed and type of employment. The RC uses the DEEOIC case create worksheet (see EEOICPA PM 1-0300, Exhibit 1), and reviews the claim materials for a determination as to benefits being sought and conditions claimed to determine under which Part a claim is being filed. At any time the RC may consult the DO for guidance as to whether an OHQ is necessary.

(1) Claims submitted by AWE employees are excluded from Part E coverage unless their employment occurred during a time when the AWE was undergoing DOE remediation. DOE remediation periods can be ascertained by reviewing the DOE covered facility website, but the RC should seek DO guidance before conducting interviews about such claims.

(2) Claims filed by contractors or subcontractors of DOE or Section 5 RECA workers are always treated as Part E claims for the purposes of conducting an occupational history interview.

d. ORISE. If employment is claimed at a covered facility listed on the DOE website, the RC staff member determines whether employment can be verified through the Oak Ridge Institute for Science and Education (ORISE) database. This database, which is accessed via ECMS, contains employment information for over 400,000 employees who worked at certain facilities from the 1940s to the early 1990s.

Complete usage instructions regarding the ORISE database are discussed in the ECMS release notes dated April 6, 2005, version 1.8.2.0. Since ORISE is part of ECMS, the RC staff member obtains ORISE information by entering an employee's Social Security Number or name.

Resource Center staff determines whether appropriate data may be found in ORISE by checking the Employment Pathways Overview Document (EPOD). If the facility description includes the statement, "ORISE – yes," then RC staff first develops employment by accessing ORISE. If

ORISE information is unavailable or inconclusive, additional development is pursued as outlined below.

In either case, the RC staff member prints the results found in ORISE as part of the evidence of file. If employment is listed at a facility not on the ORISE list, ORISE is not consulted for verification.

(1) If the ORISE matches claimed employment within six months, no additional development is required. The RC prints out the ORISE database query result, prepares a memorandum stating the date the ORISE action was taken, and forwards all available materials to the DO with an RC checklist (Exhibit 1).

If an OHQ is required on a Part E claim, the RC attempts to complete the OHQ to be forwarded with the RC checklist. The findings and associated memoranda are subject to CE review and can potentially serve as a basis for verifying and accepting claimed employment under the EEOICPA.

(2) If the claimed employment cannot be confirmed through ORISE, or is only partially confirmed, the RC prints the ORISE record and determines if other sources of employment verification are available as outlined through the Employment Pathways Overview Document as described in Chapter 2-0500.

e. The EE-5 Process/DOE POC. Employment under the EEOICPA is also verified using the EE-5 process. The EE-5 process is applicable to employment claimed at DOE facilities, including contractor and subcontractor employment, as well as Beryllium Vendor and Atomic Weapons Employer employees. The RC refers the EE-5 package according to instructions in the PM.

For those instances in which employment is claimed for which there is no applicable DOE operations office, the following steps are to be taken:

(1) Employment for which EPOD indicates that a corporate verifier is able to confirm employment. For those instances in which a corporate verifier has employment information, resource center staff prepares the appropriate correspondence to a corporate verifier. EPOD identifies the information needed by each specific corporate verifier in order for them to confirm employment. EPOD also contains the name and address for corporate verifier contact persons from whom verification should be requested.

(2) If EPOD does not provide any pathway for employment verification at a claimed facility, the RC center staff informs the claimant that DOE does not possess employment records for the facility claimed and no other knowledgeable source exists to verify employment. In writing or by

telephone, the RC advises the claimant to submit further evidence in support of his or her claimed employment directly to the DO. If the claimant is the employee or a clearly eligible survivor, the RC also asks the claimant to sign Form SSA-581 so that the DO may request SSA records. The RC does not forward Form SSA-581 to SSA, but sends it to the DO with the employment verification packet. The RC does not mail this form to a claimant.

(4) The RC prepares a memorandum documenting the dates on which employment verification actions were taken for each claimant. The memorandum is forwarded to the DO within seven days of receipt of Form EE-1/2. The memorandum is accompanied by the Resource Center Claim Checklist (Exhibit 1) listing all materials enclosed and further actions required.

(5) Each adjudicatory DO District Director (DD) designates primary and alternate RC employment verification Points of Contact (POCs) and provides the RC with their names and contact information. The DD must immediately inform the RC if a POC is replaced.

(a) Duties. The DO employment verification POC serves as the primary contact for all responses regarding initial employment verification requests made by the RCs. The POC reviews all employment verification responses, consults ECMS to determine the CE handling the claim in question, and forwards all employment responses to the handling CE within one business day of receipt of the response in the DO.

(b) E-Mail Contact. Each POC has access to e-mail for use in verifying employment. The POC's e-mail address is copied on all e-mail requests for verification (where such request is the desired method of inquiry) and the e-mail from the RC provides the POC's name and contact information and requests that the employment verification response be forwarded to the attention of the POC.

(6) The RC prepares the claim package with the accompanying memorandum and checklist outlining the actions taken and forwards all documents to the adjudicatory DO. The RC includes a copy of the DOE Verification of Employment Memorandum, which serves to acknowledge that DOE has no employment information to provide.

(a) Later submissions to the DO do not require a formal memorandum, but should be accompanied by the Resource Center Claim Checklist. Any activity the RC took that needs to be captured by the DO in ECMS can be outlined either on the Checklist or on a separate

sheet of paper.

(b) The RC manager verifies the contents of the referral package and signs the checklist. The RC manager is responsible for validating that the information in the referral package(s) reflects the RC actions taken and accurately reports the dates of all activities conducted.

(c) The DO sometimes grants extensions of time in the face of extenuating circumstances. When RC staff conduct large outreach events and take new claims, they cannot begin employment verification actions until they return to the RC. In this instance the RC may ask the DO for an extension of time. The RC manager e-mails the DO Employment Verification POC with all claim file information requesting an extension of time and outlining the reason behind the request.

f. SSA-581 and Other Evidence. The following evidence, while not exhaustive, may assist in evaluating the validity of a period of claimed employment. RC staff should use judgment to determine which of the listed items staff should request from claimants.

(1) Time and attendance forms; W-2 forms and other tax statements; wage and earnings statements; check stubs; correspondence from the employer addressed to the employee; notices of promotion, reassignment, layoff, etc; ID cards; minutes from employment related meetings; punch cards; sign in and out logs; security clearance applications; union records; letters and certificates of achievement or participation in a certain event.

(2) Also, Forms EE-4 (Employment Affidavit) from coworkers and others with firsthand knowledge may be acceptable to establish employment in conjunction with other evidence. The RC may assist the claimant in preparing Form EE-4, but only contacts employment verifiers as identified therein. The RC does not contact coworkers or other individuals or gather employment or other evidence on behalf of the claimant.

(3) If the claimant is a walk-in employee or a clearly eligible survivor, the RC asks the claimant to sign Form SSA-581 so that the DO may request SSA records for use as a tool in additional employment development. The RC does not forward Form SSA-581 to SSA, but sends it to the DO with the employment verification packet. The RC does not mail this form to a claimant.

g. SEC/Newly Designated SEC. The Secretary of the Department of Health and Human Services (HHS) has approved additional designations

to the SEC class, and other designations are anticipated in the future. Many new SEC designations are/will be employment-specific and date-specific. HHS defines SEC inclusion specifically in many instances, and it will be necessary to identify a person's job title, years of employment, place of employment, and other facts based upon the specific language defining the SEC.

Therefore, it is necessary to gather employment-specific information when verifying employment at these sites. The Policy Branch issues Bulletins outlining specific guidance for handling newly-designated SECs. The Policy Branch Chief ensures that the RCs receive all Bulletins related to SEC class inclusion.

Since Form EE-5 does not contain a section to list employment-specific information, the RCs use the cover letter to DOE for this purpose. In the DOE cover letter the RC requests specific duty station information to assist the DO when rendering determinations as to SEC class inclusion. The request is tailored to meet the exact definition of SEC employment as set out by HHS and defined in Bulletins issued by the Policy Branch.

6. Occupational History Development. In addition to initial employment verification, the RCs conduct initial occupational history development on Part E cases *only* regarding claims involving covered Part E employees and their eligible survivors. This is done in part by completion of the OHQ (Exhibit 2). There are two OHQs, one for RECA and one for non-RECA claims.

Whenever possible, this step occurs during claim intake at the RC, with the results forwarded to the DO within the seven day period in which the initial employment verification task is conducted. The RC may conduct the OHQ prior to receipt of the claim filing, but the OHQ is not to be sent to the DO until a signed claim form is received.

If no signed claim form is received, the RC returns the OHQ to the claimant with instructions to return to the RC with a signed claim form.

a. Time Frames. If the OHQ cannot be completed within the initial seven day period, the RC sends the claims package to the DO immediately upon completion of employment verification (within seven days of receipt of claim forms), and then conducts the occupational history development.

(1) The RC has a total of 14 calendar days from the date of receipt of the claim or receipt of the assignment from the DO to conclude the occupational history development steps.

(2) If all actions cannot be completed within that time frame, the RC advises the DO CE via e-mail of the reason for the delay and outlines a reasonable timeframe in which to finalize all necessary actions.

(3) If an additional seven calendar days elapse after the

14 calendar day due date, the RC telephones or e-mails the DO CE requesting a time extension and providing an action plan.

(4) As soon as the occupational history task is complete, and assuming that a signed claim form has been received, all documentation is immediately forwarded to the DO with a memo or Claim Checklist noting the date on which the interview(s) was conducted. The RC maintains a copy of all case file materials until the occupational history development process is complete.

(5) If the RC cannot conduct the OHQ within 30 days of receipt of assignment and/or filing of the claim, the RC suspends all activities and reports to the DO. No further action is taken. The DO CE sends a letter to the claimant requesting a response once all materials are received in the DO. Depending upon the claimant's response, the CE can assign the OHQ task to the RC.

b. Occupational History Development Not Conducted. Under the following circumstances, no OHQ development occurs:

(1) If beryllium illness or chronic silicosis is the only condition claimed, unless otherwise directed by the DO. In addition, no occupational history development is conducted where only ineligible survivors are claiming benefits. For a complete discussion of eligible survivors under Part E, see EEOICPA PM 2-1200.

In such instances, the claim file material is immediately forwarded to the DO upon completion of the employment verification portion, the DO reviews for necessity of further occupational history development, and assigns development tasks to the RC as needed.

(2) If benefits are approved under Part B, or a positive DOE physician panel finding exists that DOE accepted under the Part D program **and** the employee is a DOE contractor or subcontractor (not a federal employee) then the employee is also covered under Part E for those approved diagnosis. In all cases, the RC consults ECMS for the status of the Part B claim for acceptance and queries the DO for guidance if a question arises as to whether or not an occupational history development action is required.

(3) If the Department of Justice (DOJ) has accepted a RECA Section 5 claim, no occupational history development is necessary, unless the claim was filed by a survivor. All other RECA claims generally require independent adjudication and require an OHQ. Cancer claims submitted by Section 4 RECA claimants who do not wish to file with DOJ require an OHQ. See Chapter 2-1100 for details.

d. Occupational History Questionnaire and Interview. The main function of the RC staff member in his or her occupational history development role is to conduct the OHQ interview. In cases with multiple survivors, all claimants are interviewed, unless one or more claimants have been designated to represent all of the claimants with regard to the interview process.

(1) Sometimes one claimant will know more about possible worksite exposure, or be more comfortable with a formal interview process, than the others. In such instances, a simple signed statement by the other claimants designating a certain claimant to be interviewed in his or her stead will suffice.

(2) Such a signed statement is not a designation of an authorized representative, and is only used in the interview process. Where an authorized representative has been appointed on a claim file with multiple claimants, there is no need to designate a claimant to participate in the questionnaire process. Authorized representatives may determine how the questionnaire process will be conducted.

(3) Much of the information gathered through occupational history development is sensitive in nature and is subject to Privacy Act mandates. Accordingly, the information developed may not be disclosed to any individual unless he or she is an authorized representative of the claimant or an authorized DEEOIC representative (see EEOICPA PM 2-0400).

e. Timeliness Goals. An interview must be scheduled and completed within the timeframes stated in this document, and all reworks and follow-up interviews must be conducted within seven days of receipt in the RC as noted above.

To properly conduct the interview, the RC staff must understand the work performed by DOE employees. Knowledge of the types of hazardous materials potentially present at DOE sites, the covered illness resulting from claimed exposures, the standard length of exposure for the illness to occur, and the medical diagnosis required to verify the illness is also necessary.

The RC staff must also possess sufficient knowledge of the EEOICPA, the DOE and RECA sites, and hazardous materials to record sufficient, valid data in occupational history questionnaires as well as ECMS and TMS notes.

f. Proper Use of OHQ. DEEOIC developed the DOE and RECA occupational history questionnaires for use by the RC staff, who must properly use them to obtain the information DEEOIC requires to evaluate a claim for causation. This chapter deals solely with the DOE OHQ; for further guidance regarding the RECA OHQ, see EEOICPA PM 2-1100.

The interview may be conducted in person or by telephone. On created cases, all telephonic activity regarding occupational history development is captured in the ECMS TMS screen, while all in-person activity is placed in the ECMS Notes screen. All required ECMS coding is input at the DO once the occupational history development task is complete and all documentation is returned to the DO.

g. Use of Script. When conducting interviews, the RC adheres to the script prepared by the DEEOIC. It is of the utmost importance that all interviews follow the prepared script, but flexibility is allowed for follow-up questions that logically flow out of the results of the interview.

If the interviewee has little or incomplete knowledge about a particular subject, the RC notes such deficiencies so that the DO is aware that information-gathering efforts were made.

Each interview takes approximately two to three hours to complete. It is possible that multiple claimants will require an interview for one case file.

(1) Overall, the RC interviewer is responsible for the proper conduct of the interview and for producing a complete, comprehensive questionnaire, including correct grammar and spelling.

(2) The RC makes certain to comply with specific requests for information from the CE. For instance, if the CE wants specific exposure information regarding solvents (e.g., benzene exposure) the RC follows up with a line of questioning to satisfy the CE's request.

(3) Once the interview is completed, the RC staff member gives the claimant the interview confirmation letter (Exhibit 3) verifying that the interview took place, and its date. A copy is sent with the OHQ for inclusion in the case file.

(4) All information is saved to the OHQ exactly as presented by the interviewee without alteration, duplication, or summarization by the RC interviewer, and the original paper version of the OHQ and a saved copy on a CD is forwarded to the appropriate DO within two days of completion.

(5) The RC interviewer in no way interprets the information presented by the interviewee. The OHQ is a stand-alone document and only the CE may interpret its meaning when using it as a development tool.

h. No RC Action Required. Neither initial employment verification nor occupational history development is undertaken where there is no eligible survivor under the statute. Where it is obvious that no eligible survivor exists (especially in the case of adult children under Part E) no additional RC action takes place.

(1) Since occupational history development is conducted exclusively on Part E claims, no action is necessary where Part E employment is not claimed or confirmed. If employment is claimed or confirmed at an AWE, a BV, or the employee is a DOE (or predecessor agency) federal employee, no occupational history interview is conducted.

(2) AWE contractors/subcontractors are not afforded coverage under the EEOICPA, and such claimed employment does not require occupational history development by the RC.

(3) The RC does not conduct initial employment verification on claims submitted by RECA claimants. However, occupational history development is necessary on most RECA claims and should be attempted upon receipt of Form EE-1/2 in the RC.

Since the DO must begin employment verification with the DOJ, all RECA claim forms are sent to the DO on the date of receipt in the RC for case create at the DO. Since the RECA claim forms are not held for seven calendar days, as in most other cases, whenever possible the RC attempts to conclude the occupational history development on the date of receipt of the RECA claim forms prior to shipment to the DO.

Where occupational history development cannot be completed at the RC on RECA claims upon the date of filing, the RC copies the RECA claim form documents and maintains a file at the RC while conducting occupational history development actions. In such instances the RC has 14 calendar days from the date the claim is received in the RC to conclude the occupational history development actions.

The RC prepares a list of all materials being submitted on a transmittal sheet outlining the material being sent, separated by the claim number. All such documentation is associated with the proper case file upon receipt in the DO.

i. Materials Destroyed. Once all employment verification and occupational history development actions are finalized and the CE confirms by telephone or e-mail that the DO does not require further assistance, the RC destroys its file copy.

j. Follow-Up or Reworks of Complete OHQs. Upon review of a completed OHQ, the DO may determine that additional information is required or identify an error that requires remedy.

(1) Follow-up interviews are conducted when the DO identifies additional issues through further development of the claim for causation that require RC assistance. The CE makes follow-up assignments directly to the RC manager with

an accompanying memo outlining instructions as to the required additional development needed.

(2) Reworks arise when an error is found in the final product from the RC. Interview reworks are conducted only where the CE identifies a deficiency (i.e., incomplete or inaccurate data). Reworks must be approved by a CE and are forwarded to the RC manager by the DO DD with a memorandum outlining specific instructions as to the deficiency found and the required remedy.

(3) The RC must complete all follow-up and rework assignments from the DO within seven calendar days of receipt in the RC.

7. Transfer of Cases. Once all possible initial employment verification/occupational history development actions are complete, the RC sends all claim forms, associated documents, and the RC checklist to the DO with a memorandum outlining RC activities to that point.

Upon receipt of the initial submission, the case is created as set out in EEOICPA PM 1-0300. Once the case is created and the claim assigned to a CE, the CE reviews all claim file materials and employment verification/occupational history development materials for ECMS coding.

a. Codes. The CE inputs coding in ECMS to correspond with the date on which the action occurred at the RC.

b. CE Review. The CE reviews the initial submission to determine whether additional tasks are necessary at the RC level. As noted above, the DO may return any part of the package if a deficiency is identified or an additional interview is deemed necessary.

The CE uses the information obtained during the occupational development as a tool for establishing causation (based upon employment and the claimed covered illness) in the adjudication process. Also, the CE proceeds to develop the claim.

c. Receipt of Materials in the RC After Initial Seven Day Memo. Any such materials are sent to the DO with the occupational history development package if they cannot be included with the seven day memo submission. All other materials received at the RC after all development is concluded (including printouts of TMS and ECMS Notes records) are submitted without a memo or checklist.

d. Receipt of Material in the DO Prior to Case Create. In some cases the DO receives documentation from the RC prior to receipt/filing of a claim form. The DO maintains all such information in a dummy folder and retains it until the claim form is received. When the case is created, RC actions are coded to correspond with the day upon which they actually occurred, regardless of claim filing date. ECMS coding must reflect the true date a RC action was taken.

8. Part D/E Claim Files. In the past, Part D/E claims potentially required occupational history development at the RCs. The CE evaluates the older Part D/E claims on a case-by-case basis to determine whether a referral to the RC is needed.

a. Exposure Evidence. The CE examines the case file for the existence of DAR records, other DOE exposure records, and other employment records that might provide exposure evidence and eliminate the need for an OHQ.

Also, the CE consults the Site Exposure Matrices (SEM) in conjunction with the case file material to determine the need for further development by the RC. The CE must make the OHQ assignment to the RC unless he or she can establish the plausibility of exposure to a toxic substance by other means [e.g., the SEM, Document Acquisition Request (DAR) records, other employment evidence indicative of exposure].

(1) If the CE determines that an OHQ is required due to a lack of other exposure and employment evidence, an assignment to the RC is made. The RC has 14 calendar days from the date of receipt of the assignment from the DO to complete the occupational history development tasks outlined by the CE.

(2) The CE prepares a memorandum to the RC requesting that the OHQ be completed. The CE lists any specific information (e.g., toxic exposure, employment) that needs development. Any relevant case file material (e.g., claim forms, employment and exposure records) is attached for RC review. The CE includes precise instructions as to the information being sought. The Senior CE or Supervisor reviews the memorandum and approves the assignment before it is sent to the RC.

Upon receipt in the RC, the assignment is logged into ECMS Notes. Date of receipt in the RC is the first day of the 14 calendar day period.

(3) Once the CE identifies the need for an OHQ and tasks the RC with an assignment to conduct the interview, the DO sends a letter to the claimant. The letter advises the claimant that the interview is conducted on behalf of DOL, that it is different from any other prior interview the claimant may have given, and that it is intended to provide the claimant with a thorough and timely adjudication of his or her claim.

(4) The CE also "closes out" the OHQ assignment (or follow-up or rework) in this manner if the RC attempted to complete the OHQ, but was unsuccessful because the claimant could not be reached or refused to complete it. The status effective date in this situation is the date of the RC memo

to the DO explaining why the OHQ could not be completed.

9. Resource Center File Retention. Depending upon the circumstances and the need for additional follow-up regarding a task described in this chapter, RCs retain or destroy file materials as necessary.

a. Office of Worker Advocacy (OWA) Files. There is no need to retain materials related to old OWA claim files. The RCs may destroy any OWA materials on hand.

b. Part D Files without Employment Verification (EV) or OHQ Information. This material is disseminated from the DOs as necessary based upon DO review and identified assignments to the RC. Any such material on hand at the RC can be destroyed unless it is being used in the process of a DO assignment. Once completion of the assignment is confirmed via the method outlined below, all materials are to be destroyed.

c. New Incoming Cases. Where only EV is conducted, the RC destroys case file material upon completion of the EV task and DO confirmation of receipt of all documents. Case file materials regarding Part E claims that require an OHQ are retained either until the OHQ process is complete and the DO confirms receipt of the transmitted materials, or in cases where the OHQ cannot be conducted, as described above.

d. DO Transmittal. Upon receipt of the EV/OHQ and/or all other pertinent documentation required of the RC, the DO checks off each item listed on the transmittal and then faxes the transmittal to the appropriate RC instructing it to destroy its case file materials. Upon receipt of the DO transmittal, all such materials are destroyed. The transmittal may be sent by the DD or any individual designated by the DD for such purpose.

e. Receipt of Documents in the NO or FAB. If NO or FAB receives a Resource Center transmittal containing information for association to a case file at NO or FAB, the Policy Analyst/Hearing Representative/CE (or designee at the discretion of management) confirms receipt via fax to the appropriate RC, instructs the RC to destroy their copy of the transmitted material, and associates the materials to the case file. The faxed instruction sheet is also placed in the case file for record keeping purposes.

If NO or FAB receives a transmittal from a Resource Center, but the case file is no longer at NO or FAB, the Policy Analyst/Hearing Representative/CE (or designee at the discretion of management) immediately forwards the materials and transmittal sheet to the appropriate DO. When the DO receives the transmittal, the DO follows the instructions above.

10. Wage-Loss and Impairment Outreach. Due to the complex nature of the Part E benefit structure and the requirements necessary to qualify for lump-sum compensation, selected Resource Centers (RCs) have been tasked to engage in an outreach effort to educate claimants

on the requirements of filing for and obtaining impairment and/or wage-loss benefits.

a. Outreach. To facilitate communication with eligible claimants who are also the covered employee or worker (hereafter referred to as employees) certain DEEOIC RCs are assigned responsibility for contacting identified employees by telephone to explain the benefit provisions available under Part E. Assignments are as follows:

Jacksonville DO and FAB	Savannah River RC
Cleveland DO and FAB	Portsmouth RC
Denver DO and FAB	Espanola RC
Seattle DO and FAB	Hanford RC

b. RC Referral. There are two types of Part E cases that are to be identified and referred to the designated Resource Center (RC) to initiate employee communication:

1. Cases at the Final Adjudication Branch where a positive Final Decision has been issued to a living employee and there has not been a prior claim for impairment and/or wage-loss.

2. Cases at the District Office where a positive Final Decision has been issued to a living employee and initial development is underway for impairment and/or wage-loss.

c. Referral from FAB. For Part E cases at the Final Adjudication Branch, when a final decision is issued to a living employee with a positive causation determination, a copy is to be prepared and forwarded to the designated RC. This should be done **only** in situations where there is no indication that a claim has been made for impairment and/or wage-loss. Decisions that pertain strictly to survivors of a deceased employee are not to be referred to the RC, but processed in the normal fashion. The Washington, DC FAB sends final decisions that meet these guidelines to the appropriate RC, based on which DO issued the recommended decision on Part E.

d. Development. For any case at the DO that contains a final decision with a positive finding on causation issued to a living employee and where there has been no claim for impairment and/or wage-loss, an initial development letter for impairment and/or wage-loss benefits is completed and sent to the employee with a copy of the letter sent to the assigned RC. An example of an initial development letter for impairment benefits is included in EEOICPA PM 2-1300. Examples of the initial development letters for wage loss benefits are included in EEOICPA PM 2-1400.

e. Records. Upon receipt of a final decision or a development letter in the RC, the RC should take appropriate action to record its

receipt. The RC is responsible for ensuring that an appropriate system for recordkeeping is developed to track referrals, and subsequent actions in accordance with the guidance provided here. The RC uses a spreadsheet to record the date the final decision or development letter(s) was received in the RC, the employee's name, claim number, the date outreach was completed and whether or not the employee intends to pursue impairment and/or wage-loss. In addition, the RC will also report on the disposition of all referrals on a weekly basis to the DEEOIC RC Coordinator. This data should be incorporated into the routine weekly RC activity report already generated by the RC manager.

f. Contacting the Claimant. The RC staff should carefully review Procedure Manual Chapters 2-1300 and 2-1400, which explain the eligibility requirements for compensation benefits and the procedures DEEOIC follows for developing impairment and wage-loss benefit claims. For each referral, the RC initiates a telephone call to the employee identified. It is necessary for the RC to access ECMS to obtain contact information for the employee. The purpose of this call is to provide information about the potential impairment and/or wage-loss benefits available, respond to questions, and solicit claims.

A script (Exhibit 4) has been developed for use by the RC staff in explaining impairment and/or wage-loss benefits to the employee at a general level. It is important the RC staff adhere to the script. Given the complexity of the benefit structure under Part E, it is likely that the employee will have questions. The RC staff may respond to general follow-up questions; for example, eligibility requirements or program procedures to develop a claim for impairment and/or wage-loss benefits. To help the RCs anticipate and answer some of the most common questions regarding impairment and wage-loss benefits, DEEOIC has developed a Q & A Sheet (Exhibit 5) for use by the RCs.

Claim-specific questions or questions that exceed the RC's ability to assist the employee must be referred to the assigned CE or FAB hearing representative/claims examiner, per ECMS. No attempt should be made by the RC representative to offer opinion or conjecture as to the likelihood of entitlement. All adjudicatory functions are solely the responsibility of the assigned CE.

g. Statement from the Claimant. During the telephone call, if the employee expresses the intention to pursue impairment and/or wage-loss benefits or in cases where the RC staff member believes the employee may qualify for these benefits, the RC advises the employee to submit a signed statement or letter to the appropriate DO stating his or her intention to pursue benefits.

h. Claimant Information. In cases where the employee expresses the intention to pursue impairment and/or wage- loss benefits, the RC must also mail the brochures titled "How Do I Qualify for an Impairment Award" (available on the DEEOIC website at

http://www.dol.gov/esa/owcp/energy/regs/compliance/brochure/ESA_how_do_I_qualify.pdf) and/or "Wage-Loss Benefits" (available at the DEEOIC website at http://www.dol.gov/esa/owcp/energy/regs/compliance/brochure/ESA_wage_loss.pdf) with an appropriate cover letter to the employee. These brochures were developed to explain these two types of benefits and the requirements that must be met to qualify for benefits.

i. TMS. All discussions with the employee about wage-loss and/or impairment is memorialized into the ECMS via the TMS screen. In general, each TMS entry contains a synopsis outline of the discussion; the employee's question or request, if any; the guidance or solution offered; and a notation as to whether the employee intends to pursue impairment and/or wage-loss. The TMS screen is printed and the paper record of the activity is forwarded to the appropriate DO/FAB daily for association with the case file.

j. Special Instructions for Terminal Claimants. Designated RCs are responsible for immediately notifying via email the DO POC and the assigned CE or FAB HR (as denoted in ECMS), on any case needing prioritization, such as a terminally ill employee who wants to claim impairment and/or wage-loss. The designated DO POC is the same individual who handles the RC employment verification process. The RC staff member still submits the printed copy of the telephone contact in TMS to the appropriate DO/FAB for association with the case file. For easier identification, these TMS records must be marked "Priority" on top of the page.

k. Follow Up with the Claimant. The designated RC has seven calendar days from the RC's receipt of the employee's final decision or initial development letter(s) to initiate telephone contact. In cases where the RC is unable to contact the employee within seven calendar days, the RC continues to follow up with the employee and documents the contact attempts in TMS until contact is successful or the RC makes a reasonable determination that further attempts will not be productive. The RC representative may use his or her discretion to determine when to cease further contact attempts with the employee, but as a general rule, after three recorded attempts in as many days has failed to garner employee contact, the RC may cease outreach effort.

l. Disposing of the Decision. The RC is to shred the final decision and/or development letter after the employee has been successfully contacted or after the RC has ceased outreach effort with the employee.

Exhibit 1: RC Checklist Cover Sheet

Exhibit 2: Occupational History Interview

Exhibit 3: Interview Confirmation Letter

Exhibit 4: Impairment Telephone Script

Exhibit 5: Wage Loss and Impairment FAQs

2-0300 Initial Development

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1. Purpose and Scope. This chapter explains the procedures to be used by the Claims Examiner (CE) for the review and initial development of a Part B claim, a Part E claim, a Part B/E claim, and for a Part D claim that has been developed by the Department of Energy (DOE), after receipt by the designated District Office (DO) and entry in the Energy Case Management System (ECMS).

2. Resource Center Actions. Resource Center (RC) staff conduct initial employment verification on most non-Radiation Exposure Compensation Act (RECA) claims filed with the RC and occupational

history interviews on all new Part E claims with covered employment and eligible survivors. The DO conducts initial employment verification only on claims filed directly with the DO. However, the CE closely reviews all initial development actions taken at the RC and determines what additional and follow-up measures are necessary.

3. Review by the District Office for Potential Development. Regardless of the type of claim (i.e., B only, E only, B and E, or a Part D claim developed by the DOE), the CE first reviews the claim to determine what development is required to issue a recommended decision. Key items the CE needs to review to determine whether sufficient evidence exists are listed below. These three factors are applied differently for each claim type.

a. Medical Condition(s).

b. Employment History. Information provided by the RC will assist the CE in determining what additional development is required.

c. Survivorship Eligibility, When Appropriate. This excludes employee claims and RECA claims for Part B only.

4. Reviewing a New Claim. The initial review takes place upon the DO's receipt of the new claim from Mail and Files (see EEOICPA PM 1-0200). The CE reviews the claim as a whole, weighing employment, medical, and survivorship eligibility to properly categorize the claim and determine what development is required. The information contained in the RC packet assists the CE in planning additional development.

When a deficiency in the evidence is identified, the CE must notify the claimant and request evidence needed to resolve the deficiency. The CE may also assist the claimant with his or her claim by requesting evidence from other sources.

a. Medical Development. The CE reviews the claimed medical condition(s) on Forms(s) EE-1/2 and the completed Case Create Worksheet to determine whether the claim is applicable under Part B, Part E, or both. Refer to Chapter 2-0900 covered occupational illnesses under Part B and to Chapter 2-1000 for covered illnesses under Part E.

For example, the claimed condition of prostate cancer is applicable under both Part B and Part E but the claimed condition of asbestosis is applicable only under Part E.

(1) The CE must ensure that the condition claimed is covered under Part B, Part E, or both, based upon the claimed employment and the different criteria used to determine covered employment under each Part.

(2) The CE develops the medical condition(s), as needed, in accordance with EEOICPA PM 2-0800, Developing and Weighing Medical Evidence.

b. Employment Development. At the same time, the CE reviews Form

EE-3 and any employment verification request forms or evidence received from the RC to determine whether the claimed employment is applicable under Part B, Part E, or both.

(1) Under Part B, the applicable facility types include DOE, atomic weapons employers (AWE), beryllium vendors (BV), and RECA mines or mills. AWE subcontractors are not covered under Part B or Part E.

(2) Under Part E, the only applicable facility type is DOE or a covered RECA Section 5 facility. Only DOE contractors/ subcontractors are covered; federal DOE employees at such sites are not covered Part E employees.

AWE and BV employees are not covered under Part E. However, if employment is claimed at an AWE or BV during a time in which such facility was designated a DOE facility for remediation, the case file is forwarded to the National Office (NO) for review. EEOCIPA PM 2-0500 discusses DOE remediation in detail.

(3) The CE looks at the claimed facility types(s) (i.e., DOE, AWE, BV, and covered RECA mines or mills), time period(s), job title(s), and ORISE printouts, if available. The CE then determines whether the claimed employment is applicable under Part B, Part E, or both, and then develops any employment evidence needed.

c. Eligible Survivor Development. When Form(s)EE-2 is received, the CE reviews the claim and determines whether all eligible survivors have been accounted for and given the opportunity to apply for survivor benefits. Also, the CE reviews the claim for sufficient evidence to support the relationship between the survivor and the employee.

(1) Under Part B, the eligible survivors are the surviving spouse, children, parents, grandchildren, or grandparents at the time of payment.

(2) Under Part E, the eligible survivors are the surviving spouse and certain eligible children at the time of the employee's death (see EEOICPA PM 2-1200).

The RCs do not develop for employment or occupational history if it is *clear* that no eligible survivor exists (which occurs primarily in cases involving adult children under Part E). The CE must review the evidence of record to confirm the absence of an eligible survivor before issuing a recommended decision based upon RC determination, because the RCs do not perform any adjudication functions.

d. Verifying ECMS Accuracy. After reviewing the claim, the CE reviews the New Claims Review Checklist and ECMS to ensure that the claim was entered correctly in ECMS (see EEOICPA PM 2-2000).

5. Sources of Evidence. Decisions are based on the written

evidence of record. Evidence may include (but is not limited to) forms, reports, letters, notes, personal statements, and affidavits. Most of the evidence required under the EEOICPA may be obtained from the following sources:

a. Claimant. Any claimant filing for benefits under the Act is responsible for submitting the necessary evidence required for the Office of Workers' Compensation Programs (OWCP) to adjudicate the claim.

b. Department of Energy (DOE). The DOE, a federal agency, had contractual arrangements with employees, contractors, subcontractors, AWEs and BVs with respect to the United States Atomic Weapons Program. The Act requires DOE to provide the Department of Labor (DOL) with information relevant to EEOICPA claims. The DOE conducts medical screening of former DOE facility employees through its Former Worker Program (FWP). The procedures for obtaining employee-specific FWP records are set forth in Paragraph 12 of this Chapter.

c. Corporate Verifiers. While it produced atomic weapons, the DOE maintained relationships with a wide variety of external entities such as contractors and subcontractors, BVs and AWEs. The CE may need to contact these entities to obtain information about a claim for compensation.

d. Oak Ridge Institute for Science and Education (ORISE). Oak Ridge maintains the ORISE database, which may be accessed via the Internet. The ORISE database, which contains information for over 400,000 employees from the 1940s until the early 1990s, is an effective source for verifying employment for individual claims. ORISE is accessible via ECMS, and the initial ORISE search is generally conducted at the RC when a claim is filed.

e. The National Institute for Occupational Safety and Health (NIOSH). NIOSH is an agency within the Department of Health and Human Services (HHS) that is responsible for estimating the radiation exposure to DOE employees, contractors, subcontractors and AWE employees during the production of atomic weapons.

NIOSH researches site information for covered facilities and sends dose reconstruction reports to EEOICPA DOs. The DOs use the dose reconstruction reports to determine the probability of causation between a claimed cancer and exposure at a covered facility, based on the criteria established by NIOSH.

f. Medical Sources. These sources include reports from doctors and hospitals providing examination and/or treatment to covered employees. By signing Form EE-1 or EE-2, the claimant authorizes OWCP to collect medical documentation pertinent to his or her case.

g. Center for Construction Research and Training. The Center for Construction Research and Training is a research, development, and training arm of the Building and Construction Trades Department (BCTD) of the AFL-CIO.

CPWR has direct access to 15 building and construction trade international unions, signatory contractors, and union health, welfare and pension funds. CPWR also has access to employment records, union rosters, and dispatch records.

CPWR researches and provides employment information for construction and trade worker claims where DOL has been unable to obtain reliable information from other resources (e.g., DOE, corporate verifiers).

h. Site Exposure Matrices (SEM). The SEM database may be accessed via the Internet. SEM is a source for obtaining evidence of potential exposures to toxic substances at many DOE facilities.

i. Other Sources. The OWCP may receive evidence from other sources, such as individuals completing employment affidavits, claimant representatives, and other state and federal agencies.

6. Advising the Claimant of Deficient Evidence. When the CE determines that additional development is required, the claimant must be advised of the deficiency and afforded an opportunity to respond.

a. Initial 30-day Period. If the CE identifies a deficiency in the evidence that requires development, a letter is prepared which describes the deficiency and additional information necessary to overcome it. The CE thoroughly reviews the evidence in the file before writing the letter and tailors the letter to the individual case. Often 30 days will be sufficient time to allow for submission of additional evidence.

For example: If a claimant submits a claim for a non-covered condition and the evidence does not support a covered condition under the EEOICPA, the CE advises the claimant that a covered condition has not been claimed and that he or she is allowed 30 days to claim such a condition and to provide supporting medical evidence. [If the claimant does not claim a covered condition and does not provide supporting evidence, the CE proceeds with a Recommended Decision for denial.]

b. Final Notice. If the claimant fails to submit the requested evidence within a 30-day period, in most instances the CE sends a follow-up letter advising the claimant that OWCP has not received the requested evidence and that he or she will be provided with additional time to submit the evidence.

For example: If a covered condition is claimed, but the file is lacking medical documentation, the CE allows a reasonable period of time for submission of the appropriate evidence. In cases such as this, the CE makes at least two requests for medical documentation.

c. Setting Deadlines. As the EEOICPA is non-adversarial, the CE uses care when setting deadlines. The information requested is not always easily obtained because most employees were exposed many years ago. Thus the CE must be as flexible as possible and advise the claimant that additional time will be granted if the claimant requests a reasonable extension of time.

7. Requesting Evidence by Telephone. The CE may also use the telephone to gather evidence. Person-to-person contact often succeeds in obtaining information, addressing specific concerns, and defusing contentious situations. Any use of the telephone is to be conducted in a professional and courteous manner.

a. Documenting Phone Calls. CEs document each call in the Telephone Management System (TMS) in ECMS and place a copy of the automated telephone record in the case file. It is vital to enter a call summary into the TMS right after the call, while the information is still fresh in the CE's mind. For more information on TMS, see EEOICPA PM 0-0400.

8. Initial Exposure Development. RC staff conduct occupational history interviews on most new Part E claims filed after August 1, 2005, and on certain Part D/E claims filed before that date. In conjunction with this step, the CE queries the Site Exposure Matrix (SEM), and prepares the Document Acquisition Request (DAR) and forwards it to the proper DOE Operations Center or corporate verifier requesting exposure information to complement the RC findings. A DAR is not always necessary; the CE completes a DAR request based upon what medical evidence and exposure documentation is already contained in the case file.

a. Occupational History Interview. Exposure information is partially obtained through the occupational history interview conducted at the RC. Two separate interview scripts (one for DOE employment, one for RECA) are available, and the findings outlined in these documents assist the CE in clarifying what further exposure development is needed as it relates to causation.

b. Review of Evidence. The CE reviews the claimed employment, exposure documentation, the SEM (see EEOICPA PM 2-0700), and the claimed condition to determine the proper course of development for causation.

c. Assignment to RC. The CE reviews all former Part D cases, new Part E cases filed before August 1, 2005, and claims filed directly with the DO to determine whether an occupational history interview is required. Such evaluations are made on a case-by-case basis by reviewing the evidence in the file as a whole and the exposure evidence in particular.

(1) If the evidence in the file is insufficient to develop for exposure, the CE assigns an occupational history development task to the RC via memo to the RC manager.

(2) Upon receipt of such assignment, the RC has 14 calendar days to complete the occupational history interview and return the findings to the DO with a cover memorandum outlining all tasks and stating when they were conducted.

9. Former Part D Claims. Former Part D claims have been incorporated into the existing Part B EEOICPA files. DOE may have gathered documents that are relevant to DEEOIC's current development needs. The CE must review these claims for medical, employment, and survivorship information (if applicable).

The case file may contain copies of records from a Part B claim (e.g., medical records, development letters, Forms EE-5, a NIOSH dose reconstruction report, a recommended decision, a final decision) and/or records that were gathered by the DOE Office of Worker Advocacy (OWA).

As noted above, should an occupational history interview be required, the CE assigns the task to the RC. Any employment development is conducted at the DO; no RC assignment is necessary. The evidence in these claims may include:

a. Claim Forms.

(1) Form EE-1, EE-2, or EE-3.

(2) Form 350.2, Employee Request for Review by Physician Panel. This is the primary application form for current or former DOE contract employees under Part D.

(3) Form 350.3, Survivor Request for Review by Physician Panel. This is the primary application form for a survivor of a former DOE contract employee under Part D.

(4) Form KK-1, KK-2 - OWA1-7/6/01 Request for Review by Medical Panels. DOE used these forms initially for filing claims by the employee and by the survivor, respectively, and for the claims review by the Medical Panels. These were internal forms used by OWA only.

Once the Office of Management and Budget (OMB) approved these forms, they became known as Form 350.2, Employee Request for Review by Physician Panel, and Form 350.3, Survivor Request for Review by Physician Panel, respectively.

If no DOE/OWA forms are located, the CE reviews the file for any correspondence from the claimant that may contain words of claim. As with Part B, any correspondence referring to a request for benefits or a request for review by a physician panel will be considered a claim filed under Part E.

b. Highlight Sheet. This form provides a chronological description of adjudicative actions, follow-up information, and documented phone calls by the OWA. This information was entered in OWA's Case Management System (CMS).

c. Medical Records. These records include medical narratives, pathology reports, clinical reports, and diagnostic reports.

d. Survivorship Evidence. This includes marriage certificates,

divorce decrees, birth certificates, adoption papers, death certificates, obituaries, and school records.

e. Employment Evidence. This includes a Document Acquisition Request (DAR), which in turn includes employment records such as job position descriptions, personnel information, security clearance information, employment dates, medical records, accident/incident reports, radiation records, and dosimetry records.

f. Occupational Medical Questionnaire. This form is in the case file if completed by an RC staff member and/or by an OWA staff nurse based on conversations with claimants.

g. Physician Panel Report. Some case files may contain this report, which consists of the OWA physician's discussion, rationale, and conclusion as to whether a toxic substance aggravated, contributed to, or caused the claimed condition(s). Additional guidance as to the proper evaluation of these reports as they relate to causation is outlined in Paragraph 10 of this Chapter.

h. Former Worker Program (FWP) Documents. As discussed in greater detail in Paragraph 12 of this Chapter, DOE medically screens former DOE facility workers. The resulting studies document claimed illnesses and exposure. The CE may encounter DOE FWP documentation in the case file. The CE reviews DOE FWP findings together with all other evidence in file when evaluating for causation.

i. Authorized Representative Release Form. The claimant may have designated a representative to act on his or her behalf in the adjudication process with DOE. The CE contacts the claimant to determine whether this designation is still valid (see EEOICPA PM 2-0400).

j. Duplicate Records. The CE may find duplicate copies of records in the Part D case file. The CE maintains the integrity of the Part D case file by keeping it in the order that it was received in the district office. The CE does not remove any duplicate copies of individual records unless it is obvious that there is an exact duplicate photocopy of the entire case record in the file. In this instance the CE shreds the duplicate photocopy.

10. Positive DOE Panels.

a. Official Positive DOE Panels. If a positive DOE physician panel finding is present in a Part D case file and the DOE approval letter is signed by a DOE official, the physician panel finding is considered an official positive determination from DOE. Generally, such claims are in posture for acceptance of causation under Part E, but further development of survivorship and potential coordination and offset issues may be required of the CE before issuing a recommended decision:

(1) Eligible Survivor. In survivor claims the CE needs to determine whether the claimant is an eligible survivor under Part E and whether the accepted covered illness

aggravated, caused, or contributed to the covered Part E employee's death (see EEOICPA PM 2-1200).

(2) State Workers' Compensation Benefits/Tort Offset. Also, the CE needs to determine whether the claimant received any compensation from a state workers' compensation plan (see EEOICPA PM 3-0400 and 3-0500).

b. Unofficial Positive DOE Panels. If a positive DOE panel finding is present in the case file, but no accompanying approval letter signed by a DOE official is present, the case is not in posture for possible acceptance. In such a case, the physician panel report has not been sent to the claimant and the CE does not consider it an official positive determination from DOE. Therefore, the CE reviews the claim to determine if further development is needed concerning survivorship, medical, employment or exposure issues, as with any other claim.

11. Reviewing Part B/E Claims. A claim accepted under Part B is also accepted for causation under Part E for the accepted Part B covered occupational illness, if all other appropriate criteria under Part E are met.

Unlike a Part E claim with an accepted Part B claim, a claim that has been accepted under Part E is not automatically accepted under Part B.

In developing these cases, the CE needs to be alert to the differences in medical, employment, and survivorship requirements between Part B and E claims (including RECA claims), since these differences can result in the need for additional development and/or non-approval of the claim under Part E, even though it has been approved under Part B.

a. Medical Differences Between Part B and E Claims. Covered illnesses under Part E include all the covered occupational illnesses under Part B (i.e., beryllium sensitivity, chronic beryllium disease, chronic silicosis, and cancer) plus additional covered illnesses (e.g., asbestosis).

However, the covered occupational illnesses under Part B do not include all the covered illnesses under Part E (for example, asbestosis, peripheral neuropathy, and anemia).

b. Employment Differences in Facility Sites Between Part B and E Claims. Covered employment under Part B includes all covered employment under Part E (i.e., DOE contractor/ subcontractor, RECA).

However, covered employment under Part E does not include all covered employment under Part B. Part E covers employment at a DOE or RECA Section 5 facility. It also covers employment at AWE and beryllium vendor facilities only during a period when they were designated as DOE facilities or during DOE remediation periods. Part E does not cover employment for beryllium vendors or AWE facilities outside of the time they were considered DOE facilities.

c. Survivorship Differences Between Part B and E Claims. These issues are addressed in the Survivorship Chapter of the PM.

d. RECA Differences Between Part B and E Claims.

(1) An eligible survivor who is the child of the covered employee under RECA and under Part B is not an eligible survivor under Part E unless he or she meets the definition of "covered child."

(2) An employee who does not meet the employment and other requirements under RECA section 5 (and therefore under Part B) may be eligible under Part E.

(3) An employee who does not meet the medical criteria for covered conditions under RECA section 5 (and therefore under Part B) may still be eligible under Part E (i.e., all cancers, asbestosis, etc.)

e. Requirements for New Part E Claim Filing. If a former Part D claim exists, a claimant does not need to file a new claim under Part E. If there is a Part B acceptance on record, a claimant does not need to file a new claim for benefits under Part E. However, if a Part B denial is on record, or a Part B claim is pending a decision, the claimant must file a new claim form seeking benefits under Part E.

12. DOE Former Worker Program (FWP). The FWP began in 1996 and is designed to evaluate the effects of DOE's past operations on the health of workers employed at DOE facilities. The program documents medical conditions and workplace exposures that may help the CE develop and adjudicate claims. Additional information about the FWP is available at http://www.eh.doe.gov/health/.

In some instances, FWP records will appear in the Part D case file. If no records exist there, or a new Part E, B/E claim is filed, the CE requests FWP documents during initial development.

The CE reviews FWP records in light of the evidence in the file as a whole when evaluating a claim. EEOICPA PM 2-0700 explains how the CE uses FWP records in assessing causation.

a. Medical Component. FWP records contain valuable information about medical conditions and can help the CE develop for a covered illness.

(1) The FWP is a screening program and *does not provide a final diagnosis* for the medical conditions detected. If the screening tests identify a potential disease, the employee is referred to his or her treating physician for further medical workup and diagnosis.

(2) Results of medical tests conducted by the FWP (e.g., pulmonary function tests, beryllium lymphocyte proliferation tests, blood tests, X-rays with B reader interpretations, etc.) are valid when interpreted by

certified medical professionals. Therefore, the CE may use such test results in evaluating records for a covered illness, provided a physician's interpretation of the test result is present.

b. Exposure Component. FWP medical screening is conducted to evaluate former DOE workers for adverse health outcomes related to occupational exposures to substances such as beryllium, asbestos, silica, welding fumes, lead, cadmium, chromium, and solvents. Therefore, these records contain valuable exposure information. The CE reviews FWP screening records along with the evidence in the file as a whole when evaluating claimed exposure.

Also, the FWP asks the former DOE employee to undergo a Work History Interview, which examines workplace exposure at DOE facilities. The CE uses the results of the interview when assessing work history and exposure.

c. Existence of FWP Records. The CE must review the case file/claim forms to determine whether FWP records exist.

(1) Part D Cases. As indicated, some former Part D cases will contain FWP records. The CE searches the case file for cover memos or medical records provided by the FWP. The CE should also refer to DOE Form 350.2, Employee Request for Review by Physician Panel, question 11, or Form 350.3, Survivor Request, question 11, to determine if the employee participated in the FWP. If records are not present, but there is some indication that they may exist, the CE obtains them as outlined below.

(2) New B/E Claims. With regard to new claims, the CE must review Form EE-3 and/or section 5(B) of the DOL Occupational History Interview (see EEOCIPA PM 2-0200) to determine if the employee participated in a FWP screening program at the claimed work site. If so, the CE prepares a request package to be sent to the appropriate FWP.

d. Obtaining FWP Records. Where no records exist in a former Part D case, or a new Part E claim is filed, the CE requests the records from the appropriate FWP Point of Contact (POC). The complete POC list is available for viewing on the shared drive by accessing the Part E folder, Former Worker Program subfolder. If the records are unavailable at a POC, the POC cannot be determined, or a new Form EE-3 is required (see below), the CE requests assistance from the claimant.

(1) POC Request. After determining that FWP records must be requested, the CE reviews the POC list to identify the appropriate POC. The CE prepares a package and a cover letter to the POC (Exhibit 1). The package includes a letter to the FWP, a cover memo, Form EE-1 or EE-2, and *the new* Form EE-3.

The CE should state in the memo that an EEOICPA claim has been received for the named DOE employee, the employee participated in the specified FWP, and DOL is requesting a copy of all FWP records. The memo and package are faxed or mailed to the designated POC.

(2) New Form EE-3. FWPs will accept only a new Form EE-3 as a release. If the case file contains an old Form EE-3, the CE writes to the claimant asking the claimant to complete and sign a new Form EE-3. Once the new form is received, the CE prepares the request package as outlined above.

(3) No FWP Records. When the CE cannot locate FWP records, the CE contacts the claimant in writing to determine if the employee participated in a FWP at the claimed work site. The CE includes a new Form EE-3 with the letter and instructs the claimant to complete, sign and return the new Form EE-3 to the DO *only* if the employee participated in the FWP.

e. Building Trades National Medical Screening Program Database. This database contains work history and medical test results for certain employees who worked at Amchitka Island, Savannah River, Oak Ridge, and Hanford and who filed Part D claims with DOE from 2000-2004.

(1) The CE views medical data and work histories contained in the database by accessing the Shared Drive, Part E folder, Former Worker Program subfolder. The "read me" file in the FWP subfolder contains detailed instructions for navigating the database and retrieving information.

(2) The CE searches the database for medical information and prints the results. The medical results generated from the database do not contain a physician's signature.

(a) A letter from the Building Trades FWP Medical Director, Dr. Laura Welch, describing the information obtained in the database search and attesting to its validity is located on the Shared Drive, Part E folder, FWP subfolder.

(b) The CE prints Dr. Welch's letter and attaches it to the search results. The CE places these documents into the case file and weighs the information with the evidence on file as a whole.

13. Terminally Ill Claimants. OWCP strives to process claims fairly and expeditiously for all claimants. However, claimants who are end-stage terminally ill must have priority processing. These claims should be handled swiftly and compassionately.

a. Claims Actions. DO and FAB CEs and hearing representatives

(HRs) are instructed to watch for indicators of an end-stage terminally ill claimant any time they are reviewing a case file or preparing a decision. Indicators of end-stage terminally ill claimants include requests for hospice care, medical evidence stating that the claimant is at the end-stage of an illness, or telephone calls or letters from RCs, congressional offices, authorized representatives, family members, or medical providers regarding the claimant's illness. Upon receipt of information concerning the end-stage of the claimant's illness, the District Director (DD) or Assistant District Director (ADD) or FAB Manager (depending on where the file is located) must be notified immediately.

The DD/ADD or FAB Manager must use sound judgment in determining if priority handling is warranted. If medical documents or other information indicate that the claimant is in the end-stage of his/her illness, or that death is imminent, priority handling of the case is required. If the claimant's medical status is unclear, a medical report that establishes that the claimant is in the end-stage of a disease or illness must be obtained. Once this information is obtained, the DD/ADD of FAB Manager will determine whether priority handling is warranted.

Once it is determined that a claimant is in the end-stage of his/her illness, the DD/ADD or FAB Manager must enter the appropriate status code in ECMS and prepare the case file in accordance with EEOICPA PM 2-2000.

Priority handling for terminally ill claimants requires that the entire adjudication process be expedited. Whenever the file changes hands, the person receiving the file should be notified, verbally or in writing, of the claimant's terminal status. The supervisor or DD/ADD should facilitate the expedited adjudication of the claim by requesting priority processing from any other agencies involved, such as the DOE, Department of Justice (DOJ), and NIOSH.

If a case requires referral to the NO for reopening or policy clarification, the DO or FAB must identify the claimant as terminally ill in the memo to the Director. Procedures for expediting payment processes for terminally ill claimants can be found in the EEOICPA PM 3-0600.

Exhibit 1: DOL Letter to DOE Former Worker Program

2-0400 Representative Services

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1. Purpose and Scope. This chapter discusses persons who represent the interests of claimants before the Division of Energy Employees Occupational Illness Compensation (DEEOIC), the interaction between a Claims Examiner (CE) and a representative, and fees charged by representatives for their services.

2. Authority. Under 20 C.F.R. §§ 30.600 and 30.601, a claimant may authorize any person, not otherwise prohibited by law, to represent him or her.

a. No Requirement for Representation. A claimant need not be represented to file a claim or receive a payment.

b. Exclusive Representation. If a claimant chooses to have an authorized representative, he or she may appoint only one person at a time. However, an individual who holds power of attorney to act on a claimant's behalf may appoint an authorized representative (see paragraph 4 below). When that happens, DEEOIC will only recognize and communicate with the authorized representative.

c. Authorization in Writing. Any appointment must be in writing. The claimant may appoint a representative by filling out the "Authorization for Representation/Privacy Act Waiver" (Exhibit 1), but use of this form is not required (see paragraph 7 below for a discussion of Privacy Act waivers). If the appointing document does not contain the representative's full name, telephone number and address, the CE obtains that information.

d. Length of Appointment. DEEOIC recognizes the authority of a properly appointed representative throughout the entire claims process (including any hearing), unless or until the claimant withdraws the appointment.

3. Authorized Representative's Role. The authorized

representative's role in the claims process depends on the scope of the authority that the claimant grants him or her. Unless the claimant's authorization specifies otherwise, a properly appointed authorized representative has the authority, to the same extent as the claimant, to present or seek evidence, make factual or legal arguments, and obtain information from the case file.

Any notice requirement in the Act or the regulations is fully satisfied if the notice is served on an authorized representative, and it has the same effect as a notice served on the claimant. An authorized representative does not, however, have authority to sign the EN-20 for the claimant unless the authorized representative has also been granted power of attorney.

4. Powers of Attorney. A person with power of attorney to act in the name of the claimant is known as an "attorney-in-fact." The authority of an attorney-in-fact depends on the language used in the written instrument delegating such authority. It may authorize him or her to take a variety of actions, such as signing documents and DEEOIC forms as if he or she were the claimant. An attorney-in-fact may also appoint an authorized representative to act on behalf of the attorney-in-fact. Therefore, if an individual asserts power of attorney for a claimant, the CE must obtain a copy of the document conferring such authority. The CE must carefully examine the document to determine the scope of the attorney-in-fact's authority to act in specific contexts, on behalf of the claimant.

a. Form EN-20. If an individual asserts power of attorney for the claimant on Form EN-20, the CE must submit the documents purporting to grant such power for review by the Office of the Solicitor of Labor (SOL) to ensure that they are valid under the applicable state law.

b. No Form EN-20. In all other circumstances, the CE reviews the power of attorney documents to determine whether the authority granted is consistent with the actions that the attorney-in-fact seeks to perform on the claimant's behalf, such as speaking with district office staff and signing correspondence. If the power of attorney documents do not grant such authority, the CE notifies the claimant that the power of attorney designation cannot be honored for the purposes sought. The claimant has a right to remedy this situation by granting the proper authority in a signed document.

5. Interaction with Representatives. The CE must obtain a copy of the written appointment of a representative before taking any action at the representative's direction. After a claimant properly appoints a representative, the CE contacts the representative by letter (Exhibit 2). In the letter, the CE acknowledges the appointment and describes the extent to which the representative has an active role in the claims process.

6. Representative Fees. A representative may charge a claimant a fee for services associated with representation before DEEOIC. Under

20 C.F.R. § 30.602, OWCP is not responsible for any fee charged by a representative of an EEOICPA claimant, nor will it reimburse the claimant for any fees paid to the representative.

a. Fee Limits. Under 20 C.F.R. § 30.603, for services rendered in connection with a claim pending before OWCP, a representative may not receive more than the following percentages of a lump-sum payment made to a claimant:

(1) 2% for the filing of an initial claim with OWCP, provided that the representative was retained prior to the filing of the initial claim; plus

(2) 10% of the difference between the lump-sum payment made to the claimant and the amount proposed in the recommended decision with respect to objections to a recommended decision.

b. Limitations. These maximum fee limitations apply even if the claimant and representative have agreed to other amounts in a contract or otherwise.

7. Privacy Act Waivers. A Privacy Act waiver grants DEEOIC permission to copy all documents from the case file and send them to a person of the claimant's choosing. This person may be anyone the claimant wishes to receive material from the case file. The designated person will have no authority to make requests for additional information or sign documents on behalf of the claimant, unless the claimant submits additional documentation showing that the designee has such authority.

Exhibit 1: Authorization for Representation/Privacy Act Waiver

Exhibit 2: Notification to Representative

2-0500 Establishing Covered Employment

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1. Purpose and Scope. The EEOICPA lays out a set of employment criteria which must be satisfied before a claim can be considered for compensability. These criteria, taken together, form the basis of covered employment. This section of the EEOICPA Procedure Manual lays out the guidance to be followed by the Claims Examiner (CE) for gathering and evaluating evidence to determine whether a claimant meets the necessary employment criteria specified in EEOICPA.

2. Facility Coverage. The EEOICPA provides facility definitions that serve as the basis for determining covered employment. The following summaries provide a general definition of each type of facility covered:

a. Atomic Weapons Employer (AWE) Facilities. An AWE facility means a facility, owned by an atomic weapons employer that is or was used to process or produce, for use by the United States, material that emitted radiation and was used in the production of an atomic weapon, excluding uranium mining or milling. Coverage at the facility may be further extended after the period of processing or production of radioactive material for use in a weapon, if there is a finding in a NIOSH report on residual radioactive contamination that the potential exists for residual radioactive contamination at that facility. AWE facilities are designated by the Department of Energy (DOE).

(1) Coverage extends only to the employees who worked directly for the AWE at the facility. Contractor or subcontractor services provided on-site or off-site for an AWE are not covered.

(2) Atomic weapons employees are covered under Part B of the EEOICPA for cancer only. No coverage is afforded these employees under Part E.

(3) Designating additional AWE facilities is the responsibility of DOE; however, applicable time frames for AWE production activities at a particular facility are determined by DOL.

(4) Determinations on whether an AWE facility has a period

of residual radioactive contamination and the length of that period are the responsibility of the NIOSH. Periodic reports are issued listing affected sites. Facilities with residual radioactive contamination are covered as AWE facilities even if there is a change in the owner or operator of the facility.

b. Beryllium Vendor (BE Vendor) Facilities. Be Vendor facilities are companies which are either named in the Act or DOE has determined that they processed or produced beryllium for sale to, or use by DOE. The Act names several beryllium vendors by corporate name and these are known as statutory beryllium vendors. Any employee of a statutory beryllium vendor who worked for the vendor during periods when the company was engaged in activities related to the production or processing of beryllium for sale to or use by DOE, has covered employment, regardless of work location. Other beryllium vendors, which are location-specific, were designated by DOE through publication in the Federal Register. The final list of designated beryllium vendors was issued on December 27, 2002.

(1) Beryllium vendor coverage extends to direct employees of the vendor, its contractors or subcontractors, or any Federal employee who may have been exposed to beryllium at a facility owned, operated or occupied by the vendor.

(2) Coverage for beryllium vendor employment is limited to those benefits available under Part B of the EEOICPA for beryllium sensitivity and chronic beryllium disease.

c. Department of Energy (DOE) Facilities. A DOE facility means any building, structure, or premise, including the grounds upon which such building, structure, or premise is located in which operations are, or have been, conducted by, or on behalf of, the DOE (except for buildings, structures, premises, grounds, or operations covered by Executive Order 12344, dated February 1, 1982, pertaining to the Naval Nuclear Propulsion Program); and with regard to which the DOE has or had either (A) a proprietary interest; or (B) entered into a contract with an entity to provide management and operation, management and integration, environmental remediation services, construction, or maintenance services.

(1) The extent of benefits available to those who worked at DOE facilities is dependent on the type of employment, specifically whether the employee was a DOE federal employee or an employee of a DOE contractor or subcontractor. Under Part B, coverage extends to both DOE federal employees and contractor or subcontractors employees working at the site, while under Part E coverage is only extended to contractor or subcontractor employees.

(2) The definition of DOE includes its predecessor agencies including:

(a) Manhattan Engineer District (MED)(August 13, 1942-December 31, 1946)

(b) Atomic Energy Commission (AEC)(January 1, 1947 – January 18, 1975)

(c) Energy Research and Development Administration (ERDA)(January 19, 1975– September 31, 1977)

(d) Department of Energy (October 1, 1977 – present)

(3) Designations of DOE facilities or changes in DOE facility time frames are the responsibility of DOL. Further information regarding how DOL assesses claims for DOE facility status is discussed later in this chapter.

d. Remediation Employment. At many AWE facilities, there is a DOE period of remediation designated sometime after the years of active processing ended. In those instances when a facility is designated as a DOE facility for remediation only, in order to have covered employment at that location, the employee must have been employed by the contractor performing the remediation work. Such remediation workers are eligible for the full range of benefits under both Parts B and E of EEOICPA.

e. Facilities with multiple designations. Many facilities covered under the EEOICPA have multiple designations. There can exist any combination of AWE, Beryllium Vendor and DOE facility designation at the same facility. For those instances in which an employee works at such a facility during periods separately designated for different facility types, the employee will have eligibility for every category for which he/she has verified employment.

f. RECA Section 5. This is a special category of employment that involves miners, millers and ore transporters at uranium mining facilities. For the purposes of this chapter, RECA Section 5 employees are not addressed. For information regarding handling these types of claims, please refer to Chapter 2-1100 of the EEOICPA Procedure Manual.

3. Comparing initial claimed employment to the covered facilities database. The first step the CE takes in assessing covered employment is determining which claimed employment on the EE-3 Employment History form corresponds with a known covered AWE, Be Vendor or DOE facility. The CE does this by comparing what is written on the EE-3 with the facilities identified on a web utility located at:
http://www.hss.energy.gov/HealthSafety/FWSP/Advocacy/faclist/findfacility.cfm

When performing the comparison between the claimed employment and the facility database, the CE must be diligent in assessing the evidence. While in many instances, employment at a particular

location or facility will be obvious, in other situations it may not. Evidence presented by a claimant must be scrutinized against the database to assist in determining the location where employment occurred. In some situations, the claimant may use various words, phrases or other descriptors to identify a work location. Moreover, the CE must be mindful that often the name of a facility is different from the employer name provided by the claimant. Given these realities, the CE must cross reference the data provided by the claimant with the information in the facility database. This can involve searching by facility name, state or location, or key word. The "Find this Keyword" search feature is particularly helpful as it is the broadest possible way to look for potential covered employment based on claimant statements.

a. Certain employers should be screened out of the review process if it is clearly discernable that there is no affiliation to the atomic weapons industry. For example, employment as a clerk at a shoe store or cashier at a department store would not require action on the part of the CE to further consider as part of the review for potentially covered employment.

4. Matching claimed employment. The outcome of the initial employment facility screening will result in either part or all of the claimed employment having possibly occurred at a covered facility, or none of the claimed employment being linked to a facility. In any instance where all claimed periods of employment are linked to a location identified on the facility database, the CE is to proceed to employment verification as discussed later in this chapter. Alternatively, if the CE is only able to match a portion of the claimed employment to a facility listed in the facility database, or there is no match found, action must be taken to communicate the findings to the claimant. The CE is to contact the claimant to notify him or her as to which employment can form the basis of a claim and which does not appear linked to a covered facility. The claimant is to be afforded the opportunity to provide clarifying evidence. The process for this action is further discussed in paragraphs 17 and 18 of this chapter. It should be noted that this development may occur concurrently with other actions being taken in conjunction with the claim such as requests for additional medical or factual evidence.

When there is sufficient evidence to conclude that employment may have occurred at a covered facility, the CE may then proceed with the verification of employment as described later in this chapter. If the claimant does not respond to the inquiry or does not provide any type of clarifying evidence, the CE may proceed with adjudication of the claim based on the evidence of record. If there is no match between any claimed employment and a covered facility, the CE may proceed to deny the claim. In any instance where claimed employment is not verified, it must be described in any recommended decision.

5. Resource Center Actions. As outlined in Chapter 2-0200,

resource center staff take initial employment verification steps for those cases originating at a resource center. This includes matching claimed employment to covered employment and initiating action outlined in paragraphs 6 through 12, below, as appropriate.

6. Verification of Employment. Once matches are established between claimed employment and a covered facility, the next step is employment verification. Employment verification is the process by which the CE establishes the factual accuracy of the claimed employment history. Evidence must be collected that establishes that:

a. The employer qualifies for consideration under the law as an AWE, Be Vendor, DOE, or DOE contractor or subcontractor.

b. The employee worked for claimed employer.

c. The employee performed duties at that covered AWE, Be Vendor or DOE facility.

The process of employment verification is recognized as a difficult and challenging hurdle in many cases. Because the atomic weapons program dates back to the early 1940s, the large number of public and private organizations involved, the high level of security involved, and the shear scope of the industrial process, locating pertinent individual employment records can be difficult. Moreover, it is also a reality that records are missing, degraded, lost or destroyed. This imperfect situation presents particular difficulties to the CE when attempting to establish the factual accuracy of claimed employment.

As the statute allows latitude in the assessment of evidence, it is not necessary for the CE to collect evidence that establishes that the claimed employment is proven beyond a reasonable doubt, but merely that a reasoned basis exists to conclude that the employment occurred as alleged. This ensures that the claimant receives favorable treatment during the employment verification process. Once the CE has conducted an examination of the available factual evidence in support of the claimed employment, he or she must decide whether a sufficient basis exists to verify that each of the three elements of covered employment are satisfied.

a. SEC employment. In matching claimed employment to covered employment, the CE is to be mindful that there are numerous classes in the Special Exposure Cohort (SEC), described in Chapter 2-0600. It is important that the CE always consult the most current list of SEC classes so that claims fitting into the class can be promptly adjudicated, without overdevelopment of covered employment.

7. Employment Pathways Overview Document(EPOD). The EPOD is a document that has been created to assist the resource center staff and CEs in identifying the appropriate pathway(s) to be taken as part of the employment verification process. This document lists every facility published in the Federal Register that is covered under the Act (except RECA facilities) and provides an outline of the

identified methods for verifying claimed employment at each location. EPOD is initially available on the shared drive in the Employment Verification Folder within the Policies and Procedures Folder.

The pathways listed in the EPOD are not intended to provide an exhaustive list of means to verifying employment at a facility, but rather represent what constitutes best practices for verifying employment most efficiently given the programmatic experience gained since passage of the Act in 2000. The CE should locate the facility(ies) identified on the EE-3 in EPOD and ascertain the programmatic implications based upon the claimed employment.

Specifically, EPOD identifies which methods, or combinations thereof, described below are appropriate to pursue to verify covered employment in the most expeditious manner possible. The recommended sequence for utilizing resources follows the numbered items 8 through 13 in this chapter.

EPOD replaces lists 1, 2, 3 and 4 from previous guidance. It also replaces the "CE Employment Verification Referral Sheet." If EPOD is silent on verification at a facility, the CE is to utilize Social Security Records (Paragraph 11, below) and "other employment evidence" (Paragraph 13, below).

The facilities in EPOD are listed alphabetically by state. On the first page of EPOD there is a list of states and, for those states with a large number of facilities, there are additionally letters after the state name. These letters provide a rough index of the facilities in that state. The state names and letters allow the user to navigate through the document. For example, to navigate to South Carolina the user places the cursor on South Carolina and presses "Cntrl + right click" at the same time and the utility will jump to South Carolina. Alternatively, if a user wants to view the S-50 plant in Tennessee, the most expeditious method would be to move the curser over the letter S after Tennessee and then press "Cntrl + right click" at the same time and the utility will jump to S-50.

For many claims, DOE can provide employment information for employees covered under the Act. Since this is not always the case, it is necessary to include in the case file in every instance in which there is no appropriate referral to DOE, a letter from DOE so stating. (Exhibit 1) Therefore, for every facility in EPOD in which there is no referring DOE contact information, the CE is to place a copy of the DOE letter in the file.

8. Using the ORISE database. For every EEOICPA-covered facility for which there is some employment data in ORISE, EPOD will indicate "ORISE – yes." When this occurs, resource center staff and/or the CE conduct an ORISE search in ECMS as outlined below. If there is no mention of ORISE in EPOD for the facility, the resource center staff or CE proceeds to the next recommended method for verifying employment noted in the facility description in EPOD or in this chapter.

a. Resource center staff and/or the CE logs into ECMS as described in Chapter 2-2000, and chooses the "Inquiry" tab and selects "Search ORISE data." A screen appears which provides fields for the first name, last name, and social security number of the employee. To conduct a search, the CE must enter, at a minimum, a partial last name, or social security number for the employee.

b. Once resource center staff and/or the CE enters the employee's name and/or social security number, the system searches the database and provides the results at the bottom of the page under *ORISE Search Results*. If the database finds a match, the name and social security number appears. The resource center staff and/or CE select the result to review the employment data.

c. ORISE categorizes information in two rows of data. The first row categorizes the information by Facility and lists all the facilities or employers(for which data exists in ORISE) where the employee worked. The second row categorizes information in columns by Facility, Hire/Terminate Date, Dept. Code, Job Title, and Badge Number. ORISE was not created for the purpose of adjudicating claims, so information therein may be incomplete. In some cases it provides the name of the employer with a notation in the "HT" column, which provides "H" for hire and "T" for termination, with the numbers in the adjacent columns representing the corresponding dates for hire and termination.

The translations for the codes in the "pay" column are as follows:

H = Hourly

W = Weekly

M = Monthly

O = Operations (hourly)

S = Salaried

C = Construction

d. Because ORISE was not created for the purpose of adjudicating claims, resource center staff and/or the CE must consider the context of the information. For example, there may be data in ORISE confirming that an employee worked at a facility in 1949, but the resource center staff and/or CE must ensure that the covered time period for this facility includes 1949. Additionally, for many employees, the information in ORISE is incomplete. For example, for some employees the database may show the employee's name and facility, but does not include specific hire and termination dates. If this is the case, the CE develops hire and termination dates using alternate methods described in paragraphs 9 through 13 in this chapter.

e. If the information from the ORISE database is used to verify any portion of employment, a copy of the ORISE employment results is printed and placed in the case file along with the memorandum from

DOE stating that the data contained in the ORISE database is reliable(Exhibit 2). These documents may be used as affirmation of employment and are placed in the case file.

f. The absence of data from ORISE may not be used as the basis for stating that an employee did NOT work at a given facility either for the entire time period claimed or for portions of claimed employment.

g. There are some employers and/or facilities in ORISE that are not covered under the EEOICPA. Resource center staff and/or the CE need to carefully review the ORISE results for any non-covered employers. For example, the Puget Sound Shipyard for which ORISE ascribed the acronym PSSY is contained in ORISE, but is not covered under the EEOICPA. In the event that ORISE "confirms" such non-covered employment, it does not render such employment as covered. If an employer is not covered, no degree of verification that a person worked there will serve to extend EEOICPA coverage to that facility. All decisions on adding facilities are made by the National Office through the process described in paragraphs 17 and 18 of this chapter.

9. Contacting DOE. When claimed employment can not be verified in ORISE, the resource center staff/CE use the Form EE-5, found in Exhibit 2 (Forms) of Chapter 0-0500 of this Procedure Manual to obtain employment information. To determine whether the claimed employment is such that an EE-5 referral to DOE is appropriate, resource center staff and/or the CE look up the name of the facility(ies) and/or employers in EPOD. If there is a notation in EPOD signaling "EE-5 Referral to (contact information)" next to the facility, resource center staff and/or the CE proceed with the EE-5 procedures specified in this paragraph. If the employee was employed at multiple work sites for which different DOE operations offices are responsible, resource center staff and/or the CE send separate employment verification packets to each unique DOE operations office that is appropriate given what is claimed on the EE-3.

a. EE-5. The resource center staff and/or the CE complete the top portion of the EE-5 by providing the employee name, SSN, claimed employer, and named claimed facility. Resource center staff and/or the CE also write a cover letter to the appropriate DOE operations office or offices, make a copy of the EE-1 or EE-2, as appropriate, and a copy of the EE-3 to be included in the package with the EE-5. The completed package is then submitted to every appropriate DOE contact listed in EPOD for each facility requiring such a referral. It may be necessary to submit separate employment verification packets to each responsible DOE operations office.

b. Subcontractor employment indicated. Resource center staff and/or the CE review the EE-3 and make a preliminary determination of whether the employee is claiming DOE subcontractor employment. If so, resource center staff and/or the CE note this in the cover letter to DOE and request any information the DOE might have to help

substantiate that the company was hired by the DOE or a DOE contractor to provide a service on-site during the time period when the employment is claimed. Questions regarding subcontractor employment are referred to the same operations' offices as the EE-5 package, and not to DOE Germantown.

c. Upon receipt of an EE-5 from DOE, the CE reviews it for completeness. DOE is responsible for selecting one of three options provided on the form and attaching any relevant information. In addition, the DOE representative completing the form must certify its accuracy. The CE returns any form that does not meet these requirements to DOE for correction. The three options available to DOE and the appropriate procedural responses are as follows:

(1) For any of the claimed employment in which DOE selects "Option 1 – Verified Employment," the CE accepts this time period as verified and no further action needs to be taken to establish this fact.

(2) If DOE selects "Option 2 – No verification is possible, but other pertinent evidence exists," this indicates that DOE has some information on the employee, generally suggesting that the individual was on site or somehow associated with the facility, but the information is insufficient for the DOE to provide verification. If Option 2 is selected, the CE develops the case further for employment as outlined in this chapter.

(3) If DOE selects "Option 3 – No evidence exists in regard to the claimed employment," it indicates that DOE has no evidence at all regarding the claimed employment. If Option 3 is selected, the CE develops the case further for employment as outlined in this chapter.

d. Timeframes. If the CE does not receive a completed form from DOE within 30 days of the initial submission, the CE prepares a second request for the completed EE-5. If DOE is ultimately unable to verify employment, the CE is to utilize other procedures as outlined in this chapter.

e. No Response from DOE. If the CE does not receive a response from DOE within 60 days from the initial request, additional development is necessary.

(1) Contact DOE by telephone. If no response is received, the CE contacts the appropriate Operations Office by telephone. The CE asks the contact person identified in EPOD whether a response to employment verification is forthcoming. If DOE responds via telephone that they have no records to verify employment, the CE documents this to the case file with a memo outlining DOE's response. This serves as the "EE-5" for purposes of a DOE response.

(2) Contact the claimant. After 60 days with either no

response or a response that no records are available from DOE, the CE contacts the claimant for additional employment information.

f. Document Acquisition Request (DAR) Processes. For cases involving DOE contractor employees, the CE or resource center makes a request to DOE for records useful for developing information regarding toxic exposures. Although DAR records are predominately used in the adjudication of the toxic exposure component of Part E cases, DAR records can also contribute to the evidence of covered employment, especially in cases involving DOE subcontractor employment, which is further described in paragraph 14 of this chapter. DAR records can include site medical records, job descriptions, radiological records, incident or accident reports and others. Generally, a request for DAR records is only made of DOE once employment is confirmed. However, some DOE operations offices have stated that they prefer to receive the DAR request at the same time as they receive the EE-5. If resource center or district office staff are aware of such a situation, they include the request for DAR records in the EE-5 package. The point of contact at DOE for DAR records is also included in EPOD. For more details on the DAR process, refer to Chapter 2-0700 of this manual.

g. Dosimetry Records. It is general program policy for NIOSH to obtain dosimetry records from DOE as part of the dose reconstruction process. The dosimetry records become associated with the file when the district office receives NIOSH's dose reconstruction report. Nevertheless, in instances in which dose records may be useful for confirming that an individual was on site or was monitored for radiation exposure the CE may request such records from DOE as part of employment development.

10. Contacting Corporate Verifiers. Many of the facilities designated under EEOICPA are operated by private companies and neither DOE nor any of its predecessors have possession of the employment or personnel records. However, many of these companies are still in business, or have been bought by other companies which have maintained records of past employees. Many of these companies have agreed to provide employment verification for purposes of adjudicating claims under EEOICPA. These companies are referred to as corporate verifiers. For each facility that has been identified as having a corporate verifier, EPOD provides the name and contact information for the corporate verifier. The CE is to follow the instructions listed in EPOD to obtain such employment information. General procedures for handling corporate verifiers include:

a. It is not necessary for the CE to submit a copy of documentation from the case file to the corporate verifier. Instead, a cover letter providing the details of the request is to be submitted. In most cases, the cover letter includes the employee's name, SSN, date of birth, employer name and the dates of claimed employment.

b. Once the CE has received a response from the corporate verifier, the CE reviews it to determine if it is sufficient to verify the claimed period of employment. If the corporate verifier affirms the entire period of employment being claimed, the CE accepts the period as factual. The CE must obtain the verification from corporate verifiers in writing. While an employment verification can be *initiated* through a phone call, there must be documentation from the verifier in the case file to substantiate a finding of covered employment. If the corporate verifier is unable to substantiate the claimed period of employment or can substantiate a portion of it, the CE requests additional information. The CE can proceed with a request to the Social Security Administration(SSA) for information as described in paragraph 11 of this chapter, and should also ask the claimant for additional information, as outlined in paragraph 13 of this chapter, as appropriate.

c. If verification is for a beryllium sensitivity or chronic beryllium disease (CBD) case, the CE need not verify all employment, only enough employment sufficient to substantiate the exposure at any time during a covered time period. For additional information regarding development of a beryllium claim, refer to Chapter 2-1000.

d. Corporate verifiers sometimes change. If a CE learns of a change in contact information or locates new contact information, this information should be sent to the National Office Employment Contact in the Policy Branch.

11. Verifying Employment through the Social Security Administration (SSA). Absent confirmation of employment through ORISE, DOE or a corporate verifier, the CE requests additional information from SSA. Also, for those facilities for which EPOD does not provide any suggested employment verification pathway, the resource center and/or CE requests records from SSA by following the procedures outlined below.

a. Obtain a release from the claimant. Once the resource center and/or CE determine that SSA information is required to verify employment, the CE prepares a letter to the claimant for his or her release of SSA information. The claimant is advised that additional employment verification is necessary. A Form SSA-581, "Authorization to Obtain Earnings Data from SSA," should be enclosed (Exhibit 3). The following information is required on the SSA-581:

(1) For Employee Claims: The employee, the resource center staff or CE complete the following sections of the SSA-581: name; social security number; date of birth of employee; and other name(s) used. The employee or his or her authorized representative must also fill in his or her address/daytime telephone number and sign and date the form.

(2) For Survivor Claims: The survivor, resource center staff or CE complete the following sections of the SSA-581

form: name of social security number holder (employee); employee's social security number; date of employee's birth; date of employee's death; and other name(s) used. The survivor writes in his or her address/daytime telephone number; indicates the appropriate box and shows relationship; signs and dates the form and prints his or her name in the requested space.

The resource center staff or CE explains to the survivor that he or she must provide proof of the employee's death and his or her relationship to the employee. Proof of death includes: a copy of the death certificate, mortuary or interment record, or court-issued document. Proof of relationship includes: marriage certificate, birth certificate, adoption papers, or other court-issued document(s). SSA requires that these documents be submitted in order to process requests from survivors.

b. Timeframes on the SSA-581. The resource center staff or CE complete the form with the years deemed necessary to verify employment and/or establish wage-loss on the "Periods Requested" line. The CE or resource center staff identify this time period by reviewing the EE-3 and all the related documentation in the file, as well as a review of ECMS.

In the box titled, "Requesting Organization's Information," the CE or resource center staff sign the section, "Signature of Organization Official," and provides the district office toll free telephone and fax numbers.

The resource center staff or CE must ensure that the upper right hand corner of the form allocated for "Requesting Organization" indicates the correct district office where SSA's response should be sent.

c. The original (signed) SSA-581, and supporting documents (if the request is submitted by a survivor) must be submitted via Federal Express to the SSA, Wilkes Barre Data Operations Center (WBDOC), at the following address:

Social Security Administration

Wilkes Barre Data Operations Center

PO Box 1040

Wilkes Barre, PA 18767-1040

d. Once the claimant's release has been obtained, the CE or resource center staff prepare a package for SSA referral. The package to SSA includes a cover letter requesting SSA to perform an earnings search on the named employee. Attached to the cover letter is Form SSA-581 that indicates the name of the employee, employee SSN, and the years of employment to be researched. Upon release of the package to the SSA, the CE or resource center staff will input code "SS" into ECMS.

e. Following submission of a Form SSA-581, the CE (or designee) is responsible for determining if SSA has received the earnings request (Form SSA-581) and for obtaining a status update on the employment verification request.

(1) If there has been no response from SSA within thirty (30) calendar days of the date of the submission to SSA, the CE calls to obtain a status update. The telephone call should be documented in the TMS section of ECMS and a printed copy placed in the case file. If SSA indicates that no SSA-581 form has been received, the CE must resubmit the form. Otherwise, the CE obtains the status and monitors for further follow-up.

(2) Inquiries to SSA are made by calling one of ten phone numbers (Modules) depending on the last four digits of the relevant SSN. (Exhibit 4)

(3) In response to the SSA-581, SSA provides a statement of earnings, known as an SSA-L460. If the CE does not receive a completed SSA-L460 within thirty (30) days of the first inquiry call to SSA (the 60th day), the CE follows-up with a call to determine the status of the request and proceeds as necessary. After 60 days, it is necessary to obtain a newly signed SSA-581 from the claimant and resubmit the form to SSA as outlined above.

f. Tracking SSA requests and costs. After the completed SSA-581 form is sent, and a copy is placed in the case file, a SSA Point of Contact (POC) designated by the District Director ensures that the form is logged into a tracking spreadsheet. Each district office is responsible for developing a system of logging and tracking each claim, but the spreadsheet should contain, at a minimum, the case number and the date sent to SSA.

g. Response from SSA. Depending on the response from the SSA and the circumstances of the employment, the CE does one of three things. The CE either accepts the period of employment as verified; develops for additional information, such as work location or the other elements needed for subcontractor employment, as appropriate; or denies the claimed period of employment. The CE documents receipt of the SSA response by entering code "SR" into ECMS.

12. CPWR. The Center for Construction Research and Training, formerly known as the Center to Protect Workers' Rights (CPWR), and which continues to utilize the acronym CPWR, is a research, development, and training arm of the Building and Construction Trades Department (BCTD) of the American Federation of Labor-Congress of Industrial Organizations (AFL-CIO). DEEOIC has contracted with CPWR to research and provide employment information for construction/trade worker claims where DEEOIC has been unable to obtain reliable information elsewhere. It is especially useful for obtaining information on DOE subcontractors and on workers employed in the

trades. Instructions for development of subcontractor employment are provided in paragraph 13 of this chapter. Any time subcontractor employment is suggested on the EE-3, the subcontractor worksheet described in paragraph 14 must be completed. Once that is completed, there are essentially two pathways by which information from CPWR can be obtained for the use of EEOICPA claims adjudication:

a. Web-accessible database. If the resources already covered in this chapter do not provide sufficient documentation for a finding of covered employment, the CE can utilize CPWR, if appropriate. With regard to locating information to substantiate the existence of a contract between DOE and a company, CPWR has created a web-accessible database which the CE can use in identifying and confirming the existence of contractor or subcontractor employers at certain covered facilities. Facilities for which CPWR has contractor and subcontractor information have been identified in EPOD as "CPWR." If the CE determines that the claimed employment involves subcontractor employment at a facility in which EPOD indicates "CPWR has contractor/subcontractor information," the CE first reviews the EE-5, the DAR request and any material received from DOE. If this information is insufficient for a finding of covered employment, the CE reviews the CPWR database for any information therein linking the claimed employer to the claimed DOE facility, by following these instructions:

(1) The CE goes to **www.btcomp.org**. A log-on screen appears. Each district office has been assigned one original user name and password.

(2) Upon access to the web site, a disclaimer notes the database is a general information resource tool. It is not intended to nor does it contain all of the documents that relate to DOE contractors and/or subcontractors. However, the DEEOIC considers the information available in the database to be accurate and correct. Once the CE accepts the disclaimer, the database opens into basic search mode. The database allows various ways to search for information: by subcontractor name, by site, or by scrolling down the subcontractor master list.

(3) To search by contractor/subcontractor name, the CE enters the name of the company identified in the evidence from the case record. The company name may be the current recognized employer name, an acronym for the employer, or a previous version of the name. The CE searches the database using various combinations of spellings or aliases for the employer name. This increases the likelihood of a positive outcome and reduces the number of false negative results. For example, if a CE enters the name "Bowles Construction Company" the database returns a negative result. However, if the CE enters "Bowles" or "Bowles Construction" the employer appears in the return.

(4) To search by site, i.e. covered facility, the CE clicks on the list box labeled "by site" on the left hand side of the screen and selects the facility for which he or she is seeking contractor or subcontractor information. This returns all employers known by CPWR linked to that facility. It may be necessary for the CE to scroll down to view all named employers. To view detail for a named employer, the CE merely needs to access the "view" link under the options category. In some instances, a contractor or subcontractor name might be linked to multiple covered facilities. In these instances, the detailed return for the employer is separated into sections by covered site.

(5) It is also possible for the CE to search the comprehensive listing (master list) of all contractor employers listed in the database which appears if no name or site search criteria are applied or if the option "show all" is selected. A unique document identification (Doc Id) has been assigned to each contractual finding. The Doc Id is used by CPWR as a means of tracking and is not accessible by the CE.

(6) After the CE has accessed the database and conducted appropriate research to locate a contractor/subcontractor, the CE documents the case file. In the case of a positive result, the CE prints a copy of the screen for the case file. The printout must show all the results of the database search including the employer name, site name, contractual relationship indicator, dates verified, type of work performed, description of evidence, document ID, and date of database update. Generally, this information must be printed based on a "landscape" print mode setting. The printout should also list the date of the database search, the date of the latest update of a facility and any of the pertinent facts. In the situation where a database search does not return any result, the CE completes a "Memorandum to the file" noting the lack of information in the database for the claimed contractor/subcontractor. The memorandum is dated and signed by the CE. Caution: The database contains records on employers linked to DOE, but for which no probative documentation has been located. Any employer found in the database that does not have the "contractual relationship" indicator checked cannot be used to confirm that the employer is a valid contractor or subcontractor and should not be printed out for the file.

(7) The purpose of the database is solely to show a relationship between a DOE facility and a contractor or subcontractor employer. A positive result may return varying levels of information about an employer linked to a

facility. For example, a database return may merely list that a contractor or subcontractor was linked to a particular facility, but not when. In addition to the database results, additional development may be needed independent of the database to ensure that such evidentiary gaps are filled.

(8) If the contractor or subcontractor is not listed in the database, additional development is necessary. The CE is not to assume that a search of the database that does not return any results establishes that the claimed employer was not a contractor or subcontractor. The CE must use all other resources that may potentially establish a contractual relationship.

b. Referrals to CPWR. If information beyond that which is listed in the CPWR database is needed, CPWR can be asked to provide certain types of information to assist in these cases. The types of information CPWR can provide includes proof of a contractual relationship between DOE at a covered facility and an identified employer (contractor or subcontractor) during a specific time period, evidence that an employee worked for a specific employer during the claimed time period and, as appropriate proof that the employee worked on the premises of a DOE facility during a covered time period. CPWR is not permitted to offer an opinion as to the validity of the evidence presented to substantiate a claim. Weighing and evaluating the evidence is solely the responsibility of DEEOIC, with guidance provided in this chapter. Procedures for handling requests for information from CPWR are as follows:

(1) For any of the claimed contractor or subcontractor employment at a DOE facility for which CPWR has information, the CE is to determine whether the employee worked in an occupation for which CPWR has information. CPWR has information about the following:

- Asbestos Workers (can include those who worked with insulators and pipe coverings)
- Boilermakers (includes Riggers)
- Bricklayers (can also be called brick mason, mason, stone mason, tile layer, tile setter, terrazzo worker)
- Carpenters (can include latherers, millwrights, pile drivers, drywall hangers, framers and finishers)
- Electrical Workers (can include electricians, line men, power installers, wireman, telephone workers, instrument mechanic, telephone installer)
- Elevator Constructors
- Iron Workers (can include erectors, structural steel erectors, ornamental erectors, glaziers, welders, connectors and rodmen)

• Laborers (can include flaggers, miners/tunnel workers, shaft drillers at the Nevada Test Site & Amchitka, and machinists and janitors)

• Machinists

• Operating Engineers (includes heavy equipment operators such as operators of bulldozers, graders, cranes and front end loaders, also includes well drillers, mechanics and stationary engineers who operate boiler rooms, electrical generators and heating and cooling systems)

• Painters (can include glaziers, drywall finishers)

• Plasters and Cement Masons (can include masons, cement finishers, concrete pourer)

• Plumbers and Pipefitters (can include fitters, sprinkler fitters, gas welders, instrument mechanics and steamfitters)

• Roofers

• Security Guards

• Sheet Metal Workers (includes duct worker, shop worker)

• Teamsters

(2) If the employee worked at a facility for which CPWR has information and in a trade for which CPWR has employment information, the CE is to confer with the district office Point of Contact (POC) for CPWR referrals. The POC is selected by each district office to serve as the principal liaison between DEEOIC and CPWR. There is one POC per district office who is responsible for all communication between the district office and CPWR. Also, the POC is responsibility for certifying outgoing referrals and reviewing incoming responses.

(3) If the POC agrees that the claim requires a CPWR referral, the POC or CE prepares three forms. These forms are a Subcontractor Worksheet (guidance for use is in paragraph 14 of this chapter), a CP-1 Referral Sheet (Exhibit 5) and a CP-2 Employment Response Report (Exhibit 6). The subcontractor worksheet apprises CPWR of the established documentation on record relevant to establishing covered employment. The CP-1 provides general information concerning the employee's case file. The CP-2 is a form CPWR uses to respond to employment data requests.

(4) The CE or POC complete the CP-1. Section 1 requires information concerning the case to be listed, such as employee name, claim type, file number and Social Security Number. In Section 2, the referring District Office is to

be identified along with the number of attached CP-2 Employment Response Reports. Any special requests or other relevant information for CPWR is to be listed in the comment section.

(5) For each claimed employer at a facility where CPWR can provide assistance, the CE or POC prepare a separate CP-2 Employment Response Report. The CE or POC may prepare as many copies of the form as necessary. The CP-2 contains two sections. The CE or POC completes Section 1 and describes the employment to be researched by CPWR. It is important that the information specify both the periods of employment requiring verification and the type of evidence being requested, such as evidence of a contractual relationship, proof of employment with the claimed employer, or evidence of employment on the premises of the claimed facility. Section 2 of the CP-2 is reserved for CPWR to report any findings pertaining to the claimed employment.

(6) Upon completion of the DEEOIC portions of the CP-1 and CP-2, the POC reviews all the material. He or she ensures that the information contained on the referral forms is reported accurately and satisfies all of the requirements for submission to CPWR. Once the review is complete and the POC is satisfied that the forms are completed correctly, he or she signs and dates the CP-1. The CP-1 Referral Sheet is certified on the day the referral is mailed out of the district office.

(7) A copy of the completed package is kept for the case file. The original package, to include the CP-1, CP-2 and the subcontractor worksheet is express mailed to CPWR.

(8) On the same day that the referral package is mailed to CPWR, all claimants and/or the authorized representative in the case are to be notified of CPWR involvement. The CE or POC must prepare a letter for each claimant that describes CPWR's involvement in the case (Exhibit 7) and send it to each of the claimants and/or authorized representative in the case.

(9) CPWR is able to accept a minimum of 2500 through a maximum of 6000 CP-2's annually. Once the POC or backup person determines the number of cases to be sent to CPWR during a given week, he or she is to batch all the referrals and express mail (initial request should not be e-mailed) them weekly to:

Anna Chen (**achen@zenithadmin.com**)

Zenith Administrators

201 Queen Anne Avenue, North

Suite 100

Seattle, WA 98109

1-800-866-9663

(10) The POC or the backup person is the ultimate arbiter of all issues involving the CPWR referral process. He or she is not to certify for submission any referral package that does not meet the requirements for referral. Any incomplete or inaccurate referral package must be returned to the CE. The POC notifies the CE of any deficiency and the steps necessary to correct the problem. CPWR is permitted to contact claimants directly. However, any request for claimant contact must be submitted to the POC, who then provides the necessary contact information.

(11) The POC is responsible for tracking all CPWR referrals and responses. For each referral, the district office must track the following information:

(a) case number

(b) facility name(s)

(c) employer name(s)

(d) number and date of referral(s) to CPWR,

(e) number and date of response(s) received from CPWR,

(f) CE initiating request

(g) Target due date (40 days from the date of referral).

(h) Number of overdue referral (s) (41 or more dates from the date of referral).

By the tenth day of each month, the DO POC sends the National Office an email summarizing the total number of CPWR referrals and responses for the preceding month, the number of outstanding requests (>40 days), the number of referrals determined to be eligible, the number of referrals determined to be ineligible, and the total number of referrals to date. The number of referrals determined to be eligible is defined as the number of referrals that CPWR determined as valid requests. The number of referrals determined to be ineligible is defined as the number of referrals that CPWR determined as invalid requests, e.g. the name was incorrect, the social security number was incorrect, the subcontractor was not a part of their database, etc. Contractually, CPWR can process a limited number of claims during the contracted time period. The report assists the National Office in tracking the number of requests by each district office on a monthly basis.

(12) In instances in which CPWR needs additional CP-2's subsequent to their preliminary research and requests such from the POC, the CE and POC must confer on the requests and determine if additional CP-2s are needed. If they agree with CPWR's assessment, the POC forwards via email or fax the appropriate number of additional CP-2s to the aforementioned address. If they do not agree with CPWR's assessment, the POC provides an explanation to CPWR.

(13) CPWR has 30 calendar days from receipt of a referral to conduct appropriate research into the claimed employment, complete each CP-2 based on the evidence gathered, and express mail the response to the appropriate POC. Responses are bundled according to case file number.

(14) District office mailroom staff date stamp incoming responses according to established procedures and forward them to the designated POC. The POC enters the receipt date in the tracking database and immediately forwards the CPWR response to the appropriate CE.

(15) When reviewing the CPWR response, the CE or POC is responsible for carefully assessing the relevance of any evidence or information submitted by CPWR. In instances where additional action is needed subsequent to a CPWR response, the CE must further develop the case. For example, if the evidence provided by CPWR confirmed that the employee was employed by a covered employer, yet failed to place the employee on the premises during a covered period, then additional development is necessary to place the employee on the premises. Additionally, if CPWR provided the names and addresses of individuals that may have known the employee, yet this information was not previously contained in the factual evidence, the CE requests an affidavit (as outlined in Paragraph 13, entitled, "Other Evidence," of this Chapter) from individuals identified by CPWR.

13. Other Employment Evidence. Evidence of employment by DOE, a DOE contractor, beryllium vendor, or atomic weapons employer may be made by the submission of any trustworthy contemporaneous records that on their face, or in conjunction with other such records, establish that the employee was so employed, and the location and time period of such employment. No single document noted in this section is likely to provide all elements needed for a finding of covered employment, but rather each piece of evidence can contribute valuable elements needed to make a finding of covered employment.

Documentation from the following sources may be considered:

a. Records or documents created by any federal government agency (including verified information submitted for security clearance and dosimetry badging), any tribal government or any state, county, city

or local government office, agency, department, board or other entity or other public agency or office.

b. Records or documents created as a byproduct of any regularly conducted business activity or by an entity that acted as a contractor or subcontractor to DOE.

c. DEEOIC internal resources. The DEEOIC district offices each have gained experience with the facilities covered under this program. As part of adjudicating claims, each office has accumulated documentation substantiating various subcontractor relationships. Once such a relationship has been established at a facility for a given time period, the CE can use this information in the adjudication of other cases in which the same subcontractor employment is claimed during the same time period.

d. Affidavits or other types of signed statements attesting to the accuracy of a claim. The CE requests that the claimant use the EE-4 Employment History Affidavit to collect statements from knowledgeable parties. Statements provided by way of an affidavit are considered in conjunction with other evidence submitted in support of a claim. Affidavits are considered particularly appropriate as a means of demonstrating that an employee worked at a particular location and are best used with other information, such as SSA records. Affidavits alone are usually insufficient to prove the existence of a contractual relationship between DOE and a company.

Additionally, the CE has the discretion to assign different probative weight to different affidavits. For example, the CE may find that an affidavit from a former CEO of an employer has significantly more probative value than that of one from a relative who may benefit from any award granted. The CE must use his or her own judgment to ascertain what weight to give to any given piece of evidence, including affidavits.

14. Subcontractor Employment. Subcontractor employment at beryllium vendors and DOE facilities is covered under the Act, provided that certain developmental elements are met.

a. Definitions.

(1) Contractor. An entity engaged in a contractual business arrangement with DOE to provide services, produce material or manage operations.

(2) Subcontractor. An entity engaged in a contracted business arrangement with a contractor to provide a service on-site.

(3) Service. In order for an individual working for a subcontractor to be determined to have performed a "service" at a covered facility, the individual must have performed work or labor for the benefit of another within the boundaries of the facility. Examples of workers providing such services include janitors, construction and

maintenance workers. The delivery and loading or unloading of goods alone is not a service and is not covered for any occupation, including workers involved in the delivery and loading or unloading of goods for construction and/or maintenance activities.

(4) Contract. An agreement to perform a service in exchange for compensation, usually memorialized by a memorandum of understanding, a cooperative agreement, an actual written contract, or any form of written or implied agreement is considered a contract for the purpose of determining whether an entity is a "DOE contractor."

b. Standard. Mere presence on the premises of a facility does not confer covered employment. There are three developmental components that must be met before a decision of covered subcontractor employment can be reached. These elements are:

(1) the claimed period of employment occurred during the covered time frame as alleged, and

(2) a contract to provide "covered services" existed between the claimed subcontractor and a contractor at the facility or the identified vendor (during the covered time frame),and

(3) the employment activities (work or labor) took place on the premises of the covered facility.

c. Subcontractor employment at beryllium vendor facilities. Under the Act, persons providing a service on the premises of beryllium vendors during covered time periods are entitled to the same benefits as employees of the beryllium vendor during those same covered time periods. For some beryllium vendors, the corporate verifier for the vendor at which the subcontractor performed work has records of subcontractor employees, and therefore in verifying beryllium vendor sub-contractor employment the CE first contacts the corporate verifier for any information they have on the individual and his or her subcontractor employer. In those situations in which an employee is alleging beryllium sub-contractor employment and the beryllium vendor is unable to confirm employment, the CE is to use SSA records, affidavits and other evidence as described in this chapter.

d. Subcontractor employment at DOE facilities. Because DOE generally did not keep records of employees of subcontractors, particular evidentiary challenges are involved in proving subcontractor employment. To prove each of the elements needed, it is generally necessary to gather and evaluate documentation from multiple sources, including DOE, SSA and CPWR. To assist the CE in making determinations on subcontractor employment and to ensure that all the developmental elements are met for any period that is ultimately accepted as covered employment, a Subcontractor Worksheet (Exhibit 8) has been created that the CE completes in all

subcontractor situations, as described in this item. Once completed, this worksheet is kept in the case file as aid to understanding the basis used to make subcontractor employment determinations.

(1) The subcontractor worksheet has two parts, claimed and verified employment. The claimed section refers to the information provided by either the employee or survivor on Forms EE-1, EE-2 and EE-3, including claimed employment dates, facility(ies) and subcontractor (employer).

(2) The verified section refers to the documentation on record that supports the information reported on the Forms EE-1, EE-2 and EE-3. Verified contract/employment identifies the source that confirms the employer's link to the DOE; verified earnings identifies documents which support that the employee was employed by a specific subcontractor and verified premises identifies documents used to support the employee's presence at a covered facility during the covered time period.

(3) In completing the subcontractor worksheet, the CE will likely use an assortment of documentary evidence from different sources to make a finding of covered subcontractor employment. For example, SSA records may show that the employee worked for Sentell Brothers, thus establishing verified earnings. Documentation from CPWR may show that Sentell Brothers was a subcontractor during the period of verified earnings at K-25, X-20, Y-12 and Oak Ridge in general. DOE may also provide documentation showing that the employee had a clearance to work at K-25 doing construction or DOE provides dosimetry badging information specific to K-25. In this situation, the CE has sufficient documentation to make a determination that the employee worked as a K-25 subcontractor employee during the time period for which the earnings, the contractual information and the presence on the premises requirements are all met. For all instances in which the CE is required to evaluate potential subcontractor employment, the CE writes a memo to the file outlining the findings for each period, providing a narrative evaluation of the evidence for each of the developmental elements of the subcontractor standard and an explanation of why the standard was or was not met.

15. Researcher Employment at DOE Facilities. A DOE contractor employee is also defined as "An individual who is or was in residence at a Department of Energy facility as a researcher for one or more periods aggregating at least 24 months." In order for an employee to meet the "researcher" provision under the Act, the following criteria must be met:

a. Research. There needs to be probative evidence in the file that

the individual was actually performing research on the premises of the DOE facility. Visiting the site, obtaining medical tests on site or similar non-work related reasons that people may have for going on site at a DOE facility do not qualify under this provision. Evidence that can be used to document that an individual was performing research on site include published journal articles, affidavits or some other documentation affirming that the individual was engaged in research.

b. Living on-site not required. Although some DOE facilities provide dormitory-style accommodations which often house researchers, "in residence" can be satisfied by working "on the premises," and the individual need not have been living on the premises of the DOE facility.

c. Research can be unpaid. There is no requirement that the researcher is/was paid for the work.

16. Employees of Federal or State governments other than DOE and its predecessors. Employees of federal and state governments, (other than direct employees of DOE, ERDA, the AEC or MED) can be DOE contractor employees, as outlined in this paragraph.

a. Standard. A civilian employee of a state or federal government agency can be considered a "DOE contractor employee" if

(1) the government agency employing the individual is found to have entered into a contract with DOE for the accomplishment of one or more services on the premises of that DOE facility that such government agency was not statutorily obligated to perform, and

(2) DOE compensated the agency for that service.

b. Proof of contract. The district office contacts the federal or state agency directly in an effort to obtain the desired information. The District Director designates an individual in the district office to be responsible for coordinating and contacting federal and state agencies. This approach facilitates better communications with the agencies, especially for agencies with numerous requests. The point of contact is to provide copies of contracts and contacts to the National Office for development of a database. The CE should not pressure a state or federal agency to produce employment or contractual records.

c. If the evidence is unclear as to whether employment by a state or federal agency can be determined to be DOE contractor employment using the guidance in this paragraph, the CE obtains clarification from the claimant. The CE reviews any documentation submitted by the claimant and undertakes any additional development necessary to clarify the individual's employment status.

Upon finding that the employee does not meet the definition of a "DOE contractor employee" who worked for a state or federal agency, and

this is the sole employment listed on the form EE-3, the CE denies the claim. The CE issues a recommended decision denying the claim on the basis that the employment by the state or federal agency does not qualify the claimant as a "DOE contractor employee" as defined in EEOICPA.

d. Uniformed members of the Military. A claimant cannot obtain EEOICPA benefits based upon service in the military. If the claimant provides information or identifies himself/herself as military personnel, the CE sends a letter to the claimant stating that uniformed military personnel are ineligible for benefits under the EEOICPA. Only civilian employees who performed services on the premises of DOE facilities via contracts are considered DOE contractor employees.

17. Evaluating Evidence to Verify Employment. Once all evidence from appropriate sources has been received, the CE determines if the evidence is sufficient to verify the three components of covered employment listed in paragraph 6 of this chapter. The CE evaluates all evidence carefully in making this determination and uses discretion regarding documentation that reasonably establishes the presence of the employee at a particular facility during certain periods of time. Additionally, with regard to subcontractor employment, the evidence must reasonably satisfy all the components necessary to establish covered employment, as discussed in paragraph 14 of this chapter.

In weighing the evidence submitted in support of covered employment, the CE considers the totality of the evidence and draws reasonable conclusions.

18. Developing non-covered employment. As mentioned in paragraph 4, there will be instances in which the CE is only able to match a portion of the claimed employment to a facility and/or employer listed in the facility database, or there is no match found. In these instances the CE communicates this to the claimant. The CE prepares a letter to the claimant explaining which employment is covered under the Act and which is not, including any pertinent dates. A description of what constitutes an AWE, BE Vendor or DOE (as explained in paragraph 2) should be included in the letter. In the event that the claimant believes some of this non-covered employment should be covered, the CE requests that the claimant supply any pertinent evidence substantiating that the employment should be covered during specific years. Namely, the CE asks the claimant to provide evidence demonstrating that the place of work met the definition of an AWE, BE Vendor or DOE facility during the years the employee worked there. For example, the claimant can be asked to submit evidence such as contractual documents, business reports, internal memos, purchase orders, news articles, affidavits, etc. A period of 30 days is granted to the claimant to submit evidence in support of extending covered employment to additional facilities/employers and/or years.

After appropriate development, the CE decides whether any evidence submitted warrants a referral to the National Office. If the claimant has submitted pertinent evidence in regard to adding a facility/employer and/or years of coverage, the CE prepares a brief memo to the file explaining the circumstances of the situation and requests a review of the case file by the National Office which asks the National Office to make a determination regarding the new evidence of an additional covered facility/employer or years.

19. Additions or modifications to facility status. While EEOICPA defines what constitutes an AWE, Be Vendor or DOE facility, updates are periodically made to facility designations as new information becomes available. In instances when a claimant submits information in response to the request outlined in paragraph 18, the National Office takes a number of steps outlined in this paragraph to make a determination regarding whether the facility status should be modified. Depending on the facility type, authority rests with either the DOL or DOE to make modifications. Facility modifications or additions are dependent on the collection of probative evidence satisfying the legal definition of the facility.

a. Atomic Weapons Employer. New designations are the responsibility of DOE. Accordingly, requests for new AWE designations are referred to DOE.

(1) Time frame changes relating to specific years of processing at an AWE are the responsibility of DOL. Evidence must be presented clearly demonstrating that the AWE processed or produced material that emitted radiation and was used in the production of an atomic weapon.

b. Beryllium Vendor. The statutory deadline for adding additional beryllium vendors was December 31, 2002 and therefore no additional beryllium vendors can be designated under the Act.

(1) Time frame changes relating to Be Vendors are the responsibility of DOL. Evidence must be presented clearly demonstrating that the Be Vendor had a contractual agreement involving beryllium with DOE, or its predecessors, and that the company is performing/or did perform those beryllium-related contractual tasks in the years to be added to coverage.

c. Department of Energy facility (DOE). Facility or time frame changes relating to DOE facility listings are the responsibility of DOL. Evidence must be presented clearly demonstrating that the facility meets the definition of a "Department of Energy facility" under the Act. Under the EEOICPA, a DOE facility means any building, structure, or premise, including the grounds upon which such building, structure, or premise is located in which operations are, or have been, conducted by, or on behalf of, the DOE (except for buildings, structures, premises, grounds, or operations covered by Executive Order 12344, dated February 1, 1982, pertaining to the

Naval Nuclear Propulsion Program); and with regard to which the DOE has or had either (A) a proprietary interest; or (B) entered into a contract with an entity to provide management and operation, management and integration, environmental remediation services, construction, or maintenance services.

Interpreting and applying the definition of a DOE facility is within the adjudicatory authority of DEEOIC. To determine whether a facility is a DOE facility under the Act, certain parameters must be met.

(1) Operations. To show that operations were performed on behalf of DOE, the evidence must demonstrate that DOE paid for operations at that location. These operations are not limited to those involving radiation or weapons. Everyday operations such as providing library services in a technical library are sufficient to meet this statutory requirement.

(2) Proprietary Interest. To show that DOE had a proprietary interest, evidence that DOE owned the building, structure or premises, such as a deed or affirmative statement from DOE acknowledging ownership. DOE ownership of intellectual property or equipment, regardless of size, does not fulfill the proprietary interest definition.

(3) Contracts. To show that DOE entered into a contract with an entity to provide management and operation, management and integration, environmental remediation services, construction, or maintenance services, the best possible evidence is to produce the contract. Typically contracts with DOE or its predecessors identify the contract type on the first page, so in those cases in which contracts are located, it is generally not difficult to discern contract type. The contracts identified in this portion of the law are among the more common and significant contracts used throughout the DOE complex in the following ways:

(a) Management and Operation (M&O) contracts are those contracts DOE often had with major companies to manage and operate large DOE facilities, such as Union Carbide and Carbon at K-25 and Y-12.

(b) Management and Integration (M&I) contracts were also used by DOE to run major DOE sites, but an M&I contractor generally had numerous smaller site contractors for which the M&I's job was to "integrate" the work of the smaller companies. The Idaho National Laboratory is an example of a DOE facility which has been run from time to time by M&I contract. Companies holding M&O and M&I contracts at DOE facilities are generally considered the "prime contractor" for that

facility, though sometimes facilities will change from the M&O model to the M&I model.

(c) Contracts for environmental remediation services, construction, or maintenance services are also common throughout the DOE, but are generally smaller in size than the major M&O's and M&I's. Remediation contracts were also utilized by DOE to clean up radiation at numerous AWE facilities. In these instances the locations are designated as DOE facilities for the period of remediation under DOE contract and the remediation workers are covered.

(d) Some common types of contracts issued by DOE that do not meet the statutory definition include research & development, output, and procurement.

20. Special Circumstances. There are some special circumstances regarding eligibility for benefits pertinent to the Naval Nuclear Propulsion Program and EEOICPA claims from citizens of the Republic of the Marshall Islands, as outlined below.

a. Naval Nuclear Propulsion. As noted in the section above, the statutory definition of a DOE facility specifically excludes, "buildings, structures, premises, grounds, or operations covered by Executive Order No. 12344, dated February 1, 1982 (42 U.S. C. 7158 note) pertaining to the Naval Nuclear Propulsion Program." As a consequence of this exclusion, DEEOIC is unable to provide covered employment to those AEC employees and AEC contractors who worked at locations devoted to Naval Nuclear Propulsion operations.

b. Marshall Islands. DEEOIC has received claims for compensation under EEOICPA from citizens and nationals of the Republic of the Marshall Islands (RMI). The Marshallese base their claims on employment related exposure arising from the United States' nuclear weapons testing program conducted in the RMI. The DOE facility known as the Pacific Proving Ground was a weapons test site in the South Pacific from 1946 to 1962.

In 1986, the United States and the Marshall Islands terminated their trust territory relationship through enactment of the Compact of Free Association (Compact). The Compact is a comprehensive document encompassing a variety of agreements, including a number of socio-economic, agricultural, and monetary compensation programs. Under the Compact, the RMI became an independent sovereign nation and U.S. laws ceased to apply unless otherwise specified.

For the purposes of the administration of the EEOICPA, this Compact has been interpreted as precluding coverage for RMI citizens and nationals. If the CE determines that a claim for benefits is from a citizen or nationals of the Marshall Islands, the CE explains, in the conclusions of law portion of the recommended decision, that there is no provision under EEOICPA for coverage of claims based upon

employment in the RMI by citizens or nationals of the RMI. The CE inserts the following wording in the conclusions of law as a summary of the DEEOIC policy:

Since interpreting EEOICPA to apply to claims by Republic of the Marshall Islands (RMI) citizens or Nationals based upon employment in the RMI would constitute an invasion of the sovereignty of the RMI, the presumption against applying a statute extraterritorially is invoked. Furthermore, there appears to be no contrary intent by Congress to rebut the presumption and, to the extent that Congress has expressed any intent, its approval of the Compact of Free Association between the United States and the RMI suggests that it did not intend for EEOICPA to apply extraterritorially in this situation.

Exhibit 1: DOE letter regarding facilities for which DOE has no employment records

Exhibit 2: DOE memorandum serving as DOE's Form EE-5 for employment verification by ORISE

Exhibit 3: SSA-581(Authorization to Obtain Earnings Data from the Social Security Administration)

Exhibit 4: Telephone Contact Information for inquiries to SSA

Exhibit 5: CP-1 Referral Sheet to CPWR

Exhibit 6: CP-2 Employment Response Report from CPWR

Exhibit 7: Letter to claimant regarding CPWR referral

Exhibit 8: DEEOIC Subcontractor Worksheet

2-0600 Establishing Special Exposure Cohort Status

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1 SEC Class Screening Worksheet. 01/10 10-07

1. Purpose and Scope. The Energy Employees Occupational Illness Compensation Program Act (EEOICPA) established the Special Exposure Cohort (SEC) to compensate eligible members of the Cohort without the need for a radiation dose reconstruction and determination of the probability of causation. This means an employee who meets the necessary employment criteria to be included in a designated SEC class and is diagnosed with a specified cancer receives a presumption of causation that the employment caused the specified cancer. This chapter describes the procedures for establishing eligibility under the SEC.

2. Identifying SEC Claims. A person filing a claim can allege inclusion in a SEC by checking the section on Forms EE-1 or EE-2 which asks whether the employee worked at a location that has been designated for membership in the SEC.

In addition, a claimant can identify the particular location that may qualify for consideration for the SEC. The Claims Examiner (CE) must review the initial application forms including Form EE-3, Employment History, carefully to determine whether the potential exists for inclusion in one or more SEC classes.

3. Determining SEC Eligibility. To be eligible for benefits under the SEC provision, an employee must belong to a SEC class. In establishing the SEC, Congress designated four statutory SEC classes. The EEOICPA also allows for addition of new SEC classes based on analysis and determination by the U.S. Department of Health and Human Services (HHS).

A SEC class can be based on a whole facility, limited to specific buildings in a facility or even specific processes within a facility. In some cases, a SEC class may be limited to specific job titles or duties in a particular facility. In addition, each SEC class will have specific workday requirements that must be met; typically an employee must have been employed for a number of workdays aggregating at least 250 workdays at one or more SEC work sites. The workday requirement at Amchitka, Alaska SEC class is met by any employee who spent any part of one workday at that facility, during which he or she was exposed to ionizing radiation in the performance of duty related to the Long Shot, Milrow or Cannikin underground nuclear tests. Finally, to be eligible under the SEC, an employee must also have been diagnosed with at least one of twenty two (22) specified cancers as listed under paragraph 6.

4. Statutory SEC Classes. The EEOICPA designated the following statutory SEC classes according to their respective covered facilities:

a. Gaseous Diffusion Plants (GDP) located in Paducah, Kentucky, Portsmouth, Ohio or Oak Ridge, Tennessee. A DOE employee, DOE contractor employee or an atomic weapons employee qualifies for inclusion in this SEC if he or she was:

(1) Employed for an aggregate of 250 workdays prior to February 1, 1992, at one or more of the above GDPs; and

(2) Monitored during such employment through the use of dosimetry badges for exposure to radiation, or worked in a job that had exposures comparable to a job that is or was monitored through the use of dosimetry badges.

(a) If the employee qualifies for possible inclusion in the SEC on the basis of work at a GDP, but Form EE-3 does not indicate whether a dosimeter was worn, the Claims Examiner (CE) must determine whether the employee had exposure during his or her employment that is comparable to a job that is or was monitored through the use of dosimetry badges.

In making this determination, the CE assumes that the employee had comparable radiation exposure if employment occurred during the following periods at the particular GDPs:

Paducah GDP: 7/52 – 2/1/92

Portsmouth GDP: 9/54 – 2/1/92

Oak Ridge GDP (K-25): 9/44 – 12/87(not 2/1/92)

b. Amchitka Island, Alaska. The EEOICPA grants SEC membership to DOE employees, DOE contractors or DOE subcontractors, who were employed prior to January 1, 1974 on Amchitka Island, Alaska, and were exposed to ionizing radiation in the performance of duty related to the Long Shot, Milrow, or Cannikin underground nuclear tests. The CE considers the following factors in determining whether the employee was exposed to radiation in the performance of duty:

(1) Exposure to ionizing radiation from the Long Shot, Milrow, and Cannikin underground nuclear testing/explosions which occurred on Amchitka Island. The first detonation, Long Shot, occurred on October 29, 1965. The 80 kiloton underground nuclear explosion leaked radioactivity into the atmosphere. Radioactive contamination on Amchitka Island occurred as a result of activities related to the three underground nuclear tests and releases from Long Shot and Cannikin.

(2) As a result of these airborne radioactive releases, employees who worked on Amchitka Island could

have been exposed to ionizing radiation from the Long Shot underground nuclear test. It is believed that such exposure began approximately one month after the detonation occurred. Thus, for purposes of determining SEC employment, the period from approximately December 1, 1965 to January 1, 1974 is to be used, unless the claimant can show that the employee was exposed during the month immediately following the detonation.

(3) In contrast to other SEC classes with 250 workdays requirement, this SEC class requires that the employee worked at Amchitka Island for any length of time during the period from approximately December 1, 1965 to January 1, 1974 and was exposed to ionizing radiation from underground nuclear tests.

5. Additional SEC Classes. HHS has authority to designate additional classes of employees to be added to the SEC. A class of employees may be included as a member of the SEC if HHS determines that it is not feasible to estimate with sufficient accuracy the radiation dose that the members of the class received and there is a reasonable likelihood that such radiation may have endangered the health of the members of the class.

a. Overview of the SEC Designation Process. The designation process begins with a petition submitted to the National Institute for Occupational Safety and Health (NIOSH), Office of Compensation Analysis and Support (OCAS). The petitioner may include one or more DOE employees (including DOE contractor or subcontractor employees), or AWE employees, who would be included in the proposed class of employees, or their survivors. Individuals or entities authorized by these employees in writing or labor organizations representing or formerly having represented these employees may also submit a petition.

NIOSH may also initiate a petition if it determines that it cannot complete a dose reconstruction for a class of employees.

(1) NIOSH evaluates the petition for inclusion in the SEC to determine if it contains the minimal qualification to proceed with the SEC designation process in accordance with 42 C.F.R. § 83.13 or § 83.14.

(2) If NIOSH determines that minimum qualification for review and evaluation has been met, it forwards the petition to the Advisory Board on Radiation and Worker Health (Advisory Board) along with its evaluation. During one of its regular Board meetings, the Advisory Board reviews NIOSH's evaluation, hears from the petitioners if they choose and other interested parties. The Advisory Board also reviews any other information it determines to be appropriate for the petition.

(3) The Advisory Board submits a recommendation on a new SEC class to the Secretary of HHS within 30 calendar days of the Board meeting.

(4) The Secretary of HHS makes the final decision to add or deny a new class to the SEC based on the recommendation of the Advisory Board and the NIOSH evaluation. If the Secretary of HHS decides to add a new class to the SEC, he or she issues a designation letter to Congress with the definition of the class.

(5) A new SEC class becomes effective 30 calendar days after Congress receives the Secretary's designation letter, unless Congress objects or provides otherwise.

6. Workday Requirement: Eligibility under the SEC provision typically requires 250 workdays of eligible employment at one or more SEC work sites. In most cases, the determination of 250 workdays of employment is straightforward. However, there are some cases where the employee worked for less than a year, where additional guidance is required to calculate the 250 workdays.

a. A workday is considered equivalent to a work shift. Additional hours worked as overtime will not add up to additional workdays, e.g., two hours overtime for four days is not equivalent to another (8-hour) workday. However, two work shifts worked back-to-back would be two work shifts, i.e., two workdays. For an employee whose work shift spans midnight, e.g., 11 PM to 7 AM shift, the work shift is still just one workday.

b. When the employment information shows that the employee worked for a particular period, the CE should not attempt to discern and deduct from the workday any infrequent periods of non-presence or non-work, like sick leave, strikes, layoffs or vacation time that may be specified. However, if the employment evidence clearly establishes that the employee was not present and/or working at the SEC work site for an extended period(s) while on the company payroll, this extended period(s) should not be credited towards meeting the 250 workday requirement.

c. The period of 250 workdays starts with the worker's first day of employment at the SEC work site. There may be breaks in employment, but the workdays may only be accumulated at eligible SEC sites.

d. Where the number of days is not apparent in the employee's primary employment record, e.g., from the employer or union (records for pension, dues, union local records, etc.), the following table may used for conversion:

250 days =	50 five-day weeks, or
	42 six-day weeks, or

	12 months (five-day weeks), or
	10 months (six-day weeks), or
	2,000 hours
One month =	21 days (if evidence indicates six-day weeks, 25 days

e. Where records of an employee's earnings are available, such as W-2 Forms or Social Security earnings records, but the periods of employment are not, estimate the 250 workdays as follows. Divide the annual wages earned at the SEC work site by the employee's hourly rate to determine the number of hours worked. If the number is greater than 2,000 hours, it meets the 250 workday requirement. The problem with converting dollar amounts to workdays is that they may be rough estimates of actual employment. As such, this method should only be used when all primary employment data is lacking.

f. There will be some situations where the above approach will not be applicable. These cases will need to be treated on a case-by-case basis, and if necessary, a referral to the Unit of Policy, Regulations and Procedures (UPRP) may be required.

7. Specified Cancers: In addition to satisfying the employment criteria under a SEC class, the employee must also have been diagnosed with a specified cancer to be eligible for compensation under the SEC provision. The following are specified cancers in accordance with 20 C.F.R. § 30.5(ff):

a. Leukemia. [Chronic lymphocytic leukemia (CLL) is excluded]. The onset must have occurred at least two years after initial exposure during qualifying SEC employment.

b. Primary or Secondary Lung Cancer. [In situ lung cancer that is discovered during or after a post-mortem exam is excluded.] The pleura and lung are separate organs, so cancer of the pleura is not to be considered an SEC cancer.

c. Primary or Secondary Bone Cancer. This includes myelodysplastic syndrome, myelofibrosis with myeloid metaplasia, essential thrombocytosis or essential thrombocythemia, primary polycythenia vera [also called polycythemia rubra vera, P. vera, primary polycythemia, proliferative polycythemia, spent-phase polycythemia, or primary erythremia] and chondrosarcoma of the cricoid (cartilage

of the larynx).

d. Primary or Secondary Renal Cancers.

e. Other Diseases. For the following diseases, onset must have been at least five years after initial exposure during qualifying SEC employment:

(1) Multiple myeloma (a malignant tumor formed by the cells of the bone marrow);

(2) Lymphomas (other than Hodgkin's disease);

(3) Primary cancer of the:

(a) Thyroid;

(b) Male or female breast;

(c) Esophagus;

(d) Stomach;

(e) Pharynx (including the soft palate, or back of the mouth, the base of the tongue, and the tonsils);

(f) Small intestine;

(g) Pancreas;

(h) Bile ducts;

(i) Gall bladder;

(j) Salivary gland;

(k) Urinary bladder (including ureter and urethra);

(l) Brain (malignancies only, not including intracranial endocrine glands and other parts of the central nervous system);

(m) Colon *(including rectal/colon)*;

(n) Ovary;

(o) Liver (except if cirrhosis or hepatitis B is indicated);

f. Carcinoid Tumors. These tumors, except for those of the appendix, are considered primary cancers of the organs in which they are located. If the organ is one on the specified cancer list, the carcinoid tumor may be considered as a specified cancer.

(1) Carcinoid tumors should be recorded by the organ of the specified cancer. For example, the CE should use the ICD-9 code of 230.7 for a carcinoid tumor in the small intestine.

(2) Carcinoid syndrome and monoclonal gammopathies of undetermined significance are not currently recognized as malignant conditions. Consequently, these conditions should not be considered as cancers.

g. Names or Nomenclature. The specified diseases designated in this section mean the physiological condition or conditions that are recognized by the National Cancer Institute under those names or nomenclature, or under any previously accepted or commonly used names or nomenclature. Cases where there is uncertainty as to whether a diagnosed cancer should be considered a specified cancer must be referred to UPRP.

h. Spread of Cancer. Where cancer has spread to various sites (organs) it may be difficult to identify the site of origin for the cancer. If the pathology report (or medical report) lists several alternatives and at least one site is considered a SEC cancer, the claim should be processed first as a SEC cancer claim.

8. Procedures for Processing SEC Claims. Processing SEC claims entails coordination between the UPRP and District Offices/FAB staff.

a. Role of the UPRP:

(1) Issues bulletins with guidance on processing newly designated SEC classes. This will include specific instructions on how to evaluate evidence in the case file to determine SEC eligibility.

(2) Prepares a comprehensive list of all reported cases with claimed employment at a newly designated SEC work site during the period of the SEC class. It will include pending cases, cases previously denied and those at NIOSH. This comprehensive list will be provided to the District Offices and FAB at the time of the issuance of the SEC bulletin.

(3) Unresolved questions on processing SEC claims, including questions on the definition of a SEC class, uncertainty as to whether a diagnosed cancer should be considered a specified cancer or questions regarding calculation of 250 work day requirement may be referred to UPRP for guidance.

b. Role of the Claims Examiner:

(1) Identifies a potential SEC claim by reviewing the information on the claim forms or other pertinent evidence in the case file to determine if there is sufficient evidence to suggest that an employee worked as a member of a named SEC class. For newly designated SEC classes, the CE is to review the comprehensive list provided by UPRP as noted in paragraph 7a(2).

(2) Reviews corresponding bulletins for designated SEC classes for procedures on evaluating evidence to determine if the SEC criteria are met.

(3) Completes an initial screening of cases in the comprehensive list provided by UPRP for a newly designated SEC class. A screening worksheet is included as Exhibit 1.

The worksheet must be completed for all cases on the comprehensive list. Upon completion, the worksheet is to be included in the case record.

Based upon the initial screening, the cases on the comprehensive list are grouped into three categories: those likely to be included in the SEC class; those not likely to be included in the SEC class; and those for which development may be needed to determine whether the case can be accepted into the new SEC class.

The purpose of this initial screening is to prioritize handling of cases that are likely to be included in the newly designated SEC class. This screening step is only applicable to cases on the comprehensive list. It is not applicable to new claims submitted after the list is generated or when a comprehensive list is not generated. Once screening and prioritization is complete, a more detailed review of all the cases (priority given to cases that are likely to be included in the SEC class) and full development must take place to determine if a case is eligible for benefits under the SEC.

(a) For cases on the comprehensive list at FAB, the designated CE2 Unit is to conduct the initial screening and completion of the worksheet.

(4) Evaluates medical evidence in the case file of a potential SEC case to determine if the employee has been diagnosed with a specified cancer.

(5) If the employee has a specified cancer, the CE must verify that the employee meets all employment criteria in the SEC class designation, including the workday requirement. In determining whether the employment history meets the workday requirement, the CE can consider employment at a single SEC class, or in combination with work days at other SEC classes.

The CE also reviews any documentation that NIOSH may have acquired or generated during the dose reconstruction process to determine if the employee satisfies the employment criteria of a SEC class(es).

(a) NIOSH will identify and return dose reconstruction analysis records for cases with specified cancers that may qualify under a SEC class to the appropriate district office along with a CD for each case. The CD contains all of the information generated to date, e.g., CATI report, correspondence, and dose information. Also included on the CD in the Correspondence Folder, should be a copy of the NIOSH letter sent to each claimant informing the claimant of

the new SEC class and that his or her case is being returned to DOL for adjudication. The CE must print out a hard copy of the NIOSH letter for inclusion in the case file.

(b) There may be some cases not identified by NIOSH that the CE determines may be included in the SEC class. If any such case qualifies under the SEC class and the case is with NIOSH for a dose reconstruction, the CE notifies the appropriate point of contact at NIOSH via e-mail to pend the dose reconstruction process and return dose reconstruction analysis records to the appropriate district office. The CE then prints a copy of the "sent" e-mail (making sure the printed copy documents the date it was sent) for inclusion in the case file. In addition, the CE must write a letter to the claimant to advise that the case file has been withdrawn from NIOSH for evaluation under the SEC provision.

(6) Proceeds in the usual manner for a compensable claim and prepares a recommended decision if the employee has a diagnosed specified cancer and meets the employment criteria of the SEC class. The CE notifies the appropriate point of contact at NIOSH via e-mail so that they may close their file. The CE then prints a copy of the "sent" e-mail for inclusion in the case file.

(7) Refers potential SEC cases that were evaluated but which do not qualify under the SEC provision, e.g. cases with non-specified cancers, specified cancers with insufficient latency period, or cases with insufficient SEC employment, to NIOSH for full or partial dose reconstruction.

(a) For those cases which were previously submitted to NIOSH for dose reconstruction but were returned to the district office for consideration in a SEC class, a new NIOSH Referral Summary Document (NRSD) is not required. Instead, the CE notifies the appropriate point of contact at NIOSH via e-mail to proceed with the dose reconstruction. The CE then prints a copy of the "sent" e-mail for inclusion in the case file. The e-mail should include a brief statement of why the case should proceed with dose reconstruction, e.g., non-specified cancer, insufficient latency period or does not meet the 250 work day requirement.

The CE also notifies the claimant by letter that the case is returned to NIOSH for dose reconstruction and the reason(s) it does not qualify for the SEC class. The CE is to send a copy of this letter to NIOSH.

(b) If the claim meets the SEC employment criteria and includes both a specified cancer and a non-specified cancer, medical benefits are only paid for the specified cancer(s), any non-specified cancer(s) that has a probability of causation of 50 percent or greater, and any secondary cancers that are metastases of a compensable cancer.

For the non-specified cancer, the CE prepares a NRSD for a dose reconstruction to determine eligibility for medical benefits. In these SEC cases, all cancers must be listed on the NRSD, including the specified cancer(s).

(1) One exception to this rule is an accepted SEC claim where the specified cancer is a secondary cancer. For instance, prostate cancer (non specified cancer) metastasizes to secondary bone cancer. If secondary bone cancer is accepted as a specified cancer under the SEC provision, both primary and secondary cancers (prostate and bone cancer) are accepted for medical benefits under Part B.

However, per regulation 20 C.F.R. § 30.400, "payment for medical treatment of the underlying primary cancer…does not constitute a determination by OWCP that the primary cancer is a covered illness under Part E of the EEOICPA." As such, it may be necessary for the CE to refer the prostate cancer to NIOSH for dose reconstruction to determine eligibility for benefits under Part E. In this case, only prostate cancer is included in the NIOSH NRSD for a dose reconstruction since the secondary bone cancer metastasized from the prostate cancer.

(8) If the CE determines that a case on the comprehensive list, which includes a final decision, does not require any action, the CE writes a brief memo to the file indicating that the file was reviewed and noting the reason why no additional action is necessary. A case classified as not requiring any action is a case that does not meet the SEC criteria and there is no need to return it to NIOSH for dose reconstruction.

c. Role of the District Director:

(1) The District Directors have been delegated authority to sign a Director's Order to reopen a denied final

decision if the evidence of record establishes that the employee is diagnosed with a specified cancer and likely to be included in the SEC class. If the District Director is unsure whether the SEC is applicable to a case, the case must be referred to UPRP.

(2) Once a Director's Order is issued, the CE is responsible for issuing a new recommended decision.

d. Role of the Hearing Representative (HR):

(1) Reviews cases pending a final decision for possible inclusion under the SEC provision. If the employee qualifies under the SEC provision and the district office issued a recommended decision to deny, the HR is to reverse the district office's recommended decision and accept the case.

Every effort should be taken to avoid a remand of a potential SEC claim to the district office. However, if the HR determines that the case cannot be approved based on the SEC designation and that referral to NIOSH is appropriate, the HR must remand the case for district office action.

(2) All cases on the comprehensive list provided by UPRP that are located at a FAB office must be reviewed for possible inclusion under the SEC provision. If no action is required, FAB must write a brief memo to the file as noted under paragraph 7b(8).

Exhibit 1: SEC Class Screening Worksheet

2-0700 Establishing Toxic Substance Exposure

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1. Purpose and Scope. This chapter describes the procedures that the Division of Energy Employees Occupational Illness Compensation (DEEOIC) uses to establish toxic substance exposure under Part E of the Energy Employees Occupational Illness Compensation Program Act (EEOICPA).

These procedures outline means to develop for exposure to toxic substances at a covered Department of Energy (DOE) and Radiation Exposure Compensation Act (RECA) Section 5 facility. In particular, the chapter addresses the Site Exposure Matrices (SEM) and guidance for its use and explains required actions when SEM data is lacking or incomplete.

2. Rules for Establishing Exposure. To establish that an employee was exposed to a toxic substance, the evidence of file must show evidence of potential or plausible exposure to a toxic substance and evidence of covered DOE contractor/subcontractor or uranium employment at a covered DOE/RECA facility during a covered time period.

a. Documentation. Exposure to a toxic substance can be established by the submission of probative documentation that shows such substance was present at the facility where the employee worked, that there was a reasonable likelihood for employee exposure, and that the employee came into contact with such substance.

b. Presence and Contact. Whenever possible, the claims examiner (CE) considers such issues as whether the substance was present, not only in the facility, but in the specific building(s) and/or areas where the employee worked, and whether the substance was used during the processes involved as part of the employee's job duties and exposure routes (e.g., a welder exposed to fumes). The SEM (discussed below) will be especially helpful in evaluating for the presence of a toxic substance in a certain building/area/work process.

(1) Presence of toxic substance. The CE may look to the SEM, facility exposure records, Data Acquisition Request

(DAR) records, the Occupational History Questionnaire (OHQ), employee records, verified affidavits, DOE Former Worker Program (FWP) screening records, NIOSH site profiles, employee submitted evidence, and other evidence that establishes a toxic substance was present at the facility where the employee worked. The CE may also use Industrial Hygienist (IH) referrals as discussed below.

(2) Employee contact with a toxic substance. The CE's review of the evidence described above may be sufficient to establish that the employee came in contact with the toxic substance. Information such as the claimant's response to the OHQ performed by the Resource Center (RC), reviewed in conjunction with DAR records and the SEM, may help the CE decide what further development may be necessary (e.g., to determine whether contact was likely given the employee's labor category, labor process, or given safety controls or risk factors that may have been present at the worksite).

(3) Plausibility. When evaluating the evidence to determine whether a toxic substance was potentially present at a given facility (by building, area, work process, labor category) and whether it is likely that an employee came into contact with a toxic substance in the course of employment at a covered facility, the CE must determine whether such contact is plausible.

To do so, the CE must review all evidence on file and decide whether it makes sense that the claimed exposure could have potentially occurred. Sometimes this evaluation will require a referral to an IH.

For example, if an employee is claiming lung cancer due to exposure to uranium metal maintained exclusively in a glove box (an enclosure to protect the worker from uranium exposure), the CE must examine whether or not an exposure route is plausible.

Without evidence that the employee was involved in machining uranium or cleaning out the glove box, or that he or she was exposed in some other way such as a leak in the glove box, no exposure route (inhalation which would potentially be linked to lung cancer) is plausible.

(4) Sample Evaluation of Presence and Contact. A chemical operator involved in cascade operations at K-25 claims peripheral neuropathy. His responses to the OHQ show he worked with a variety of toxic substances on a routine basis, including mercury. Information obtained through the DAR records confirms his worksite (K-33), which is located within K-25, and job duties.

The CE searches SEM (see paragraph 10 below) and confirms

the presence of mercury at the K-33 cascade building. Further, SEM supports a link between mercury and peripheral neuropathy. A physician's report indicates a diagnosis of peripheral neuropathy and mentions that the employee has had tingling in his arms for approximately a year. An accident report notes a major mercury spill during the time in which the claimant worked at K-33.

The evidence is sufficient to establish that the employee had peripheral neuropathy and potential exposure to mercury in the course of his employment at a covered DOE facility. The mercury spill accident report lends support to the finding that it is plausible, given the facts, to assume that the claimant encountered an occupational exposure to a toxic substance in the course of his work.

Any question as to route of exposure (e.g. inhalation, absorption), even if presence is established, should be referred to an IH, as outlined in paragraph 12 below.

c. Burden of Proof. If no medical evidence is submitted that would lend support to a connection between the claimed condition and potential exposure to a toxic substance (and no such evidence is available from the sources referenced in the previous section), the CE requests such evidence from the claimant before issuing a denial. While the CE must exhaust all reasonable development prior to issuing a denial, the claimant does bear the overall burden of proving his or her claim.

d. Causation Test for Toxic Exposure. The CE must develop the requisite employment and exposure evidence to render a causation determination. Specific causation requirements for cancer and other conditions are outlined in other chapters. In general, the CE develops the evidence on file and a determination is made based upon the "at least as likely as not" causation test.

While resources are provided to assist the CE, there is no simple one-step tool for making this determination. Instead, the CE must base the determination on the totality of evidence in the case file. The CE does not use studies or reports obtained from the Internet or other sources to justify case decisions, unless the National Office (NO) has specifically authorized such usage. In addition, the CE may not base a decision on a vague reference to "medical literature."

(1) Causation Test for Toxic Exposure. Evidence must establish a relationship between exposure to a toxic substance and an employee's illness or death. The evidence must show that it is "at least as likely as not" that such exposure at a covered DOE/RECA facility during a covered time period was a *significant factor* in aggravating, contributing to, or causing the employee's illness or death, *and* that it is "at least as likely as not" that exposure to a toxic substance(s) was related to employment

at a covered DOE/RECA facility.

(2) "At Least as Likely as Not." Part E only requires proof that established exposure "at least as likely as not" was a *significant factor* in aggravating, contributing to or causing the employee's illness, disease or death. As with Part B, "at least as likely as not" means 50% or greater likelihood.

When a referral to NIOSH for a cancer claim related to radiation results in a probability of causation of greater than or equal to 50%, the regulations provide that this requirement has been met. In other cases the CE bases a determination on a review of the evidence of file as a whole, to determine if the "at least as likely as not" standard has been met. The CE weighs all of the evidence available and provides a clearly written rationale supporting his or her findings in the recommended decision.

(3) Significant factor. The CE evaluates the evidence as a whole when attempting to determine whether or not exposure to a toxic substance was indeed a significant factor in contributing to, aggravating, or causing the claimed illness or death of the employee. In most instances this evaluation will be done on a case-by-case basis.

In some cases a District Medical Consultant (DMC) evaluation will be necessary. The CE looks at the claimed exposure, the presence of such exposure, the duration of the verified employment, and any other important exposure/employment factors when ascertaining the possible role the toxic substance exposure played in the onset of the covered illness.

e. Using SEM to Evaluate Causation in General. The SEM is not used to establish or deny causation by itself, but is used as a tool to assist in the evaluation of causation in light of the evidence as a whole. The purpose of this searchable database is twofold. First, the database details many possible toxic substances that may have been present at a given facility. Second, the database describes the relationship between a specific toxic substance and a covered illness.

The CE reviews the database to assist in a determination of whether the claimed toxic substance was present at the facility where employment occurred and whether or not a relationship exists between exposure to a toxic substance and a particular covered illness. However, the database does not serve as a comprehensive list of all potential toxic substances that could be present at a facility, and the CE must confirm additional claimed toxic substances through employment records, DAR records, DOE FWP records, and other means. If the CE cannot confirm the presence of a toxic substance through

these sources, the claimant should be notified and given an opportunity to present additional evidence that establishes the presence of such a toxic substance. Finally, once the CE completes all reasonable development and carefully weighs the evidence on the whole, including the SEM findings, the CE must determine whether or not a referral is needed to a DMC or Industrial Hygienist/Toxicologist to further evaluate causation. Procedures for this and other actions are outlined below.

f. DOE Physician Panels. Cases with positive DOE physician panel findings approved by DOE (signed by a DOE official) under the old Part D are accepted for causation on the basis of those findings for all conditions claimed under Part E that were approved by the panel. The CE uses the DOE physician panel finding as the basis for the decision and no further development for causation is required.

If the positive physician panel decision is not approved by DOE (not signed by a DOE official) it is not an approved finding, however, unsigned reports still may contain useful information for causation development such as medical and exposure evidence that might prove useful in reaching a causation decision based upon all of the other evidence of file. The CE reviews negative panel reports like any other piece of medical evidence in light of the weight of the evidence of file as a whole.

g. Evidentiary Requirements for Survivor Claims. The CE uses any and all of the medical evidence of file in order to develop for causation in a survivor claim. Not only must the evidence of file establish that it is at least as like as not that toxic exposure caused, contributed to, or aggravated a covered illness, the evidence must also establish that the covered illness caused or contributed to the death of the covered employee.

h. Developing for Toxic Substance Exposure. When developing Part E cases the CE uses established development techniques in addition to certain other steps unique to the Part E adjudication process. The Final Adjudication Branch (FAB) develops medical conditions and employment where possible to avoid issuing a remand order for further development if such development can be conducted at the FAB with little additional effort.

(1) Development Using Existing Case File Materials. In many instances a Part E claim has a corresponding Part B and/or D case file already in existence. When an existing Part B and/or D case file exists, the CE examines the case file materials for medical, employment, and exposure evidence to assist in the causation development process.

Under Part D, DOE collected exposure and employment data through DARs. The CE must examine all existing Part D case file material for DAR records and review all documentation presented with the new Part E claim filing and any corresponding Part B or D case file to render a causation

determination. A filing under Part D is automatically considered a filing under Part E, without a requirement for the filing of another claim form.

(2) A General Rule about Reasonable Development. Given the complex nature of claim file development under Part E, it is necessary for the CE to judiciously determine whether or not the facts warrant issuing a decision or whether additional development is necessary. As a general rule, the CE utilizes the tools outlined in this chapter to the fullest extent possible and issues a decision once all development avenues have been reasonably explored. While the CE issues decisions accepting claims for benefits as soon as the evidence support an acceptance and all statutory criteria are met, denial situations must be heavily weighed and decisions issued only when additional development is unlikely to produce the evidence needed to reach a decision. In essence, the CE evaluates all of the evidence of file to determine whether or not it is plausible that, given the evidence at hand, the claimed illness arose out of the claimed occupational exposure to a toxic substance at a covered facility.

When attempting to determine whether or not sufficient development has been conducted, the CE can look to the claimed condition and the evidence at hand to make an informed determination. If the claimed condition is generally a condition that arises out of occupational exposure, it is incumbent upon the CE to pursue additional development whenever possible. However, if the condition is one that is unlikely to be caused by occupational exposure, the CE can be more certain that additional development might not be necessary and a decision can be issued.

(3) Example. If the claimed illness is chronic silicosis, chronic beryllium disease (CBD), asbestosis, or another condition known to arise almost exclusively out of occupational exposure, but the evidence is not sufficient to accept the claim, the CE refrains from issuing a denial if additional development might establish the employee's claim for benefits.

However, if the claimed illness is heart disease, diabetes, arteriosclerosis, thrombosis, or another disease that often is caused by non-occupational risk factors, the CE can send a development letter and allow the claimant an opportunity to present evidence. If no evidence is received, the CE may issue a decision after weighing the evidence as a whole and determining that no causal link exists between the claimed illness and the covered Part E employment.

3. Sources of Evidence. Establishing exposure to a toxic substance is a key element in developing claims filed under Part E. Developing for such exposure can be complex, and many tools are available to assist the Claims Examiner (CE) in this endeavor.

a. DAR records, which are obtained from DOE, contain a wealth of employment and exposure evidence. They contain a mixture of employment, medical, and exposure evidence. The CE prepares a DAR to DOE pursuant to the guidance in paragraphs 5 and 6 below. If the site information contained in SEM is reasonably complete and sufficient to establish the claimed exposure, no further exposure information should be sought from DOE through a DAR. The DAR can be used to obtain specific information if a claimant is alleging an incident that might not have been captured in SEM.

b. The DOE Former Worker Program (FWP) is an ongoing effort to evaluate the effects of occupational exposures (e.g., to beryllium, asbestos, silica) on the health of DOE workers. These records contain employment, medical, and exposure data.

Exposure information obtained from FWP work history interviews taken after the enactment of the EEOICPA, in October 2000, should be used only when corroborated by other evidence that supports the claimed exposure (i.e., DAR information, SEM).

c. Center to Protect Workers' Rights (CPWR) can provide data for use in verifying contractor/subcontractor employment and exposure.

d. Employment and exposure evidence from the claimant or other sources, such as verified affidavits, facility records, is weighed along with the evidence as the whole.

e. The SEM (see paragraph 8 below) provides site-specific exposure information, information about toxic substances and employment processes at a given site, and some limited information concerning potential adverse health effects produced by exposure to certain toxic substances.

f. DOE Physician Panel findings are also a source of employment, medical, and exposure information.

g. Occupational History Questionnaire (OHQ) data obtained by the RC staff document the workplace exposure experienced by an employee. The OHQ is used as a piece of evidence to be evaluated along with the evidence of the file as a whole.

4. Document Acquisition Request. The DAR is the process by which the DO gathers DOE work records on a specified employee. The CE reviews the case file before deciding which documentation to request from the DOE on the DAR Questionnaire. The CE must carefully consider the specific data needs for the individual case. Information received in response to the DAR may vary from site to site, but will contain some or all of the following information:

a. Radiological Dose Records. These documents are radiation

exposure records based on readings from dosimetry badges or similar personal recording devices. They are generally taken at regular intervals over the employee's employment.

b. Incident or Accident Reports. Any abnormal incidents or large plant accidental substance releases affecting the employee are documented in these types of documents.

c. Industrial Hygiene or Safety Records. Documents in these categories could contain periodic inspection reports for health and safety purposes.

d. Pay and Salary Records. These documents include an employee's pay, salary, any workers' compensation claim or other documents affecting wages.

Examples of records from the DOE database could include, but are not limited, to Official Personnel Files of Contractor Employees, Contractor Job Classification, Employee Awards Files, Notification of Personnel Actions, Classification Appraisals, Wage Survey Files, and Unemployment Compensation records.

The CE generally does not need these types of documents unless wage loss is either being claimed by the claimant or a wage-loss claim is obvious to the CE from the case file.

e. Job Descriptions. These are descriptions of the various employment positions at the plant and the duties required to perform the job.

f. Medical Records. These include personal medical histories of the employee if that employee visited the plant infirmary (e.g., Health Unit Control Files, Employee Medical Folder).

g. Other. This category includes any other documentation needed on a case-specific basis which does not fit into any of the other six categories. If this category is checked and a specific request is listed by the CE, DOE personnel may contact the DOL CE for clarification of the request.

5. Requesting the DAR. After reviewing the case file, including the OHQ from the RC, the CE requests the DAR information. This is done concurrently with FWP development. The process for collecting the information differs slightly depending on whether DOE or a corporate verifier (CV) is receiving the DAR. The CE must also review SEM to determine what exposure information already has been assembled from DOE records and other sources. If exposure information necessary to develop the claim already exists in SEM, the CE does not request such information in the DAR.

a. DAR Point of Contact (PoC) List. This list can be found on the NO shared drive and is divided into two sections: DOE DAR PoC and No Known Contact. Each District Director (DD) is responsible for updating and maintaining these records.

The DOE DAR PoC is similar to the current DOE Operations Center PoCs

for employment verification. There are some differences, however, so the CE must use this list when requesting DAR documentation directly from the DOE. A DAR Cover Letter and DAR Questionnaire are sent only to a DOE DAR PoC.

b. Sites With No Known DAR PoC. For these sites, the CE undertakes alternate exposure development. Since no known contact exists, a DAR Questionnaire is not used.

6. Completion of DAR. When appropriate, the CE completes a DAR Cover Letter and Questionnaire asking for toxic exposure evidence. If a particular DOE site does not have the ability to scan and submit documentation digitally on a CD, the DOE submits paper documents.

a. Package to DOE. The package includes a cover letter (Exhibit 1) addressed to the DOE PoC, DAR Questionnaire (Exhibit 2) completed by the CE, and copies of Forms EE-1/EE-2 and EE-3.

(1) The CE prints or types the identifying information of the employee in Blocks 1 and 2 of the DAR. The CE annotates any maiden names in Block 1.

(2) The CE indicates the DOE facility on Form EE-3 in Block 3 of the DAR and any employer name information in Block 4. If the claimant indicates on Form EE-3 that he or she worked for multiple subcontractors at the same DOE facility, the CE completes a separate DAR Questionnaire for each subcontractor. This process helps distinguish between contractors or subcontractors for which DOE has records and those for which it does not.

Similarly, if the claimant claims multiple DOE sites on Form EE-3, the CE completes a separate DAR for each DOE site, as the DAR PoC may be different.

(3) After reviewing the case file, the CE requests the records that are relevant to the case by checking the appropriate box(es) in Block 5, "Types of Records Being Requested."

(4) If the CE has a specific question(s) that needs to be addressed which is not covered in the broader categories listed on the DAR request, the CE completes the "Site Specific Exposure Questions" section of the Questionnaire. The CE considers the condition(s) claimed as well as any specific alleged exposures.

For example, if the claim is for aplastic anemia, the CE may want to ask DOE if and when arsenic or benzene was used in a particular building at the site during a particular timeframe.

b. DAR Response. When DOE's response is received, the CE enters an "ER" code into ECMS (see DEEOIC ECMS procedures for status effective dates and other information).

(1) DOE will have collected the documents requested in Block 5. The DOE checks the corresponding box in Block 6 immediately to the right of the requested category, either "Included on CD" or "Unavailable", depending on whether the DOE has any records related to that particular set of records. "Included on CD" also includes hard copy documentation in the event the DOE facility does not have imaging capability.

(2) Also, DOE will respond to any site-specific exposure questions posed by the CE in Block 8, confirming the exposure, denying the possibility of exposure, or indicating there is insufficient evidence to answer the question accurately. The DOE may attach a piece of evidence to the DAR which particularly answers a site-specific question or otherwise clarifies the DOE response to the question. In these instances, the DOE also checks the "SUP" or supplemental box signaling the special response.

(3) Once the DAR response is received, the CE reviews both the questionnaire and the contents of the CD to confirm that all requested documents have been received and that the specific questions about exposure have been adequately answered. Any documents identified on the CD as material to the claim must be printed and placed in the case file.

c. Follow-up with DOE. If DOE does not respond to the RC's initial employment verification request or the DAR questionnaire, the CE contacts the DOE to determine the status of the request.

(1) The DOE is given 30 days to respond to the request (Form EE-5 or DAR). If the DOE does not respond within that time, the CE drafts an inquiry to the DOE, noting the date of the initial request and asking the DOE to respond as soon as possible. The CE provides his or her contact information so that the DOE can quickly respond.

7. DOE Remediation Employment. Since Part E provides coverage for DOE contractor/subcontractor employees and their eligible survivors, a claimant alleging DOE contractor/subcontractor employment due to remediation must prove that a contract/subcontract in fact did exist between the claimed employer and DOE/DOE contractor to conduct remediation activities for DOE at the facility in question during the time when DOE was conducting remediation. When developing for exposure in a remediation case, the CE should follow the same steps as is used to develop for DOE contractors and subcontractors.

8. Site Exposure Matrices (SEM). The SEM is a web-based tool designed to assist the CE in developing for exposure to a toxic substance. The SEM identifies the toxic substances that were commonly used in each DOE and RECA Section 5 facility, and contains two general categories of information that may be searched: chemical

profiles and site-specific information tailored to the covered facility or site.

Under no circumstances is SEM used as a stand alone tool to deny a claim. Information in SEM can sometimes be used in conjunction with other supporting case file evidence to approve a claim.

a. Site-Specific Data. For a given covered facility or site, SEM provides information about the nature and location of work processes performed (e.g., fuel separation, instrument maintenance, or welding); the work groups involved (e.g., first line supervisor, instrument mechanic, or welder); the toxic substances used (e.g., plutonium nitrate, arsenic, or mercury); and site-specific aliases and potential exposure information about work processes, work groups, toxic substances, buildings, and areas.

b. Potential Nature of Exposure. Data from SEM is interpreted to mean that a worker had a *potential* for exposure to a toxic substance. The CE must review the information yielded from DAR responses, DOE FWP records searches, and the OHQ to hone the SEM search.

c. Employment Data. The CE must obtain as much background as possible to determine the type of work or process the employee performed, the dates of such work or process, the building(s) or area(s) involved, and the toxic substance(s) alleged to have been present to determine through SEM the type of chemicals an employee could potentially have been exposed to while working in a particular building and/or performing a certain job or process. This information can be gathered from the OHQ, DAR, EE-5, or other sources.

d. Validity of SEM. All information in SEM is considered valid and factual. The toxic substance, work process, and facility information in SEM is deemed verified by DOE or other sources, and if a certain toxic substance is listed as present in a given building or facility, the data is accepted as fact and no additional confirmation from DOE or any other source is necessary.

e. Additions to SEM. The database is continually updated and does not contain 100% of the toxic substances potentially present at a given facility. As a result, simply because certain information is absent from SEM does not warrant a claim denial and also does not warrant delaying adjudication until such information might be included in SEM. The CE conducts reasonable development by reviewing the evidence as a whole and issues decisions once such development allows the CE to adjudicate a claim.

9. SEM Policy and Management. The following paragraphs provide a basic outline of SEM and its use as a developmental tool. See the "Site Exposure Matrices Website User Reference Guide" (available on the Shared Drive, Part E folder, SEM subfolder, or accessed through the SEM menu) for complete and detailed instructions as to the use of

SEM.

a. Policy. SEM is used as a tool to assist the CE in evaluating the evidence as a whole to determine the existence of a causal link between covered employment, exposure to a toxic substance during such covered employment, and a resultant illness arising out of such exposure.

As noted above, in certain cases it will be possible to accept a claim based upon the information contained in SEM if such information can be coupled with approved policy guidance as outlined below.

Under no circumstances is a claim for benefits denied solely due to a lack of information contained in SEM, because the data for each facility will never be 100% complete.

b. Management of SEM at NO. A NO SEM Point of Contact (PoC) manages all issues arising out of SEM usage. Implementation questions, requests for access/denial of access to SEM, and any new evidence that might warrant inclusion into SEM are forwarded to the NO SEM PoC.

(1) The NO SEM PoC has a counterpart in the DO SEM PoC, who, the DD appoints to interact with the NO.

When evidence of an exposure not listed in SEM is verified or strongly alleged (supported by documentation) at a facility, the DO SEM PoC prepares a memorandum to the NO SEM PoC (for signature by the DD or designee) requesting IH review for possible inclusion of the toxic substance in SEM. All associated evidence of the presence of the toxic substance is attached to the memorandum.

The NO SEM PoC will review the evidence with the NO IH and other NO staff (i.e., Medical Director, Toxicologist, and Health Physicists) to determine whether the evidence should be included in SEM. If so, the NO PoC advises the Web Site Administrator or appropriate individual to add the information to the database.

In general, the DO SEM PoC interacts with the NO SEM PoC on all issues arising out of SEM operations.

(2) The DO SEM PoC obtains SEM access for DO staff by e-mailing the NO SEM PoC with a request that a staff member be granted access to the system and providing the employee's name, job title, and e-mail address. After review, the NO SEM PoC advises the Web Site Administrator by e-mail to grant access to the individual in question.

The Web Site Administrator contacts all individuals with newly granted access through e-mail, providing access information such as a user name and a temporary password.

(3) Access is disabled when an employee resigns or is terminated. The DO SEM PoC provides an e-mail to the NO

SEM PoC with the name of the employee whose access is being disabled and the precise date upon which access must be denied. The NO SEM PoC e-mails the Web Site Administrator requesting that the access be disabled on the requested date, and access is terminated. Due to the sensitive nature of the information housed in SEM, it is important that the DO SEM PoC notify the NO SEM PoC of the need to disable an account within 7 days of an employee's departure.

c. Additions to SEM. DEEOIC encourages claimants and other interested parties to submit new site-related scientific research, studies, or information concerning the presence of toxic substances at covered facilities for evaluation and possible inclusion in SEM. The SEM website at www.sem-dol.gov contains a link for individuals to provide comments or documentation of toxic substance use at a particular facility.

10. SEM Searches. The CE reviews all evidence of file to properly craft his or her SEM query. The CE reviews employment evidence for job description and facility. Also, employment and exposure evidence in the case file (e.g., facility records, DAR records, OHQ responses, NIOSH/PHS/DOJ data about RECA claims) is reviewed to determine as best as possible exactly where the employee worked and what processes or toxic substances were used in the building or area in which the employee worked. In order to effectuate a thorough and proper search, it is necessary for the CE to develop SEM queries from multiple criteria, including: labor category; process; and health effect. While labor category is the preferred field to begin a search, it is not the only field that should be investigated.

a. Data Fields. Various fields in SEM hold an array of valuable data viewable by site: the number of toxic substances present (with information about each substance); health effects or diseases known to be associated with a toxic substance; site history; buildings; processes; labor categories; known incidents; and exposure factors.

All fields contain references to the document utilized by SEM to provide the given information. The CE navigates the search fields based upon the known evidence of file, triangulating on the necessary information required to assist in the development and determination of causation.

A search based upon facility-wide information (e.g., all toxic substances known to have been present at the Nevada Test Site) generally will not be specific enough without other qualifiers such as work category and/or work process, and may not produce usable information for a causation determination.

At a minimum, especially when searching DOE sites, the CE establishes the employee's job category, work process, and/or building/area or employment before performing a SEM search. The more information a CE has about an employee's occupational history when searching SEM, the

more likely it is that the SEM search will prove useful in helping the CE determine causation.

b. Searches of Universal Information. This set of fields contains the most recent scientifically based evidence about toxic substances and their relation to illnesses. The occupational disease links in SEM are imported from the widely accepted and well rationalized medical science database called Haz-Map, a database of the National Library of Medicine (NLM). While the NLM database, Haz-Map, is often utilized in other circumstances as a resource, the CE must never use Haz-Map as a development or adjudicatory tool. Only SEM is acceptable for use in case file development and adjudication. It is unacceptable to base a decision, particularly a remand order, on any information contained in Haz-Map beyond the established links populated directly into SEM. Haz-Map serves many purposes for the public and medical professional fields and will often cite suggestive research that it has not accepted as a basis for finding a demonstrable link between a given substance and an occupational illness.

(1) The "Toxic Substance Information" field is useful when the evidence indicates the toxic substance(s) to which the claimant was potentially exposed. When a toxic substance is selected, SEM provides a "chemical profile" of the substance, including its Chemical Abstracts Service (CAS) number, which identifies the chemical, aliases for the substance name, chemical and physical properties (e.g., liquid or gas, odor, and color), and health hazard ratings assigned by sources routinely used by industrial hygienists to evaluate workplace substances.

(2) The "Toxic Substance by Alias or Property" field is used to find a toxic substance using an unofficial name, or by a physical or chemical property. Using this link allows the CE to find the identity of toxic substances by keying in part or all of the name, unofficial name (alias), or description of a toxic substance using a physical or chemical property.

The result may be no match, one match, or multiple matches. For example, searching for "yellow" will return a list which includes uranium dioxide, and searching for "yellowcake" will return a shorter list which still includes uranium dioxide.

(3) The "Toxic Substance by Chemical Category" field is used to find a toxic substance by category, such as gases or metals. If the claimant is not specific about the substance to which he or she was exposed, but describes it in general terms, this link will allow the CE to review a list of substances to which the employee may have potentially been exposed. After selecting a chemical

category from the drop down menu (gases, metals, acids, etc.), a listing of all toxic substances within that category at the site is shown.

Example: The CE knows that the employee worked as a laborer in the pilot plant at the Feed Materials Production Center (Fernald) and is claiming chronic bronchitis. The OHQ indicates that the claimant does not recall exact exposures, but does recall a sharp, pungent odor and states that he "breathed in this gas all the time." The CE selects "Gasses" from the chemical category drop down menu and all gasses known to have been present at Fernald are listed. The CE searches each gas and finds that sulfur dioxide was present in the pilot plant and that laborers are a labor category of possible exposure and that the gas has a pungent odor and that chronic bronchitis is a health effect of exposure.

(4) SEM provides a list of known health effects produced by a given toxic substance. SEM can also be searched to determine whether or not a given facility contained a toxic substance that could produce the health effect claimed. When searching this way, the CE searches by the claimed illness (e.g., asthma, skin cancer) to determine what toxic substances at a given site could have potentially caused, contributed to, or aggravated the claimed condition.

(a) The "Toxic substance by health effect" section displays the toxic substances that could cause the health effect or disease.

For example, the above-described laborer from the Fernald Pilot Plant claims chronic sinusitis as a result of his or her employment at Fernald. A search of the condition "chronic sinusitis" shows that no toxic substances contained within the Fernald database match the search criteria, meaning that no known substances involved in a work process at Fernald could have induced chronic sinusitis.

While this is not sufficient evidence to deny causation, the CE must evaluate other evidence to determine whether or not the employee's condition was caused, contributed to, or aggravated by his or her employment.

(b) The CE also can search SEM for toxic substances that cause a health effect by searching with a disease or health effect alias. That is, if the CE does not know the official name of the disease (e.g., pulmonary disease, chronic obstructive, a general term for lung ailments that can include emphysema, chronic bronchitis, and in some cases asthma) the CE can

search by the word "lung." This generates a search of all toxic substances present at a given facility that could affect lung function.

The CE can review the list of substances to determine if they were present in the employee's work process or building and whether these substances could potentially cause one of the lung diseases commonly referred to as COPD.

(c) The CE uses the "Disease or Health Effect by Alias" search if the organ affected by the disease is known. Using this link opens a page which allows the CE to find health effects or diseases by keying in all or a portion of the formal name of a health effect or disease. The SEM provides a list of health effects or diseases, which contain the search text in their formal names. For example, searching for "liver" returns *Hemangiosarcoma* of the liver.

c. Searches Specific to Selected Site. This section contains the most recent information about covered DOE facilities, uranium mines, uranium mills, and uranium transport operations. The CE searches these site fields for specific information about a facility, the work processes performed there (e.g., PUREX fuel separation, instrument maintenance, welding), and the toxic substances involved in those work processes, broken down by labor category (e.g., welder, yellow cake operator, electrician).

This group of searchable fields assists the CE in evaluating whether or not the employee's work history meets the presence and contact standard in the causation test for toxic substance exposure set out above. The CE searches site-specific fields when the CE knows the site of employment and also when the CE knows the building/area of employment, the work process performed and/or the labor category claimed.

(1) Site History. This section contains unclassified references from official DOE or DOE contractor web sites providing a description of the DOE facility or uranium mine or uranium mill. It provides dates of operation, known owners/operators, and historical reference data about the site. This description is available in SEM for both DOE facilities and uranium mines and mills.

(2) Areas. This section is only displayed if the selected site has defined areas. All defined areas are viewable by selecting a drop down menu identifying each known area by number and/or title. This section is used when the CE knows the area in which the employee worked. Work processes, labor categories, toxic substances and incidents will be listed for each specified area at the site.

For example, the employee claims to have worked on the bull gang in Area 16 at the Nevada Test Site from 1966 to 1970 and is claiming occupational asthma. The CE searches the Nevada Test Site facility by Area and queries Area 16, which shows all known potential toxic substances in that area, all labor categories, and work processes.

A search of the toxic substances present at the time of the claimed employment shows that of all substances present, cobalt can cause occupational asthma. A further search indicates that the bull gang labor category, involved in the labor process of reentry and mineback operations, is shown as a risk factor for cobalt exposure during the time in which employment is claimed. Verification of the claimed employment by DOE is sufficient to establish potential exposure.

(3) Buildings. This section is searchable when the CE knows the official or unofficial name of the building in which the employee worked. This section lists all historical references to the building, hazardous chemicals present, the area where the building was located, work processes, labor categories, and known incidents involving the building. This search category is available only for DOE sites. Data for uranium mines and mills will simply state the site history, processes, and searchable labor categories.

(a) The building information subsection lists all the major buildings (by number and title) at the site (e.g. the K-33 Process Building within the K-25 East Tennessee Technology Park).

(b) The CE enters a building by alias, or common name, for a worksite that does not appear in the searchable buildings list (e.g., the K-33 Process Building above is also known as the "Cascade Building"). SEM lists the proper names and numbers of buildings to which the slang or common name could refer. This search capacity assists in locating a building when no formal building name is identified in the employment history.

(4) Processes. This section lists all known processes at the site (e.g., carpentry, ash crushing, crane operations) and contains the related labor categories, timeframes, and toxic substances. This category is searchable for DOE facilities and uranium mines and mills. When searching for a labor process, the CE may know the type of process in which the employee was involved (e.g., welding, drillback core sampling, solvent recovery), but not the specific labor category involved.

Knowing the work process can assist the CE in conducting a search for potential exposure to toxic substances, because sometimes several different job categories can be involved in one work process and a process might be spread out among several different buildings within a facility (e.g., a process operator at Portsmouth GDP involved in cascade operations could have worked in X-326, X-330 and X-333, all buildings in which the work process "cascade operations" took place).

(a) DOE facilities list all processes known to have occurred at the site. For instance, if the CE knows an employee worked in Building 202-A at the Hanford Site, SEM indicates that the process in that building was PUREX fuel separation, lists all labor categories involved in this operation, and the toxic substance present when this operation took place.

This assists the CE in determining the toxic substances to which an employee could potentially have been exposed, based upon the process listed and the timeframes in which the employee may have been involved in such processes.

(b) For RECA mills, the following categories are examples of processes: laboratory, maintenance, and all other than laboratory and/or maintenance. Some mills did not have a laboratory component and therefore list fewer than three processes (e.g., Slick Rock in Colorado lists only maintenance and all processes other than maintenance). The CE must identify the labor sub category (actual work performed) whenever possible.

For example, if the CE knows that an employee worked as a bulldozer operator at Grand Junction in Colorado, the CE searches the labor subcategory field to identify that job title. Once it is identified, the CE clicks on the bulldozer labor subcategory and finds that a bulldozer operator is classified in the labor process "all other than laboratory and maintenance." All potential toxic substance exposure for that subcategory and labor process group is listed, and the CE can match the findings against the claimed/verified illness and exposure.

(c) Much of the work performed at RECA mines was fairly uniform and easily categorized with regard to process. While SEM does not list work processes for a RECA mine, labor categories exist as outlined below. Only exposure arising from processes and work that actually took place at a uranium mine or mill is

considered when evaluating a claim for causation.

(d) Individuals employed in the transport of uranium ore or vanadium-uranium ore to and/or from covered RECA mines or mills are covered under the EEOICPA. However, when developing exposure for an ore transporter, the CE only counts exposure that could potentially have taken place on the premises of a covered RECA mine or mill.

Exposure that could have potentially occurred when the ore transporter was *in transit* is not covered under the EEOICPA and is not considered by the CE when developing for causation. See EEOICPA PM 2-1100 for a more complete discussion of covered exposure under RECA.

(5) Labor Categories. The CE can search by labor category if the employee's job title or job title alias specific to a certain facility is known. It is important to narrow down employment verification requests and information obtained on Form EE-3 to determine the exact labor function performed by an employee if possible.

The RC staff must make certain to obtain the most specific employment information that is available from the employee/survivor and the employment verifier entity when conducting initial employment verification.

The CE must conduct additional development where necessary to further identify the exact definition of the employee's functions and the timeframe(s) of those functions at a given site, seeking the greatest specificity possible.

(a) Labor category information lists all the labor classifications or work group titles at the site (e.g., electrician, crane operator, barrier operator).

(b) If the employee's job title does not appear on the drop down list of labor categories above, the entry on the claims form may be a slang or unofficial title. The CE may be able to find the official labor category, (e.g., maintenance mechanic) by keying in the slang or commonly used title (e.g., pipe fitter).

(c) Construction worker exposures are separated into two categories: those due to toxic substances inherent to the construction craft, and those caused by performing the construction work on a DOE site. The CE must consider both exposure categories when assessing exposure for construction workers.

Construction exposure is searched as its own category outside of the facility lists. As such, it does not

matter where the construction took place. If the CE is searching SEM for a construction worker's claim, the CE searches by toxic substance and by work process (e.g., adhesive work, brazing, carpentry) and labor category (e.g., electrician, millwright, iron worker). Searches for construction trade exposures contain the same toxic substances, work processes, and labor categories for all covered facilities.

(d) For RECA mines, three labor categories are listed: prospecting, mining, and support/maintenance. The CE determines the duty performed (e.g., mining or maintenance) when searching SEM for information about a site listing more than one process. Some sites list only one possible work process and the CE need only confirm that employment is claimed or verified at the given site.

Once the work process is identified at the mine where employment took place, the CE can search a list of toxic substances to determine the one(s) to which an employee could have potentially been exposed while working at the mine.

For instance, the Arrowhead #1 mine in Eagle County, Colorado, lists "prospecting, no mining" as the only work process performed at that site. This means that the only work process performed at the Arrowhead #1 site was prospecting for uranium and that no actual uranium mining operations took place at that site.

The Bay Mule mine in San Miguel County, Colorado, lists "mining" as its only work process. A mixture of possible work processes will be listed for the RECA facilities depending upon what type of work activities actually occurred at the site.

(6) Incidents. The incident information field lists known major incidents and accidents experienced at the site. The entries provide a brief descriptive title of the incident, the year the incident occurred, and the location of the incident (building or area). An example would be: Uranium cylinder rupture and release, 1976, Building X-344.

(a) This information may assist in corroborating a claim if the claimant has referred to a particular accident or incident as having caused acute or extreme exposure to a toxic substance. Facility incident and accident information may be found in DAR responses, employment records, DOE FWP records, and OHQ summaries.

(b) The CE must evaluate incidents and accidents with

regard to the evidence of file as a whole. Simply corroborating a claimed exposure is not sufficient to establish causation. The CE must review the medical evidence and, if necessary, seek the opinion of an IH or DMC about the possibility as to whether or not the type of incident or high exposure event (as viewed in association with the evidence as a whole) could prove a significant factor in causing, contributing to, or aggravating the claimed illness. Further, certain incidences of high or extreme exposure should be considered when evaluating whether or not a required disease latency period can be eased or waived entirely.

(7) Exposure Factors. This section lists the safety programs, risk factors and timeframes used to gauge an employee's potential exposure as it relates to work process, labor category, building, and area.

(a) Safety programs serve as controls that may have reduced the likelihood of employee exposure to toxic substances (e.g., through use of respirators, protective clothing).

(b) Risk factors are conditions or practices that may have increased the likelihood of employee exposures to toxic substances, such as periods of time when employees were not properly protected.

(c) Timeframes reflect known periods within which a known correlation exists. For example, certain timeframes outline the period in which it is known that a certain toxic substance was present in a certain building (e.g., from 1956 to 1988 ammonium fluoride was present in Area 200 East and involved in the work process of PUREX fuel separation activities).

Also, timeframes outline periods in which certain safety programs or measures were in place at a given building or area. This information may assist the CE when evaluating the likelihood that a claimant was exposed to a toxic substance.

Safety Control Example: In 1999, DOE enforced beryllium controls such that work could only be performed in certain buildings. The employee claims beryllium illness from beryllium exposure in 2000, yet the employment evidence shows that he or she worked in a building where beryllium *was never* present due to DOE controls. When dealing with beryllium, the CE must be aware of the potential for residual contamination, and in this instance it must be unequivocally verified that beryllium was never

present at the facility in question.

d. Links Within Searchable Fields. Within SEM the various areas, facilities, buildings, processes, activities, labor categories, incidents and toxic substances which are known to have existed or occurred onsite are linked to one another. For example, such relationships expressed in the matrices might be:

(1) "Toxic *xxx* was in building *aaa* at some time;"

(2) "Activity *bbb* was performed by Labor Category *ddd* and involved work with Toxic *yyy* in Building *lll;*"

(3) "Activity *bbb* was performed during Labor Process *ddd* and involved work with Toxic *zzz* in Building *lll;*" and

(4) "Labor category *ppp* involved work at all parts of the site").

e. Sample SEM Search # 1. DOE verifies employment at the Portsmouth GDP from 1955 to 1960. Form EE-3 indicates that the employee worked as an instrument mechanic in Building X-333 from 1955 to 1960. The verified diagnosed medical condition is aplastic anemia.

A search of the SEM by Health Effect shows that aplastic anemia can be caused by arsenic, benzene, and plutonium exposure. The CE further consults the Haz-Map database link which provides a description of aplastic anemia and indicates that arsenic, benzene, and plutonium are among the hazardous agents that can cause the disease. A latency period of weeks to years is indicated.

The Building information for Building X-333 lists all known chemicals used at that site, and arsenic, benzene, and plutonium are among them. The SEM further shows that the Labor Process of Instrument Maintenance took place in Building X-333 from 1953 to 1957 and lists the Labor Category Instrument Mechanic as involved in this process during this timeframe.

The CE reviews the SEM findings as well as other relevant evidence (medical opinions provided by qualified physicians that opine a link between the occupational exposure and the aplastic anemia, DAR records showing definite arsenic and benzene exposure, DOE FWP records, and OHQ results supporting a finding of potential occupational exposure to benzene, arsenic and plutonium) to determine whether sufficient evidence exists to accept the claim. In this instance, the evidence as a whole supports acceptance.

f. Sample SEM Search # 2. An employee claims employment as a chemical operator in Building X-705 at the Portsmouth GDP from 1966 to 1982. DOE confirms the employment. The employee is claiming asthma and chronic bronchitis, and medical evidence diagnosing COPD has been received. The CE reviews the OHQ and finds that the claimant indicated in his interview that he does not know specifically what chemicals he was exposed to, but does recall working with an acidic

substance with a sour, vinegar-like odor.

The CE reviews SEM, searching by labor category and building, and finds that acetic acid was used in the employee's work process in Building X-705 and that it has a sour, vinegar-like odor. A SEM search for health effects for acetic acid shows that it is known to be associated with occupational asthma. The DAR record response does not show that the claimant worked with acetic acid in the course of his employment, but that he did come into contact with various solvents.

The CE should follow up with the treating physician to clarify the diagnosis. The CE may consider referral to a DMC to review the evidence and determine whether or not the potential for acetic acid exposure caused the claimant's lung condition. The CE will also want the DMC to try and specify the lung condition.

g. RECA SEM Searches. When searching for a specific RECA location (mine or mill), the CE locates the facility by the state in which it operated, by its name, or by its alias. For instance, the uranium mill "Durango" can be found by searching mills in Colorado, by the name "Durango," or by searching the site alias: Vanadium Corp of America, or VCA.

RECA mines are also located in SEM by the county in which they operated. RECA mine and mill work process categories are more general than the DOE work process categories. The CE attempts to determine the exact labor category (specific job title or activity) whenever possible when conducting a SEM search about a RECA facility.

Uranium mines are categorized as being either underground or surface mines, and typical mining operations include the following: drilling; blasting; shovel/machine digging; and hauling materials.

11. SEM Inquiries. Whenever a SEM query is conducted, the CE must document the case file record to show that a SEM search took place and enter the corresponding ECMS coding.

a. Recommended Decision. Prior to issuing a recommended decision (RD) denying benefits, the CE must ensure that the most updated version of the SEM data is contained in the case file and referenced properly in the decision.

(1) This is done by double checking the search initially conducted to make certain that an element not found in the initial search (i.e., a toxic substance) has not been added to the SEM since the date of the initial search. The CE prints out the results of the new search immediately prior to issuing the RD.

(2) The CE must make certain that the SEM record is properly preserved in the case file for FAB review. SEM will show the latest date on which an update was made to the system that changes the data available about a given facility.

(3) If the date listed in SEM remains the same as it was when the original search was conducted, the CE will know that no new information has been added to SEM and no new search is required. However, if the date has been changed since the date of the last search, the CE must search SEM again to determine whether additions or changes will change the outcome of the SEM search and potentially affect the outcome of the adjudication.

b. Decisions Issued As Needed. Because SEM is a living document that is updated as data becomes available, the CE does not wait for information in SEM to be updated before issuing a decision. If a SEM search is conducted and no information is available, or the site is not yet complete or searchable in the database, the CE issues a decision after developing the case as completely as possible, pursuant to normal procedures.

c. FAB Review. FAB ensures that the SEM search was conducted, where applicable, during the FAB review of the recommended decision.

(1) FAB may remand the case to the DO if a SEM search was needed but not conducted, or if the search was conducted improperly in a way that materially affects the outcome of the RD, or if the SEM data relied upon by the DO was changed or updated significantly enough to warrant additional development or a potentially different adjudicatory outcome.

(2) Before issuing the FAB decision, the FAB must ensure that the SEM record is the most complete and updated data available in SEM and that no significant changes (additions of toxic substances or changes in work process definitions or timeframes) have been made since the issuance of the recommended decision.

(3) This checking of the SEM search data to determine whether or not a new data element was added that will alter the outcome of the decision is conducted in the same manner as set out above for denied recommended decisions.

(4) The FAB CE/Hearing Representative (HR) does not print out a copy of a new search, but places an entry into ECMS Notes indicating that no new evidence exists in SEM to alter the findings in the recommended decision.

(5) If new evidence is uncovered that does alter the findings of the RD, a remand order may be necessary. However, if the SEM data is updated after the issuance of the recommended decision or the DO SEM search, and such update does not affect the outcome of the decision, a remand is not warranted.

d. Use of SEM Findings. When using SEM as a finding in an RD or a decision of the FAB, the CE/HR cites the technical document upon

which the SEM data search result is founded, as well as SEM, in the decision. As always, the DO CE or FAB CE/HR clearly outlines the rationale for accepting or denying causation based upon all of the evidence weighed as a whole. Below is an example of the language approved for use when referencing SEM.

Decision Language Example: Source documents used to compile the U.S. Department of Labor Site Exposure Matrices (SEM) establish that a person in the labor category of "Operator" at the Savannah River Site could potentially be exposed to the toxic substance asbestos. The SEM lists asbestosis as a possible specific health effect of exposure to asbestos and contains a list of the buildings at the Savannah River Site where that particular toxic substance is or was present during the years that the claimant worked there. The employment record provided by the Department of Energy (DOE) contains several numbers that appear to reference the employee's work location including a number G160-235. The most comparable building listed in the SEM was 235F. Data contained in SEM for 235F establishes that asbestos was used in this building and that the labor category of "Operator" is associated with this building.

12. National Office Specialist Review. If the CE identifies an exposure issue that requires review by an IH, the CE alerts his or her supervisor. *Prior to seeking NO assistance, the CE must exhaust all reasonable exposure development pursuant to the guidance set out in this Chapter.*

If the supervisor grants approval for the referral, the CE prepares an e-mail to the Health Services Program Analyst (HSPA) requesting review. The HSPA forwards the e-mail to a Medical Health Science Unit (MHSU) specialist who reviews the contents and assigns the question to the appropriate specialist based upon their scientific discipline.

However, if the MHSU specialist determines that the issue does not warrant a referral, the e-mail is returned instructing the CE to pursue further development. Once the issue is assigned to an IH for review, the IH conducts such review and responds to the CE in a timely manner.

a. Questions for IH. The CE outlines succinctly what information is known about the issue (e.g., the employee was a stainless steel welder at Savannah River from 1982 to 1985 who is diagnosed with asthma) and what is needed from the expert (could the employee have been exposed to nickel)? The CE uses the information in SEM and the case file as a whole to frame the question as carefully as possible based upon the claimed employment, process and illness. A Statement of Accepted Facts (SOAF) must accompany the referral to the IH.

(1) The facility in question (narrowed down to building and area where possible) and the work performed is always a critical factor when querying the IH about exposure. The CE uses SEM whenever possible to assist in this narrowing

process, but if no information exists in SEM, the CE crafts the question as best as possible based upon whatever evidence is available in the case file.

(2) The CE may also forward a general question about a facility when information cannot be found in SEM and the facility in question is either not yet uploaded to SEM or the data is incomplete.

For instance, a CE may need to know whether asbestos was present as a general rule in the Clarksville facility. The CE may ask a general question such as this of the IH, but should include as much specificity in the query as possible, especially labor category, processes, and time periods.

b. IH Review. The IH reviews the issue framed by the CE and determines whether more information from the case file is required to answer the question, or if the entire case file is needed. The IH role is to anticipate, recognize, and evaluate hazardous conditions in occupational environments, and to opine based upon his or her specialized knowledge. The IH strives to answer the question based upon the information outlined by the CE.

However, if additional information is required, the IH may request whatever documentation from the case file is necessary. If required, the IH requests the entire case file if individual pieces of information from the file will not suffice to answer the question posed by the CE.

(1) The IH mainly addresses issues about routes of exposure (e.g., whether or not a welder at a given facility could have been exposed to nickel). An IH also may verify whether or not a toxic substance was/could have been present during a certain work process (e.g., welding, or instrument maintenance) at a given site, or if a certain labor category (e.g., welder, or instrument mechanic) could have come into contact with a given toxic substance in the performance of his or her duty at the site.

The IH may also be asked to determine the *plausibility* that a certain toxic substance was present or that a claimed exposure could have occurred based upon the work history and/or accident/incident report.

(2) The IH also reviews SEM searches performed by the DO to determine whether or not they were performed correctly and accurately.

c. Request for Case File. If the IH requests the entire case file, the CE prepares the WS/WR memorandum for the DD's signature. The WS/WR memorandum is addressed to the Policy Branch Chief at NO. Upon receipt of the case file, the Policy Branch Chief forwards the case file to the IH for review.

d. IH Memorandum. The IH renders an expert opinion in the form of a memorandum that addresses the issue as specifically as possible. The IH's reply addresses the specific question posed by the CE in the e-mail/SOAF/WS/WR memorandum, and employs his or her specialized training to make findings based upon the evidence of file and clearly rationalized science.

e. DMC Referrals to IH. In certain instances, a case forwarded to a DMC may not contain enough information regarding occupational toxic exposure for the DMC to render an expert opinion. In these situations, the DMC should refer the case to an IH through the DO.

(1) DMC referrals for causation which do not adequately identify a route and extent of exposure require the DMC to contact the Medical Scheduler (MS) via e-mail within 3 days of receipt of the referral package, and request an IH referral. If exposure data are inadequate due to an incomplete SEM profile, incomplete DOE records, or other missing information that makes a causation determination impossible without a clearer exposure evaluation, then an IH referral is warranted. If the Medical Scheduler is unavailable the DMC should then contact the assigned CE.

(2) The MS forwards the DMC's IH referral request via email to the assigned CE for review. A copy of this email is placed in the case file. Telephone requests for an IH referral must be documented in the Telephone Management System (TMS).

(3) Upon receipt of the email from the MS, the CE forwards the case file and Statement of Accepted Facts (SOAF) to the Supervisor/Senior CE for review. If the Supervisor/Senior CE concurs with the need for an IH referral, he or she sends an email with the SOAF attached to the Health Services Program Analyst (HSPA) located at the NO, requesting an IH review and places a copy of the SOAF and the sent email in the claimant's file. The CE enters the "WS" code into ECMS (Washington, DC: Sent To), with a reason code of "IH" (Industrial Hygienist Review) (see DEEOIC ECMS procedures for status effective dates and other information). The "WS" code ensures that the time taken for review by an IH will not be counted as time necessary for DMC review.

(a) Upon receipt of the email from the Supervisor/Senior CE, the HSPA assigns the referral to an IH.

(b) The IH reviews the SOAF and any other relevant information that may be requested, and renders an expert opinion in the form of a memorandum based upon the facts of the claim, the information available through SEM, and professional judgment regarding the

likelihood and extent of any exposure(s). The IH then emails a copy of the memorandum to the CE, Senior CE, and Supervisor.

(c) The IH has 15 days from receipt of the referral to complete the memorandum. If 15 or more days pass without receipt of the memo, the CE notifies the Senior CE/Supervisor, who then follows up with an email to the HSPA.

(d) When the IH memo is received the CE reviews the opinion to ensure that the question asked has been sufficiently answered, gives a copy of the memorandum to the MS, and places a copy in the claimant's file. The CE then enters the "WR" code into ECMS (Washington, DC: Received Back From).

(e) The MS will FedEx a copy of the IH memorandum to the DMC for review and notify the CE, Senior CE, and the Supervisor via e-mail of when this action was taken.

(4) The CE continues to monitor and track the file after the IH memorandum has been furnished to the DMC.

(a) The DMC has 21 days from the date of receipt of the IH memorandum to return a completed report accompanied by a bill to the MS. If the DMC report is not received within 21 days from the date of the IH memorandum, the CE notifies the MS, who follows up with a phone call to the DMC. The call is documented in TMS.

(b) If, upon review of the IH memorandum, the DMC has questions, the DMC contacts the IH via email.

(5) If the Supervisor/Senior CE determines that the case does not warrant an IH referral after receiving the SOAF and file from the CE, the Supervisor/Senior CE returns the SOAF and case file to the CE with instructions to pursue further exposure development.

(a) The CE notifies the MS via email that further exposure development is needed, places a copy of the sent email in the case file, and mails an exposure development letter to the claimant. In the letter to the claimant, the CE advises that exposure development is needed for adjudication. The CE enters code DO (TD) - Development of Toxic Exposure into ECMS with a status effective date the date of the letter. Upon mailing the request to the claimant the CE enters an ECMS note describing the action and inserts a 30-day call-up.

(b) The MS notifies the DMC via phone that further

exposure development is needed for the case. The call is documented in TMS.

(c) After 30 days has passed with no response from the claimant, the CE prepares a second letter to the claimant (accompanied by a copy of the initial letter), advising that following the initial letter, no additional information has been received. The CE advises that an additional period of 30 days will be granted for the submission of requested information, and if the information is not received a decision will be issued. The CE enters code DO (TD) - Development of Toxic Exposure into ECMS with a status effective date the date of the second letter.

(d) The CE notifies the MS via email that the requested information has not been received, places a copy of the sent email in the case file.

(e) Upon receipt of the email from the CE the MS prepares a letter to the DMC notifying that the requested information has not been received. In the letter, the MS requests the DMC to return or destroy the case material. A copy of this letter is placed in the case file.

(f) If the claimant submits relevant exposure data in response to the CE's request, it must be reviewed to determine if it is of sufficient probative value to request an IH referral or return to the DMC. If the CE determines that there is insufficient evidence to warrant an IH referral, a decision can be issued. If the CE determines that the new information is sufficiently comprehensive to obviate the need for IH review, referral to the DMC can be completed.

f. Complex Referrals. Some referrals to NO will be so complex as to require IH and medical or possibly toxicology review. In these instances, the NO Medical Director and/or the NO Toxicologist may also review the case materials/case file to assist in addressing the CE's inquiry. The proper specialist will be determined by an MHSU specialist at NO upon review of the query and/or case file materials. The NO Medical Director and/or Toxicologist will provide expert opinions in such cases where a review is necessary by more than one specialist at the same time.

If an issue referred to the NO contains elements that might require expertise in the field of occupational exposure, medicine, and/or toxicology, it is forwarded to NO as outlined above with an initial e-mail query. The appropriate specialist(s) will review the query and determine what additional information (including the case file) is necessary to resolve the issue at hand.

g. Synergistic or Additive Effect. In certain instances a physician might opine that a claimant's radiation and toxic substance exposure together worked in tandem to produce a synergistic or additive effect that brought about a cancer. DOL has not found scientific evidence to date establishing a synergistic or additive effect between radiation and exposure to a toxic substance, and if the physician presents this finding he or she must provide actual scientific or medical research evidence to support the finding before the CE may consider the assertion.

If a physician makes this assertion the CE requests that the physician provide medical evidence of a synergistic or additive effect and a clearly rationalized medical opinion as to whether or not the effect is of a significant nature to establish that the combination of the radiation and the exposure to a toxic substance was "at least as likely as not" a significant factor in aggravating, contributing to, or causing the cancer.

(1) If the physician provides rationalized scientific evidence revealing a synergistic or additive effect, the DO sends the case file to NO for review by a NO Health Physicist (HP) and/or the DEEOIC Medical Director. The HP reviews the physician report and all evidence of file and drafts a memorandum containing his or her professional opinion as to causation which is sent to the CE for use in issuing a determination in the case. See the ECMS section to this Chapter for referral coding.

Exhibit 1: DAR Cover Letter

Exhibit 2: DAR Questionnaire

2-0800 Developing and Weighing Medical Evidence

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1. Purpose and Scope. Proper development and weighing of medical evidence is essential to the sound adjudication of claims for benefits and to the comprehensive management of Energy Employees Occupational Illness Compensation Program Act (EEOICPA) claims. This chapter discusses the Claims Examiner's (CE) function in developing and evaluating medical evidence and weighing conflicting medical opinions.

2. Sources of Medical Evidence. Most medical reports come from one of these sources:

a. Claimant's health care provider, including the attending physician, consulting experts and medical facilities. Treatment records from a clinic operated at an employing facility would also be considered records of a health care provider.

b. Department of Energy's Medical Monitoring Programs, administered by certain Department of Energy (DOE) facilities that maintain medical examination records and exposure data on their employees. For example, the DOE Former Worker Programs began in 1996 and are designed to evaluate the effects of the DOE's past operations on the health of former workers at DOE facilities, and offer medical screening to former workers.

c. ORISE (Oak Ridge Institute for Science and Education), which administers the beryllium screening program by providing initial beryllium-related testing at various locations across the country. Individuals who test positive for beryllium sensitivity are offered more extensive testing for chronic beryllium disease (CBD) and medical monitoring.

d. District Medical Consultants (DMC), who furnish medical opinions, guidance and advice based upon review of the case file and familiarity with EEOICPA requirements.

e. Second Opinion Physicians, who may provide examination, diagnostic testing, and rationalized medical opinion when a detailed, comprehensive report and opinion are needed from a specialist in the appropriate field.

f. Referee Specialists, who may examine the employee, arrange diagnostic tests and furnish rationalized medical opinion to resolve conflicts between the claimant's physician and the DMC/Second Opinion Physician where the weight of medical evidence is equally balanced.

3. Types of Medical Evidence. Medical evidence in EEOICPA cases consists of the following major categorie

a. Treatment records are the most prevalent form of medical evidence. They consist of any record made during the evaluation, diagnosis and treatment of a patient by his or her health care providers. They include:

(1) Attending physician records (e.g., chart notes, reports, etc.) They include records of medical consultants assisting the attending physician.

(2) Records of doctors consulted by the patient for an independent medical opinion.

(3) Evidence of diagnostic testing (e.g., x ray films, EKG tracing, etc.) and the reports of medical providers interpreting the tests.

(4) Treatment records from hospitals, hospices, or other health care facilities.

b. Medical evaluations may occur for a variety of reasons other than to further the diagnosis and treatment of the patient. What distinguishes medical evaluations from treatment records is the purpose of the examination. Medical evaluations include:

(1) Evidence from the Department of Energy's Medical Monitoring Programs (e.g., former worker screening records, pre employment physicals, termination

physicals, etc.)

(2) Examinations required under state or federal compensation programs (e.g., evaluations for state workers' compensation claims, Social Security disability examination, etc.)

(3) Medical reports or opinions obtained for litigation under state or federal rules of evidence.

c. EEOICPA reports produced following a referral to a DMC, second opinion physician or referee specialist.

d. Other types of medical evidence include:

(1) Death certificates which contain information about the cause of death or date of diagnosis.

(2) Secondary evidence relied upon by a doctor in forming an opinion. For example, a doctor may rely upon information provided by an Industrial Hygienist (IH) in determining the cause of an illness.

(3) Affidavits containing facts based on the knowledge of the affiant regarding the date of diagnosis.

(4) Cancer Registry records may be used in some cases to establish a diagnosis of cancer and date of diagnosis.

4. Contents of a Medical Report. The value of findings and conclusions contained in medical records varies.

a. Treatment Records.

(1) A doctor's report of examination usually contains a description of subjective complaints, objective findings, assessment and plan for follow up or treatment. The Subjective, Objective, Assessment and Plan format is often shown in the medical records by the letters S, O, A and P. Even where the SOAP

abbreviation is not used, the records tend to follow this pattern.

(a) The subjective section records information obtained from the patient. It generally contains information about why he or she is seeking treatment, complaints, medical history and current treatment. A subjective section might state, for example, "Patient comes in today to have us look at a lump on his neck that has gotten larger over the last month."

(b) The objective section records the doctor's findings based on his observation, examination and

testing. An objective section might state, for example, "The patient looks older than his stated age, his breathing is labored and his x-ray shows a spot on his left lung." The three general classes of objective findings are:

(i) Laboratory findings such as complete blood count (CBC), tissue biopsy, bone marrow smear or biopsy, beryllium lymphocyte proliferation test (LPT), etc.

(ii) Diagnostic procedures such as x-rays, ultrasound, computerized axial tomography (CAT), magnetic resonance imaging (MRI), electromyelogram (EMG) and similar techniques of visualizing or recording physiological conditions. Some objective tests are subject to greater interpretation by the health care provider.

For example, an x ray used to diagnose a broken leg is more objective, while a Minnesota Multiphasic Personality Inventory (MMPI) used to diagnose schizophrenia is more subjective.

(iii) Physical findings which are noted by the doctor's visual inspection, palpation and manipulation of the body. They include description of demeanor, readings of temperature or pulse, description of respiration, observation of affect, etc.

(c) The assessment section contains the doctor's opinions, suspicions and diagnoses. In most cases, the value of a medical report is found in the assessment. The scope of the assessment will vary with the type of medical condition and its complexity.

The assessment section may contain statements such as, "The pathology report was reviewed and showed the presence of small cell carcinoma of the lung" or "Based on the patient's rest tremor, balance problems and rigidity of muscles, I believe he has Parkinson's disease."

(d) The plan section describes the treatment plan and prognosis. The doctor may, for example, prescribe medication, refer the patient to an expert, or suggest additional testing.

(2) Reports of tests and procedures should contain the employee's name, date of the test, the objective data obtained, and the signature of the person responsible for conducting the test or procedure. Where appropriate, reports should include a physician's interpretation of

laboratory tests or diagnostic procedures.

Tests for which interpretation is necessary include, but are not limited to, pathology reports, lymphocyte proliferation tests, X-rays, MRIs, CAT scans, pulmonary function tests, MMPIs, and the Beck Depression Inventory. In cases where no interpretation is provided, the CE must seek a medical interpretation. The CE is not to interpret test results, as that is a medical judgment.

(3) Hospital, hospice and clinic records will contain the same type of doctor's records and diagnostic testing as outlined above. Also, the CE should review the admission summary, surgery reports, nursing notes, the discharge summary, autopsy reports, etc.

b. Medical Evaluations. Generally, medical evaluations contain the following types of information:

(1) A description of why the examination is being conducted. The report may state, for example, "Mr. Smith is referred by the Department of Labor and Industries for an independent medical evaluation regarding his claim for asbestosis."

(2) A description of the information the physician has reviewed and relied upon in reaching his or her conclusions. This often includes a discussion of the course of treatment, which describes past treatment undergone by the patient and the physician's recommendation for present and future care.

(3) A description of any examination and tests performed during the evaluation.

(4) Opinions of the evaluating physician with an explanation of evidence used and a discussion of how the conclusions were reached.

c. EEOICP Referrals. DMC, Second Opinion Physician or Referee Specialist reports should contain the same general information as any other medical assessment. In addition, the report should contain a well-reasoned response to any questions presented by the CE in the referral, including a summary of the evidence and medical references used.

5. Developing Medical Evidence. Although it is ultimately the responsibility of the claimant to submit medical evidence in support of his or her claim, the CE must assist the claimant to meet the statutory requirement for medical evidence for any illness claimed. This may include seeking clarification from a DMC, a second opinion physician or a referee specialist. The CE develops medical evidence to adjudicate a claim, determine percentage of impairment, establish a causal relationship between a covered illness and wage-loss, and

resolve inconsistencies and conflicts in medical opinions.

a. Deficient Evidence. When a deficiency in the medical evidence is identified, the CE contacts the claimant or the treating physician to request additional medical evidence.

For example, an initial claim is submitted to the District Office (DO) for skin cancer but does not include a pathology report or any other positive diagnostic evidence. The CE writes to the claimant, identifies the deficiency and requests the specific evidence needed to establish skin cancer under Part B and Part E.

b. Telephone Requests. In many situations, a minor deficiency in the medical evidence can be easily overcome with a telephone call to the physician's office to request specific documents. If, however, a phone call does not produce a favorable result, the CE should send a written request.

(1) Statements made by the physician over the telephone do not constitute valid medical evidence.

(2) If the doctor relays information essential to the outcome of a claim, the CE must document the call in ECMS and request that the physician submit a written statement.

c. Written Requests. The CE may decide that the best method of collecting the evidence is to submit a written inquiry directly to the physician (with a copy to the claimant).

(1) If records are requested from a treating physician, the Form EE 1/EE 2 submitted by the claimant serves as a medical release to obtain the requested medical information.

(2) If a reply is not received within 30-45 days or the response does not resolve the deficiency, the CE considers other options for obtaining the required medical evidence (e.g., a DMC referral, cancer registry or death certificate).

d. Unavailable Medical Records. If a treating physician's records have been destroyed or are otherwise unavailable, the CE attempts to obtain a statement from that physician.

(1) The Physician's Statement should contain the following information:

(a) An affirmation that the physician treated the employee for the claimed condition(s).

(b) A statement that the requested medical records are no longer available.

(c) A discussion that includes the diagnosis and date of diagnosis.

(d) The physician's signature and the date signed.

(2) A Physician's Statement is considered a medical document and not an affidavit.

6. Weighing Medical Evidence. When medical evidence is submitted from more than one source, the CE must evaluate the relative value, or merit, of each piece of medical evidence. This is particularly important in cases where there is a conflict between the medical evidence received from the DMC and the treating physician. A thorough understanding of how to weigh medical evidence will assist the CE in determining when and how further medical development should be undertaken and assigning weight to the medical evidence received.

a. How to Evaluate Evidence. In evaluating the merits of medical reports, the CE assigns greater value to:

(1) An opinion based on complete factual and medical information over an opinion based on incomplete, subjective or inaccurate information.

(2) A well-reasoned or well-rationalized opinion over one that is speculative.

(3) The opinion of an expert in the relevant medical field over the opinion of a general practitioner or an expert in an unrelated field.

(a) Medical evidence used to establish a compensable medical condition must be from a physician. The definition of physician includes surgeons, podiatrists, dentists, clinical psychologists, psychiatrists, occupational medicine practitioners, optometrists, and osteopathic practitioners within the scope of their practice as defined by state law.

(b) Chiropractors may only be considered physicians in EEOICPA cases for treatment of manual manipulation of the spine to correct a subluxation as demonstrated by x ray to exist (usually relevant only in consequential injuries).

(c) However, chiropractic care may be authorized as treatment for an accepted condition. Any such treatment must be prescribed by a physician, and the physician must provide rationale as to how the type of treatment in question relates to the covered condition.

b. In weighing medical evidence, the CE evaluates the probative value of each piece of the evidence of file and considers the following questions with respect to each report.

(1) Is there a definitive test? Some conditions can be established by objective testing. A positive pathology report from a physician is sufficient evidence of the diagnosis of cancer. A physician's report of a positive

beryllium lymphocyte proliferation test of lung lavage cells showing abnormal findings is sufficient evidence of the diagnosis of beryllium sensitivity.

(2) Is the physician's opinion rationalized? The term "rationalized" means that the statements of the physician are supported by an explanation of how his or her conclusions are reached. This explanation and discussion are what constitutes medical rationale. This is of particular importance when there is a complex medical issue or when there are conflicting medical opinions in the case file.

(3) Is the physician's opinion based upon a complete and accurate medical and factual history? For example, a physician opined that his patient's lung cancer is related to exposure to diesel engine exhaust. This doctor's opinion has less probative value if the doctor erroneously cites an incorrect date of diagnosis or exposure date.

(4) Is the physician a specialist in the appropriate field? The physician's qualifications will have a bearing on the probative value of his or her opinion. For example, if a general practitioner has a patient with rest tremors, balance problems and muscle rigidity, a diagnosis of alcohol abuse with dehydration may seem reasonable. However, if a conflicting report is received from a board-certified neurologist diagnosing Parkinson's disease based on the same symptoms, it would carry greater weight because a neurologist is an expert on neurological disorders. This is particularly true for an illness like Parkinson's disease that cannot be confirmed by an objective laboratory test.

(5) Is the physician's opinion consistent with the findings? A physician's preoperative opinion that a patient has cancer is of little probative value if the pathology report of a tumor biopsy shows no malignancy.

7. Using Death Certificate to Establish Diagnosis. A death certificate signed by a physician may be used to establish a diagnosis of cancer if the following actions have failed to produce viable medical evidence:

a. Claimant Advised. The CE must advise the claimant in writing of the medical evidence necessary to establish a diagnosis of cancer and grant him or her the opportunity to submit all available medical records. This letter must address the specific documents that are missing and explain the specific types of records needed.

b. Additional Medical Development. If the claimant cannot secure medical records, the CE must contact potential sources of medical information, such as doctors' offices, hospitals, clinics, nursing facilities, or laboratories, to determine whether any records exist

which could establish a diagnosis. The CE requests, either in writing or by telephone, any medical records and reports that may include a diagnosis (i.e., pathology report, autopsy report, physicians' reports, lab results, medical payments, hospitalization, surgeries, initial examinations, referrals, etc). Any contact with a medical facility must be documented in the case file or ECMS even if the outcome is not positive.

In most cases, a death certificate must be signed by a physician to be accepted as medical evidence. However, if the death certificate lists the name of the physician as the certifier, but is not signed, this is still acceptable if the death certificate is signed by another official attesting to its truthfulness.

Some states have implemented electronic upload of death certificates. A death certificate may be used to establish a diagnosis of cancer if it listed the physician as the certifier along with a license number and an electronic signature.

Nothing in this section should be interpreted as limiting the use of a death certificate for other purposes, such as evidence of the cause of death under Part E.

8. Using Affidavits to Establish Date of Diagnosis. While an affidavit cannot be used to establish a medical diagnosis, it can be used to establish a date of diagnosis after the CE has made a reasonable effort to establish the date of diagnosis from the medical records. CE actions should include the following:

a. Advice to Claimant. The claimant must be advised in writing that medical evidence (i.e., pathology report, autopsy report, physician's reports) should be submitted to establish a date of diagnosis.

b. Additional Medical Development. If the claimant and the CE cannot obtain medical evidence to establish the date of diagnosis, the CE must request copies of affidavits from those in a position to know the former worker's condition during the illness. For example, a home health nurse or relative who provided care to the employee may provide an affidavit.

c. Death Certificate. If reliable affidavits are not received, then the CE may use the date of diagnosis or date of death from the death certificate.

d. Medical Review. If an affidavit reveals evidence of a medical condition, but no physician's diagnosis is contained in the file, the case may be forwarded to either the DMC or to an outside physician for review and possible confirmation of a diagnosis.

9. Reviews by District Medical Consultant (DMC). A DMC plays a vital role in resolving medical issues by evaluating medical evidence and rendering independent medical opinions. The DMC is crucial in cases where the employee is deceased and the medical records are minimal or inconclusive. Some other examples of DMC services include

the following:

a. Clarification and confirmation of diagnosis if the evidence is inconclusive.

b. Opinion about consequential injuries or surgical procedures to determine coverage under the Act.

c. Opinion on the appropriateness of medical treatment.

d. Opinion on causation under Part E from a medical standpoint.

e. Opinion regarding the onset and period of illness-related disability for a wage-loss claim.

f. Opinion on impairment if the employee elects to have a DMC perform the rating.

g. DMC may interpret and clarify other physicians' reports, test results or technical language in complex cases or cases where the attending physician is deceased.

10. Role of CE in DMC Referrals. The CE maintains responsibility for the case and uses the services of the DMC only for direction and clarification. Under Part E, the CE must have fully evaluated toxic exposure including the use of Site Exposure Matrix (SEM) or referral to Industrial Hygienist (IH) prior to DMC referral.

a. CE determines when a DMC referral is required.

(1) The following are some examples of when a DMC referral may be required:

(a) The CE is unable to conclude whether pre-1993 medical evidence is sufficient to diagnose chronic beryllium disease.

(b) Medical tests are submitted which do not provide clear diagnosis or interpretation (e.g., an LPT that does not clearly state that the test is positive or negative).

(c) It is unclear if a medical condition not shown on the death certificate was a significant factor in causing, contributing to or aggravating an employee's death. For example, an employee dies of a heart condition, but the covered condition claimed by a survivor was asbestosis.

(d) To determine if the confirmed exposure to a toxic substance is linked to the illness claimed by the employee.

(2) The followings are examples of when a DMC referral may not be necessary:

(a) The CE determines other action, such as requesting additional records from the claimant or treating physician, may be more appropriate. In most

cases, a DMC referral is not necessary if the treating physician with the proper expertise provides plausible medical evidence that is well rationalized.

(b) The CE determines that additional evidence relevant to the DMC referral might be available through an Occupational History Interview or Document Acquisition Request. Once the relevant evidence is reviewed, a DMC referral may not be necessary, e.g., when there is no evidence of exposure to a toxic substance.

b. Referral to DMC. When referring a case to a DMC, the CE must provide the following to the Medical Scheduler as a complete package:

(1) A Medical Consultant Referral Form (Exhibit 1). The CE completes the entire form (except the name and address of the DMC, which the Medical Scheduler enters), signs it and places it on the front of the referral package. It is crucial that the CE selects the most appropriate preferred medical specialty to perform the review. The CE considers the following in determining the preferred medical specialty:

(a) Causation questions are usually best handled by occupational medicine specialists. Occupational medical specialists can also evaluate the diagnosis and treatment of occupational lung conditions, i.e. asbestosis, silicosis, CBD, pneumoconiosis, and COPD.

(b) Diagnosis or treatment questions are usually best handled by medical specialists for the condition or procedure being considered. Selecting generalist/internal medicine/family practice is appropriate if the condition involves a medical specialty not listed on the referral form. For example, heart problem, kidney problem or bone and joint problem should be directed to a generalist.

(c) Impairment questions are best performed by specialists with specific impairment experience for the particular organ system.

(2) A Statement of Accepted Facts (SOAF) (Exhibit 2), which is a narrative summary of the factual findings in a case. It must include:

(a) Identifying information, including the claimant's name, case file number and relevant personal information (e.g., date of birth, date of death, etc).

(b) A description of the medical evidence, including any accepted conditions or other diagnosed medical

conditions. Medical information in the case file that is not relevant to the referral need not be reiterated in the SOAF.

(c) A detailed description of the claimant's employment history and exposure data including any relevant information from Site Exposure Matrices (SEM) and opinion from the industrial hygienist (IH) referral.

(i) Where the employee worked, dates of employment, and his or her job title and duties if relevant to the referral.

(ii) Any exposure of the employee to toxic substances that are linked to the claimed medical condition.

(iii) Information about the nature, extent and duration of exposure.

(iv) Job descriptions or industrial hygiene records, if available. If not, data from the United States Department of Labor, Bureau of Labor Statistics, Occupational Outlook Handbook, found on the internet at: http://www.bls.gov/search/ooh.asp?ct=OOH

For example, using this site the CE might state, "The DOL Bureau of Labor Statistics has found that the job of *Boilermakers* and *boilermaker mechanics* is to make, install, and repair boilers, vats, and other large vessels that hold liquids and gases. Boilers supply steam to drive huge turbines in electric power plants and to provide heat and power in buildings, factories, and ships."

(d) General Requirements for SOAF:

(i) All evidence on which the SOAF is based must be part of the case record. The CE may not make findings based on undocumented evidence.

(ii) Facts must be complete and correctly stated. Omission of a critical fact or incorrect statement diminishes the validity of a medical opinion.

(iii) Facts must be specific as to time of occurrence. Whenever possible, workplace factors should be quantified so the physician can correlate the exposure with medical or scientific data on causality.

Quantification might include levels of exposure,

concentrations of asbestos fibers in the air, levels of noxious substances, the (approximate) number of times exposed, etc. Terms such as light, heavy, undue, severe, and abnormal should be avoided, since they are subject to great differences of interpretation.

(iv) Facts must be clearly stated. Simple words and direct statements reduce the potential for ambiguity or misinterpretation. Use of legal terms and program jargon should be avoided.

(v) Facts must be presented in an orderly manner, and grouped chronologically within sections relating to employment, exposures, and medical conditions.

(3) List of Questions for the DMC to address. (See Exhibit #3 for example)

(a) For referrals under Part B, questions should be specific to each statutory requirement for any of the compensable occupational illnesses.

(b) The CE must limit the questions to those that address the particular issue or problem for which clarification is required. Questions must be specific.

For example, in a pre-1993 CBD claim, a general question is, "Based upon your review of the enclosed medical evidence, do you feel that the claimant had CBD?" A specific question is, "Does the x-ray show characteristic abnormalities consistent with CBD?"

(c) For referrals under Part E, questions should identify the standard of proof required.

For example, rather than ask "Was asbestosis a cause of death?" the CE asks, "Is it at least as likely as not that asbestosis was a significant factor in causing, contributing to or aggravating the employee's death?"

(d) The CE is not to rely upon the DMC for any non-medical issues, for example requesting legal conclusions (e.g., whether the employee has cancer as defined by the EEOICPA).

(4) A Form OWCP-1500 (Health Insurance Claim Form), completed as outlined:

The CE or Medical Scheduler initially completes the following portions of Form OWCP-1500: Employee's name, address, date of birth, sex and SSN. (If the employee is deceased, the address section does not need to be

completed). Section 24C (type of service) and 24E (diagnosis code) must both be completed with a "1." The CE or Medical Scheduler must also enter an ICD-9 code in section 21 and a procedure code in section 24D. Exhibit 4 provides a list of ICD-9 codes and procedure codes that correspond to the type of medical service requested. For example, if the OWCP-1500 is for payment of a DMC file review for impairment, the CE enters ICD-9 code V49.8 in section 21 and procedure code FR004 in section 24D.

The DMC completes sections 24 A, F, G; 25; 28; 30; 31 and 33 and signs the bill. The completed form is given to the Medical Scheduler.

c. Post Referral to DMC. The Medical Scheduler advises the CE via email that the case has been sent to the DMC. The CE continues to monitor and track the file after the request has been sent to the DMC.

(1) If the DMC identifies exposure issues that require further development before he or she can render a medical opinion, the DMC must contact the Medical Scheduler within 7 days of receipt of the referral package. The Medical Scheduler advises the CE and the CE supervisor.

The CE and the supervisor evaluates the exposure issue as noted by the DMC to determine if the CE can pursue further exposure development or if an IH referral is warranted.

After development, the Medical Scheduler submits the IH report or additional exposure information to the same DMC to proceed with the medical evaluation. Once the issue has been resolved, the DMC has 21 days to return a completed report accompanied by a bill to the Medical Scheduler. If the DMC has further questions or is unable to proceed with rendering a medical opinion, the DMC must contact the Medical Scheduler.

(2) If the CE does not receive the medical report from the DMC within 30 days from the date of the completed referral, the CE notifies the Medical Scheduler, who follows up with a phone call to the DMC.

(3) Once the medical report and completed OWCP-1500 is received from the DMC, the CE reviews it for accuracy and completeness. The review should include the DMC's interpretation of test results, evaluation of medical reports submitted for review, answers to each question posed, and the DMC's rationale showing how his or her opinion is supported by the evidence in the file. The CE also reviews the OWCP-1500 to ensure that fees charged are appropriate to the services performed. The basic fee for file review and narrative medical report is $300 per hour.

DEEOIC has established $2,400 as limits for a file review. If a bill for medical file review is over $2,400, the CE must advise the District Director.

(a) If the medical report and OWCP-1500 are accurate, appropriate and complete, the CE contacts the Medical Scheduler to authorize payment of the medical bill no later than the next business day.

(b) If the report and OWCP-1500 are not accurate, appropriate or complete, the CE determines whether a telephone call to the DMC can resolve the deficiency. If not, the CE notifies the Medical Scheduler by memo or email, indicating the discrepancies or deficiencies. If necessary, the Medical Scheduler notifies the DMC and requests an addendum report and/or clarification of the fees charged.

d. ECMS. To ensure prompt payment of all physician referral bills (i.e. DMC, second opinion, referee or expert medical bills), ECMS must also be updated to set up the "prior approval" process through the medical bill processing agent (BPA). The CE enters the prior approval as if entering a new medical condition. The following fields in ECMS are required:

(1) Condition Type – Select 'PA', for prior approval

(2) ICD-9 Code – Enter the ICD-9 code that corresponds to the type of medical bill to be paid. The ICD-9 code entered in ECMS must match the ICD-9 code in the OWCP-1500 as specified in paragraph 10b(4). See Exhibit 4 for a list of ICD-9 codes.

(3) Status Effective Date - Enter the date of the physcial examination or the date of referral for file review.

(4) Eligibility End Date - Enter the date of the physcial examination for second/referee/expert opinions, or the date the DMC's response.

(5) Medical Condition Status – Change the medical condition status to 'A'.

e. Request for Report. If the claimant requests a copy of the DMC's report, the CE provides a copy of the report with a cover letter, which includes a disclaimer paragraph. For example, "Attached is a copy of the medical report that you requested. Please be advised that {Enter the DMC's name} is a medical consultant for the Department of Labor. The Department of Labor will make the final decision in this claim. Please do not contact {Enter the DMC's name} regarding this report. If you have additional evidence to submit in support of your claim or if you have any questions or concerns regarding this report, please contact me at {Enter the DO's toll free number}.

f. Advises the District Director or designee, through a CE or supervisor, of any problems with regards to the timeliness or quality of the DMC reports or complaints from the claimant.

11. Role of Medical Scheduler in DMC Referrals. Each District Director designates a Medical Scheduler, who processes and tracks DMC referrals and ensures prompt payment of the bills. The following are the Medical Scheduler actions:

a. Returns any incomplete DMC package to the CE with a memo in the front of the file listing the information needed.

b. If the DMC package is complete, emails designated National Office staff person on all referrals to an outside DMC. This email includes the employee's name, file number and the preferred DMC medical specialty requested. To ensure equitable distribution of work among the DMCs, the designated National Office staff person chooses a DMC from a master list and emails the Medical Scheduler the name of the assigned DMC, mailing address, phone number and email address.

c. Compares the list of treating physicians shown on the Consultant Referral Form to the assigned DMC from the National Office. If a DMC has been involved in the treatment of the claimant or if the DMC is not available to perform the review, the Medical Scheduler requests another DMC from the National Office.

d. Prepares a cover letter to the DMC after ensuring availability. The cover letter includes a description of the billing specifications (Exhibit 5). If the package does not contain a Form OWCP-1500, the Medical Scheduler completes one as outlined above.

e. Sends a copy of the cover letter, Medical Consultant Referral form, SOAF, List of Questions, medical records and OWCP-1500 to the DMC, and retains a copy of the cover letter and Medical Consultant Referral form outside the case file for tracking purposes.

If referral is to an internal DMC, the cover letter, Medical Consultant Referral form and copies of medical records need not be provided to the DMC. Rather, the entire file can be routed to the internal DMC, who can respond to the list of questions submitted based on review of the original SOAF and records contained in the case file.

(1) Includes an express mail envelope and air bill so that the external DMC can return the completed report and bill to the proper DO.

f. Notifies the CE via email once the package is mailed to the external DMC or the file is forwarded to an internal DMC.

g. Maintains a copy of the Form OWCP-1500 along with a copy of the medical report in a separate folder when the DMC responds within 30 days. The original medical report and OWCP-1500 are forwarded to the CE for review and inclusion in the case file.

h. Requests an addendum report if the CE cannot resolve

deficiencies in the DMC report directly with the DMC. The second request to the DMC for an addendum report must include:

(1) A cover letter to the DMC indicating the discrepancies as written by the CE.

(2) Copies of all medical evidence (or the case file for internal DMC referrals).

(3) The SOAF.

i. Submits approved OWCP-1500 and a copy of the DMC report to the BPA for processing upon confirmation by the CE that the DMC report and OWCP-1500 are complete and accurate. To ensure prompt payment of the medical bill, the Medical Scheduler or Fiscal Officer writes "Approved" in the top right hand corner of the OWCP-1500 with a signature and date in black ink. The OWCP-1500 must also be stamped PROMPT PAY in black ink, and the Prompt Pay date (date received in the DO plus 7 days) must be entered in block 11. The Medical Scheduler destroys the DMC report and OWCP-1500 once BPA has paid the bill.

j. Serves as the liaison between the DMC and DEEOIC claim staff. For example, if the DMC is unable to proceed with the medical review for any reason,(e.g., need for an IH referral, SOAF is incomplete, etc.), the DMC discusses the issue with the Medical Scheduler. The Medical Scheduler notifies the CE or the supervisor.

k. Notifies the District Director or assigned National Office staff person of any problems dealing with the DMC or a staff member of the DMC.

12. Second Opinion Examinations. Section 30.410 of the EEOICPA regulations states that:

OWCP sometimes needs a second opinion from a medical specialist. The employee must submit to examination by a qualified physician who conforms to the standards regarding conflicts of interest adopted by OWCP as often and at such times and places as OWCP considers reasonably necessary.

To prevent conflicts of interest, a DMC cannot serve as a second opinion physician. The databases for DMCs and second opinion physicians are separate and distinct.

a. Role of the CE.

(1) Determines when a second opinion is necessary and indicates the specialty of the second opinion physician required and, if necessary, the time period within which the examination is to take place.

(2) Ensures that all necessary medical information is sent to the Medical Scheduler. The same procedure for a referral to a DMC (see paragraph 10 above) including providing paperwork (Medical Consultant Referral Form,

SOAF, OWCP-1500, etc.) and prompt payment of second opinion medical bills will be followed. The exception is that the Medical Scheduler must call the second opinion physician to schedule a timely appointment. In addition, section 21 of the OWCP-1500 must be entered with ICD-9 code V68.2 and section 24D must be entered with the procedure code SEP01 for second opinion file review only or SEP02 for second opinion file review requiring physical examination (See Exhibit 4).

(3) Prepares a letter to the physician that lists the questions that he or she must specifically address. The CE must limit the questions to only those that address the particular issue or problem for which clarification is required.

(4) Calls the physician's office to ensure that the claimant has attended the appointment.

(5) Makes all required entries in ECMS for activities related to second opinion referrals (See paragraph 10d).

(6) Advises the District Director or designee, through a CE or supervisor, of any problems with regards to the timeliness or quality of the medical reports or complaints from the claimant.

b. Role of the Medical Scheduler.

(1) Follows the same procedure for a referral to a DMC (see paragraph 11 above) for completing and providing paperwork including prompt payment of second opinion medical bills.

(2) Schedules the second opinion medical appointment in accordance with the CE's request.

(a) The Medical Scheduler must make the appointment within a reasonable amount of time after initially requested by the CE.

(b) If the CE indicates a certain period within which the examination is required, the Medical Scheduler contacts the physician to see if the deadline can be accommodated. If not, another physician is selected, if possible.

(3) Selects the physician through the ACS web portal http://owcpstaff.dol.acs-inc.com under Provider Search link.

(a) To allow for the rotation of physicians used for second opinions, the DO must develop and maintain an internal tracking system (e.g., a spreadsheet) that the Medical Scheduler can use to identify when a

particular physician last provided a second opinion. It should be possible to add contact information as well.

If a physician subsequently states that he or she no longer wishes to be involved in the program, this information must be added to the system so the Medical Scheduler knows not to contact that physician.

(b) For jurisdictions that have small numbers of available physicians, it may be necessary to use the same second opinion physician on a more regular basis. This is acceptable as long as the physician has not been involved with any medical examinations of the claimant.

(4) Arranges for the examination within a reasonable distance from the residence of the employee, if possible. Unless unusual circumstances exist, the examination must be scheduled within 100 miles of the employee's residence. A distance of 25 miles or less is preferable. If extended travel is required, the arrangements and reimbursement are handled on a case by case basis.

(5) Ensures that the physician is enrolled in the EEOICPA program. A DEEOIC provider number is required before the physician can be paid. If the physician does not have a DEEOIC provider number, the Medical Scheduler must include a copy of the Provider Enrollment Form OWCP-1168 and the complete provider package with the letter sent to the physician. After the completed form is returned, the Medical Scheduler forwards it to the BPA, which provides the Medical Scheduler with a DEEOIC provider number for the physician.

(6) Contacts the physician to make sure he or she is willing to accept the employee for evaluation and schedules an appointment.

(7) Notifies the claimant, in writing, of the second opinion examination. The claimant must be notified at least 30 days prior to the scheduled appointment.

(8) Forwards the Form OWCP-1500, cover letter describing the billing specifications (Exhibit 6), list of questions for the second opinion physician to address, SOAF and any medical documentation.

(9) Enters a call-up for the CE in ECMS for the date of the appointment so the CE can call the physician to determine if the employee attended the appointment.

c. Role of the District Director/Designee.

(1) Evaluates complaints about specific physicians.

(2) Evaluates and reviews medical evaluations $2,400 or higher.

(3) Evaluates problems with the quality and timeliness of the physician's reports.

(4) Determines whether a physician should be removed or added to the pool of physicians to be considered for future examinations.

13. Referee Specialist Examinations. The same referral procedures are followed as a second opinion examination. However, section 21 of the OWCP-1500 must be entered with ICD-9 code V65.8 and section 24D must be entered with procedure code REF01 for referee referrals requiring only a file review or REFER for referee referrals requiring also a physical examination.

a. Regulatory Authority. Section 30.411(b) of EEOICPA states that:

> If a conflict exists between the medical opinion of the employee's physician and the medical opinion of either a second opinion physician or an OWCP medical adviser or consultant, or a qualified physician submitting an impairment evaluation; the OWCP shall appoint a third physician qualified in the appropriate specialty who conforms to the standards regarding conflicts of interest adopted by OWCP to make an examination. This is called a referee examination.

In most instances, careful weighing of the medical evidence should allow for resolution of the issues without having to resort to a referee or "impartial" specialist. However, where the weight of medical evidence is divided equally between the opinion of the treating doctor and that of the second opinion physician, a referee opinion must be obtained.

b. Value of Report. The probative value of the referee specialist's report, if sufficiently rationalized, is granted special weight. Usually, the opinion of a referee specialist constitutes the greater weight of the medical evidence of record.

c. Factors to Consider. The CE/Medical Scheduler should consider the following points with respect to referee medical examinations:

(1) A conflict of medical opinion must actually exist as determined by weighing the medical evidence. The CE must decide the relative value of opposing opinions in the medical record by considering all factors, to include each physician's specialty and qualifications, completeness and comprehensiveness of evaluations and rationale, and consistency of opinions.

(2) The questions to the referee medical examiner must be case-specific. Since this examination is made to resolve a particular conflict, the CE must ensure that the questions

to the physician are sufficiently detailed and narrow to resolve the conflict.

(3) The referee specialist's report, once received, must fulfill its intended purpose, i.e., it must resolve the conflict in medical opinion. Therefore, the CE must ensure that the referee specialist's report is comprehensive, clear and definite; that it is based on accurate information; and that it is supported by sound and substantial medical reasoning.

If the report is vague, speculative, or incomplete, or it does not contain sufficient rationale to justify the conclusion reached, it is the responsibility of the CE to secure a supplemental report from the referee specialist to correct the defect.

(4) If the referee specialist is unable or unwilling to provide a supplemental report, or if the supplemental report is still incomplete, vague, speculative or unjustified, the Medical Scheduler arranges for a second referee evaluation. This measure is undertaken with care, since a premature or inappropriate second referee examination would defeat the intent of Section 30.411 and could lead to a suspicion that OWCP is "shopping" for a physician whose opinions it prefers.

14. Failure to Undergo Medical Examination. Under the following circumstances, the adjudication process may be suspended for failure to undergo a medical examination.

a. Follow-up Action. If the employee is to be examined as part of a second opinion or referee examination, the CE contacts the physician’s office on the date of the examination to confirm the employee kept his or her appointment. If the employee was examined, the CE should expect a report within 30 days. This guideline also applies if a case is referred for a file review.

b. Failure to Appear. If the physician’s office reports that the employee did not appear for his or her scheduled appointment, the employee and any representative should be contacted by a documented phone call or in writing to request an explanation. If a reasonable explanation is provided, the CE re-schedules the examination, through the Medical Scheduler and sends written confirmation of the date, time and location of the rescheduled examination to the employee and representative, if any.

If the employee does not respond to the CE’s request for an explanation or if an explanation is provided and the CE determines good cause is not established, or if the employee fails to appear for the re-scheduled examination without good cause, the CE issues a letter advising the employee and representative that the issue to be resolved (i.e., adjudication of a consequential injury, request for

surgery, medical supply, etc.) cannot be further adjudicated until the medical examination is completed.

The CE suspends any further action to adjudicate the outstanding issue until the employee agrees to undergo a medical examination. This suspension does not affect the employee's entitlement to ongoing benefits for other medical conditions and/or treatments which have been accepted in the case.

Exhibit 1: Medical Consultant Referral Form

Exhibit 2: Statement Of Accepted Facts (SOAF)

Exhibit 3: Sample Questions for DMC

Exhibit 4: ICD-9 Codes and Corresponding Procedure Codes

Exhibit 5: Sample Letter to District Medical Consultant

Exhibit 6: Sample Letter to Second Opinion/Referee Physician

2-0900 Eligibility Criteria for Cancer and Radiation

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1. Purpose and Scope. This chapter discusses the procedures for determining whether an employee has been diagnosed with a covered cancer and the procedures for establishing causation as a result of exposure to radiation.

2. Identifying a Claim for Cancer. The Claims Examiner (CE) must first identify whether the claim is being made for cancer. If Form EE-1 or Form EE-2 is marked for a cancer, then a cancer claim is established. The claimant is expected to identify the specific type of diagnosed cancer on the claim form.

3. Covered Cancers. Energy Employees Occupational Illness Compensation Program Act (EEOICPA) regulations states that to establish a diagnosis of cancer, medical evidence must be presented which sets forth the diagnosis and the date of the diagnosis. The CE must verify that sufficient medical evidence is submitted to substantiate a diagnosis of cancer.

a. Diagnosis of Cancer. The case record must include medical report from a qualified physician that lists a cancer diagnosis. The cancer diagnosis must be based on the following evidence:

(1) Tissue examination is the most conclusive method for making a cancer diagnosis as it provides the physician with the following vital information regarding the tumor or lesion:

(a) The tissue of origin (where the tumor or lesion originated); and

(b) The benign, uncertain, or malignant status. Only malignant (cancerous) tumors/lesions are addressed in this chapter.

(2) Tissue examinations are described by the following methods:

(a) Pathology report (tissue has been removed from site);

(b) Surgical pathology report (organ, tumor, or lesion has been surgically removed);

(c) Autopsy report; or

(d) Post-mortem examination report.

(3) A diagnosis can sometimes be made based on one or more of the following methods which are listed in order of preference. If the CE is unable to determine an affirmative diagnosis based on the medical evidence submitted, the case may be referred to a District Medical Consultant (DMC).

(a) Cytology report describes cells obtained by scraping (e.g., from bone marrow), or by washing (e.g., fluid from lungs). An examination conducted by one of these cytology methods is generally less conclusive than tissue examination because the organization and extent of the tumor may not be as apparent. A positive cytology report would be a basis for further tests.

(b) Imaging (e.g., X-ray, CAT Scan, MRI) are the least specific type of tests in the diagnosis of cancer. Generally, X-rays are used as a basis for further tests. Radiology tests are extremely beneficial in determining the spread of cancer and/or determining the effects of cancer treatments.

(4) If the employee is deceased and none of the tests listed above were done, a survivor's claim will likely be based on official documents. In this situation the CE must attempt to obtain the documents listed below. Referral to a DMC should be made only if the CE is unable to determine an affirmative diagnosis.

(a) Hospital admission/discharge reports or physician's reports describing the tumor;

(b) Hospice records;

(c) If all efforts to obtain additional documents fail, a death certificate signed by a physician may be used to establish a cancer diagnosis. However, a death certificate alone should be used only as a last resort.

b. Diagnosis of Multiple Primary Cancers.

(1) If more than one primary cancer is identified in the medical evidence in the same organ with the same diagnosis date and the cancers are classified as the same type of cancer, all of the identified cancers are to be considered as only one primary cancer.

For example, if three biopsies are taken from the left breast on the same date and all are listed as infiltrating ductal carcinomas, the biopsies are to be considered as indicating only one primary cancer of the left breast.

However, if biopsies taken from the left breast on the same date indicate a lobular carcinoma and an infiltrating ductal carcinoma, these cancers are considered as two primary cancers, since the cancer types are different.

If a physician clearly notes that there are two (or more) separate primary cancers, the physician's interpretation prevails whether or not a pathology report confirms

multiple primary cancers.

(2) The above guidance applies only to multiple primary cancers of the same type in an organ. Situations involving bilateral organs are more complicated. Bilateral organs include the lungs, kidneys, adrenals, ovaries, and testes.

Biopsies taken from the left and right lungs might indicate the same type of cancer, e.g., non-small cell adenocarcinoma, in the right and left lungs. While one cancer may actually be metastatic from the other lung, without any indication in the pathology report or other medical evidence, it would be impossible to determine whether these two adenocarcinomas are two primary cancers or just one cancer.

Cases involving primary cancers identified in bilateral organs and classified as the same type of cancer should be referred to an oncologist DMC for review.

If biopsies identify two different cancers, e.g., a non-small cell adenocarcinoma in the right lung and an oat cell carcinoma in the left lung, these two carcinomas should be considered as separate primary cancers.

c. Date of Diagnosis. The date of initial diagnosis is required in any claim for cancer. The date of diagnosis is also a critical element used in the Interactive Radio-Epidemiological Program (IREP) for calculating the probability of causation (PoC). The employee's occupational exposure to radiation must be before the initial date of diagnosis for cancer in order for it to be compensable under Part B. While the date of diagnosis may be noted on Form EE-1 or Form EE-2, the CE must independently review all of the medical evidence submitted in a claim package to determine the earliest date of cancer diagnosis.

(1) When using a pathology report to determine the date of diagnosis, the date that the tissue is obtained should be used as the date of diagnosis. The pathology report must be signed by a physician.

(2) In certain claim situations, the CE will have to use reasonable discretion in the type of evidence that will be used to accept the date of diagnosis. For example, if the employee is deceased, and the only documentation available to support the diagnosis of cancer is the employee's death certificate signed by a physician, the CE may accept affidavits from survivor(s) and/or other individuals to establish that the cancer was diagnosed subsequent to the employee's initial exposure to radiation.

For example, a home health nurse might indicate in an affidavit his or her knowledge that on a specified date, a physician made a diagnosis of the employee's condition, as

well as the circumstances under which he or she acquired such knowledge. However, affidavits may *not* be used to establish the medical diagnosis itself, only the date of diagnosis.

d. Deficiency in Medical Evidence. The CE must advise the claimant of any deficiency in medical evidence and allow the claimant a period of up to 60 days to submit additional medical evidence.

4. Pre-Cancerous and Non-Malignant Conditions. With the types of diagnostic methods described above, some conditions, which could develop into cancer if left untreated, are being diagnosed and treated in the very early stages of development. If the medical evidence provided by the claimant establishes a diagnosis which demonstrates the condition is in a pre-cancerous stage of development or is non-malignant, the condition is not covered under this chapter and would not be covered under Part B. However, the CE may still need to develop for benefits under Part E for causal relationship between the pre-cancerous conditions or non-malignant conditions and toxic exposure.

5. Specified Cancers. Members of the Special Exposure Cohort (SEC) who are diagnosed with any of the 22 specified cancers are eligible for benefits without the need for a dose reconstruction. Eligible members of a SEC class have a presumption that the diagnosed specified cancer was caused by eligible SEC employment.

Meeting the criteria of the SEC does not guarantee survivor compensation under Part E. Under Part E, the evidence must also establish that the covered cancer caused, contributed to, or aggravated the death of the employee.

6. Non-SEC Cancers. Any primary cancer that cannot be considered as a specified cancer for a SEC claim is considered a non-SEC cancer. A primary cancer incurred by an employee at a non-SEC site is also considered a non-SEC cancer. In some cases, a cancer is identified by its secondary site because the primary site is unknown. In these cases, the primary site must be established by inference (see paragraph 17e). If the primary site that was established by inference is not considered a specified cancer, it is also considered a non-SEC cancer.

7. Non-SEC Cancer and Dose Reconstruction. Once the CE has determined that the employee has a diagnosed non-SEC cancer (other than chronic lymphocytic leukemia (CLL))and covered employment, the claim must be referred to the National Institute for Occupational Safety and Health (NIOSH) for a dose reconstruction to determine the PoC between the diagnosed non-SEC cancer and the dose potentially received during the covered employment. If CLL is the only diagnosed cancer, the CE does not send the case to NIOSH because NIOSH has identified CLL as a non-radiogenic cancer. However, the CE must still develop CLL for toxic substance exposure if there is a claim under Part E. Refer to paragraph 17i for further handling.

a. Claimant Not SEC Member. When a claim is filed based on SEC membership but the employee is not a SEC member (i.e. the employment was outside the designated SEC time period or the employee did not work the necessary workdays at the SEC site), the CE must forward the claim to NIOSH for dose reconstruction, as long as the employee was diagnosed with a cancer and has confirmed covered employment.

b. SEC Case with Award. For any SEC cases where an award has been made for a specified cancer, any non-SEC cancers for the case must be forwarded to NIOSH for dose reconstruction to determine eligibility for medical benefits. In these SEC cases, all cancers must be listed on the NIOSH Referral Summary Document (NRSD), including the specified cancer(s).

(1) An exception to this rule includes those SEC claims where a primary cancer which is not a specified cancer metastasizes to a secondary cancer site that is considered a specified cancer. For instance, prostate cancer (non-specified cancer) metastasizes to secondary bone cancer (specified cancer). If the bone cancer is accepted as a specified cancer under the SEC provision, both primary and secondary cancers (prostate and bone cancer) are accepted for medical benefits under Part B. However, per regulation 20 C.F.R. § 30.400, "payment for medical treatment of the underlying primary cancer…does not constitute a determination by OWCP that the primary cancer is a covered illness under Part E of the EEOICPA." As such, it may be necessary for the CE to refer the prostate cancer to NIOSH for dose reconstruction to determine eligibility for benefits under Part E for prostate cancer. In this situation, since the bone cancer is a secondary cancer with known primary site (prostate), it is not included in the NIOSH NRSD for dose reconstruction.

c. Multiple Skin Cancers. When a claimant provides evidence that the covered employee had a relatively large number of skin cancers, the CE will proceed as follows.

(1) Each malignant skin neoplasm (e.g., basal or squamous cell cancer) will be considered as a separate primary cancer, unless it is noted in the medical record that the neoplasm is a metastatic lesion.

(2) For NIOSH dose calculations, the date of diagnosis and the location (e.g. arm, neck, back) of the skin cancer are important and should be indicated in the medical section of the NRSD.

d. Multiple Primary Cancers for Other Organs/Locations. If more than one primary cancer location is identified for an organ in the medical records (e.g., multiple sites of primary cancer in the lung), the CE should note that fact in the medical section of the NRSD, including the cancer locations within the organ and the diagnosis

date. NIOSH will perform dose calculations for each primary cancer site in a specific organ. When NIOSH reports the dose reconstruction results, the CE will calculate PoC values for each of the primary cancers in that organ.

8. Preparing Non-SEC Cancer Claim Files for Referral to NIOSH. This preparation includes completion of a NIOSH Referral Summary Document (NRSD). The NRSD (Exhibit 1) is a tabular form containing the medical and employment information accepted by the CE as factual. This form provides NIOSH with the necessary information to proceed with the dose reconstruction process.

a. Instructions. Step-by-step instructions for completing the NRSD are included in Exhibit 2. Only the NRSD is approved for use in submitting a case to NIOSH.

b. Smoking History. The employee's smoking history is required for cases that include primary lung cancer (including primary trachea, bronchus, and lung) or for secondary cancer with an unknown primary cancer that includes lung cancer as a possible primary cancer.

(1) The method used to gather smoking history is Form EE/EN-8 (Exhibit 3).

(2) Upon receipt of the information from the claimant, indicate the smoking level (at the time of cancer diagnosis) using the designations shown in the NRSD. If the case evidence contradicts information obtained on the questionnaire, the CE should clarify the discrepancy with the claimant prior to referral to NIOSH.

(3) If the claimant does not return the initial questionnaire within 30 days, the CE must send a follow-up letter advising that the questionnaire must be returned within the next 30 days or the case will be administratively closed. After a total of 60 days has elapsed, the CE informs the claimant by letter that the case will be administratively closed under Part B. The case may still be developed for causation based on toxic substance exposure under Part E.

(a) If the CE can obtain the relevant information from the employee's medical records or Document Acquisition Request (DAR), the NRSD may be completed using that information and forwarded to NIOSH with an explanation of where the information was acquired.

c. Ethnicity. Employee's ethnicity is required for skin cancer cases.

(1) The method used to gather this information is Form EE/EN-9 (Exhibit 4).

(2) Upon receipt of the information from the claimant, indicate the ethnicity using the designations shown in the

NRSD.

(3) If the initial questionnaire is not returned by the claimant within 30 days, the CE must send a follow-up letter advising that the questionnaire must be returned within the next 30 days or the case will be administratively closed. After a total of 60 days has elapsed, the CE informs the claimant by letter that the case will be administratively closed.

If the CE can obtain the relevant information from the employee's medical records or DAR, the NRSD may be completed using that information, and forwarded to NIOSH with an explanation of where the information was acquired.

d. Case Referred to NIOSH.

(1) The evidence in file must support any finding made by the CE and documented in the NRSD. The CE must make a copy of the NRSD and place it in the case file.

(2) A copy of the entire case file is forwarded with the NRSD to NIOSH.

(3) The CE advises the claimant in writing that the case has been sent to NIOSH for dose reconstruction (Exhibit 5).

9. Preparing Amendments to NRSD for Non-SEC Cancer Claims. Sometimes CEs obtain additional information on a case after it has been referred to NIOSH but before the completion of the dose reconstruction. This includes new information related to the employee's employment, new medical condition(s), or other survivor-related information.

When new information become available, this information must be forwarded to NIOSH so it is available for dose reconstruction. The CE must include the portion of the NRSD that has changed based on new evidence reviewed by the District Office (DO). Mark "Amendment" on the top of the NRSD and include the employee's name, DOL case number, NIOSH tracking number, and DOL Information (including the Senior CE or journey level CE's signature). The CE clearly identifies and separates any "Amendment" NRSDs from NRSDs that are submitted with the DO's weekly package to NIOSH.

a. NIOSH Reports. NIOSH provides weekly reports to the DOs listing the cases for which the NIOSH contractor started performing dose calculations in the past week. The CE responsible for the case(s) listed on the report must review the information in the case file against the information sent to NIOSH in the NRSD. Any revisions to information contained in the original NRSD must be forwarded to NIOSH using an amended NRSD. This will allow NIOSH to use the correct information in its dose reconstruction.

b. "Supplement" NRSD. If the CE needs to submit additional

evidence to NIOSH, such as additional medical information for the same reported cancer, this must be submitted using a NRSD with "Supplement" marked, and only the DOL case number, NIOSH tracking number, and employee's name need be included. A supplemental NRSD should be used only for a submission that does not change the original information in the NRSD. Clearly mark any supplemental packages and separate them from NRSDs that are submitted with the DO's weekly package to NIOSH.

10. Cases Pended While at NIOSH. During the dose reconstruction process, NIOSH may place a case in a "pend status" for technical reasons. Examples may include: the addition of time to a facility's covered period; a technical dose reconstruction issue for a facility; or a change to a site profile, based on the identification of additional dose data.

Placement in pend status does not stop the dose reconstruction process, but may delay completion of the dose reconstruction. Placing a case in a pend status alerts the NIOSH staff that clarification is needed on a specific issue that may affect the dose reconstruction. DOL is not necessarily notified of a case placed in pend status for technical reasons or when these issues are resolved.

11. Cases Pulled While at NIOSH. During the dose reconstruction process, it may be necessary for NIOSH to contact the CE to resolve a discrepancy, or request clarification. Normally this contact is via e-mail or telephone. All contact from NIOSH is to be handled as quickly as possible, and a response provided within three working days. If the question cannot be answered without further development, the CE advises NIOSH of the steps being taken and an approximate time frame for completion.

In cases where further development is needed as determined by NIOSH or DOL, NIOSH pulls the case from the dose reconstruction process and advises the CE by email. NIOSH may also pull a case to allow DOL to determine if a case can be accepted under a SEC class. Since a pulled case stops the dose reconstruction process, the CE must proactively develop the case so the dose reconstruction process can proceed or a decision can be rendered on a SEC case.

a. Cases Pulled by DOL. When DOL determines that further development is needed before a dose reconstruction can proceed, the supervisor, Senior CE (or journey level CE), or DO NIOSH liaison sends an e-mail (with copies to the other two DO staff) to the NIOSH Public Health Advisor (PHA) with a request that NIOSH pull the case status while DOL develops the case for additional information. The CE must advise the claimant in writing when a case is pulled by DOL from the dose reconstruction process.

(1) The e-mail briefly explains the specific information the DO is attempting to clarify or obtain, e.g., employment, medical, smoking or race/ethnicity

questionnaire, etc.

(2) On receipt of the development information, DOL staff notifies the appropriate NIOSH PHA (with copies to the other two DO staff) by e-mail of the resolution of the issue and requests that the case be removed from pulled status. The DO must also prepare and forward, as necessary, an amended NRSD containing the new information. The CE must also advise the claimant in writing that the case is removed from pulled status and dose reconstruction may proceed.

b. Cases Pulled Due to SEC. NIOSH may identify cases submitted for dose reconstruction that should be considered for inclusion in a SEC class, typically when a new SEC class is designated. NIOSH pulls these cases from the dose reconstruction process and returns these cases with the dose reconstruction analysis records in the form of a CD to the appropriate district office for further development. NIOSH also sends a letter advising the claimant that his or her claim is being returned to DOL for adjudication.

If DOL identifies a case that qualifies under the SEC provision but was not pulled by NIOSH from the dose reconstruction process, the CE, through the Senior CE (SrCE) or journey level CE, notifies the appropriate NIOSH PHA via e mail to return the dose reconstruction analysis records for further development. In these cases, the CE will send a letter to the claimant advising that the case is pulled from the dose reconstruction process for evaluation under the SEC provision.

If it is determined that the case does not qualify for the SEC class, the CE, through the SrCE or journey level CE, notifies the appropriate NIOSH PHA via e-mail to proceed with the dose reconstruction. The CE prints a copy of the "sent" e-mail for inclusion in the case file. The e-mail includes a brief statement explaining why the case should proceed with dose reconstruction, e.g., non-specified cancer, insufficient latency period or does not meet the 250-work-day requirement. In addition, the CE notifies the claimant by letter that the case is returned to NIOSH for dose reconstruction and the reason(s) it does not qualify for the SEC class. The CE also sends a copy of this letter to NIOSH.

12. NIOSH Actions. Upon receipt of a claims package from DOL, NIOSH takes several actions to determine the employee's radiation dose.

a. Request DOE Records. These records will include radiation dose monitoring and radiation exposures associated with the employment history.

b. Interview the Claimant(s). The purpose of the interview(s), also known as the Computer Assisted Telephone Interview (CATI), is to identify any additional relevant information on employment history and develop detailed information on work tasks and radiological

exposures.

c. Apply Dose Reconstruction Methods. This allows NIOSH to estimate radiation doses for workers seeking compensation for cancer who were not monitored or inadequately monitored, or whose records are missing or incomplete for exposure to radiation at a Department of Energy (DOE) or Atomic Weapons Employer (AWE) facility.

d. Conduct Closing Interview. After providing the claimant with a copy of a draft dose reconstruction report, NIOSH conducts a closing interview with the claimant to review the dose reconstruction results and the basis upon which the results were calculated. This is the claimant's final opportunity during the dose reconstruction process to correct or provide additional information that may affect the dose reconstruction.

e. Obtain Signature on Form OCAS-1. Subject to any additional information provided by the claimant, the claimant is required to sign and return Form OCAS-1 to NIOSH within 60 days, certifying that he or she has no additional information and that the record for dose reconstruction should be closed.

Upon receipt of the signed Form OCAS-1 and completion of any changes in the dose reconstruction resulting from new information provided, NIOSH forwards a final dose reconstruction report, "NIOSH Report of Dose Reconstruction under EEOICPA", to DOL and to the claimant.

(1) NIOSH does not forward the dose reconstruction report to DOL for adjudication without receipt of Form OCAS-1 signed by the claimant or an authorized representative of the claimant.

(a) The claimant's signature on Form OCAS-1 does not mean that the claimant agrees with the dose reconstruction. Rather, the claimant is agreeing to the process and that he or she provided NIOSH with all relevant evidence.

(b) If the claimant or the authorized representative fails to sign and return Form OCAS-1 within 60 days, NIOSH will administratively close the dose reconstruction and notify DOL of this action after notifying the claimant or the authorized representative.

(c) Upon receiving this notification by NIOSH, the CE must also administratively close DOL's claim by entering a "NO" in the case status screen, since DOL cannot determine the PoC, a necessary step in adjudication of the claim, without a dose reconstruction estimate produced by NIOSH. The CE enters the date of receipt of the NIOSH letter (date stamp) as the status effective date.

(d) If the employee meets the employment requirements, prior to entering the administratively closed code ("NO") in Part E ECMS, the CE must determine if a causal link exists between the claimed illness and exposure to toxic substances (other than radiation) at a DOE facility or certain RECA facility. If no causal link is established, the CE places a "Memo to the File" explaining the sequence of events and then administratively closes the case in ECMS Part E.

(e) The CE must advise the claimant by letter that the case is closed. If the claimant later decides to sign the Form OCAS-1, he or she will be required to notify DOL, after which the claim will be referred back to NIOSH for reopening. The claimant should be advised that DOL cannot complete adjudication without NIOSH's findings.

(f) If additional information is submitted, NIOSH will review the evidence, prepare a new dose reconstruction report, and send a new Form OCAS-1 to the claimant and allow for an additional 60-day comment period.

(2) If the case has multiple claimants, NIOSH will wait 60 days for receipt of all signed Forms OCAS-1. If, after 60 days, NIOSH does not receive Form OCAS-1 from any of the claimants, NIOSH will administratively close the dose reconstruction and notify DOL of this action after notifying the claimants or the authorized representatives. The CE must also administratively close DOL's claim in accordance with paragraph 12e(1). If, after 60 days, NIOSH receives only one signed Form OCAS-1, NIOSH will forward the dose reconstruction package to DOL.

(a) The CE writes to the claimant(s) who did not sign Form OCAS-1 and ask why he or she did not sign Form OCAS-1. The claimant(s) should be asked to provide this information within 30 days. The CE should consider any arguments given by the claimant(s), and if substantive, refer the case back to NIOSH. Substantive arguments may include discovery of additional relevant information related to dose reconstruction, e.g., information or documents concerning radiological exposures, other co-workers, or operations and radiological controls at the specific facility.

(b) If arguments for refusals to sign are not provided or not substantive, or if no response is received within 30 days, the CE should issue a

Recommended Decision (RD) awarding (or denying) benefits to all eligible claimants (even those claimants who did not sign the form). One signed Form OCAS-1 is sufficient to proceed with issuing a decision.

13. Receipt of Dose Reconstruction Results from NIOSH.

a. Content of NIOSH Report. The "NIOSH Report of Dose Reconstruction under EEOICPA" provides the information that the CE needs to perform a PoC calculation, which is necessary to render a decision on the claim. The NIOSH report includes the following information:

(1) Annual dose estimates related to covered employment for each year from the date of initial radiation exposure at a covered facility to the date of cancer diagnosis;

(2) Separate dose estimates for acute and chronic exposures, different types of ionizing radiation, and internal and external doses, providing dose information for the organ or tissue relevant to the primary cancer site(s) established in the claim;

(3) Uncertainty distributions associated with each dose estimated, as necessary;

(4) Explanation of each type of dose estimate included in terms of its relevance for estimating PoC;

(5) Identification of any information provided by the claimant relevant to dose estimation that NIOSH decided to omit from the basis for dose reconstruction, justification for the decision, and if possible, a quantitative estimate of the effect of the omission on the dose reconstruction results; and

(6) A summary and explanation of information and methods applied to produce the dose reconstruction estimates, including any factual findings and the evidence upon which those findings are based.

b. NIOSH CD. When the case is returned to DOL, NIOSH will forward all case file documents via compact disc (CD), since all documents referred to NIOSH and used in the dose reconstruction are optically scanned into the NIOSH computers. NIOSH will uniquely identify (on the label on the CD case) the employee's Social Security number. The CD will include the dose reconstruction input file (Excel spreadsheet) to be used for calculating the IREP probability of causation. The NIOSH CD should be kept with the case file.

(1) Information contained on the NIOSH CD will include:

(a) Dose reconstruction files, CATI; dosimetry data; the NIOSH Report of Dose Reconstruction under EEOICPA; NIOSH's PoC calculation; Form OCAS-1; the

NIOSH-IREP input file; and pertinent Atomic Energy Commission (AEC)/DOE reports, journal articles or other documents.

(b) Correspondence, including NIOSH letters to claimants, phone conversation notes, and e-mails.

(c) DOE files (data files listed in order of importance on the CD), including DOE dose and work history information and other DOE documents that NIOSH requested, such as incident reports and special studies.

(d) DOL files, including a copy of the case file optically imaged by NIOSH and the OCAS tracking sheets (signatures and dates).

(2) NIOSH will incorporate all important information from the above sources into the dose reconstruction report. Publicly available documents will be referenced by citation. Documents not publicly available will be placed in the record and, as noted above, will be included on the CD.

(3) The CE need not review all of the documents on the CD. Those documents that normally will not require review include the DOE documents, the claimant interview, the NIOSH-run PoC calculation, and the NIOSH-conducted closing interview.

NIOSH runs the PoC calculation to reduce the time needed to complete the dose reconstruction, and the PoC results are incorporated into the dose reconstruction findings. NIOSH's IREP run is used for its internal purposes only, and the CE should not use NIOSH's IREP calculations as a basis for a determination in the claim. The CE must always run the IREP separately.

(4) NIOSH will have the pertinent documents (dose reconstruction report, other records of import to the CE) in a directory titled "A_DR Files" so that the CE can include those documents in the hard copy for review. The CE prints the dose reconstruction report and the signed Form OCAS-1 and includes them in the case file.

After running the PoC calculation, the CE prints and retains a hard copy of the DOL IREP run in the case file.

c. NIOSH Unable to Perform Dose Reconstruction. In some cases, it may not be possible for NIOSH to complete a dose reconstruction because of insufficient information to reasonably estimate the dose potentially received by the employee. In these situations, NIOSH notifies any claimant for whom a dose reconstruction cannot be completed and describes the basis for this finding. NIOSH forwards its determination to DOL and the CE issues a Recommended Decision

(RD) to deny the claim based on NIOSH's inability to complete the dose reconstruction.

The CE notes in the decision the claimant may pursue the SEC petition process per 42 C.F.R. Part 83.13 or 83.14. The claimant has the opportunity to seek administrative review of this result after a Final Decision to deny the claim.

14. Review of Claim for Rework of Dose Reconstruction. The CE must compare the dose reconstruction (DR) report to the evidence in the case file. If there are any significant discrepancies or changes between the information in the case file and the DR report, including erroneous or incomplete information, or for which new information was recently received, the CE must determine if rework may be necessary.

Significant discrepancies or changes would include, for example, additional cancer identified or changed cancer site, changed employment facilities or dates, different ICD-9 code, or change in date of cancer diagnosis.

a. Cancer Changes Rework.

(1) If additional cancer(s) is identified after the DR is performed and:

(a) PoC is less than 50%, the CE submits a rework request to the DEEOIC Health Physicist.

(b) PoC is 50% or greater, a rework is not required. All additional primary cancers would be eligible for medical benefits. The CE documents the newly identified cancer(s) in the case file and notifies the NIOSH PHA of the additional cancer(s) so NIOSH can update their records.

(2) If two or more primary cancers are addressed in the DR, and it is later determined that one or more of the cancers should not have been included in the DR (e.g., the cancer was found to be a recurrent cancer or an erroneously reported cancer) and:

(a) PoC is less than 50%, a rework is not required. The PoC for the remaining cancers will still be below 50%. The CE should: use the PoC as calculated as the PoC of record and note appropriately; document the discrepancy between the cancer(s) identified in the DR and those determined by DOL to be cancers in the case file and in the RD; and notify the NIOSH PHA of the change to the cancer(s) status so NIOSH can update its records.

(b) If PoC is 50% or greater, submit a rework request to the DEEOIC Health Physicist. Also, if a primary cancer addressed in the DR is subsequently found to be a secondary cancer with an unknown

primary, or an in-situ cancer, submit a rework request to the DEEOIC Health Physicist.

DOs cannot substitute newly identified cancers or additional cancers not used in the DR, or their diagnosis dates, for incorrectly reported cancers found in the DR.

b. Smoking and Race/Ethnicity Changes Rework. If information related to race/ethnicity or smoking history changes after the DR is performed, the CE should re-run IREP using the revised information. A rework is not required except for the following:

(1) If the PoC is initially below 45% and then increases above 50% or greater after re-running IREP using the revised information, the CE submits a rework request to the DEEOIC Health Physicist.

(2) If the PoC was above 50% and the change reduces the PoC below that threshold, the CE submits a rework request to the DEEOIC Health Physicist.

c. ICD-9 Code Changes Rework. Changes can affect the internal and/or external dose models used in the DR and/or the IREP model. Accordingly, the CE submits a rework request for changes in ICD-9 codes, other than those exceptions listed below, to the DEEOIC Health Physicist. If the ICD-9 code changes *within* the following series, no rework is required (e.g., 188.8 to 188.5):

Series	Cancer	Internal (IMBA) Organ	External Organ	IREP Model
151	Malignant Neoplasm Stomach	Stomach	Stomach	Stomach
152	Malignant Neoplasm Small Bowel	Small Intestine	Stomach	All digestive
154	Malignant Neoplasm Rectum/Anus	LLI	Colon	Rectum
156	Malignant Gallbladder /Extra hepatic	Gallbladder	Bladder	Gallbladder
157	Malignant Neoplasm Pancreas	Pancreas	Stomach	Pancreas
161	Malignant Neoplasm Larynx	Extra-thoracic (ET2)	Esophagus	Other Respiratory
162	Malignant	Lung	Lung	Lung

	Neoplasm Trachea/Lung			
174	Malignant Neoplasm Female Breast	Breast	Breast	Breast
175	Malignant Neoplasm Male Breast	Breast	Breast	Breast
180	Malignant Neoplasm Cervix Uteri	Uterus	Uterus	Female genitalia less ovary
182	Malignant Neoplasm Uterus Body	Uterus	Uterus	Female genitalia less ovary
186	Malignant Neoplasm Testis	Testes	Testes	All male genitalia
188	Malignant Neoplasm Bladder	Bladder	Bladder	Bladder
232	Carcinoma in situ skin	Skin	Skin	Malignant Melanoma **AND** Non-melanoma skin-Squamous cell

(1) For ICD-9 code 232.0, if the type of cancer is specified by DOL (Malignant melanoma or Non-melanoma skin-Squamous cell), NIOSH will use only the specified IREP model. If the cancer is not specified, NIOSH will run both IREP models and the model which results in the highest PoC will be used.

(2) This table is excerpted from NIOSH document ORAUT-OTIB-0005, "Internal Dosimetry Organ, External Dosimetry Organ, and IREP Model Selection by ICD-9 Code".

d. NIOSH-IREP Changes Rework. If the ICD-9 code changes, but the organs used by NIOSH for calculating internal and external dose remain the same (only the IREP model organ changes), the DO should request direction by the DEEOIC Health Physicist for instructions to rerun IREP for the proper IREP cancer model (organ).

e. Diagnosis Date Changes Rework. The net effect of a change in the diagnosis date depends mostly on the type of cancer, the worker's age at the time of diagnosis, and whether or not the year of diagnosis falls within the latency period for development of cancer

(which, in turn, varies by IREP cancer model). Depending on the factors listed above, it is possible for an earlier diagnosis date to result in an increase in the PoC. For changes to the diagnosis date:

(1) When the PoC is less than 40% and,

(a) The diagnosis date is in the same calendar year, a rework is not required.

(b) If the diagnosis date is found to be outside the calendar year (either earlier or later), the CE submits a rework request to the DEEOIC Health Physicist.

(2) When the PoC is between 40% and 49.99%, and there is any change to the diagnosis date, the CE submits a rework request to the DEEOIC Health Physicist.

(3) When the PoC is 50% or greater,

(a) If the diagnosis date is found to be later, but still within the same calendar year, a rework is not required.

(b) If the diagnosis date is found to be outside the calendar year (either earlier or later), the CE submits a rework request to the DEEOIC Health Physicist.

(c) The CE documents the difference in the diagnosis date in the case file and ensures that the difference in the diagnosis date used in the DR is noted in the RD.

(d) The CE notifies the NIOSH PHA of the change in the diagnosis date so NIOSH can update its records.

f. Employment Changes Rework.

(1) If the PoC is 50% or greater and additional DOL-verified employment is identified, a rework is not required.

(2) If the PoC is 50% or greater and the DOL-verified employment is found to be less than that used in the DR, the CE submits a request for rework to the DEEOIC Health Physicist for review, and includes an electronic copy of the DR report.

(3) If the PoC is between 40% and 49.99%, and additional DOL-verified employment is identified, the CE submits a request for rework to the DEEOIC Health Physicist for review, and includes an electronic copy of the DR report.

(4) If the PoC is less than 40%, and additional DOL-verified employment is identified:

(a) If all the additional employment falls within the same calendar year and the year is addressed in the DR, a rework is not required.

(b) If the additional employment extends into, or is wholly within another calendar year not addressed in the DR, the CE submits a rework request to the DEEOIC Health Physicist.

(5) Some DRs contain more employment than originally verified by DOL in the NRSD. NIOSH may have DOE dosimetry or employment records for periods not identified by DOL, or the DR may use a continuous period rather than considering numerous breaks in employment.

(a) If the case is likely non-compensable, NIOSH may add the additional time period to the DOL-verified employment for the purpose of completing a dose reconstruction (unless it is military, navy nuclear or non-DOE federal service)in a timely manner.

(b) If the PoC is less than 50% and the DR contains employment added by NIOSH, a rework is not required. However, the CE must write a memo to file that DOL did not verify part of the employment period assumed by NIOSH, but that the employment period was assumed correct for the purpose of completing the DR in a timely manner.

Should new information arise to warrant performing the dose reconstruction again (e.g., additional cancer diagnosis, additional employment at another site), only employment verified by DOL will be used, which may be more restrictive than that allowed in the current DR. This must also be explained in the RD.

If NIOSH has added employment to a claim that is likely compensable, NIOSH must contact the CE with the additional employment information for DOL review and verification. After verification the CE must submit an amended NRSD to NIOSH.

(c) If the PoC is 50% or greater and the DR contains employment added by NIOSH but not approved by the DO, the CE submits a rework request to the DEEOIC Health Physicist.

(6) If military, navy nuclear, or non-DOE federal service is identified in the DR, the CE submits a rework request to the DEEOIC Health Physicist.

(7) For any PoC, if changes to the employment site(s) are identified, the CE submits a rework request to the DEEOIC Health Physicist.

(8) When a rework is not required, the CE must still document the changes to the employment in a memo to file and ensure that the difference(s) between the employment used in the DR compared to the DOL-verified employment is noted in the RD. Finally, the CE notifies the NIOSH PHA of the change(s) in employment so NIOSH can update its records.

g. Additional Survivors (Claimants) Identified Rework.

(1) If the PoC is 50% or greater, NIOSH does not need to interview any newly identified claimants. A rework is not required.

(2) If the PoC is less than 50%, NIOSH will interview the new claimant(s), at the claimant(s)' request, to determine if there is some information that could significantly affect the DR and therefore prompt the submission of a rework request to the DEEOIC Health Physicist.

15. Procedures for Requesting Rework. For cases in which the CE determines that a rework is necessary, the CE must e-mail the Supervisory CE (SCE), SrCE or journey level CE with the Amended NRSD (ANRSD) attached, noting the issues with the DR.

a. A copy of the e-mail message (printed from the sent file to document the date of issue) must be placed in the case file.

(1) Use an e-mail subject that is specific to the individual rework request. For example: last four digits of DOL ID, NIOSH ID Number, DO, and "Rework", i.e., *1234-NIOSH ID #123456-Denver-Rework*.

(2) Briefly summarize how the current NIOSH DR was performed. Include the employment history used by NIOSH in the DR; the cancer(s), ICD-9 code(s) and diagnosis date(s) used in the DR, and the PoC resulting from this information used in the DR.

(3) Describe the reason(s) for the rework request. For example, an additional cancer has been verified, the wrong cancer was reported in the NRSD, the primary cancer was determined for a secondary cancer reported as an "unknown primary," more or less employment was determined, or the diagnosis date for one of the cancers in the DR was found to be incorrect.

(4) Determine whether the employment history and cancer information listed on the DR Coversheet is the exact information used by NIOSH in the DR. If the information reported in the NRSD does not match the information stated on the DR Coversheet, review the DR report, particularly in the sections "Dose Reconstruction Overview," and

"Information Used", where NIOSH describes in more detail the information used to complete the DR. This text may resolve an apparent discrepancy.

(5) Refer to Exhibit 6 for examples of rework requests and types of information needed.

b. An amended NRSD is prepared as necessary.

c. The PoC value is not entered in ECMS when a case is referred back to NIOSH. If a PoC value is already entered, the CE deletes the previous PoC value.

d. The DEEOIC Health Physicist serves as the central liaison between NIOSH and DOL on all issues related to dose reconstruction. If the SCE, SrCE or journey level CE agrees with the CE's e-mail findings regarding rework, he or she must forward the CE's e-mail along with the amended NRSD to the DO NIOSH liaison. In turn, the DO NIOSH liaison sends the request along with the amended NRSD to the DEEOIC Health Physicist and copies the CE, SCE, SrCE or journey level CE, and District Director.

(1) The DEEOIC Health Physicist reviews the request for rework and determines whether a rework is required.

(2) If additional information is needed to make a determination, which may include requesting the case file, the DEEOIC Health Physicist contacts the CE.

e. Rework Not Needed. If the DEEOIC Health Physicist determines that information would not change the outcome of the DR, he or she will send an e-mail to the DO NIOSH liaison, with a copy to the CE, or SCE, and District Director, explaining the rationale for not continuing the review of the DR. When the CE receives this response, he or she must print the e-mail for the case file and proceed with the IREP calculation and enter the PoC value(s) into ECMS.

(1) Updating Records. Any changes made to a case with a DR, regardless of whether the case is submitted for a formal rework review by a DEEOIC Health Physicist, should be documented in the case file and should reference the guidelines used to make that determination.

When the DO makes changes to information used in the NIOSH DR, and no rework is required, the DO NIOSH liaison or other designated person sends an e-mail to the appropriate NIOSH PHA. This e-mail must indicate what information was changed, such as the ICD-9 code, cancer name, employment dates, etc.

This allows NIOSH to update its records for the case, which is most critical with respect to changes involving ICD-9 codes and PoC values different from those initially generated by the dose reconstruction. Forwarding these changes also allows NIOSH to more accurately compile

statistics on the types of cancers addressed in EEOICPA decisions that required a NIOSH DR.

If a new PoC calculation was performed using new information without the need for rework, the DO NIOSH liaison must advise the NIOSH PHA via e-mail and attach the new IREP summary file. For example, in a case with an initial PoC less that 45%, the DEEOIC Health Physicist determined that a change in the ICD-9 code did not require a rework of the dose reconstruction, but just a different NIOSH-IREP model run. If the new IREP run resulted in a PoC less than 45%, the CE may use the new IREP run and PoC as the value for the dose reconstruction but must advise NIOSH as noted above.

(2) If the DEEOIC Health Physicist has determined that a rework is not necessary, but discrepancies appear to exist between the NIOSH dose reconstruction and DOL's analysis of the DR and subsequent calculation of the PoC (e.g., one or more cancers were subsequently deemed not covered, changes in the diagnosis date, differences in NIOSH employment dates and DOL-verified employment dates) the CE addresses the discrepancies in the RD.

(3) Any future DR rework based on additional verified cancer(s) or employment will be performed using only DOL-verified information, which may be more restrictive than information used in the previous DR (i.e., in some likely non-compensable cases, NIOSH may assume a continuous employment period rather than considering numerous breaks in employment for purpose of completing a DR in a timely manner). Therefore, it is possible in some cases for the subsequent PoC to remain the same, increase only slightly, or even decrease to some degree if the DR is reworked in the future.

f. Rework Needed. If the DEEOIC Health Physicist determines that a rework is necessary, he or she will e-mail the CE, SrCE or journey level CE, SCE, District Director and the DO NIOSH liaison to proceed. In certain non-standard rework requests, the DEEOIC Health Physicist will also copy the designated NIOSH Office of Compensation Analysis and Support (OCAS) contact person(s) on the e-mail. The CE must place a copy of the e-mail in the case file.

(1) The CE must take the following actions:

(a) Forward the amended NRSD as an electronic attachment via e-mail to the NIOSH PHA assigned to the DO.

(b) Send a letter to the claimant (Exhibit 7) explaining that the case has been returned to NIOSH for a review of the dose reconstruction.

(c) Send a copy of this letter to the appropriate NIOSH PHA along with the weekly DO submissions to NIOSH. The dates on the amended NRSD and the letter to the claimant must be the same, since this will be the date used for the new status code entry into ECMS.

g. After a new draft dose reconstruction (DR) report is completed, NIOSH will send it to the claimant along with another Form OCAS-1. The claimant has 60 days to sign and return the form.

16. Reviews of Dose Reconstruction. If the claimant objects to NIOSH's decision on the results of the dose reconstruction, the objection must be filed with the FAB. FAB evaluates the factual findings upon which NIOSH based the dose reconstruction. All objections related to dose reconstruction must be sent to a DEEOIC Health Physicist for review, unless the objections are solely related to factual findings, i.e., whether the facts upon which the dose reconstruction report was based were correct.

a. Factual Objection: If the HR or CE determines that the factual evidence reviewed by NIOSH was properly addressed, the HR or CE accepts NIOSH's findings, in which case no referral to a DEEOIC Health Physicist is necessary. However, if the HR or CE determines that NIOSH did not review substantial factual evidence, he or she contacts a DEEOIC Health Physicist to determine if a rework of the dose reconstruction is necessary.

If the DEEOIC Health Physicist determines that a rework of the dose reconstruction is necessary, the HR or CE then remands the case to the DO for referral to NIOSH for a rework.

b. Technical Objection: A technical objection may involve either methodology or application of methodology. Examples of methodology of dose reconstruction may include but is not limited to analyzing specific characteristics of the monitoring procedures in a given work setting; identifying events or processes that were unmonitored; identifying the types and quantities of radioactive materials involved and using current models for calculating internal dose. The NIOSH "efficiency" process of using overestimates and underestimates in dose reconstruction is another example of a methodology. Upon receipt of the technical objection(s), the HR or CE discusses it with his or her supervisor to obtain approval to submit the objection(s) for DEEOIC Health Physicist review. Following are steps taken to track technical objections submitted for DEEOIC Health Physicist review:

(1) The HR or CE prepares a memo to the DEEOIC Health Physicist that identifies only the dose reconstruction-related technical objections (not including any factual objections).

(2) The HR or CE attaches electronic version of the memo (in addition to the NIOSH dose reconstruction report, IREP

summary for each cancer and CATI summary for each claimant from the NIOSH disc) to an e-mail message addressed to the DEEOIC Health Physicist with copies to the FAB supervisor and FAB support team. The e-mail message should contain the following information in the subject line: the HR or CE's FAB office location; "Tech Obj"; the last 4 digits of the claim #; and the name of the covered facility, e.g., (FAB NO) Tech Obj-4112(Hanford).

(3) The HR or CE spindles the memo in the file and documents ECMS Notes to explain that supervisory approval has been granted and that the aforementioned actions have been completed.

(4) Upon receipt of the technical objection(s), the DEEOIC Health Physicist determines whether the technical objection is one of application or methodology. Methodology used by HHS in arriving at reasonable estimates of the radiation doses received by an employee, established by regulations issued by HHS at 42 CFR Part 82, is binding on FAB. Objections concerning the application of that methodology (20 CFR § 30.318) is referred by the DEEOIC Health Physicist to NIOSH for their opinion. NIOSH is asked to respond within 30 days. The DEEOIC Health Physicist then sends his or her written opinion (and NIOSH's opinion, if any) to FAB. Upon receipt of the DEEOIC Health Physicist's review of technical objections, the HR or CE spindles the responses in the file. If the case needs to be reviewed by NIOSH, the FAB will be instructed to remand the case back to the DO for referral to NIOSH.

17. Proving Causation Between Diagnosed Non-SEC Cancer and Covered Employment. Under Part B, a covered employee seeking compensation for cancer, other than as a member of the SEC seeking compensation for a specified cancer, is eligible for compensation only if DOL determines that the cancer was "at least as likely as not" (that is, a 50% or greater probability) caused by radiation doses incurred in the performance of duty while working at a DOE facility and/or an Atomic Weapons Employer (AWE) facility.

This includes radiation doses from medical X-rays for the pre-employment physical examination, annual physical examinations, and a termination (exit) physical examination, but does not include radiation to which the employee may have been exposed during airline flights, as such exposures are not incurred from activities at the sites.

EEOICPA does not include a requirement limiting the types of cancers to be considered radiogenic; CLL is considered non radiogenic pursuant to HHS regulation.

a. NIOSH-IREP. The CE must use the updated version of radioepidemiological tables developed by the National Institutes of

Health as a basis for determining PoC. This software program, named the NIOSH-Interactive RadioEpidemiological Program (NIOSH-IREP), is based on NIOSH regulations found at 42 C.F.R. Part 81. NIOSH-IREP allows the CE to apply the National Cancer Institute risk models directly to data on individual claimants.

b. Uncertainty. NIOSH-IREP allows the CE to take into account uncertainty concerning the information being used to estimate PoC. There typically is uncertainty about the radiation dose levels to which a person has been exposed, as well as uncertainty relating to levels of dose received to levels of cancer risk observed in study populations.

Accounting for uncertainty is important because it can have a large effect on the PoC estimates.

c. Credibility Limit. As required by the Act at Section 7384n(c)(3)(A), the NIOSH-IREP uses the upper 99 percent credibility limit to determine whether the cancers of employees are at least as likely as not caused by their occupational radiation doses. This helps minimize the possibility of denying compensation for those employees with cancers likely to have been caused by occupational radiation exposures.

d. Guidelines. Specific guidelines concerning the calculation of the PoC for certain cancers are noted below.

(1) Carcinoma in situ (CIS), or cancers in their early stages, are not specifically included in NIOSH-IREP models. These lesions are becoming more frequently diagnosed, as the use of cancer screening tools, such as mammography, has increased in the general population. The risk factors and treatment for CIS are frequently similar to those for malignant neoplasms, and, while controversial, there is growing evidence that CIS represents the earliest detectable phase of malignancy. Therefore, for purposes of estimating PoC, carcinoma in situ (ICD-9 codes 230-234) should be treated as a malignant neoplasm of the specified site.

Current NIOSH guidance on which IREP models to run for in situ squamous cell carcinoma (SCC) skin cancer is contained in Table 4, "Cancer Models to be Used in the Calculation of Probability of Causation," in the NIOSH-IREP Technical Documentation. The guidance in the table directs the use of two models for in situ skin cancer cases. For the ICD-9 code 232 series the CE must use the IREP models for both malignant melanoma and non-melanoma skin-squamous cell.

When a physician specifically identifies the in situ skin cancer as squamous cell carcinoma (SCC), the IREP guidance in the above-mentioned tables is not applicable and the CE must run the SCC model only. If not so identified, then

the CE continues to run both models for in situ skin cancers.

(2) For other cancers requiring the use of NIOSH-IREP, the CE must assume that neoplasms of uncertain behavior (ICD-9 codes 235-238) and neoplasms of unspecified nature (ICD-9 code 239) are malignant, for purposes of estimating PoC.

e. Cancers for Which the Primary Site is Unknown. Some claims involve cancers identified by their secondary sites (sites to which a malignant cancer has spread), where the primary site is unknown.

(1) This situation most commonly arises when death certificate information is the primary source of a cancer diagnosis. It is accepted that cancer-causing agents, such as ionizing radiation, produce primary cancers. In a case in which the primary site of cancer is unknown, this means that the primary site must be established by inference to estimate PoC.

(2) For background purposes, Exhibit 8, which is reproduced from Table 1 in 42 C.F.R. Part 81, indicates, for each secondary cancer, the set of primary cancers producing approximately 75% of that secondary cancer among the U.S. population (males and females were considered separately). NIOSH performs the dose reconstruction for the cancer site that yields the highest PoC.

If the PoC yields a PoC greater than 50%, all of the secondary cancers are covered for medical benefits even if no dose reconstruction was performed for that secondary cancer.

f. Cancers of the Lymph Node. The CE must consider all secondary and unspecified cancers of the lymph node (ICD-9 code 196.0) as secondary cancers (those resulting from metastasis of cancer from a primary site). For claims identifying cancers of the lymph node, Exhibit 8 provides guidance for assigning a primary site and calculating the PoC using NIOSH-IREP.

g. Claims With Two or More Primary Cancers. For these claims, DOL uses NIOSH-IREP to calculate the estimated PoC for each cancer individually. The CE then performs an additional statistical procedure following the use of NIOSH-IREP to determine the probability that at least one of the cancers was caused by radiation (discussed further in the NIOSH-IREP procedures). This approach is important to the claimant because it determines a higher PoC than is determined for either cancer individually.

For cases involving multiple primary cancers where the PoC is greater than 50%, all of the primary cancers will be covered for medical benefits.

h. Claims for Leukemia. Sometimes NIOSH guidance requires that two or three NIOSH-IREP models be run for a particular cancer. This most

often occurs with different types of leukemia. NIOSH only includes the NIOSH-IREP input and associated summary sheet providing the highest PoC in the "DR Files" on the disk sent to the DO.

i. Claims for Chronic Lymphocytic Leukemia (CLL) Only. CLL is a form of leukemia not found to be radiogenic in studies conducted worldwide of a wide variety of radiation-exposed populations. Therefore, pursuant to HHS regulations, the PoC for CLL is assigned a value of zero. The CE will insert Exhibit 9 into the file for the record. Exhibit 9 is a letter from NIOSH that states the Department of Health and Human Services (HHS) guidelines for determining the PoC for CLL. Since CLL has a PoC of zero, the CE adjudicates the claim without sending the case to NIOSH. The RD must contain a reference to the DHHS regulations and cite 42 C.F.R. § 81.30 denying compensation benefits under Part B of the Act.

(1) In cases where there are multiple primary cancers including CLL, and the PoC is greater than 50%; medical benefits will be covered for CLL. When CLL is diagnosed after an award has been made for a greater than 50% PoC, medical benefits are paid for CLL.

(2) CLL may be compensable under Part E of the Act. The CE must determine if causation can be established for CLL and exposure to toxic substances other than radiation under Part E.

18. Calculation of PoC Using NIOSH-IREP Computer Program. DOL must calculate the PoC for all cancers, except CLL, using NIOSH-IREP. The risk models developed by the National Cancer Institute and the Center for Disease Control for NIOSH-IREP provide the primary basis for developing guidelines for estimating PoC under EEOICPA. They directly address 33 cancers and most types of radiation exposure relevant to claimants covered by EEOICPA.

a. NIOSH Cancer Models. The NIOSH Cancer Models take into account the employee’s cancer type, year of birth, year of cancer diagnosis, and exposure information such as years of exposure, as well as the dose received from gamma radiation, X-rays, alpha radiation, beta radiation, and neutrons during each year. A glossary of cancer descriptions for each ICD-9 code is provided in 42 C.F.R. Part 81 and is reproduced as Exhibit 10.

b. Smoking History and Racial/Ethnic Identification. The risk model for lung cancer takes into account smoking history. The risk model for skin cancer takes into account the race or ethnic identification of the claimant. (However, it does not consider exposure to sunlight, since sunlight is not a toxic substance.)

None of the risk models explicitly account for exposure to other occupational, environmental, or dietary carcinogens. For cases with lung (primary or secondary, with unknown primary) or skin cancer, the CE must determine the smoking history or race or ethnic

identification of the claimant.

c. Risk Models. NIOSH-IREP is specifically designed for adjudication of claims under EEOICPA and incorporates cancer risk models that have been modified to reflect the radiation exposure and disease experiences of employees covered under EEOICPA.

d. NIOSH-IREP Operating Guide. The CE must use procedures specified in the NIOSH–IREP Operating Guide to calculate PoC estimates under EEOICPA.

The guide provides step-by-step instructions for the operation of NIOSH–IREP. The procedures include entering personal, diagnostic, and exposure data; setting/confirming appropriate values for variables used in calculations; conducting the calculation; and obtaining, evaluating, and reporting results. There are two user guides, one for cases with a PoC less than 45% or greater than 52%; and another, termed the Enterprise Edition, for cases with PoCs of 45% to 52%. Enterprise Edition cases can be identified by looking at the Excel input file name which would include the notation "EE."

(1) For cases with a PoC less than 45% or greater than 52%, the CE accesses NIOSH-IREP on the NIOSH website at http://198.144.166.6/irep_niosh/ to perform the PoC calculation. The CE must use data from the CD for the NIOSH-provided input file for each cancer.

After the IREP calculation is completed for each cancer, the CE prints out the NIOSH-IREP PoC results directly from the web page and retains it in the case file. The copy shows the web page address and date at the bottom, which documents that the CE independently ran the IREP.

When two or more cancers are present, the CE uses the multiple primary cancer equation to calculate the total PoC, and saves this report as a hard copy.

(2) For cases with POCs between 45% and 52%, another software program, called the NIOSH-IREP Enterprise Edition (NIOSH-IREP-EE), is used to perform the PoC calculation. The website address for the program, the User's Manual, and the password (which NIOSH will change every few months), is available by contacting the DOL Health Physicist.

The Enterprise Edition is used for this PoC range to achieve better statistical precision and further reduces the chance of denying a claim because of sampling error.

In summary, the simulation sample size will be increased to 10,000; 30 additional IREP runs will be performed using a new random number seed for each run; and the average value of the upper 99% credibility limit (CL) of the 30 runs (PoC) will determine the claim outcome.

(a) To facilitate the 30-run process, another Excel

input file is used specifically for this software. This input file contains all the claims data found in the regular NIOSH-IREP input file, but are preset with 30 different random number seeds and a simulation sample size of 10,000.

(b) NIOSH will provide this preset file (or files, if there is more than one primary cancer) for each claim that falls into the PoC range. To perform the required calculations, this input file need only be uploaded once into NIOSH-IREP-EE.

(c) After the CE uploads the file and clicks the "Generate 30 Results" button, the input is submitted to the NIOSH-IREP-EE server where the calculations are to be performed. Upon completion, the results are displayed in the form of IREP Summary Report. They will include the average value of the upper 99% CL of the PoCs for the 30 results.

(d) While the CE waits for the results to be returned, the computer may be used for other tasks. However, clicking on an internet link in an e-mail while the file is running will disrupt the calculation process. To access the internet while waiting for the calculations to be performed, a new and separate instance of the browser should be opened.

(e) Since some calculations could take over two hours to complete, it may be best to run the NIOSH-IREP-EE at the end of the day to allow the computer to process overnight. When complete, the calculations will remain on the CE's screen to be printed and saved the next morning.

(3) For multiple primary cancers (or secondary cancers with no known primary), the CE performs the NIOSH-IREP-EE calculation for each cancer. As with the standard NIOSH-IREP, the PoC results must be printed and placed in the case file.

19. Establishing Causation for Cancer Under Part E. Coverage under Part E is limited to confirmed DOE contractor employees or RECA Section 5 uranium workers who contracted any diagnosed illness (this Chapter focuses on cancer) after beginning employment at a DOE facility or a RECA Section 5 facility. Certain RECA Section 4 eligible claimants who have not received any Section 4 benefits may also be eligible for EEOICPA benefits if otherwise eligible under EEOICPA. To establish causation under Part E, evidence must show that it is "at least as likely as not" that the exposure to a toxic substance (which may include radiation) at a DOE facility or certain RECA facilities was a significant factor in causing, contributing to, or aggravating the covered illness. In certain cases, there is a

presumption of causation under Part E.

a. Presumption of Causation:

1. Approved Part B Conditions. Medical conditions approved under Part B are given a presumption of causation under Part E. As such, an acceptance for a medical condition under Part B will correlate to an automatic acceptance under Part E for the same medical condition.

2. DOE Physician's Panel. If, under former Part D, a DOE physician's panel finding signed by a DOE official provides the opinion that the employee sustained an illness or died due to a toxic substance at a DOE facility, the CE accepts the determination for causation under Part E.

3. SEC Cases. A determination that an employee is entitled to compensation based on meeting the criteria required under SEC establishes causation for that cancer under Part E (non-SEC cancers must be developed for causation). However, for claims involving survivors, evidence must establish that the covered cancer was a significant factor that caused or contributed to the death of the employee.

4. RECA Section 5. Conditions approved under Part B based on a RECA Section 5 awarded to a living employee will correlate to an automatic acceptance under Part E to the same living employee for the same medical condition. However, survivors of Section 5 RECA award recipients, and survivors who are award recipients in their own right, must submit the requisite documents to establish survivorship eligibility under Part E. All Part E survivorship rules apply to RECA survivors.

b. Causation Development of Non-SEC Cancer Cases. Under Part E, non-SEC cancer cases without presumption of causation are developed for causation by evaluating the causal nexus between the cancer and potential occupational exposure to radiation and/or other toxic substances at a covered facility. While development actions for radiation and other toxic substances (non radiation) exposures have distinct paths, they are undertaken concurrently to determine whether or not a claimant meets the causation test under Part E.

(1) When developing a cancer claim for causation due to radiation, the CE refers the case file to NIOSH for dose reconstruction in accordance with the instructions in this Chapter. The CE must determine whether or not the cancer is "at least as likely as not" related to the verified covered employment at a DOE or RECA facility. The "at least as likely as not" causation standard is met if the PoC is 50% or greater.

Part E claims based on RECA Section 5 employment that are

for cancers other than those accepted by DOJ (i.e., lung cancer) are also referred to NIOSH for dose reconstruction and determination of the PoC.

(2) In conjunction with the dose reconstruction, the CE develops the Part E cancer claim for causation based upon toxic substance other than radiation.

(3) A cancer claim may meet the causation test by either means:

(a) If the dose reconstruction results in a PoC of 50% or greater, the CE issues a RD to accept the claim under Part B and/or Part E. In a survivor case, the CE must also establish that the covered cancer was at least as likely as not a significant factor that caused, contributed to or aggravated the death of the employee.

(b) If the CE is able to establish toxic exposure causation and no Part B benefits are claimed, the CE renders a factual determination as to acceptance under Part E only and issues the RD. If the case is pending at NIOSH for a dose reconstruction, the CE pulls the case file from NIOSH without waiting for the dose reconstruction to be completed. For example, a claimant is the survivor of a uranium miller covered under Section 5 of the RECA. The claimant is seeking survivorship benefits under Part E based upon a claim of esophageal cancer. No Part B benefits are being sought, as the survivor was awarded Part B benefits as a RECA Section 5 beneficiary, and is not eligible for Part B benefits under the esophageal cancer claim. In this case only Part E benefits are sought for the cancer claim, and should the CE establish a causal link between the esophageal cancer and exposure to a toxic substance at a RECA mine, the claim can be immediately accepted and withdrawn from NIOSH without waiting for the dose reconstruction.

If, however, Part B benefits are also claimed, the case file remains at NIOSH until the dose reconstruction is complete so a RD can be issued for both Parts B & E at the same time.

(4) In certain instances a physician might opine that a claimant’s radiation and toxic substance exposure together worked in tandem to produce a synergistic or additive effect that brought about the cancer. DOL has not found scientific evidence establishing a synergistic or additive effect between radiation and exposure to a toxic substance, and if the physician presents this finding he or she must provide actual scientific or medical research evidence to

support the finding before the CE may consider the assertion.

If a physician makes this assertion, the CE requests that the physician provide medical evidence of a synergistic or additive effect and a clearly rationalized medical opinion as to whether or not the effect is significant enough to establish that the combination of the radiation and the exposure to a toxic substance was "at least as likely as not" a significant factor in aggravating, contributing to, or causing the cancer.

If the physician provides rationalized scientific evidence revealing a synergistic or additive effect, the DO sends the case file to NO for review by a NO Health Physicist (HP), Toxicologist and/or the DEEOIC Medical Director. The HP reviews the physician's report and all evidence of file and makes a recommendation as to causation.

Exhibit 1: NIOSH Referral Summary Document (NRSD)

Exhibit 2: Instructions for Completing the NRSD

Exhibit 3: Smoking History Request, Form EE/EN-8

Exhibit 4: Ethnicity Request, Form EE/EN-9

Exhibit 5: NIOSH Referral Letter to Claimant

Exhibit 6: Examples of Rework Request

Exhibit 7: Review of Dose Reconstruction Letter to Claimant

Exhibit 8: Primary Cancer Sites

Exhibit 9: HHS Chronic Lymphocytic Leukemia Guideline Letter

Exhibit 10: Glossary of ICD-9 Codes and Their Cancer Descriptions

2-1000 Eligibility Criteria for Non-Cancerous Conditions

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1. Purpose and Scope. This chapter describes the criteria necessary to establish eligibility for non-cancerous conditions covered under Part B and/or Part E of the EEOICPA and the development of their causal relationship with toxic substance exposure at a covered Department of Energy (DOE) or Radiation Exposure Compensation Act (RECA) Section 5 facility.

Any covered occupational illness under Part B has the potential to be a covered illness under Part E, but that conversely, a covered illness under Part E is not necessarily a covered occupational illness under Part B.

2. Approved Part B Illnesses. Occupational Illnesses approved under Part B are given a presumption of toxic substance exposure and causation at a DOE or RECA Section 5 facility under Part E. In all instances when issuing a Part E Recommended Decision based on an already issued Part B acceptance, the CE only uses the findings of the original Part B Final Decision. This includes the establishment of verified covered employment, diagnosed medical condition(s), and survivor relationship to the deceased employee, if applicable. However, survivors approved under Part B also need to establish eligible survivorship under Part E and that it is "at least as likely as not" that the exposure to a toxic substance was a significant factor that aggravated, contributed to, or caused the employee's death.

Part B acceptances for atomic weapons employees, beryllium vendor employees, and DOE federal employees do not receive the above causation presumption because they are not covered under Part E. The exception to this is if the employee worked at an atomic weapons employer (AWE) facility or with a beryllium vendor (BV) that was designated as a DOE facility for remediation and the employee worked for the remediation contractor.

3. Identifying Claimed Condition as Part B, Part E, or Both. The CE first determines whether the type of claim filed is for employee benefits (i.e., Form EE-1) or for survivor benefits (i.e., Form EE-2). Then the CE reviews the condition(s) claimed, either marked or written on the form, and determines whether the claimed condition is potentially covered under Part B, Part E, or both.

Those conditions covered under Part B are beryllium sensitivity, chronic beryllium disease, chronic silicosis, and cancer. Under Part E, all conditions (not symptoms of a condition) are covered, including those covered under Part B. This includes, but is not limited to, diagnosed cancers, respiratory illnesses, cardiac illnesses, and also mental illnesses that originate from a physical condition, such as a neurological condition.

In order to accurately identify a claimed condition as covered under Part B, Part E, or both, the CE must also consider the claimed employment. Two examples describing this two-fold consideration are provided below.

a. Chronic Silicosis. For chronic silicosis coverage under Part B, the employee has to be a DOE or DOE contractor employee who was present for an aggregate of at least 250 work days during the mining of tunnels at a DOE facility located in Nevada or Alaska for tests or experiments related to an atomic weapon. However, for consideration of coverage under Part E, chronic silicosis is not subjected to this specific employment requirement; only that there is covered DOE contractor employment.

b. Covered Part E Employment Requirement. As further described in paragraph 2 above, regardless of the condition being claimed under Part E, coverage is not afforded to those employees who worked as atomic weapons employees, beryllium vendor employees, or as DOE federal employees. The exception to this is if the employee worked at an AWE facility or with a BV that was designated as a DOE facility for remediation and the employee worked for the remediation contractor. However, this employment stipulation is not applicable when the CE considers if the claimed condition is covered under Part B.

Therefore depending upon the condition and employment claimed, the CE develops each condition according to its respective criteria under Part B and/or Part E of the Act.

4. Proof of Covered Employment for Beryllium Illness.

a. Under Part B. To satisfy the employment and causation requirements, the evidence needs to establish either (1) that the employee had at least one day of verified employment at a DOE facility during a period when beryllium dust particles, or vapor may have been present at the facility; or (2) that the employee was present for at least one day at a DOE facility, or a facility owned and operated by a beryllium vendor,

b. Under Part E. To satisfy the employment and causation requirements under Part E, the employee must meet the same requirements as stated above for Part B, but the employee must be a DOE contractor or subcontractor employee.

5. Beryllium Sensitivity. Beryllium sensitivity is an allergic reaction of the immune system to the presence of beryllium in the body as a result of inhaling dust particles or fumes from beryllium. The evidence required to establish beryllium sensitivity is described under 42 U.S.C. §73841(8)(A) and the CE develops the beryllium claim accordingly, verifying whether or not the medical evidence submitted by the claimant is sufficient.

a. Testing. A claimant establishes beryllium sensitivity under Part B and/or Part E by submitting the results of either one beryllium lymphocyte proliferation test (BeLPT) or one beryllium lymphocyte transformation test (BeLTT), performed on blood or lung lavage cells, which shows abnormal or positive findings. A claimant can also establish beryllium sensitivity by submitting the results of

one beryllium patch test, which shows a positive reaction.

b. Evaluation. The abnormal BeLPT/BeLTT or beryllium patch test is evaluated by a physician, with his or her findings specifically outlined (e.g., abnormal response to beryllium). A BeLPT/BeLTT or beryllium patch test exhibiting a "borderline" result is not sufficient to establish beryllium sensitivity.

The CE does not attempt to interpret the findings of the BeLPT/BeLTT or the beryllium patch test. If the test is not accompanied by a physician's interpretation, the CE obtains the interpretation from the physician who performed the test. If the testing physician is not available, the CE obtains an evaluation from another qualified physician (e.g., a District Medical Consultant (DMC)).

c. False Negative Results. If the claimant has a history of steroid use, a false negative result on the BeLPT/BeLTT or the beryllium patch test can occur. If there is evidence that this has occurred, then the CE requests that the employee undergo a repeat BeLPT/BeLTT or beryllium patch test. If the claimant is deceased, the CE should try to obtain as much information as possible on past LPT results and possible steroid use. If exhaustive efforts produce little or no results and the evidence of record contains the normal/borderline LPT result along with a biopsy of the lung tissue showing the presence of granulomas, the CE may accept the claim.

d. Definitions. A BeLPT/BeLTT is defined as a laboratory test that examines how a type of disease-fighting blood cell, called a lymphocyte, reacts to beryllium. The blood cells' reaction to beryllium determines whether the test results are normal or abnormal. If the cells do not react very strongly to beryllium, the test result is normal; if the cells react very strongly to beryllium, the test result is abnormal.

The Bronchoalveolar Lavage Beryllium Lymphocyte Proliferation Test (BAL BeLPT) is defined as a laboratory test performed on lung tissue that is washed from the lungs. The lung wash contains lung tissue that is obtained via an intranasal insertion of a bronchoscope into the lung. When the bronchoscope is lowered into the lower lung, a saline solution is washed into the airways and retrieved (lung washing). The retrieved solution is cultured in the presence of beryllium salts. A reaction or response to the beryllium salts represents a lymphocytic process and is sufficient to establish beryllium sensitivity.

e. Benefits Under Part B. Once the medical, employment, and causation criteria have been met for a beryllium sensitivity claim under Part B, the employee is awarded medical monitoring, treatment, and therapy for the condition effective on the date of filing. Unlike for CBD, no lump sum compensation is awarded for beryllium sensitivity under Part B.

f. Benefits Under Part E. Once the medical, employment, and

causation criteria have been met for a beryllium sensitivity claim under Part E, the employee is awarded medical monitoring, treatment, and therapy for the condition effective on the date of filing. In addition, the employee is eligible for lump sum compensation for impairment and/or wage loss if the criteria for those benefits are met. If found entitled, in addition to the $125,000 survivor benefit, the survivor may also receive lump sum compensation for wage loss.

6. Established Chronic Beryllium Disease (CBD) Before 1993, Part B. The evidence required to establish a claim for established chronic beryllium disease (CBD) under Part B of the Act is described under 42 U.S.C. §7384l(13). Whether to use the pre- or post-1993 CBD criteria depends upon the totality of the medical evidence, including when the employee was tested for, diagnosed with, and/or treated for a chronic respiratory disorder.

If the earliest dated document showing that the employee was either treated for, tested or diagnosed with a chronic respiratory disorder is dated prior to January 1, 1993, the pre-1993 CBD criteria may be used. If the earliest dated document is dated after January 1, 1993, the post-1993 CBD criteria may be used. If the employee sought treatment before 1993 and the document verifies that the treatment was performed prior to January 1, 1993, but the document is dated on or after January 1, 1993, the pre-1993 CBD criteria may be used.

To establish pre-1993 CBD, the medical documentation must include at least three of the following: characteristic chest radiographic (or computed tomography (CT)) abnormalities; restrictive or obstructive lung physiology testing or diffusing lung capacity defect; lung pathology consistent with CBD; a clinical course consistent with a chronic respiratory disorder; or immunologic tests showing beryllium sensitivity (e.g., skin patch test or beryllium blood test preferred).

a. Characteristic Chest Radiograph (X-ray). In a chest X-ray, rays are emitted through the chest and the image is projected onto film, creating a picture of the image. Characteristic chest X-ray findings are identified by the following:

(1) Small round areas of opacity distributed throughout all of the lung fields. Mixtures of round and irregular areas of opacity are also often seen.

(2) Other characteristic X-ray findings include interstitial lung fibrosis, interstitial or pleural fibrosis (i.e., pleural fibrosis alone is not sufficient, as there has to be other findings present), and granulomas (i.e., non-calcified and non-caseating).

(a) Caseating granulomas are sometimes considered characteristic; however, the treating physician or a DMC needs to review these findings for a

determination. The term "caseating" identifies necrosis (i.e., decay) in the center of a granuloma. This term was originally applied to a granuloma associated with tuberculosis or a fungal infection. A non-caseating granuloma is one without necrosis and is characteristic of CBD.

(b) Calcification in a granuloma is usually associated with the healing of the granuloma. A calcified granuloma is not characteristic of CBD.

(3) Coarse linear fibrosis is sometimes found with advanced CBD which results in progressive loss of lung volume.

b. Characteristic Computed Tomography (CT) Scan. A Computed Tomography (CT) scan uses X-rays to produce detailed pictures of structures inside the body. Each X-ray pulse lasts only a fraction of a second and represents a "slice" of the organ or area being studied. A CT scan is sometimes referred to as a CAT (computed axial tomography) scan. CT scan abnormalities indicative of CBD include the following:

(1) Consolidation, ground glass, septal thickening, diffuse nodules (different distributions), interstitial fibrosis, bronchiectasis, and honeycombing.

(2) Other CT scan findings include parenchymal nodules, septal lines, patches of ground-glass attenuation, bronchial wall thickening, and thickening of the interlobular septa. Nodules are often seen clustered together around the bronchi or in the subpleural region. Subpleural clusters of nodules sometimes form pseudo plaques. In advanced CBD, large subpleural cysts are sometimes found.

c. Radiographic Patterns. The following list represents radiographic (X-ray/CT) patterns characteristic of CBD:

Chest X-ray	CT/*HRCT
Alveolar Patterns	*Alveolar Patterns*
- Consolidation	- Consolidation
- Ground glass	- Ground glass
Interstitial Patterns	*Interstitial Patterns*
- Reticular (irregular lines)	- Septal thickening
- Diffuse Nodules	- Diffuse Nodules
- Reticulonodular	(different distributions)
- Ground glass	
Interstitial Fibrosis	*Interstitial Fibrosis*

- Honeycombing
- Traction Bronchiectasis
- Upper lobe retraction
- Honeycombing

**HRCT = high-resolution computed tomography*

In CBD claims, which contain the above-listed abnormalities, the DEEOIC staff accepts these diagnostic findings as either being characteristic of or denoting abnormalities consistent with CBD.

d. Restrictive or Obstructive Lung Physiology Testing or Diffusing Lung Capacity Defect. Obstruction, either severe or mild, is the most common abnormality found by spirometry. Severe obstruction prevents complete exhalation (i.e., air trapping). A definitive diagnosis of restriction (e.g., reduced lung volumes) through spirometry is not made without lung volumes. Generally, the pulmonary function studies include the physician's interpretation of whether there is restriction or obstruction.

e. Arterial Blood Gas (ABG). An ABG test is not used in lieu of a pulmonary function test. There are many factors involved in interpreting an ABG test. If the CE is unable to obtain a pulmonary function test and the ABG test is the only test available, the treating physician or a DMC needs to review the ABG test results along with the medical evidence of record to determine whether it is indicative of a restrictive or an obstructive lung physiology. An ABG test result generally does not show a diffusing lung capacity defect.

f. Pathology Report. A lung pathology that is consistent with CBD is generally identified as such in the interpretation provided by the physician within the pathology report. If no interpretation is provided, or if the CE is unsure whether the findings are consistent with CBD, the CE obtains clarification from the treating physician or a DMC.

g. Clinical course consistent with chronic respiratory disorder may include the following disorders and methods of treatment:

(1) Hypoxemia requires supplemental oxygen and supplies.

(2) Air flow obstruction (e.g., COPD, Emphysema) and Asthma/wheezing-like symptoms require inhalers (e.g. Flovent, Advair, Serevent, Albuterol, etc.), corticosteroid drugs, bronchodilators, and oxygen therapy.

(3) Right heart failure, *Cor pulmonale*: Cardiology consult and subsequent management, diuretics (e.g. Lasix, HCTZ, Spironolactone, etc.), supplemental oxygen.

(4) Pulmonary Hypertension: Cardiology consult and subsequent management, supplemental oxygen.

(5) Respiratory infections (Pneumonia, Acute bronchitis): Antibiotics, sputum cultures, blood cultures, sometimes bronchoscopy.

(6) Sarcoidosis: corticosteroid drugs, such as prednisone.

h. Immunologic Tests. Examples of immunologic tests that establish beryllium sensitivity include skin patch tests and beryllium blood tests which involve the interaction of antigens with antibodies.

7. Established Chronic Beryllium Disease On/After January 1, 1993, Part B. The medical documentation needs to include an abnormal BeLPT/BeLTT performed on either blood or lung lavage cells or a positive beryllium patch test, in addition to evidence of lung pathology consistent with CBD. Proof of lung pathology consistent with CBD includes, but is not limited to: a lung biopsy showing granulomas or a lymphocytic process consistent with CBD; a computerized axial tomography (CAT) scan showing changes consistent with CBD; or a pulmonary function or exercise test showing pulmonary deficits consistent with CBD.

a. Lung Biopsy.

(1) The term "lung biopsy" is interpreted as any sampling of lung tissue. Lung tissue samples include any one of the following:

(a) Lung tissue obtained from whole lung specimens at the time of an autopsy;

(b) Lung tissue obtained by open or video-assisted thoracotomy;

(c) Lung tissue obtained by bronchoscopic transbronchial biopsy; or

(d) Lung tissue obtained by bronchoalveolar_lavage, which includes alveolar and bronchial epithelial cells, macrophages, lymphocytes, neutrophils, eosinophils, and other lung cells.

Tissue samples obtained by any one of these methods are used to document the presence of a lymphocytic process consistent with CBD.

(2) In claims that contain a normal or borderline LPT, and the lung tissue biopsy confirms the presence of granulomas consistent with CBD, the CE may accept the claim for CBD. The lung biopsy is considered the "gold standard." However, the following steps must be followed before accepting a claim in this manner.

(a) If the claimant is living, the CE should contact the treating physician and obtain a detailed narrative report detailing the past history of the claimant's LPT results (if possible). Specifically, the physician should address whether the claimant has a past history of positive LPTs with recent normal or borderline LPT results. The CE should note that if the claimant has a history of steroid use, this may

cause a false negative on the LPT result.

(b) If the claimant is deceased, the CE should try to obtain as much information as possible on past LPT results and possible steroid use. If exhaustive efforts produce little or no results and the claim contains the normal/borderline LPT results along with a biopsy of the lung tissue showing the presence of granulomas, the CE may accept the claim.

(c) If there is no LPT and the lung tissue biopsy confirms the presence of granulomas consistent with CBD, the CE may accept the claim.

In those instances, the tissue evidence must be very obvious and the recommended decision must address all the statutory requirements for CBD claims in a well-reasoned manner (e.g., LPT negative due to steroid medication giving a "false negative.").

b. Lymphocytic Process. A lymphocytic process consistent with CBD is measured in the lungs by any one of the following methods:

(1) Biopsies showing lymphocytes (i.e., part of the population of so-called mononuclear cells) in bronchial or interstitial (alveolar) lung tissue;

(2) Biopsies showing non-caseating granuloma;

(3) Bronchoalveolar lavage (BAL) showing an increase in the percentage of lymphocytes in the differential cell count (i.e., typically >10% lymphocytes is considered a BAL lymphocytosis); or

(4) BAL Beryllium Lymphocyte Proliferation Test (BeLPT) showing that the lymphocytes washed from the lungs react/respond to beryllium salts.

An abnormal BeLPT/BeLTT, performed on either blood or lung lavage cells, or a positive beryllium patch test, in addition to lung tissue obtained through a positive BAL BeLPT showing a lymphocytic process in which a physician has identified as being consistent with CBD, are sufficient to support the diagnosis of CBD. This is especially important when the BAL BeLPT is the only test used to establish the diagnosis. However, the CE does not use a positive BAL BeLPT solely to support a claim for CBD on or after January 1, 1993.

c. Computerized Axial Tomography (CAT) Scan. A CAT scan uses X-rays and computers to produce an image of a cross-section of the body. For post-1993 CBD claims, the results of the CAT scan are evaluated by a physician for a determination on whether the findings are consistent with CBD.

d. Pulmonary Function or Exercise Testing. For this criterion,

the treating physician or a DMC evaluates the results of the pulmonary function study or exercise tests for a determination on whether or not the deficits are consistent with CBD.

8. Established CBD Decisions, Part B. The pre-1993 CBD criteria are more generalized because before 1993, it was difficult to confirm beryllium sensitization. As such, the respiratory problems potentially related to beryllium were often misdiagnosed and thought to be related to other causal factors. After 1993, diagnostic measures reliably identified a patient's sensitivity to beryllium and linked it to the potential onset of CBD. As such, the post-1993 CBD criteria are considered significantly more accurate for confirming or negating the existence of beryllium sensitization and CBD.

a. Conflicting Medical Evidence. During the adjudication process, there are instances when the CE encounters claims containing pre-1993 medical evidence which supports a chronic respiratory disorder and meets three of the five criteria for pre-1993 CBD claims. The CE approves a claim where the evidence of record is sufficient to establish that the medical record meets either the pre- or post-1993 criteria.

> Example: If a claim contains a post-1993 BeLPT with normal results and also pre-1993 medical evidence which meets the pre-1993 CBD criteria (i.e., three of the five criteria are met), the CE can approve the claim based upon the pre-1993 CBD criteria, whether the employee is living or deceased.

b. Referral to a DMC. CEs should refer claims to a DMC for a medical review after all means of obtaining the evidence from the treating physician is exhausted. Referrals are also sent to a DMC when the medical reports and/or tests do not include a clear interpretation and/or if there is a specific question(s) about the medical evidence. When a referral to a DMC is made, all the medical records in the case file are sent to the DMC for review. Examples of situations when a referral is needed include:

> (1) Medical test results that do not provide a clear interpretation (e.g., pathology report, BeLPT, X-ray, CT scan); and
>
> (2) Pre-1993 and/or post-1993 CBD tests (e.g., chest X-ray, diffusion lung capacity defect, lung biopsy showing granulomas, lymphocytic process, or pulmonary function study) that do not denote abnormalities or defects, contain the finding "consistent with chronic beryllium disease", or are inconclusive.

The opinion of the DMC, when properly supported by medical rationale, carries significant probative value and is considered reliable when issuing the Recommended Decision and/or Final Decision.

c. Beryllium Sensitivity Decision When CBD Is Claimed. When CBD is claimed on Form EE-1 for a living employee, but the evidence supports

the existence of beryllium sensitivity only, the CE still develops the claim for CBD.

(1) The CE advises the claimant of the medical evidence necessary to establish a claim for CBD, and provides the claimant with a period of up to 60 days for submission of additional medical evidence, with a follow up letter to the claimant after the first 30- day interval.

(2) If the claimant responds with additional evidence, the CE evaluates the claim and issues a Recommended Decision accepting the beryllium sensitivity (if established) and either accepting or denying the claim for CBD, based upon the totality of the medical evidence on record. If the claimant either does not respond within the allotted period of time, or provides evidence that he or she has not yet developed CBD, the CE issues a Recommended Decision accepting the claim for beryllium sensitivity (if established). The CE also sends a letter to the claimant advising that there is currently insufficient evidence of CBD, but that if the beryllium sensitivity later develops into CBD, the claimant may contact a DEEOIC Office and provide supporting medical evidence.

(3) If the claimant later advises a DEEOIC Office that the beryllium sensitivity has developed into CBD, the CE develops the case accordingly and issues a Recommended Decision based upon the medical evidence the claimant submitted.

(4) If the claimant advises that he or she wants a Recommended Decision on the CBD, despite the lack of supporting medical evidence, the CE issues a recommended denial of the CBD.

9. Beryllium Sensitivity and CBD, Part E. Causation under Part E is developed in one of two ways for beryllium sensitivity and CBD. The first way is through a positive determination under Part B. The second way is through medical evidence as described below.

a. Beryllium Sensitivity. As under Part B, beryllium sensitivity is established by one abnormal beryllium lymphocyte proliferation test (BeLPT) or BeLTT result indicating that an employee's blood showed an abnormal proliferative response to beryllium sulfate.

b. Physician Narrative. A Part B Final Decision under the EEOICPA approving beryllium sensitivity or CBD is sufficient to establish the diagnosis and causation under Part E. However, if there is no Part B decision, a positive LPT result is required to establish a diagnosis of beryllium sensitivity and a rationalized medical report including a diagnosis of CBD from a qualified physician is required to establish CBD under Part E. The rationalized report should contain an evaluation of the employee's medical condition and a finding that

it is "at least as likely as not" that exposure to beryllium at a DOE covered facility was a significant factor in aggravating, contributing to, or causing the CBD.

c. Referral to DMC. The CE thoroughly reviews all the medical evidence. If the CE determines that the totality of the evidence is inconclusive in establishing the diagnosis or causation for the claimed condition, a DMC referral is warranted, especially if the treating physician is unavailable or unable to provide the necessary information.

d. Causal Relationship, Survivor Development. When a survivor claim for CBD is accepted under Part B and an "Other Chronic Pulmonary Disease" is listed on the death certificate as contributing to or causing the employee's death, the CE concludes that it is "at least as likely as not" that the presence of CBD, or the chronic respiratory disorder consistent with CBD, aggravated or contributed to the "Other Chronic Pulmonary Disease," and therefore to the employee's death.

Exhibit 1 serves as medical evidence that the CE uses in this determination. The CE places a copy of the Memorandum from the DEEOIC Medical Director in the case file. As a result, it is not necessary for the CE to determine whether the "Other Chronic Pulmonary Disease" was directly due to toxic exposure from covered DOE contractor/subcontractor employment.

The accepted "Other Chronic Pulmonary Diseases" are:

(1) Asbestosis;

(2) Silicosis;

(3) Chronic Obstructive Pulmonary Disease (COPD);

(4) Emphysema; and

(5) Pulmonary Fibrosis

Once the medical, employment, and causation criteria have been met for a beryllium sensitivity or CBD claim under Part E, the employee is awarded medical monitoring, treatment, and therapy for the condition effective relative to the date of filing. In addition, the employee is eligible for lump sum compensation for impairment and/or wage-loss.

10. Presumption of CBD, Diagnosis of Sarcoidosis, and History of Beryllium Exposure. A diagnosis of sarcoidosis is not medically appropriate if there is a documented history of beryllium exposure. In these situations, the CE considers the diagnosis of sarcoidosis as a diagnosis of CBD. However, the application of this presumption in the adjudication of the claim differs between Parts B and E of the Act.

a. Presumption of CBD, Under Part B. The CE establishes that the employee is a "covered beryllium employee" as defined under 42 U.S.C.

§7384l(7) and as further discussed in paragraph 4 above. Since a diagnosis of sarcoidosis for a covered beryllium employee is not medically appropriate, in any instance when this situation occurs, CBD is presumed to be the diagnosis. However, Part B of the EEOICPA delineates the specific diagnostic criteria to qualify for compensation, therefore the evidence of record needs to meet one of the statutory criteria for CBD to allow for an acceptance, as discussed in paragraphs 6 and 7 above.

b. Presumption of CBD, Under Part E. The CE establishes that the employee has at least one day of verified DOE contractor/subcontractor employment at a covered site during a covered time period when beryllium dust, particles, or vapor may have been present. Whenever the evidence of record contains medical evidence of a diagnosed sarcoidosis and the potential for occupational exposure to beryllium exists, a diagnosis of CBD is presumed. However, the medical requirements for CBD claims under Part E must be met before the claim may be approved.

11. Consequential Illnesses from CBD or its Treatment. Individuals diagnosed with CBD have the potential to develop an illness as a consequence of this condition or the treatment thereof, especially when the patient uses steroids, such as Prednisone.

Consequential conditions include, but are not limited to, the following: weight gain; elevated blood pressure; hypertension; elevated cholesterol and abnormal lipids; liver function abnormalities; blood sugar change; diabetes; eye/vision problems such as cataracts, glaucoma, and visual acuity changes; gastrointestinal conditions such as gastric reflux or peptic ulcers; psychiatric or psychological conditions such as depression or anxiety; skin problems such as thrush or other fungal infections; metabolic changes such as folic acid depletion; decreased immune response leading to infections and viruses; sleep apnea and other sleep disorders; deconditioning requiring pulmonary rehabilitation, physical therapy, and/or nutritional counseling; and decreased bone density leading to osteoporosis/osteopenia.

12. Silicosis. Chronic silicosis is a non-malignant disease of the lung caused by prolonged exposure to silica dust. Under Part B, if all covered employment and exposure criteria are met, only chronic silicosis is covered. However under Part E, if all covered employment and exposure criteria are met, chronic silicosis, acute silicosis, accelerated silicosis, and complicated silicosis are covered.

If chronic silicosis, acute silicosis, accelerated silicosis, or complicated silicosis is claimed on the Form EE-1 or EE-2, then the CE develops for that specific silicosis under the appropriate Part(s) of the Act.

a. Silicosis Employment and Exposure Criteria, Part B. 42 U.S.C. §7384r(c) and (d) describes the employment requirements for an

employee diagnosed with chronic silicosis. The CE reviews the evidence with the claim to ensure that the employee was:

(1) A DOE employee or a DOE contractor employee; and

(2) Present for an aggregate of at least 250 work days during the mining of tunnels at a DOE facility located in Nevada or Alaska for tests or experiments related to an atomic weapon (Part B claims only).

b. Medical Evidence. 42 U.S.C. §7384r(e) describes the medical evidence needed to establish a diagnosis of chronic silicosis. The CE verifies that all the necessary medical evidence is present in accordance with the requirements listed in the statute, as follows:

(1) The initial occupational exposure to silica dust preceded the onset of chronic silicosis by at least 10 years; and

(2) A written medical narrative from a qualified physician that includes a diagnosis of chronic silicosis and the date of initial onset. In addition, one of the following is required:

(a) A chest radiograph, interpreted by a physician certified by the National Institute for Occupational Safety and Health (NIOSH) as a B-reader, classifying the existence of pneumoconiosis of category 1/0 or higher;

(b) Results from a computer assisted tomograph or other imaging technique that are consistent with chronic silicosis; or

(c) Lung biopsy findings consistent with chronic silicosis.

Upon review of the evidence submitted, the CE verifies the presence of the necessary medical and diagnostic evidence to support a diagnosis of chronic silicosis. If deficiencies are noted, the CE requests evidence from the claimant and/or the treating physician.

c. Silicosis Employment and Exposure Criteria, Part E. Silica exposure in the performance of duty is assumed if, and only if, the employee was present at a DOE or RECA section 5 facility where silica is known to have been present. The initial occupational exposure to silica dust needs to precede the onset of silicosis by at least 10 years. However, there are instances where an employee's initial occupational exposure to silica dust can be great enough to result in the onset of silicosis prior to 10 years. Therefore the CE reviews the employment evidence and weighs the exposure evidence, accordingly, when making causation determinations.

The provisions regarding separate treatment for chronic silicosis set forth in §7384r of the Act for Part B do not apply to Part E. Therefore, for purposes of evaluating the employee's Part E claim for

silicosis, the element of causation is not presumed unless it was determined that the employee was entitled to compensation under Part B for silicosis (*see* §7385s-4(a)) or the Secretary of Energy has made a positive determination of causation (*see* §7385s-4(b)). In all other cases of claimed silicosis under Part E, the employment and exposure criteria applicable to all other claimed illnesses under Part E shall also apply to silicosis claims; that is, the employee must have been a DOE contractor employee and it must be at least as likely as not that exposure to a toxic substance at a DOE facility was a significant factor in aggravating, contributing to, or causing the employee's silicosis and it must be at least as likely as not that the exposure to such toxic substance was related to employment at a DOE facility.

Silicosis is a nonmalignant respiratory disease covered under RECA section 5. Therefore, for purposes of evaluating the Part E silicosis claim of a uranium employee covered under section 5 of RECA, the Department of Justice (DOJ) verifies covered employment and the CE makes the causation determination under §7385s-4(c) as to whether the employee contracted silicosis through exposure to a toxic substance at a section 5 mine or mill.

(1) Exceptions – Acute, Accelerated, and Complicated Silicosis. The extreme nature, function, or duration of exposure can trigger various forms of silicosis. The CE determines whether or not the employee's occupation entailed such exposure that the disease manifested into an acute, accelerated, or complicated form due to such exposure. These forms of silicosis are not covered under Part B, but are covered under Part E based upon the CE's review of the totality of the evidence.

(2) Employment and Exposure Evidence. The CE obtains evidence of employment and exposure from various sources. The Department of Justice (DOJ) verifies employment for RECA section 5 claimants. The CE obtains other evidence from Document Acquisition Request (DAR) records, DOE Former Worker Program (FWP) records, Site Exposure Matrices (SEM), employment records, Occupational History Questionnaire (OHQ) findings, affidavits, and from the claimant.

d. Medical Evidence, Part E. A physician's written diagnosis and date of initial onset is required to establish silicosis.

When there is insufficient evidence of exposure, diagnostic testing, and/or diagnosis, the CE requests additional information from the claimant and affords the claimant sufficient time to respond.

Where no diagnosis exists, but the required employment element is met and evidence of a lung disease is presented, the CE requests additional medical evidence to establish the diagnosis of silicosis from either the claimant and/or the treating physician, or makes a referral to a DMC if the requested evidence is not submitted. The CE

evaluates the DMC opinion and the evidence of file to make a factual determination as to the diagnosis and/or causation.

13. Pneumoconiosis, Part E. Pneumoconiosis is the deposition of particulate matter, such as coal dust, asbestos, and silicon in the lungs. Pneumoconiosis is a Part E covered illness only.

a. Sufficient Evidence to Establish as a Covered Illness. Such evidence includes sufficient exposure to a toxic substance(s) at a covered DOE or RECA section 5 facility, in order to establish that the exposure was a significant factor in aggravating, contributing to, or causing the pneumoconiosis. In particular, it needs to include:

(1) A sufficient period of latency between initial exposure to a toxin(s) and the onset of the disease; and

(2) Written evidence of one of the following two criteria:

(a) A written diagnosis of pneumoconiosis made by a physician; or

(b) Results from a breathing test (e.g., a Pulmonary Function Test (PFT) or spirometry) showing a restrictive lung pattern of an FVC less than 80% predicted; and

(c) Any one of the following three criteria:

(i) A chest radiograph, interpreted by a NIOSH certified B reader classifying the existence of pneumoconiosis of category 1/0 or higher;

(ii) Results from a chest X-ray or computer assisted tomography (CT) or other imaging technique that are consistent with asbestosis and/or findings of pleural plaques or rounded atelectasis; or

(iii) Lung biopsy findings consistent with pneumoconiosis.

b. Physician Review. Review by a physician is required, if the following evidence is insufficient:

(1) Insufficient evidence of exposure to a toxic substance(s) at a covered DOE or RECA Section 5 facility in order to establish that the exposure was a significant factor in aggravating, contributing to, or causing the pneumoconiosis;

(2) An insufficient period of latency between initial exposure to a toxin(s) and the onset of the disease;

(3) Some, but not all, of the medical evidence criteria to establish pneumoconiosis are met;

(4) The medical record (e.g., any physician’s report,

results from imaging studies, surgical, or pathology reports) without a definitive diagnosis of silicosis, possible asbestosis, restrictive lung disease, or pneumoconiosis;

(5) Death certificate with no mention of silicosis, possible asbestosis, restrictive lung disease, or pneumoconiosis;

(6) A chest radiograph interpreted by a NIOSH certified B reader classifying the existence of pneumoconiosis of category 0/1 (i.e., the X-ray is normal and there is no presence of pneumoconiosis); or

(7) Results from a chest X-ray or computer assisted tomography (CT) or other imaging technique that are not suggestive of pneumoconiosis.

14. Asbestosis, Part E. Asbestosis, a form of pneumoconiosis, is a chronic, progressive pulmonary disease caused by the inhalation and accumulation of asbestos particles or fibers in the lungs. Asbestosis is a Part E covered illness only.

a. Medical and Diagnostic Requirements. Asbestosis is characterized by extensive pulmonary interstitial fibrosis (e.g., scarring) and pleural thickening. Progressive thickening and scar formation of the lung tissues occur along with associated loss of respiratory function. These developments are noticeable in the lower part of the lungs, because this area of the lungs receives a greater part of the inhaled load of particulate matter.

Various types of medical evidence can establish an asbestosis diagnosis. Not all types of medical evidence need to be present, and the CE weighs the evidence as a whole to make a determination. Each form of medical evidence described below is given greater weight if the test results include an evaluation by a physician that suggests asbestosis.

(1) Chest X-ray reports that show pulmonary interstitial fibrosis and cardiac enlargement are regarded as characteristic of asbestosis. The CE takes into account such findings as possibly indicative of asbestosis, based upon the totality of the evidence. However, cardiac enlargement is not always seen with asbestosis. Therefore if cardiac enlargement is not noted in the chest X-ray report, the CE still considers the possibility of asbestosis, based upon the totality of the evidence.

(2) Computerized axial tomography (CAT) and magnetic resonance imaging (MRI) that show characteristic lung scarring, pleural thickening, and cardiac enlargement are also possible indications of asbestosis.

(3) A Pulmonary Function Test (PFT) reveals pulmonary function and capacity. Asbestosis typically restricts

pulmonary function; therefore, total lung capacity, vital capacity, compliance measurements, and pulmonary diffusing capacity are reduced if asbestosis is present. It is necessary that the CE obtains a physician evaluation of the PFT results.

(4) A lung biopsy is a sampling of lung tissue. Cytological examination of the sputum or bronchial lavage often shows the presence of asbestos bodies. This test is not considered as definitive for the diagnosis of asbestosis because it is commonly positive in cases of asbestos exposure alone and is seen in other populations such as hematite (i.e., iron ore) miners.

(5) A report by a physician diagnosing asbestosis and providing a diagnosis date.

(6) Screening by DOE through the FWP that is found to be positive. Such a finding is sufficient to establish the diagnosis of asbestosis.

(7) A Referral to a DMC is required in instances of claimed and/or verified high levels of occupational exposure to asbestos in order to determine whether or not the normal required latency period for onset is to be waived. When the medical evidence is vague, clarification from the treating physician or a referral to the DMC would be necessary to evaluate the medical evidence and render a medical opinion regarding the existence of asbestosis. As always, the CE gives consideration to the opinion of the treating physician, if one is available.

(8) Asbestosis identified on the death certificate, signed by a physician, as a cause of or contributing factor to death establishes a diagnosis. If the death certificate shows any respiratory illness other than asbestosis, the CE needs to provide a well rationalized conclusion that asbestosis contributed to the death based on the totality of the medical evidence contained in the file.

If the evidence supports a diagnosis of asbestosis and the death certificate lists the cause of death as pneumoconiosis, the CE is to presume that causation to death has been established.

b. Employment/Exposure Requirements. The CE verifies that the employee was a covered DOE employee at a covered DOE or RECA section 5 facility, during a covered time period, and in the course of employment was exposed to asbestos while at the DOE or RECA section 5 facility.

However, if an employee’s occupation was such that there is question as to whether or not the labor category and the work processes engaged in exposed the employee to asbestos, or the potential for

extreme exposure existed and the employee worked less than 250 aggregate work days, or there is a latency period of less than 10 years existing between the covered DOE or RECA Section 5 employment and the onset of the illness, the CE evaluates the evidence as a whole, considering the amount of occupational exposure, and makes a determination on causation. In instances when the evidence on file is not clear in reference to an employee's occupation, the work processes engaged in, and/or the amount of occupational exposure, a referral to an Industrial Hygienist (IH) is necessary.

(1) DOE/RECA Section 5 Employment and Asbestos Exposure. With the collection of exposure data contained in SEM, it has been determined that asbestos existed in all covered DOE and RECA section 5 facilities. However, based upon the labor category and the work processes engaged in, coupled with the possibility of the existence of extreme exposure and the number of verified covered work days, the CE determines if sufficient evidence exists to support that the employee was exposed to asbestos.

If sufficient exposure evidence is not available (e.g., DAR records) and the employee's exposure is questionable because of the labor category and the work processes engaged in (e.g., secretary), the CE requests the following information from the claimant:

(a) Medical evidence discussing the employee's work history and exposure to asbestos at the covered facility. The presence of pleural thickening, interstitial fibrosis, neoplasia, or other medical findings characteristic of asbestosis, as discussed above, also helps establish the relationship between employment and exposure;

(b) Personnel or incident records disclosing exposure to asbestos; or

(c) Affidavits from other employees attesting to the employee's asbestos exposure and other evidence such as independent studies of the facility or newspaper articles discussing asbestos exposure at the site.

(2) Latency Period. A sufficient latency period also needs to exist between the covered DOE or RECA section 5 employment and the onset of the illness. Asbestos-related diseases and abnormalities usually do not occur for at least 10 years, but sometimes less, after onset of exposure. Therefore if all diagnostic criteria for asbestosis are satisfied, as discussed in paragraph 14a above, and the evidence of file shows 10 years or more of asbestos exposure at a DOE or RECA section 5 facility, the CE accepts the claim without a DMC review.

If the latency period is less than 10 years, the CE reviews the evidence of file to determine if sufficient evidence exists to support that the exposure was "at least as likely as not" a significant factor in aggravating, contributing to, or causing asbestosis. In some instances when the medical evidence from the treating physician is not compelling, a referral to a DMC is necessary.

15. Medical Conditions Associated with Asbestos Exposures.

a. Mesothelioma. Mesothelioma is a rare cancer of the pleura that is caused almost exclusively by asbestos exposure. Because of this relationship to asbestos, any claims involving a confirmed diagnosis of mesothelioma are accepted, given the requirements for asbestos exposure at a covered facility (e.g., latency period) have been met.

b. Pleural Plaques and Pleural Effusions. Pleural plaques and pleural effusions are considered conditions caused by asbestos, but do not constitute an asbestosis diagnosis or finding. If a claim is made for asbestosis but only pleural plaques can be accepted, the claim for asbestosis is explicitly denied.

Although generally asymptomatic, the CE accepts pleural plaques and pleural effusions for medical benefits which encompasses the following: chest radiology (e.g., X-rays, CT scans, or MRIs); PFTs; bronchoscopy with or without biopsy; pleural biopsy; and other tests to rule out malignant tumors of the chest.

In addition, it is possible for pleural plaques or pleural effusions to result in an impairment rating and/or wage loss.

(1) Sufficient Evidence to Establish an Asbestos Related Disorder Includes the Following:

(a) Medical evidence as established by the results from a chest X-ray, CT scan, or other imaging technique that are consistent with pleural plaques or pleural effusions, as evidenced by any of the following findings:

(i) Pleural plaques;

(ii) Pleural thickening, not associated with an area of prior surgery or trauma;

(iii) Rounded atelectasis; or

(iv) Bilateral pleural effusions, also known as benign asbestos-related pleural effusion; and

(b) The employee was exposed to asbestos at a covered DOE or RECA Section 5 facility for a DOE contractor or subcontractor for an aggregate of at least 250 work days; and

(c) The latency period between the initial exposure to asbestos and the onset of pleural plaques or

pleural effusions is more than 20 years for pleural plaques and between 5 and 30 years for pleural effusions.

(2) When a DMC's Review Is Required Due to Insufficient Evidence:

(a) If the totality of the medical evidence is inconclusive or insufficient to establish a diagnosis of pleural plaques or pleural effusions. Also, if the results from a chest X-ray, computer assisted tomography (CT), or other imaging technique are consistent with any of the following findings:

(i) Pleural thickening in an area of prior surgery or trauma; or

(ii) Pleural effusion, only if the record does not indicate that there is another disease process that would otherwise account for the effusion, such as congestive heart failure (CHF), cancer, or other lung disease;

(b) If the employee was a DOE contractor or subcontractor employee who was exposed to asbestos for less than an aggregate of 250 work days at a DOE or RECA section 5 facility. If the exposure period is less than the required aggregate 250 days, but the employee worked in an occupation that typically experiences heavy asbestos exposure, the CE includes that information in the referral to a physician; or

(c) If the latency period between the initial exposure to asbestos and the onset of pleural plaques or pleural effusions is less than 20 years for pleural plaques, or less than 5 years or more than 30 years for pleural effusions.

c. Lung Fibrosis (Pulmonary Fibrosis).

(1) Sufficient Evidence to Establish as a Covered Illness Includes the Following:

(a) Sufficient exposure to a toxic substance(s) at a covered DOE or RECA section 5 facility for a DOE contractor or subcontractor to establish that the exposure was a significant factor in aggravating, contributing to, or causing the lung fibrosis;

(b) A period of latency between the initial exposure to the toxin(s) and the initial onset of the lung fibrosis; and

(c) A written diagnosis of lung fibrosis made by a physician along with any one of the following three criteria:

(i) Results from a chest X-ray, CT scan, or other imaging technique that are consistent with fibrosis such as small lung fields or volumes, minimal ground glass opacities, and/or bibasilar reticular abnormalities;

(ii) Results of breathing tests (e.g., PFTs or spirometry) showing a restrictive or mixed pattern, such as FVC less than 80% predicted; or

(iii) Lung biopsy findings consistent with fibrosis; and

(d) The medical evidence does not contain any indication that the lung fibrosis is present due to another disease process.

16. Chronic Obstructive Pulmonary Disease (COPD). COPD is a disease that causes airflow blockage and breathing-related problems.

a. Evaluating Medical Evidence. Any one of the following tests below can provide an indication of COPD, but a diagnosis is not based solely on one of the following criteria. The CE weighs all the medical evidence before making a finding. Exposure to certain toxic substances that induce lung ailments are considered when the CE is reviewing the evidence.

All test results are to be accompanied by a physician's interpretation in order to have probative value. If a physician's interpretation is not available, the CE seeks such interpretation from either the treating physician or a DMC. The CE is not qualified to make medical opinions as to the results of the tests described below.

(1) Arterial Blood Gas (ABG) Test. Abnormal results from the blood gas components include such findings as the body is not getting enough oxygen, is not getting rid of enough carbon dioxide, or that there is a problem with kidney function.

(2) Consistent Chest X-rays/CAT scans. Chest X-ray results vary and show interstitial patterns, scarring, and other abnormalities.

(3) Abnormal Spirometry. The Spirometer measures air flow and air volume. An abnormal reading includes an indication of COPD or some other lung condition.

(4) Bronchoscopy. A bronchoscopy is used by physicians to examine the major air passages of the lungs. A finding of an obstruction in the air passages includes an indication of COPD or some other lung condition.

(5) DMC Referral. If the totality of the medical evidence is insufficient to establish a lung condition, the CE refers the case file to a DMC for an opinion.

b. Employment and Exposure Requirements. The CE develops for covered DOE or RECA section 5 employment at a covered DOE or RECA section 5 facility during a covered timeframe, or for eligibility as a qualified RECA 4 claimant. Site profiles, SEM, and evidentiary employment evidence (e.g., DAR records, OHQ findings, affidavits, etc.) are used to determine what toxins were present at the site.

Based upon the totality of the evidence, the CE determines whether it is "at least as likely as not" that the established occupational exposure was a significant factor in aggravating, contributing to, or causing the condition.

c. Unique Conditions within COPD. Emphysema is caused by only a small subset of the toxic substances associated with chronic bronchitis, but is sometimes aggravated by toxins associated with COPD.

If all of the COPD criteria are otherwise met, individuals with Alpha-1 Antitrypsin Deficiency (AAT Deficiency) are considered to have a covered illness.

17. Other Conditions. Like asbestosis and the lung ailment COPD, there are a host of other non-cancerous conditions potentially covered under Part E that are not covered under Part B.

a. Exposure. The CE uses site profiles, SEM, DAR records, and other employment exposure data in evaluating causation. The SEM acts as a repository of information related to toxic substances potentially present at covered DOE and RECA sites, and is particularly helpful as an exposure development tool. The SEM is a living database which is updated with toxic substances and facilities as they are evaluated. The SEM assists the CE in verifying the presence of a toxic substance at a given building or during a given work process.

In some instances, with or without sufficient exposure data, it is necessary to refer the case file to a DMC, IH, or toxicologist to evaluate the evidence and render an expert opinion as to causation and exposure.

b. Medical Requirements. With the wide variety of conditions claimed under Part E, this chapter cannot address diagnostic requirements of all possible conditions.

However, the matrices in Exhibit 2 have been created which provides descriptions of medical evidence sufficient to establish some conditions as covered illnesses and they include the following: kidney disease; occupational asthma; heart attack; toxic neuropathy; and chronic toxic encephalopathy. Ultimately, the CE uses his or her best judgment in reviewing and evaluating the probative value of the medical evidence.

Referrals to DMCs, IHs, or toxicologists are necessary for some conditions, based upon the evidence of record in a case-by-case basis. A physician's narrative or DMC report that is well

rationalized and provides a diagnosis holds the greatest weight.

c. Causation. For Part E claims, the evidence must establish that there is a relationship between exposure to a toxin and an employee's illness or death. This relationship defines the intensity, duration, and route of exposure, which is characteristic of that specific toxin and illness or death. The evidence further needs to demonstrate whether it is "at least as likely as not" that such exposure at a covered DOE or RECA section 5 facility during a covered time period was a significant factor in aggravating, contributing to, or causing the employee's illness or death, and that it is "at least as likely as not" that exposure to a toxic substance(s) was related to employment at a covered DOE or RECA section 5 facility.

18. Hearing Loss. Hearing loss can be compensable under Part E of the Energy Employees Occupational Illness Compensation Program Act (EEOICPA) if such loss arises as a result of exposure to one or more of the organic solvents listed below in conjunction with employment in at least one of certain specified labor categories during a prescribed timeframe.

a. Conditions for Acceptance. To be compensable, all of the following conditions must be satisfied for the employee:

(1) Exposure to certain specific organic solvents for 10 consecutive years; and

(2) Verified covered employment within at least one specific job category for a period of 10 consecutive years, completed prior to 1990; and

(3) Diagnosed sensorineural hearing loss in both ears (conductive hearing loss is not known to be linked to toxic substance exposure).

If an employee has a diagnosis of sensorineural hearing loss in both ears, and the employee was exposed to one of the listed chemical solvents, and worked in one of the listed labor categories for the required concurrent and unbroken 10-year period, then the claim can be accepted for the covered illness of hearing loss.

b. Organic Solvents. Compensable claims for sensorineural hearing loss due to organic solvent exposure must have evidence in the case file that the employee was concurrently exposed to certain specific organic solvents and worked within a certain job category for a consecutive and unbroken period of ten years, completed prior to 1990. Experts have determined that at least one of these organic solvents would likely have been used in covered facilities prior to 1990. Currently, the only organic solvents shown in research literature to contribute to sensorineural hearing loss are the following:

- Toluene
- Styrene
- Xylene

- Trichloroethylene
- Methyl Ethyl Ketone
- Methyl Isobutyl Ketone
- Ethyl Benzene

(1) Evidence (either from the Site Exposure Matrices or some other, probative source of exposure information) must establish exposure to at least one of the above listed solvents. Exposure to derivatives of the listed solvents does not create a presumption of causation for hearing loss, regardless of labor category or duration of exposure.

c. Labor Categories. To be compensable, the employee must have worked in one of the following labor categories for a continuous 10-year period, completed prior to 1990.

- Boilermaker
- Chemical Operator
- Chemist
- Electrician/Electrical Maintenance/Lineman
- Electroplater/Electroplating Technician
- Garage/Auto/Equipment Mechanic
- Guard/Security Officer/Security Patrol Officer (i.e. firearm cleaning activities)
- Instrument Mechanic/ Instrument technician
- Janitor
- Laboratory Analyst/Aide
- Laboratory Technician/Technologist
- Lubricator
- Machinist
- Maintenance Mechanic
- Millwright
- Operator (most any kind)
- Painter
- Pipefitter
- Printer/Reproduction clerk
- Refrigeration Mechanic/HVAC Mechanic
- Sheet Metal Worker
- Utility Operator

d. Nonconforming circumstances. Claims for other conditions based on exposure to the listed organic solvents must be verified using the

Site Exposure Matrices, a medical report from a qualified physician, or review by the National Office (NO) toxicologist.

(1) Other hearing loss claims based on rationalized medical evidence asserting a causative link between covered employment and exposure to other solvents not listed in this Circular should be forwarded to the NO for specialist review.

(2) Claims for hearing loss due to organic solvent exposure where the employee has less than 10 years of employment completed prior to 1990 must likewise be forwarded to the NO for specialist review.

Exhibit 1: Statutory CBD and Other Respiratory Disorders Memorandum

Exhibit 2: Matrix for Confirming Sufficient Evidence of Non-Cancerous Covered Illnesses

2-1100 Eligibility Requirements for Certain Uranium Workers

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1. Purpose and Scope. This chapter describes the policies and procedures for processing claims involving uranium miners, millers, and ore transporters who worked at facilities covered by Section 5 of the Radiation Exposure Compensation Act (RECA) and, where applicable, the survivors of such employees. This chapter also describes the policies and procedures for processing claims involving claimants who applied for an award under Section 4 of the RECA.

2. RECA Background.

a. Department of Justice (DOJ) Administered. On October 5, 1990, Congress passed the Radiation Exposure Compensation Act ("RECA"), 42 U.S.C. § 2210 note, providing for payments to individuals who contracted certain cancers and other serious diseases as a result of their exposure to radiation released during above-ground nuclear weapons tests or as a result of their exposure to radiation during covered employment. It was the intent of Congress in enacting EEOICPA to treat certain uranium workers covered under RECA the same as Department of Energy (DOE) workers under EEOICPA.

b. Section 5 of RECA.

(1) Covered Employee. Uranium miners, uranium mill workers and uranium and vanadium-uranium ore transporters who transported ore from mines or mills.

(2) Covered States. Colorado, New Mexico, Arizona, Wyoming,

South Dakota, Washington, Utah, Idaho, North Dakota, Oregon and Texas.

(3) Covered Time Period. January 1, 1942 through December 31, 1971.

(4) Covered Illnesses. Primary lung cancer, renal cancer, other chronic renal diseases including nephritis and kidney tubal tissue injury, and the following nonmalignant respiratory illnesses: pulmonary fibrosis, fibrosis of the lung, cor pulmonale related to pulmonary fibrosis, silicosis and pneumoconiosis.

(5) Benefits Payable by DOJ. A payment of $100,000 is available to eligible employees or their survivors.

c. Section 4 of RECA.

(1) Downwinders.

(a) Coverage: Individuals who were physically present in one of the affected areas downwind of the Nevada Test Site during a period of atmospheric nuclear testing, and later developed a covered illness.

(b) Covered Illnesses: Leukemia (other than chronic lymphocytic leukemia), multiple myeloma, lymphomas (other than Hodgkin's disease), and primary cancer of the thyroid, male or female breast, esophagus, stomach, pharynx, small intestine, pancreas, bile ducts, gall bladder, salivary gland, urinary bladder, brain, colon, ovary, liver (except if cirrhosis or hepatitis B is indicated), or lung.

(c) Benefits Payable by DOJ: A payment of $50,000 is available to eligible individuals.

(2) Onsite Participants.

(a) Coverage: Individuals who participated onsite in a test involving the atmospheric detonation of a nuclear device, and later developed a covered illness.

(b) Covered Illnesses: Same as downwinders.

(c) Benefits Payable by DOJ: A payment of $75,000 is available to eligible individuals.

d. All claims identified as RECA claims, Section 4 or Section 5, should be referred to the Denver District Office for adjudication regardless of the employee's last place of employment.

3. How DOL Identifies a RECA Section 5 Uranium Worker. The Claims Examiner (CE) can identify a claim submitted by a Section 5 RECA uranium worker, or an eligible surviving beneficiary of such uranium worker, by reviewing the information provided on the EE-1 or EE-2. If the claimant indicated on the EE-1 or EE-2 that the employee was a

uranium worker, or that a Section 5 RECA award was applied for or has been approved, the claim is to be developed in accordance with the guidance set out under this Chapter. In cases where the EE-1 or EE-2 does not specify if the employee was/is a uranium worker and/or the Section 5 RECA status, the CE will review the EE-3, if provided, for an indication of possible RECA employment.

4. Determining Uranium Worker Eligibility. Under Part B, eligibility is entirely dependent upon a Section 5 RECA award. Under Part E, denial of a Section 5 award by the DOJ has no effect on a claimant's eligibility. The CE must independently develop a claimant's Part E claim as set forth in this Chapter.

a. Benefits Available Under Part B.

(1) Award Letter from DOJ. 42 U.S.C. § 7384u describes the requirements for determining eligibility for benefits under Part B of the EEOICPA. An individual is a "covered uranium employee" when the DOJ has determined that the employee or his or her survivor is entitled to payment of $100,000 as compensation due under Section 5 of the RECA for a claim made under that statute and has issued a Section 5 RECA award. Receipt of payment is not required. DOJ advises DOL of Section 5 RECA awards in writing (Exhibit 1).

(2) No Additional Development. Once the CE receives confirmation of the Section 5 award, the Part B claim is in posture for acceptance. The illness awarded under RECA by DOJ must also be awarded under Part B of the EEOICPA.

(3) Benefits Payable. If the Section 5 RECA recipient is a uranium worker and was approved for a lump sum compensation payment of $100,000 under Section 5 of the RECA, the additional lump sum payment of $50,000 under Part B of the EEOICPA will be made to the uranium worker. The uranium worker is also eligible for medical benefits in relation to his or her accepted covered condition(s) per 42 U.S.C § 7384t.

(a) If the Section 5 RECA recipient is deceased, the uranium worker's eligible survivor(s) is entitled to the additional lump sum payment of $50,000 compensation. The CE will review the claim for survivor benefits per 42 U.S.C. § 7384u(e).

(b) If the Section 5 RECA recipient(s) was awarded benefits as surviving beneficiary(s) of a covered uranium worker, the additional lump sum payment of $50,000 under the EEOICPA will be made to the same recipient(s). No survivorship development is conducted. For example, it is unnecessary to obtain a marriage certificate from a surviving spouse who has

already received a Section 5 RECA award as a surviving beneficiary.

(c) If the uranium worker's survivor(s) received the Section 5 RECA award and died, only the eligible survivor(s) of the uranium worker described in 42 U.S.C. § 7384u(e) are eligible for EEOICPA benefits.

(4) Issuing Recommended and Final Decisions. A decision of acceptance of a Part B claim will address the fact that the additional lump sum payment of $50,000 and medical benefits are awarded in addition to and as a result of Section 5 RECA award of $100,000.

b. Benefits Available Under Part E.

(1) NO DOJ Award Required. As noted above, a DOJ Section 5 award denial has no effect on a claimant's eligibility under Part E due to expanded definition of a covered uranium worker under Part E and coverage extending to any medical condition if it is determined to be related to exposure to toxic substances at a covered DOE facility or covered uranium mine or mill. The CE must independently develop a claimant's Part E claim where there is no DOJ award.

(2) DOJ Award Letter / Part B Acceptance. In all instances other than awards involving survivors, an acceptance under Part B will correlate to an automatic acceptance under Part E as to the medical conditions accepted by DOJ and the CE can prepare a recommended decision to accept the claim for benefits under the Act and proceed with whatever other development that is required (i.e. other claimed illnesses, impairment claims and wage loss claims).

(a) Eligible survivors of Section 5 RECA award recipients, and survivors who are award recipients in their own right, are approved for benefits under Part B of the EEOICPA. However, such acceptance under Part B does not automatically translate to an acceptance under Part E. Survivors of Section 5 RECA award recipients, and survivors who are award recipients in their own right, must submit the requisite documents to establish survivorship eligibility under Part E. All Part E survivorship rules apply to RECA survivors. The CE develops all necessary requirements to establish survivorship eligibility as it is defined under Part E of the EEOICPA.

(3) Benefits Payable. In addition to medical benefits, Part E of the Act grants covered employees compensation for impairment and/or wage loss related to an accepted illness.

5. Developing RECA Section 5 Claims. The CE must evaluate the

status of the Part B and Part E claims as follows in order to proceed with adjudication. In all cases where employment verification is required, the CE proceeds under the guidance set forth under paragraph 6. In all instances where a uranium worker files a claim under EEOICPA without demonstrating a RECA award, DOL must write to DOJ for additional information.

a. Section 5 RECA Covered Condition. Once a Section 5 RECA claim is identified, the CE prepares a letter to DOJ (Exhibit 2) notifying DOJ that a claim based on RECA has been submitted and requesting information concerning whether the claimant either received an award or filed a claim under Section 5 of the RECA. This letter provides DOJ with options for response depending on the status of the RECA claim. The initial inquiry to DOJ is not done via email. As discussed below, no further information is required of DOJ if a Section 5 RECA award has been approved for all claimed conditions. If a Section 5 RECA claim is pending, the letter requests that DOJ send a letter verifying employment and all medical, employment and survivorship evidence on file. If the Section 5 award is denied, the letter requests the following: a copy of DOJ's decision and all employment, medical and survivorship evidence available to DOJ. If no Section 5 RECA claim exists, the letter requests that DOJ send a letter verifying employment.

b. Condition Not Covered Under RECA Section 5, But Claim Involves a Uranium Miner. The CE prepares a different letter to DOJ (Exhibit 3) if the claimed condition is not a covered RECA Section 5 illness. This letter requests that DOJ send all employment, medical and survivorship evidence available to DOL and a statement verifying employment regardless of the outcome of the Section 5 claim.

c. If the claimant filed for a medical condition that is not covered under the RECA in addition to covered RECA conditions, the CE may send the standard request to DOJ (Exhibit 2) and defer the request for copy of records until additional development is conducted to avoid multiple requests for the same claim. The CE may also defer the request for copy of records based on the nature and quality of the medical evidence in the case file. Upon receipt of the requested documentation from DOJ, the CE can request whatever additional evidence deemed necessary for development at a later date via follow up email communication with DOJ. The CE attaches a copy of the EE-1 or EE-2 to the letter in all instances. The EE-1 or EE-2 signed by the claimant serves as a Privacy Act waiver allowing DOJ to release information to DOL regarding specific individuals.

d. Response from DOJ.

(1) DOJ Approves the Section 5 Award. DOJ advises DOL of Section 5 RECA awards in writing (Exhibit 1). Once the CE receives confirmation of the award, the Part B claim is in posture for acceptance.

(2) DOJ Award Adjudication Pending. If a Section 5 RECA

claim is filed but pending DOJ adjudication, DOJ will provide DOL with a letter (Exhibit 4). DOJ also provides DOL with the factual statement of employment as requested and all employment, medical and survivorship evidence available to DOJ. The CE proceeds to develop for benefits under Part E. Any factual statement provided by the DOJ verifying the uranium worker's specific dates and places of employment covered under Section 5 of the RECA suffices to verify employment as to those specific dates and places only.

(3) DOJ Denies Section 5 Award. A DOJ Section 5 award denial automatically translates into a DOL denial under Part B. However, due to the expanded definition of a covered uranium worker and expanded covered conditions under Part E, a DOJ Section 5 award denial has no effect on Part E adjudication, and the CE continues to develop for coverage regardless of any negative determination or pending action on the part of DOJ. DOJ may deny Section 5 awards based upon RECA employment requirements that have no bearing on the EEOICPA. Additionally, DOJ denies Section 5 awards if the claimed condition is not a covered condition under the RECA. Expanded covered conditions under Part E might allow for an acceptance where DOJ has denied a claim. Accordingly, the CE proceeds to develop for Part E benefits, obtains all information relevant to DOJ's adjudication process from DOJ, and evaluates all available evidence to reach a determination as to coverage under the Act.

(4) No DOJ Section 5 Claim Filed. If the DOJ responds (Exhibit 5) indicating the claimant has not filed for an award under Section 5 of the RECA, the CE will contact the claimant in writing (Exhibit 6) and advise the claimant that benefits may only be awarded under Part B of the EEOICPA if the covered employee or claimant has been approved for an award under Section 5 of the RECA. The letter also notifies the claimant their Part E claim is not dependent on a Section 5 RECA award and is being developed. In such cases, the CE requests employment verification from DOJ (See Exhibits 2 and 3). The letter should ask the DOJ to confirm the accuracy of the claimed employment and whether the reported employment is covered under the RECA. The CE completes development of the Part E claim and issues a recommended decision as soon as all the required facts are examined and a coverage determination made.

(5) If a claimant was denied due to having no Section 5 RECA award and later obtains an award and submits it to DEEOIC, there is no need to require the claimant to file a

new claim. In this instance, the claim is simply reopened and adjudicated under the guidance set out in this Chapter.

e. Evaluating and Obtaining Evidence from DOJ. In some cases DOJ initially provides verification of RECA Section 5 employment in the form of a factual statement of employment. The initial communication with DOJ (Exhibit 2) indicates that additional evidence may be sought as claim adjudication proceeds. The DO CE seeks additional evidence from DOJ as necessary by contacting DOJ in writing (either by letter or email) requesting whatever additional documentation is required to adjudicate the claim under Part E. DOJ has requested that all medical, employment and survivorship (if applicable) evidence be requested at the same time to avoid multiple requests on the same claim.

In cases where DOJ does not grant a Section 5 award based upon employment, the CE requests all employment and medical evidence in DOJ's possession and renders an independent finding as to employment. The CE reviews all evidence obtained from DOJ to assist in reaching a decision regarding the acceptance or denial of benefits under the EEOICPA.

(1) Concurrent Development. While obtaining information from DOJ is important, the CE concurrently conducts independent development as needed to obtain employment, medical, survivorship and exposure evidence that assists the CE in adjudicating the claim under Part E. Such development should begin immediately upon receipt of the claim file in the DO if a medical condition is claimed that is not covered under the RECA or if the applicant indicates a RECA claim was not filed. The CE pursues additional evidence from the claimant, treating physicians, other health care providers, employers, and exhausts all other sources of information when developing for adjudication. The CE reviews and weighs all evidence obtained through the development process before issuing the recommended decision.

f. Cancer Claims. Based upon a diagnosed cancer not accepted under RECA and covered employment, the case file must be referred for dose reconstruction to the Department of Health and Human Service's National Institute for Occupational Safety and Health (NIOSH). The dose reconstruction is used to determine the probability of causation between the diagnosed cancer and the radiation dose potentially received during the covered employment. If a cancer claim is accepted under Part E based on exposure to a chemical or biological toxic substance, there is no need to refer the case to NIOSH.

g. Issuing the Recommended / Final Decision and Post Adjudication Actions. Once the CE receives confirmation of a Section 5 RECA award, a recommended decision to accept the Part B claim should be issued. In all instances other than awards involving survivors, an acceptance

under Part B will correlate to an acceptance under Part E as to the medical conditions accepted by DOJ and the CE can prepare a recommended decision to accept the claim for benefits under the Act and proceed with whatever other development that is required (i.e. other claimed illnesses, impairment claims and wage loss claims). The recommended decision of acceptance will address the fact that the additional lump sum payment of $50,000 and medical benefits when applicable, are awarded in addition to the Section 5 RECA award of $100,000.

(1) Part E Claim in Posture for Denial. If after complete development, the CE determines that the Part E claim is in posture for denial, no recommended decision denying benefits is issued until DOJ has issued its decision regarding the Section 5 award, because a DOJ acceptance may prompt an automatic approval under Part B and Part E (except in certain survivorship cases). In such cases where the Part E EEOICPA claim is in posture for denial and is pending adjudication at DOJ, the CE may administratively close the claim for timeliness purposes and reopen once DOJ issues its decision.

(2) Acceptances. If after complete development the CE determines that any part of the Part E EEOICPA claim is in posture for acceptance, a recommended decision is issued accepting the claim under Part E. The CE must address the status of the Part B claim in the recommended decision.

(3) Part B Reopening. If a Part B claim is denied by the Final Adjudication Branch because the claimant has not filed for or received an award under Section 5 of the RECA and the claimant later submits evidence showing a Section 5 award, a reopening should be initiated by the district office.

6. Verifying RECA Section 5 Part E Employment. Under Part E, the CE must develop claimed employment if the employee or survivor claims a medical condition not included in the claimant's RECA award. If not already submitted, the CE will send a Form EE-3 to the claimant so that all potentially eligible employment can be identified and developed. This should be done upon the initial review of the claim file if a medical condition is claimed that is not covered under the RECA. The CE does not need to develop employment under Part E where all claimed medical conditions were awarded under RECA.

a. DOJ Employment Verification. Upon receipt of the notification letter that the Department of Labor has received a RECA claim, DOJ searches its records. DOJ issues a letter to DOL regarding the status of the claimant's Section 5 RECA claim. If requested, DOJ will also provide copies of all medical, employment and survivorship evidence on file for the employee. DOJ refers to survivorship documents as "identification" documents.

(1) Employment Verified. In instances where employment is verified by a Section 5 RECA award, the CE accepts this as proof establishing covered employment under the EEOICPA for the medical conditions upon which the RECA award is based.

(2) Employment Not Verified. In cases where DOJ has denied a Section 5 award based upon employment, the CE requests from DOJ (Exhibit 2) all evidence at its disposal that was used to determine that employment could not be verified. In instances where DOJ denies a Section 5 RECA claim because employment cannot be verified, or where no Section 5 RECA claim exists, the CE must independently develop employment.

(a) Reasons for Failure to Verify: DOJ cannot verify employment if no record of employment exists or if claimed employment at a certain mine or mill falls outside of the period in which the mine or mill was in operation or outside of the covered time period. In such instances, the CE conducts further development and obtains additional evidence where available in an attempt to verify employment during the covered time period of January 1, 1942 through Decem ber 31, 1971.

b. Use of SEM for Employment Development. The SEM cannot by itself verify employment. However, SEM should be used to verify the claimed site of covered employment years of operation and known operating contractors during the period of claimed employment. SEM contains a list of uranium mines, uranium mills and vanadium-uranium ore transporters and the time period each was in operation. By obtaining Social Security Administration (SSA) earnings records, the CE can confirm the employee worked for the reported employer(s). However, an affidavit (such as a Form EE-4) or verification from the DOJ is needed to place the worker at the covered site. Additionally, the SEM "Site History" section for each facility lists all prime operating entities and respective operating dates. The CE should attempt to match the operator's name and dates to employment evidence as an additional corroborative step toward verifying employment.

c. Uranium Worker Employment Requirements. In developing a claim for a uranium worker, only one day of employment exposure is required, but additional employment may be necessary to satisfy certain causation criteria regarding exposure as will be outlined in the new unified EEOICPA PM 2-0700 Establishing Toxic Substance Exposure.

d. The CE assesses exposure for a uranium ore transporter based upon that individual's confirmed presence at a uranium mine or mill. Claimed exposure in transit will not be considered when conducting a causation analysis. Only the time in which an ore transporter is actually physically present at a mine or mill will be counted as

covered employment for exposure development purposes.

7. Verifying Part E Exposure for RECA Section 5 Claims. The CE evaluates exposure for uranium workers based upon SEM and/or other data which will be outlined in the new unified EEOICPA PM 2-0700. The CE also verifies exposure through employment exposure records and supporting evidence submitted by the claimant. In addition, the Resource Center (RC) calls the claimant to complete an occupational history questionnaire (OHQ) on RECA claims to obtain information regarding exposure.

a. Ensuring SEM Accuracy. - All covered RECA Section 5 uranium mines, mills and ore transporters should be listed in SEM because all such employment is covered under the EEOICPA. If the CE identifies a uranium mine, uranium mill or a vanadium-uranium ore transporter in operation during the covered time period but not listed in SEM, the CE should provide all pertinent facts regarding the omitted site or employer to the designated DO SEM point of contact (POC). The DO SEM POC will contact the National Office SEM POC via email. The National Office SEM POC will then contact DOJ to determine coverage.

b. Employment Evidence. The CE uses employment records, where available, to evaluate for exposure. The CE obtains such evidence from either the claimant or the employer and reviews the totality of the evidence of file to determine whether or not it is established that the employee was exposed to a toxic substance.

c. Occupational History Development. As noted above, the RC calls the claimant to complete an OHQ on most RECA claims involving the worker or eligible survivors. An OHQ is designed specifically to develop information regarding workplace exposure. The CE is to request that the RC conduct an OHQ interview if one has not been conducted for an eligible claimant.

8. RECA Section 4 Claims. Some EEOICPA claimants may have filed a claim under Section 4 of the RECA. The statutory language in 42 U.S.C. § 7385j of the EEOICPA acts as a bar to any cancer claim filed by an individual under EEOICPA who has received compensation under Section 4 RECA. Section 4 of the RECA only provides benefits for cancer. As such, a claimant cannot receive an award under both Section 4 RECA and the EEOICPA for a cancer claim regardless of whether the claimant filed for different cancers under EEOICPA than awarded under RECA 4 or if the claimant filed for multiple cancers and one or more cancers is the same as the cancer awarded under RECA Section 4. If a claimant has not yet received a Section 4 RECA award and is eligible for an EEOICPA award, the claimant must choose between the Section 4 RECA award and the EEOICPA award. A RECA Section 4 award has no effect on non-cancerous conditions claimed under the EEOICPA.

Under RECA, an individual cannot receive an award under both Section 4 and Section 5. Without an award under RECA section 5, a claim based on RECA employment will not meet the Part B requirements.

a. Identifying a Section 4 RECA Claimant. The CE can identify a claim submitted by a Section 4 RECA claimant by reviewing the information provided on the EE-1 or EE-2. If the claimant checked the box indicating he or she applied for an award under Section 4 RECA, the claim is to be developed in accordance with the guidance set out in this section.

b. Letter to DOJ – Section 4 RECA. Once a Section 4 RECA claim is identified, the CE prepares a letter to DOJ (Exhibit 7) requesting information concerning whether the claimant either received an award or filed a claim under Section 4 of the RECA. The CE attaches a copy of the EE-1 or EE-2 to the letter in all instances.

c. DOJ Approves the Section 4 Award. Should cancer be the only claimed illness under the EEOICPA, and an acceptance of an award under RECA Section 4 is confirmed, the CE may proceed with a recommended denial of compensation under Part E. The denial of compensation should specifically reference the exclusion of benefits for cancer under both EEOICPA and RECA contained in 42 U.S.C. § 7385j.

d. DOJ Award Adjudication Pending. If the response from DOJ indicates that a RECA Section 4 decision is pending, the CE takes the following actions depending on the claimed conditions:

(1) Cancer. - The CE must prepare a letter to the claimant(s), explaining that an EEOICPA and a RECA Section 4 cancer claim cannot be adjudicated concurrently. The claimant(s) must be asked to select which program they wish to pursue benefits under, for the claimed cancer(s). The claimant(s) must be notified that if they accept the RECA Section 4 award, they cannot receive an award under the EEOICPA for a cancer claim. The claimant(s) should be notified that if they either fail to respond within 30 days, or if they elect to pursue their cancer claim under RECA, their EEOICPA cancer claim will be denied. The claimant(s) should also be advised that if they wish to pursue their cancer claim under EEOICPA, they must formally withdraw their claim from RECA, and confirmation of such withdrawal must be obtained from DOJ. The letter should further state that if their RECA claim ultimately ends in a denial, then they may seek to have their EEOICPA cancer claim reopened.

Depending upon the response from the claimant(s), the CE will either proceed with the adjudication of the claimed cancer (upon confirmation of RECA Section 4 withdrawal) or will proceed with development of the case for non-cancerous conditions, and will issue a recommended decision that includes a denial for the claimed cancer. Any recommended decision that includes a denial of a claimed cancer, on the grounds that compensation cannot be awarded under both RECA

Section 4 and EEOICPA, must reference 42 U.S.C. § 7385j.

(2) Non-Cancer. Any non-cancerous condition will be treated like any other claim.

e. Rejection of Section 4 RECA Award. If DOJ reports that a RECA-4 award has been granted, but the claimant has elected to reject the settlement, and if a copy of the Acceptance of Payment form confirms this, the CE can proceed with the adjudication of the cancer claim under the EEOICPA.

9. Interagency Consistency. As noted above, since uranium workers and their survivors are treated and defined differently under Part E than Part B, and the universe of covered conditions has expanded significantly under Part E, uniform consistency in agency decision making is not always possible. Nonetheless, DOL and DOJ will inform each other when decisions are to be issued that are inconsistent with the other agency's findings. Both DOJ and DOL will work to issue consistent decisions where employment verification findings are concerned, but this may not always be possible. As such, FAB supplies DOJ with copies of final decisions issued to RECA claimants. DOJ will provide DEEOIC National Office with copies of those decisions inconsistent with DEEOIC findings. Additionally, the Senior CE in the DO will inform DOJ via email when a recommended decision is being issued that is inconsistent with a DOJ decision.

Exhibit 1: DOJ Response to District office Request for Identification of Pending RECA Claim

Exhibit 2: Letter to DOJ for RECA Award Confirmation

Exhibit 3: Alternate Letter to DOJ for RECA Documentation

Exhibit 4: DOJ Response to District Office Request for Identification of Pending RECA Claim

Exhibit 5: DOJ Letter Indicating No Claim Filed

Exhibit 6: Letter to Claimant Advising of Part B RECA Award Requirement

Exhibit 7: Letter to DOJ for Section 4 RECA Claim Status

2-1200 Establishing Survivorship

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1 Sample Letter to Potential Survivor Advising of Right to File Claim
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1. Purpose and Scope. This chapter contains procedures for the development and review of survivor claims under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA). It also describes the process followed when a non-covered spouse or child opts for the alternative to filing a Part E claim.

2. Policy. The Claims Examiner (CE) is responsible for processing survivor claims and ensuring that benefits are properly paid to eligible survivors under the provisions of 42 U.S.C. 7384s(e) and 7384u(e) for Part B and 42 U.S.C. 7385s-1(2), and 7385s-3 for Part E.

3. Eligible Survivors. If an employee eligible for EEOICPA benefits is deceased, one or more of the employee's survivors may file a claim for compensation under the EEOICPA. Along with a completed Form EE-2, the claimant must document his or her relationship to the covered employee. If documentation is not submitted with the claim, the CE writes to the claimant requesting the necessary evidence. When developing a survivorship claim, the CE

sends letters to all survivors claiming benefits, requesting medical and employment evidence sufficient to establish eligibility of the deceased employee. However, a request for documentation necessary to support the eligibility of a specific claimant is only to be sent to that claimant.

When a survivor files a claim, the CE is responsible for adjudicating the claim(s) and for processing any compensation which may be payable in the order of eligibility outlined below.

a. Part B. Compensation may be payable to eligible survivors in the following order: spouse, children, parents, grandchildren, and grandparents of the deceased covered Part B employee.

b. Part E. Compensation may be payable to eligible survivors in the following order: spouse; then children who were under the age of 18 years at the time of the employee's death, or under the age of 23 years and continuously enrolled as a full-time student at the time of the employee's death, or were any age and incapable of self-support at the time of the employee's death.Unlike Part B, the following claimants are not eligible for survivor benefits under Part E: adult children (with the exception of those incapable of self-support at the time of the covered employee's death), parents, grandchildren, and grandparents of the deceased covered Part E employee.

c. Conviction of Fraud. A person convicted of fraud in the application for or receipt of benefits under the EEOICPA or any other federal or state workers' compensation law forfeits any entitlement to the EEOICPA benefits for any occupational illness or covered illness due to an exposure on or before the date of the conviction.

4. Filing a Claim for Survivor Benefits. A claim for survivor benefits must be in writing. Any written communication that requests survivor benefits under the Act will be considered a claim for purposes of case creation and claim development. However, a completed and signed Form EE-2 must be submitted for DEEOIC to fully adjudicate the claim and issue a recommended and final decision to that survivor.

a. Acting on Survivor's Behalf. Any person acting on behalf of a survivor may file a claim under the EEOICPA for that survivor. In the case of a minor child, it is preferable that a parent or legal guardian complete the form on the child's behalf. A legal guardian is a person with the responsibility for providing care and management of a child and his or her affairs.

b. No New Claim Needed for Part E. There is no need for a survivor to file a new claim for benefits under Part E when there is an existing, accepted Part B claim, or when the survivor filed a Part D claim (Form 350.2) with DOE as long as the accepted condition under Part B was causally related to the employee's death.

c. Excluding Claims Due to Tort or State Workers' Compensation Benefit. A survivor may choose to exclude from his or her claim any

condition caused by an exposure for which there has been a settlement from a tort action or, under Part E, any condition leading to receipt of a payment under a state workers' compensation program. This may preclude any need to reduce payable benefits. (Refer to PM Chapter 3-0400, Tort Action and Election of Remedies and PM Chapter 3-0500, Coordinating State Workers' Compensation Benefits.)

5. Establishing Employee's Death. For any survivor claim, the initial action to be taken by the CE is the confirmation of the employee's death.

a. Death Certificate. The document used to verify the death of an employee is a death certificate, typically issued by an official state or local governing agency. For the most part, a death certificate lists the name of the decedent, date of death, his or her marital status at time of death, usual occupation, and cause of death certified by a physician or some other official. A death certificate is required to be submitted to confirm the death of an employee in a survivor claim filed under Parts B and E.

(1) An official copy (stamped) of an employee's death certificate is not required. A copy can be accepted.

(2) Some states have implemented the use of electronic death certificates, which may be used to establish the death of the employee. To be acceptable, a printed copy of the electronic record must be obtained that identifies the certifying official. If a physician is the certifying official, his or her license number must also be included.

6. Linking Employee's Death to an Occupational or Covered Illness. For a compensable claim under Part B, it must be shown that the employee was diagnosed with an occupational illness including: cancer, chronic beryllium disease or chronic silicosis. The evidence does not need to show that any one of these conditions was linked to the employee's death, merely that one or more was diagnosed. This also applies to a covered illness that develops over the course of the employee's life and resolves by way of medical treatment. However, for a compensable claim under Part E, the evidence must establish that an occupational exposure to a toxic substance was at least as likely as not a significant factor in causing, contributing to, or aggravating the death of the employee.

7. Surviving Spouse. For either a Part B or Part E claim for spousal survivorship, the necessary documentation to establish a viable claim usually consists of a copy of the marriage certificate issued or recognized by a State Authority or an Indian Tribe Authority. A "Certificate of Blessing of Marriage" from a church is not considered the equivalent of a marriage certificate. A marriage license is also unacceptable. To be an eligible surviving spouse, the spouse must have been married to the employee for one year immediately prior to the death of the employee. This prior year includes the date of marriage, through the day prior to the date of

death. For example, if an employee married on September 4, 2004 and died on September 3, 2005, the CE does not include September 3, 2005 when calculating the required 365-day term. The CE counts each calendar day from September 4, 2004 up through and including September 2, 2005.

a. In cases where evidence shows that the employee was previously married, it is not necessary to obtain proof of divorce. However, in the event that the evidence in a case raises concern as to the legitimacy of the marriage for which survivorship is being established, the CE should develop further and obtain a copy of the divorce decree (or death certificate if marriage ended due to death of spouse) validating that the marriage was dissolved.

b. In some instances a common-law marriage may exist between the employee and the surviving partner. When the evidence does not sufficiently establish that the claimant had a licensed/certified marriage with the employee for the 365 days immediately prior to the employee's death – or where there is some evidence to suggest that the marriage was not valid – the CE may have to gather sufficient evidence to make a determination as to whether the parties established a common-law marriage *in a state or other territory which authorizes such* marriages. As a general rule, the existence of a common-law marriage is determined by the law of the state that has the most significant relationship to both spouses and to the alleged marriage. If full development of the claim results in evidence that the alleged common-law marriage occurred in a state that does not allow the creation of such marriages within its borders – and no other state is involved – the inquiry may end there.

(1) The CE must develop evidence sufficient to establish that any claimed (or potential) common-law marriage meets two threshold issues. The first is *when* the common-law marriage was entered into, and the second is *where* it was entered into.

(2) Once the "when and where" elements have been established, the CE should proceed with additional development to document the five standard elements of a common-law marriage outlined in the *Common-Law Marriage Handbook*.

(3) Evidence which may be used to document a common-law marriage may consist of the following items, as delineated in the handbook: affidavits, marriage and divorce documents, death certificates, children's records, real estate documents, tax records, banking and loan documents, contracts including insurance documents, employment documents, medical records, tribal documents, wills, trusts, power of attorney documents, utility bills, letters, and/or other significant formal or informal documents.

(4) The burden to produce all necessary evidence and to establish each element of their eligibility by a preponderance of the evidence rests with the claimant(s). The purpose of development regarding a claimed common-law marriage is to obtain sufficient information and probative evidence to support a determination regarding whether a common-law marriage was ever created, and if so, its duration. If the evidence is sufficient to reach a decision, the CE may proceed with adjudication. If the evidence is not clear, or is in dispute, guidance may be obtained by the Policy Branch, by referring the case file along with a memorandum of explanation.

8. Surviving Child. A "child" of an individual under both Parts B and E of the EEOICPA can only be a biological child, a stepchild, or an adopted child of that individual. A person who is or was a dependent of the employee but does not fit within the definition of a qualifying "child" is not an eligible survivor. In the vast majority of situations, a birth certificate showing the employee as the parent of a child is sufficient to establish survivorship. Where the claimant claims to be a child of the deceased employee and the birth certificate does not list the deceased employee as the father or mother of the claimant, the CE must undertake development to ascertain the circumstances of the claim. Development is also necessary in any instance where the paternity of a child or his or her connection to the employee is challenged. The CE must use discretion when evaluating evidence in support of a survivorship claim and weigh all evidence received in its totality.

a. Categories of eligible children.

(1) Biological Child. The term "biological child" is broad and refers to all persons with either a presumed or established genetic link to a deceased employee. Because a recognized natural child is presumed to have a genetic link to a deceased employee, a recognized natural child is one type of biological child. Another type of biological child is a person whose birth certificate lists the deceased employee as their mother or father, because these persons are also presumed to have a genetic link to their listed mother and father. However, these two presumptions may be rebutted if substantial evidence exists that rebuts the existence of the genetic links, consistent with 20 C.F.R. § 30.111(d). The final type of biological child is any person who can establish an actual genetic link to a deceased employee through the submission of probative DNA evidence that shows such a link.

A person who either is or was only a "dependent" of a deceased employee, but does not fit within the above comprehensive definition of a "child" of that deceased employee, is not a "child" of the employee for the purposes

of EEOICPA.

(2) Stepchildren. Claims for eligibility as a stepchild will be decided by the District Offices (DO) unless there is an issue that cannot be determined by the CE. In circumstances where the status of a stepchild as a potentially eligible survivor cannot be determined, the matter should be referred to the National Office Policy Branch.

(a) A stepchild is defined as any individual who establishes a parent-child relationship with the employee through the marriage of their parent to the employee. This determination is made once the CE receives documentation from the stepchild in support of their claimed relationship.

(b) Documentation supporting a regular parent-child relationship may include school records (e.g., report card) listing the employee as having a familial relationship to the stepchild, employment or tax returns showing that the covered employee claimed the stepchild as a dependent, photographs taken at family gatherings, newspaper articles, obituaries, insurance policies listing the stepchild as the son or daughter of the covered employee, wills, and/or any other documents that refer to the stepchild and the deceased employee in a familial way.

(c) Under Part B, where a stepchild was an adult at the time of the deceased employee's marriage, the evidence will be considered on a case by case basis. Evidence that may document eligibility includes records that the stepchild was the primary contact in medical dealings with the deceased employee, that the stepchild provided financial support for the deceased employee, and/or provided housing for the deceased employee, etc. Evidence consisting of medical reports, letters from the physician, or receipts showing that the stepchild purchased medical equipment, supplies or medication for the employee may be helpful. These items of evidence will be considered on a case-by-case basis and each should be weighed together to fully evaluate the eligibility of the survivorship claim.

(d) There is no minimum time requirement for a stepchild to have lived in the same household as the covered employee, merely that a parent-child relationship existed. To determine if a parent-child relationship existed, the CE/FAB representative must consider the above information in conjunction with the following: Did the stepchild visit the employee during

the holidays?; Did the stepchild take care of the employee for days at a time?; and is it logical that the stepchild and employee stayed at one another's home at any given time? As long as a reasonable basis exists to show that a parent child relationship existed, the CE can make an affirmative finding.

(e) For claims involving a divorce between the biological parent and the stepparent, the dissolution of the marriage does not terminate the parent-child relationship for eligibility purposes. As such, because a parent-child relationship did exist at one time, the child is considered an eligible stepchild. An ongoing parent-child relationship following divorce is not necessary.

(f) The CE or FAB representative must consider the totality of the evidence when determining whether the stepchild qualifies, and must provide the rationale supporting whatever outcome in the Recommended and/or Final Decision.

(3) Adopted Child. An adopted child is defined as a child that is not biologically related to the employee, but whose parental responsibilities have been permanently transferred by a legal mechanism to the employee. The CE obtains the relevant legal document(s), whether state, tribal, or otherwise, confirming the transfer of responsibility to the employee.

b. Qualifications for eligibility under Part B vs. E.

(1) Part B Surviving Child. A surviving child is a biological, stepchild, or adopted child of the employee regardless of age.

(2) Part E Surviving Child. Under Part E, a "covered" child must also have been, *as of the date of the employee's death:* either under the age of 18 years, under the age of 23 years and a full-time student who was continuously enrolled in one or more educational institutions since attaining the age of 18 years, or any age and incapable of self-support regardless of their marital status.

(a) Student Status. To be considered a full-time student at the time of the employee's death, the child must have been continuously enrolled as a full-time student in one or more educational institutions since attaining the age of 18 years and must not have reached the age of 23 years, regardless of marital status or dependency on the employee for support.

(1) Enrollment as a full-time student generally consists of a 12-month period, with a break of no

more than four months, during each year of post high school education.

(2) If the child's status as a full-time student is uncertain, the CE consults the academic institution to determine what was considered to be the minimum number of hours required to qualify as "full-time" (versus part-time), at the time of the child's enrollment, as this may vary from one institution to another.

(3) With certain programs such as co-op, intern, or graduate school programs, while the student might not actually be enrolled in any courses for a particular term, he/she could still be "registered" as a full-time student while fulfilling other requirements of the program.

(4) If a student is prevented by reasons beyond his or her control from continuing education for a period of reasonable duration, (such as a brief but incapacitating illness,) the CE has discretion to determine whether the student's status as a continuously enrolled full-time student should be preserved. A suspension from school for a limited period should not affect the child's status as a continuously enrolled full-time student.

(5) Leaving school to care for a sick parent/employee, lack of funds to pay for school as a result of a parent/employee's illness, or dropping/failing out of school is not a sufficient basis to maintain the child's status as a continuously enrolled full-time student.

(6) Documentation to support eligibility includes transcripts from the accredited educational institution(s), school records, and affidavits.

(b) Incapable of Self-Support. To establish eligibility for benefits as a covered child who was incapable of self-support at the time of the employee's death, the child must have been physically or mentally incapable of self-support, regardless of marital status or dependency on the employee for support, regardless of the temporary or permanent nature of the incapacity.

(1) A child is incapable of self-support if, at the time of the employee's death, his/her physical or mental condition was such that he/she was unable to obtain and retain a job or engage

in self-employment that could provide he/she with a sustainable living wage.

(2) Medical evidence must show that the child was diagnosed with a medical condition establishing that he/she was physically/mentally incapable of self-support at the time of the employee's death.

(3) Documentation to support the incapability of self-support can include medical records, social security disability records, tax returns showing that the covered child was claimed as a dependent, state guardianship documents, and affidavits.

SSA or State disability records alone, showing lack of self support, should not be used to establish that the child is incapable of self-support. The CE must consider the evidence as a whole to determine if it demonstrates that the person was/is incapable of self-support for purposes of the EEOICPA.

(4) When medical evidence demonstrates incapacity for self-support, this determination will stand unless refuted by sustained work performance.

(5) A child is not incapable of self-support merely because of an inability to obtain employment due to economic conditions, lack of job skills, incarceration, etc.

(6) There is no specific timeframe required to establish that a child was incapable of self-support prior to the death of the employee (e.g. accident). It is only necessary to establish that the child was incapable of self-support on the day the employee died.

c. Non-spousal children. In certain situations, a special provision of the Act allows for the division of benefits between an eligible spouse and an employee's child who is not related to the spouse.

(1) Under Part B only. If there is at least one child of the employee who is a minor at the time of payment, and who is not a recognized natural child or adopted child of the spouse, half of the payment is made to the covered spouse and the other half is made in equal shares to each child of the employee who is a minor at the time of payment, without regard to whether the child is a spousal child, or non-spousal child. A recognized natural child is a child acknowledged by the

employee as their own during their lifetime. The RD and FD must fully explain the distribution of compensation to the spouse and all children who have filed a claim.

(2) Under Part E only. If there is at least one child of the employee who is living at the time of payment, who qualifies as a "covered child" (i.e., under the age of 18 at the time of the employee's death, between the ages of 18 and 23 and continuously enrolled as a full-time student since attaining the age of 18, at the time of the employee's death, or any age and incapable of self-support at the time of the employee's death) and who is not a recognized natural or adopted child of the spouse, half of the payment is made to the covered spouse, and the other half is made in equal shares to each "covered child" of the employee, who is living at the time of payment, without regard to whether the child is a spousal child or non-spousal child. Refer to the definition of a recognized natural child found under Part B above. The RD and FD must fully explain the distribution of compensation to the spouse and all children who have filed a claim.

9. Parents, Grandchildren and Grandparents. Under Part B only, parents, grandchildren (including biological, adopted and step-grandchildren), and grandparents may be eligible for survivor benefits provided there is no surviving spouse or living child who is eligible to receive compensation. When adjudicating a survivorship claim for a parent, grandchild, or grandparent, documentation must establish the relationship of the survivor to the deceased employee (i.e. employee's birth certificate listing parent's name, parent's birth certificate showing grandparent's name, etc.). Parents, grandchildren and grandparents are not eligible for survivor benefits under Part E.

10. Potential for Additional Survivors. When an additional potential survivor is identified on Form EE-2 or through some other development action, the CE contacts the individual by letter explaining their right to file a survivor claim (Exhibit 1).

a. Letter to Survivor. The letter to the survivor does not indicate whether the individual is qualified to receive benefits, as this is a function of the claims process after a Form EE-2 has been filed. Rather, the letter outlines the general requirements for survivor eligibility. The CE explains that filing a claim does not guarantee that benefits will be payable, as both statutory and regulatory requirements must still be met before compensation can be awarded.

b. Form EE-2. A blank Form EE-2 is enclosed with the correspondence.

The potential survivor is asked to complete and submit the form within 30 days. If the claim is not received within the 30-day time period, the CE can proceed to adjudicate the case on the assumption that a claim is not forthcoming. Additional information on handling non-filing claimants can be found in the PM Chapter 2-1600, Recommended Decisions.

c. Additional Documentation. To ensure that compensation is paid to eligible survivors of the deceased employee, the CE may require the survivor to provide documents, affidavits, or records sufficient to substantiate the veracity of their claim.

11. Claims Involving Multiple Claimants. When a claim is filed, it is created in ECMS B, ECMS E, or both based on claimed employment and claimed illness(es). In some cases, multiple claimants will file a claim for one or more illnesses. And in some of these cases, not all claimants will claim the same illness(es). Therefore, in cases involving multiple claimants, an illness claimed by one claimant will be considered claimed by all parties to the case (unless the claimant specifically states they do not wish to claim the additional illness) and should be entered in the appropriate ECMS system for each claimant. This means that all illnesses will be addressed for all claimants without the request for additional claim forms.

a. Findings for Each Survivor. Once appropriate development is completed and review of evidence undertaken, one comprehensive RD addressing the claims of all filing parties may proceed. Each party to the claim must receive an individual finding in the decision with respect to his or her eligibility. The decision references each survivor who has filed a claim and specifies whether they are entitled to receive compensation, the amount of compensation payable to each eligible survivor, and the basis for the conclusions reached.

b. One Comprehensive Decision - Given the procedure requiring each individual in a multi-claimant case be party to a decision on entitlement of benefits, all claims associated with the case must be reopened before a new decision can be issued (Refer to PM 2-1900, Reopening Process).

b. Individual Addresses. The RD does not include the addresses of the various claimants. Instead, a cover letter is addressed to each claimant and a copy of the RD is sent to all filing parties.

c. Lack of Form EE-2. The CE may encounter a situation where a survivor has made a claim for benefits in writing but has not filed Form EE-2. Alternatively, the CE may have evidence indicating the existence of a potentially eligible survivor but is unable to contact the survivor to obtain a completed Form EE-2. Under these circumstances, the CE proceeds to issue an RD (See PM Chapter 2-1600, Recommended Decision).

12. Issues During the Payment Process.

a. Death Before Payment. If the employee/survivor is alive when

the FD is issued but dies before payment is received, the employee/survivor's claim must be administratively closed in ECMS. Receipt of payment is defined as the date the Electronic Funds Transfer (EFT) is received at the payee's bank or the date the paper check is received by the payee or someone legally able to act for the employee in receiving the payment.

(1) Any compensation payment (whether check or EFT) received after the employee/survivor's death must be returned to the Treasury Department, and the payment must be cancelled in ECMS. (Refer to PM 3-0600 Compensation Payments for the payment cancellation steps.)

(2) Survivor claims are appropriately developed and a new RD is issued to all survivors who have filed a claim.

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 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. However, if the employee received any compensation for impairment or wage-loss, prior to his death, such payment voids the election of benefit option.

(1) When an election of benefits is available, the CE contacts the survivor via telephone or letter advising the survivor of the option to receive the benefits that the employee would have received had he/she not died prior to receiving payment. The CE obtains a verbal response and follows with written confirmation of the survivor's option.

(2) The survivor could be awarded the impairment benefit the employee would have received, but *only* if the medical evidence meets all the criteria in the AMA's Guides to the Evaluation of Permanent Impairment, and is in conformance with the regulations regarding medical evidence used to support an award for impairment. (Refer to PM Chapter 2-1300, Impairment Ratings)

(3) Also, the survivor could be awarded the wage-loss benefit the employee would have received. (Refer to PM Chapter 2-1400, Wage-Loss Determinations)

(4) Under the election, survivor benefits are payable up to the aggregate limit under Part E.

(5) The survivor is not entitled to the $125,000 lump-sum payment

because death was not caused by the covered illness(es).

c. Change in Child Status. Under Part B, a non-spousal child who is a minor at the time of filing may be advised in the FD that he or she is approved for compensation. However, at the time of payment that child may no longer meet the state law definition of a minor. In this situation, compensation cannot be awarded. The final decision is vacated and a new final decision is issued denying the claim with a finding that the non-spousal child is an ineligible survivor. However, every effort should be taken by the CE/FAB representative to avoid such a situation.

d. Survivor's Death. An eligible survivor must be alive to receive any payment awarded under the Act. If one eligible survivor in a multiple survivor claim dies before payment is received, the deceased survivor's claim is administratively closed and a new recommended decision must be issued reapportioning compensation among the remaining eligible survivors.

e. Survivor Compensation Part B. A survivor may receive one lump sum payment under Part B for each employee for whom he/she qualifies as an eligible survivor. If a survivor files a claim for benefits and a lump sum payment has previously been paid to the employee, the CE is to deny the survivor's claim because the maximum allowable benefit has already been paid. The maximum benefit under Part B is $150,000.

f. Survivor Compensation, Part E. An eligible survivor is entitled to the amount of $125,000 if it is determined that an accepted illness caused, contributed to, or aggravated the death of the employee.

A survivor may receive more than the basic $125,000 survivor benefit if the deceased, covered Part E employee experienced compensable wage-loss as a result of any covered illness prior to his or her attainment of normal Social Security retirement age as defined by the Social Security Act. The additional benefit of $25,000 or $50,000 is dependent upon the number of years for which the employee experienced wage-loss (Refer to PM Chapter 2-1400 on wage-loss determinations). The maximum survivor benefit payable under Part E is $175,000.

g. Aggregate Compensation Payable under Part E. The total amount of compensation payable, excluding medical benefits, may not exceed $250,000 per covered employee. The CE does not develop for additional medical conditions once the aggregate compensation amount is reached, unless the potential for covering medical expenses exists. If a survivor files a claim for benefits and the aggregate compensation amount has been reached, the CE must deny the survivor's claim.

13. Alternative to Filing a Survivor Claim under Part E. A non-covered spouse or child of a deceased DOE contractor employee or RECA section 5 uranium worker may submit a written request for an informal evaluation of whether the employee contracted a covered illness as a

result of employment at a covered facility. Once the alternative filing review is complete, the CE issues a determination letter to the claimant. No RD or FD is required.

a. Written Notice. An individual seeking a determination regarding the cause of an employee's illness must send a letter to DEEOIC requesting an alternative filing determination.

(1) Alternative filing requests may be submitted to the resource centers or the district offices.

(2) Only individuals listed in Subtitle E of the EEOICPA as potential survivors (i.e., spouses or children of an employee) may seek a determination letter regarding an employee.

(3) The survivor seeking a determination letter must provide evidence of a familial relationship with the employee.

b. Acknowledgement Letter. Each requester should be sent a letter acknowledging receipt of their request to receive an alternative determination letter, upon submission of their filing (Exhibit 2). The acknowledgement letter serves to explain the alternative filing process and offers the requester the opportunity to pursue full adjudication of the claim.

(1) The requester is notified that the alternative filing will result in the issuance of a determination letter, following development of the claim. The CE explains what will be contained in the determination letter and discusses the steps necessary to reach a determination on an alternative filing.

(2) If the requester has not already received a final decision denying his or her claim, the acknowledgement letter gives the requester the opportunity to opt out of the alternative filing process and to pursue full adjudication of the claim leading to a recommended/final decision. Upon receipt of a requester's decision requesting a recommended and final decision, the CE sends a follow-up letter informing the requester that full development will be completed and outlines the evidence required to adjudicate the claim. If full adjudication of the claim is requested, the requester will need to submit a completed form EE-2.

(3) The "Alternative to Filing" letter must explicitly instruct the requester that the determination reached cannot be used in any claim for benefits under the EEOICPA. The CE instructs the requester that the information presented in the forthcoming determination letter does not represent a final agency decision on the illness or causation.

c. Review of the Evidence. The CE undertakes full development of the alternative filing, in accordance with the instructions contained in the EEOICPA Procedure Manual. The CE will gather any evidence necessary to arrive at a determination on the claim, including sending the case file to a DMC or NO health specialist for resolution of a question of exposure, diagnosis, or causation.

d. Determination Letter. Upon completion of development on the alternative filing, the CE sends a determination letter to the requester (Exhibit 3).

(1) The determination letter must be written in clear language that is easily understood and must state specific details. The letter does not take the format of a recommended decision, and no certificate of service is required.

(2) The determination letter must reach a conclusion about whether the employee contracted an illness as a result of exposure while employed at a covered facility.

(3) The letter must state that the requester is not afforded any appeal or review rights as a result of the conclusion reached.

(4) The CE reiterates that the determination cannot be used as evidence in a claim for benefits under EEOICPA.

(5) The CE explains that the requester may seek full adjudication on the claim, including issuance of a recommended and final decision, at any time.

(6) The determination is reviewed by a Senior CE or supervisor, and is prepared for the District Director's signature.

e. Receipt of Form EE-2. If the survivor files a Form EE-2, the CE can render a recommended decision on eligibility, which is then reviewed by the FAB for issuance of a final decision.

Exhibit 1: Sample Letter to Potential Survivor Advising of Right to File Claim

Exhibit 2: Sample Acknowledgement Letter

Exhibit 3: Sample Determination Letter

2-1300 Impairment Ratings

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1. Purpose and Scope. This chapter provides guidance on the responsibilities of the Claims Examiner (CE) in regard to awards based upon a covered Part E employee's impairment that is attributable to a covered illness, how the District Office (DO) and the Final Adjudication Branch (FAB) will evaluate medical evidence of impairment in the case record, what is considered to be a ratable permanent impairment, and the potential eligibility for additional impairment benefits following previous award of impairment benefits.

2. Policy. The CE is responsible for processing impairment rating determinations and ensuring benefits are appropriately paid under the provisions of 42 U.S.C. 7385s, 7385s-2, 7385s-4, and 7385s-5 and as outlined in the procedures in this chapter.

3. Definition of Impairment.

a. Impairment. The American Medical Association's *Guides to the Evaluation of Permanent Impairment* (AMA's *Guides*) 5th Edition defines impairment as "a loss, loss of use or derangement of any body part, organ system or organ function." Furthermore, "Impairment percentages or ratings developed by medical specialists are consensus-derived estimates that reflect the severity of the medical condition and the degree to which the impairment decreases an individual's ability to perform common **Activities of Daily Living (ADL)**,*excluding work.*" (Emphasis in original).

4. General Requirements for Impairment Ratings.

a. Covered Employees. The employee must be a covered Department of Energy (DOE) contractor or subcontractor, or Radiation Exposure Compensation Act (RECA) section 5 employee found to have contracted a covered illness through exposure to a toxic substance at a DOE facility or RECA section 5 facility.

b. Claiming Impairment. The employee must claim impairment as a result of a covered illness or illnesses in writing.

c. Maximum Medical Improvement (MMI). An impairment that is the result of a covered illness will be included in the employee's impairment rating only if the physician concludes that the condition has reached MMI, which means the condition is unlikely to improve substantially with or without medical treatment. Conditions that are progressive in nature and worsen over time, such as chronic beryllium disease (CBD), are considered to have reached MMI when the condition is not likely to improve.

(1) Terminal Employees. An exception to the MMI requirement exists for terminal employees undergoing

ongoing treatment for an illness that has not reached MMI. In these situations, the terminal employee could die before the outcome of treatment is known and eligibility for an impairment award would be extinguished. Therefore, if the CE finds probative medical evidence that the employee is terminal, the impairment that results from such a covered illness is included in the impairment rating even if MMI has not been reached.

(2) MMI Has Not Been Reached. After reviewing the medical evidence, if the CE determines that the condition has not reached MMI, and the employee is not in the terminal stages, the CE does not make an impairment determination. A letter is sent to the employee informing him or her that the claim will be administratively closed and an impairment determination will not be made because MMI has not been reached. The letter should also state that the employee should contact the DO when MMI is reached. (See Exhibit 1).

(a) A treating physician may state that an employee is not at MMI and recommend treatment that could improve the condition. If the employee chooses to forgo the recommended treatment, the CE must request a written statement from the employee attesting to this choice to forgo the recommended treatment. After receipt of this written statement, the CE may proceed with an impairment determination.

(b) Once medical evidence is received in the DO indicating that the employee is at MMI, development is resumed and an **RD** ("Reopened – Development Resumed") code is entered into ECMS. The status effective date is the date the evidence of MMI is received in the DO.

(3) Multiple Covered Illnesses. In a case of multiple covered illnesses where one condition is at MMI and another is not, the CE should proceed with a determination regarding impairment for the condition at MMI. If different covered illnesses affect the same organ, and one condition is not at MMI, the CE cannot proceed with an impairment rating until all conditions in that organ have reached MMI.

d. Impairment Rating. An impairment evaluation performed by a qualified physician is the basis for the CE's determination of impairment benefit entitlement. Therefore, the physician's impairment rating report must be clearly rationalized and grounded in sound medical opinion.

(1) Evaluation. An impairment evaluation of the employee must be based upon the 5th Edition of the AMA's *Guides*.

(2) Rating Physician. An impairment evaluation must be performed by a qualified physician who satisfies the Division of Energy Employees Occupational Illness Compensation's (DEEOIC) criteria for physicians performing impairment evaluations. In order for a physician to be deemed qualified, he/she must hold a valid medical license and Board certification/eligibility in their field of expertise (e.g., toxicology, pulmonary, neurology, occupational medicine, etc.). The physician must also meet at least one of the following criteria: certified by the American Board of Independent Medical Examiners (ABIME); certified by the American Academy of Disability Evaluating Physicians (AADEP); possess knowledge and experience in using the AMA's *Guides;* or possess the requisite professional background and work experience to conduct such ratings.

(a) In order for a physician to demonstrate that he/she is qualified, there is no need to submit copies of their medical license or certificates. Qualifications may be determined by the submission of a letter or a resume which demonstrates that the physician is licensed and meets the requisite program requirements.

(b) If a physician does not possess ABIME or AADEP certification, the physician must submit a statement certifying and explaining his/her familiarity and years of experience in using the AMA's *Guides*.

(3) Rating Percentage. The impairment rating is a percentage that represents the extent of a whole person impairment of the employee, based on the organ(s) or system(s) affected by a covered illness or illnesses. The rating accounts for all Part E accepted covered illnesses and includes all conditions that are present in the covered organ(s) or system(s) at the time of the impairment evaluation.

(4) Whole Person Impairment. The physician must specify the percentage points of whole person impairment that are the result of all accepted covered illness or illnesses.

(a) In some instances, there are multiple diseases or life style choices (e.g., smoking and the lungs), in addition to the covered illness, that affect an organ. DEEOIC does not apportion damage, thus the impairment rating should assess the functionality of the whole organ regardless of the multitude of other factors.

(b) If the CE finds that the employee contracted more than one covered illness, the physician should specify

the total percentage points of impairment that result from each of the employee's accepted covered illnesses. The total percentage points of impairment are determined by a combined value chart in the AMA's *Guides*. Therefore, the sum of each individual impairment rating may not equal the total combined rating (i.e., 2% + 2% does not necessarily equal 4%).

(c) An impairment that is the result of any accepted covered illness that cannot be assigned a numerical impairment percentage using the 5th Edition of the AMA's *Guides* will not be included in the employee's impairment rating, and the physician performing the impairment evaluation needs to explain the rationale as to why a numerical impairment percentage cannot be assigned.

5. Developing an Impairment Claim. This section discusses the developmental steps and evidence necessary to adjudicate an impairment claim.

a. Resource Centers' (RCs) Role: RCs assist employees with the submission of their impairment claims.

(1) When a final decision is issued to an employee with a positive causation determination, the FAB sends a copy of the final decision to the designated RC. This is done only in situations where there is no indication that a claim has already been made for impairment.

(2) Upon receipt of the final decision, the RC calls the employee to provide information about the potential impairment benefits available, explains eligibility requirements or program procedures, and responds to any questions. The RC then memorializes the telephone call in the Telephone Management System (TMS) section of ECMS and forwards a printout to the appropriate DO or Co-Located Unit (CE2) for association with the case file.

b. Initial Impairment Development Letter. In conjunction with the RCs' outreach to the employee as mentioned in paragraph 5a above, the CE sends a development letter (Exhibit 3 with attachments) to the employee.

(1) Timeframe. This development letter is sent after issuance of a final decision accepting an employee's claimed condition as a covered illness under Part E. This letter is only sent for employee claims. (See section 12 for survivor claims).

(2) Explanation. In the letter, the CE explains what an impairment rating is and that the employee may be eligible for an award based on permanent impairment.

(3) Request for Impairment Claim. In the letter, the CE

requests that the employee advise DEEOIC in writing as to whether or not he/she would like to claim impairment for a covered illness or illnesses. The CE further explains that if the employee has more than one covered illness, he/she must also advise the DO on which covered illness he/she is claiming. However, an employee may not elect to file an impairment claim on some, but not all, covered illnesses in an effort to avoid a tort offset or coordination of state workers' compensation benefits. The letter includes a response sheet on which the employee may claim impairment. (See Exhibit 3 and attachments)

(4) Required Medical Evidence. In the letter, the CE outlines the medical evidence that will need to be submitted, based on individual conditions as outlined in Exhibit 4, for a physician to conduct the rating. If a condition is not listed in Exhibit 4, the CE should consult with a DMC to determine what medical information is required as outlined in the AMA's *Guides*.

(5) Physician Choice. In the letter the CE explains that the employee may choose to have his or her own qualified physician or a DMC perform an impairment evaluation. The employee indicates this choice on the response sheet attached to the letter. If the employee is requesting his or her own physician, the employee must provide the physician's name and address. The response sheet provides a space for this information.

(a) If the employee does not indicate who should perform the impairment evaluation, the CE assumes that the employee wishes to have a DMC perform the evaluation. The CE sends a letter to the employee outlining the evidence needed for a DMC to perform the impairment evaluation. (See Paragraph 4, Required Medical Evidence, above, and Exhibit 3).

(6) Timeframe. The employee is allotted 60 days to respond to the initial impairment development letter, with a follow up request sent to the employee at the first 30 day interval. The CE does not develop the impairment issue until a response is received from the employee.

(a) If the employee does not respond to the development letter within 60 days, or informs the CE that he or she does not want to pursue a claim for impairment, the CE sends a letter (Exhibit 5) to the employee advising that DEEOIC will not undertake further development of the claim for impairment at this time. The CE also notifies the employee of the right to claim impairment in the future. Lastly, the CE codes ECMS with the proper code. The status

effective date is the date the letter is received from the employee stating he/she does not wish to claim impairment or the date the timeframe of the letter expires.

(b) If the employee responds in writing that he/she wants to claim impairment, ECMS is coded appropriately. The status effective date is the postmark date of the letter, if available, or the date the letter is received in the DO or RC, whichever is the earliest determinable date.

c. Impairment Ratings by the Employee's Own Physician.

(1) Letter to Selected Physician. The CE sends a letter (Exhibit 6 with attachments) to the physician selected by the employee. In the letter, the CE notifies the physician of the employee's eligibility, and the covered illness or illnesses with respective ICD-9 code(s). The CE also explains that in order for DEEOIC to pay for an impairment evaluation, the evaluation must have been performed within one year of receipt by DEEOIC. The letter explains that the impairment evaluation must be performed in accordance with the 5th Edition of the AMA's *Guides*, and that specific reference to the appropriate page numbers and tables used from the AMA's *Guides* is required in the report. Lastly, the CE includes a medical bill pay agent enrollment package, which includes: an OWCP-1500, Health Insurance Claim Form (Exhibit 6 attachments), OWCP-1168, the EEOICP Provider Enrollment Form (Exhibit 6 attachments), and a form (SF Form 3381, available on the share drive at the Policies and Procedures folder, forms subfolder) to allow the medical bill pay agent to process electronic fund transfers to the provider. The OWCP-1168 explains how a physician enrolls with the medical bill pay agent. If a physician is already enrolled, there is no need to enroll again. If the employee opted to select his/her own physician to perform the impairment rating but does not know of one, the CE may direct the employee to the appropriate RC for a list of physicians who perform impairment ratings and are enrolled in the program.

(2) Scheduling an Appointment with the Selected Physician. The employee must schedule the impairment appointment within 30 days of DEEOIC receiving the employee's written choice of physician. The appointment does not need to occur within this first 30 days, but must be scheduled for a definite date in the future.

The CE places a call up note in ECMS for 60 days from receipt of the employee's choice of physician. If after 60 days the CE finds no evidence of an impairment evaluation

or that the employee scheduled an appointment, the CE makes a phone call to determine the status of the appointment (whether it has been made or is in the process of being made, etc.). The CE advises the employee verbally of the need to schedule the appointment within the next 30 days and to provide written evidence of such to the DO. It is important that the CE record this discussion carefully in the TMS section of ECMS. The CE sends a written summary of the call and need for confirmation of an appointment within the 30 day time period to the employee.

If at the end of this 30 day period no evidence exists to show progress in obtaining the necessary impairment evidence, the CE may issue a recommended decision to deny the impairment claim.

d. Impairment Ratings by a DMC. If DEEOIC is to arrange for the impairment evaluation, the CE reviews the medical evidence received from the initial impairment development letter and in the case file to determine if the evidence is sufficient for a DMC to perform the impairment evaluation.

(1) Insufficient Evidence. If the CE determines that the medical evidence of record is not sufficient, the CE sends a follow up development letter to the employee explaining the additional evidence and/or diagnostic test(s) required in order to conduct an impairment evaluation.

(2) Unavailability of Records. If the employee is unable to provide some of the necessary medical records, whether or not an impairment evaluation can be performed is completely dependent upon what the AMA's *Guides* allow for rating the covered illness. The information may be forwarded to a DMC to determine if the available records are sufficient to perform a rating. If the DMC is able to perform a rating based on partial medical evidence and states that additional testing could potentially increase the rating, the employee must be notified that the rating is based solely on the present evidence of record, and additional testing is needed to allow for the highest potential rating. The CE sends the employee a letter and gives the employee the option of getting the necessary testing, or of notifying the CE in writing that the additional testing cannot be obtained, and that a decision may proceed based on the available medical evidence. If the employee does not respond, the CE proceeds with the impairment evaluation based on the available medical evidence.

(3) Outdated Evidence. If the employee has been given the opportunity to obtain current medical evidence and supplies little or no medical evidence, the CE may use medical

evidence in the file that is older than 12 months to obtain an impairment rating from a DMC. In some instances the DMC may still not be able to render an opinion with older or missing medical records.

(4) Referral and Payment to a DMC. Procedures for referring a case to a DMC and "Prompt Pay" of DMC bills can be found in EEOICPA Procedure Manual (PM) Chapter 2-300 and will be in the new EEOICPA PM Chapter 2-0800 Developing and Weighing Medical Evidence.

6. Impairment Ratings for Certain Conditions:

a. Mental Disorders.

(1) Upon receipt of a claim for a mental impairment, the CE must determine whether the claimed impairment originates from a documented physical dysfunction of the nervous system.

(2) Once it has been established that an employee's mental impairment is related to a documented physical dysfunction of the nervous system, the employee should obtain an impairment evaluation from the physician based on Table 13-8 of Chapter 13 in the 5th Edition of the AMA's *Guides*.

(3) If the mental impairment is not related to a documented physical dysfunction of the nervous system, it cannot be assigned a numerical percentage using the 5th Edition of the AMA's *Guides*. The CE communicates this with the employee and provides the employee with 30 days to submit documentation from a physician if the employee believes there is a link between the exposure to a toxic substance at a covered facility and the development of a mental impairment. The report from the employee's physician must contain rationalized medical evidence establishing that the mental impairment is related to neurological damage due to a named toxic exposure. Speculation or unequivocal statements from the physician reduce the probative value of a physician's report, and in such cases the CE may find it necessary to refer the case to a District Medical Consultant (DMC) or a DEEIOC toxicologist to determine whether toxic exposure caused physical dysfunction of the nervous system.

(b) Breast Cancer.

(1) Upon receipt of a claim for impairment for the breast in either a male or female, the CE submits a request to the physician undertaking the evaluation explaining all the criteria that must be considered and referenced in the final report. For the purposes of considering impairment due to breast cancer in a female, child bearing age will not be a determining factor when issuing an impairment

rating, as the AMA's *Guides* do not define "child bearing age."(See Exhibit 2)

(2) When the completed impairment evaluation is returned, the CE must review it to ensure that the physician has comprehensively addressed each of the factors necessary for an acceptable rating. The report must show that the physician has considered: (1) the presence or absence of the breast(s); (2) the loss of function of the upper extremity (or extremities if there is absence of both breasts due to cancer), including range of motion, neurological abnormalities and pain, lymphedema, etc.; (3) skin disfigurement; and (4) other physical impairments resulting from the breast cancer. The total percentage of permanent impairment of the whole person must be supported by medical rationale and references to the appropriate sections and tables (with page numbers) of the AMA's *Guides*.

(3) If the CE determines the physician has not provided a complete rating for a claimed impairment of the breast, a follow-up letter is sent to the physician. The CE explains the noted deficiency in the assessment and that the purpose for obtaining a complete response is to ensure the employee received the maximum allowable rating provided by the AMA's *Guides*.

(4) Upon receipt of an acceptable report pertaining to an assessment of permanent impairment of the breast, the CE should proceed with additional development of the claim, as necessary, and issuance of a recommended decision.

(c) Pleural Plaques/Beryllium Sensivity.

(1) While it is very unlikely that a ratable impairment will exist for the covered conditions of pleural plaques or beryllium sensitivity alone, the employee may claim impairment for these conditions. In the initial impairment development letter to these employees, the CE explains that the rating for these conditions is generally very low to 0%. (See Exhibit 3 with attachments). When sending this letter, as with any impairment development letter, send all necessary attachments.

(d) Metastatic Bone Cancer.

(1) In situations where the CE accepts a case under the SEC provision based on metastatic (secondary) bone cancer, often the primary source of the metastatic bone cancer will prove to be the prostate. If the CE does not accept the prostate cancer due to a lack of a causative link and because prostate cancer is not a SEC specified cancer, it is important that the CE ensure that the non-covered

prostate cancer is not considered in the impairment rating. Only the accepted condition of SEC metastatic bone cancer is considered for the impairment rating. If a rating is received for the prostate, the report must be resubmitted and a new rating must be requested.

7. Receipt of the Impairment Evaluation. Upon completion of the impairment evaluation and receipt in the DO, the CE reviews the report to assure that all DEEOIC criteria has been met. While by no means exhaustive, the CE reviews impairment evaluations to determine the following: whether the opining physician possesses the requisite skills and requirements to provide a rating as set out under paragraph 4d(2); whether the evaluation was conducted within one year of receipt by DEEOIC; whether the report addresses the covered illness or illnesses; and whether the whole person percentage of impairment is listed with a clearly rationalized medical opinion as to its relationship to the covered illness or illnesses. The employee is entitled to an award of impairment benefits if one or more percentage points of the impairment are found to be related to a covered illness or illnesses.

a. Awards. To calculate the award, the CE multiplies the percentage points of the impairment rating of the employee's covered illness or illnesses by $2,500. For example, if a physician assigns an impairment rating of 40% or 40 points, the CE multiplies 40 by $2,500, to equal a $100,000 impairment award.

b. Incomplete Ratings. If the impairment rating report is unclear or lacks clearly rationalized medical evidence as support, additional clarification is required. In such instances, the CE returns the impairment rating evaluation to the rating physician with a request for clarification, indicating what areas are in need of remedy. If the report was performed by the employee's physician and no response is received or is returned without sufficient clarification, the CE notifies the physician of the need for additional justification. If no response is received, the case is sent to a DMC for a new rating. If the incomplete report was submitted by a DMC, the CE must notify the DMC of the deficiency and request a more comprehensive report.

8. Pre-Recommended Decision Challenges. The CE may provide the employee with a copy of the impairment rating report if the employee specifically requests a copy. The employee may submit written challenges to the impairment rating report and/or additional medical evidence of impairment. However, any additional impairment evaluations must meet the criteria discussed above in paragraph 7 before the CE can consider it when making impairment determinations. DEEOIC will only pay for one impairment evaluation unless DEEOIC directs the employee to undergo additional evaluations. Subsequent evaluations not directed by DEEOIC must be paid by the employee. If the additional evaluation differs from the existing rating, the CE must review the two reports in detail to determine which report has more probative value. In weighing the medical evidence, the CE must

use his or her judgment in the analysis of the reports. If the reports appear to be of equal value, the CE may refer the case to a second opinion physician for additional consideration.

a. Equally Probative Reports. If the second opinion physician opines that both impairment evaluations are of the same probative value, the CE may obtain a referee medical examination.

9. Issuance of a Recommended Decision. The recommended decision must contain a thorough discussion of the impairment evidence submitted in the case. If a decision recommends denial of an impairment claim based on an insufficient evaluation, or if one evaluation is relied upon by the DO over another evaluation(s) in the file, the CE must provide a detailed discussion regarding the probative value of the evaluation(s).

The employee must be informed of the reasons why a report is insufficient, and/or why one report offers more probative value than another. This is necessary in the event the employee submits additional impairment evidence to the FAB, as any additional impairment evidence submitted must have more probative value than the evidence relied upon by the DO for the employee to have met his or her burden of proof.

a. Recommended Decision. Any claim that is coded in ECMS for impairment must be developed and adjudicated by way of recommended decision. If a claim has been filed for impairment and the necessary documentation to allow for a decision is not presented, a recommended decision to deny must be issued.

10. FAB Development. Once a recommended decision on impairment has been issued and forwarded to the FAB, the employee may submit new medical evidence and/or additional impairment evaluations to challenge the impairment determination discussed in the recommended decision.

a. Reviewing Ratings. The employee bears the burden of proving that additional impairment evidence has more probative value than the evaluation relied upon by the DO to determine the impairment benefit eligibility.

b. Probative Value Determinations. The FAB Hearing Representative (HR) must take into consideration the list of factors in paragraph 7 when weighing impairment evaluations for probative value.

In the event an employee's file contains multiple impairment evaluations, the HR reviews each report to determine which, on the whole, provides the most probative value given the totality of the evidence. For example:

(1) The RD is based upon Dr. X's impairment rating of the employee, finding 20% whole person due to the covered illness asbestosis. Dr. X's opinion is clearly rationalized and provides a detailed analysis as to how the

medical findings were deduced, addressing the covered illness and its relation to the rating. The employee submits an impairment rating from Dr. Y that finds a 30% whole person impairment due to asbestosis and other unrelated conditions. The report provides little analysis as to how the medical findings were reached and does not provide a rationale as to why the 30% rating is related to the covered illness of asbestosis. Both doctors possess the requisite credential and the reports were submitted timely. The HR gives credence to the impairment rating by Dr. X, as it has more probative value than the report submitted by Dr. Y. The clear medical rationale provided by Dr. X lends more explanation as to how the rating was determined compared to the rating by Dr. Y.

c. FAB Review. In addition to the impairment rating(s), the FAB reviews all the relevant evidence of impairment in the case record and bases its determination on the evidence it finds to be most probative.

d. Final Decision. The final decision must contain detailed rationale and discussion for any determination, especially decisions concerning multiple impairment evaluations. The final decision also includes analysis of all relevant evidence and argument(s) in the record.

11. Additional Filings for Impairment Benefits. An employee previously awarded impairment benefits may file a claim for additional impairment benefits for the same covered illness included in the previous award. This claim must be based on an increase in the impairment rating that formed the basis for the previous award. Such a claim must be submitted on Form EE-10. (See Exhibit 7).

a. Timeframe. The employee may not submit a Form EE-10 for an increased impairment rating earlier than two years from the date of the last award of impairment benefits (date of the final decision).

(1) New Covered Illness. An exception to the two year time period requirement exists if the DO adjudicates an additional impairment claim based upon a new covered illness not included in the previous award. A new covered illness involves a different disease, illness, or injury that was not the basis of the original impairment rating.

b. Untimely Requests for Re-evaluation. If the two year date is near, the impairment claim can be developed, but not adjudicated, until the two year mark has been reached. In circumstances in which an employee submits an untimely request for re-evaluation and it is too early to proceed with adjudication, i.e., six months prior to the two year mark, the CE should inform the employee in writing that he/she is not eligible for an impairment decision and that a decision will be deferred until such time as the employee is eligible. The CE enters a call up note in ECMS to follow-up at the two year mark, but

no action is taken to administratively close out the impairment claim.

(1) ECMS Coding of Untimely Requests for Re-evaluation. If an employee claims re-evaluation of a covered illness for which an impairment final decision has been issued prior to the two year mark, the proper ECMS code for impairment claimed should be entered for the postmark date or the date received by the DO, FAB, or the RC, whichever is earliest determinable date.

(2) Follow Up. The RCs maintain a list of employees that have received impairment ratings. Upon two years of the final decision, a representative from designated RCs will contact the employee to determine if additional impairment will be claimed. If the CE had already contacted the employee regarding additional impairment filing, the RC may forgo this contact.

c. Time Requirements Not Applicable. If an employee is issued a 0% impairment rating final decision and subsequently obtains new evidence concerning the covered illness that received the 0% rating, a two year wait period does not apply and the new evidence should be evaluated for reopening.

12. Issues Involving Survivor Election. If a covered Part E employee dies after submitting an impairment claim but before compensation is paid and death is caused solely by a non-covered illness or illnesses, the survivor may elect to receive the compensation that would have been payable to the employee, including impairment and/or wage loss.

a. Instances Where Impairment is Not Available to a Survivor. If the necessary diagnostic or medical evidence will not allow for a viable rating, and there is no way to collect new information following the death of the employee, the CE should advise the survivor that he/she may only elect to receive compensation for wage loss. The DMC in this situation would advise that given the available evidence, no rating is possible in accordance with the AMA's *Guides*. The specific deficiencies should be noted by the DMC, and this information should be furnished to the survivor in a letter from the CE.

13. The RCs' Role in Developing Impairment Claims. The RCs facilitate the development of impairment claims by engaging in outreach efforts and educating covered employees on the requirements for filing and obtaining impairment benefits. This outreach effort takes place after the issuance of a Part E final decision to an employee with a positive causation determination (see paragraph 6a) and also after the two year re-filing mark for impairment claims is reached (see paragraph 11b).

In some situations, the RCs may be used when waivers and forms EN-20

need to be signed quickly due to the health of the employee and the possibility that the benefit may be extinguished due to the employee's death. The RCs also advise the employee concerning the tests to obtain an impairment rating.

Exhibit 1: Not at MMI Letter

Exhibit 2: Breast Impairment Letter

Exhibit 3: Development Letter for Impairment with Attachments

Exhibit 4: Required Medical Evidence Specific to ICD-9 Codes

Exhibit 5: Not Claiming Impairment Letter

Exhibit 6: Impairment Eligibility Letter to Physician with Attachments

Exhibit 7: Form EE-10

2-1400 Wage-Loss Determinations

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1. Purpose and Scope. This chapter contains the procedures to solicit, develop, calculate, and issue wage-loss determinations under Part E of the Energy Employees Occupational Illness Compensation Program Act (EEOICPA). This chapter also describes some relevant terminology and definitions. The Claims Examiner (CE) determines whether a claim for wage-loss, as a result

of a covered illness contracted through work related exposure to a toxic substance at a Department of Energy (DOE) facility or Radiation Exposure Compensation Act (RECA) section 5 facility, needs to be solicited for a covered Part E employee or survivor claim. If claimed, the CE develops for the necessary wage and medical evidence, calculates the amount of compensable wage-loss and issues a recommended decision for Final Adjudication Branch (FAB) review and issuance of a final decision.

2. Policy. Division of Energy Employees Occupational Illness Compensation (DEEOIC) staff is responsible for processing wage-loss determinations and ensuring that benefits are appropriately paid as defined under 42 U.S.C. §7385s, §7385s-1, §7385s-2(a)(2), §7385s-3, §7385s-5, § 7385s-11, and §7385s-12.

3. Definitions.

a. Average Annual Wage (AAW) refers to four (4) times the average quarterly wages for the twelve (12) quarters that preceded the quarter during which the covered Part E employee first experienced wage-loss due to a covered illness that was caused by exposure to a toxic substance at a DOE facility or RECA section 5 facility, excluding any quarter during which the employee was unemployed.(See subparagraph f below). The calculated AAW is the baseline wage against which the CE measures a subsequent calendar year wage earned by a covered Part E employee.

b. A calendar year is defined as the twelve-month period from January through December.

c. The Consumer Price Index (CPI) is a measure of the average change over time in the prices paid by urban consumers for a market basket of consumer goods and services. The CPI is the most widely used measure of inflation. The CPI is often used to adjust benefit payments (for example, Social Security and Federal Employee Compensation Act payments) and income eligibility levels for government assistance, and to automatically provide cost-of-living wage adjustments.

d. Normal Social Security Retirement Age is the age at which an employee receives unreduced Social Security retirement benefits. This age varies by date of birth and is set by §216(1) of the Social Security Act, 42 U.S.C. §416(1).

In general, persons born during or before 1937 are eligible for unreduced Social Security retirement benefits at age 65. The eligibility age increases in two-month increments for persons born between 1937 and 1960 until it reaches 67, which is the age at which persons born during or after 1960 become eligible for unreduced Social Security retirement benefits. (See Exhibit 1)

To determine the normal Social Security retirement age for a covered Part E employee, the CE may also use the Social Security Administration website

http://www.socialsecurity.gov/OACT/ProgData/nra.html.

e. A quarter is defined as the three-month period of January through March, April through June, July through September, or October through December.

f. A quarter during which the employee was unemployed (for purposes of determining AAW) is a quarter during which $700 (in constant 2005 dollars) or less in wages were earned by the covered Part E employee, unless the quarter is one where the employee was retired. If the CE determines that the adjusted value is $700 or less, then the employee is considered to have been unemployed during that quarter and it will not be included in the calculation of the AAW.

g. A quarter during which the employee was employed (for purposes of determining AAW) is a quarter in which the adjusted value of the employee's wages for the quarter exceeds $700 in constant 2005 dollar values. For example, $700.01 in adjusted value is considered to be a quarter of employment. A quarter in which the employee was employed will be included in the AAW calculation.

h. A year of wage-loss is defined as a calendar year in which the covered Part E employee's wages were less than the employee's AAW, as a result of the covered illness that is due to the covered Part E employee's exposure to a toxic substance at a covered facility. Prior to making this finding, the CE adjusts the yearly wages for inflation to determine their values during the calendar year in which the covered Part E employee first experienced wage-loss due to a covered illness.

4. General Requirements for Wage-Loss. Wage-loss determinations are based upon the calendar years of wage-loss occurring up to and including either the calendar year the employee reaches normal Social Security retirement age or the last calendar year of wage-loss prior to the submission of the wage-loss claim, whichever occurs first.

a. Criteria to Establish a Claim for Wage-Loss:

(1) Covered Part E Employee. The employee is, or was, an employee of a covered DOE contractor or subcontractor; and

(2) Covered Illness. The employee developed a covered illness as a result of exposure to a toxic substance at a covered DOE facility or RECA section 5 facility; and

(3) Documented Wage-Loss. The employee experienced wage-loss as a result of the covered illness prior to his or her normal Social Security retirement age.

b. Instances When Wage-Loss Is Not Developed:

(1) The employee is not a covered Part E employee if he or she worked for an atomic weapons employer or for a beryllium vendor (unless the employee was employed during a period in which the facility was designated as a DOE facility for remediation and the employee was employed by a

remediation contractor).

(2) The covered Part E employee experiences wage-loss (as a result of contracting a covered illness) only after his or her normal Social Security retirement age.

(3) The covered Part E employee dies no more than 10 years before his or her normal Social Security retirement age and does not experience any wage-loss prior to his or her death (for survivor claims).

5. How to Claim Wage-Loss. The Resource Centers (RCs) and the district offices (DOs) solicit wage-loss claims from claimants who are potentially eligible for wage-loss benefits.

a. RCs' Role: RCs engage in outreach efforts and educate employees on the requirements for filing and obtaining wage-loss benefits. The RCs also assist employees with the submission of their wage-loss claims.

(1) When a final decision is issued to a living employee with a positive causation determination under Part E, the FAB sends a copy of the final decision to the designated RC. This is done only in situations where there is no indication that a claim has already been made for wage-loss. Final decisions that pertain strictly to survivors of a deceased employee are not referred to the RC, but instead processed as described in subparagraph b below.

(2) Upon receipt of the final decision, the RC calls the employee to provide information about the potential wage-loss benefits available, explains eligibility requirements or program procedures, and responds to any questions. The RC then memorializes the telephone call in the Telephone Management System (TMS) section of ECMS and forwards a printout to the appropriate DO or Co-Located Unit (CE2) for association with the case file.

b. District Offices' Role. In conjunction with the RCs' outreach of the employee as mentioned in paragraph 6a above, the CE sends initial wage-loss solicitation letter (Exhibit 2) to the claimant (employee or potentially eligible survivor).

(1) Timeframe. This solicitation letter is sent after issuance of a final decision to accept under Part E.

(2) Explanation. The letter explains the criteria to establish wage-loss.

(3) Request for Wage-Loss Claim. The letter requests that the claimant advises DEEOIC in writing if claiming wage-loss, identify the condition(s) for which he or she is claiming wage-loss, and provide the dates (month and year) of claimed wage-loss. Evidence of 12 quarter wages prior to the first quarter of claimed wage-loss is also required. An

SSA Form 581 (Authorization to Obtain Earnings Data from the Social Security Administration) is enclosed with the solicitation letter. Additional factual employment evidence that supports the claimed wage-loss is also requested, along with medical evidence supporting a causal relationship between the covered illness and the wage-loss claimed.

(4) Follow-up Solicitation Letter. The claimant is allotted 60 days to respond to the initial solicitation letter with a follow-up solicitation letter (Exhibit 3) sent to the claimant at the first 30 day interval. Prior to mailing the follow-up solicitation letter, the CE calls the claimant to ensure the receipt of the initial solicitation letter and determines if the claimant wants to file a wage-loss claim.

(5) Final Solicitation Letter. If a written response to initiate a claim for wage-loss is not received within 30 days of the follow-up solicitation letter or if the claimant informs the CE that he or she does not want to pursue a claim for wage-loss, the CE sends a letter to the claimant advising that DEEOIC will not develop the claim for wage-loss at this time (Exhibit 4). The CE also advises the claimant of his or her right to claim wage-loss in the future.

6. Development of Wage-Loss Claims. Upon receipt of a signed statement claiming wage-loss, the CE determines if there is sufficient medical and wage evidence to develop for wage-loss. If not, the CE sends a letter requesting the required evidence from the claimant. If there is no response within 30 days, the CE sends a follow-up letter to the claimant. Prior to mailing the follow-up letter, the CE contacts the claimant by telephone to assist the claimant with obtaining the required evidence. If the claimant does not submit the necessary evidence within the allotted 60 days from the first development letter, the CE may proceed by issuing a recommended decision to deny the claim for wage-loss benefits.

7. Medical Evidence to Establish Wage-Loss. The claimant is required to submit medical evidence that is of sufficient probative value to establish that the period of wage-loss claimed is causally related to the covered Part E employee's covered illness.

There are instances when the medical evidence shows multiple conditions contributing to the wage-loss. As long as the evidence establishes that any covered illness contributed to the employee's wage-loss, then the medical evidence is sufficient to prove causal relationship.

An acceptance of Social Security Disability benefits alone is not sufficient evidence to establish a causal relationship, unless accompanied by supporting medical evidence.

If a secondary cancer is the accepted covered illness but the primary is not accepted(e.g., secondary bone cancer is accepted but the primary prostate cancer is not accepted), the medical evidence needs to support that the wage-loss is causally related to the secondary cancer, because the causation requirement has not been met for the primary cancer.

The CE develops the case for a causal relationship between the claimed years of wage-loss and the covered Part E employee's covered illness by requesting medical evidence from the claimant and/or medical provider. Medical evidence can include the following:

a. Narrative Report from a Physician. A physician's narrative report needs to explain the causal relationship between the covered illness and the period(s) of wage-loss and reference medical evidence that is contemporaneous to the claimed period(s) of wage-loss. A narrative report that is based solely on the physician's expectations is not considered sufficient evidence of probative value.

b. Return to Work Slips Signed by a Physician.

c. Physician's Office Notes. Physician notes that indicate the covered Part E employee had stopped working, reduced his work hours or missed work due to the covered illness.

d. District Medical Consultant (DMC) Opinion. The CE must use discretion when determining if a DMC referral is warranted. A referral to a DMC is not required when the wage evidence supports that the employee's adjusted wages is greater than 75% of his or her AAW. Additionally, the CE does not refer to a DMC if the claimant and/or treating physician have not been contacted first for the requisite medical information.

The CE may request the opinion of a DMC on causal relationship between the covered illness and wage-loss if the evidence is inconclusive. The DMC may also provide an opinion regarding the period of illness-related wage-loss. In most instances, wage-loss questions are best handled by a DMC who specializes in occupational medicine. In the DMC referral, the CE must specify the period of wage-loss in question and the accepted covered illness. The DMC must be instructed to provide a detailed rationale for his or her opinion.

> Example of a wage-loss question to DMC: Please review the case records to determine if the employee's wage-loss for the period from June 1975 to August 1999 is causally related to the accepted illness of asbestosis. If the available medical evidence is insufficient to make a wage-loss determination for a certain period, please indicate the dates. Please provide your rationale to support your conclusion.

Procedures for referring a case to a DMC and "Prompt Pay" of DMC bills can be found in EEOICPA Procedure Manual (PM) Chapter 2-0300

and will be in the new EEOICPA PM 2-0800 Developing and Weighing Medical Evidence.

8. Wage Evidence Required to Establish Wage-Loss. Wages are defined as all monetary payments that the covered Part E employee earns from employment or services that are taxed as income by the Internal Revenue Service. Salaries, overtime compensation, sick leave, vacation leave, tips, and bonuses received for employment services are considered wages. However, capital gains, IRA distributions, pensions, annuities, unemployment compensation, state workers' compensation benefits, medical retirement benefits, and Social Security benefits are not considered wages. The CE obtains evidence of the employee's wages for the calendar year(s) during the claimed period(s) of wage-loss and for the 12 quarters immediately preceding the first quarter of claimed wage-loss. These 12 quarters wages immediately preceding the first quarter of claimed wage-loss are used to determine the AAW. (See paragraph 9)

The CE generally relies upon the earnings information that has been reported to the Social Security Administration (SSA), but can also rely upon additional wage information submitted by the claimant.

a. SSA earnings records are received from the claimant if available or the CE submits a signed Form SSA-581 (see Exhibit 5) from the claimant to SSA to gather this information.

(1) RC staff are responsible for obtaining a completed SSA-581 from all employees and from clearly eligible survivors at the time the employee or survivor completes or submits his or her claim form at the RC in person. Each DO has an office specific form indicating where SSA must send the results of the inquiry. The SSA-581 forms for each office are located on the Share Drive in the Policies and Procedures folder, Forms subfolder.

(2) If the RC does not obtain a signed SSA-581, or if a claim (EE-1 or EE-2) is submitted directly to the DO or mailed to the RC, the CE should send an SSA-581 to the claimant, if it is needed for employment verification and/or determination of wage-loss.

(3) To be processed by SSA, a signed SSA-581 must be dated no earlier than 60 days from the date of submission to the SSA. If the timeframe between the signature date of the SSA-581 and submission to SSA exceeds sixty (60) days, the CE or RC staff will need to obtain a new, signed and dated SSA-581.

(4) Whenever subsequent development is undertaken with regard to employment verification, a request should be made to the claimant to complete a SSA-581 form, if pertinent wage and earning documentation is not present in the case record. A claimant should be advised that completion of the

SSA-581 is a crucial part of the employment verification and/or wage-loss process and that their signature on the SSA-581 is only valid for sixty (60) days.

The information required on the SSA-581 form depends on the type of request. In a development letter, the CE advises the claimant of the information needed on the SSA-581:

(a) **Employee Claims**: The employee, authorized representative, CE or the RC staff is to complete the following section of the SSA-581: name of employee; social security number; date of birth of employee; and other name(s) used. The employee or the authorized representative will fill-in the employee's address/daytime telephone number, and date the form was signed. The employee or the authorized representative must sign the SSA-581 and print his or her name.

(b) **Survivor Claims**: The survivor, CE or the RC staff is to complete the following sections of the SSA-581 form: name of social security number holder (employee); employee's social security number; date of employee's birth; date of employee's death; and other name(s) used. The survivor will fill-in the survivor's address/daytime telephone number; indicate the appropriate box to show relationship; add the date signed; sign the form; and print his or her name in the requested space.

The CE or the RC staff explain that the survivor must provide proof of the employee's death and his or her relationship to the employee. Proof of death includes: a copy of the death certificate, mortuary or interment record, or court issued document. Proof of relationship includes: marriage certificate, birth certificate, adoption papers, or other court issued document(s). SSA requires that these documents be submitted in order to process requests from survivors.

(5) Once the claimant returns the signed SSA-581 document and any accompanying documents, the CE or RC staff complete the following sections:

(a) The CE or RC staff fill in the years deemed necessary to verify employment and/or establish wage-loss on the "Periods Requested" line. The CE or RC staff is to identify the time period for employment history by searching the Energy Case Management System (ECMS), the records in the case file, wage-loss claims, or other documents or forms in the file.

In the box titled, "Requesting Organization's Information," the CE or RC staff sign in the section, "Signature of Organization Official" as well as provide the district office toll free telephone number and fax number.

(b) The CE or RC staff ensure that the upper right hand corner of the form allocated for "Requesting Organization:" indicates the correct district office where the SSA's response should be sent.

(6) The original (signed) SSA-581, and supporting documents (if the request is submitted by a survivor) must be submitted via Federal Express to the SSA, Wilkes Barre Data Operations Center (WBDOC), at the following address:

The Social Security Administration

Wilkes Barre Data Operations Center

PO Box 1040

Wilkes Barre, PA 18767-1040

The CE updates the case status screen in ECMS and date stamp the forms at the time that the form is sent to SSA. This date serves as the status effective date. A copy of the form is retained in the case file.

(7) Following submission of a Form SSA-581, the CE or someone designated by the District Director, is responsible for determining if SSA has received the earnings request (Form SSA-581) and for obtaining a status update on the employment verification request.

(a) If there has been no response from SSA within thirty (30) calendar days of the date of the submission to SSA, the CE calls for status update. The telephone call is documented in the TMS section of ECMS and a printed copy placed in the case. If SSA indicates that no SSA-581 form has been received, the CE must resubmit the form. Otherwise, the CE obtains the status and monitors for further follow-up.

(b) Inquiries to SSA are made by calling one of ten phone numbers (Modules) depending on the last four digits of the relevant employee's Social Security number (Exhibit 6).

(c) If the CE does not receive a completed SSA-L460 within thirty (30) days of the first inquiry call to SSA (the 60^{th} day), the CE makes another follow-up call to determine the status of the request and proceeds as necessary. At this point, it will be necessary to obtain a newly signed SSA-581 from the claimant and resubmit the SSA-581 to SSA as outlined

above.

(8) After the completed SSA-581 form is sent, and a copy is placed in the case file, a SSA Point of Contact (POC) designated by the District Director ensures that the form is logged into a tracking spreadsheet. The spreadsheet should contain, at minimum, the case number, date sent to SSA, and cost of the request.

(a) DO determines the cost of the request according to the number of years for which information is sought. Form SSA-7050-F4 (Request for Social Security Earnings Information, available on the SSA website at http://www.ssa.gov/online/ssa-7050.pdf) identifies the cost by the number of years requested. For example, if one (1) year of earnings information is requested, the cost is $15.00. The cost increases incrementally by year, up until forty (40) years of requested employment. For each year after forty (40) years, add $1.00 for each year.

(9) At the end of each quarter, the DOL National Office SSA POC obtains the SSA-581 submission logs maintained in each DO and sample the contents to properly evaluate contract outlays.

(10) Upon receipt of a completed SSA-L460, the CE updates the case status screen in ECMS. The designated employee confirms that the years received by SSA equals the years used to determine the cost. If there is a discrepancy, the DO SSA POC must contact SSA immediately to rectify the issue.

b. Tax Returns and W2 Forms provide proof of the covered employee's wages in instances where the employer did not report accurate and/or complete earnings to SSA or when the covered Part E employee worked for an employer where there was no reporting of income to SSA. If a W2 Form is submitted, the claimant must also submit an affidavit attesting that he or she has submitted all W2 Forms for that calendar year;

c. Pay Stubs that provide proof of the employee's wages;

d. Union records that provide proof of the employee's wages;

e. Pension records that provide proof of the employee's wages; and

f. Document Acquisition Request (DAR) for Pay and Salary Records that provide an employee's pay, salary, any workers' compensation claim or other documents affecting wage. Examples of records from the DOE database include, but are not limited to, Official Personnel Files of Contractor Employees, Contractor Job Classification, Employee Awards Files, Notification of Personnel Actions, Classification Appraisals, Wage Survey Files, and Unemployment Compensation Records.

9. Calculation of Average Annual Wage (AAW). The AAW is the baseline wage against which the CE measures each claimed year of wage-loss to determine wage-loss percentage. To calculate the AAW, the CE adds up the wages from the quarters (up to 12 quarters) immediately prior to, but not including, the quarter where the covered Part E employee first experiences wage-loss due to a covered illness. The CE must exclude the wages from any quarter during which the employee was unemployed (See paragraph 3f). The sum of the total wages must be divided by the number of quarters included in the sum to get the average quarterly wage. The CE then multiplies the average quarterly wage by four (4) to determine the AAW.

To determine if a quarter must be excluded because the employee was unemployed, the CE must determine if the employee earned $700 or less in constant 2005 dollars for that quarter. The following chart provides the value of $700 in constant 2005 dollars from the years of 1942 through 2008.

1942	1943	1944	1945	1946	1947	1948	1949
$58.66	**$62.26**	**$63.34**	**$64.78**	**$70.18**	**$80.26**	**$86.74**	**$85.66**

1950	1951	1952	1953	1954	1955	1956	1957
$86.74	**$93.57**	**$95.37**	**$96.09**	**$96.81**	**$96.45**	**$97.89**	**$101.13**

1958	1959	1960	1961	1962	1963	1964	1965
$104.01	**$104.73**	**$106.53**	**$107.61**	**$108.69**	**$110.13**	**$111.57**	**$113.37**

1966	1967	1968	1969	1970	1971	1972	1973
$116.61	**$120.21**	**$125.24**	**$132.08**	**$139.64**	**$145.76**	**$150.44**	**$159.79**

1974	1975	1976	1977	1978	1979	1980	1981
$177.43	**$193.62**	**$204.78**	**$218.10**	**$234.65**	**$261.29**	**$296.56**	**$327.15**

1982	1983	1984	1985	1986	1987	1988	1989
$347.30	**$358.46**	**$373.93**	**$387.25**	**$394.45**	**$408.84**	**$425.76**	**$446.27**

1990	1991	1992	1993	1994	1995	1996	1997
$470.39	**$490.18**	**$504.94**	**$520.05**	**$533.37**	**$548.48**	**$564.68**	**$577.63**

1998	1999	2000	2001	2002	2003	2004	2005
$586.63	**$599.59**	**$619.74**	**$637.38**	**$647.46**	**$662.21**	**$679.85**	**$700.00**

2006	2007	2008
$722.58	**$743.16**	**$771.70**

The CE may also calculate the dollar value of any wages for any given year to reflect their value (buying power/worth) to 2005 dollars by using the CPI Inflation Calculator on the Bureau of Labor Statistics' website http://www.bls.gov/data/inflation_calculator.htm.

Example: If the evidence indicates the employee earned $100 in a quarter of employment in 1963, the CE, using the CPI Inflation Calculator, determines that $100 in 1963 has the same adjusted value as $638.24 in 2005 dollars. Since the adjusted value of $638.24 is less than $700 in constant 2005 dollars, the CE considers the employee to have been unemployed for that quarter and that quarter is excluded in the calculation of the AAW.

If a covered employee is unemployed for three quarters during the AAW period; the CE adds the wages from the nine (9) quarters of employment (excluding the wages from the three quarters of unemployment) and divides by nine (9) rather than twelve (12) to get the average quarterly wages. The CE then multiplies the average quarterly wages by four (4) to obtain the AAW. (See Exhibit 7 for Wage-Loss Worksheet #1, Calculate Average Annual Wage)

a. Retirement. If a covered Part E employee is retired prior to his or her normal Social Security retirement age, he or she is not considered unemployed under Part E. Even though the retired employee has no wages reported to SSA, this time period is not excluded from the calculation of the AAW. The CE determines that the AAW of the employee is $0 if he or she was retired (prior to his or her normal Social Security retirement age) during the entire twelve (12) quarters immediately preceding the quarter during which he or she first experienced wage loss due to a covered illness.

If the employee earned wages during any of the 12 quarters and then retired before the end of the 12 quarters, those earned wages are included in the AAW calculation.

Example: If the covered employee earned no wages for two quarters during the AAW period due to retirement, the CE adds the covered employee wages for the 12 quarters including the two quarters of retirement and divides the sum by twelve (12) to get the average quarterly wages. The CE then multiplies the average quarterly wages by four (4) to obtain the AAW.

b. Maximum Amount of Taxable Earnings. If the employee's earnings meet SSA's maximum amount of taxable earnings for that year, those earnings that exceed the maximum limit are not reflected in the SSA statement. The CE can find the maximum amount of taxable earnings under the SSA for a specific year at the SSA website: http://www.ssa.gov/OACT/COLA/cbb.html.

(1) Multiple Employers. For any year in which the covered Part E employee is employed by multiple employers, according to SSA, each of the employers withholds Social Security taxes on the wages without regard to what the other employers may have withheld. Therefore, the covered Part E employee can potentially meet the maximum amount of taxable earnings under SSA from each employer for the same year in question.

To determine if any additional wages may have been unaccounted for in the SSA earnings summary, the CE contacts the claimant by telephone and requests evidence to support additional wages (see paragraph 8 for different types of wage evidence). The CE must memorialize the claimant's response in the TMS section of ECMS. The CE follows up with a letter notifying the claimant of the earnings information included in the SSA earnings summary for the applicable year(s). The letter requests that the claimant submit evidence of wages that may have been unaccounted for as a result of reaching the maximum amount of taxable earnings under the SSA. If the claimant does not submit additional evidence within 30 days of the letter, the CE uses the earnings summary information as reported by the SSA.

c. Additional Wages. If there is evidence of wages based on records other than SSA, the CE adds any additional wages earned by the employee during those same quarters as supported by the submitted evidence.

d. Annual SSA Earnings Report. In the late 1970's, SSA began reporting yearly earnings summary instead of quarterly earnings summary. In instances when only a detailed SSA yearly earnings summary is available, the CE divides the yearly earnings by 4 (representing 4 quarters in a year) to estimate the quarterly earnings for each year.

10. Determination of Wage-Loss Percentage. The CE compares the AAW of a covered Part E employee with his or her adjusted (for inflation) wages in later calendar years to determine the wage-loss percentage. The CE begins with the calendar year that includes the quarter in

which the claimed wage-loss commenced, and concludes with the last calendar year of claimed wage-loss, the calendar year in which the employee reached normal Social Security retirement age or the calendar year in which the employee would have reached his normal Social Security retirement age but for his covered illness related death.

a. Adjustment of Wages for Inflation. Wages must be adjusted for inflation for each calendar year that wage-loss is claimed. The wages are adjusted for inflation to reflect the value (buy power/worth) during the calendar year in which the covered Part E employee first experienced wage-loss due to a covered illness. The CE can perform this calculation by using the CPI Inflation Calculator on the Bureau of Labor Statistics' website http://www.bls.gov/data/inflation_calculator.htm.

> Example: The employee claims wage-loss first commencing in 1993 and ending in 2002 when the employee reaches normal Social Security retirement age. The CE must adjust the yearly wages for inflation to reflect the value of the wages for the calendar year in which the wage-loss first commenced (which in this example is 1993). If the employee earned $38,000 in 1995, this wage is adjusted for inflation using the CPI Inflation Calculator to $36,030.20 to reflect the value in 1993 dollars. (See Exhibit 8 for Wage-Loss Worksheet #2, Adjust Wage for Each Year of Claimed Wage-Loss)

b. Comparison with the AAW. The CE compares the AAW of the covered Part E employee with his or her adjusted wages in later calendar years to ascertain the wage-loss percentage for each claimed year of wage-loss. For example, $36,030.20 (Adjusted Wage) ÷ $46,000 (AAW) = 78% (Wage-Loss Percentage). (See Exhibit 9 for Wage-Loss Worksheet #3, Determine Percentage of Wage-Loss and Award Amount).

11. Employee Wage-Loss Compensation. The CE uses the wage-loss percentage to determine the amount of the employee's wage-loss compensation.

a. If the employee's adjusted wages during a claimed calendar year is greater than 75% ($X > 75\%$) of his or her AAW, then the employee is not considered to have wage-loss for that calendar year and the employee is not awarded wage-loss benefits for that calendar year.

Example #1: AAW = $46,000

Adjusted wages = $36,030.20

Percentage of AAW = 78%

b. $10,000 is awarded for each year in which the employee's adjusted wages during a claimed calendar year is greater than 50% but less than or equal to 75% ($50\% < X \leq 75\%$) of his or her AAW.

Example #1: AAW = $46,000

Adjusted wages = $34,662.00

Percentage of AAW = 75%

Example #2: AAW = $46,000

Adjusted wages = $23,661.80

Percentage of AAW = 51%

c. $15,000 is awarded for each year in which the employee's adjusted wages during a claimed calendar year is equal to or less than 50% (X ≤ 50%) of his or her AAW.

Example #1: AAW = $46,000

Adjusted wages = $23,076.00

Percentage of AAW = 50%

Example #2: AAW = $46,000

Adjusted wages = $11,646.75

Percentage of AAW = 25%

The following is an example of a Wage-Loss Calculation:

AVERAGE ANNUAL WAGE: $46,000.00

Year	Actual Wages	Adjusted Wages	Percent of AAW	Compensation
1993	**$44,000.00**	**$44,000.00**	**96%**	**$0**
1994	**$40,000.00**	**$39,001.30**	**85%**	**$0**
1995	**$38,000.00**	**$36,030.20**	**78%**	**$0**
1996	**$35,000.00**	**$32,233.90**	**70%**	**$10,000.00**
1997	**$38,500.00**	**$34,662.00**	**75%**	**$10,000.00**
1998	**$30,000.00**	**$26,595.10**	**58%**	**$10,000.00**
1999	**$26,000.00**	**$22,551.00**	**49%**	**$15,000.00**
2000	**$27,500.00**	**$23,076.00**	**50%**	**$15,000.00**
2001	**$29,000.00**	**$23,661.80**	**51%**	**$10,000.00**
2002	**$14,500.00**	**$11,646.75**	**25%**	**$15,000.00**
Total Compensation for Wage-Loss				**$85,000.00**

12. Survivor Wage-Loss Compensation. The CE first determines whether the survivor is entitled to benefits under Part E of the EEOICPA. If the survivor is found to be entitled to survivor benefits, he or she may also be entitled to additional compensation for wages lost by the employee as a result of the covered illness. The CE undertakes the same medical and employment development and AAW

calculation as if the employee had filed a claim. The difference is that the monetary benefit provided to a survivor is limited to an additional $25,000 or $50,000 based on the number of years in which the employee's adjusted wages during a claimed calendar year is equal to or less than 50% (X ≤ 50%) of his or her AAW.

a. Percentage of Loss: If the covered Part E employee dies as a result of the covered illness prior to his or her normal Social Security retirement age, the CE performs the same inflation adjustment calculation as an employee claim for each calendar year of wage-loss claimed through and including the calendar year of death to determine the percentage of loss.

For the years after the employee's death, the CE assumes that the employee had no wages and therefore the adjusted wages were less than or equal to 50% of the AAW for each year after the year of the employee's death up to and including the calendar year of his or her normal Social Security retirement age.

In some instances, the employee may have lost wages due to a covered illness prior to his or her death. In this situation, the CE calculates the period of wage-loss (prior to and including the calendar year of the employee's death) and adds any calendar years in which adjusted wages were less than or equal to 50% of the employee's AAW to the number of calendar years after the year of the employee's death up to and including the calendar year of his or her normal Social Security retirement age (based on the assumption that the employee did not earn any wages after his or her death) in order to determine the survivor's entitlement.

(1) $25,000 Award. For the survivor to be awarded an additional $25,000, the employee must have 10 to 19 years in which the employee's adjusted wage is equal to or less than 50% (X ≤ 50%) of his or her AAW.

(2) $50,000 Award. For the survivor to be awarded an additional $50,000, the employee must have 20 or more years in which the employee's adjusted wage is equal to or less than 50% of his or her AAW.

b. Survivor Election. If a covered Part E employee dies after submitting a wage-loss claim but before compensation is paid and death is caused solely by a non-covered illness or illnesses, the survivor may elect to receive the compensation that would have been payable to the employee, including wage-loss and/or impairment.

13. Maximum Aggregate Compensation. The amount of monetary compensation provided under Part E (impairment and wage-loss compensation), excluding medical benefits, cannot exceed $250,000. The CE considers any previous compensation awarded under Part E for impairment and/or wage-loss to determine if a subsequent award needs to be reduced to ensure that it does not exceed the $250,000 maximum aggregate compensation. In determining the aggregate compensation,

reduction of compensation based on state workers' compensation coordination or tort offset is not taken into consideration. For example, if the employee was previously awarded benefits for impairment in the amount of $100,000 but his compensation was reduced because of tort offset to $60,000, the amount of compensation used to determine the maximum aggregate compensation is $100,000.

14. Wage-Loss Calculator. The Wage-Loss Calculator in ECMS is an instrumental tool and the preferred method to calculate wage-loss benefits. The CE enters the employee's wages for all claimed years of wage-loss and the twelve (12) quarters immediately prior to the first quarter of experienced wage-loss into the Wage-Loss Calculator. The Wage-Loss Calculator will calculate the twelve (12) quarterly wages immediately prior to the first quarter of experienced wage-loss into 2005 dollar value. The CE must designate any quarter that is below the $700 in constant 2005 dollar threshold as either unemployed or retired quarters (See paragraph 9 above) before the Wage-Loss Calculator determines the AAW. The Wage-Loss Calculator adjusts for inflation the annual wages for each calendar year that wage-loss is claimed and compares the adjusted wages with the AAW to determine the percentage of loss. The Wage-Loss Calculator calculates the wage-loss compensation that is payable. Detailed instructions on the use of the Wage-Loss Calculator are located on the National Office Shared Drive.

15. Recommended Decisions and Final Decisions. The CE first determines if the employee contracted a covered illness due to exposure to a toxic substance at a DOE facility or RECA section 5 facility prior to making a determination on wage-loss. The CE can develop for the wage-loss simultaneously with the development of other aspects of the case, but this development should not delay the issuance of a recommended decision to award medical or impairment benefits. If a Part E claimant files a signed statement requesting wage-loss, CE must develop the wage-loss claim and issue a recommended decision for potential wage-loss benefits. If the claimant formally files a claim for wage-loss and then subsequently submits a signed written request to withdraw the wage-loss claim, a recommended decision on wage-loss benefits is not required.

Prior to the issuance of a recommended decision that deals with wage-loss benefits, it is important that either the Part E Wage- Loss Worksheets are completed or the Wage-Loss Calculator in ECMS has been used, and printouts of the calculation are placed in the case file. The recommended decision must include a discussion of the figures used to come to a wage-loss decision. Wage-loss calculations must be clearly explained so that a claimant may request a hearing if he or she disagrees.

The FAB Representative must evaluate the figures and calculations used by the CE. Printouts of the calculation performed by the FAB Representative are placed in the case file. If the FAB Representative cannot determine the basis for a wage-loss calculation made by the CE in a recommended decision the case file may be

remanded.

16. Additional Filings for Wage-Loss Compensation. A covered Part E employee who has been previously awarded compensation for wage-loss may file a Form EE-10 for subsequent calendar years of wage-loss. The covered Part E employee may file a Form EE-10 on a yearly basis, or for an aggregate of calendar years in which wage-loss is alleged. The EE-10 must be supported by sufficient employment and medical evidence to establish that the claimant is entitled to additional wage-loss benefits.

a. The RCs maintain a list of employees that have received wage-loss awards. When one year following issuance of the last wage-loss award has elapsed, the RC contacts the employee to determine if he or she wishes to claim an additional year of wage-loss.

Exhibit 1: Normal Social Security Retirement Age Table

Exhibit 2: Initial Solicitation Letter

Exhibit 3: Follow-Up Solicitation Letter

Exhibit 4: Final Solicitation Letter

Exhibit 5: SSA 581 Form

Exhibit 6: Telephone Inquiries to SSA

Exhibit 7: Part E Wage-Loss Worksheet #1 Calculate Average Annual Wage

Exhibit 8: Part E Wage-Loss Worksheet #2 Adjust Wages for Each Year Of Claimed Wage-Loss

Exhibit 9: Part E Wage-Loss Worksheet #3 Determine Percentage of Wage-Loss and Award Amount

2-1500 Consequential Conditions

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1. Purpose and Scope. This chapter discusses the Claims Examiner's (CE) role when developing claims for consequential conditions. It also provides examples of the types of injuries, illnesses, impairments, or diseases that may be accepted as consequential conditions under EEOICPA.

2. Defining a Consequential Condition. A consequential condition covered by EEOICPA is any diagnosed injury, illness, impairment or disease that has occurred as a result of an accepted occupational illness under Part B and/or covered illness under Part E. Consequential conditions also include independent incidents related to an accepted condition.

Any illness, injury, impairment, or disease shown by medical evidence to be a consequence of an accepted Part B or Part E condition is covered for medical benefits under the Act. Additionally, under Part E, any illness, injury, impairment, or disease shown by medical evidence to be a consequence of a covered Part E condition may affect the calculation of an impairment rating and/or wage-loss.

3. Consequential Condition Claims. The claimant must make a claim for a consequential condition in writing. He or she may use any method of written notification, including a Form EE-1/2. Additionally, in some situations the CE develops a potential consequential condition upon receipt of medical evidence that discusses medical conditions other than the accepted condition that

may be consequential.

4. Claim Development. Consequential condition(s) must be developed factually and medically in accordance with 20 C.F.R. 30.114(b)(3) of the EEOICPA regulations and DEEOIC procedures relating to weighing medical evidence.

There are four types of consequential conditions:

a. Metastasized Cancer(s);

b. Conditions resulting from medical treatment of the accepted condition/s;

c. Independent incidents related to an accepted condition/s;

d. Natural progression and/or development (pathogenesis).

5. Metastasized Cancer(s). Metastasized cancer(s) is a secondary cancer that originates from the primary cancer site.

a. Assessing and Developing Medical Evidence in Metastasized Cancer Claims. The CE can accept a metastatic cancer claim, if the claimant provides medical evidence, including a rationalized medical report from a physician that identifies the metastatic cancer and links the cancer to a primary site that had previously been accepted. The evidence must also establish:

(1) The diagnosis of a secondary cancer; and

(2) The date of diagnosis for the secondary cancer.

The date of diagnosis for the secondary cancer will be: a) subsequent to the date of diagnosis for the primary cancer; b) the same diagnosis date for the primary cancer; or c) before the date of diagnosis for the primary cancer if the primary site is not obvious.

If the medical evidence is inconclusive and the CE is unable to determine if the cancer is a metastasis, the CE seeks clarification from the treating physician and/or a District Medical Consultant (DMC).

b. Examples of Metastasized Cancers. It is widely accepted that certain carcinomas and/or sarcomas metastasize from the primary site. For example:

(1) Carcinomas of the lung, breast, kidney, thyroid, and prostate tend to metastasize to the lungs, bone, and brain.

(2) Carcinomas of the gastrointestinal tract, reproductive system, and abdomen tend to metastasize to the abdominal lymph nodes, liver, and lungs. Later in their course, these carcinomas can metastasize to the brain and other organs.

(3) Sarcomas often first metastasize to the lungs and

brain.

(4) Primary malignant tumors of the brain seldom metastasize to other organs, but they can spread to the spinal cord.

6. Conditions Resulting from Medical Treatment. These conditions require a fully rationalized medical report by a physician that shows the relationship between the injury, illness, impairment or disease and the compensable illness.

a. Examples of Common Consequential Conditions Resulting from Medical Treatment for Accepted Conditions. As part of a patient's medical treatment or protocol, a patient may undergo treatment and/or other drug therapy that will produce side effects that can be considered common consequential conditions.

Examples of such conditions are:

(1) Radiation pneumonitis as a result of radiation treatment;

(2) Skin rashes and radiation burns because of radiation treatment;

(3) Osteoporosis (which causes weakening of the bones and injuries such as spontaneous hip fractures) as a result of steroid treatment;

(4) Chronic Pain, extreme fatigue, anemia, and gastrointestinal conditions such as nausea, vomiting, constipation, diarrhea, and weight loss are additional examples of side effects of medical treatment.

b. Developing evidence for conditions resulting from medical treatment. When a claim is made for a consequential condition caused by medical treatment of the accepted condition, the CE investigates the submitted documentation to ensure the medical evidence supports the claim. The CE obtains the following supporting documentation from the claimant:

(1) Medical Evidence that establishes a causal connection between the claimed consequential condition and the accepted condition. The physician discusses the causal relationship between the consequential condition and the accepted condition, and establishes that the prescribed treatment is a recognized medical response to the accepted condition.

c. Assessing the medical evidence. The CE must use reasonable judgment when assessing the medical evidence required for a claim for a consequential condition.

7. Independent Intervening Causes.

a. Condition(s) resulting from an accident during travel to a medical appointment. If the employee sustains an injury in transit

to or from a medical appointment or other necessary travel, it is considered a consequential condition. The CE must obtain the following factual and medical evidence:

(1) A Personal Statement that describes the circumstances of the event that resulted in an injury during travel to or from a medical appointment.

Examples of personal statements include: The employee trips down the stairs when exiting the doctor's office and breaks an arm or leg.

The employee is assaulted in the parking lot of the doctor's office, and obtained bruises, cuts, possible concussion, etc.

The employee is involved in a motor vehicle accident while en route to the doctor's office and has whiplash. In this event, reasonable assessment of the situation is needed. If the employee's accident occurred at 8 am and the doctor's appointment was scheduled for 1 pm, the CE must determine the distance between the employee's residence and his or her doctor's office.

(2) Medical Evidence must include a diagnosis of the condition being claimed as a consequence of a travel-related injury and confirmation that the scheduled appointment was for treatment or care of a previously accepted covered illness.

b. An independent intervening incident caused by, or attributed to the employee's own conduct. Injuries, illnesses, impairments or diseases suffered as a result of the employee's own actions will not be accepted as consequential conditions.

8. Natural Progression/Development (Pathogenesis). There are medical conditions that are expected to develop due to the natural progression of the accepted illness. Natural progression is an expected measurable change in the illness that occurs with the passage of time.

The CE may accept certain conditions arising as a natural progression of accepted condition(s) when he or she is notified of the existence of these secondary medical conditions. Exhibit 1 outlines secondary conditions that are known to result from Chronic Beryllium Disease and Silicosis, and can be accepted upon the receipt of notification. Notification must be in the form of a well-rationalized medical report diagnosing a secondary condition that progressed/developed from the accepted condition. When notified of such a condition listed in Exhibit 1, the CE updates ECMS and sends an appropriate letter to the employee.

However, some medical conditions could develop as a result of either the natural progression of the accepted condition or the natural aging process (see Exhibit 2). Hypertension, gout, and heart disease

are examples of medical conditions that potentially result from either the aging process or natural progression of the accepted condition. When a claimant presents evidence of such a medical condition, the CE assesses the medical evidence as described below.

a. Assessing the medical evidence. The CE must use reasonable judgment when assessing the medical evidence required for a claim of consequential condition. In some instances, the CE may accept conditions caused by the natural progression upon receipt of the medical evidence describing the conditions listed in Exhibit 1.

In other situations where the relationship is questionable, more medical evidence (e.g., DMC review, clarification from treating physician, or second opinion) may be required.

Given that these conditions have not yet been accepted, any bills that are initially submitted to the medical bill processing agent relating to the non-accepted condition will suspend and/or reject until ECMS is updated.

9. Psychological Conditions. Psychological conditions can arise as a consequence of the accepted condition and/or treatment of that condition. They can also arise with no physiological basis. Depression, anxiety, or chemical imbalance are a few examples of psychological conditions that have no physiological basis. In addition to a specific diagnosis, these conditions may be described as "psychogenic pain disorder," "conversion disorder," or "psychological syndrome."

However described, the symptom or pain is quite real to the individual involved although there is no demonstrable physical disorder.

Unless expressly claimed by a claimant, the CE develops for psychological conditions only if the attending physician indicates that such a component is present and that it is directly related to the accepted physiological condition. In such cases, the CE refers the claimant to a Board-certified psychiatrist for evaluation and opinion concerning causal relationship.

10. Accepting or Denying the Consequential Condition. The CE is responsible for taking the appropriate steps in developing any claimed consequential condition. This includes notifying the claimant of any deficiencies in the evidence and allowing him or her an opportunity to respond and submit additional evidence.

a. Acceptances. If the consequential condition is accepted, the CE notifies the claimant in a letter decision. However, if the decision is to deny the consequential condition, the CE advises the claimant of his/her determination by issuing a recommended decision. The recommended decision affords the claimant the opportunity to object to the determination, and present new evidence.

b. Issuing the Decision. When the case is in posture for the CE to accept a primary covered condition and a potential consequential

condition exists, the CE proceeds with the immediate release of a recommended decision for the primary condition. A recommended decision accepting a primary covered condition must not be delayed while developing a consequential condition. However, if the case is in posture to also accept the consequential condition, this acceptance is included in the recommended decision. While the case file is at the Final Adjudication Branch (FAB), the FAB hearing representative (HR) or CE2 Unit staff pursues all development regarding consequential conditions. A letter accepting a consequential condition or a recommended decision denying a consequential condition cannot be issued before FAB issues a final decision on the primary covered condition. Decisions of this nature can be issued concurrently. Once the case file is returned to the District Office, the CE can continue development on the consequential condition and/or issue the letter accepting the consequential condition or the recommended decision denying it.

11. Impairment and Wage-Loss. Consequential conditions may cause additional impairment or wage-loss under Part E, but do not result in an additional lump sum award under Part B.

a. Impairment rating. An impairment rating assesses the functionality of the whole organ or system. DEEOIC does not apportion impairment by disease (see EEOICP PM 2-1300 for further discussion of impairment ratings). If the accepted condition and consequential condition affect the same organ or system, a rating for impairment to that organ or system should proceed. However, if the accepted condition affects one organ/system and the consequential condition involves another, the impairment rating on the organ/system affected by the consequential condition could be developed either concurrently with the impairment for the primary system (if the consequential condition has been accepted), or later. Ideally, the CE develops the primary and consequential conditions concurrently; however, this may not be possible if, for example, the system affected by the consequential condition has not reached maximum medical improvement (see EEOICPA PM 2-1300). As soon as an impairment rating is completed for the primary affected system an impairment decision should proceed. There would be nothing to preclude a later decision on the impairment due to the consequential condition as long as the organ or system affected by the consequential condition was not rated within the past two years. After passage of two years, the claimant can receive an impairment rating based on the consequential condition affecting the same organ system as the accepted condition.

b. Wage-Loss. The acceptance of a consequential condition may affect the claimant’s entitlement to wage-loss. Wage-loss is calculated using the first day that the employee lost wages due to the covered illness (see EEOICPA PM 2-1400 for further discussion of wage-loss).

In certain instances, the consequential condition may be the initial cause of the employee’s wage-loss. For example, a claimant submits

medical evidence showing that pulmonary hypertension caused his or her wage-loss, and shows a diagnosis of Chronic Beryllium Disease (CBD) three years thereafter. In this instance, CBD is accepted under Parts B and E as the primary condition and pulmonary hypertension is accepted as the consequential condition under Parts B and E. Also, the claimant may receive wage-loss benefits under Part E dating from the time that the he or she first lost wages due to the pulmonary hypertension.

12. State Workers' Compensation (SWC) Claims, Lawsuits and Fraud. Prior to accepting a consequential condition, the CE collects information to determine if a claimant has filed an SWC claim, lawsuit, or if the claimant has been convicted of fraud in connection with the consequential condition.

Exhibit 1: Medical Conditions with Likely Secondary Disorders

Exhibit 2: Conditions that Require Additional Development

2-1600 Recommended Decisions

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1. Purpose and Scope. The District Office (DO) issues Recommended Decisions for claims filed under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA). A Recommended Decision is a written decision made by the Claims Examiner (CE) regarding the eligibility of a claimant to receive compensation benefits available under the EEOICPA. As a recommendation, it does not represent the final program determination on claim compensability. It is a preliminary determination made by the program that is subject to challenge by any claimant party to the decision, and ultimately must undergo independent action by the Final Adjudication Branch (FAB). This chapter describes the procedures for issuing a Recommended Decision.

2. Authority. 20 C.F.R. § 30.300 grants the DO authority to make determinations with regard to compensability and issue Recommended Decisions with respect to EEOICPA claims. Under this section, the DO is authorized to recommend the acceptance or denial of a claim for benefits under the EEOICPA. All Recommended Decisions are forwarded to the FAB for review.

3. When a Recommended Decision is Required. A Recommended Decision is required in situations where a claimant seeks an entitlement benefit provided for under either Part B or E of the EEOICPA. Entitlement benefits include medical benefits under Part B and/or E; lump-sum compensation under Part B; impairment or wage-loss awards under Part E; and lump-sum survivor compensation under Part E. In certain situations, as explained later, exceptions to this guidance apply to decisions involving new cancer claims after a prior finding of Probability of Causation (PoC) of 50% or greater, consequential illnesses, or approval or denial for medical procedures, equipment or other medically indicated necessities.

Claims made under Part B or E of the EEOICPA can involve multifaceted elements, filed at varying points in time, involving a multitude of medical conditions, or periodic claims for monetary lump-sum benefits, i.e. recurring wage-loss and impairment. The question of when a case element is in posture to be decided and a Recommended Decision issued is dependent on several factors that the CE must consider. First, the CE must identify the parties seeking benefits, i.e., employee vs. survivor claims. This includes individuals who have filed claims or potential claimants who have not filed, but may be eligible. Secondly, the actual claimed entitlement benefit for which a decision is required must be identified. In some instances, there may be multiple benefits being sought under Part B and/or E,

especially if more than one illness is being claimed.

Based on examination of the evidence of record, development must then be completed to overcome any defect in the case evidence that does not satisfy the eligibility criteria for a claimed benefit. Once development has occurred, the CE then performs an examination of the case evidence to determine if it is sufficient to accept or deny a claim for benefit entitlement.

a. When a Claim is Submitted. Documents containing words of claim are acceptable to begin the adjudication process and set the effective date for the date of filing; however, the CE is to obtain the applicable claim form before issuing a Recommended Decision. The CE notifies the claimant of the need to submit the required form. A period of 30 days is to be allotted for the claimant to submit the required documentation. If the appropriate form is not forthcoming, the CE administratively closes the claim. Notice should be provided to the claimant that no further action will be taken on their claim until such time as the proper claim form is submitted.

(1) The CE has the discretion to conclude that a new claim actually has been previously addressed in a prior determination under the EEOICPA. For example, a claim for "lung disease" is filed and denied lacking any diagnosed condition. Subsequent filing is made for "lung problems." While the exact wording of the claimed condition is dissimilar, the nature of the claim is the same and, in this situation, would not require new adjudication, unless the claimant provides evidence of a more specific diagnosis.

Additionally, no Recommended Decision is needed if a newly claimed condition has been previously addressed by a Final Decision. In such instances, the claimant should be notified that the condition has previously been decided and no further action will be taken without a request from the claimant to reopen the claim.

b. On the Initiative of the Director of the Division of Energy Employees Occupational Illness Compensation (DEEOIC). Upon the issuance of a Director's Order, the DO may be instructed to issue a new Recommended Decision to address new evidence.

c. At the Request of a Claimant. The claimant may request a Recommended Decision be issued either after or in lieu of a letter decision. This may occur in any of the situations discussed later in this chapter where a letter decision is permitted.

d. Administrative Closures. Several situations exist that require administrative closure of a claim without the issuance of a Recommended Decision. For example, situations where an administrative closure is necessary include the death of a claimant, failure to complete the OCAS-1, withdrawal of claim prior to the issuance of a

Final Decision, and lack of response to a request for information regarding State Workers' Compensation or Tort payments. When the circumstances of the case lead to an administrative closure, a Recommended Decision is not required for the affected claimant. Instead, when appropriate, the DO issues a letter to the claimant and/or his or her representative advising of the administrative closure, and the steps required to reactivate the claim.

(1) When multiple claimants have filed for benefits and an administrative closure is required for one or more individual claim(s), the CE proceeds with the adjudication of the remaining active claims. The decision will describe the basis for any administrative closure, and the persons whose claims were closed will not be a party to the Recommended Decision. If at a later date, the administrative closure ends and development resumes, any Final Decision that deferred action on an administratively closed claim will need to be vacated to allow for a new decision to all individuals named in the case record.

4. Who Receives a Recommended Decision. Each individual who files a claim under a case, and has not had their claim administratively closed, is required to be a party to a Recommended Decision that decides a benefit entitlement.

Given the variant benefit filings that may exist in a single case, the CE may divide benefit entitlement claims to be addressed by separate Recommended Decisions. This will occur when one or more entitlement benefit claims can be decided based on the evidence of record, while concurrent development is required on outstanding claimed components. For example, separate decisions may be issued awarding medical benefits for a cancer under Part E, and a subsequent decision issued for any impairment linked to that cancer.

a. Multiple Claimant Recommended Decisions. All claimants who have filed a claim under Parts B and/or E, and have not had their claim administratively closed, are to be parties to any Recommended Decision deciding a benefit entitlement. This is necessary to ensure that any decision comprehensively addresses the entitlement for all claimants with an interest in the claim. Each claimant is provided with the information necessary to understand the outcome for all claims. Moreover, it grants all claimants equal opportunity to present objections, should they disagree with any particular aspect of the decision. A CE should not issue a Recommended Decision determining any single individual claimant's eligibility to receive benefits in a multiple person claim, except in the circumstance of a newly filing ineligible survivor.

(1) Once a Final Decision is issued, should a new individual subsequently file a claim seeking benefits, the CE will undertake normal development to determine the claimant's eligibility to benefits. Should the new

claimant be deemed ineligible, a recommended denial of benefits that addresses his or her individual claim may be issued without reopening the previously decided claims. However, if the circumstances of the case develop to the point where a newly filing claimant may be eligible for benefits, it will be necessary to reopen all previously decided claims to allow for a new combined Recommended Decision.

b. Discretionary Authority in the Decision Process. The CE employs appropriate discretion to decide the most effective course to bring timely resolution to all entitlement claims. Particular attention should be directed at benefit entitlement determinations that will result in a positive outcome. In these situations, the CE is not to delay the issuance of a Recommended Decision, even if other benefit entitlements may exist that require development. For example, two survivors of an employee file for lump sum compensation under Parts B and E. Development is undertaken and both are found to be eligible to a Part B benefit of $150,000 because the employee had lung cancer related to covered employment. However, under Part E, only one of the survivors has submitted evidence to establish that he or she was under the age of 18 at the time of the employee's death. The other survivor indicates he or she is having problems obtaining school transcripts to show full-time student status. In this situation, the CE proceeds to issue a decision on the benefit entitlement of both claimants under Part B, but would defer any decision on the Part E claim.

c. Non-Filing Survivors. The situation may arise where a potentially eligible survivor has been identified through development, but whose whereabouts are unknown or who does not wish to seek benefits. This includes situations where a survivor specifically notifies the CE that he or she does not wish to pursue benefits or states that he or she is clearly ineligible and will not file a claim. Under these circumstances, it is not possible for the CE to include them as party to a Recommended Decision. The CE may proceed with the issuance of the Recommended Decision to the remaining claimants; however, the decision must reference the fact that there is a potentially eligible survivor who has not filed a claim.

(1) In the situation where the non-filing survivor's eligibility to benefits cannot be ascertained, any payable lump-sum compensation will be allocated with the presumption that the non-filing survivor is eligible. The potential survivor's share of compensation is held in abeyance until a claim is filed, evidence is received establishing the survivor's status as ineligible, or notice of his or her death is received. Should the CE obtain evidence establishing that the non-filing survivor is clearly ineligible or deceased, any payable compensation

being held in abeyance can be allocated among the remaining survivor(s).

(2) When non-filing survivors have been advised of the requirement for establishing eligibility and have communicated to the CE that they will not file as they consider themselves ineligible, the CE attempts to obtain a signed, written statement confirming the survivors' ineligible status. If written confirmation can not be obtained, the CE must be clearly document that the survivor intends not to file. Under this circumstance, unless the CE has reason to doubt the accuracy of the survivor's ineligibility; the fact that there is a non-filing, ineligible, survivor is to be noted in the decision. However, the non-filing survivor is not to be named, but addressed as a non-filing survivor. The non-filing survivor is not a party to the decision and no money is held in abeyance.

(3) Development involving a non-filing survivor should not extend past a reasonable period, as to significantly delay the issuance of a Recommended Decision to other claiming survivors. The CE should make a reasonable effort to obtain either a claim form or written confirmation of the non-filing survivor's status. In most situations, the CE should allow 30 days to provide requested documentation. When there is no response to a request for information within an allowable time frame, the CE may proceed with the adjudication of the claim based on the evidence present in the case record and the procedural guidance provided on handling non-filing. However, the non-filing survivor will be excluded as a party to the case. The administrative closure of the claim is to be noted in the decision, and the non-filing claimant is to be presumed eligible. As such, compensation is held in abeyance until such time as the CE obtains the properly completed claim form.

(4) Once a Recommended Decision has been issued that involves a non-filing survivor, if the survivor later decides to file a claim form, it will be necessary to issue a new Recommended Decision. Should development result in the claimant being found ineligible, a Recommended Decision is permitted to be issued solely to the new claimant denying his or her claim. Under this circumstance, a reopening of any prior claims is unnecessary, because the denial has no effect on the previously decided claims. Alternatively, if the claimant is eligible to a benefit, a reopening of all previously decided claims is required to enable the issuance of a new Recommended Decision to all individuals who are party to the claim.

d. Non-Responsive Claimants. In situations in which a claim is

filed and the claimant subsequently becomes unresponsive, reasonable steps should be taken to obtain confirmation of the non-responsive claimant's status. However, development should not extend past a reasonable period. In most situations, the CE should allow 30 days to provide the requested documentation. When there is no response within an allowable time frame, the CE may proceed with adjudication of the claim and issuance of a Recommended Decision based on the evidence present in the case record.

(1) In the situation where the non-responsive claimant is a party to a multiple survivor claim, and the non-responsive survivor's eligibility cannot be ascertained, any payable lump-sum compensation will be allocated with the presumption that the non-responsive survivor is eligible; and his or her share of compensation is held in abeyance until such a time evidence is received establishing the survivor's eligibility. In such cases, the non-responsive claimant must be a party to the Recommended Decision. Should the CE obtain evidence establishing that the non-responsive survivor is clearly ineligible or deceased, any payable compensation being held in abeyance can then be allocated among the remaining survivor(s).

5. Writing a Recommended Decision. When the CE has completed development to allow for a decision involving an entitlement benefit, the CE issues a Recommended Decision. The decision either recommends acceptance or denial of entitlement benefits in accordance with the legal criteria set out under the EEOICPA. Any outstanding, unadjudicated claims are deferred.

Any decision issued must be well-written, use appropriate language to clearly communicate information, and address all the facets of the evidence that led to the conclusion, including evidence the claimant submitted. Particular attention should be directed at any denial of benefits. With a denial, the CE is to provide a robust, descriptive explanation of the specific reason(s) why the evidence fails to satisfy the eligibility requirements of the EEOICPA and any interpretive analysis the CE relied upon to justify the decision. Moreover, the discussion should address the actions taken to assist with the development of the case.

a. Use Simple Words and Short Sentences. Avoid technical terms and bureaucratic "jargon", and explain the first time any abbreviation is used in the text.

b. Use the Active Rather than the Passive Voice. For example, the decision is to read "We received the medical report" rather than "The medical report was received."

c. Divide Lengthy Discussions into Short Paragraphs. The progression of the text is to follow a logical and chronological pattern.

d. Confine the Discussion to Relevant Issues. These are the issues before the CE that need to be resolved. It may be necessary to state an issue is pending, but there is no need to discuss it in detail.

e. Address All Matters Raised by the Claimant. This includes any issue or medical condition relevant to the decision, whether raised in the initial report of the claim or during adjudication. Make certain to address all claimed conditions (accepted, denied or deferred) in the discussion and conclusion. If the CE recommends acceptance of a covered condition, and the claimant has also claimed other conditions that are not covered, the non-covered conditions are to be denied. The CE will also recommend denial of claimed conditions in survivor claims that have previously reached the maximum allowable benefit entitlement and no further compensation is payable.

f. Mailing Addresses. The decision must be addressed to each claimant who has filed a claim, and his or her authorized representative. This ensures that each person who has filed a claim receives official notification of the decision and is granted the opportunity to object, should he or she disagree with any aspect of the conclusions.

6. Content and Format. A Recommended Decision is comprised of a cover letter, a written decision, a waiver, and an information sheet provided to a claimant explaining his or her right to challenge the recommendation. The CE is responsible for preparing the Recommended Decision and all its component parts. The format and content of a Recommended Decision is as follows:

a. Cover Letter. A cover letter summarizes the recommendation(s) of the DO to accept, deny or defer claimed benefit entitlement(s) under Part B, Part E or both. It advises that the accompanying decision is a recommendation and that the case file has been forwarded to the FAB for review and the issuance of a Final Decision; listing the address of the FAB office where the case file is to be forwarded. Further, the cover letter advises the claimant of his or her right to waive any objection or to file objections within 60 days of the date of the Recommended Decision. Finally, if the decision was made using the opinion of a District Medical Consultant (DMC), the cover letter must advise the claimant that the DMC report is available for review upon request.

A separate cover letter is addressed to each individual party to the claim. In some instances, it may be necessary to tailor or individualize each cover letter to the specific circumstances affecting the claimant addressed. Exhibit 1 provides a sample cover letter.

b. Written Decision. The written decision is comprised of an Introduction, a Statement of the Case, Explanation of Findings, and Conclusions of Law. Exhibit 2 provides a sample Recommended Decision which includes each component discussed below.

(1) Introduction. This portion of a Recommended Decision succinctly summarizes what benefit entitlement is being recommended for acceptance, denial or deferral. Distinction is made between benefits addressed under Part B vs. Part E. An example of introductory language is provided in the sample cover letter as part of Exhibit 2.

(2) Statement of the Case. The Statement of the Case is a clear, chronological, and concise narrative of the factual evidence leading up to the Recommended Decision. It describes the steps taken by the CE to develop evidence, the outcome of any development, and any other relevant factual information derived from examination of the case records. The Statement of the Case should not be overly technical covering every minute detail of the case evidence, nor should it include interpretation of the evidence; as this is to be covered in the "Explanation of Findings" outlined below. Essentially, the Statement of the Case tells the story of the case leading up to the present decision and includes basic information such as:

(a) Name of the claimant or survivor, name of employee, and when the claim was filed;

(b) Benefit(s) the claimant is seeking. In the case of a survivor claim, the relationship of the claimant to the employee and documentation submitted in support of the relationship, if any;

(c) Claimed employment and evidence submitted to establish covered employment, if any;

(d) Claimed medical condition and medical evidence submitted to establish a diagnosed illness;

(e) In a recommended acceptance, pertinent issues may include specific medical documents received from the claimant or other sources which confirm the diagnosis of the claimed condition, and evidence establishing the claimed employment and exposure. Also, searches conducted in the Site Exposure Matrices (SEM), Occupational History Questionnaires (OHQ), records from the Former Worker Program, and Document Acquisition Request (DAR) records are important.

In a recommended denial, the CE discusses, particularly in relation to the denied element, what evidence was needed, how the DO advised the claimant of the deficiencies, any assistance provided to overcome a defect, and the claimant's response.

(3) Explanation of Findings. This section of the Recommended Decision explains the CE's analysis of the case evidence used to arrive at the various factual findings

necessary to substantiate a conclusion on benefit entitlement. It should be labeled as "Explanation of Findings."

The CE follows a logical and sequential presentation of findings and explains how the evidence does or does not meet the legal, regulatory or procedural guidelines of DEEOIC claim adjudication. In this manner, the CE communicates to the claimant the reason(s) for claim acceptance or denial; and upon which FAB will independently assess appropriateness. A Recommended Decision lacking a comprehensive and rationalized explanation of findings increases the likelihood that a claimant will not understand the outcome of the claim adjudication and increases the potential for a remand by FAB.

Given the various types of benefit entitlements for which a claim may be made, the content of this section will vary depending on the context of the matter under review. However, the CE must communicate information pertinent to the issue under determination in a logical, comprehensive manner. For example, the logical presentation of findings for a new Part E claim for causation will follow this general order – diagnosis, employment, relation to employee (in survivor claims), exposure, and causation. However, a different presentation of findings may be needed depending on the circumstances of the claim; such as with impairment, where the presentation of findings would follow a different order – accepted condition, evaluation for impairment, and outcome of evaluation with award or denial of impairment benefit.

Given the disparate types of evidence that may exist in a claim record, there may be instances where the discussion is based exclusively on the presentation of undisputed evidence that clearly affirms findings leading to a conclusion. In other instances there will be a need to use inference or extrapolation to support a finding. In either situation, the CE is to provide a compelling argument as to how the evidence is interpreted to support the various findings leading to acceptance or denial of a benefit entitlement. The assessment will rest on various factors; such as the probative value of documentation, relevance to the issue under contention, weight of medical opinion, or the reliability of testimony, affidavits, or other circumstantial evidence. It is within the discretion of the CE to decide the appropriate level of narrative required to justify a particular position.

Within the context of decision analysis, the CE is to maintain a claimant-oriented perspective. This can be defined as decisions made within the scope of the law that

has the effect or potential to produce a positive benefit to the claimant(s).

(a) Contested Factual Items and Other Claim Disputes. Written analysis is particularly important when reaching judgment on a claim issue that differs from the position of the claimant or has negative consequences to the claim. The CE is to identify the difference, clearly note the decision made, and the evidence or argument that supports such a decision. This is frequently the case where there is disagreement over medical diagnosis, dates or location of employment, health effects of toxic exposure, interpretation of program procedure, or medical opinion on causation. In any instance where a dispute involves a decision based on the weight of medical evidence, the CE is to completely describe the weighing methodology in support of the chosen medical opinion.

(b) Complex subject matter and other complicated evidentiary situations. Evidence presented in support of DEEOIC claims can often be open to a variety of interpretations, especially in situations involving complicated subject matter or in situations where evidence is vague. Whenever a CE is presented with a situation involving a complex set of issues for which a finding is necessary; e.g. establishing intermittent covered employment at multiple facilities, it is essential that the CE provide sufficient explanation as to how he or she chose to apply the evidence in arriving at a finding. Simply making a factual statement in these situations without providing the underlying rationale for making such a finding will not suffice.

(c) Mathematical Calculations. In any decision involving a mathematical calculation, the CE must fully explain the figures used to arrive at the finding listed. Situations where calculations need to be described include: impairment or wage-loss, division of benefits between multiple claimants or Part B vs. Part E claims, aggregated work days for SEC classes, latency periods for diseases, and offsets for State Worker’s Compensation or tort settlements.

(d) Application of Written Program Policy, Regulations, Procedure or case precedent. A CE may have to explain the use of policy guidance from various program resources in support of a decision being made in a claim. In these situations, the CE must clearly reference the resource being used, and if

necessary, make a specific citation or reference. The program policy must pertain to the issue at hand and the CE must explain how it provides guidance in resolving a particular claim issue.

(1) Case precedent. A CE is permitted to use only those case decisions that are specifically authorized and recognized as setting precedent. These can be found on the DEEOIC main web page and are updated periodically. It is not appropriate for a CE to generalize information or findings from a non-precedent setting case to address a separate case under review.

(4) Conclusions of Law. A conclusion of law is a determination as to how the law is applied to the accepted facts in a case to arrive at a determination of eligibility. The CE's conclusion either accepts or rejects the claim in its entirety, or it may address a portion of the claim presented. In a section headed "Conclusions of Law," the CE lists the critical conclusions rendered to determine whether the claimant is legally entitled to benefits under the EEOICPA.

(a) The CE cites the relevant sections of the EEOICPA or its governing regulations that support the offered conclusion. The citations must be accurate and specific to the issues addressed. The CE must employ appropriate discretion to limit citations to that which is most pertinent to the situation at hand and avoid repetitious or redundant legal references.

(b) When the conclusion is to accept a claim, the CE must include a reference to the legal provisions permitting a positive determination. This may include provisions pertaining to the qualification of the claimant to receive benefits (employee or survivor), covered or occupational illness, qualifying employment, establishment of causation by SEC membership, PoC, or linkage to toxic substance exposure, and the amount of payable lump-sum compensation or award of medical benefits.

(c) In a conclusion that results in a denial of benefits, the CE is to identify the claimed condition, benefit being denied and the specific legal criteria that the evidence of record does not satisfy. In any denial of benefits, the CE is not to state the lump-sum amount to be denied.

(6) Signatory Line. The signature line must include the name, title, and signature of the person who prepared the recommendation and the name, title, and signature of the

person who reviewed and certified the decision, when applicable.

(7) Notice of Recommended Decision and Claimant's Rights. Provides information about the claimant's right to file specific objections to the Recommended Decision and to request either a review of the written record or an oral hearing before the FAB. A sample Notice of Recommended Decision and Claimant's Rights is included as part of Exhibit 2.

(8) Waiver of Rights. A waiver form is sent with each Recommended Decision and is to include the last four digits of the file number, name of the employee, name of the claimant, and the date of the decision in the upper right hand corner. The claimant may waive his or her right to a hearing or review of the written record and request that the FAB issue a Final Decision. In this instance, the claimant is required to sign a waiver and return it to the FAB. Exhibit 3 contains a sample Waiver.

(a) Bifurcated Waivers. In many instances, the DO accepts one element of a claim and denies another, all within one Recommended Decision. It is therefore possible for a claimant to waive the right to object to the acceptance portion of the decision and file an objection regarding the denied portion of the same decision. A claimant has 60 days from the date the Recommended Decision is issued to file an objection, and may waive this right at any time.

Exhibit 4 provides a sample Bifurcated Waiver of Rights for a partial acceptance/partial denial. Option 1 allows the claimant to waive the right to object to the benefits awarded but reserve the right to object to the findings of fact or conclusions of law. Option 2 allows the claimant to waive the rights to object to all findings and conclusions.

7. Types of Recommended Decisions. Due to the wide variety of possible benefit entitlements available under Part B and Part E, various claim elements may be in different stages of development and adjudication at any given time. Following are examples of several types of Recommended Decisions that may be necessary:

a. Acceptance. Where the entire case can be accepted and no outstanding claim elements [e.g., wage-loss, impairment, additional claimed illness, or a cancer claim pending dose reconstruction at the National Institute for Occupational Safety and Health (NIOSH)] need further development, the CE issues a Recommended Decision to accept in full. The acceptance addresses all the elements that have been claimed.

b. Denial. If after all development is complete and all elements are in posture for denial, the CE issues a Recommended Decision recommending denial on a claim as a whole. The CE waits until every element of a claim has been developed, if possible, before issuing a denial.

(1) Addressing all claimed elements. The CE must be alert to the various adjudicatory issues in the case and clearly identify each element being denied.

(2) Where no objection is pending at the FAB, the CE develops all claim elements in posture for denial and, whenever possible, issues one comprehensive decision denying all possible claims for benefits under the EEOICPA as a whole. If other portions require further development, a partial denial/partial develop decision may also be necessary.

c. Partial Accept/Partial Deny. If the CE determines that no further development is necessary on a case file and concludes that some claim elements should be recommended for acceptance and some for denial, the CE issues a Recommended Decision that clearly sets forth those recommendations. The claimant is provided with a notice of his or her rights and a bifurcated wavier; which provides the claimant the opportunity to contest only the portion of his or her claim which was recommended for denial, or waive his or her right to object to the decision as a whole (see Exhibit 4).

For instance, if an illness that can be covered under both Part B and Part E of the EEOICPA (cancer, beryllium illness, chronic silicosis) is claimed and meets the evidentiary requirements only under Part E but not under Part B, (or vice versa) the CE states that the Part E benefits are being accepted and the Part B benefits are being denied.

(1) Example. A claimant files a claim for chronic beryllium disease (CBD) and submits medical evidence that contains a medical diagnosis of CBD that is sufficient to meet the Part E causation burden, but not the statutory criteria under Part B; the CE issues a Recommended Decision awarding benefits under Part E and denying benefits under Part B. In the denial under Part B, the CE should clearly explain what evidence was lacking and why the case is being denied. The CE clearly delineates the benefits being awarded and denied under Part B and Part E.

d. Partial Accept/Partial Develop. When a claim element is fully developed and ready for acceptance, but other elements remain for further development (e.g., wage-loss, impairment, another claimed illness, or a cancer pending dose reconstruction at NIOSH), the CE issues a Recommended Decision accepting the claimed illness and specifies all associated benefits awarded under the EEOICPA as a whole. With regard to other claim elements requiring further development, in the Recommended Decision the CE advises that these

elements are deferred until they are fully developed and adjudication is possible. Partial adjudication of a claim should be avoided whenever possible. In any instance where a part of a claim is deferred, it is the CE's responsibility to ensure that action is ultimately taken to address the outstanding claim by way of a Recommended Decision or administrative closure, when appropriate. Development for a deferred claim may be required by the assigned CE2 unit while other components of the claim are addressed by FAB.

e. Partial Accept/Partial Deny/Partial Develop. If one portion of the claim is in posture for acceptance and another portion is in posture for denial, while yet a third portion requires additional development, the CE addresses all claim elements in one comprehensive Recommended Decision. Where one or more claim elements are accepted and other elements are either denied or deferred for additional development, the CE must clearly outline the status of each element that is accepted, denied and deferred. The claimant is provided with a notice of his or her rights and a bifurcated waiver.

8. Decision Issuance. After preparing a Recommended Decision, the CE routes the decision and case file to the appropriate signatory for review, signature, date, and release.

a. Clearing the Recommended Decisions for Release. The appropriate signatory reviews all Recommended Decisions. Requests for medical treatment, equipment/supplies, and surgery requests are reviewed by the CE. Medical bill processing is discussed further in Chapter 3-0200.

(1) Deficiency Identified. If the appropriate signatory discovers a deficiency or other problem, the Recommended Decision is returned to the CE with a detailed explanation of why the decision is not in posture for release. When the appropriate signatory has provided comments or has extensively edited the Recommended Decision, the CE is to revise the decision accordingly.

(2) Decision Approved. If the signatory agrees with the decision, he or she signs and dates the Recommended Decision. The date shown on the Recommended Decision must be the actual date on which the decision is mailed.

b. Mailing the Recommended Decision. The signed and dated Recommended Decision is mailed to the claimant's last known address, and a copy is sent to the claimant's designated representative, if any. Notification to either the claimant or the representative will be considered notification to both parties.

(1) A copy of the Recommended Decision is filed in the case record.

(2) See Chapters 2-2000 and 2-2100 for coding instructions.

c. Forwarding the Case. Within the appropriate timeframe, the CE

sends the case record to the appropriate FAB office.

9. Letter Decisions. In certain situations, an entitlement determination can be addressed in a simple letter to the claimant. If a CE makes a decision in this format, the CE merely needs to communicate the nature of the claim that was made, evaluate the evidence supporting the outcome and the conclusion. A formal Recommended Decision is not necessary, unless the claimant submits a written request for one or objects to a letter decision. Circumstances where a letter decision is permitted include:

a. Approval of additional claims for medical benefits for cancer:

(1) Once a PoC value has been calculated at 50% or greater and a Final Decision accepting the cancer has been issued, any subsequent new claim for cancer related to the same organ system will be presumed linked to occupational exposure to radiation under either Parts B or E of the EEOICPA.

(2) Once a Final Decision accepting a specified cancer under an SEC class has been issued, any subsequent new claim for a specified cancer will be presumed linked to occupational exposure to radiation under either Parts B or E of the EEOICPA.

b. Consequential illness acceptance.

c. Acceptance or denial of medical care or treatment, including home health care.

d. Acceptance or denial of durable medical equipment or housing/vehicle modification.

e. Alternative filing determination (see survivorship Chapter 2-1200 for further guidance)

10. Special Circumstances. As noted previously, there are disparate issues that confront the CE during the process of making a Recommended Decision. This section provides guidance in certain unique situations that the CE may encounter.

a. Cases Where the Maximum Aggregate Lump Sum Compensation Has Been Attained. The maximum lump sum compensation payable under Part B is $150,000 and $250,000 under Part E. Once the maximum aggregate compensation has been awarded, claims for any new medical condition(s) are to be addressed for medical benefit coverage only. Under Part E, once the maximum lump sum figure has been reached, any new claim for impairment or wage-loss benefit is to be denied.

(1) If the employee dies after receiving the maximum lump sum compensation available to him or her, any subsequent claim by a survivor is to be denied as no additional compensation is payable. For guidance for Part E claims in which an employee dies subsequent to receiving a lump sum payment less than the maximum aggregate allowable, refer to

b. Death of Employee Prior to Claim Adjudication. In a scenario involving an employee who files for benefits, but dies prior to claim adjudication, the CE administratively closes the claim and no Recommended Decision is issued. If a survivor claim is later presented, the CE is to proceed with claim adjudication based on the condition(s) claimed only by the survivor. In this scenario, the CE is not to resume development for conditions previously claimed by the employee. Instead, the CE is to contact the survivor to discuss any potential benefit that may be derived from filing a claim for a condition previously filed by the employee, but for which the survivor has not claimed, e.g., such as a potentially compensable condition that may have contributed to the death of the employee.

c. Issuing a Recommended Decision After the Maximum Aggregate Compensation Has Been Paid in a Part B or E Survivor Claim. Once the maximum available compensation has been awarded in a survivor claim, i.e., $150,000 under Part B or $175,000 under Part E, and a new survivor presents a valid claim, the CE is to develop the claim to determine the new survivor's eligibility. Should the survivor be deemed eligible, it will be necessary to vacate any prior decision to other survivors to allow for a new decision to all claimants. In the decision, the CE explains the circumstances of the new claim, the eligibility of the new survivor to receive benefits, and the reallocated award based on the number of qualifying survivors. The new survivor is awarded his or her share of payable compensation, regardless of the fact that the maximum payable compensation was previously paid. Once a Final Decision has been issued with regard to this matter, the CE takes action to assess any survivor in the case who has a potential overpayment.

d. Issuing a Recommended Decision When There is a Prior Overpayment. When there is an overpayment in a case, and the CE needs to issue a new Recommended Decision, the case file is to be transferred to the Policy & Procedures Unit at National Office **before** the Recommended Decision is issued. The National Office will send the claimant(s) an initial overpayment notice advising them of the overpayment. The claimant then has thirty (30) days to dispute the overpayment or request a waiver. When a Final Decision on the overpayment is sent to the claimant(s), the case file will be returned to the DO for issuance of the Recommended Decision. The DO will be instructed on how to address the overpayment in the Recommended Decision.

Exhibit 1: Sample Cover Letter

Exhibit 2: Sample Recommended Decision

Exhibit 3: Sample Waiver

Exhibit 4: Sample Partial Accept/Partial Denial Bifurcated Waiver

2-1700 FAB Review Process

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1. Purpose and Scope. This chapter describes the functions of the Final Adjudication Branch (FAB), focusing on the administrative and preparatory aspects of its work under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA).

2. Authority. The regulations governing the administration of EEOICPA specify at 20 C.F.R. § 30.300 that each recommended decision (RD) is to be forwarded to the FAB for issuance of a final decision (FD). Section 30.310 allows a claimant to object, in writing, to all or part of the RD within 60 calendar days from the date the RD is issued. If a claimant requests a hearing within the 60 day time period, a FAB Hearing Representative (HR) will conduct a hearing, pursuant to 20 C.F.R. § 30.314. Otherwise, the objections will be responded to by a review of the written record, pursuant to 20 C.F.R. § 30.312.

Whether or not an objection is filed, the FAB reviews all RDs, all arguments and evidence of record, and issues a FD pursuant to 20 C.F.R. § 30.316 or a Remand Order returning the case to the district office for additional development, pursuant to 20 C.F.R. § 30.317. Also, the FAB reviews claimant requests for reconsideration of a FD under 20 C.F.R. § 30.319. FAB can also issue a FD reversing the findings and conclusions of the RD in certain circumstances.

3. Organization. The Final Adjudication Branch (FAB) is a National Office organization with District Office locations (FAB-DOs) in: Jacksonville, Florida; Cleveland, Ohio; Denver, Colorado; and Seattle, Washington. The FAB-DO is a distinct entity with a separate operational and management structure. In addition to the FAB-DOs, a National Office FAB (FAB-NO) is located in Washington, D.C. The FAB Chief is located in the Washington, D.C., office and oversees the operations of the FAB-NO and the four FAB-DOs.

a. The FAB Chief and Assistant Branch Chiefs:

(1) Coordinate the administration of the four FAB-DOs and the FAB-NO. Oversee policy implementation, manage adjudication timeliness, and ensure general compliance with FAB procedures.

(a) Hearing requests received by FAB-DOs are sent to the FAB-NO for assignment. A hearing coordinator, as designated by the FAB Chief, manages the assignment of hearings nationwide.

(b) Reconsideration requests are

forwarded to FAB-NO, Attn: FAB Ops, and are assigned to an office different from that which issued the FD.

(2) Can redistribute certain case files at their discretion to ensure balanced case loads among the four FAB-DOs and the FAB-NO.

b. FAB Offices:

(1) Review RDs, conduct hearings, reviews of the written record, and issue FDs or Remand Orders on reviewed cases. The cases reviewed by FAB, and the cases for which FAB conducts hearings, can originate from any DO. A FAB Hearing Representative can be assigned a hearing anywhere in the nation; not just in his or her FAB office's jurisdiction.

(2) Processes requests for reconsideration of FDs.

(3) Works with Co-Located Secondary Claims Examiners (CE2) who develop cases and issue RDs in certain cases with pending actions in the FAB unit.

4. Processing, Monitoring, and Transferring Case Files. When a DO issues a RD, it will forward the entire case file to its affiliated FAB-DO or the FAB-NO, as directed, for review and issuance of a FD. Because each FAB office, including the FAB-NO, is separate and distinct from the DOs, each maintains a separate mail and file operation.

a. Initial Screening/Review. A case file received from the DO is assigned and delivered to the responsible FAB Claims Examiner (CE) or HR for initial review. The CE or HR timely reviews the RD for accuracy. The CE or HR reviews the evidence of record to ensure that all evidence and documentation referenced in the RD accurately describes what is in the file. The CE or HR also determines whether the claimant has filed a waiver, a written objection(s), or a request for a hearing. If some deficiency or defect is found which requires the case be remanded to the DO, the case is to be remanded immediately.

5. Waivers. A waiver gives a claimant(s) the opportunity to voluntarily relinquish their right to object to the findings and conclusions of law contained in a RD, either in part or in full. The FAB may issue a FD at any point after receiving a written notice of waiver. To expedite the FAB review process, the DO must immediately forward all signed waivers to FAB upon receipt.

a. Implied Waivers. A claimant's rights to object and/or to request a hearing are considered waived if not timely exercised.

b. Signed Waivers. A claimant may waive his or her rights to object and to request a hearing by submitting a signed waiver form to the DO or the FAB within 60 calendar days of the RD issuance date. The submission of a signed waiver denotes the claimant's willingness

to accept the findings of fact and conclusions of law reached by the DO in the RD.

However, in cases where the FAB has determined that the claimant is to be awarded less benefit than those identified in the RD, the FAB remands the claim to the DO for the issuance of a new RD.

c. Bifurcated Waivers. By submitting a bifurcated waiver, a claimant may waive his or her rights to object to one portion of the decision while retaining his or her rights to object to another portion of the decision.

If the claimant files a bifurcated waiver objecting to the denial of a claim, but waiving his right to object to another portion which has been accepted, the FAB issues a timely FD adjudicating the waived portion of the RD. FAB then issues a separate FD adjudicating the objected-to portion of the RD after a review of the written record or a hearing, or upon the expiration of the 60-day period in which the claimant may submit objections or new evidence. However, in cases in which a claim is recommended for denial based on multiple components, and the claimant objects to one or more portions of the denial, the FAB must issue a single FD adjudicating all components of the RD.

If FAB receives a bifurcated waiver that is unclear, or does not specify to which portion of the decision the claimant objects, FAB contacts the claimant for clarification prior to conducting its review and issuing its decision.

6. Objections and Review of the Written Record. The regulations allow a claimant to file written objections to all or part of a RD. When the claimant has submitted a timely written objection to a RD, but has not requested a hearing, FAB conducts a review of the written record.

a. Timeliness. A claimant has 60 calendar days from the date of the RD to file an objection in writing. The claimant does not need to specify the basis for the objection for it to be considered, but can merely state that he or she disagrees with a finding of fact, a conclusion of law, or the RD in general.

A written objection is considered timely if the envelope containing it is postmarked no later than the 60th calendar day after the RD issuance date (the date of the RD is not included in the 60 calendar days). If the 60th day falls on a non-business day, the envelope must be postmarked by the next business day for the objection to be considered timely filed. If no postmark is available, the date of the objection is considered to be the earliest date it is received, as determined by the date stamp. As long as at least one objection is timely filed by a claimant, the FAB must consider ALL objections filed by that claimant, even objections raised after the 60-day period has expired. Any objection filed after the 60-day objection period has passed is reviewed by FAB to determine if it is material to the outcome of the claim.

b. Review of the Written Record. A review of the written record is an analysis of the documentation contained in the case file to determine if the conclusions reached in the RD are accurate in light of the objections filed and the requirements of the EEOICPA.

If the claimant objects to one portion of the RD and agrees with the other portion, the FAB may issue a FD on the accepted portion and issue a separate "Final Decision Following a Review of the Written Record" on the objected portion. RDs addressing multiple claimants generally should be issued under one FD.

(1) Acknowledgement. The FAB acknowledges receipt of the objection in writing. The letter to the claimant indicates that the claimant has an additional 20 calendar days from the date of the acknowledgement letter to submit new evidence in support of the objection. For claims involving multiple claimants, a single objection from any one claimant is sufficient to warrant a review of the entire written record. Upon receipt of an objection in a case with multiple claimants, individual acknowledgments are sent to each claimant explaining the course of action to be undertaken. A sample acknowledgement letter is shown in Exhibit 1. It is the policy of the Division of Energy Employee's Occupational Illness Compensation (DEEOIC) that the acknowledgment letter to the claimant(s) that did not submit the objection should indicate that an objection was received, but should not indicate the basis of the objection. Each claimant's response to any objections is reflected in ECS.

(2) Conduct of Review of the Written Record. Guidelines for conducting a review of the written record are set out in 20 C.F.R. § 30.313. The FAB representative considers the written record forwarded by the DO and any additional evidence and/or argument submitted by the claimant.

After the review of the written record, FAB issues a FD, remands all or part of the case to the DO, or reverses all or a portion of the RD if advantageous to the claimant. A FD following a review of the written record contains a narrative summation of the claimant's objections, and the HR/CEs assessment of the evidence in response to those objections. The HR/CE ensures that any decision is based on an objective analysis of the evidence; and applies well-reasoned judgment, sound exercise of discretion, and correct application of law, regulations, and DEEOIC policy and procedures.

7. Hearing Requests. An oral hearing permits the claimant, his or her authorized representative, and any witnesses to voice objections to a HR.

a. Initial Handling of Hearing Requests. When a timely request for

an oral hearing is received in the DO, action is immediately taken to forward the request to the FAB-NO. The referring office makes note of any special requests or needs of the claimant. The hearing scheduler tracks incoming requests for oral hearings and assigns the hearing to an HR in one of the five FAB offices.

b. Acknowledgement. Following the assignment of a hearing request to a FAB hearing scheduler, the hearing scheduler sends an acknowledgement letter to the claimant and any authorized representative confirming receipt of the hearing request. See Exhibit 2 for a sample acknowledgment letter. Each claimant party to the FD is to be sent an acknowledgment. The acknowledgement must be sent 30 days prior to the date of the hearing and includes the following notifications:

(1) The hearing will be conducted within 200 miles roundtrip of the claimant's residence, absent compelling reasons to the contrary.

(2) All sworn testimony offered during the hearing will be transcribed for inclusion into the case file.

(3) The FAB, at its discretion, may schedule a telephone or video conference hearing. See paragraph d(2) below.

(4) If the claim involves multiple claimants, each is allowed to participate in the hearing.

c. Hearing Assignments. The hearing scheduler may assign a hearing to an HR from any one of the five FAB offices. The hearing scheduler sends a hearing acknowledgment letter, schedules a date and time for the hearing, reserves the physical space for the proceedings, arranges for a court reporter to record the proceedings, and transmits the entire case file to the assigned HR. All pertinent information relating to the hearing and related correspondence is captured in ECS.

d. Scheduling. Each claimant is provided written notice of the hearing at least 30 days prior to the scheduled date (unless waived by the claimant); advised that a one week notice must be provided to the FAB should he or she desire a person(s) other than himself or herself and his or her authorized representative to attend the hearing; and advised that no independent video or audio recording of the hearing is allowed. See Exhibits 3 and 4 for Sample Hearing Notice letters.

(1) Travel to Hearing. While the FAB will try to set the hearing within a reasonable distance of the claimant, the claimant may be required to travel up to 200 miles roundtrip to attend the hearing. There is no reimbursement to the claimant for the expense of this travel. However, if an unusual circumstance causes the FAB to schedule a hearing that requires the claimant to travel more than 200 miles roundtrip, OWCP will reimburse him or her for

reasonable and necessary travel expenses as outlined in 20 C.F.R 30.314(2).

In instances when multiple claimants request a hearing, the hearing is scheduled nearest the first claimant who requested a hearing. The remaining claimants are given the option to attend the hearing in person or participate via telephone.

(2) Telephonic and Video Conference Hearings. A hearing may be conducted by telephone or video conference at the FAB's discretion, or by claimant request. Only the hearing scheduler can schedule such a hearing, which will include all the aspects of an in-person hearing.

(3) Scheduling Changes. The FAB will entertain any reasonable request for scheduling the time and place of a hearing, but such requests should be made when the hearing is requested. The hearing scheduler will make every effort to accommodate the scheduling request of the claimant. An in-person hearing may be changed to a telephone hearing if a claimant or authorized representative so requests. This change must be coordinated through the hearing scheduler.

Once the hearing has been scheduled and written notice has been mailed, it cannot be postponed at the claimant's request for any reason except as indicated in paragraph 4 below. However, the hearing scheduler may accommodate minor scheduling changes requested by a claimant or authorized representative.

HRs may not independently make changes to the scheduled hearing time or place without supervisory approval. The change request must be made to the HRs supervisor and the supervisor will contact the hearing scheduling unit supervisor.

The HR contacts the claimant(s) by telephone prior to the hearing to confirm they are planning to attend the hearing at the arranged date, time and location.

(4) Postponing a Hearing. The FAB may grant a postponement of a hearing when the claimant or his or her authorized representative has a medical reason that prevents attendance or when the death of the claimant's parent, spouse or child prevents attendance. The claimant or authorized representative should provide at least 24 hours notice. The FAB will make every effort to accommodate timely requests to postpone a hearing.

In such cases, a new hearing will be set for the next hearing trip. Hearing scheduling unit supervisor approval is needed to postpone a hearing.

(5) Failure to Attend. If a claimant does not attend the

hearing at the designated time and place, and makes no effort to contact the HR to request a rescheduling based on one of the reasons outlined in paragraph d(4) above, the claimant will not be allowed to reschedule his or her hearing. In such instances, the claimant will be considered to have withdrawn the hearing request, and a review of the written record will be undertaken. If new evidence or argument accompanied the objection, it will be reviewed in the review of the written record.

(6) Cancellation of Hearing. If upon review, the HR determines that an error or other deficiency in the RD or in the initial case adjudication precludes the need for a hearing, and the FAB supervisor agrees, the HR will notify the claimant that the hearing will not be scheduled and a Remand Order will be prepared.

When a hearing is canceled for any reason, the FAB acknowledges the cancellation in writing and gives the claimant 10 days from the date of the acknowledgement to submit additional evidence. The FAB representative then conducts a review of the written record.

e. Review of Case File. Prior to the hearing, the HR reviews the evidence of record, as well as any additional evidence or materials submitted by the claimant, and conducts whatever additional investigation is deemed necessary to prepare for the proceedings. If the additional evidence received establishes compensability or the need for further development and the FAB supervisor agrees, the HR will notify the claimant and/or authorized representative that the claim will be remanded and the hearing will be canceled. If the evidence is sufficient to warrant reversal in favor of the claimant, FAB may issue a reversal.

f. Multiple RDs. Since more than one RD can be issued prior to a hearing and additional objections and hearing requests may result, measures are needed to streamline the hearing process.

If more than one RD is pending a FD, the HR contacts each objecting claimant and advises that all objections, not just those pertaining to the RD that is the subject of the hearing request, may be discussed during the hearing. The claimant(s) will be encouraged to bring relevant evidence, even if it concerns a RD for which a timely objection was not filed. All telephonic contact prior to the hearing is documented in ECS.

(1) Hearing Requests on Multiple RDs Pending a FD. When additional timely hearing requests are submitted based on other recommended denials prior to the date of the previously scheduled hearing, the HR contacts the requesting party to advise that all objections will be considered so that one hearing may serve to accept evidence and testimony on several different RDs. This process is

designed to avoid multiple hearings.

The HR notes the conversation with the claimant in ECS, confirming that the claimant was advised that all outstanding objections will be considered at the hearing. The HR updates ECS for each RD and each claimant requesting the hearing.

Separate hearing request acknowledgments and hearing notices are not required. The HR must be prepared to entertain objections about all RDs issued up to the date of the hearing and will take testimony and evidence on all outstanding objections. Each RD in question is considered in a single FAB decision once the FAB hearing process is concluded.

(2) Hearing Request on One RD, Request for Review of the Written Record on Another. If a claimant has requested a hearing on one outstanding RD and a review of the written record on another, the HR allows the claimant to present evidence about the objections which are not the subject of the hearing, so long as FAB has not issued a FD on the review of the written record request.

[If FAB has issued a FD on the request for review of the written record, see paragraph (4) below.]

(a) The objections and evidence are considered at the hearing and addressed in the post-hearing FAB decision. No review of the written record decision is issued. ECS must be updated to reflect a Request for a Hearing, rather than a Request for a Review of the Written Record.

(b) In cases with multiple claimants when one claimant requests a review of the written record and another requests a hearing, no decision is issued to either claimant until the hearing process is complete. FAB may contact the claimant who requested a review of the written record and ask if he or she would like to address objections to the RD for which a review of the written record was requested at the time of the hearing on the other RD. If he or she agrees, the Review of the Written Record is changed to a hearing in ECS. If he or she declines, his or her objections will be reviewed as part of the hearing decision. Coding in ECS must be updated to reflect a Request for a Hearing rather than a Request for a Review of the Written Record and a note should be added to ECS explaining this action. All claimants, whether they request a

hearing or not, are served with notice of the hearing and are afforded the opportunity to be present at the hearing and participate. The request for Review of the Written Record objections and the objections discussed at the hearing will be addressed in one FD.

(3) Hearing Request on One RD, No Objection Filed on Another. While awaiting a hearing on one RD, the FAB may issue a FD on another RD if the 60-day period for objecting has passed without objection from the claimant. However, if at the time of a hearing, there is one or more pending RDs, the claimant may offer testimony or evidence in response to any of the pending decisions, even if outside of the 60-day period in which to object. The FAB HR must subsequently address such testimony or evidence to determine whether a FD or Remand Order is appropriate.

(4) Hearing Request on One RD, FD Issued on Another. A claimant may request a hearing on one RD and a reconsideration of a previously issued FD within 30 days of its issuance.

(a) If a FD has been issued and a hearing is held regarding an outstanding RD within the 30 day post-decision reconsideration period, the HR reviews any new evidence related to the previously issued FD as a request for reconsideration. Reconsideration requests cannot be assigned to a FAB representative who has had prior involvement with the claim. If the FD was issued by the HR present at the hearing, the reconsideration request should be assigned to another FAB representative. A decision on the reconsideration should be issued separately from the hearing decision.

(b) If the claimant presents evidence or argument pertaining to a FD at the hearing and the hearing date is outside of the 30 day post-decision reconsideration period, the evidence is referred to the DD with jurisdiction over the case file for reopening consideration.

8. Conduct of the Hearing. The hearing is an informal proceeding and the HR is not bound by common law or statutory rules of evidence or by technical or formal rules of procedure. Generally, the hearing is scheduled to last one hour, but the HR should not specifically limit the hearing to one hour and should *never* tell a claimant that he or she is limited to one hour. Also, the HR must bring a tape recorder to the hearing in case a court reporter is not present. The HR must ensure that the court reporter is using required back-up

recorders.

a. Convening. At the scheduled time and place, the HR will meet with the court reporter, the claimant, and any authorized representative.

(1) If any other individual(s) is in attendance, the HR will request the identity of this individual(s) and have the claimant(s) sign a "Waiver of Right to Confidentiality" (See Exhibits 5) before convening the hearing. The claimant(s) sign a separate waiver (see Exhibit 6) if he or she requests that a member of the media be present.

(2) If there are multiple claimants present, each is required to sign a waiver of confidentiality.

(3) At the start of the hearing, the HR indicates to the court reporter that he or she wishes to open the record of the hearing. He or she will note the date and time, identify all persons present by name, and enter a brief narrative into the record describing the events leading to the hearing, including the specific objection(s) raised by the claimant. If no specific objections have been raised, the HR should indicate this.

For hearings addressing National Institute for Occupational Safety and Health (NIOSH) Dose Reconstruction issues, the HR strictly follows the hearing script shown as Exhibit 7. The HR advises participants that he or she can discuss issues of a factual nature about the information provided to NIOSH and the application of methodology (see example below), but is not permitted to consider in the FD objections to the methodology employed by NIOSH in preparing the dose reconstruction report.

APPLICATION OF METHODOLOGY

A claimant may present argument to the FAB that NIOSH made an error in the application of methodology such as applying the radiation dose estimate methods to his or her individual circumstances, or that NIOSH did not address a specific incident discussed in the phone interview.Another application issue might involve the use of "worst case" approach (which is a NIOSH method). The application aspect of this issue might be whether the "worst case" selected was the worst case (e.g., there were 20 more people working there that were not monitored and the worst case was based only on monitored individuals).

Example of Application of Methodology. The objection alleges that NIOSH did not properly consider the "proximity to the source." The NIOSH exposure matrix considers that the worker was one foot away from uranium billets/rods for six hours and one meter away for four hours. NIOSH considers this to adequately account for times when the worker would touch the uranium rods/billets, since there

would also be times when the worker was at a much greater distance. This exposure matrix is drawn as the example of highest possible exposure, as no individual exposure records are available. The objection indicates that the worker handled the uranium metal more often than NIOSH allowed in the exposure matrix. This is a challenge to the application of the dose reconstruction methodology and can be addressed as part of the hearing process.

METHODOLOGY

20 CFR 30.318(b) provides that the "methodology" NIOSH uses in making radiation dose estimates is binding on the FAB. The "methodology" NIOSH uses is the way NIOSH performs the dose reconstruction, which is addressed in the statute and 42 CFR Part 82. "Methodology" is dictated by sections 7384n(c) and (d) of the statute. For example, those methods must be based on the radiation dose received by the employee (or a group of employees performing similar work) and the upper 99 percent confidence interval of the probability of causation in the radioepidemiological tables published under the Orphan Drug Act. The Act also requires NIOSH to consider the type of cancer, past health-related activities (such as smoking), and information on the risk of developing a radiation-related cancer from workplace exposure.

The "methods" of dose reconstruction are set out in 42 CFR Part 82 and include: analyzing specific characteristics of the monitoring procedures in a given work setting; identifying events or processes that were unmonitored; identifying the types and quantities of radioactive materials involved; evaluating production processes and safety procedures; applying certain assumptions that err reasonably on the side of overestimating exposures while achieving efficiency; and using current models for calculating internal dose published by the International Commission on Radiological Protection (ICRP). The NIOSH "efficiency" process of using overestimates and underestimates in dose reconstruction is another example of a methodology. It is these "methods" that cannot be addressed by FAB. Any questions related to the content of NIOSH-IREP software are also related to methodology, whereas questions related to the Department of Labor's probability of causation calculation (which relies on NIOSH-IREP software) can be considered.

Example of Objections to Methodology. The radiation dose to the claimant's gall bladder was calculated using the highest recorded doses from other co-workers at the facility as the basis for the claimant's dose estimate. This was noted in the text of the dose reconstruction report as being "the highest reasonably possible radiation dose." No uncertainty values were assigned to the claimant's estimate because it was considered that the claimant's "dose was no higher than this estimate."

b. Testimony and Evidence. The HR will administer an oath to each person giving testimony. The HR should make clear at the outset that he or she cannot receive testimony from participants who are not under oath. If a witness arrives late, he or she must be sworn in before testifying. An attorney must not be sworn in since he or she simply presents arguments, objections or evidence but not testimony.

(1) A court reporter shall record oral testimony and place it into the record. A court reporter may use only audio (not video) equipment. Moreover, neither the claimant(s), any authorized representative nor anyone else present at the hearing may bring audio or video equipment to obtain an independent record of the hearing.

(2) Any evidence or testimony a claimant wishes to enter into the record is entered, even if it pertains to a RD that was previously issued and the 60-day post-decision timeframe to object has expired. The HR will accept all testimony and evidence presented at the hearing.

(3) During the claimant's testimony, the HR should note any additional questions or areas for exploration and make appropriate inquiries. The claimant can raise additional objections at this time. The HR should ask questions or request the claimant to elaborate so the objections are clearly understood.

(4) Each exhibit is marked separately and identified on the record by name and number with a brief description of its content. The HR will state on the record that the exhibit is being entered into the evidence of record.

(5) During the testimony the HR states whether there is a need to interrupt testimony and go off the record. When it is time to return on the record, the HR indicates this and, once back on record, provides a brief description of why it was necessary to go off the record. Time and issues discussed off the record should be kept to a minimum.

The HR is responsible for maintaining order during the hearing. The HR should keep testimony on point. Should any of the hearing attendees cause a disruption or unreasonable delay in the proceedings, the hearing representative will warn the disruptive attendee and terminate the hearing if the warning goes unheeded.

(6) The HR spells unfamiliar words or names to help the court reporter maintain an accurate record of the hearing.

c. Conclusion. When all testimony has been given and all the exhibits marked and clarifications made, the HR explains that the record will remain open 30 days after the date of the hearing to permit the submission of additional written evidence or argument on the issue(s) in question.

The HR also advises that the claimant will receive a copy of the transcript and will have 20 days from the date of mailing to request changes in writing to the record. The HR then closes the proceedings by noting the time and date.

9. Post-Hearing Actions. After the hearing, the HR obtains a copy of the transcript from the reporting service. FAB must timely send the claimant a copy of the hearing transcript.

A cover letter accompanies the transcript, reminding the claimant that he or she has 20 days from the date of the letter to comment on the accuracy of the transcript in writing. The claimant is also advised that the record will remain open 30 days from the hearing date for the submission of additional evidence.

a. Collecting Comments and Additional Evidence. The HR keeps the hearing record open for 30 calendar days after the hearing. At his or her discretion, the HR may choose to grant the claimant an extension for the submission of new evidence. However, the HR may only grant one extension not to exceed another 30 calendar days.

(1) If the claimant submits additional evidence within 30 days after the date of the hearing, or comments on the transcript, the HR will enter such evidence into the record and weigh it when issuing the decision.

(2) If the claimant does not submit additional evidence within 30 days after the date of the hearing, and does not comment on the transcript, the HR reaches a decision based on examination of the evidence of record. However, the HR must consider all evidence submitted, even if it arrives after the 30 day period, prior to issuing a FD.

b. Final Decision. After examining the documents associated with the hearing, the HR independently assesses the evidence, analyzes the conclusions of the RD for appropriate application of law, regulations and procedures, and evaluates the objections. If a determination can be made without further development, the HR issues a FD.

c. Disposition of Case File. Once the HR issues the FD, the case file is returned to the DO that issued the contested decision, unless additional FAB review is needed on an outstanding RD.

10. Receipt of New Claim or New Medical Evidence. If the DO receives new medical evidence or a new claim while the case file is at FAB, the DO promptly transfers the documents to the FAB office where the case file is located.

a. New Medical Evidence Received. If FAB has the case file, receives new medical evidence, and has not issued the FD, the CE or HR reviews the new medical evidence and determines if the evidence pertains to a claimed condition or to a new, as-yet-unclaimed condition.

(1) New Medical Evidence Pertaining to Claimed Condition.

If the evidence pertains to a previously claimed condition and the RD recommends denial of benefits based on insufficient evidence relating to that condition, FAB has the discretion to determine if the new evidence, when reasonably considered with the totality of the evidence, is likely to support a reversal of the RD in favor of the claimant.

(a) If FAB concludes that the new medical evidence of the claimed condition supports a reversal of the RD to deny the condition, and no further development is needed, FAB reverses the decision in favor of the claimant and accepts the claim.

(b) If FAB concludes that the new medical evidence does not support a reversal of the RD to deny, FAB upholds the denial.

(c) If FAB concludes that the new medical evidence does not support a reversal of the RD, but that further development is needed, FAB remands the case to the DO.

(2) New Medical Evidence of an Unclaimed Condition. If new evidence is of a condition that has not yet been claimed, FAB sends the case to the CE2 who issues a letter to the claimant addressing receipt of the new evidence and explaining the ability to file a new claim form. FAB then proceeds with its review of the case and issues the FD on the claimed conditions.

b. New Claim Filed. If FAB has the case file, receives a new claim from a current claimant, and has not issued the FD, the CE or HR reviews the new claim and determines if any medical condition is being claimed for the first time.

If the conditions are determined to be duplicative, FAB acknowledges receipt of the new claim in writing and advises that it will not lead to further development as no new medical conditions were claimed. However, in certain instances, a subsequent claim for a condition such as skin cancer may lead to the need for further development.

In the event the claim is for a condition which has not previously been claimed, the FAB transfers the case file to the CE2 to add a new claim or a new medical condition to an existing claim and to develop the claim if necessary. If FAB receives new medical evidence or a new claim form while the case file is at a DO, FAB promptly transfers the documents to the DO where the case file is located.

(1) New Condition Claimed, Case in Posture for Denial. If a claim for a new medical condition is filed while the case is at FAB for denial of benefits, FAB has the discretion to determine if the new claimed condition, when considered

with the totality of the evidence, is likely to lead to acceptance of benefits for the condition presently before FAB.

(a) If FAB determines that coverage is likely, FAB remands the case to the DO without issuing a FD.

(b) If FAB determines that coverage is not likely, the issue is forwarded to the CE2 for development. FAB then issues a FD on the matter adjudicated in the RD and notes in the opening of the FD that the development of the new claim is pending by the DO.

(2) New Condition Claimed, Case in Posture for Acceptance. If a claim for a new medical condition is filed while the case is at FAB for a review of a RD awarding benefits, the case is forwarded to the CE2 to acknowledge receipt of the new claim and to advise that the DO will develop the newly claimed condition. FAB then proceeds to issue a FD on the conditions adjudicated in the RD.

(3) New Claimant. In multi-claimant cases, if a new claim is received while the case is at FAB, and the claimant had not previously filed a claim, FAB remands the case to the district office for development of the new claim.

11. One Year Requirement. To prevent undue delays in adjudication, 20 C.F.R. § 30.316(c) imposes a one-year limit on the amount of time a RD can be pending at the FAB before it automatically becomes a FD. Once the one year time frame has elapsed, there is essentially a regulatory/administrative FD. FAB CEs and HRs must ensure that a FD is issued prior to the expiration of a one-year deadline. FAB managers ensure that cases are assigned or re-assigned so as to prevent the expiration of a one-year deadline.

a. No Objection or Hearing Request Filed. If the claimant did not object to the RD and did not request a hearing, and the RD has been pending at FAB for more than one year from the last date on which the claimant was allowed to file an objection or request a hearing, the RD becomes final on the one-year anniversary of that date. This would be 425 days [60 days to object + 365 days (one year)] after the RD date.

b. Objection or Hearing Request Filed. A RD awaiting either a hearing or a review of the written record at the FAB will automatically become a FD on the one-year anniversary of the date the objection or request for a hearing was received in the FAB (as indicated by the date stamp).

c. DEEOIC Director Reopened the Claim. A RD awaiting a FD following an order by the DEEOIC Director reopening the claim for a

new FD shall be considered a FD on the one-year anniversary of the date of the Director's reopening order.

d. One-Year Event Occurs. If the one-year time limit has expired, the RD automatically becomes a FD, and the case shall be transferred to the FAB-NO for review.

The FAB CE/HR ensures the case file is sent to the FAB-NO to the attention of the FAB Operations Specialist. A memo from the district FAB Manager, through the FAB Chief, dated and signed by the FAB Chief, to the Director must be included with the case file. The FAB Operations Specialist ensures that the case file is sent to the National Office to the attention of the Office of the Director. The memo requests that the regulatory/administrative FD (based on the one-year rule) be vacated so a formal FD can be issued.

Once the case file is received in the National Office, an assessment will be undertaken to determine whether it is necessary to vacate the regulatory/administrative FD. The Director may choose to allow an administratively finalized decision to stand and not issue a Director's Order. However, if a Director's Order is deemed necessary, it will specify whether the case file needs to be returned to FAB for a FD or to the DO for a new RD based on the evidence of record. Once the file is received back in the FAB or DO, the DO or FAB proceeds as instructed by the Director's Order.

e. Jurisdiction. Upon expiration of the one-year time period described above, FAB has no jurisdiction to remand the case for further development or to take any action other than that described above.

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 District Director (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 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 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.

Exhibit 1: Sample Acknowledgment Letter, Review of Written Record

Exhibit 2: Sample Acknowledgment Letter, Hearing

Exhibit 3: Sample Hearing Notice to Claimant Who Filed an Objection

Exhibit 4: Sample Hearing Notice to Claimant Who Did Not File an Objection

Exhibit 5: Waiver of Rights to Confidentiality

Exhibit 6: Waiver of Rights to Confidentiality (Media)

Exhibit 7: Sample Hearing Script

Exhibit 8: Sample Letter to Postmaster

Exhibit 9: Sample Change of Address Letter

2-1800 FAB Decisions

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1. Purpose and Scope. This chapter describes how the Final Adjudication Branch (FAB) reviews recommended decisions (RDs) issued by district offices (DOs) and issues final decisions (FDs) on claims filed pursuant to the Energy Employees Occupational Illness Compensation Program Act (EEOICPA). It also describes how the FAB issues remand orders, conducts reviews of the written record, schedules and conducts hearings, and reviews requests for reconsideration of FAB final decisions.

2. Remand Orders. 20 C.F.R. § 30.317 gives FAB the authority to return cases to the DO without issuing a FD. A remand order is a written directive issued in lieu of a FD.

A remand order may instruct the DO to administratively close the case, perform further development, address an error or other deficiency contained in a RD, address new evidence or a new claim received prior to the issuance of the FD, or address a change in the law, regulations, policies or procedures.

A remand order can be warranted at any point during a review of the written record, before or after a hearing, or during the review of a RD. The FAB develops evidence rather than issues a remand order where such development will produce a timely FD. If substantial or prolonged development is necessary, the FAB will issue a remand order and return the file to the DO.

a. Automatic Remands.

(1) Claimant Dies. FAB remands a case if the claimant dies after the issuance of the RD but prior to issuance of the FD. Where there are multiple claimants and one or more, but not all, claimants die prior to the issuance of the FD, FAB will issue a Notice of Final Decision and Remand Order, which adjudicates the claims of the surviving claimants, adjusts compensation if applicable, and remands the claim of the deceased claimant(s) for administrative closure.

(2) Claimant Withdraws Claim. FAB remands a case for administrative closure if a claimant withdraws his or her claim prior the issuance of the FD.

(3) Claimant Cannot be Located. When a RD is returned by the Postal Service and a current address for the claimant cannot be obtained by the Co-Located Unit within a reasonable period of time, FAB remands the case for administrative closure until a correct address can be obtained.

(4) SWC/Tort/Fraud Statements Not Obtained. Where signed statements regarding tort lawsuits, state workers' compensation (SWC) claims and whether fraud was committed in connection with an application for or receipt of any federal or state workers' compensation are required and not all claimants have submitted such statements, FAB remands the case if FAB cannot obtain such statements prior to the due date of the FD.

In this situation, the DO should attempt to obtain the claimants' signed statements and issue a new RD.

When a consequential injury is to be accepted, the CE must get a new signed SWC/Tort/Fraud affidavit from the claimant for that consequential injury.

b. Discretionary Remands. FAB is to use reasonable discretion and common sense when assessing a case for remand. If the RD provides sound reasoning, rationale and discussion and does not include material factual errors or erroneous application of law, the FAB must respect the DO's adjudicatory function. If FAB can make a reasonable determination that the outcome of the case would not be materially affected regardless of further development, FAB should exercise its discretion and not issue a remand order.

(1) Change in Law, Regulations or Policies. If FAB determines that a conclusion of law or the recommended determination in the RD is erroneous in light of a recent change in the law, regulations, or policy, FAB may remand the case. If this occurs, the remand order identifies the changed law, new Special Exposure Cohort (SEC) class,

Program Evaluation Reports (PERs), or other regulatory or policy changes and the effect on the adjudication of the case.

(2) Erroneous Application of Law, Regulations, Policies or Procedures. If FAB determines that the recommended determination in the RD resulted from a misapplication of the law, regulations, policies or procedures, FAB may remand the case. The remand order identifies the misapplication of law, regulations, policies or procedures and describes how it effects the adjudication of the case. To expedite a favorable decision, the FAB CE/HR can reverse the decision without issuing a remand order.

(3) Receipt of New Medical Evidence or a New Claim. If new medical evidence or a new claim is received while the case is at FAB, FAB may remand or reverse to accept the claim, as applicable.

For example, if the RD denies a claim for CBD on the basis of a lack of medical evidence and the claimant later submits medical evidence establishing CBD, the FAB may remand the claim or reverse the RD if all elements of adjudicatory process are complete.

If a new claim is received, the case will be remanded for development of the new claim if it will affect the outcome of the issue before the FAB. If filing of a new claim will not affect the issue before the FAB, the FAB can issue a FD and return the new claim to the DO for further development. If the FAB is not immediately ready to issue the FD, than the Co-Located Unit should create the new claim and begin development while the case is at FAB.

(4) Receipt of Other New Evidence. If FAB receives new evidence that was not a part of the file when the RD was issued and that is material to the recommended determination, (such as employment evidence, survivorship evidence, or evidence of a SWC/tort suit), FAB may remand the case or reverse the RD if it is advantageous to the claimant. The remand order will describe the new evidence and its possible effect on the adjudication of the case.

(5) Evidence Already in File. If the RD fails to properly address material evidence in the file and the failure could have an effect on the adjudication of the claim, FAB may remand the case. The remand order will describe the evidence and its possible effect on the adjudication of the case. If advantageous to the claimant, and all adjudicatory issues are complete, FAB may reverse the RD and accept the claim.

For example, if evidence in the file sufficiently supports a diagnosis of a claimed cancer but the cancer was not included in the dose reconstruction, FAB may remand the case for a re-work of the dose reconstruction if a DEEOIC Health Physicist determines that a re-work is required.

(6) Miscalculation of Tort Offset or SWC Coordination. If FAB determines that the RD contains a finding of fact or conclusion of law that is based on a material miscalculation of the offset arising from a tort lawsuit or SWC coordination, FAB may remand the case.

(a) If a case is remanded for this reason, FAB includes its calculation worksheet in the file and, if necessary, a supplemental explanation of what FAB considers the evidentiary basis for its calculation.

(b) If FAB determines that the miscalculation was relatively minor and was not favorable to the claimant, FAB may exercise its discretion and issue a FD which corrects the calculation in the claimant's favor, without a remand.

(7) Procedural Problems. If FAB determines that the RD was not issued in a manner consistent with EEOICPA procedures, FAB may remand the case.

For example, if the DO sends a development letter and explicitly allows the claimant 30 days to provide evidence, but upon review of the letter it did not identify the specific evidence that was needed or a RD was issued before the 30 day period expired, FAB may determine that proper procedures were not followed and may remand the case.

c. Format of Remand Order. A remand order follows a narrative format and is directed to the individual claimant(s). It includes a brief discussion of the case's adjudicatory history, the basis for the remand, any explanation and supplemental documentation required and an explanation of the actions to be undertaken by the DO. A sample remand order is shown in Exhibit 1.

d. Notification and Transfer of File. When a remand order is issued, FAB inserts into the case file a copy of the remand order, certificate of service, and any supporting calculations or supplementary documentation. FAB sends a copy of the remand order, certificate of service, and cover letter to the claimant and the authorized representative, if any.

(1) The cover letter explains the remand order and the DO's responsibility for preparing a new recommended decision after further development. See Exhibit 1.

(2) A certificate of service, which certifies the remand order was mailed on a certain date, is also prepared for each individual recipient, attesting to the date the remand

order is sent. See Exhibit 2.

(3) Upon issuance of a remand order, FAB transfers the case file to the DO that issued the RD.

e. Challenging a Remand Order. No procedure allows a claimant to directly challenge a remand order, but each DD has the authority to formally challenge a FAB remand order with the EEOICP Director if sufficient cause exists to do so.

3. Reviews of the Written Record. Where the claimant has submitted a timely written objection to the RD but has not requested a hearing, FAB conducts a review of the written record. If the claimant objects to one portion of the RD and agrees with the other portion, the FAB may issue a FD on the accepted portion and issue a separate "Final Decision Following a Review of the Written Record" on the objected portion. RDs addressing multiple claimants generally should be issued under one FD.

A review of the written record (RWR) is an analysis of the documentation contained in the case file to determine if the conclusions reached in the RD are accurate in light of the objections filed and the requirements of the EEOICPA.

a. Acknowledgement. The FAB acknowledges receipt of the objection in writing. The letter to the claimant indicates that the claimant has an additional 20 calendar days from the date of the acknowledgement letter to submit new evidence in support of the objection.

For claims involving multiple claimants, a single objection from any one claimant is sufficient to warrant a review of the entire written record. Upon receipt of an objection in a case with multiple claimants, individual acknowledgments are sent to each claimant explaining the course of action to be undertaken. Because the submission of an objection is considered private, the acknowledgment letter to the claimant(s) that did not submit the objection should indicate that an objection was received but must not indicate the claimant who submitted the objection. A sample acknowledgement letter is shown in Exhibit 3. The appeal screen will be updated in ECMS only for the claimant(s) requesting the RWR.

b. Conduct of Review of the Written Record. Guidelines for conducting a review of the written record are set out in 20 C.F.R. § 30.313. The FAB representative considers the written record forwarded by the DO and any additional evidence and/or argument submitted by the claimant.

After the RWR, FAB issues a FD, remands all or part of the case to the DO, or reverses all or a portion of the RD if advantageous to the claimant. A FD following a RWR contains a summation and examination of the claimant's objections. The HR ensures that any decision is based on an objective analysis of the evidence, well-reasoned judgment and sound exercise of discretion.

4. Hearing Requests. An oral hearing permits the claimant, his or her authorized representative, and any witnesses to voice objections in person to a HR. Section 30.314 of the regulations describes how hearings are to be conducted.

a. Initial Handling of Hearing Requests. When a FAB office receives a timely request for an oral hearing and the HR determines that an error or other deficiency in the recommended decision or in the initial case adjudication precludes the need for a hearing, and the FAB supervisor agrees, the HR will notify the claimant that the hearing will not be scheduled and a remand order will be prepared. The claimant can still request that the hearing be scheduled. However, if the HR finds no basis for remand, the request, Hearing Review Checklist, and case file are immediately forwarded to the FAB-NO, noting any special requests or needs of the claimant. The hearing scheduler tracks incoming requests for oral hearings and assigns the hearing to an HR in one of the four FAB DOs or an HR at the NO.

b. Acknowledgement. Following the assignment of a hearing request to a FAB hearing scheduler, the hearing scheduler sends an acknowledgement letter to the claimant and any authorized representative confirming receipt of the hearing request. See Exhibit 4 for a sample acknowledgment letter. Each claimant involved with the case is to be sent an acknowledgment. The acknowledgement must be sent 30 days prior to the date of the hearing and includes the following notification:

(1) The hearing will be conducted within 200 miles roundtrip of the claimant's residence, absent compelling reasons to the contrary.

(2) All sworn testimony offered during the hearing will be transcribed for inclusion into the case file.

(3) The FAB at its discretion can schedule a telephone hearing. See paragraph d(2) below.

(4) If the claim involves multiple claimants, each is allowed to participate in the hearing.

c. Hearing Assignments. The hearing scheduler may assign a hearing to either a FAB-DO or NO HR. The hearing scheduler sends a hearing acknowledgment letter, schedules a date and time for the hearing, reserves the physical space for the proceedings, and arranges for a court reporter to be present. The hearing scheduler denotes the hearing assignment in ECMS and transmits the entire case file to the assigned HR. The hearing scheduler also issues the notice of hearing scheduling letter under the name of the HR assigned to the case.

d. Scheduling. Each claimant is provided written notice of the hearing at least 30 days prior to the scheduled date; advised that one week's notice must be provided to the FAB should he or she desire a person(s) other than himself or herself and his or her authorized

representative to attend the hearing; and advised that no independent video or audio recording of the hearing is allowed. See Exhibits 5 and 6 for Sample Hearing Notice letters.

(1) Travel to Hearing. While the FAB will try to set the hearing within commuting distance of the claimant, the claimant may be required to travel up to 200 miles roundtrip to attend the hearing. There is no payment to the claimant for the expense of this travel. However, if an unusual circumstance causes the FAB to schedule a hearing that requires the claimant to travel more than 200 miles roundtrip, OWCP will reimburse him or her by for reasonable and necessary travel expenses as outlined in 20 C.F.R 30.314(2).

(2) Telephonic Hearings. A hearing may be conducted by telephone at the FAB's discretion or by claimant request. Only the hearing scheduler can schedule such a hearing, which will include all the aspects of an in-person hearing.

(3) Scheduling Changes. The FAB will entertain any reasonable request for scheduling the time and place of a hearing, but such requests should be made when the hearing is requested. The hearing scheduler will make every effort to accommodate the scheduling request of the claimant. An in-person hearing may be changed, based upon a claimant or authorized representative request, to a telephonic hearing. This change must be coordinated through the hearing scheduler.

In most instances, once the hearing has been scheduled and written notice has been mailed, it cannot be postponed at the claimant's request for any reason except as indicated in paragraph 4 below. However, the hearing scheduler may accommodate minor scheduling changes requested by a claimant.

HRs may not make changes to the scheduled hearing time or place without supervisory approval. The change request must be made to the HR's supervisor and the supervisor will contact the hearing scheduling unit.

(4) Postponing a Hearing. The FAB may grant a postponement of a hearing when the claimant or his or her authorized representative has a medical reason that prevents attendance or when the death of the claimant's parent, spouse or child prevents attendance. The FAB will make every effort to accommodate timely requests to postpone a hearing.

The claimant or authorized representative should provide at least 24 hours notice and a reasonable explanation supporting his or her inability to attend the scheduled

hearing. In such cases, a new hearing will be set for the next hearing trip. Supervisory approval is needed to postpone a hearing.

(5) Failure to Attend. If a claimant does not attend the hearing at the designated time and place, and makes no effort to contact the HR to request a rescheduling based on one of the reasons outlined in paragraph d(4) above, the claimant will not be allowed to reschedule his or her hearing. In such instances, the claimant will be considered to have withdrawn the hearing request, and a Review of the Written Record (RWR) will be undertaken. If new evidence or argument accompanied the objection, it will be reviewed in the RWR.

(6) Cancellation of Hearing. The FAB acknowledges the cancellation in writing and gives the claimant 10 days from the date of the acknowledgement to submit additional evidence. The FAB representative then conducts a review of the written record.

e. Review of Case File. Prior to the hearing, the HR reviews the evidence of record, as well as any additional evidence or materials submitted by the claimant. If the additional evidence received establishes compensability or the need for further development and the FAB supervisor agrees, the HR will notify the claimant and/or authorized representative that the claim will be remanded and the hearing will be canceled. If the evidence is sufficient to warrant reversal in favor of the claimant, FAB may issue a reversal. If the claimant and/or authorized representative states he/she wants to proceed with the hearing, the hearing will be conducted as scheduled.

Moreover, the HR conducts whatever additional investigation is deemed necessary to prepare for the proceedings. The HR contacts the claimant by telephone prior to the hearing to confirm they are planning to attend the hearing at the arranged date, time and location.

The HR reviews the adjudicatory history of the case file as a whole to determine the proper handling of additional evidence and/or objections that might be received at the hearing. This is particularly important when more than one RD is pending.

f. Multiple RDs. Since more than one RD denying benefits can be issued prior to a hearing and additional objections and hearing requests may result, measures are needed to streamline the hearing process.

If more than one RD is pending, the HR contacts each objecting claimant and advises that all objections, not just those pertaining to the RD that is the subject of the hearing request, may be discussed during the hearing. The claimant(s) will be encouraged to bring relevant evidence, even if it concerns a pending RD for which a

timely objection was not filed. All telephonic contact prior to the hearing is documented in ECMS.

(1) Hearing Requests on Multiple Pending RDs. When additional timely hearing requests are submitted based on other recommended denials prior to the hearing date, the HR contacts the requesting party to advise that all objections will be considered at the previously scheduled hearing so that one hearing may serve to accept evidence and testimony on several different RDs. This process is designed to avoid multiple hearings where possible.

The HR notes the conversation with the claimant in ECMS, confirming that the claimant was advised that all outstanding objections will be considered at the hearing. The HR updates the appeal screen in ECMS for each RD and each claimant requesting the hearing.

Separate hearing request acknowledgments and hearing notices are not required. The HR must be prepared to entertain objections about all RDs issued up to the date of the hearing and will take testimony and evidence on all outstanding objections. Each RD in question is considered in a single FAB decision once the FAB hearing process is concluded.

(2) Hearing Request on One RD, Request for Review of the Written Record (RWR) on Another. If a claimant has requested a hearing on one outstanding RD and an RWR on the other, the HR allows the claimant to present evidence about the objections at the hearing, as long as FAB has not issued a FD on the RWR request. [If FAB has issued a FD on the request for RWR, see paragraph (4) below.]

(a) The objection and evidence are considered at the hearing and treated with all other objections and evidence in the post-hearing FAB decision. No review of the written record decision is issued. Coding in ECMS should be changed to reflect a Request for a Hearing, rather than a Request for a Review of the Written Record.

(b) In cases with multiple claimants when one claimant requests a review of the written record and another requests a hearing, no decision is issued to either claimant until the hearing process is complete. FAB can contact the claimant who requested an RWR and ask if he or she would like to address objections to the RD for which an RWR was requested at the time of the hearing on the other RD. If he or she agrees, the RWR is changed to a hearing in ECMS. If he or she declines, his or her objections will be reviewed as part of the hearing decision. Coding in ECMS should

be changed to reflect a Request for a Hearing rather than a Request for a Review of the Written Record and a note should be added to ECMS explaining this action. All claimants, whether they request a hearing or not, are served with notice of the hearing and are afforded the opportunity to be present at the hearing and participate. The RWR objections and the objections discussed at the hearing will be discussed in one FD.

(3) Hearing Request on One RD, No Objection Filed on Another. While awaiting a hearing on one RD, a FD may be issued on another RD for which no objection has been filed following the expiration of the 60 day period. At the hearing, the HR will take testimony and evidence on any outstanding RD that has been issued up to the hearing date. If testimony or evidence is presented about a RD for which the 60 day post-decision objection period has expired and a FD has not been issued, all testimony and evidence will be entered into the record. The timeliness of such objections will be addressed when the post-hearing FAB decision is issued.

(4) Hearing Request on One RD, FD Issued on Another. A claimant may request a hearing on one RD and a reconsideration of a previously issued FD within 30 days of its issuance.

(a) If a FD has been issued and a hearing is held regarding an outstanding RD within the 30 day post-decision reconsideration period, the HR reviews any new evidence related to the previously issued FD as a request for reconsideration. Reconsideration requests cannot be assigned to a FAB representative who has had prior involvement with the claim. If the FD was issued by the HR present at the hearing, the reconsideration request should be assigned to another FAB representative. A decision on the reconsideration should be issued separately from the hearing decision.

(b) If the claimant presents evidence or argument pertaining to a FD at the hearing and the hearing date is outside of the 30 day post-decision reconsideration period, the HR reviews the evidence as a possible reopening.

5. Conduct of the Hearing. The hearing is an informal proceeding and the HR is not bound by common law or statutory rules of evidence or by technical or formal rules of procedure. Generally, the hearing is scheduled to last one hour, but the HR should not specifically limit the hearing to one hour and should *never* tell a claimant that he or she is limited to one hour. Also, the HR must bring a tape recorder to the hearing in case a court reporter is not present. The

HR must ensure that the court reporter is using required back-up recorders.

a. Convening. At the scheduled time and place, the HR will meet with the court reporter, the claimant, and any authorized representative.

(1) If any other individual(s) is in attendance, the HR will request the identity of this individual(s) and have the claimant(s) sign a "Waiver of Right to Confidentiality" (See Exhibit 7) before convening the hearing. The claimant(s) sign a separate waiver (see Exhibit 8) if he or she requests that a member of the media be present.

(2) If there are multiple claimants present, each is required to sign a waiver of confidentiality.

(3) At the start of the hearing, the HR indicates to the court reporter that he or she wishes to open the record of the hearing. He or she will note the date and time, identify all persons present by name, and enter a brief narrative into the record describing the events leading to the hearing, including the specific objection(s) raised by the claimant. If no specific objections have been raised, the HR should indicate this.

For hearings addressing NIOSH Dose Reconstruction issues, the HR strictly follows the hearing script shown as Exhibit 9. The HR advises participants that he or she can discuss issues of a factual nature about the information provided to NIOSH and the application of methodology (see example below), but is not permitted to consider in the final decision objections to the methodology employed by NIOSH in preparing the dose reconstruction report.

APPLICATION OF METHODOLOGY

A claimant may present argument to the FAB that NIOSH made an error in the application of methodology such as applying the radiation dose estimate methods to his or her individual circumstances. Other examples of objections include: did NIOSH identify all sources of exposure to the worker; were the air samples chosen to represent the air breathed by the worker appropriate; is the group of co-workers appropriate for determining exposure to the worker; and were proper assumptions made about the particular physical or chemical form of radioactive material that was used in the facility where the employee worked and its solubility class. Another application issue might involve the use of "worst case" approach (which is a NIOSH method). The application aspect of this issue might be whether the "worst case" selected was the worst case (e.g., there were 20 more people working there that were not monitored and the worst case was based only on monitored individuals).

Example of Application of Methodology. The objection alleges that NIOSH did not properly consider the "proximity

to the source." The NIOSH exposure matrix considers that the worker was one foot away from uranium billets/rods for six hours and one meter away for four hours. NIOSH considers this to adequately account for times when the worker would touch the uranium rods/billets, since there would also be times when the worker was at a much greater distance. This exposure matrix is drawn as the example of highest possible exposure, as no individual exposure records are available. The objection indicates that the worker handled the uranium metal more often than NIOSH allowed in the exposure matrix. This is a challenge to the application of the dose reconstruction methodology and can be addressed as part of the hearing process.

METHODOLOGY

20 CFR 30.318(b) provides that the "methodology" NIOSH uses in making radiation dose estimates is binding on the FAB. The "methodology" NIOSH uses is the dose reconstruction, which is addressed in the statute and 42 CFR Part 82. "Methodology" is dictated by sections 7384n(c) and (d) of the statute. For example, those methods must be based on the radiation dose received by the employee (or a group of employees performing similar work) and the upper 99 percent confidence interval of the probability of causation in the radioepidemiological tables published under the Orphan Drug Act. The Act also requires NIOSH to consider the type of cancer, past health-related activities (such as smoking), and information on the risk of developing a radiation-related cancer from workplace exposure.

The "methods" of dose reconstruction are set out in 42 CFR Part 82 and include: analyzing specific characteristics of the monitoring procedures in a given work setting; identifying events or processes that were unmonitored; identifying the types and quantities of radioactive materials involved; evaluating production processes and safety procedures; applying certain assumptions that err reasonably on the side of overestimating exposures while achieving efficiency; and using current models for calculating internal dose published by the International Commission on Radiological Protection (ICRP). The NIOSH "efficiency" process of using overestimates and underestimates in dose reconstruction is another example of a methodology. It is these "methods" that cannot be addressed by FAB. Any questions related to the content of NIOSH-IREP software are related to methodology, whereas questions related to the Department of Labor's probability of causation calculation (which relies on NIOSH-IREP software) can be considered.

Example of Objections to Methodology. The radiation dose to the claimant's gall bladder was calculated using the highest recorded doses from other co-workers at the facility as the basis for the claimant's dose estimate. This was noted in the text of the dose reconstruction report as being "the highest reasonably possible radiation

dose." No uncertainty values were assigned to the claimant's estimate because it was considered that the claimant's "dose was no higher than this estimate."

b. Testimony and Evidence. The HR will administer an oath to each person giving testimony. The HR should make clear at the outset that he or she cannot receive testimony from participants who are not under oath. If a witness arrives late, he/she must be sworn in before testifying. An attorney must not be sworn in since he or she simply presents arguments, objections or evidence but not testimony.

(1) A court reporter shall record oral testimony and place it into the record. A court reporter may use only audio (not video) equipment. Moreover, neither the claimant(s), any authorized representative or anyone else present at the hearing may bring audio or video equipment to obtain an independent record of the hearing.

(2) Any evidence or testimony a claimant wishes to enter into the record is entered, even if it pertains to a RD that was previously issued and the 60-day post-decision timeframe to object has expired. The HR will accept all testimony and evidence presented at the hearing.

(3) During the claimant's testimony, the HR should note any additional questions or areas for exploration and make appropriate inquiries. The claimant can raise additional objections at this time. The HR should ask questions or request the claimant to elaborate so the objections are clearly understood.

(4) Each exhibit is marked separately and identified on the record by name and number with a brief description of its content. The HR will state on the record that the exhibit is being entered into the evidence of record.

(5) During the testimony the HR states whether there is a need to interrupt testimony and go off the record. When it is time to return on the record, the HR indicates this and, once back on record, provides a brief description of why it was necessary to go off the record. Time and issues discussed off the record should be kept to a minimum.

(6) The HR spells unfamiliar words or names to help the court reporter maintain an accurate record of the hearing.

c. Conclusion. When all testimony has been given and all the exhibits marked and clarifications made, the HR explains that the record will remain open 30 days after the date of the hearing to permit the submission of additional written evidence or argument on the issue(s) in question.

The HR also advises that the claimant will receive a copy of the transcript and will have 20 days from the date of mailing to request changes in writing to the record.

The HR then closes the proceedings by noting the time and date.

6. Post-Hearing Actions. After the hearing, the HR obtains a copy of the transcript from the reporting service. FAB sends the claimant a copy of the hearing transcript within seven calendar days of the transcripts receipt in the FAB.

A cover letter accompanies the transcript, reminding the claimant that he or she has 20 days from the date of the letter to comment on the accuracy of the transcript in writing. The claimant is also advised that the record will remain open 30 days from the hearing date for the submission of additional evidence.

a. Collecting Comments and Additional Evidence. The HR keeps the hearing record open for 30 calendar days after the hearing. At his or her discretion, the HR may choose to grant the claimant an extension for the submission of new evidence. However, the HR may only grant one extension not to exceed another 30 calendar days.

(1) If the claimant submits additional evidence within 30 days after the date of the hearing, or comments on the transcript, the HR will enter such evidence into the record and weigh it when issuing the decision.

(2) If the claimant does not submit additional evidence within 30 days after the date of the hearing, and does not comment on the transcript, the HR reaches a decision based on examination of the evidence of record. However, the HR must consider all evidence submitted, even if it arrives after the 30 day period, prior to issuing a FD.

b. Final Decision. After examining the documents associated with the hearing, the HR prepares a FD if a determination can be made without further development.

c. Disposition of Case File. Once FAB issues a decision on the RD considered at the hearing, the case file is returned to the DO. However, if FAB reviewed multiple RDs and additional FAB review is required after a hearing decision has been issued on only one of the RDs, the case file remains at FAB until such pending action is resolved.

(1) Reconsiderations. If FAB is reviewing a FD for reconsideration and has held a hearing on another RD, the case file remains at FAB until all review is completed. In such instances, if a remand order is issued based upon any of the RDs considered at the hearing but the reconsideration is outstanding, or if the HR grants the reconsideration and remands that issue but a FD following a hearing is outstanding, the Secondary CE (CE2) designated to work FAB issues receives the remand order and addresses all issues contained therein.

If reconsideration is not granted, once the request for reconsideration is reviewed and a decision issued, the case

file is returned to the DO as long as no other outstanding issues remain.

(2) Remand Orders. As noted above, if the case file remains at FAB for additional action, the CE2 addresses the remand order.

If no additional FAB action is required, the case file is immediately returned to the DO, which addresses the remand order and issues a new RD.

d. Cases Returned to DO. Where there are no outstanding issues as outlined above, the case file is returned to the DO that issued the contested RD.

7. FAB Final Decisions. The FAB reviews the case record and all evidence of file and makes findings of facts and conclusions of law. The FAB CE issues an independent decision and ensures that the claim has been thoroughly developed and a correct conclusion has been reached.

There are several types of FAB FDs:

a. Acceptances. When FAB receives a RD accepting benefits, the FAB makes findings of fact and conclusions of law and issues the FD to accept, provided no technical or procedural errors exist.

(1) If the RD accepts the claim in full and independent review by FAB concludes the acceptance is correct, FAB issues the FD awarding benefits in full. In such instances FAB issues the FD within 30 days of receipt of the waiver or upon expiration of the 60 day post-RD objection period, whichever comes first. If a claimant submits a waiver on day 59, this does not grant an additional 30 days to issue a FD. To be issued timely, the FD must be issued upon expiration of the 60 day objection period.

(2) If the DO has issued a RD accepting one or more claim element(s) while denying and/or deferring other elements, the FAB issues the FD as soon as possible to expedite the claimant's receipt of benefits. FAB does not wait to issue the FD until the elements under development at the DO are adjudicated, as those elements will usually require their own RDs and FDs once development is completed.

(a) A bifurcated waiver (see EEOICPA PM 2-1700, Exhibit 2) is issued with RDs that are partial acceptances/partial denials.

If the claimant mistakenly selects both options, or provides an ambiguous response, a FAB representative contacts the claimant and requests clarification in writing.

If the claimant advises in writing that he or she did not wish to waive his or her right to object, the waiver code is removed from ECMS by a FAB manager and

a note put into ECMS explaining why it was deleted.

(b) Where there are multiple claimants, FAB must wait until all waivers are received before issuing the FD. However, as stated above, receipt of a waiver on day 59 for example, does not grant an additional 30 days to issue a FD. To be issued timely, it must be issued within the 75 day period.

(c) If no waiver is submitted, FAB issues the FD once the 60-day post-RD objection period expires.

(d) If a claimant files a timely written objection, FAB cannot issue a FD until the objection is duly considered, either through the hearing process or a review of the written record. Contested decisions are addressed below.

One exception to the situation described above is where a claimant waives the right to object to the accepted portion of the claim but does object to the denied portion. In that instance, FAB issues the FD accepting the approved portion and considers the objection as outlined below.

b. Denials. When FAB receives a RD denying the claim in full or in part, FAB reviews the RD and independently reviews the case to ensure that it has been adjudicated consistent with the law, regulations, policies and procedures. If there is evidence in the case that warrants a reversal, the FAB CE/HR reverses the decision with approval from the FAB chief and issues benefits to the claimant without delay. If the claimant submits additional evidence, the FAB CE/HR reviews such evidence and determines whether it is sufficient to accept the case. If it is sufficient, and there are no outstanding development issues (such as SWC/Tort information), the FAB CE/HR may reverse the decision immediately and accept the case. If the evidence is sufficient to warrant further development, FAB remands the case. Provided no technical or procedural errors exist, FAB upholds the RD and issues a final decision to deny the claim. If the RD denies one claim element and develops another claim element, the designated CE2 continues to develop the claim element that is not before the FAB.

(1) For non-contested denials, absent any technical or procedural error, the FAB issues a FD accepting the RD findings and denying the claim for benefits in cases where no timely objection is filed or a waiver is received. Where no waiver is received, the FD is issued as soon as possible after the 60-day post-RD objection period expires.

(2) For contested denials, the FAB considers the timely filed written objection by either conducting a hearing or a review of the written record before a FD is issued, as appropriate.

c. Contested Decisions. After considering a timely filed written objection by conducting a hearing or reviewing the written record,

FAB issues a decision based upon its independent findings. The FAB can issue a FD, a remand order returning the case file to the DO for further development or some other action, or a FD reversing a RD denying benefits. Remand orders and FD reversals are discussed below and can be issued on both contested and non-contested claims.

(1) A review of the written record (RWR) is performed after a claimant has objected to the findings of a RD without requesting an oral hearing. The FAB will review the written record, the claimant's objection, and any additional evidence submitted to determine whether the RD findings can be reversed to accept the claim or remanded for further development. Once this review is complete, the FAB issues a decision accordingly.

(2) Once the FAB conducts the hearing and satisfies all of the requirements of the hearing process, a decision is issued. While the hearing itself may entertain objections raised from several RDs, one FAB decision will be issued that addresses each contested RD after the resolution of the entire hearing process.

(3) Each FAB decision following a hearing outlines the facts of the case, lists and comprehensively addresses the objection(s) raised at the hearing through testimony, exhibits presented, objections noted in the hearing request letter and subsequent letters, briefly outlines the hearing process, and thoroughly discusses the findings and/or conclusions of the FAB. In the case of an RWR, the FAB CE/HR must review all objections raised in the RWR objection letter and respond to each objection clearly and comprehensively.

d. Remand Orders. Should the FAB find a technical, procedural, or some other error requiring a remand order, the FAB returns the case file to the DO with instructions as to how to proceed further. Remand orders are largely issued in instances where further development is required at the DO level.

(1) FAB does not issue a remand order where FAB personnel can conduct minor development to resolve the issue at hand. Such minor development is conducted by FAB staff, not the CE2. An example is a missing divorce certificate, birth certificate, or an updated SWC/Tort Questionnaire. If FAB cannot resolve the issue in a timely manner, the FAB CE/HR will remand the case.

(2) Where a case is at FAB for review of one claim element and a remand order is issued on another claim element, the designated CE2 addresses the remand order. If there are no outstanding issues before FAB, the remand order and case file is returned to the DO that issued the RD.

(3) FAB may also issue remand orders in part, returning one portion of the claim to the DO for further action and issuing a FD on other portions of the claim.

(4) A remand order is written in narrative format to the claimant(s), but does not contain the normal sections of a FD (Statement of Case, Findings of Fact, and Conclusions of Law). However, it should discuss the objections raised and provide an overview of the hearing process.

e. Reversal. A reversal is a FD issued when the evidence shows that either the RD denied benefits in error or new and compelling evidence warrants overturning a RD denial and accepting a claim for benefits.

(1) A reversal can be issued when a case is denied in full or in part. In partial denials, the FAB may reverse to accept if the portion of the claim denied by the RD is found to be in posture for acceptance, a DO error is identified, or new evidence is received that warrants a reversal.

(2) A decision reversing the RD is used only where a denial is reversed to accept benefits. The rationale for reversals must be clearly stated in the body of the decision and forwarded with the case file to the FAB Chief for review and approval. A reversal cannot be issued without such approval.

(3) When considering a reversal, FAB must be mindful of tort offset/SWC coordination and determine whether anyone received a settlement that might reduce the EEOICPA benefit.

f. Reconsiderations. FAB-NO and all DO FABs have authority to review requests for reconsideration and issue decisions according to 20 C.F.R. 30.319.

8. Preparation of FDs. As with RDs, multiple FAB decisions are possible on one case. Given the requirement that any RD deciding the eligibility of any one claimant to receive benefits include all claimants' party to the decision; a FD cannot be issued deciding any one claimant's eligibility to receive benefits without including all claimants as party to the decision. Accordingly, it is the responsibility of the FAB to remand any RD which does not comply with these procedures and instruct the DO to issue a new RD to address the eligibility of each party to the claim. This may require the reopening of certain claims (see EEOICPA PM 2-1900).

FAB decisions are written to be as transparent to the claimant as possible and are designed to avoid confusion on the part of the recipient. The FAB decision clearly identifies the Part of the Act under which benefits are awarded or denied so that the claimant clearly understands the decision. They include statutory/regulatory language in the conclusions of law when outlining the benefits being awarded or denied.

a. Three Components. The FAB representative must prepare three components before issuing a FD (a sample of a complete FD is shown as

Exhibit 10):

(1) A cover letter explaining that a final decision has been reached. The cover letter must clearly identify what is being accepted or denied and under what part of the Act. This letter provides general information about the FD process and the administrative review available to the claimant.

(2) The final decision.

(3) Certificates of service certify that each listed claimant and his or her authorized representative was mailed a copy of the FD. A separate certificate of service is created for each claimant, but a claimant and his or her authorized representative may appear on the same certificate of service.

An acceptance may include two other components: (1) a medical benefits letter explaining entitlement to medical benefits for an accepted condition; and/or (2) an Acceptance of Payment form (EN-20), which is required before a payment can be issued.

b. Formatting and Content, FD for Acceptances, Contested Decisions, Denials, and Reversals. Where a FD is prepared for an acceptance, contested decision, denial or reversal, it must contain the following sections in the following sequence:

(1) Statement of the Case. This section sets out the case history up to the point of the issuance of the FD, including FAB actions, and other pertinent information in a clear, concise narrative. No analysis of the facts or law and no citations appear in this section.

(2) Objections. This section discusses any objection raised by the claimant in writing or through an oral hearing and includes FAB's response to the objection. No analysis of the law or citations appear in this section.

(3) Findings of Fact. This section is a recitation of all facts pertinent to the ultimate decision rendered by the FAB. The findings of fact are the most significant findings from the Statement of the Case that are needed to support the FD ruling. Each finding is numbered sequentially in bullet form. The findings should draw conclusions from the evidence of record, not simply recite the statement of the case.

(4) Conclusions of Law. This section contains the statutory and regulatory analysis used by the FAB reviewer to reach his or her decision. This section must be well reasoned and provide appropriate legal citations. It should not, however, consist of a list of statutory references without any explanation. An overall legal conclusion supporting the decision must be reached. The

conclusions of law must specifically identify whether or not benefits are being awarded and under which Part.

c. Objections to NIOSH Dose Reconstruction Decisions. Detailed procedures for objections to the NIOSH process and referrals to the DEEOIC Health Physicist are found in EEOICPA PM 2-1700.

(1) Factual objections in FD. If the claimant submits a factual objection and the factual findings reported to NIOSH are supported by the evidence of record, the FAB CE/HR addresses the objections in the FD. No referral to the DEEOIC Health Physicist is necessary. If the factual findings reported to NIOSH do not appear to be supported by the evidence of record and the health physicist determines that a rework of the dose reconstruction is necessary, the FAB CE/HR remands the case to the DO.

(2) Technical Objections in FD. A technical objection involving either methodology or application must be referred to the DEEOIC Health Physicist. If the DEEOIC Health Physicist deems none of the technical objections plausible, the FAB CE/HR incorporates the findings on these technical issues into the FD.

However, if the DEEOIC Health Physicist determines that there is substantial factual evidence that NIOSH had not previously considered and/or that NIOSH should consider an issue relating to application of methodology, he or she notifies the FAB CE/HR, who then remands the case, after supervisory approval, to the DO with instructions to refer the case back to NIOSH. In most cases, NIOSH will perform a new dose reconstruction based on circumstances of the remand.

(3) Objections to Methodology in FD. When an objection is directed at NIOSH's methodology, the FAB CE/HR states in the decision that the objection cannot be addressed based on 20 CFR § 30.318(b) (methodology that NIOSH uses in arriving at reasonable estimates of radiation doses). The FAB CE/HR makes this statement only if so advised by the DEEOIC Health Physicist. Objections related to the content of NIOSH-IREP software are related to methodology. However, the calculation of the probability of causation using the IREP software is the responsibility of the DEEOIC; therefore, FAB should address these objections in the FD.

d. Return of FD by Postal Service. Should FAB receive a returned FD, the FAB CE/HR will attempt to obtain the new or updated address for the claimant and re-mail the decision. If the case has already been returned to the DO, FAB staff may request the file. Upon receiving a returned FD, the FAB CE/HR contacts the claimant by phone to confirm the correct address and request a change of address in

writing, if needed.

(1) Correct Address Found, Claimant Did Not Notify DO or FAB. Upon receiving the new address in writing, the FAB CE/HR photocopies the returned mail and sends it to the claimant along with another certificate of service for the new date and new address and a short cover letter explaining that "a decision was previously issued and a copy is attached and is being sent to you at your new address. Your appeal rights are as explained in the attachments to the final decision." The returned mail, certificate of service and cover letter are to be spindled in the file, and a note written in ECMS describing the actions taken. ECMS should not be coded with a new FD issuance date.

(2) Correct Address Found, Claimant Notified DO or FAB. If the FD was returned because the FAB CE/HR used the incorrect address, a new decision will have to be issued with a new issuance date. Only the claimant whose FD was returned receives a new decision. The returned mail and the new FD with attachments are to be spindled in the file and a note written in ECMS describing the actions taken. The new issuance date should be coded in ECMS.

(3) Correct Address Not Found. If the FAB CE/HR cannot obtain the claimant's correct address, the final decision is no longer valid and the FAB CE/HR issues a remand order to the DO for administrative closure.

9. Claimant Rights Following the Issuance of FAB Final Decisions. A claimant may seek review of a FD by filing a request for reconsideration or by filing a request for reopening of the claim. This paragraph discusses requests for reconsideration and provides guidance relating to the initial receipt of requests for reopening.

a. Receipt of a Request for Review.

(1) A request for reconsideration will be considered timely if it was filed within 30 calendar days of the date of issuance of the FD. Pursuant to 20 C.F.R. § 30.319(b), the request will be considered to be "filed" on the date the claimant mails it to the FAB, as determined by the postmark, or on the date the written request is actually received by the DO or FAB, whichever is the earliest determinable date. A request for reopening may be filed at any time after the FD is issued.

(2) Any correspondence from a claimant or authorized representative which is received in the DO or FAB within 30 calendar days after the FD is issued, and which contains either an explicit request for reconsideration or language which could be reasonably interpreted as an intent to

disagree with the FD, will be considered a timely filed request for reconsideration.

If new evidence is received in the DO or FAB within 30 calendar days after the FD issuance, and the new evidence relates to an issue which was adjudicated and denied in the FD, this new evidence will be considered a timely filed request for reconsideration. If the DO receives the request for reconsideration, it must be sent to the FAB office which issued the FD as soon as possible.

(3) Upon receipt of correspondence or new evidence which constitutes a timely filed request for reconsideration, FAB will send a letter to the claimant acknowledging receipt of the correspondence or evidence and advising that such receipt is considered a timely filed request for reconsideration.

(4) If correspondence received within 30 calendar days of the FD specifically requests a reopening instead of reconsideration, it will be handled as a reopening request by the DO. If both reconsideration and reopening are requested, FAB will process the reconsideration request first and then forward the claim to the DO to process the reopening request.

(5) A request for reopening may take several forms:

(a) Any correspondence or evidence containing or accompanied by a specific request for reopening, which is received at any time after the issuance of the FD, will be treated as a reopening request.

(b) If FAB receives correspondence or evidence without a specific request for reopening after the deadline for a timely reconsideration request, and the FD denied the claim to which the correspondence or evidence relates, FAB will review the evidence for possible reopening.

If FAB determines that such correspondence or evidence meets the evidentiary requirements set forth in 20 C.F.R. § 30.320(b), the FAB-DO district manager or the FAB-NO Branch Chief will prepare a memorandum to the EEOICP Director outlining the case history and the nature of the evidence and forward the case file to the EEOICP Director for review for possible reopening.

Should the evidentiary requirements not be met, FAB will associate the correspondence or evidence with the case file. In either case the claimant will not be notified of the actions taken by the FAB, because the claimant has not requested a specific action.

(6) Upon receipt of a request for review:

(a) Any request for reconsideration, along with the case file, is forwarded to FAB and assigned to a FAB CE/HR for review. A reconsideration request will not be assigned to a FAB CE/HR who issued the final decision for the specific claim element being addressed in the reconsideration request. The FAB CE/HR will screen the case to determine if the correspondence constitutes a request for reconsideration and, if so, if the request was timely filed.

(b) All requests for reopening received in the DO are initially reviewed by the DD. If a reopening request is received in FAB, the FAB-DO district manager or FAB-NO Branch Chief will transfer the request, any supporting evidence, and the case file to the DD for review.

(7) Upon receipt of a timely request for reconsideration, the FD in question will no longer be deemed "final" until a decision is reached on the reconsideration request. Receipt of a request for reopening does not have a similar effect and the subject FD remains "final" until such time as the EEOICP Director issues an order reopening the claim.

(8) A reconsideration request does not come with reconsideration rights, but only reopening rights. Therefore, if FAB denied a request for reconsideration and the claimant subsequently files another request for reconsideration of the same FD, FAB will not entertain the subsequent request. In this case, no denial order needs to be issued and no acknowledgment letter needs to be sent.

b. Processing an Untimely Request for Reconsideration.

(1) Any request for reconsideration which is not accompanied by a specific request for a reopening is considered a request for reconsideration. Any such request which is filed after the above-noted deadline for filing timely reconsideration requests is an untimely filed request for reconsideration.

(a) No letter is sent to acknowledge receipt of an untimely request for reconsideration. FAB issues a Denial of Request for Reconsideration advising the claimant that the request for reconsideration was not filed within 30 days of the issuance of the final decision and must be denied.

(b) If FAB concludes that any evidence received with an untimely request for reconsideration may warrant a reopening, FAB may forward the request to the District Director of the DO with jurisdiction over the claim

for review.

(2) If an untimely filed request for reconsideration is accompanied by a specific request for reopening, FAB issues a Denial of Request for Reconsideration based on the untimely filing. The FAB CE/HR then forwards the reopening request with the case file to the DD of the office with jurisdiction over the claim for review for possible reopening.

c. Processing a Timely Request for Reconsideration. Upon determining that a request for reconsideration has been timely filed, the FAB CE/HR reviews the request and any accompanying evidence and decides whether to grant or deny the request. If, based on a review of the new evidence or argument submitted, the FAB CE/HR considers a review of the record to be warranted, the request will be granted.

(1) To warrant a review of the evidence, the evidence or argument must be of sufficient weight and probative value to convince the FAB CE/HR that the potential exists to alter a material finding of fact or conclusion of law referenced in the FD.

For example, if the FD denies a claim for CBD because the medical evidence was insufficient to establish CBD and the claimant submits a reconsideration request along with new medical evidence that could meet the statutory requirements for establishing CBD, the FAB may grant the reconsideration request.

(a) A timely request for reconsideration may be denied if it does not contain sufficient probative evidence or substantiated argument that directly contradicts a material finding of fact or conclusion of law set forth in the FD.

For example, if the FD denies a claim for skin cancer because the calculation of probability of causation was less than 50% and the claimant submits a reconsideration request but does not submit any additional medical or employment evidence that would alter the dose reconstruction, the FAB may deny the reconsideration request.

(b) Mere disagreement with the findings or conclusions of the FD is not sufficient to grant a reconsideration request. Such requests are to be denied on the grounds that no new information was presented that would affect the FD.

(2) If FAB grants the request for reconsideration, FAB performs a detailed review of the record. Specific procedures for conducting this review can be found in paragraph 6 above.

(a) Granting reconsideration will not necessarily result in a reversal of the FD. It merely denotes that the FAB CE/HR considers the argument or evidence presented by the claimant to be of sufficient weight and quality to require a thorough review of the case and issuance of a new FD.

(b) Upon granting the request for reconsideration, the existing FD is considered vacated and a new FD is required. If, after the review, FAB concludes that the case should be remanded to the DO for further development, FAB may issue an order granting the request for reconsideration and remanding the case to the DO for issuance of a new RD.

Otherwise, FAB issues an order granting the request for reconsideration and a new FD on the claim. A new FD that is issued after FAB grants a request for reconsideration will be "final" upon the date it is issued.

(3) If FAB denies the request for reconsideration, a review of the record is not performed. In the case of a denial, FAB issues an order denying the request for reconsideration and the FD which formed the basis for the request is considered "final" upon the issuance of the order denying the request.

(4) If a timely request for reconsideration is accompanied by a specific request for a reopening, then upon the issuance of a denial of request for reconsideration FAB forwards the case file to the DD of the office with jurisdiction over the claim for processing of the reopening request.

If FAB grants the request for reconsideration and issues a new FD, there is no need to process the reopening request and the case file is transferred to the DO.

10. Alternative Filing, Part E. If a claimant is denied as an ineligible survivor under Part E, he or she has the right to alternatively receive a non-decision determination regarding the employee's claimed illness(es). FAB advises the claimant of this right in the cover letter of the FD (see Exhibit 11 for a sample letter).

Exhibit 1: Sample Remand Order and Cover Letter

Exhibit 2: Certificate of Service

Exhibit 3: Sample Acknowledgment Letter, Review of Written Record

Exhibit 4: Sample Acknowledgment Letter, Hearing

Exhibit 5: Sample Hearing Notice to Claimant Who Filed an Objection

Exhibit 6: Sample Hearing Notice to Claimant Who Did Not File an Objection

Exhibit 7: Waiver of Rights to Confidentiality

Exhibit 8: Waiver of Rights to Confidentiality (Media)

Exhibit 9: Sample Hearing Script

Exhibit 10: Sample Complete Final Decision

Exhibit 11: Sample Cover Letter, Alternative Filing

2-1900 Reopening Process

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2 Sample Denial of a Request for Reopening		04/12	12-01

1. Purpose and Scope. This chapter describes the process by which the Director of the Division of Energy Employees Occupational Illness Compensation (DEEOIC) reopens claims for benefits under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA) and vacates decisions of the Final Adjudication Branch (FAB).

2. Authority. Under 20 C.F.R. § 30.320, the Director of the DEEOIC has the authority to reopen a claim and vacate a FAB decision at any time after the FAB has issued a Final Decision pursuant to 20 C.F.R. § 30.316. Also, under 20 C.F.R. § 30.320(a), the Director may vacate a FAB Remand Order. While a reopening review can be initiated by written request by a party to a Final Decision, it may also occur at the discretion of the Director of the DEEOIC for administrative reasons, due to procedural error, or a change in the law, regulations, agency policy, or any other reason at the sole discretion of the Director. If the Director initiates such a review, the National Office (NO) requests the case file from the District or FAB Office for the reopening to be handled locally or delegates the authority to reopen at a District Office (DO) through procedural directive. The Director's decision to reopen a claim and vacate a FAB decision is not reviewable.

The Director will delegate reopening authority from time to time by issuance of policy directives or other formal guidance that explains the extent of reopening authority conferred. Certain delegated authority has been granted to the Branch Chief of the Policy Branch, the Unit Chiefs for the Policies, Regulations and Procedures Unit (PRPU), and the District Directors (DDs). For delegated reopening authority granted to the DDs, the delegation applies to Assistant District Directors (ADDs) when agreed to by a DD. The DEEOIC Director can grant reopening authority to other individuals in the program as needed. The Director retains sole reopening authority where no delegation has been issued.

3. Claimant's Explicit Request for Reopening. The regulations allow a claimant or a claimant's duly authorized representative, at any time after the FAB has issued a Final Decision, to file a written request seeking reopening of a Final Decision under the EEOICPA, pursuant to 20 C.F.R. § 30.320(b). The Regulations allow that such a request may be filed:

Provided that the claimant also submits new evidence of either covered employment or exposure to a toxic substance, or identifies either a change in the Probability of Causation (PoC) guidelines, a change in the dose reconstruction methods or an addition of a class of employees to the Special Exposure Cohort (SEC).

There is no limit as to how many times a claimant may request a reopening. A written request for a reopening is to result in a written decision either accepting or denying the reopening.

a. Timeliness. A claimant may file a request for reopening at any time after the FAB has issued a Final Decision.

b. Initial Review. All correspondence in which a claimant explicitly requests a Final Decision be reopened, whether received in a district or FAB office, is forwarded to the DD responsible for the case file. Requests for reopening received in the National Office FAB (FAB-NO) are to be reviewed by the FAB-NO Branch Chief. The DD or FAB-NO Branch Chief is to conduct an initial review of the correspondence to determine whether the request is accompanied by new evidence, or other information, which is of a sufficiently compelling nature to warrant a reopening.

c. Referral for Reopening Action. Once initial review of a reopening request is completed, the DD or FAB-NO Branch Chief is to determine the responsible party for issuing a reopening decision. In many instances, the DD will have authority to issue a reopening decision on his or her own authority, as delegated by the Director. The FAB-NO Branch Chief, however, does not have the capacity to reopen a Final Decision. Accordingly, he or she must decide the appropriate office to which the reopening request must be referred for review. The options available to the FAB-NO Branch Chief are to either refer the matter to a DD with jurisdiction over the case or to the DEEOIC Director. Circumstances in which a DD can reopen a claim are as follows:

(1) Employment. In instances where a denial is based on employment issues: employment records that establish previously denied or unverified time periods of covered Department of Energy (DOE), DOE contractor/subcontractor, Atomic Weapons Employer (AWE), beryllium vendor, or Radiation Exposure Compensation Act (RECA) section 5 employment.

(2) Survivorship. In instances where the denial is based on survivorship issues: records or documents that demonstrate a relationship between a previously denied survivor and the covered employee. Or, cases under Part B where an employee claim has received a Final Decision to approve, but the claimant died before payment could be made. Additionally, instances in which a new survivor is identified; as discussed later in this chapter.

(3) Site Exposure Matrices (SEM). In instances where an update to the SEM or the submission of new factual evidence establish a previously denied, closed, or unverified toxic substance exposure, which is known to be linked to the claimed illness(es). [Or, in cases where new evidence of exposure is received that demonstrates a link to the claimed illness(es).] This guidance applies to any case requiring reopening as a result of SEM Quality Assurance Plan actions or other programmatic re-assessment of denied Part E claims based on SEM exposure or illness link updates.

(4) PoC. In instances where a Final Decision has been issued to deny a claim for any cancer based upon a dose reconstruction returned from the National Institute for Occupational Safety and Health (NIOSH) with a PoC of less than 50%, and the claimant has submitted a diagnosis of a new cancer, the case file is returned to NIOSH for completion of a new dose reconstruction. In cases in which the revised dose reconstruction results in a PoC of 50% or greater, the case is then reopened and a new Recommended Decision is issued accepting the claim. However, if the latest dose reconstruction results in a PoC of less than 50%, no reopening action is necessary, and the new claim for cancer is denied.

(5) New Medical Evidence – In instances where a previous Final Decision has been issued to deny a claim based on the lack of evidence to establish a diagnosis, and medical evidence is submitted which clearly establishes a diagnosis, the Director may reopen the claim as an exercise of discretion when the new evidence is determined to be material to the outcome of a claim.

(6) Change in Law, Regulations or Policies. If the initial review reveals that the claimant has identified a change in the law, regulations, or policies governing the EEOICPA, the DD determines whether the nature and extent of such information satisfies the requirements of 20 C.F.R. § 30.320, and whether it is sufficient to warrant reopening.

d. Denial of Request for Reopening. If the evidence submitted, and/or the change in law, regulations, or policies identified by the claimant, is insufficient to support a reopening, the DD issues a Denial of Request for Reopening.

e. Referral to DEEOIC Director. If the DD or FAB-NO Branch Chief cannot determine whether the evidence submitted, and/or the change in law, regulations, or policies identified by the claimant, is sufficient to warrant a reopening, or if the request presents an issue for which the Director has not delegated reopening authority, the case is to be referred to the DEEOIC Director. Reopening requests involving uniquely complex or potentially sensitive topics are to also be referred to the Director. A memorandum to the Director recommending that the case be reviewed for possible reopening is to accompany the case record. The memorandum is to outline the case history, the evidence of record and explain why the new evidence, or other information, is material to a potential reopening.

4. Claimant’s Non-Specific Correspondence or Evidence. Once a Final Decision is issued, there may arise situations where non-specific correspondence or evidence is received. Under these circumstances, it is difficult to interpret the documentation to determine if the claimant is pursuing a challenge to a Final

Decision. To address this problem, it will be necessary to first attempt to contact the claimant by telephone. This action is to be undertaken by the district or FAB office with possession of the case record at the time that the non-specific correspondence or evidence is received. As such, it is vital that the evidence be directed to the appropriate designation upon receipt.

The claimant should be notified of the options available to him or her given the evidence submitted. These options include reconsideration within 30 days of the Final Decision (if applicable) or evaluation under the authority granted to the Director to reopen a claim. If the claimant provides clarification of his or her intention, a note is to be entered in ECS clearly documenting the information provided. Should the Claims Examiner (CE) or FAB representative not reach the claimant by phone within a reasonable period of time (approximately 3 days), and clarification cannot be obtained by telephone, it will be necessary to evaluate the evidence to determine the appropriate action to be undertaken.

a. Non-Specific Correspondence or Evidence Received Within 30 Days of a Final Decision. If attempts to clarify the intent of the claimant are not successful, and the 30-day period granted to request reconsideration has not expired, a DO FAB Manager or the FAB-NO Branch Chief will need to determine if a sufficient basis exists to treat the documentation as a request for reconsideration. If it is determined that the evidence warrants reconsideration, FAB is to proceed with a decision. Otherwise, as explained later, the documentation may be added to the case record with no action taken other than to denote in the case record that the material was received and reviewed.

b. Non-Specific Correspondence or Evidence Received After 30 Days of a Final Decision. Once the option of reconsideration is extinguished, the claimant has only the ability to pursue reopening should they disagree with a Final Decision. Without clarification from the claimant, any non-specific correspondence or evidence will need to be evaluated to determine if sufficient reason exists to require a reopening decision.

(1) Received in DO or DO FAB. If non-specific correspondence or evidence is received in a district or FAB office, the correspondence or evidence is transferred, along with the case file, to the DD with jurisdiction over the case file. The DD reviews the evidence to determine whether there is sufficient basis to warrant a reopening, and whether he or she has been delegated authority to reopen based on the case circumstance. If the DD possesses the authority to reopen a Final Decision, the DD issues a Director's Order vacating the Final Decision. If the DD does not have the requisite authority to reopen the Final Decision, or there is some other complication, the matter is referred to the DEEOIC Director.

(2) Received in FAB-NO. If such non-specific correspondence or evidence is received in the FAB-NO, the case is submitted to the FAB-NO Branch Chief for evaluation. Depending on the delegations that exist for issuing a reopening decision, as explained earlier in this chapter, he or she will then determine whether the matter is to be referred to a DD or the DEEOIC Director.

(3) Case Referred to the DEEOIC Director. If the DD or FAB-NO Branch Chief is unsure if the evidentiary requirements for a reopening or if some other extenuating circumstance exists to preclude a decision on the sufficiency of the reopening, the matter is to be referred to the DEEOIC Director. Since the claimant has not requested a specific action, he or she is not notified that the case has been sent to the DEEOIC Director for review. The DEEOIC Director, or his or her designated representative, reviews the materials and issues a decision based upon the merits of the evidence. Where review of the case results in a decision that a reopening is not appropriate, a memo is to be prepared for the file responding to the request for review. The case file is then returned to the appropriate office with jurisdiction over the claim.

c. Insufficient Evidence to Pursue Reconsideration or Reopening. In any situation where non-specific evidence or correspondence has been reviewed, clarification has been sought, but not received from a claimant, and there is determined to be insufficient reason to warrant action, the DD or the FAB-NO Branch Chief is to file all the documentation in the case record. A memo is to be placed in the case record which indicates that the non-specific evidence has been reviewed and found insufficient to warrant further action. No decision is required at that time, as no specific action has been requested or deemed warranted.

5. Reopening and Vacating a FAB Decision. The decision to reopen a case or vacate a FAB remand is explained in a Director's Order. A Director's Order is prepared under the signature of the DEEOIC Director or an individual with delegated reopening authority.

a. Director's Order Content. A Director's Order contains three components.

(1) Cover Letter. The cover letter is addressed to the claimant(s) receiving the Director's Order. It cites the authority by which a Final Decision or Remand Order is being vacated, and provides a summary of the issue under review, a clear indication of all actions taken under the Order and the reopening conclusion.

(2) Director's Order. A Director's Order is the written notice which explains the basis for reopening and vacating

a FAB decision. It is generally divided into three parts; including: a Background section, which discusses the history of the case record leading to the Final Decision under contention; a Discussion section which includes analysis of the evidence supporting the decided outcome; and a Conclusion (See Exhibit 1). The decision narrative is to provide descriptive explanation of the rationale supporting the reopening and the basis for vacating a FAB Final Decision or remand. This may entail the identification of misapplied program policy or incorrect interpretation of evidence. A Director's Order may provide corrective action instruction to a district or FAB office responsible for the case record.

(3) Certificate of Service. This confirms the mailing date of a Director's Order, and lists the name and address of the intended decision recipient. A Certificate of Service is completed individually for each claimant (or his or her authorized representative) who is party to the Director's Order. It must be date stamped on the date of decision mailing.

b. Reopening Multiple Claimant Claims. Given the procedure requiring each individual in a multi-claimant case record be party to any decision determining benefit entitlement, situations may arise which require a Final Decision be reopened for a new Recommended Decision and/or Final Decision to be issued. This may be the result of new evidence presented after a Final Decision; or the development of new circumstances that necessitate reopening, such as the identification of a new eligible survivor. In some situations, the new evidence may only affect one claimant; however, if there is any evidence justifying the reopening of one claim, all claims associated with the case file are to be reopened, and all parties to the claim are to be included in a new decision.

c. District or FAB Offices are Responsible for Complying With Any Guidance or Instruction Provided in a Director's Order.

d. Disagreement to DEEOIC Director. In certain situations, a DD or the FAB-NO Branch Chief may disagree with a Director's Order issued by the DEEOIC Director. Such disagreements must be brought to the attention of the Director immediately. However, the Director will entertain only disagreements deemed material to the potential outcome of a claim. The DD or FAB-NO Branch Chief must comply with the determination of the Director once any disagreement with a Director's Order is addressed.

6. Denying a Specific Request for a Reopening. A Denial of Reopening Request is a written decision issued by either the DEEOIC Director or a designated representative. The content of a denial is similar to that of a Director's Order in that it contains a cover letter, decision notice, and Certificate of Service. Much like a

Director's Order the decision notice provides a background of the case history leading up to the decision under contention, and a discussion of the evidence or argument presented in support of a reopening. However, the decision must provide a detailed explanation as to why the evidence presented is insufficient to warrant reopening of a Final Decision or Remand Order (Exhibit 2). Each objection presented by a claimant is to be addressed in a denial of reopening.

a. Issuance of a Denial of Reopening Request is to be Limited to the Individual(s) Requesting Review of a Final Decision.

b. Denying a Request to Vacate a FAB Remand Order. Only the DEEOIC Director may vacate a FAB Remand Order. In most instances, a reopening review of a Remand Order will originate from within DEEOIC due to the identification of misapplied program policy or challenge to FAB's rationale for returning a case to the DO. Upon review of the matter, should the Director agree with the Remand Order, he or she will deny the request to vacate by issuing a memorandum to the requesting party. Otherwise, a Director's Order is to be issued to the claimant(s) which vacates the remand under review and returns the matter to the appropriate office for handling.

7. ECS Implications. All reopening requests, requests to vacate FAB decisions, and decisions granting or denying such requests must be properly documented in the Energy Compensation System (ECS) pursuant to DEEOIC procedures.

Exhibit 1: Sample Director's Order to Reopen

Exhibit 2: Sample Denial of a Request for Reopening

2-2000 Energy Case Management System--General

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1. Purpose and Scope. This chapter describes in general how to use the Energy Case Management System (ECMS). It focuses on the early and developmental stages of a claim. Codes for decisions rendered by the District Offices (DOs), Secondary Claims Examiner (CE2) Unit, and the Final Adjudication Branch (FAB) are addressed in EEOICPA PM 2-2100. The information in this chapter applies to both ECMS B and ECMS E unless otherwise indicated.

2. ECMS Components.

a. Case Information Screen. The Case Information screen is used to maintain core employee-related personal information from Form EE-1 and Form EE-2. Also included on this screen are CE assignment, case and DO locations, both current and historical.

b. Work Site Screen. The Work Site screen is accessed through the case screen and is used to enter and update data on all relevant work sites reported for an employee. This data is found on Form EE-3 (Employment History), and also includes any new worksites discovered throughout the development of the case.

c. Claim Screen. The Claim screen is used to maintain individual claim (including employee and/or survivor) relevant information for each claim filed. This includes filing, receipt and creation date in ECMS, as well as a record of actions made for a claimant during the adjudication process in the claim status history. The medical conditions and payee information are also accessed through this screen.

d. Claim Status History Screen. The Claim Status History screen is used to enter codes for events taking place during adjudication. Claim Status History displays the actions that have taken place and the date of each action.

e. Medical Condition Screen. The Medical Condition screen is used to enter medical conditions reported for each case/claim. All conditions are updated throughout the development process with relevant information, such as ICD-9 codes, condition status, PoC information, medical status effective dates, and diagnosis dates.

f. SEC/SEC Desc Screen (ECMS B only). The SEC/SEC Desc screen is used to enter and update SEC data reported on Form EE-1, Form EE-2, and/or Form EE-3. If it is claimed that an employee worked at an SEC facility, that SEC ID is entered in this field. This field records that an SEC facility has been claimed, not that it has been verified.

If SEC is marked on the claim form, and no SEC site is listed on the EE-3, use 'unspecified' in the SEC description field.

g. Payee Screen. The Payee screen is used to enter payee information from Forms EE-1 and EE-2. This screen is updated as payees become eligible or ineligible for compensation. Upon eligibility, updated Electronic Funds Transfer (EFT) or payment

mailing information is added.

3. Receipt of Claim in District Office. Case Create procedures are covered in EEOICPA PM 1-300. When a claim is received in the DO, the Case Create Clerk (CCC) enters the data into ECMS. The fields are completed as follows:

a. General case assignment information entered by the CCC.

(1) CE name. From the list box, the CCC selects the responsible CE, based on internal DO procedures.

(2) Location. From the list box, the CCC selects the location of the Responsible CE. The location codes are unique for each individual in a DO and are assigned by the DO.

b. Form EE-1/2. The CCC enters the following fields directly from Form EE-1/2:

(1) Employee SSN, Name, and Address.

(2) Survivor Information (if applicable). This includes survivor name, sex (M-Male or F-Female), SSN, date of birth, relationship to the deceased, address, and telephone number(s).

(3) Employee Census Information. This includes Date of Birth, Date of Death (if applicable), Sex (M-Male or F-Female), Autopsy Indicator (if applicable), and Autopsy Facility 'Y' for Yes (if applicable).

(4) Employee Dependents (if applicable). 'Y' for Yes or 'N' for No is selected for spouse, child, or other._

(5) Employment Classification. If any field (DOE, Atomic, Beryllium, Uranium, Other) is checked on the claim form (Form EE-1/2 prior to April 2005, Form EE-3 for April 2005 or after), then the appropriate field(s) must contain a 'Y' for Yes on this screen. If a field is not checked on the claim form, the following are acceptable: '-', 'N'.

(6) Filed dt. The date the claimant sends Form EE-1/2. This is the earliest of the following: postmark date or date stamp in the Resource Center or DO (but not earlier than July 31, 2001 for Part B or October 30, 2000 for Part E). The envelope must be kept with the claim form and put in the case file.

(7) Rcvd dt. The actual date the DO receives Form EE-1/2, as shown by date stamp.

(8) Signature dt. The date the claimant signed Form EE-1/2, but not earlier than October 30, 2000.

(9) Recvd RECA ind. For the questions "Have you (or the deceased employee) applied for an award under Section 4 of

the Radiation Exposure Compensation Act (RECA)?" and "Have you (or the deceased employee) applied for an award under Section 5 of the Radiation Exposure Compensation Act (RECA)?" the CCC selects 'Y' if the "YES" box is checked on either question, or 'N' if the "NO" box is checked on both questions. If neither box is checked, the CCC leaves the indicator blank.

(10) Civil lawsuit ind. For the questions "Have you (or the deceased employee) filed a lawsuit seeking either money or medical coverage for the above claimed condition(s)?" and "Have you (or the deceased employee) filed any workers' compensation claims in connection with the above claimed condition(s)?" and "Have you or another person received a settlement or other award in connection with a lawsuit or workers' compensation claim for the above claimed condition?" the CCC selects 'Y - SWC Checked Yes on Claim' if the "YES" box is checked on the claim form for either question, or 'N - SWC Checked No on Claim' if the "NO" box is checked. If neither box is checked, the CCC leaves the indicator blank.

b. Worksite. The CCC enters all relevant worksite information directly from the claimant's Form EE-3. This includes all potentially covered worksites and any contractor/subcontractor employment that either is or could possibly be directly related to Department of Energy (DOE) employment. The criterion is whether the CE must gather employment verification for that worksite.

If the CCC is unsure as to whether to enter a worksite, the CCC references the DOE Facility List, or seeks further guidance from a supervisor. If the CCC determines that a worksite might be a contractor or subcontractor, but the DOE facility to which the worksite is connected is undetermined, that worksite is entered with the worksite ID '0998 - Not specific in DOE table', and the contractor/ subcontractor name listed out in the 'Notes' field.

The following information for each worksite comes directly from Form EE-3:

(1) Position Title. This field matches the 'Position Title or Mine/Mill Activity' from Form EE-3.

(2) Work Start Dt. This date matches the 'Start Date' field on Form EE-3. The CCC enters the exact date entered on the form, unless the date is partially written. If the month or date is missing, the CCC enters '01/01' as the placeholder. For example, if the form shows 1969, the CCC enters 01/01/1969. If the date is left blank on Form EE-3, the CCC leaves the date blank.

(3) Work End Dt. This date matches the 'End Date' field on Form EE-3. The CCC enters the exact date shown on the

form, unless the date is partially written. If the month or date is missing, the CCC enters '12/31' as the placeholder. For example, if the form shows 1969, the CCC enters 12/31/1969. If the date is left blank on Form EE-3, the CCC leaves the date blank in ECMS.

(4) Note. If the CCC enters the Worksite Desc field with the worksite ID for '0998 – Not specific in DOE table', then the contractor/subcontractor name is listed out in the 'Notes' field. Also, if there are several consecutive dates of employment at the same worksite with different contractors/ subcontractors, this can be entered under one worksite entry with the various dates and contractors/subcontractors listed out in the notes field.

(5) Dosim Badge Ind. The CCC completes this field with a 'Y' for Yes, 'N' for No, or leaves it blank based on the answer to the question "Was a dosimetry badge worn while employed?" on the Form EE-3.

(6) Badge No. If a badge number is provided on the Form EE-3, the CCC enters it in this field.

c. Medical Conditions. All reported conditions on Form EE-1/2 must be entered. If there are multiple claimants on a case and they claim different illnesses, generally all claimed illnesses must be entered for all claimants. The exception to this is when an employee files and then dies and the survivor claims something different or if a survivor specifically is not claiming an illness because he or she may have received a state workers' compensation or tort settlement. See EEOICPA PM 1-300 as to whether medical conditions should be entered into ECMS B, ECMS E, or both. The CCC looks at all the conditions claimed on Form EE-1 (Box 8) or Form EE-2 (Box 14) and matches each condition with a code from the list box in the Cond Type field on the Medical Condition Screen.

(1) If the claimant lists an occupational illness under Part B, each condition must be entered individually in the Cond Type field.

CODE	Covered Medical Condition Types
BD	Chronic Beryllium Disease
BS	Beryllium Sensitivity
CN	Cancer
CS	Chronic Silicosis
OL	Other Lung Conditions (Covered for RECA Only)
MT	Metastatic Cancer (Secondary cancers)

(2) For all cancer ('CN') and other lung ('OL') conditions, the CCC enters the specific type of cancer or lung condition reported on the claim form in the Notes text field.

(3) If the case is "B Only", and the claimant lists a non-covered condition, each non-covered condition must be entered individually in the Cond Type field in ECMS B. The CCC selects from the list box any conditions shown on the claim form.

For example, if the illness claimed is hearing loss, the CCC selects 'HL' from the list box in the Cond Type field on the Medical Condition screen. No further explanation is required in the Notes Text field, since the condition type indicates the condition reported.

(4) The CCC selects '99' (Other Condition – not in table) from the list box if the reported condition does not appear in the list box. He or she also types the reported condition in the Note Text field as it appears on the claim form.

For example, if the condition cuts/bruises is reported on the claim form, the CCC selects 99 from the list box and in the Note section types "cuts/bruises."

If the claimant lists multiple non-covered conditions which are not in the list box, the conditions can be listed under one '99' condition type, although each individual condition must be listed in the Note Text field.

(5) If no condition is reported on Form EE-1/2, the CCC selects 'NR' from the list box.

CODE	Non-Covered Medical Condition Types for Part B
99	Other Condition - not listed in table
AN	Anemia
AS	Asbestosis
BK	Back or Neck problems
BT	Benign Tumors, Polyps, Skin Spots
BU	Burns
CL	CLL (Chronic Lymphocytic Leukemia)
CT	Cataracts
DI	Diabetes
HF	Heart Failure/ Heart Attacks/Hypertension
HL	Hearing Loss
HM	Other Heavy Metal Poisoning (e.g. chromium, cadmium, arsenic, lead, uranium, thorium, and plutonium)
MC	Multiple Chemical Sensitivity
MP	Mercury Poisoning
NE	Neurological Disorder
NR	No condition reported
OL	Other Lung Conditions: Bronchitis; Asthma; Pulmonary Edema (Considered covered only for RECA claims)
PD	COPD (Chronic Obstructive Pulmonary Disease); Emphysema
PK	Parkinson’s Disease
PL	Pre-Leukemia
PP	Pleural Plaques
PS	Psychological Conditions
RN	Renal Conditions (e.g. kidney failure, kidney stones)
TH	Thyroid Conditions (e.g. Hypothyroidism)

4. General ECMS Coding. Each development action taken requires a

claim status code entry. It is necessary to enter the claim status code only in the specific system, B or E, to which the development action pertains.

a. Part B Only. For these claims, all claim status coding is entered directly into ECMS B.

b. Part E Only. For these claims, all claim status coding is entered directly into ECMS E.

c. Part B/E Claims, Both Active. Where Part B and Part E are both still active (i.e., both are currently in development), all development actions (i.e., employment verification, medical or survivorship development) must be entered into both ECMS Part B and ECMS Part E if they apply to bot

For example, upon receiving a Form EE-5 back from DOE, the 'ER' code is necessary in BOTH systems. Since the case is B/E, the code is entered in ECMS B and ECMS E.

Note: Some ECMS entries (coding for Document Acquisition Request (DAR), Former Worker Protection (FWP) requests, Site Exposure Matrices (SEM) usually pertain to Part E development and are usually entered in ECMS E only. However, there are circumstances where DARs, FWP requests, and SEM searches are completed relevant to the development of the Part B case, such as placing an employee on Line 1. In these types of circumstances these usual E only codes can be entered in ECMS B.

d. Part E/B Claims, Only One Part Active. Where just one part is currently active (i.e., a final decision was issued previously under Part B of the claim, and the only part in development is Part E, or vice versa), development actions will be entered only in the system that corresponds to the currently active Part.

(1) To limit the number of key strokes and ensure that cases are keyed to the same location and transferred at the same time, some information on the first screen is shared between ECMS B and ECMS E. Case information, in addition to case notes and call ups, that automatically transfer between the two systems include:

- CE
- CE Assign Dt
- Dist Office
- Location
- Location Assign Dt
- Employee Name and Address fields
- Worksite fields

(2) However, when different medical conditions are claimed

under Parts B and E, the development code is entered only in the relevant part.

For example, if cancer is claimed under Parts B and E, and asbestosis only is claimed under Part E, and a development letter is sent to the claimant requesting additional medical evidence for the Asbestosis claim, the 'DM' code is entered in ECMS E only.

5. Development of a Claim. Although the CCC enters certain data elements from EEOICPA forms, the CE verifies all data entered. The CE is also responsible for updating all data elements throughout the adjudication process.

a. Worksite/Employment Verification. The CE confirms that ECMS correctly identifies all relevant worksite information listed on the Form EE-3, and is responsible for updating the employment information throughout the claims process.

The CE keeps ECMS updated with the latest worksite information in the case file. This includes updating the worksite table with any newly claimed or verified employment. As employment is developed and verified, worksite and date information should be updated accordingly. For any worksite and dates that are verified, the notes field must be annotated with *V as the first 2 characters to indicate the employment listed on that line has been verified. Other notes can be entered in the notes field, but *V must be the first 2 characters if the employment has been verified. There could be multiple line items of verified employment if there are multiple employers and dates that are verified. Claimed employment that is not verified must also be retained in a separate line item (or line items if there are multiple dates of employers). If the verified employment is the same as the claimed employment, then only a *V needs entered in the notes field. Since all claimed employment was verified, there would be no need for a line item to show what was claimed and not verified.

Upon receipt of an employment verification (e.g. DOE, Corporate Verifier, SSA response, Other), the CE updates the following fields with as much information as possible from the verifier. (Note: Each worksite time period could possibly be verified from multiple sources. Therefore, if multiple verification sources are used to verify a single timeframe, be sure to enter the overall employment timeframe that is considered verified.)

(1) Covered Emp Ind - This field (located on the case screen) must be completed by the time of the Recommended Decision (RD).

If the CE determines that the employee has covered employment under the EEOICPA, the field must be 'Y' for Yes.

If the CE determines that the employee does not have covered employment, the field must be 'N' for No. (As long as any employment is verified, this field will become 'Y' for Yes.)

(2) Cov Emp Start Dt and Cov Emp End Dt - This field was created with the assumption that employment would be continuous, which is not always the case. Completion of this field is optional.

(3) Worksite Desc - The worksite can be selected by clicking on the 'worksite' button and entering a DOE facility name in the 'worksite description' line and pressing the 'Select' button. If the exact name in the table is unknown, enter at least the first letter of the facility name, and select 'Look Up' to see a list of facilities that meet the search criteria.

If the facility is listed, highlight the correct choice and select the 'OK' button. The worksite can also be added by entering the worksite description number, if known, directly in the blank field next to the 'worksite' button.

If the CE determines that an employer might be a contractor or subcontractor, but it is undetermined where employment occurred, the worksite is entered with the worksite ID '0998 - Not specific in DOE table', and the contractor/ subcontractor name listed out in the 'Notes' field.

(4) Position Title - If the job title appears differently on the verification document received (e.g. DOE, Corporate Verifier, SSA response, Other) than it was listed on Form EE-3, the CE updates the field to reflect the verification document.

(5) Work Start Dt - The 'Work Start Dt' must match the 'From' or 'Start' date per the employer on the verification document received (e.g. DOE, Corporate Verifier, SSA response, Other).

(6) Work End Dt - The 'Work End Dt' must match the 'To' or 'End' date on the verification document received (e.g. DOE, Corporate Verifier, SSA response, Other). If the person is currently still working at the facility being verified, the CE enters the date the verification document was signed by the certifying official as the 'To Dt'.

(7) Note - This field is used at the CE's discretion. However, if the CE identifies that the employee worked for either a contractor or subcontractor, the CE enters the contractor/subcontractor name in this field.

b. RECA Indicator. The RECA Indicator shows whether the Department of Justice (DOJ) confirmed that the claimant or deceased employee received benefits under the Radiation Exposure Compensation Act

(RECA). The RECA indicator must be entered on all EEOICPA cases. The CCC enters 'Y' for Yes or 'N' for No, based on what was checked on Form EE-1/2. This includes RECA and non-RECA cases in all four DOs.

(1) The following are entered directly from Form EE-1/2:

(a) 'Y' – Yes - The claimant checked the Y box(es) indicating that he or she or the deceased employee applied for an award under Section 4 or 5 of the RECA.

(b) 'N' – No - The claimant checked the N box(es) indicating that he or she or the deceased employee did not apply for an award under Section 4 or 5 of the RECA.

(2) If the CE determines, after reviewing the claim, that it may be a RECA claim filed by a uranium worker or a survivor of a uranium worker, the CE leaves the RECA Indicator (Y/N) blank, or as entered by the CCC, until confirmation is received from DOJ. After a confirmation letter is received from DOJ, the CE inputs one of the following RECA Indicator codes:

(a) '4' - Used when the employee or RECA survivor is confirmed as a RECA Section 4 award recipient.

(b) '5' - Used when the employee or RECA survivor is confirmed as a RECA Section 5 award recipient.

(c) 'X' - The claim is non-RECA. The CE may enter the X indicator at any time to confirm his or her determination that the case is non-RECA. That is, an X entry is not tied solely to receipt of a letter from DOJ that confirms non-RECA status. The X is also used if there is a confirmed RECA Section 4 eligibility where the claimant has opted not to accept the award.

c. State Workers' Compensation (SWC) Indicator (EMCS E Only). This field reflects what is currently known about the status of any state workers' compensation claims.

(1) The following are entered directly from Form EE-1 or EE-2:

(a) 'Y - SWC Checked Yes on Claim' - The claimant checked the Yes box on Form EE-1/2, indicating that the employee/claimant filed a state workers' compensation claim.

(b) 'N - SWC Checked No on Claim' - The claimant checked the No box on Form EE-1/2, indicating that the employee/claimant has not filed a state workers' compensation claim.

(2) During development, the CE/Hearing Representative (HR)

updates this field to reflect the current status of the employee/claimant's state workers' compensation claim. The State Workers' Compensation Indicator must be entered on all Part E cases, even if no SWC claim was filed.

(a) 'X – Confirmed No SWC Claim' - Used when the employee/claimant is determined to have not filed a state workers' compensation claim.

(b) 'R – Benefits Rec'd; Reduce Comp' - Used when the employee/claimant is determined to have received benefits from state workers' compensation for an accepted Part E medical condition where compensation benefits must be reduced.

(c) 'S – SWC; No Reduce Comp' - Used when the employee/claimant is determined to have state workers' compensation, but there is no reduction in benefits required. This code is also used in the case of a denied SWC claim where the employee received no benefits.

(d) 'P – SWC Pending' - Used when the employee/claimant is determined to have a state workers' compensation claim that is currently pending.

(3) Once the existence of a SWC claim is verified, the CE accesses the 'SWC State' drop-down box and selects the state in which the SWC claim was filed (e.g.,'OH' if the claim was filed in the State of Ohio).

d. SEC Description. Completion of this field is no longer required. Historically, if the employee claimed to have worked at an SEC worksite, the CCC or CE was to identify the worksite in the SEC description field. This field recorded that an SEC facility had been claimed, not that it had been verified.

e. Employment Classifications. As discussed in Paragraph 3.b(5), if any field (DOE, Atomic, Beryllium, Uranium, Other) is checked on the claim form (Form EE-1/2 prior to April 2005, Form EE-3 for April 2005 or after), then the appropriate field(s) must contain a 'Y' for Yes on this screen. If a field is not checked on the claim form, the following are acceptable: '-', 'N'.

These fields are initially completed when the case is created and they are NOT tied to any employment verification received back from any source.

For example, if a claimant checks "Atomic Weapons Facility" on the claim form, this field should be changed to 'Y'. If it turns out the employee did not work at an AWE, or employment was not verified at an AWE, this field does not need to be updated to reflect that lack of employment.

However, the CE must update these fields in certain circumstances to

reflect something other than 'Y', '-', or 'N'. These circumstances are outlined below.

(1) Since there is no "Subcontractor" field in ECMS, if the CE determines that an employee could have worked for a subcontractor at a DOE facility, he or she must update the 'DOE' field with an 'S'.

(a) If Form EE-3 or another type of employment documentation (e.g., affidavit) shows that the employee worked for a private employer at a DOE facility (e.g., Joe's Electric Company at Hanford), and the CE determines that a reasonable link exists between the employer (a subcontractor) and a DOE facility, the CE identifies the case as one with a subcontractor.

To do this, the CE selects 'S' (a subcontractor at a DOE facility has been identified) from the DOE list box in the Employment Classifications Field, Case Screen. The 'S' code permanently replaces the 'Y' code in the DOE list box.

(b) After entering the 'S' code, the CE continues to develop the employment aspect of the claim to determine whether employment can be verified with a DOE subcontractor. If the CE determines that the employee did not work for a verified subcontractor at a DOE facility, the 'S' code remains in the DOE list box (Employment Classifications Field, Case Screen).

For the 'S' code to be used, employment with a subcontractor at a DOE facility need not be confirmed, but there must be evidence that such employment was claimed.

(c) The CE enters the 'S' code only once regardless of whether the employee worked for one or multiple DOE subcontractors.

(2) If the CE reviews claimed AWE employment and determines that the period is entirely outside of the weapons-related production period and either partially (meaning partially during the residual contamination period and partially after the residual contamination/ non-covered period) or entirely during the site's period of residual radioactive contamination, the CE enters an 'R' into the AWE worksite indicator field. The 'R' represents that employment at an AWE site is qualifying solely on the basis of residual contamination.

This code has not always been in existence and must be backfilled for prior claims as encountered. If employment at multiple AWE sites is claimed and at site's qualifying

employment is solely due to residual radiation, utilize the 'R' code.

f. Claim Status History Coding. Generally, for every development action taken by the CE, there is a corresponding claim status history code to document that action. And for every claim status code, there must be corresponding file documentation. See Paragraph 6 below for detailed instructions for claim status history coding.

g. Coding Actions Taken by RC. Where the claim was filed at the RC, the RC prepares a memorandum accompanying all submissions of claim materials to the DO/CE2 Unit for case create. The memo chronologically outlines RC actions. The CE reviews the memo and enters the proper coding into ECMS to correspond with the date of occurrence in the RC. No coding is done at the RC.

(1) The CE deletes the 'UN' code upon entry of the code indicating a RC action took place on a date prior to the case create date, since all RC actions must be entered into ECMS corresponding with the actual date upon which they took place.

(2) The CE enters the 'OR' claim status code to correspond with the date on which the ORISE search took place at the RC. The ECMS status effective date is the date the RC searched ORISE. The code is entered whether the ORISE search confirms employment or not.

(3) The CE enters the 'ES' and/or 'CS' claim status code(s) with a status effective date of the date on which such action(s) was taken in the RC. If the CE enters an 'ES', he or she then enters the appropriate reason code from the drop down menu, which includes the Operations Center and that Form EE-5 was sent [e.g., 'AL5 – Albuquerque Operations Office (EE-5)']

(4) The CE enters the 'DO' claim status code, and selects the reason code 'OH - Occupational History' with a status effective date of the date on which the occupational history questionnaire (OHQ) was completed by the RC as noted on the RC memo to the DO. (This applies to completion of OHQs from follow-ups and reworks, discussed below, as well.)

The CE should also "close out" the OHQ assignment (or follow-up or rework) in this manner if the RC attempted to complete the OHQ, but was unsuccessful because the claimant could not be reached or refused to complete it. The status effective date in this type of situation is the date of the RC memo to the DO/CE2 Unit explaining why the OHQ could not be completed.

Note: If the OHQ is completed by an authorized rep, it is not valid and should not be coded as completed in ECMS.

(5) The CE enters the 'RC – Resource Center' claim status code when making assignments to the RC on identified existing cases in ECMS that require occupational history development. The CE selects the appropriate reason code from the drop down menu to reflect the appropriate type of assignment to the RC:

(a) 'AS' – Assignment – This reason code is selected when an initial assignment for an OHQ is made to the RC. For example, a claim is filed with the DO instead of the RC and the OHQ needs to be completed. The status effective date is the date of the DO memo to the RC outlining the assignment task.

(b) 'FW' - Follow-up – This reason code is selected when the DO/CE2 Unit identifies a need for a follow-up interview because of issues that arise out of development. The status effective date is the date of the DO/CE2 Unit memo to the RC outlining the follow-up task.

(c) 'RK' – Rework – This reason code is selected when an error is found in the final product from the RC. Reworks are not generated out of an issue identified by the DO as an area in need of additional development, but arise when the CE identifies a deficiency (i.e., incomplete or inaccurate data).

The status effective date is the date of the DO/CE2 Unit's memo to the RC outlining the rework task.

h. Employee Medical Condition. The CCC enters information directly from the claimant's Form EE-1 or EE-2. The CE updates ECMS with additional medical information as it is received, including new, relevant medical conditions that are reported or discovered during development of the case. The CE is responsible for updating ECMS with the latest medical information in the case file.

ECMS requires entry for each employee's medical condition(s) for each claimant. For multiple claimants, the CCC enters and the CE updates all medical conditions claimed for each claimant. [Note: the CE enters and updates any new medical conditions identified for data entry while in the development process.]

(1) Reported Ind - If the claimant reported the medical condition on Form EE-1 or Form EE-2, this field will be 'Y', for Yes. If the CE discovers another medical condition that needs to be developed, the CE enters the new medical condition with the 'Reported Ind' field as 'N', for No.

(2) Cond type - The CE verifies the accuracy of the information entered by the CCC and makes changes as needed. Every condition claimed is entered as a medical condition

for each claimant. Even if claimants claim different medical conditions, and they all pertain to the employee, each must be entered for each claim into ECMS B and/or E.

For example, if there are two child claimants, C1 and C2, where C1 claims lung cancer and C2 claims prostate cancer, both C1 and C2's claim screens would reflect both lung and prostate cancer.

The CE updates the Condition Type field on the Medical Condition screen as new conditions are reported or discovered (possible work-related or covered conditions only, as well as all secondary cancers) during case development. The CE enters these updates as they occur.

(3) Diagnosis dt - The claimant might list a diagnosis date on Form EE-1 or EE-2, and if so, the CCC enters the date. However, this date is not always accurate, and the CE must confirm the date through the medical evidence. The diagnosis date is considered the earliest date of any test, pathology or doctor's report evident in the case file referring to the diagnosis of the covered condition.

(4) ICD9 - The ICD9 can be selected by either clicking on the 'ICD9' button and entering a medical condition (or just alpha characters) in the 'V14 ICD9 description' line, and pressing select, or entering the ICD9 number directly in the blank field next to the 'ICD9' button.

This field is required for all conditions where the case file is being sent to NIOSH, and for all conditions that are 'Accepted'. An ICD9 is not required for non-covered conditions in ECMS B, or for medical conditions that are 'Denied' (unless the case was sent to NIOSH) or 'Reported'.

(5) Note - This field is used at the CE's discretion. However, if the employee has a condition not specifically listed in the 'cond type' field, so the condition type is '99-Other (Not Listed)', the CE enters (or assures that the CCC entered) the medical condition claimed in this field.

(6) Cond status - This status code represents the outcome of each claimed medical condition at the time of the decision. Generally, this is coded at time of recommended decision. However there are some exceptions, such as when the DO or CE2 Unit renders a decision on a consequential injury or inputs a prior approval for medical bill payments. Another exception would be if the decision on a medical condition is remanded, reversed, or vacated.

(a) Using the 'R' status code: In the creation of a medical condition entry or in the adjudication of a claim, the medical cond status list box in the Medical Condition screen will default to an 'R' status code.

The ‘R’ status code equals what is ‘Reported’ by the claimant, usually on Form EE-1 or EE-2.
The medical condition status will remain ‘R’ until a recommended decision is rendered on that condition. Essentially, ‘R’ equals pending adjudication. So, if a decision is issued that defers a decision on a medical condition, that condition’s medical condition status will remain in an ‘R’ status.
If the decision on a medical condition is remanded or vacated, its medical condition status should be changed back to ‘R’ until a new recommended decision is issued.
(b) When a recommended decision is issued that accepts a medical condition, the medical condition status for that condition is changed from an ‘R’ (Reported) to an ‘A’ (Accepted). An ‘A’ code indicates that medical benefits associated with that condition should be paid for an employee claimant or that a survivor is eligible for benefits related to the employee’s development of that condition. The DO/CE2 Unit can also enter ‘A’ to award medical benefits for consequential injuries or for bills to be paid on prior approvals.
Note that for employee cases, use of the ‘A’ code alone will not create an eligibility file for medical benefits. All of the coding discussed in Paragraph 2 of Chapter 2-2100, including a final decision code to accept, must be completed before medical bills will be payable. The FAB must ensure the associated medical coding is correct.
(c) When a recommended decision is issued that denies a medical condition, the medical condition status is changed from an ‘R’ to a ‘D’ (Deny). A ‘D’ code is used any time a condition is being denied, whether the denial is for insufficient medical evidence, inability to establish causation, lack of covered employment, or ineligibility of the survivor. If the condition is not being accepted or a decision on that condition is not being deferred, it is denied.
(d) When a claim for a condition is withdrawn, the associated medical condition field(s) must be deleted, a note entered into ECMS case notes, and the file documented. If it is the only claimed condition, the claim can be administratively closed.
(e) When a case is known to be affected by a surplus where the employee’s medical bill payment must be suspended until the surplus is absorbed, the FAB representative changes the affected medical condition from an ‘A’ to an ‘O’ (Offset) status. This prevents

medical bills from being paid related to that condition until the surplus is absorbed and the 'O' status is changed back to an 'A'. The remaining medical related coding for offset cases is the same as outlined in this chapter.

(7) Status effect dt - This field defaults to blank whenever a condition is entered on the medical condition screen. This field must be changed for all 'A' medical conditions. The 'status effect dt' is equal to the 'filed dt' for all claimed conditions. This field is required for all employee and survivor claims on accepted medical conditions.

For consequential illnesses that are being accepted, the status effective date is equal to the filing date of the underlying accepted condition.

(a) For multiple survivor claims, ECMS does not allow a status effective date earlier than the claim filing date. The CE enters each survivor's own claim filing date. This field is only required for Accepted medical conditions.

(b) For all medical conditions with the medical status condition of 'R' or 'D', no date is necessary. [In earlier versions, ECMS used to default this field to the current date. It is not considered an error if there is a date entered for conditions of the 'R' or 'D' status.]

(8) Elig end dt - This field remains blank unless there is an actual end date to the eligibility of medical benefits. The 'Elig end dt' must be filled in when a condition is 'A' and the case file has a recommended or final decision to accept, and the CE is aware of an end date for medical benefits. This happens when an employee files a claim for benefits and then dies during or after adjudication, and some medical bills will be covered prior to death, or a consequential illness is only acceptable over a period of time, or for prior approvals that should be paid for a specific day or period of time. Otherwise, the field remains blank.

(9) PoC (Probability of Causation) - After the CE runs the National Institute for Occupational Safety and Health (NIOSH) Interactive RadioEpidemiological Program (IREP), the results of the 'PoC' are entered. [If the case is a B/E case, the PoC (and date and version of IREP) is entered into ECMS B and ECMS E.]

For a single cancer, the total from the '99th Percentile' line is entered in this field. For multiple cancers, the CE runs each primary cancer 'Probability of Causation for

Multiple Primary Cancers'. The grand total, under 'Result: Total PC', is entered for PoC for each cancer included.

For every cancer included on the NIOSH Referral Summary Document (including any Amended NRSD), a PoC is required in that medical condition's PoC field, even if an IREP is not run for that particular cancer.

For example, if three primary cancers are sent to NIOSH, and the dose reconstruction includes an IREP for only one cancer since the PoC is already over 50%, the total result is entered for all cancers sent to NIOSH.

If there are additional metastatic cancers that are not sent to NIOSH, the PoC result is not entered in ECMS for these cancers. The med cond status, however, must be updated to 'A' or 'D' based on the result of the dose reconstruction.

(10) PoC dt - The PoC date is the date the NIOSH-IREP is run in the DO/CE2 Unit, as reflected on the NIOSH IREP Probability of Causation Results printout.

(11) IREP version - The CE takes the NIOSH-IREP version directly from the CDC/NIOSH website. For example, the IREP heading states, 'Interactive RadioEpidemiological Program, NIOSH-IREP v5.2'. The actual IREP version is '5.2'. The CE enters 5.2 in this field. The version is also listed on the NIOSH IREP Probability of Causation Results printout. For CLL cancer-only, where no IREP is run, the CE enters 'N/A' in this field.

i. Medical Exceptions for ECMS Coding. There are two exceptions to the above coding requirements. One occurs when an employee files a claim and dies prior to an acceptance, and the other occurs when the CE must set up payment options for medical appointments, consultants and records before the case is accepted.

(1) Since ECMS was set up to download medical information from employee claims to the eligibility file that is used by the bill processing agent, the employee's claim needs to be updated with certain data to allow for payment of medical bills between the employee's filing date and date of death, even though the final decision to award those benefits is coded on the survivor's claim.

To ensure that data is properly downloaded for medical benefits, the CE must ensure the following is completed on the employee's claim prior to entering the final decision code on the survivor's claim:

(a) Enter the employee's date of death on the case screen.

(b) Enter the 'C3' claim status code, with a status

effective date of the date when the Resource Center, DO/CE2 Unit, or FAB was notified of the death (i.e., phone call, letter), whichever is earlier.

(c) For ALL accepted medical conditions on the case, the CE enters or updates the following information for the employee claim:

(i) Correct medical condition type.

(ii) Correct ICD-9 of the condition.

(iii) Med cond status of 'A' (for accepted).

(iv) Status effective date, which is the employee's claim filing date.

(v) Eligibility end date, which is the employee's actual date of death.

(2) When a case is referred to a District Medical Consultant (DMC), sent out for a second opinion, or approved for payment of fees for the release of medical records to DOL, the CE uses ECMS to set up the 'prior approval' process through the medical bill processing contractor. The CE enters the prior approval as if entering a new medical condition. The following fields are required:

(a) cond type – Select 'PA', for prior approval

(b) ICD-9 code – See chapter 2-0800 for the appropriate ICD-9 code to enter in different situations.

(c) status effective date - Enter the date of the medical exam for second opinions, or the date of referral for DMC or authorization for medical records.

(d) eligibility end date - Enter the date of the medical exam for second opinions, or the date of the DMC's response or medical records are date-stamped as received in the DO.

(e) medical condition status – Change the medical condition status to 'A'.

j. Payee Information. The CCC enters information directly from the claimant's Form EE-1 or EE-2.

(1) Change of Address and/or Phone Number - If address changes are documented, the CE forwards that information to the PCA (Payee Change Assistant) to update ECMS. The CE updates ECMS with any changes to the claimant's telephone number.

(2) Eligibility Ind – This field identifies whether or not a claimant is eligible for compensation, either in the form

of a lump sum payment or medical benefits. This field defaults to 'N', for No, and the CE updates the 'Eligibility Ind' only if a case is in posture for a Recommended Accept decision. The 'Eligibility Ind' is then changed to 'Y', for Yes. During adjudication, and if the case is in posture for a Recommended Denial decision, the indicator remains 'N', for No.

6. Claim Status History Coding. Generally, for every development action the CE takes, there is a corresponding claim status history code to document that action. And, for every claim status code, there must be corresponding file documentation.

Only development actions taken on that particular claim are to be entered for a claimant. For example, any employment action codes to DOE, Corporate Verifiers, or SSA are related to all claims in the case, and are entered for each claimant. However, if individual development actions are related to a particular claimant(s) only, then the claim status codes are entered for the applicable claimant(s) only.

Note: Telephone calls recorded in the Telephone Management System (TMS) do not qualify as actions that require a claim status code (except for telephone calls to a corporate verifier, see 'DE' and 'CS' coding, discussed in this chapter).

If, for example, the CE telephones the claimant and asks for medical documentation, that is not considered the development action. The CE follows up in writing for any requested information sought over the telephone. For the letter documenting the requested information, the CE enters the appropriate claim status coding. The following are the current claim status codes, organized by action type:

a. Development Action Codes. When selecting which code to enter, the development code is to be as specific as possible to the corresponding action. If there are multiple issues included in one letter, select the development code that best fits the overall content.

For example, if a single letter requests both medical 'DM' and survivor 'DO' information, the CE would select 'DO' because it represents the contents of the letter better than 'DM', which would exclude the survivorship development. Only one code is to be entered, since the development was done in one letter.

Since every development action requires a development code, if two actions are taken on the same date, such as requesting medical information from the claimant and sending a NIOSH smoking history questionnaire, these are different actions. The development letter is coded 'DM', while the NIOSH smoking history questionnaire is coded 'DO.' Even though they might be mailed in the same envelope, they are still considered separate actions.

Only development actions pertinent to the adjudication of the claim

require a code. Items such as acknowledgement letters do not require a code.

(1) DB - 'Developing Both Medical and Employment'- For development that includes both medical and employment, the CE enters the 'DB' code. This could be either one development action that includes both medical and employment, or two separate actions, one for medical and one for employment, but completed on the same date.

This should not include initial employment verification requests or follow-up on employment verification to DOE, SSA, CPWR, or a corporate verifier. [All initial requests require use of the 'ES', 'CS', 'SS', or 'US' code with the appropriate reason code, and follow-up to the various employment verification sources requires use of the 'DE' code with the appropriate reason code.]

The status effective date is the date of the letter.

(2) DE - 'Developing Employment' - When developing initial or follow-up employment directly with the claimant, searching the subcontractor database, or as a follow-up to DOE (for DARs or EE-5s), a corporate verifier, CPWR, or the SSA, the CE enters the 'DE' (Developing Employment) claim status code.

The status effective date of the 'DE' code is either the date of the letter to the claimant, the date the subcontractor database is searched, or the date of the follow-up action to the employment verifier. 'DE' is not used for initial development to employment verifiers (except for the CPWR database search), only follow-up.

Certain verifiers (e.g. corporate verifiers, SSA) have asked to be contacted by telephone. The printout of the telephone call will serve to document the development action for those. The CE enters the 'DE' with the status effective date of the telephone call. Verification will still need to be in writing.

Upon entry of the 'DE' code, the CE selects a specific reason code from the 'reason cd' field. This field is a drop-down box that corresponds with the 'DE' claim status code. Included in the reason cd field are both the full reason for the 'DE' code and a two-character code representing each option. The reason codes available for the 'DE' claim status code are:

(a) Follow-up Letter to Claimant/Other(s) - 'LE' - Used for initial or follow-up letters mailed directly to the claimant or other entity (for miscellaneous employment issues, such as affidavits or subcontractor issues) when asking for employment clarification or

information.

(b) Follow-up to DOE - 'DE' - Used exclusively for follow-up to the DOE for employment verification (EE-5).

(c) Follow-up to Corporate Verifier -'CS' - Used exclusively for follow-up to a Corporate Verifier.

(d) Follow-up to CPWR – 'US' - Used exclusively for follow-up to CPWR.

(e) Follow-up to SSA – 'SS' - Used exclusively for follow-up to the SSA.

(f) Document Acquisition Request – 'DAR' – Used for DAR second requests.

(g) CPWR Subcontractor Database Searched – 'CD' – Used when the CPWR subcontractor database is searched.

(3) DJ - 'Developing Department of Justice' – Deactivated. This code was used when a letter was sent to the DOJ requesting Section 5 award status, but it has been deactivated.

(4) DM - 'Developing Medical' - For any medical development the CE enters the 'DM' code, whether or not there is a claimed covered condition. If the CE sends a letter to the claimant stating that no covered condition was claimed, or if a covered condition is claimed and more medical evidence is sought, either from the claimant or a physician/hospital, the 'DM' code is used. This includes any initial development and/or follow-up.

The status effective date is the date of the development action. Upon entry of the 'DM' code, the CE has the option to select a reason code.

A reason code is not required for general medical development as listed above. However, there are two types of specific medical development letters that do require a reason code. The reason codes available for the 'DM' claim status code are as follows:

(a) DMB - Deny Specific Medical Benefits on Accepted Conditions – This reason code must be selected when an initial letter is sent to deny a specifically requested medical benefit (that is not currently being paid) on an accepted condition.

For example, a claimant requests a vehicle modification, but it is deemed "not medically necessary," and the request is denied. If the claimant challenges the decision, a more formal

decision is required (see the decision coding section in Chapter 2-2100.)

(b) RMB – Reduce Medical Benefits on Accepted Condition – This reason code must be selected when an decision is made to reduce a medical benefit that is currently being paid for an accepted condition.

For example, an employee was receiving home health care, but upon further evaluation, it is determined that the in-home health care is unnecessary and will no longer be a covered medical expense. If the claimant challenges the decision, a more formal decision is required (see the decision coding section in Chapter 2-2100.)

(5) DO - 'Developing Other'- When sending an initial or follow-up letter that does not solely address medical or employment issues, but includes some other development action (e.g., survivorship), or when sending initial or follow-up NIOSH questionnaires, the CE enters the 'DO' code with no associated reason code.

The status effective date is the date of the development letter. More specific development actions can be captured by selecting one of the following from the corresponding reason code drop down menu:

(a) OH – 'Occupational History' (E only) - Selected to reflect that an OHQ was completed or attempted.

(b) IM – 'Impairment' (E only) - Selected when letter developing impairment is sent.

(c) TD – 'Toxic Exposure Development' (E only) – Selected when a letter developing toxic exposure is sent.

(d) WL – 'Wage Loss' (E only) - Selected when a letter developing wage loss is sent.

(e) WI – 'Wage Loss and Impairment' (E only) – Selected when a letter developing wage loss and impairment is sent.

(f) E12 – 'EN/EE-12 Sent' (E only) – Form EN/EE-12 Sent.

(g) E10 – 'EN/EE-10 Sent' (E only) – Form EN/EE-10 Sent.

(6) 'SM' – Site Exposure Matrix (SEM) Searched – The CE enters this code into the claim status history when searching SEM for the first time. No coding is required for additional SEM searches unless SEM is consulted to develop causation for another claimed condition at another

time.

Regardless of the outcome of the SEM search, the CE places the search results in the case file to show that the search was conducted. The status effective date of the code is the date of the search, as reflected on the bottom right hand corner of the SEM printout.

b. Medical Action Codes.

(1) MS - 'Sent to Medical Consultant' - When a CE identifies a case for referral to a District Medical Consultant (DMC) or medical expert, the Medical Scheduler prepares the file for mailing. If the Medical Scheduler has claim status coding capability, he or she must enter the 'MS' code into ECMS. Otherwise, the Medical Scheduler must notify the CE once the package is mailed to the medical specialist so the CE can enter the 'MS' code.

The status effective date for the 'MS' code is the date of the cover letter of the referral package to the DMC. When entering the 'MS' code, the CE must select the appropriate reason code that describes the subject matter of the request.

The reason codes available are:

(a) Impairment (E only)- 'IM' - Used for a referral related to an impairment evaluation.

(b) Causation (E only)- 'CA' - Used for a referral related to establishing causation.

(c) Medical Condition Referral - 'MC' - Used for a referral related to establishing a claimed illness.

(d) Wage Loss (E only) - 'WL' - Used for a referral related to establishing wage loss.

(e) Other/Referred for Multiple Issues - 'OT' - Used for a referral encompassing several different reasons or any reason not listed above.

(2) MR - 'Received Back from Medical Consultant' - Upon completion of the review, the DMC returns the narrative report and the completed HCFA-1500 to the CE within 30 days of the referral. Upon receipt of the narrative report and the bill, the CE enters the code 'MR'.

The status effective date for the 'MR' code is the date the report from the DMC is stamped "received" by the DO. If the report received is insufficient, the CE should not code the MR code until a corrected report is received. When entering the 'MR' code, the CE must select the appropriate reason code that describes the subject matter of the response. The reason codes available are:

(a) Impairment (E only)- 'IM' - Used for a response related to an impairment evaluation.

(b) Causation (E only)- 'CA' - Used for a response related to establishing causation.

(c) Medical Condition Referral - 'MC' - Used for a response related to establishing a claimed illness.

(d) Wage Loss (E only) - 'WL' - Used for a response related to establishing wage loss.

(e) Other/Referred for Multiple Issues - 'OT' - Used for a response encompassing several different referral reasons or any reason not listed above.

(3) 2S - 'Sent for 2nd Opinion'- When a CE identifies a case requiring a medical second opinion, the Medical Scheduler prepares the documentation for mailing. If the Medical Scheduler has claim status coding capability, he or she must enter the '2S' code into ECMS. Otherwise, the Medical Scheduler must notify the CE once the package is mailed to the medical specialist so the CE can enter the '2S' code.

The status effective date for the '2S' code is the date of the cover letter of the referral package. When coding the '2S' code, the CE must select the reason code that describes the subject matter of the request. The reason codes available are listed below:

(a) Impairment (E only)- 'IM' - Used for a second opinion examination in support of impairment.

(b) Causation (E only)- 'CA' - Used for a second opinion examination in support of causation.

(c) Medical Condition Referral - 'MC' - Used for a second opinion examination in support of establishing a claimed illness.

(d) Wage Loss (E only) - 'WL' - Used for a second opinion examination in support of establishing wage loss.

(e) Other/Referred for Multiple Issues - 'OT' - Used for a second opinion examination encompassing several different referral reasons or any reason not listed above.

(4) 2R - 'Received 2nd Opinion' - Once the CE receives the medical narrative from the second opinion specialist and determines that it adequately addresses the CE's questions, the CE enters the '2R' code.

The status effective date for the '2R' is the date the medical narrative is date-stamped in the DO. When entering

the '2R' code, the CE must select the reason code that describes the subject matter of the response. The reason codes available are:

(a) Impairment (E only)- 'IM' - Used for a response related to a second opinion examination in support of impairment.

(b) Causation (E only)- 'CA' - Used for a response related to a second opinion examination in support of causation.

(c) Medical Condition Referral - 'MC' - Used for a response related to a 2nd opinion examination in support of establishing a claimed illness.

(c) Wage Loss (E only) – 'WL' – Used for a response related to a second opinion examination in support of establishing wage loss.

(e) Other/Referred for Multiple Issues - 'OT' – Used for a response related to a second opinion examination encompassing several different referral reasons or any reason not listed above.

c. Employment Action Codes.

(1) CS - 'Employment Verification Request Sent to a Corporate Verifier' - When an initial employment verification request is sent to a corporate verifier, the CE enters the 'CS' code. A 'CS' code is entered for each initial request. If the CE sends requests to two different corporate verifiers, then the CE enters two 'CS' codes.

The status effective date is the date of the letter to the corporate verifier. If the request is faxed, it is the date the fax was sent. (When the CE follows up on the initial request, no 'CS' claim status code is entered; rather, the CE enters the 'DE' claim status code with the 'CS' reason code.)

Certain corporate verifiers have asked to be contacted by telephone. For those verifiers, the printout of the telephone call serves to document the development action. The CE enters the 'CS' with the status effective date of the telephone call.

(2) CR - 'Complete Employment Verification Received from a Corporate Verifier' - The CE uses the 'CR' code only when the response from the corporate verifier is sufficient to establish that all information available has been provided. Such a response may address all of the claimed employment, or it may address some or none of the employment, if the corporate verifier notes that no other information is available. Such a response may also state

that the corporate verifier has no employment records for the individual.

The status effective date of the 'CR' code is the date the DO/CE2 Unit received the response, i.e., the date the written response is received.

The 'CR' code is NOT used when a follow-up to the corporate verifier is required because the response is returned blank, the information provided is confusing or incomplete, or the response does not indicate which period of employment is or is not verified.

(3) EC - 'Employment Verification Process Complete' - When multiple "sent" codes ('ES','CS') exist, and the CE receives a single response that confirms all outstanding employment dates, the claim is coded 'EC'. The 'EC' code signifies that a response has been received that fully addresses the employment issue and that further employment development is unnecessary.

The CE also uses the 'EC' code when issuing RDs to deny benefits if he or she determines that further development of the employment verification issue is unnecessary, since other evidence (or lack thereof) will result in a recommended denial. Only one 'EC' code is used no matter how many outstanding "sent" codes are in ECMS.

Whenever an 'EC' code is entered into ECMS, the CE completes the EC Code Justification Memo (Exhibit 1) for the case file. The status effective date of the 'EC' code is the date of the EC Code Justification Memo.

(4) ES - 'Employment Verification Sent to DOE'- This code is used when a Form EE-5 is sent to the DOE, when a Document Acquisition Request (DAR) is made, or when the initial contact letter is sent to DOJ requesting employment verification/RECA award status.

When an employment information request is sent to the DOE or DOJ, the CE enters the 'ES' code. An 'ES' code is entered for each initial request sent to a DOE Operations Center or DOJ. If the request is sent to two different Operations Centers, then the CE enters two 'ES' codes.

The status effective date is the date the request is made. (When the CE follows up on the initial request, no 'ES' claim status code is entered; rather, the CE enters the 'DE' claim status code with the appropriate reason code. For follow-up to DOJ if no response has been received, the CE enters a 'DO' code with corresponding case note).

(a) For EE-5 (or DOJ) employment verification requests, the CE selects the DOE Operations Center and notes the sending of a Form EE-5 from the 'reason cd'

field that corresponds with the 'ES' claim status code being recorded. The three-character code and the DOE Operations Center to which the Form EE-5 is sent are included on the same line, so only one selection will be made from the drop-down box.

For example, if Form EE-5 is sent to the Chicago Operations Center, the CE selects 'CH5 – Chicago Operations Center (EE-5)' from the 'reason cd' drop-down menu. For the initial contact letter sent to DOJ requesting employment verification/ RECA award status, the CE selects 'RE5 - RECA employment (EE-5)' from the 'reason cd' drop-down menu.

Note: If a CE sends one Form EE-5 to one Operations Center, and that Operations Center sends a copy of Form EE-5 to more than one facility for response, the CE enters one 'ES' code for the appropriate Operations Center.

(b) For DARs, the CE selects the appropriate reason code from the drop down menu that reflects that a DAR was sent, as well as where it was sent (e.g., 'ALD – Albuquerque Operations Office (DAR]'). The 'ES' code is equipped with drop down boxes that include a breakdown of DOE Operations Centers for DAR submissions sent to DOE. The CE selects the proper DOE Operations Center from the drop down box when submitting the DAR package.

The ECMS status effective date of the code is the date reflected on the DAR request form.

DARs can also be made to the DOJ on RECA cases. In these types of cases, the CE will select the reason code 'RED – RECA Employment (DAR)'.

(5) ER - 'Employment Verification Received from the DOE' - The CE uses the 'ER' code when the DAR response is received, when the DOJ response is received, or when Form EE-5 from DOE is sufficient to establish that all the information available has been provided (i.e., the response addresses all of the claimed employment; addresses some, or none, of the employment, if DOE notes that they have no other information; or states that DOE has no employment records for that individual.)

The 'ER' date is the date the response is date-stamped in the DO. The 'ER' code is NOT used if Form EE-5 is returned blank, or the information provided is confusing or incomplete, or the response does not indicate which period of employment is or is not verified.

(a) For EE-5 (or DOJ employment/award) responses, the

CE selects the DOE Operations Center from which a Form EE-5 was received from the 'reason cd' field that corresponds with the 'ER' claim status code being recorded. The three-character code and the DOE Operations Center from which Form EE-5 is returned included on the same line, so only one selection will be made from the drop-down box.

Example 1: If Form EE-5 is returned from the Chicago Operations Center, the CE selects 'CH5 – Chicago Operations Center (EE-5)' from the 'reason cd' drop-down menu. The CE enters an 'ER' for each Form EE-5 received from the Operations Center(s).

Example 2: If the CE receives one Form EE-5 from the Richland Operations Office and another from the Ohio Field Office, the CE enters the 'ER' code with reason code 'RI5-Richland Operations Office (EE-5)' for Richland, and a separate 'ER' code with reason code 'OF5-Ohio Field Office (EE-5)' for the Ohio Field Office.

If a CE sends one Form EE-5 to one Operations Center, and that Operations Center sends a copy of Form EE-5 to more than one facility for response, the CE enters one 'ES' code for the appropriate Operations Center.

Where DOE notifies the CE as to how many copies the Operations Center sent to the facilities (oftentimes Oak Ridge Operations Office), or when the CE is aware that multiple Forms EE-5 are expected from that original inquiry, the CE enters the corresponding 'ER' code only after all anticipated EE-5 forms are returned.

Note: If an unsolicited Form EE-5 is received after a documented Form EE-5 was already received and for which an 'ER' was previously entered, the additional Form EE-5 must also be documented in ECMS as a new 'ER' if Form EE-5 contains additional/new information. This means that entries of 'ES', 'ER', 'ER' may potentially appear in ECMS. This is acceptable since DOE may send out follow-up Form EE-5 documents which could further clarify employment verification.

When the DOJ response regarding employment verification/RECA award status is received, the CE selects 'RE5 - RECA employment (EE-5)' from the 'reason cd' drop-down menu.

(b) For DAR responses, the CE selects the appropriate reason code from the drop down menu (described above), [e.g., 'ALD – Albuquerque Operations Office (DAR)'] to

show that the DAR response was received and to denote which DOE Operations Center responded. For DAR responses from the DOJ, the CE will select the reason code 'RED – RECA Employment (DAR)'.

(6) OR - 'ORISE Employment Evidence Received' - When a claim is initially reviewed, if it is determined that a request for employment verification is appropriate, and the employee worked at one of the facilities on the ORISE list, the CE searches the ORISE database.

Regardless of whether the information from the ORISE database addresses all, part or none of the employment data, the CE enters the 'OR' status code, with the status effective date as the date on the printout of the results of the ORISE database search.

(7) SS - 'Employment Verification Request Sent to Social Security' - When an employment verification request(Form SSA-581) is sent to the Social Security Administration (SSA), the CE enters the 'SS' claim status code in ECMS.

The status effective date is the date the SSA-581 form is sent to SSA. The CE date stamps the form at the time the form is sent to SSA and a copy is kept for the case file. (When the CE follows up on the initial request, whether by phone call or letter, no 'SS' claim status code is entered. Instead, the CE enters the 'DE' claim status code with the 'SS' reason code.)

(8) SR - 'Employment Verification Received from Social Security' - When employment verification is received from the Social Security Administration (Form SSA-L460, the end product of Form SSA-581), regardless of whether the response addresses all, part or none of the employment data, the CE enters the 'SR' code.

The status effective date is the date the response is date-stamped in the DO. (Note: The 'SR' code is not entered if the SSA records are received from the claimant or another source.)

(9) US - 'Union Sent' - When an employment verification request is sent to the Center for Construction Research and Training (CPWR), the CE or Point of Contact (POC) enters the 'US' code. The status effective date is the date of the referral mailing. The 'US' code signifies that all actions pertaining to a CPWR mailing, including release of a completed referral package and mailing of a cover letter to the claimant(s), are complete.

Upon entry of the 'US' code, the CE must select the number of CP-2s that are sent to CPWR from the corresponding drop-down box. The drop-down menu will allow the CE to select

only a number between one and twenty. In the rare occurrence that more than twenty CP-2s are sent to CPWR, the CE will enter an additional 'US' code and select the remaining number of CP-2s (greater than twenty) that are being mailed.

For example, if twenty-five CP-2s are being sent to CPWR, the CE will have to enter one 'US' code and select '20' from the drop-down menu. Then the CE will have to enter a second 'US' code and select '5' from the drop down menu.

After entering the 'US' code, a note must be entered in the 'Worksite Desc' field on the main case screen. For each facility where employment is claimed and for which CPWR is assisting in collection of employment evidence, the CE or POC must enter the following note using the first 13 characters of the 'Worksite Desc' field for outstanding CPWR referrals: 'CPWR pending'. This note is not to replace any existing entry pertaining to the site.

The CE also enters a 40-day call-up effective the date of referral to notify the POC of the overdue request if needed. The POC is to input a claim status code of 'DE' with the reason code 'US' in the claim status history screen effective the date contact is made with CPWR concerning an overdue response.

Notes of all phone calls or e-mails are to be recorded in the case file. The POC has three working days to report all overdue referrals to CPWR. Also, he or she must update the status of the referral in the CPWR tracking program.

(10) UR - 'Union Received'- Upon receipt of a CPWR response, the CE or POC enters the claim status code 'UR' (Received from Union) in the claim status history screen. The status effective date is the date the DO received the referral, according to the date-stamp. Upon entering the 'UR' code, the CE must select a 'VN-Verified None', 'VS-Verified Some', or 'VA-Verified All' from the corresponding drop-down box.

(a) 'VN - Verified None' - Selected when none of the data requested from CPWR was used to verify the claimed covered employment.

(b) 'VS - Verified Some' - Selected when some portion of the data requested from CPWR was used to verify the claimed covered employment.

(c) 'VA - Verified All' - Selected when all of the data requested from CPWR was used to verify the claimed covered employment.

(11) SF – 'Records Request Sent to Former Worker Program' - When a records request is made to the Former Worker Program

(FWP), the CE enters the claim status code 'SF' into the claim status history screen with a status effective date equal to the date of the cover letter/memo to the FWP.

(12) RF – 'Response Received From Former Worker Program' - Upon receipt of records from the FWP, the CE enters the claim status code 'RF' into the claim status history screen. The status effective date is the date the response was received in the DO/CE2 Unit, according to the date stamp.

d. NIOSH Action Codes.

(1) NI - 'Sent to NIOSH for Dose Reconstruction' - While the NI code is used in both ECMS B and ECMS E, the use of the code varies on B only cases versus BE cases:

(a) For B Cases – the 'NI' claim status code is entered for each individual claimant within a case sent to NIOSH for dose reconstruction. When a case is sent to NIOSH, the CE prepares the NIOSH Referral Summary Document (NRSD), which includes a listing of all of the claimants. When this form is signed by the Senior CE, journey level CE, or Supervisor, the 'NI' is coded for each claimant included on the NRSD. The status effective date is the date of the signature on the NRSD.

If the case is already at NIOSH and the DO/CE2 Unit receives a claim from a new claimant, the CE prepares an Amended NIOSH Referral Summary Document, which includes all additional claimants since the original NRSD. (Note: All claimants on the case should be forwarded to NIOSH, regardless of survivorship eligibility at the time of the referral.) When this form is signed by the Senior CE, journey level CE, or Supervisor, the 'NI' is coded for each new claimant included on the Amended NRSD. The status effective date is the date of the signature on the Amended NRSD.

If the case is already at NIOSH and the DO/CE2 Unit receives notice of a new claimed cancer, the CE prepares an Amended NIOSH Referral Summary Document, which includes all additional cancers since the original NRSD. When this Amended NIOSH Referral Summary Document is sent to NIOSH, no additional 'NI' code is needed.

(b) For B/E cases - When a non-SEC cancer claim is referred to NIOSH, or was originally referred to NIOSH as a Part B claim and a new Part E claim now exists, the CE does not input the 'NI' (SENT TO NIOSH) code into ECMS E to show that the claim is pending dose

reconstruction at NIOSH. The 'NI' code is input into ECMS B only (unless the case is a RECA Section 5 case with claim for cancer other than lung cancer). The CE must concurrently develop for exposure to toxic substances for *all* Part E claimed conditions (cancerous and non-cancerous conditions).

When toxic exposure development is complete for *all* claimed Part E conditions (cancerous and non-cancerous conditions) and the CE cannot accept causation, the CE creates a memorandum to file stating that the toxic exposure development is complete and then codes 'NI' into ECMS E. The status effective date is the date of the memorandum.

(c) PEP – 'Rework Based on Program Evaluation Plan' – This reason code is available for selection for Part B or Part E cases in association with the 'NI' claim status code. When it is determined a case needs a rework based on a program evaluation plan/report (PEP/PER), an amended NIOSH referral summary document (ANRSD) is prepared and submitted to NIOSH. The 'NI' code is entered with a 'PEP' reason code to indicate the case is being referred to NIOSH for a rework based on a program evaluation plan/report. The status effective date of the 'NI' code with 'PEP' reason code is the date of the ANRSD.

Again, the 'NI' status code with 'PEP' reason code should only be entered in ECMS E after toxic exposure development is complete and the CE has placed a memo the file stating that toxic exposure development is complete. The CE then enters status code 'NI-PEP' into ECMS E with the date of the memorandum as the status effective date.

If the NI code had been entered into ECMS E prior to the rework and there are no new claimed conditions, the 'NI-PEP' should be coded into ECMS E with a status effective date of the ANRSD, just as in ECMS B, and no new memo is required.

Since this is considered a new dose reconstruction, the CE should not change the existing 'NR/DR' status code to 'NR/RW' as typically done for rework cases. Furthermore, if a PoC value is already entered into ECMS, the CE should not delete the PoC. The new PoC will simply be updated into both ECMS B and E once it is calculated.

(2) NO - 'NIOSH, Administrative Closure' - For cases at NIOSH, Form OCAS-1 is provided to the claimant after completion of the dose reconstruction report. The claimant

is required to sign and return the form to NIOSH before NIOSH can return the case to DOL.

If none of the claimants sign the OCAS-1 form or submit comments within 60 days, NIOSH will close the case administratively and send a letter/e-mail to DOL addressing the closure. The CE enters the 'NO' claim status code in ECMS B, with a status effective date of the receipt of the letter/e-mail from NIOSH. (If the district office cannot obtain an OCAS-1 from any claimant on the case, the case will also need to be administratively closed with DOL by entering a 'C2' code on the claims.)

If the case is a Part B/E case where toxic exposure development is complete and the 'NI' code has already been entered into ECMS E, the CE enters the 'NO' code into ECMS E as well. If toxic exposure development has not yet been completed and the 'NI' code has not yet been coded into ECMS E, the CE does not enter the 'NO' code into ECMS E.

(3) NR - 'NIOSH Dose Reconstruction Received' - When a case is returned from NIOSH with a dose reconstruction, or it is returned from NIOSH because a dose reconstruction could not be performed, the CE enters the 'NR' (Received from NIOSH) claim status code into ECMS B. If the case is a Part B/E case where toxic exposure development is complete and the 'NI' has already been coded in ECMS E, the 'NR' code is entered into ECMS E as well. The status effective date is the date the DO received the dose reconstruction (according to the date-stamp).

The PoC and IREP information must be entered into ECMS Parts B and E on B/E cases regardless of whether an NI was previously entered into ECMS E.

Upon entry of the 'NR' code, the CE selects a specific reason code from the 'reason cd' field. This field is a drop-down box that corresponds with the 'NR' claim status code. Included in the reason cd field are both the full reason for the 'NR' code and a two-character code representing each option. The reason codes available for the 'NR' claim status code are:

(a) Dose Reconstruction Received, POC-'DR' - Used when the DO receives a routine dose reconstruction (not fitting one of the other specific reason codes listed below).

(Even though the CE might not yet have had an opportunity to review the dose reconstruction report, this is the appropriate reason code to use at this time. If it is determined after review that the reason code needs to be changed, e.g., for a rework,

the CE updates the reason code.)

(b) Reworks of Dose Reconstruction, no POC-'RW' - Used exclusively if it is determined that the received dose reconstruction is not to be used, based on the review by the Health Physicist at National Office (NO). Once the Health Physicist determines the case must be returned to NIOSH for a rework, the CE changes the reason code for the 'NR' claim status code from 'DR' to 'RW.' If a PoC was entered into ECMS, it should be removed.

(Note: A new 'NR' claim status code is not to be entered. Only the reason code for the existing 'NR' code is to be updated with the new reason code of 'R'. However, the date of the original claim status code is not changed or updated. This is because the 'NR' code documents the receipt date of the dose reconstruction disc.)

Once the CE prepares the rework and a new Amended NIOSH Referral Summary Document (ANRSD) is ready to be sent back to NIOSH, a new 'NI' claim status code is entered, with a status effective date of the ANRSD.

(c) CLL only, no POC- 'CL' - In Part B cases when after full medical development the only claimed primary cancer is CLL, the CE enters the 'NR' claim status code in ECMS, even though there will not be an 'NI' code. On these cases, the status effective date of the 'NR' code with the 'CL' reason code is the date of the RD to deny based on CLL (0% PoC). The CE should not bother entering the 'NR' code with the 'CL' reason code in ECMS E because of the presumption of a 0% PoC with regards to radiation exposure, only toxic exposure development would be pursued under Part E.

(d) No Dose Reconstruction Possible, SEC – 'ND' - Used for non-SEC cancers claimed at an SEC facility where NIOSH determines that no dose reconstruction is possible. Note: Denials based on this situation are coded D7/F9.

(e) Partial Dose Reconstruction, SEC – 'PD' - Used for non-SEC cancers claimed at an SEC facility where NIOSH can only perform a partial dose reconstruction, such as occupational medical x-ray doses only or external dose only. The dose reconstruction report must be carefully reviewed to determine if a partial dose reconstruction was performed.

(4) NW - 'NIOSH, Returned without a Dose Reconstruction' - When withdrawing a case from NIOSH for any reason (e.g.,

the CE realizes there was no covered employment and the case should not have been sent to NIOSH), and the DO will not be sending the case back to NIOSH, the CE requests the return of the case from NIOSH without a dose reconstruction and enters the 'NW' code in ECMS B. The CE only enters the 'NW' code into ECMS E on BE cases where the toxic exposure development was completed and the 'NI' code had been entered into ECMS E. The CE notifies NIOSH that the dose reconstruction is no longer needed for the case. The status effective date is the date of the notification to NIOSH.

There are also instances when NIOSH requests that DOL withdraws a case that is currently at NIOSH (e.g., during NIOSH interview claimant claims additional cancer or employment period which requires development, claimant passes away). In these types of situations, the file must be documented with the TMS record of the NIOSH call requesting withdrawal and the CE codes an 'NW' with a status effective date of the NIOSH email.

Please note, the 'NW' code is not applicable in instances where NIOSH advises DOL that the case is pended at NIOSH. Cases pended at NIOSH do not require ECMS coding.

Also note that an administrative closure of a claim in ECMS does not "close out" a pending NIOSH case. For example, if an employee dies while his or her case is at NIOSH, an 'NW' code and a 'C3' code must be entered. The 'C3' code alone is not sufficient.

(5) NAR – 'No Additional Review Needed' with Reason Code NRC – 'NIOSH Returned Case' – This code indicates that all processing is completed on a case that was returned from NIOSH with an 'NR' or 'NW' code and no further processing is necessary. Typically a case should be returned or withdrawn from NIOSH ('NR'/'NW') before a recommended and/or final decision is issued, but there are some rare instances that the case is returned or withdrawn after a recommended and/or final decision is rendered and there is no additional development required on the case. Another circumstance where this code combination would be used is when the claim is withdrawn from NIOSH after a claim has been closed.

When a decision is issued or a claim is closed on a case that is currently at NIOSH and the dose reconstruction is received or the claim is withdrawn after the fact, the 'NAR' claim status code with 'NRC' reason code is entered. Otherwise, reports would show that a decision or closure were pending, which would be inaccurate.

The 'NAR' claim status with 'NRC' reason code must be

approved by the District Director, Assistant District Director, FAB Manager, and/or designated person. Once the CE/HR determines that the 'NAR/NRC' code is applicable, he/she prepares a memo to the file explaining the context in which the 'NAR/NRC' code is needed and the applicable ECMS system (Part B, E or both) for the claim. The designated person then approves and signs off on the memo and codes the 'NAR/NRC' code in ECMS accordingly, with a status effective date of the date of the approved memo.

(6) LNS – 'Letter Sent to NIOSH' - This code is used when a letter is sent to NIOSH inquiring as to the applicability of a Program Evaluation Report (PER) on a case's previous dose reconstruction. The status effective date is the date the letter is sent to NIOSH. This is a B/E code, but is only entered into ECMS E if the 'NI' had previously been entered, indicating the toxic exposure development was complete.

(7) LNR – 'Letter Received from NIOSH' - This code was initially created to document NIOSH's response to our request (LNS). However, the use of 'LNR' is now used to document the receipt of an Individual Case Evaluation/Individual PER from NIOSH indicating that the case was evaluated against a PER and any other changes that may affect the dose reconstruction. The status effective date is the date stamp received into the DO. This is a B/E code, but is only entered into ECMS E if the 'NI' had previously been entered, indicating the toxic exposure development was complete.

The 'LNR' code has several associated reason codes. The reason codes represent the EEOICPA Bulletin that addresses a particular PER or possibly multiple PERs. The applicable reason code must be selected from the reason code drop down list (i.e. '824' – PER/ICE addressed in Bulletin 08-24). New reason codes are added as new PERs are released.

e. Additional Action Codes.

(1) 15 - 'EE-15 Form Sent' - Deactivated. The '15' code was previously used when the CE mailed Form EE-15 (which was required with older versions of Form EE-1/2) with a status effective date of the date the form was mailed. However, the EE-15 is no longer used. When a CE requests information similar to what was on Form EE-15, such as tort suit information, the CE will enter the 'DO' code, instead of a '15'.

(2) RD - 'Development Resumed' - The 'RD' code is used to resume development on claims two ways in ECMS. The first use is when a case has a Final Decision, and a current claimant on the case submits a subsequent claim form for a

new medical condition. In this case, the status effective date of the 'RD' is equal to the new filing date (postmark date, if available, or received date) for the new claim form.

The second use is when a claim has been closed prior to adjudication, and the claimant (or DOJ, in the case of a pending RECA claim) writes a letter asking to resume development on the claim. The CE then enters the 'RD' code and resumes development.

The status effective date of the 'RD' in this case is equal to the date-stamp of the letter requesting development be resumed. This code can be used in conjunction with the following closure codes: 'C0','C1','C2','C9', or'C10' where the claimant was not at MMI, since none of these closure codes refer to the death of a claimant (Note: This code is not to be used for the Reopening of Claims due to Director's Orders.)

(3) UN - 'Unadjudicated' - The 'UN' code is a default claim status code created when a new claim is entered in ECMS. This code is generated by the system when a claim is created, and the CE does not use it as a development code. If Resource Center development pre-dates the 'UN' code, the 'UN' code should be deleted when the development actions are entered.

(4) SER – 'SEC Recommended Acceptance' [Replaces former 'SE' (Confirmed SEC Claim) code] - When a recommended decision is being issued that includes an SEC acceptance, the CE enters the 'SER' code into the claim status history, in addition to the usual recommended decision coding (see PM Ch 2-2100). This code is entered with the same status effective date as the recommended decision (it doesn't matter which one is entered first). For cases that have already been adjudicated with an 'SE' code, there is no need to go back and update them with the new 'SER' code.

When the CE enters the 'SER' code, the CE is required to select a reason code from the drop down that represents the SEC class that the acceptance is based upon. Each SEC class has its own unique reason code, generally based on the related bulletin number (like the NA, ISL, ISU, and ISD codes). New reason codes are added continuously, as new SEC classes are added.

For example, if the acceptance is based on the Blockson Chemical Company SEC, the CE enters the 'SER' code (along with the final decision code) and selects reason code "101 - Rvwd per Bulletin 11-01, Blockson Chemical Company SEC (3/1/51 – 6/30/60)."

In situations where the employee is found to be a member of multiple qualifying SEC classes, the CE is required to input a "**SER**" and corresponding reason code for each, regardless of the combination of qualifying SEC employment leading to approval of a claim. For example, if the employee worked for 250 days of SEC covered employment at Texas City Chemicals, Inc. and another 125 days of SEC employment at the Metallurgical Laboratory, the employment at Texas City Chemicals, Inc. alone would satisfy inclusion in the SEC. However, the CE would enter one "**SER**" with a "**106**- Rvwd per Bulletin 11-06, Texas City Chemicals SEC (10/5/53-9/30/55)" reason code. Then the CE would also enter a second "**SER**" with a "**907**-Rvwd per Bulletin 09-07, Metallurgical Laboratory SEC" reason code. The CE also enters the recommended decision code(s) with the same status effective date as the "**SER**" codes. The recommended decision is to reference each class for which the employee qualifies. The content of the decision should state compensability derived from satisfaction of the SEC criteria given the combination of all qualifying SEC employment. The CE is not to assign acceptance of a claim to one class over another.

(5) SEF – 'SEC Final Acceptance' - When a final decision to grant benefits based on inclusion in an SEC Class is issued, the FAB CE/HR must enter the code "SEF" (SEC Final Acceptance)into the claim status history, in addition to the usual final decision coding (see PM Ch 2-2100). This code represents that an SEC acceptance is included in the final decision being issued. This code is entered with the same status effective date as the final decision (it doesn't matter which one is entered first).

When the "SEF" code is entered, a reason code must be entered to reflect which SEC class the acceptance is based on. For example, if the acceptance is based on the Blockson Chemical Company SEC, the reason code selected will be "101 - Rvwd per Bulletin 11-01, Blockson Chemical Company SEC (3/1/51 – 6/30/60)."

Should the evidence establish the employee's inclusion in multiple SEC classes, each must be coded in ECMS using the "SEF" and corresponding reason codes. This will result in multiple "SEF" code entries. The final decision should identify each SEC class for which the employee is found to be a member. The final decision should also explain that the decision to accept the claim is based on membership in all qualifying SEC classes. No attempt should be made to differentiate acceptance based on inclusion in one SEC class in lieu of another.

See the example outlined above in Item 6.e(4) regarding

"**SER**" coding for more than one SEC Class.

If FAB remands a case that the district office had recommended for an SEC acceptance and had coded "SER," there is no need for the "SER" code to be removed, as it reflects the language in the recommended decision that was issued on that date. Similarly, if a final decision is vacated on an SEC final decision to accept where "SEF" has been coded, there is no need to remove the "SEF" code, as it reflects the language in the final decision that was originally issued.

(6) WS - 'Washington, DC: Sent to' - When the CE or HR identifies a policy or procedural issue that requires NO attention, the CE prepares an email to a member of the Medical and Health Sciences Unit (MHSU) or a memo if the file is being referred. When the case file or issue is referred to NO, the 'WS' code is entered. The status effective date is the date the DD or FAB manager (or designee) signs and dates the memo or the date of the email to the MHSU.

The use of the 'WS' code is restricted to the DD and FAB Manager (or designee), to ensure that he or she agrees with the CE's rationale for the referral to NO and also agrees that the CE cannot continue working on the case until the outstanding issue is resolved. Included in the 'reason cd' field are both the full reason for the 'WS' code and a two-digit code for each option. The reason codes available for selection with the 'WS' code are:

(a) PR – 'Policy Review' - Used for referral to NO for general policy review.

(b) HP – 'Health Physicist Review' - Used for a referral to NO for review by the Health Physicist.

(c) IH – 'Industrial Hygienist Review' (E only) - Used for referrals to the Industrial Hygienist.

(d) TX – 'Toxicologist Review' (E only) – Used for referrals to the Toxicologist.

(e) OP – 'Overpayment Review' – Used for referrals to NO because either for review of a potential overpayment or for overpayment processing/ handling.

(f) FR – 'Facility Review' – Used for referrals to NO for a determination on whether a facility should be covered or for expansion of dates of a covered facility.

(7) TL – 'Terminal Claimant Designated by DD/FAB Manager' - This code is used when a determination has been made that the claimant is in a terminal condition. Use of this code

is restricted to the DD or FAB Manager (or designee). If the case is a B/E case, the 'TL' code must be coded into both ECMS B and ECMS E. The status effective date of the code is equal to the date the DD or FAB Manager (or designee) determines the claim is in need of expedited processing due to a terminal illness, such as the date of a phone call (with corresponding TMS message printout), email, or other communication.

(8) WR - 'Washington, DC: Received Back From' - When NO resolves a pending 'WS' issue, the NO will send a response via email or memo to the District Office. The District Director (or designee) enters the 'WR' in ECMS, with an effective date of the receipt of the memo or email.

(9) IC – 'Impairment Claimed' (E only) - Used when the claimant informs DEEOIC in writing of intent to pursue an impairment claim. The status effective date is the postmark date of the letter, if available, or the date the letter is received in the DO/RC. If impairment is claimed multiple times, the 'IC' code is entered only once (unless it is claimed again after the final decision, after an 'NIM' code has been entered, or after the impairment claim was withdrawn with a 'C10' – 'ICW'). If the claimant prematurely claims impairment (prior to the two-year re-evaluation mark), the 'IC' code must still be entered. The status effective date is the postmark date of the letter, if available, or the date the letter is received in the DO/RC. Also, if the claimant does not submit a written claim for impairment, but submits an impairment rating, this is treated as a claim for impairment and the 'IC' code is entered with a status effective date of the receipt date of the report.

(10) WC – 'Wage Loss Claimed' (E Only) - Used when the claimant informs the DEEOIC in writing of intent to pursue a wage-loss claim. The status effective date is the postmark date of the letter, if available, or the date the DO/RC receives the letter. If wage loss is claimed multiple times, the 'WC' code needs to be entered only once (with the initial claim for wage loss) until a decision is rendered (unless it is claimed after the final decision or when withdrawn 'C10' – 'WLW').

(11) NIM – 'Not Claiming Impairment' (E Only) - This code is used when the claimant informs the DEEOIC in writing that he or she is not claiming impairment (even though it was never actually claimed) or after the appropriate development for an impairment claim has been completed and the claimant has been unresponsive. The status effective date is the date the letter is received in the DO from the claimant stating that he or she does not wish to claim

impairment or the date on the letter from the DO to the claimant confirming an impairment claim will not be pursued at this time because of the lack of response.

'NIM' has an optional reason code that must be selected in circumstances where the maximum payable benefit has already been paid, so a claim for impairment is not being solicited. This reason code is 'MBM - Maximum Payable Benefits Met'. This code is not to be used if impairment has been claimed. In those circumstances, the claim must be withdrawn by the claimant or adjudicated.

If a claimant requests an impairment rating prematurely, the CE must then issue a letter to the claimant advising the claimant that he or she is not yet eligible for a new impairment rating. The CE enters the 'NIM' code into ECMS with a status effective date equal to the date of the letter, along with a call-up note so follow-up can be done when the two-year mark (from previous award) is reached.

(12) NWL – 'Not Claiming Wage Loss' (E Only) - This code is used when the claimant informs the DEEOIC in writing that he or she is not claiming wage loss (even though it was never actually claimed) or after appropriate development for a wage loss claim has taken place and the claimant has been unresponsive. The status effective date is the date the letter is received in the DO from the claimant stating they do not wish to claim wage loss or the date on a letter sent to the claimant confirming a wage loss claim will not be pursued at this time because of the lack of response.

'NWL' has an optional reason code that must be selected in circumstances where the maximum payable benefit has already been paid, so a claim for wage loss is not being solicited. This reason code is 'MBM - Maximum Payable Benefits Met'. This code is not to be used if wage loss has been claimed. In those circumstances, the claim must be withdrawn by the claimant or adjudicated.

(13) NA – 'No Action Necessary – SEC/PEP/PER' – This code has several associated reason codes. Each reason code is generally specific to a Bulletin number regarding a new SEC or PEP/PER (B only). On occasion the reason codes are associated with a special project (B or E). Use of the 'NA' code and its associated reason code indicates that a claim was reviewed under the pertinent instructions and no action is necessary at this time. New reason codes are added as new SEC/PEP/PERs (or special projects) are released.

(14) ISL – 'Initial SEC Screening, Likely SEC' (B only) – This code is used when the CE screens a case and determines

that it is likely to meet the criteria for inclusion into an SEC class, as per a Bulletin. The status effective date of the 'ISL' code is to correspond with the completion date of the screening worksheet. This code has several reason codes associated with it. Each reason code is specific to a bulletin number related to a new SEC class. As new SEC classes are added, additional reason codes are added as well.

(15) ISU – 'Initial SEC Screening, Unlikely SEC' (B only) – This code is used when the CE screens a case and determines that it is unlikely to meet the criteria for inclusion into an SEC class, as per a Bulletin. The status effective date of the 'ISU' code is to correspond with the completion date of the screening worksheet. This code has several reason codes associated with it. Each reason code is specific to a bulletin number related to a new SEC class. As new SEC classes are added, additional reason codes are added as well.

(16) ISD – 'Initial SEC Screening, Development Needed' (B only) – This code is used when the CE screens a case and determines that development may be needed in order to reach a determination on SEC class inclusion, as per a Bulletin. The status effective date of the 'ISD' code is to correspond with the completion date of the screening worksheet. This code has several reason codes associated with it. Each reason code is specific to a bulletin number related to a new SEC class. As new SEC classes are added, additional reason codes are added as well.

7. Case Management. ECMS contains 'Notes' and 'Call-Ups' sections, as well as a Telephone Management System (TMS), to assist the claims staff with managing cases,

a. Notes and Call-Ups. The 'Notes and Call-ups' are intended primarily as a tool for CEs, Senior CEs, HRs, and Supervisors in managing their caseloads. Each call-up is a note with an associated 'action date' used to display pending actions by date and type.

(1) Each ECMS note consists of up to 255 characters of text, note type, code claim type associated with note, DO Code, call-up date priority, public flag, update, current owner id, and date created by/transferred to current owner. (See below for detailed information about these date elements),

(2) Each note is Public, and visible to all authorized ECMS users. Notes are included in the case file for any FOIA requests. ECMS no longer allows for the saving of private notes.

(3) Assigning a priority is strictly at the discretion of

the owner of the note (1 = highest priority, 5 = lowest priority). A user can sort notes and call-ups by selecting the Manage Call-ups/Notes under the 'Inquiry' menu option based on priority, but this is not required. The default is '1'.

(4) A 'call-up date' can be entered in the notes screen to serve as a "tickler" system for the CE. ECMS will then prompt the assigned CE to read the associated note when the call-up date is reached. It will continue to prompt the CE until the 'task completed' field is changed from 'N' to a 'Y' (or the call-up date is changed to a future date).

b. Telephone Management System (TMS). The TMS was established to document each incoming call received and outgoing call placed, particularly calls related to existing case files. There is no single "TMS" Screen in ECMS. Rather, TMS refers to a combination of screens and functions related to on-line telephone message tracking and management. For example, the phone message screen is accessed by clicking the red phone icon, and phone message reports are accessed through the 'Inquiry' menu in ECMS or through clicking the ECMS Reports icon.

An automated telephone record must be created for every telephone call received or initiated by DOL, regardless of whether the caller is a DEEOIC claimant or a representative or other interested party to a DEEOIC claim (including NIOSH, DOE, and DOJ). For example, calls taken by contact representatives, workers' compensation assistants, and supervisors must be entered into the system and, if needed, assigned to specific individuals for return calls.

(1) Entering phone calls into ECMS.

(a) Incoming phone calls: All incoming calls from DEEOIC claimants, survivors, attorneys, Congressional Offices and/or any other parties to a DEEOIC claim (including NIOSH, DOE, and DOJ) must be recorded in TMS, whether or not a return call is required, under the case number in ECMS.

Calls from medical representatives, members of interest groups, or elected officials (or their staff members) must be documented. Also, calls that result in sending informational packets or application forms related to the EEOICPA to potential claimants or any other persons must be recorded in TMS, under each office's "dummy SSN", with a description in the text field of what was sent, to whom, and when.

If the person receiving an incoming telephone call answers it completely (i.e., no return call is needed), he or she immediately enters the call into the system as an incoming call and the call will be

marked 'Y' in the Call Completed field.

(b) Outgoing phone calls - A call initiated by claims personnel, to a claimant or a party to the claim, must be entered as a phone message into TMS. After entering all appropriate data to record, the call will be marked 'Y' in the Call Completed field, and ensure that the phone message is closed.

If an outgoing call generates the need for a call-up, the person making the call first must document the call in the phone message screen, then open the Notes and Call-ups screen to enter a call-up note and date.

(2) Fields to be completed - When a call requiring TMS entry is taken, the required data that must be entered into TMS are:

(a) Call Reason - Select from list; use 'other' if none apply.

(b) Claim Type - Select from list; 'other' values are available for calls unrelated to existing claims.

(c) Note - The individual taking the call enters a note - up to 2000 characters - describing the substance of the inquiry. This note is known as the Primary Phone Message.

(d) Caller Name - Enter name of caller.

(e) Call For - Enter name and/or title/position of person to whom the caller asked to speak; use 'N/A' if specific person was not requested.

(f) Relation - Select from list - caller's relationship to the claimant identified in Claim Type field.

(g) Received by - System will default to logged-in user id.

(h) Call Type - Select from list:

'D-Direct Call' when an incoming phone call is received and completed without requiring a return call.

'O-Outgoing Call' when the CE or other DOL employee initiates a phone call to any source and completes it, as long as the call is not a return call as part of a previously opened return call.

'R-Return Call' when returning a phone call that could not be completed at the time of the incoming or outgoing phone call, and required the DOL employee to return the telephone call.

(i) Receive date - System will default to current date.

(j) Callback No. - Enter caller's phone number, if provided by caller.

(k) Assign to - Select from list - any user in DO. The user name entered in the Assign to field becomes the 'owner' of the telephone note.

(l) Call Completed – 'Y' or 'N' - phone call will remain open and pending until 'Y' is entered and saved to this field. The CE must ensure that the date corresponds with the call return. Return calls are the only call type that do not automatically have a call completed status of 'Y'.

(m) Returned by - Select from list; the user ID of the person who returned the phone call.

(3) Calls Requiring a Return Call. The owner (user name appearing in the Assign to field) of the phone call is responsible for returning it and closing out the TMS phone message. After returning an open or pending call, he or she must take two actions to close out the pending call in TMS:

(a) Return/completed call messages must be entered on a supplemental message screen (Callback/Addendum Notes) accessed via the bottom portion of the phone message screen.

(The TMS user moves the cursor into one of the rows in the grid and then depresses the <INSERT> key to add a new callback/addendum note.)

A blank callback/addendum note will appear on the screen - the user enters the details of the return call here. A callback note must comprehensively describe the reply to the caller's inquiry. TMS will allow up to 1000 characters.

After this addendum note is saved, it appears as a new row in the grid view at the bottom of the Phone Message Screen. Double-clicking on the specific row for a Callback/Addendum note displays the full text of the note.

(b) After the addendum note is entered and saved, the CE or other user must return to the telephone message Add/Update screen and click the 'Y' in the Callback Completed box, and ensure that the (Callback Completed On) date reflects the actual return call date.

If 'Y' is selected, the call will no longer appear on the pending phone messages list. If 'N' is selected,

the TMS system will not close out the call and the call will appear on the owner's pending phone message list.

(4) General Information about TMS.

(a) Any returned telephone call entered into TMS will remain an open call until closed out in TMS.

(b) The note field of the primary phone message must not be modified or updated, except in two instances:

(i) By the creator of the message, and then only to correct or clarify the text entered on the date of call creation.

(ii) By the owner of the message (or supervisory personnel), to explain why he or she is reassigning the message to another user.

(c) When a user logs into ECMS, TMS displays a message identifying the number of pending phone messages which have been logged (that is, assigned to, or owned by) for that user. By selecting the 'Open Phone Msgs' option, TMS displays all the outstanding return calls that do not contain a completed call date.

(d) Once a phone call is assigned to a person, it is owned by that person. TMS permits only the person who owns a call, or supervisory personnel, to reassign a phone call. TMS permits reassignment of an individual phone message from within that message screen - the current owner simply selects the new owner of the message from among the list of users in the Assign To box.

When reassignment occurs in this manner, the owner must type his or her user ID and the date within the 'Notes' portion of the primary message, along with a brief reason for the reassignment.

The owner will reassign a phone call only when he or she does not actually speak to the caller. The call will not be closed out until a return call is made.

For example, a customer service representative answers a call and refers it to CE-1. CE-1 receives the referral and becomes the owner; however the case is actually managed by CE-2. CE-1 does not return the call, and reassigns the case to CE-2. CE-2 then becomes responsible for returning the call timely.

(e) While in any one of the telephone screens, the user may go into another ECMS screen to check the status of the case. All claim-related telephone call

messages must be printed and spindled down in the case file, but only after the phone call record is closed, i.e., for calls requiring a response, after the response is recorded in the Callback/Addendum Note.

(f) Documentation of all calls not related to a specific case must be printed and kept in a central location in the office for reference and tracking purposes.

Exhibit 1: EC Code Justification Memo

2-2100 Energy Case Management System--Decisions

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

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

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

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

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

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

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

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

as follows:

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

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

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

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

4. General Decision Coding. When a recommended or final decision is issued, the Claims Examiner (CE), Senior Claims Examiner (SrCE), or Hearing Representative (HR) enters the appropriate claim status code(s) into ECMS. The coding must match the wording in the decision. There are three possible outcomes for each claimed element: accept, deny, or defer. Deferring a decision means that a decision is not being made on that element at this time because further development is needed, essentially holding the decision in abeyance.

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

a. Primary Decision Codes. All decisions require at least one 'primary' decision code. If the decision addresses Part B benefits only, a primary decision code is entered into ECMS B. If the decision addresses Part E benefits only, a primary decision code is entered into ECMS E only. If the decision addresses Part B and Part E benefits, there is a primary decision code entered into ECMS B and

a separate primary decision code in ECMS E. Generally, there is no more than one primary decision code in either ECMS B or ECMS E, per decision. Exceptions will be listed in this chapter. The status effective date for the decision codes is the date of the decision.

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

Some primary decision codes also have reason codes associated with them that give more detail as to what is being accepted or denied. Primary recommended decision codes and their associated reason codes are discussed in detail in Paragraph 5. Primary final decision codes and their associated reason codes are discussed in detail in Paragraph 7.

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

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

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

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

The 'PD' status code can be used in conjunction with the

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The final decision coding, if upheld by FAB, would be: 'F0' [Final

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

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

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

The final decision coding, if upheld by FAB, would be nearly identical to the recommended decision coding: Status Code 'F9' [Final Deny - medical information insufficient to support claim/non-cancer causation denial] with Reason Code 'B' in ECMS B and 'G2' [Final Partial Accept/Partial Deny/Partial Develop] with Reason Code 'CAU' in ECMS E, along with status codes 'DV', with Reason Code 'IMW'; and 'PD', with Reason Code 'IN'.

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

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

5. Recommended Decision Codes. The CE/SrCE must enter the appropriate recommended decision code when issuing a recommended

decision. The status effective date of the code equals the recommended decision issuance date.

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

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

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

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

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

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

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

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

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

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

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

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

deactivated with the potential to be reactivated if the need arises.

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

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

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

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

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

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

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

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

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

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

wage loss and additional development of another claimed element is required (e.g., a cancer that is undergoing dose reconstruction at NIOSH).

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

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

For Part B cases only, status code 'A2' is used with reason code 'B' [Part B] in ECMS B for recommended decisions that describe a partial acceptance for at least one claimed condition under Part B and partial denial and partial development for one or more other conditions under B.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Note 1: In ECMS E, the 'D5' code can also be used in conjunction with the 'DV' code to capture partial deny/partial develop decisions, for which there isn't a single, unique primary decision status code. The CE/SrCE enters the 'D5' code with a reason code denoting what is

being denied. The CE/SrCE then enters the 'DV' status code and appropriate associated reason code listed in Paragraph 4 above to identify which benefits are being held for further development. The status effective date of both codes is the date of the decision.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(14) CA0 – 'Causation and Impairment (0%)' (E only) -Used when causation and 0% impairment are being denied simultaneously. Impairment is denied because the impairment

rating is 0% or because the claimant failed to provide the necessary medical documentation or because the impairment rating was not performed because causation could not be established.

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

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

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

The status effective date is the date of the recommended decision. Upon entry in ECMS of the 'D7' code, the CE/SrCE selects a specific reason code from the "reason cd" field, which is a drop-down box that corresponds with the 'D7' claim status code. The reason codes available for the 'D7' claim status code are listed below. The reason code 'B' [Part B] is only to be used in ECMS B.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

documentation.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Example 2: If the Part B decision is an acceptance and the Part E

decision is a partial accept/partial deny, and a bifurcated (partial) waiver is received, the CE/HR would enter a 'FJ-WF' (full waiver) into ECMS B and an 'FJ-PW' (partial waiver) into ECMS E. Please note that if a bifurcated waiver is received for a recommended decision pertaining to one part of the Act and the final decision to accept is issued prior to the final decision to deny because the claimant has reserved his or her right to object to the denial, that decision must be coded as a "partial develop" because a portion of the decision has been deferred. In this particular example the Part B decision would be coded 'F0-B' and the first Part E decision would be coded 'G1' (partial accept/partial develop) with an appropriate reason code + 'DV' (partial develop) with an appropriate reason code. The second Part E decision that would be issued after the objection period expired, would be coded as a denial (assuming nothing changed from the recommended decision).

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

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

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

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

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

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

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

(5) Dist Office – This field is automatically populated

with the office location of the FAB representative.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

This code allows for benefits to be administered while development

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

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

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

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

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

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

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

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

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

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

c. F1 - 'Final Deny - Employee Not Covered'. When the CE/HR renders

a final decision to deny benefits due to employment that is not covered, the CE/HR enters the 'F1' code. The status effective date is the date the final decision was issued.

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

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

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

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

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

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

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

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

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

(7) CIW – 'Accept Causation, Impairment, and Wage Loss' -

Used when causation is accepted along with both impairment and wage loss, a portion of the claim is being denied, and a portion of the claim requires additional development (e.g., a cancer claim is undergoing dose reconstruction at NIOSH).

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

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

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

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

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

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

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

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

Note 2: If there is also a finding in the Part E decision to deny one

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

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

The reason codes associated with the F5 code are:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(15) CAN – 'Causation and Impairment (not ratable)' (E

only) - Used when causation and an impairment for a non-ratable condition, such as certain psychiatric conditions, are being denied simultaneously.

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

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

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

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

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

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

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

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

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

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

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

(5) WAG – 'Wage Loss Only Accepted' - Used when causation was established on a previous decision and wage loss is all

that is being accepted in this decision under Part E.

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

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

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

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

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

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

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

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

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

(a) ERM – 'Error – Medical (Dx, Disease, Causation,

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

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

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

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

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

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

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

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

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

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

(1) Partial Accept/Partial Remand – 'F0' + reason

code to show what is accepted, followed by 'F7' + remand reason code.

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

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

(4) Partial Accept/Partial Deny/Partial Remand –

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

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

(5) Partial Accept/Partial Deny/Partial Develop/ Partial Remand –

(a) If the Partial Accept/Partial Deny/Partial Develop/Partial Remand is for Part B – code 'G2' (FAB Accept in Part/Deny in Part/Develop in Part) + reason code 'B', followed by 'F7' + remand reason in ECMS B.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

cancer causation denials; for when the maximum payable benefit is met; or for decisions that solely address impairment and/or wage loss claims (whose related conditions were not previously denied under F5). The status effective date is the date of the final decision.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(16) CNW – 'Causation, Impairment (Not Ratable), and Wage Loss' (E only) - Used when a claim is made based on causation, wage loss, and impairment, all of which are

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

To record any accepted Part E component of the decision, the CE/HR must select one of the following

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

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

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

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

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

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

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

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

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

(c) WAG – 'Wage Loss' (E only) - Used in the rare

circumstance when a wage loss claim is received and adjudicated after a cancer denial.

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

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

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

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

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

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

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

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

medical documentation or because the impairment rating was not performed because causation could not be established.

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

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

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

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

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

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

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

Upon entering the 'R6' code, the CE/HR selects a specific reason code from the "reason cd" field, which is a drop-down box that corresponds with the 'R6' claim status code.

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

(a) B – 'Part B' – Used to record any accepted Part B

component of the decision.

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

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

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

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

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

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

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

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

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

The FAB CE/HR codes 'R7' into the appropriate system (ECMS B for a B only remand, ECMS E for an E only remand, and both for a Part B/E remand. If the Part B and E decisions

are remanded, an 'R7' goes into ECMS B and E, but could have different reason codes in each.

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

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

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

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

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

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

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

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

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

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

(d) OTH – 'Error – Other (Error – Not Med, Emp, or

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

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

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

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

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

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

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

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

(g) Partial Accept/Partial Deny/Partial Develop/Partial Remand is Part E – Enter 'R8'(FAB

Recon Accept in Part/Deny in Part) + reason code to show what is accepted, 'PD' + reason code to show what is denied, 'DV' + reason code to show what is deferred, and 'R7' + remand reason code in ECMS E._

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

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

(9) R8 – 'FAB RECON - ACCEPT IN PART/DENY IN PART'.

When the reconsideration is granted and the post-reconsideration final decision is issued where part of the claim is approved for benefits, while another part of the claim is denied, the CE/HR enters the 'R8' code. The status effective date is the date the post-reconsideration final decision is issued.

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

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

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

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

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

(d) CAI – 'Causation and Impairment Accepted' - Used

when causation and impairment are being accepted simultaneously under Part E.

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

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

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

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

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

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

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

Upon entry of the 'R9' code, the CE/HR selects a specific reason code from the "reason cd" field, which is a drop-down box that corresponds with the 'F9' claim status code. The reason codes available for the 'R9' claim status code are listed below.

(a) B – 'Part B'(B only) - Used when a condition is

denied in ECMS B.

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

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

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

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

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

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

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

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

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

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

(l) I0W – 'Impairment (0%) and Wage Loss (E only) - Used when wage loss and impairment are both being

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

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

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

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

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

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

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

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

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

simultaneously.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

If the death notification is received between the recommended and

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

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

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

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

g. C10 – 'Partial Claim Closure'. This claim status code is used when the wage loss or impairment portion of the claim is being closed without the issuance of a recommended or final decision. (Other closure codes reflect a closure of the entire claim, but this code closes only the individual impairment or wage loss component.) Once the 'C10' status code is entered, the CE selects the reason code from the drop-down menu that corresponds with the reason the impairment or wage loss claim is being closed.

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

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

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

If the claimant decides to file at a later date, enter a

new 'WC' code.

(3) ICW – 'Impairment Claim Withdrawn' - Where impairment had been claimed, but the claimant chooses to withdraw the claim for impairment in writing, the

CE codes the 'C10' claim status code with the 'ICW' (Impairment Claim Withdrawn) reason code. The status effective date is the date stamp of receipt in the Resource Center, DO, or FAB, whichever is earlier.

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

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

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

a. Case File at DO. If the case file is at the DO, and a new claim form is received after a final decision has been issued:

(1) The CE enters the new claim in ECMS by entering an 'RD'- Development Resumed in the claim status history screen of ECMS. The status effective date will be the new claim filing date. This is the earliest of the following: postmark date or date stamp of receipt on the claim form, or the initial piece of evidence that instigated the claim in a DO or FAB office, or Resource Center. [The envelope must be kept with the claim form, and put in the case file.]

Once the 'RD' code and status effective date are entered in ECMS, the CE enters the newly claimed medical condition on the Medical Condition screen. The CE reviews the new condition and begins development of the new medical evidence.

(2) Development of the case will continue through new recommended and final decisions (or consequential acceptance letter if the newly claimed condition turns out to be a consequential illness). All previously entered ECMS codes in the Claim Status History are still relevant for the case and will apply to the new claim. They do not need to be re-entered following the 'RD' code. However, all new development for the claim must now be entered in ECMS, including all further development claim status history codes.

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

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

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

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

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

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

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

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

The CE/HR then enters the newly claimed medical condition on the Medical Condition screen. The CE/HR does not begin development of the new medical condition. This is completed by either the CE2 or the CE upon case return to the DO.

(2) If the case is in posture for denial, it is remanded back to the DO/CE2 Unit for development and adjudication of the new claimed condition.

(3) If a new claim form or medical evidence for the same medical condition(s) is received after a final decision,

regardless of its current location, and the claimant sends in additional medical evidence for the original medical condition(s) or a new claim form for the same medical condition(s) already adjudicated in the final decision, this is not considered a new claim.

For either of these occurrences, the 'RD' - Development Resumed claim status code is not entered. Development cannot be resumed for any claims after a final decision without either a new claimed medical condition or a Director's Order. New evidence for previously adjudicated medical conditions must be properly reviewed.

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

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

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

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

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

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

This code can also be entered by the CE, senior, or supervisor when a

memo is drafted to the DD/ADD requesting a case be reopening, possible because of SEM database changes or new residual contamination information.

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

d. 'MQ' - Reopening Request Received in NO. NO staff enter this code. When a reopening request is received in NO from the DO, or the FAB, this code is required to denote receipt of the request and to indicate that the case file is physically present at the NO. The status effective date is the date of receipt of the request for a reopening in the NO.

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

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

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

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

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

g. 'MF' – Claim Reopened, File Returned to FAB. After the Director has determined a claim must be reopened and a new FAB final decision

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

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

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

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

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

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

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

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

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

Order vacating the final decision and granting the reopening.

Note: If a decision awarding medical benefits is vacated, the 'A' medical condition status must be set back to 'R' until a new decision is rendered. This will require technical support, but must be done to stop medical bills from being paid on ineligible claims.

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

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

a. 'ACP' – Additional Conditions Pending. If there is at least one additional condition (regular or consequential) that requires a decision (either a new CA code or new Recommended & Final Decision), the CE selects the 'ACP' reason code.

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

PM Part 3 – Fiscal

3-0100 Introduction

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1. Purpose and Scope. Part 3 describes the policies and procedures

related to the financial aspects of claims under the EEOICPA. Topics include bills for medical care and ancillary medical expenses; tort offset; state workers' compensation coordination; compensation for beneficiaries in disability and death cases; verifying continued entitlement to benefits; and overpayments.

Claims staff and fiscal officers are jointly involved in fiscal actions, and a medical bill processing agent is responsible for processing all medical bills.

2. Structure of Part 3.

a. Medical Bills. PM 3-0200 addresses medical bill processing in general, while PM 3-0300 addresses entitlement to and payment for ancillary medical services.

b. Payments and Offsets. PM 3-0400 discusses lawsuits and the effects of recovery from them on payments of benefits under EEOICPA, while PM 3-0500 addresses state workers' compensation benefits and the effect of their receipt on EEOICPA benefits.

PM 3-0600 discusses payment of compensation, to include exception processing of payments to terminal claimants; while PM 3-0700 describes the requirements for verifying continued entitlement to medical benefits.

c. Overpayments. PM 3-0800 provides an overview of the overpayment process and describes the actions taken when an overpayment is identified. PM 3-0900 addresses the debt collection process.

3. Reference Materials. A list of references available to staff is shown in EEOICPA PM 2-0100.

3-0200 Medical Bill Process

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1. Purpose and Scope. This chapter describes the roles of the Claims Examiner, Fiscal Officer, and District Medical Scheduler, in the medical bill process; and outlines the procedures for evaluating and approving requests from employees and their families who are in need of medical services, supplies, or reimbursement of expenses related to medical care.

2. Roles and Responsibilities. Upon issuance of a final decision approving a specific medical condition, the Claims Examiner (CE), the Bill Processing Agent (BPA), the Fiscal Officer (FO), and the Medical Scheduler (MS) must ensure that the basic medical needs of the claimant, as they relate to his or her accepted medical condition, are reasonably provided for.

a. Medical Bill Processing Agent (BPA). The use of a contractor for processing medical bills allows the DEEOIC to provide a high level of service to eligible claimants and their providers. Once a claimant has been accepted for a covered condition under the EEOICPA, an eligibility file is automatically generated in ECMS and sent to the BPA electronically.

(1) When the BPA receives the eligibility file, the BPA sends a medical bill identification card (MBIC) and general information about the medical bill process to the claimant.

(2) DEEOIC sends all medical bills, treatment notes, and

requests for claimant reimbursement directly to the contractor for scanning and keying into their system.

(3) The BPA maintains a customer call center, medical staff, and bill resolution units.

b. Point of Contact Claims Examiner. The Point of Contact Claims Examiner (POC CE) is a specialized claims examiner responsible for reviewing, developing, and approving or denying requests for in-home health care. Each District Director is to appoint one to three CEs (as appropriate) to serve in this role.

c. Claims Examiner. The Claims Examiner (CE) considers for approval those Level 4 services (see Para. 3), appliances, supplies, modifications, or travel expenses that are recommended or prescribed by a licensed physician, and necessary to cure, give relief, or aid in reducing the overall cost of services required by the employee for an accepted condition. (Refer to EEOICPA PM 3-0300 for detailed information on approval of durable medical equipment, hospice services, in-home health care, gym memberships, extended medical travel, and other ancillary medical services.)

(1) The CE considers the level of care prescribed by the treating physician as it relates to the accepted medical condition and the facts of the case. The CE must then make an informed judgment based on the level of care prescribed by the doctor.

(2) This decision must take into account the overall desires and needs of the patient, as well as those of the family. DEEOIC will not dictate or demand what option an employee must accept, nor will decisions be made based solely upon cost.

The CE must also consider what level of care or services satisfy the patient's needs.

(3) The CE is responsible for communicating all decisions (approval/denial) to the requestor.

(a) If a request for services or payment originates from the BPA, the fiscal officer notifies the CE via e-mail. These requests may come to the CE as a prior authorization request, or may come after submission of a charge to the BPA.

The CE's determination are communicated via e-mail to the fiscal officer, input into ECMS notes, and communicated to the BPA via letter explaining the decision.

(b) If the request originates from a claimant or provider, the CE immediately sends a copy via facsimile to the BPA, and concurrently begins development for approval or denial of the request.

All approvals or denials are communicated to the requestor as outlined above.

d. Fiscal Officer. The Fiscal Officer (FO) acts as liaison between the CE and the Medical BPA, serves as coordinator for medical bill issues between the District Offices and the National Office, and maintains a District Office record of persons authorized to access the BPA website. The FO does not determine eligibility or authorize payments.

e. Medical Scheduler. The Medical Scheduler (MS) coordinates all requests for both internal and external District Medical Consultant reviews. The Medical Scheduler serves as the primary assistant to District Medical Consultants who are assigned to the District Office on a part-time basis.

f. District Medical Consultant (DMC). The DMC reviews and evaluates the medical evidence of record and provides medical opinions about various aspects of cases, such as:

(1) Causation: The DMC determines medical causation by reviewing medical, employment and exposure evidence to determine if the medical history is indicative of toxicity (arising out of exposure to a toxic substance) or of an organic/other nature (arising out of a natural medical occurrence, such as hereditary factors, or a lifestyle illness). The DMC may also be called upon to determine the likely role of an accepted condition as it relates to a cause of death, or the appearance of secondary or consequential illnesses or diseases.

(2) Explanation of treatment modalities, the interpretation of clinical test results, and the clarification of other physician's reports.

(3) Determining the level of impairment in a given case in accordance with the AMA Guides to the Evaluation of Permanent Impairment, 5th Edition, subject to DEEOIC's guidance.

3. Parameters for Payment. OWCP procedures employ four levels of review in the medical bill process, only two of which DEEOIC currently uses. The BPA automatically processes charges for Level 1 services and the CE is not required to approve. Any higher level of service (i.e. two, three or four) is treated as a Level 4 service in our program and requires that the CE review the proposed procedures or service(s), the proposed charges if applicable, and the supporting medical documentation, prior to approving or denying the request. All of the following services (Paragraphs 4 through 11) are Level 4 services.

4. Mailbox for Medical Bill Inquiries. The Policy, Regulations and Procedures Unit (PRPU) of the DEEOIC Policy Branch, located in the National Office (NO), has created an electronic mailbox (email) for

use in resolving medical bill questions. This mailbox is to be used when submitting inquiries concerning medical bills, travel reimbursement, treatment suites, provider outreach, or policy questions regarding medical bill processing.

The Fiscal Officers (FO) in each respective district office serve as liaison for Claims Examiners (CE) with questions that require review by the PRPU, at the NO. CE2 staff submit questions to the mailbox through the CE2 Unit Manager. The Fiscal Officers and CE2 Unit Managers act as the District Office Point of Contact (DO POC) for purposes of communicating medical bill issues to the PRPU. A Medical Bill Processing POC at the National Office (Medical Bill POC) is responsible for routing email inquiries to the proper party at the NO.

Use of this mailbox provides for expedited resolution of medical bill issues as they arise, and provides a more uniform process for responding to these questions and issues, program wide. The email address is DEEOICbillpay@dol.gov, and is to be used exclusively by the DO POCs, upon completion of the following steps:

a. When a CE receives an inquiry regarding reimbursement of a medical bill, for an accepted condition, the CE first reviews the bill in the Achieve medical bill inquiry system, and/or the Stored Image Retrieval(SIR)system, available at: http://owcp.dol.acs-inc.com/portal/main.do) in order to verify that the supporting medical documentation is on file. If, after reviewing the supporting documentation in the ACS web portal and in the case file, the CE still has questions related to medical bill processing, travel reimbursement, treatment suites, provider outreach, or a policy question regarding medical bill processing, additional assistance may be requested through the medical bill inquiries mailbox.

b. The CE prepares an email to the DO POC, or the CE2 prepares an email to the CE2 Unit Manager. In order to maintain consistency and to provide clarity in the communication process, it is imperative that the CEs provide sufficient information in the email, clearly defining the nature of the question, so that it can routed to the proper entity at the NO. Inquiries to the mailbox should be categorized using the subject headings below, and the subject line of the email must contain one of the following four subject headings:

(1) Policy Questions. Questions regarding policy interpretation or implementation are answered by the Medical Bill POC.

(2) Treatment Suites. The treatment suites and ICD-9 codes utilized by the DEEOIC are contained within a database, administered by medical professionals within the OWCP. This database compares an ICD-9 coded diagnosis, and associated services being billed by a provider, with a group (or suite) of acceptable, allowable treatments or services for that accepted condition. The use of treatment

suites allows bills to be paid automatically when the treatment being billed is reasonable and customary for the accepted condition. Often, issues arise when a claimant is trying to obtain payment for a consequential illness and the medical bills are being denied because the consequential illness is not being recognized within the treatment suite(s) for the accepted condition. Inquiries of this nature will be directed to the Medical Bill POC, for a response.

(3) Provider Outreach. Questions from medical providers regarding assistance with enrollment, submission of bill(s), or understanding DEEOIC's medical billing process, must be forwarded to the Medical Bill POC, who will then coordinate with the Resource Center (RC) Manager on these issues. Provider outreach issues must be coordinated through the Medical Bill POC.

(4) Bill Payment Processing. Questions regarding reimbursement of medical bills should use this subject heading, and will be routed to Payment Systems Manager for a response.

The body of the email itself must contain the following information (as applicable):

- District Office Location;
- CE Name;
- Employee's Name;
- DOL File Number(not to be used in the subject line);
- Accepted Condition(s) with ICD-9 code(s);
- Billed Amount(s);
- Date(s) of Service(s)or Travel day(s);
- Medical Provider Name(s);
- Type of Service(s) (i.e., Pharmacy, In-Home Health);
- Question(s) or issue(s) to be resolved.

c. Upon receipt of an email question being posed, the DO POC reviews the email carefully and determines whether the issue warrants review by the NO. If the question does warrant such review, the POC forwards the inquiry to DEEOICbillpay@dol.gov.

d. The Medical Bill POC reviews all submissions received in the medical bill inquiries email box and determines the proper course of action. As noted above, all policy, treatment suite, and medical provider outreach questions will be evaluated and answered directly by the Medical Bill POC. Issues related to medical bill payments

will be forwarded to the NO Payment Systems Manager, who is responsible for evaluating each inquiry and providing a response. Some referrals to the mailbox may have elements related to several topics in the inquiry, and the Medical Bill POC ensures that the question is evaluated by the proper individual(s), and coordinates the response to the DO.

e. In the case of a policy or treatment suite issue, the Medical Bill POC researches the inquiry and provides an answer to the requesting DO within five (5) business days. If a policy question requires additional research, a reasonable extension of time is granted by one of the PRPU Policy Unit Chiefs. Complex policy issues might require the involvement of the Policy Branch Chief before a response can be generated, and the Medical Bill POC must monitor such issues to ensure that they are resolved in a timely manner.

f. The Medical Bill POC forwards all medical bill payment inquiries directly to the Payment Systems Manager, who assesses each question and provides an answer directly to the inquiring DO within five (5) business days of receipt of inquiry.

g. The Medical Bill POC refers all medical inquires to the RC Manager for response. The RCs serve as the primary point of contact for DEEOIC's provider enrollment inquiries. The RC Manager will provide a response to the Medical Bill POC within three (3) business days of receipt detailing the planned response to these types of inquiries. The Medical Bill POC will relay the proposed response(s) to the inquiring DO so the DO is aware that resolution is being sought.

h. Upon receipt of inquiry responses, the DO POC forwards the response to appropriate CE/CE2 via e-mail. The CE/CE2 is responsible for notifying the employee, claimant, authorized representative and or provider (if applicable), via telephone or in writing, of appropriate response to the issue at hand. All telephone activity is documented in the Energy Case Management System (ECMS) Telephone Management System (TMS) and a copy of the email response from the Medical Bill POC or Payment Systems Manager is placed in the case file.

i. Policy decisions rendered through this process, which have the potential for program-wide impact, are treated like policy teleconference notes, and are placed on the shared drive for use by all DEEOIC staff. It is the responsibility of the Medical Bill POC to ensure that such issues, as identified by the PRPU Unit Chiefs/Policy Branch Chief, are added to the policy teleconference answers, on the shared drive.

5. District Medical Consultant Reviews. For detailed information on the DMC referral process, refer to DEEOIC procedures on weighing medical evidence.

6. Medical Records Procurement. DEEOIC pays cost associated with

obtaining medical records regardless of whether a claim has been approved for benefits. This reimbursement is payable only to a hospital, physician's office, or other medical facility that charges a fee to produce records. The maximum allowable reimbursement is $100 per employee.

a. Form of Request. The provider provides the CE with the written fee request on official letterhead or billing statement. The request includes the tax identification number of the facility, total amount charged for the record request, and the provider enrollment number. If the provider is not enrolled, the CE forwards an enrollment package to the provider with a letter requesting that the provider enroll, and after completion of the enrollment process, the provider informs the CE of their new provider number.

b. Approval of Payment. Upon receipt of the required information, the CE approves the payment of the bill by completing a Form OWCP-1500, sending an approval letter to the requestor, and completing ECMS coding as required in DEEOIC procedures. The CE then forwards the completed Form OWCP-1500, approval letter, and invoice to the Fiscal Officer for payment processing.

7. Psychiatric Treatment. Prior to approval of psychiatric treatment, the CE must conduct the necessary medical development to substantiate a psychiatric condition as a consequential condition of an accepted illness; and the consequential condition must be accepted.

a. Expense of support groups that meet on a periodic basis, for individuals with a similar covered illness, are acceptable for reimbursement under the EEOICPA.

b. For ongoing therapy or for personalized care for a psychiatric condition, the CE obtains medical records and reports that support the need for these specific services as treatment for a consequential condition of the covered illness.

c. A narrative medical report from a licensed psychologist or psychiatrist must be submitted which includes:

(1) Diagnosis (with correct code);

(2) Medical rationale in support of how the psychiatric condition is related to the approved illness.

d. After appropriate development the CE decides whether to approve a psychiatric condition as a consequential illness. The CE advises the claimant of the decision to accept (via letter) or deny (via a Recommended Decision followed by a Final Decision), and updates ECMS as appropriate.

8. Hearing Aids (above $5000). The CE approves hearing aids in excess of $5,000 when hearing loss has resulted from an accepted illness, if the treating physician so recommends. DEEOIC may authorize maintenance of hearing aids, including batteries, repairs,

and replacement as needed. For hearing aids under $5,000, see DEEOIC procedures regarding durable medical equipment.

9. Chiropractic Services. Chiropractic services may be authorized, but are limited to treatment for correction of a spinal subluxation, along with the tests performed or required by a chiropractor to diagnose such subluxation. A diagnosis of spinal subluxation must be documented with an x-ray in the chiropractor's report prior to the CE considering payment.

10. Acupuncture Treatments. Acupuncture treatments may be authorized when recommended by the treating physician to provide relief. Such treatment shall be supervised by the treating physician, who shall submit periodic reports to show progress or any relief of the symptoms. If the treatment continues beyond six months and/or the results are questionable, the case should be referred to the DEEOIC Medical Director.

11. Organ Transplants (including Stem Cell). Treating physicians send all requests for organ transplants to DEEOIC's bill processing agent (BPA) via fax, mail, or electronically, to begin the authorization process. The BPA creates an electronic record of all such requests, and initiates a thread to the district office FO, advising of a new, pending organ transplant request. The FO alerts the CE of the request for a transplant, and the CE ensures that the case file contains the necessary documentation, including a letter describing the necessity of the transplant from the treating physician, laboratory and diagnostic test results, CT or MRI scan results, and a transplant protocol. Once the CE has verified that this information is on file, and is contained in the thread, the CE forwards the information to the Medical Bill POC. The Medical Bill POC forwards all pertinent information to the DEEOIC Medical Director, who prepares a memorandum approving or denying the transplant for signature by the DEEOIC Director. The signed memorandum is returned to the DO following signature by the DEEOIC Director. All approved requests for organ transplants must be performed at a CMS (Center for Medicare and Medicaid Services) approved facility. See http://www.cms.hhs.gov/ApprovedTransplantCenters/

An organ donor is not considered an "employee" or "claimant" within the meaning of DEEOIC and is not entitled to compensation for wage-loss or permanent impairment, nor is a donor entitled to benefits for any complications resulting from the transplant. Only those medical and related expenses of the donor which are necessary to secure treatment for the employee are allowable.

a. In-Patient or Out-Patient. Depending upon the transplant center, the condition of the patient, and geographic limitations, transplant procedures may be performed on an in-patient or out-patient basis. Once a treating physician has requested approval for an organ transplant of any type, the CE forwards a letter to the

transplant center requesting a detailed schedule of the procedures to be performed, and whether the procedure(s) require in-patient stay.

(1) Autologous transplants may be performed on either an in-patient or out-patient basis, depending upon the transplant center. This type of transplant requires stem cells that have been gathered and stored, coming directly from the patient. No unrelated donor, related donor, or cord blood search needs to be authorized.

(2) Allogenic transplants may also be performed on either an in-patient or out-patient basis. Allogenic transplants require that donor-blood stem cells be drawn, stored, and then transplanted into the patient.

b. Choice of Donors.

(1) The first choice of a donor is generally a family member or relative. If the transplant facility approves a related donor, transportation expenses and the cost of required medical procedures for obtaining the organ(s) or blood stem cells are reimbursable. The transplant facility bills DEEOIC, referencing the employee's (recipient) SSN, in addition to pertinent information pertaining to the donor. Travel is reimbursed following the same guidelines established for companion medical travel, and is paid to the employee.

(2) If no suitable match is available through a relative, an unrelated donor search must be authorized. The transplant center coordinates with the National Donor Program for the testing of each potential donor. The transplant center bills for all such tests and procedures. The average time waiting for an unrelated donor is four months. Unrelated donors are not paid for their donation; the only coverage is for the medical expenses related to the organ donor procedure. These procedures are billed by the transplant facility, the same as with related donors, referencing the covered employee's social security number on all bills.

c. Long-Term Living Expenses. In many cases, transplants involve prolonged out-patient procedures requiring the patient to remain within a short distance of the transplant center. If the transplant procedure is authorized, and if it requires extended residency near the facility, lodging, per diem, companion, and other travel-related expenses may have to be authorized on a long-term basis. (Refer to Chapter 3-0300 for additional guidance on reimbursement for extended medical travel.)

12. Experimental Treatment and Clinical Research. Experimental treatments, or those which are generally not accepted, will be considered if: the accepted condition is life-threatening;

established therapy has been tried to no avail; and a significant body of data supports the view that the experimental procedure is indeed beneficial.

All such requests are forwarded to the DEEOIC Medical Director for concurrence using the same procedures for organ transplants as outlined above, with the exception of the documents needed to approve the treatment. To request experimental treatment, the treating physician must send the treatment protocol, medical rationale, and peer reviewed documents supporting the treatment to the CE, to be forwarded to the NO for review.

13. Treatment Suites. At the core of the medical bill reimbursement process is the use of treatment suites. The treatment suites used by the DEEOIC are contained in a database maintained by medical professionals within the OWCP. They compare an accepted (ICD-9 coded) diagnosis for which a provider has billed, with acceptable, allowable treatments for that condition. The use of treatment suites allows automatic payment of bills, for authorized services, when the amount billed is reasonable and customary for an accepted condition.

14. Eligibility Files. In order for a claimant's bills to be paid, an eligibility file is automatically generated in ECMS and sent to the bill processing agent once a condition has been accepted. This eligibility file contains the accepted condition for which a claimant is entitled to medical treatment. When the accepted condition(s) are coded and billed with the correct ICD-9 Code, the volume of suspended and denied bills is significantly reduced. Consequently, accurate code selection expedites provider reimbursement for all approved medical services rendered to the claimant.

15. ICD-9-CM. The International Classification of Diseases, 9th Revision, and Clinical Modification, (referred to simply as ICD-9 codes), is a statistical classification and coding system used to assign appropriate codes for signs, symptoms, injuries, diseases, and other medical conditions.

These codes are assigned, based on the claimants' medical documentation (records), including, but not limited to physician notes, diagnostic tests, and surgical reports. ICD-9 codes are composed of numbers with 3, 4, or 5 digits. Three-digit category codes are generally subdivided by adding a fourth and/or fifth digit to further specify and clarify the nature of the disease or medical condition. The CE entering an ICD-9 code must identify and enter the code that references the disease, illness or medical condition that was reported, and should identify the organ(s) or portion of the body affected by the condition.

In general, three-digit codes identify a category of illness, while codes with fourth digits are called subcategory codes, and those with fifth digits are referred to as sub-classifications.

When a specific condition, illness, etc., contains a 4th or 5th

digit, the CE uses all available digits to identify the condition. In addition to providing further specificity of the anatomical site, the 4th and 5th digits also provide additional pertinent clinical information related to the injury or medical condition. Therefore, when selecting ICD-9 codes, the CE should always use the code that most specifically describes the medical condition reported.

a. Examples of valid 3-digit codes:

(1) 496- Chronic Obstructive Pulmonary Disease (COPD).

(2) 501- Asbestosis.

b. Examples of 4-digit and 5-digit codes:

(1) 162.5- malignant neoplasm, lower lobe, bronchus or lung (requires a 4th digit).

(2) 508.0- Acute pulmonary manifestation due to radiation (requires 4th digit).

(3) 205.10- Myeloid leukemia, chronic, in remission (requires a 5th digit).

(4) If an employee was diagnosed with diabetes mellitus, it would be incorrect to assign code 250, since all codes in the diabetes series (250) have five digits.

16. Coding Software. Claims examiners are to utilize the coding software which is available at http://www.ingenixexpert.com/expert. This is an online tool that helps to identify the appropriate ICD-9-CM code. These guidelines are to be used as a supplement to the ICD-9-CM Coding books.

17. Prompt Pay. The Prompt Payment Act requires federal agencies to pay vendors in a timely manner. The Act requires assessment of late interest penalties against agencies that pay vendors after a payment due date. The DEEOIC has identified three classes of bills that fall under the Prompt Pay Act: Reviews by a District Medical Consultant, Second Opinion/Referee Medical Examinations, and Impairment Rating Examinations. These bills must be processed within seven calendar days from date of receipt in the District Office. (Refer to PM 2-800 for the specific actions to be taken by the CE and the Medical Scheduler in the processing of DMC bills.)

18. Time Limits for Submission of Medical Bills. DEEOIC pays providers and reimburses employees promptly for all bills that are properly submitted on an approved form and which are submitted in a timely manner. No such bill is paid for expenses incurred if the bill is submitted more than one year beyond the end of the calendar year in which the expense was incurred, or the service or supply was

provided; or, more than one year beyond the end of the calendar year in which DEEOIC first accepted the claim, whichever is later.

19. Fee Schedule. For professional medical services, OWCP maintains a schedule of maximum allowable fees for procedures performed in a given locality.

The schedule consists of:

a. An assignment of a value to procedures identified by HCPCS/CPT code which represents the relative skill, effort, risk and time required to perform the procedure, as compared to other procedures of the same general class.

b. An index based on a relative value scale that considers skill, labor, overhead, malpractice insurance and other related costs.

c. A monetary value assignment (conversion factor) for one unit of value in each of the categories of service.

Generally, bills submitted using HCPCS/CPT codes can not exceed the fee schedule. If the time, effort and skill required to perform a particular procedure varies widely from one occasion to the next, DEEOIC may choose not to assign a fee schedule limitation. In these cases, the allowable charge is set individually based on consideration of a detailed medical report and other evidence. At its discretion, DEEOIC may set fees without regard to schedule limits for specially authorized consultant examinations, and for other specially authorized services.

20. Fee Schedule Appeal Process. As part of the medical bill review process, the EEOICPA regulations provide for the appeal of fee schedule reductions (charges by a provider that have been reduced in accordance with the OWCP fee schedule for that specific service.) In order to maintain consistency, record responses, and track fee schedule appeals, the following procedures have been developed to further delineate this process.

a. When the BPA receives a fee appeal request letter, the BPA stores an electronic copy of the appeal letter in the Stored Image Retrieval system (SIR), linked to the remittance voucher, and sends a printed copy of the letter to DEEOIC Central Bill Processing, through the NO Payment Systems Manager (PSM).

b. For each fee schedule appeal letter received, the PSM creates a record, and maintains them in a tracking system (spreadsheet or database) created for this purpose.

c. The PSM reviews the fee appeal request to determine if the provider has met any of the conditions below which justify a reevaluation of the amount paid. These three conditions, as found in 20 C.F.R. 30.712, are:

(1) The service or procedure was incorrectly identified by the original code; or

(2) The presence of a severe or concomitant medical condition made treatment especially difficult; or

(3) The provider possesses unusual qualifications (i.e. possesses additional qualifications beyond board-certification in a medical specialty, such as professional rank or published articles.)

d. Within 30 days of receiving the request for reconsideration, the PSM prepares a response to the medical provider outlining DEEOIC's decision to either:

(1) Approve an additional payment amount: In this instance, the PSM generates a draft letter for the District Director's (DD) signature, informing the provider of the approval for additional payment. [Where an additional amount is found to be payable based on unusual provider qualifications, the DD determines whether future bills for the same or similar service from that provider should be exempt from the fee schedule.] The PSM also prepares a memorandum for the case file stating the findings and the basis for the approval of the additional amount, or;

(2) Deny any additional payment: In this instance the PSM prepares a draft letter-decision for the DD's signature, advising that additional payment is denied, based upon the provider's failure to establish one of the conditions listed above, in Item c above(1,2,3). Where additional payment is denied, the letter decision must contain a notice of the provider's right to further review, similar to the following:

If you disagree with this decision, you may, within 30 days of the date of this decision, apply for additional review. The application may be accompanied by additional evidence and should be addressed to the Regional Director, District _____, Office of Workers' Compensation Programs, U.S. Department of Labor, [Insert appropriate Regional Office address and Zip Code.]

e. The draft approval or denial letters are prepared by the PSM, for the signature of the District Director (DD) whose office has control of the claim file(s) being addressed in the decision(s). The PSM sends the draft letter (via email) to the District Director for review, signature, and mailing. The DD places a copy of the signed letter in the case file and also returns (via email) a scanned copy of the signed letter, to be retained by the PSM.

f. The PSM continues to track the status of any fee schedule appeal case, and maintains an electronic copy of all correspondence. This includes a copy of the draft letter and a scanned copy of the signed letter mailed by the DD.

g. If a denial is subsequently appealed to the Regional Director (RD), the RD must consult with the PSM to obtain copies of relevant

bills and documents, and to discuss the appeal. The PSM also provides the RD with a copy of the denial letter signed by the DD. This can be handled via email.

h. After consultation with the PSM, the RD prepares a written response to the provider within 60 days of receipt of the request for review. Where additional payment is denied at the regional level, the letter decision from the RD advises the provider that the decision is final and is not subject to further administrative review. The RD forwards a scanned copy of the signed letter decision to the PSM. The PSM also retains that response as part of the appeal record.

i. The final outcome of each appeal letter is recorded in the PSM tracking system to indicate:

(1) Additional payment made.

(2) DD Denial letter.

(3) RD Appeal letter.

(4) Time limit (30 days) has expired for appeal to RD.

(5) The final disposition date for each appeal letter.

3-0300 Ancillary Medical Services and Related Expenses

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1. Purpose and Scope. This chapter describes the procedures for evaluating and approving requests from claimants who need ancillary medical services and supplies, and who seek reimbursement of expenses related to ancillary services. The roles and responsibilities of those who authorize such expenses are described in EEOICPA PM 3-0200.

2. In-Home Health Care. This section provides clarification with regard to the evidence needed to authorize in-home health care, as well as procedural guidance with regard to the process for review, development, and authorization of in-home health care services.

a. All requests for in-home health care must be submitted to DEEOIC's bill processing agent (BPA) via fax, mail, or electronically, to begin the authorization process. The BPA creates an electronic record of all such documents and requests, and initiates a thread to the district office Fiscal Officer (FO), advising of a new pending in-home health request. FO is the point of contact with DEEOIC's BPA for all in-home health care requests.

b. All requests for in-home health care require prior authorization from the POC Claims Examiner (expedient review occurs under certain emergency situations - see "q" below for further information), including authorization for initial nurse assessment. If a physician requests that an initial in-home assessment be performed to determine the need for in-home health care, the request for that initial assessment must be submitted to the BPA with appropriate supporting medical documentation.

c. Written requests that are received in the district office from the claimant, the authorized representative, the treating physician, or a service provider, must be faxed by the POC CE to the BPA to begin the authorization process. Concurrently, the POC CE begins

development on any such request while awaiting an acknowledgement from the BPA.

d. If the POC CE receives a request for an initial assessment without a physician's signature or recommendation, the POC CE must fax it to the BPA and begin concurrent development, the same as in step "c" above. The POC CE sends a letter to the claimant advising that a request for an initial in-home assessment was received without a physician's recommendation. In the letter, the POC CE provides 30 days for receipt of a physician's authorization or request for the assessment. If medical documentation is not received within 30 days, the POC CE denies the request for assessment pursuant to the instructions in "y" below.

e. Telephone requests for in-home health care must be documented in ECMS. Except in cases of an emergency nature (See "r" below), the POC CE may provide information and answer questions pertaining to in-home care covered by DEEOIC, however all callers should be advised that they must submit their requests in writing before the authorization process can begin. Written requests must include a medical rationale and a detailed explanation of the type and level of service the patient requires.

f. Valid requests do not always have to be initiated by a claimant to be considered valid requests. Requests for an in-home assessment of a patient's needs, and/or requests for in-home care can be initiated by an authorized representative, or any licensed doctor or medical provider.

g. Upon receipt of an authorization request for in-home health care from the BPA, the FO forwards the information to the appropriate POC CE for review and adjudication.

h. Upon receipt of such request, the POC CE must determine the particular in-home health services or care being requested. Generally, the types of requests that are submitted include: a physician's request for authorization of an initial in-home assessment; discharge summary from a hospital requesting specific in-home health care services; or requests from a physician for continuing in-home health care services (following expiration of a previous authorization).

i. Upon receipt of a request, the POC CE reviews the medical evidence to determine if the initial assessment or in-home health care was requested by the treating physician. If the request comes from the treating physician, or another appropriate doctor, the POC CE approves the initial assessment only (if applicable). When an initial assessment request precedes a request for in-home health care, the POC CE may not approve in-home health care until after the initial assessment has been completed and a plan of care has been submitted. Once the POC CE approves the initial assessment, the POC CE sends an email to the FO, who sends a thread to the BPA authorizing the request (see "p" for more information concerning

approvals).

j. Upon receipt of a plan of care, discharge summary, or physician's recommendation delineating a specific request for in-home health care services, the CE must conduct a complete review of the case file to determine if there is any recent medical documentation from the primary care physician (or treating specialist for the accepted condition), describing the need for in-home medical care as it relates to the covered medical condition. The primary information that the treating physician must provide (often contained in the plan of care signed by a physician) should include:

(1) Description of the in-home medical needs of the patient arising from the covered medical condition. This includes a narrative of the patient's medical need for assistance while in the home and how this is linked to the covered medical condition. The physician must describe the findings upon physical examination, and provide a complete list of all medical conditions (those accepted by DEEOIC and those not accepted by DEEOIC). If a claimant has one or more non-covered conditions, medical evidence must demonstrate how the requirement for in-home health care is related to the accepted conditions. The physician should also describe laboratory or other findings that substantiate a causal relationship between the accepted condition(s) and the need for assistance or skilled nursing care in the home. Generally, approved in-home services include: administration of medication, medical monitoring, bathing and personal hygiene, meal preparation and feeding, wound dressing changes, and medical equipment checks.

(2) Level of care required, i.e. Registered Nurse (RN), Licensed Practical Nurse (LPN), Home Health Aide (HHA), etc. The doctor must specify the appropriate type of professional who will attend to the patient. Services requiring specialized skills such as administration of medication and medical monitoring generally require a RN or LPN, while services of a general nature (typically referred to as activities of daily living), such as bathing, personal hygiene, and feeding are generally performed by home health aides and attendants.

(3) Extent of care required (months, days, hours, etc). A written medical narrative must describe the extent of care to be provided in allotments of time. (Example: RN to administer medication and check vitals once a day, every three days, with a home health aide to assist with bathing, personal hygiene, and feeding, eight hours a day, seven days a week for three months.)

k. If upon review the POC CE finds that the medical evidence is incomplete and the file does not contain an adequate description of the in-home health care needs of the patient, the POC CE prepares a letter to the claimant advising that the DEEOIC has received a

request for in-home health care. In the letter to the claimant, the POC CE advises that additional medical evidence is required before services can be authorized. Additionally, the POC CE forwards a copy of the claimant letter to the treating physician, requesting a narrative medical report that includes all of the information described in "j" (above). In addition, the physician is asked to estimate the length of time for which the patient will ultimately require in-home health care assistance. The POC CE advises in the letter that the medical report is required within 30 days. (see Exhibit 1 for sample letter) The POC CE also faxes a copy of the letter to the treating physician's office.

l. Upon mailing the request to the claimant (copy to the treating physician) the POC CE enters an ECMS note describing the action and inserting a 15-day call-up. If on the fifteenth day the physician has not responded, the CE contacts the physician's office to inquire if the letter was received, and to ask if there are any questions regarding the request for information. The call is documented in TMS and another 15-day call-up inserted in ECMS.

m. After 30 days has passed with no satisfactory response from the treating physician, or no response from the claimant, the POC CE prepares a second letter to the claimant (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 POC CE 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 in-home care may be denied by the DEEOIC (see Exhibit 2 for a sample letter).

n. If the claimant or the physician does not provide a response to the second request for information within the 30-day period allowed, the POC CE issues a letter decision to the claimant denying the claim for in-home health care. (See "y" below for more details.) The POC CE further sends an email to the FO, who sends a thread to the BPA advising that the service has been denied.

o. If the claimant calls and states that he/she does not require in-home health care, the POC CE requests that the claimant put this in writing. Upon receipt of any written statement from the claimant stating that he/she is not requesting in-home health care, the POC CE writes a letter to the claimant with a copy to the treating physician advising that the claimant is not requesting in-home health care and thus the matter is closed. In this situation, the POC CE sends an email to the FO, who sends a thread to the BPA advising that this service is denied.

p. If medical evidence is received, the POC CE must determine if it is of sufficient probative value to authorize in-home health care. It is absolutely critical that the POC CE undertake appropriate analysis of any documentation pertaining to in-home services before authorizing such care.

The underlying function of the POC CE is to ensure that the covered employee receives the necessary medical care for the accepted medical condition and that any such request for care reasonably corresponds with the medical evidence in the case file. If the physician does not provide sufficient details concerning the claimant's physical condition, relationship to accepted conditions, or specific reasons for in-home health care, the POC CE must refer the case to a District Medical Consultant (DMC) for review. Upon receipt of a DMC's opinion, the CE weighs the medical evidence in the file. If the DMC opinion is clearly in conflict with the recommendations of the treating physician, and the POC CE attempts to resolve the situation by communicating with the treating physician have not been successful, the POC CE is to arrange for a second medical opinion or referee evaluation, depending on the circumstances. In evaluating the medical evidence, the POC CE must base any determination solely on the weight of medical evidence in the case file. The POC CE must not under any circumstances deny or reduce in-home health care services without a medical basis for such denial.

q. In certain emergency claim situations (see "r" for a full discussion of the types of emergencies), the CE may authorize in-home health care for a preliminary 30-day period while additional development is undertaken.

(1) Under these circumstances, the physician or hospital staff contacts DEEOIC's BPA for immediate attention. The physician or hospital employee must notify the BPA that the situation is of an emergency nature (e.g., the claimant is being released from the hospital and requires immediate in-home care). The BPA obtains any pertinent documentation and assesses the emergency nature of the request. Once the medical evidence is obtained, the BPA contacts the FO immediately, advising of the situation and providing electronic copies of documentation obtained. The BPA does not make a decision regarding the request, but simply obtains the pertinent documentation and advises the FO of the emergency request.

(2) Upon receipt of the documentation, the FO forwards the information to the POC CE for review. If discharge information from a treating physician supports the need for immediate authorization, the CE provides approval for 30 days pending additional development. The POC CE concurrently sends an email to the FO advising of this approval. The FO sends a thread to the BPA with the approval information and places a telephone call to the BPA, alerting them of an impending emergency request.

(3) After the initial approval for 30-day emergency care, the POC CE sends a letter to the treating physician with a copy to the claimant requesting necessary evidence to fully substantiate that the care being provided is medically

necessary to give relief for the accepted medical condition. This should occur within the preliminary 30-day authorization period. Extensions may be granted in increments of 30 days, but should generally never exceed a total of 120 days without the collection of the necessary evidence to fully document that the care being provided is medically warranted and necessitated by the accepted medical condition.

(4) In some situations the request for emergency home health care may not be accompanied by evidence supporting the emergency nature of the request. For example, the claimant's condition may be stable, or he/she is not being discharged from a hospital. In these situations, the POC CE sends a letter to the claimant, with a faxed copy to the requestor if other than the claimant. The letter advises that no evidence was submitted to support the request for emergency care, and that additional medical evidence is required. In addition, the POC CE sends an email to the FO advising that the request for emergency care is under development. The FO sends a thread to the BPA advising of this determination and places a telephone call to the BPA, alerting them of an impending emergency request.

r. Emergency situations warranting short-term preliminary authorization for in-home health care include:

(1) Requests for in-home health care for terminal patients with six months or less to live. Terminal status must be based on the opinion of a physician.

(2) Patients discharged from in-patient hospital care with need for assistance. The CE must carefully evaluate these situations to ensure the medical documentation clearly indicates that the patient's care and well-being is dependent on the assignment of a medical professional in the home, (normally following a hospital stay). If the BPA has not already obtained this, the POC CE requests the attending physician discharge summary and discharge planning summary, which is normally available within 72 hours of discharge.

When pre-authorization of emergency in-home care is to be granted, the POC CE prepares a memorandum for the case file documenting the rationale applied in authorizing care. For each subsequent 30-day pre-authorization granted, a new memo is prepared outlining the basis for such authorization. In addition, the POC CE notifies the claimant and provider in writing of additional periods of authorization. The POC CE sends an email to the FO advising of any authorizations, and the FO forwards the information to the BPA in the form of a thread.

s. For all requests, if upon review of the medical evidence the POC CE decides that in-home health care is required, authorization is to

be granted. The POC CE prepares a letter notifying the claimant and the home health care provider of the decision, and delineating the following information (see Exhibit 3 for a sample authorization letter):

(1) Covered medical condition(s) for which care is being authorized.

(2) A specific narrative description of the service approved (e.g. in-home assistance in administering medicine, monitoring accepted conditions, assistance in/out of bed, preparing meals and feeding, and medical equipment checks).

(3) Level and duration of the specialized care to be provided, i.e. RN 1 hour per day and Home Health Aide 8 hours per day, 7 days a week for a period of 3 months.

(4) Authorized billing codes relevant to the level of authorization (see Exhibit 4 for a description of the pertinent codes).

(5) Period of authorization with specific start and end dates.

t. The authorization must be limited to in-home medical services that are reasonably necessary for the treatment or care of the patient's covered medical condition. These services generally include: Home Health Aide or attendant for mobility, food preparation, feeding and dressing; skilled nursing should be limited to the scope of practice of an RN or LPN, as long as there is medical evidence of such. The POC CE may not authorize a lower level of care than that requested by the physician unless the weight of medical evidence supports a lower level of care and the claimant has been provided the right to a recommended decision.

u. Once the responsible POC CE sends the letter of authorization to the claimant and the provider, the POC CE prepares an email to the fiscal officer (FO).

In the email, the POC CE advises the FO of the precise level of care, billing codes, and time period of authorization. The POC CE is not required to advise the FO of the number of correlating units per billing codes. In assigning billing codes, the POC CE references Exhibit 4.

v. Once the email authorizing the services has been sent, the POC CE enters a note into ECMS detailing the level of service and time period of authorization. In addition, the POC CE enters a call-up note into ECMS for 30 days prior to the expiration date for which services have been authorized.

w. If no request for additional authorization for in-home health care is received prior to the date of the call-up, the POC CE sends a letter to the provider, with a copy to the claimant. In the letter, the provider is notified of the expiration date of the in-home health care services. The provider is further advised of the medical evidence required if additional services are necessary. If the POC CE does not receive an additional request, further action is

unnecessary. However, if the provider or the claimant submits an additional request for ongoing services, the POC CE evaluates the evidence as above.

x. Upon receipt of the email authorization from the POC CE, the FO prepares a thread to the BPA authorizing the specific level of care, billing codes (with units), and period of authorization. The FO calculates the authorized number of units based upon the POC CEs description of the level of care, weekly authorized amount for each level of care, and the time period of authorization.

y. If upon review of the medical evidence in the file, and if after appropriate development as outlined above, the POC CE determines that there is insufficient evidence to warrant authorization of in-home health care, the POC CE sends a detailed letter-decision to the claimant (with a copy to the in-home provider). The letter-decision must include a sentence at the end with language as follows:

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.

z. In the event that the claimant does request a Recommended Decision, the POC CE prepares a Recommended Decision (see Exhibit 5 for a sample decision).

aa. At any time after a period of authorized services and after the POC CE has undertaken any medical development (i.e. letter to the claimant requesting additional documentation, referral to DMC or second opinion) the POC CE may receive new medical evidence that warrants a change in the level of in-home care currently authorized. If this occurs, the POC CE must review that evidence, employing the same decision-making process described in "p." If the new medical evidence supports a denial of services, or reduction in the level of services currently being authorized, that reduction or denial must be communicated to the claimant in a detailed letter as discussed in "y", (with a copy to the in-home care provider) explaining the change.

bb. Letters that advise of a reduction or termination of services must be copied to the in-home care provider and must specifically advise the claimant that:

(1) Any reduction in the current level of service being provided will occur 15 days from the date of the letter. This letter must also contain information describing the new level of care being authorized; or,

(2) Any termination of services will occur 30 days from the date of the letter.

cc. After the expiration of the 15 or 30 day periods, the POC CE sends a letter-decision to the claimant advising as to the final action taken on the request for in-home health care services. In

this letter the POC CE advises the claimant of his/her rights of action as delineated in action item "y" above.

In addition, the POC CE sends an email to the FO advising of the new level of care or the termination of current level of services. The FO then sends a thread to the BPA advising of the determination. It is very important for the POC CE to note that only a single authorization can exist at any one time. If the POC CE has authorized a certain level of care that subsequently changes, it is essential that this information be clearly communicated in an email to the FO. The FO sends a thread to the BPA advising of any change in the level of care being authorized, or of any additional period of authorization beyond the existing expiration date. The POC CE must also document the information in the notes section of ECMS when a thread is sent to the BPA.

dd. If the claimant requests a recommended decision on a termination of services, the POC CE proceeds with a recommended decision. If the claimant requests a recommended decision on a reduction in the level of care, the POC CE proceeds with a recommended decision.

ee. If, after initial approval of services, the claimant's treating physician sends in medical documentation (without prior POC CE development) recommending a lower level of care, the POC CE authorizes the new level of care via letter to the claimant (with a copy to the provider). Since the new level of care is requested by the treating physician without development by the POC CE, the POC CE does not need to provide the claimant with a right to a recommended decision. The POC CE concurrently sends an email to the FO advising of the new level of care. The FO sends a thread to the BPA advising of this change.

(1) Period of Service. In-home health care may be authorized for a period of up to six months. Recertification is required for any period of time beyond six months. Recertification should be completed before the current authorization expires, to allow for care to continue uninterrupted.

3. Attendant Services. This section provides clarification with regard to the evidence needed to authorize attendant services. Refer to item 2 of this chapter for guidance regarding development of attendant services.

a. Section 7384t of the EEOICPA authorizes payment for personal care services whether or not such care includes medical services, as long as the personal care services have been determined to be medically necessary and are provided by a home health aide, licensed practical nurse, or similarly trained individual.

(1) Attendant services are non-skilled services routinely provided in an in-home setting. These services assist

claimants with activities of daily living (i.e. bathing, feeding, dressing, etc). Attendant services must be provided by a trained individual.

(2) The POC CE may authorize attendant services to a claimant when a treating physician determines that these services are required for an accepted condition. The physician must provide a written statement, prescription or plan of care to that effect.

b. A claimant's relative may provide attendant care (if properly trained), but may not be reimbursed for care that falls within the scope of household duties and other services normally provided by a relative. Duties such as maintaining a household, washing clothes, or running errands are not considered attendant services, and will not be authorized. A claimant's relative who provides attendant care services to a claimant can be authorized for reimbursement up to 12 hours per day.

c. All requests for attendant services must be submitted to DEEOIC's BPA via fax, mail, or electronically, to begin the authorization process. The BPA creates an electronic record of all such documents and requests, and initiates a thread to the district office FO, advising of new, and pending attendant service requests. Upon receipt of an authorization request for attendant services from the BPA, the FO forwards the information to the appropriate POC CE for review and adjudication

(1) Period of Service. Attendant services may be authorized up to six months. Recertification is required for any period of time beyond six months. Recertification should be completed before the current authorization expires, to allow for care to continue uninterrupted.

(2) Billing. Attendant care services should be billed weekly or monthly. Supporting documentation (i.e., weekly or monthly notes) must be submitted with the bill to the DEEOIC's BPA. The DEEOIC's BPA then forwards weekly/monthly notes to the district office for review. In assigning billing codes, the POC CE references Exhibit 4.

4. Hospice Care. This section provides clarification with regard to the evidence needed to authorize hospice care services. Refer to item 2 for guidance regarding the development of hospice care.

a. Hospice care is generally requested and authorized when a claimant is determined to be terminally ill and has no more than six months to one year of life remaining.

(1) When a treating physician determines that hospice care is required for an accepted condition and provides a written statement, prescription or plan of care to that effect, the CE may authorize the services.

(2) Hospice, once authorized, is responsible for assessing

the claimant's needs and providing all levels of care to the claimant.

b. All requests for hospice care in the home must be submitted to DEEOIC's BPA via fax, mail, or electronically, to begin the authorization process. The BPA creates an electronic record of all such documents and requests, and initiates a thread to the district office FO, advising of a new, pending hospice request. All requests for hospice care require prior authorization from the CE. Upon receipt of an authorization request for hospice care from the BPA, the FO forwards the information to the appropriate CE for review and adjudication.

(1) Period of Service. Hospice services may be authorized for up to six months. Recertification is required for any period of time beyond six months. Recertification should be completed before the current authorization expires, to allow for care to continue uninterrupted.

(2) Billing. Supporting documentation (i.e., medical notes) must be submitted with the bill to the DEEOIC's BPA. The DEEOIC's BPA then forwards monthly notes to the district office for review. In assigning billing codes, the CE references Exhibit 4.

5. Extended Care Facilities. This section provides clarification with regard to the evidence needed to authorize placement in an extended care facility.

a. Care in a nursing home, skilled nursing facility and assisted living facility may be authorized when the claimant does not need acute care but does require medical services and assistance with daily activities of living.

b. All requests for extended care must be submitted to DEEOIC's BPA via fax, mail, or electronically, to begin the authorization process. The BPA creates an electronic record of all such documents and requests, and initiates a thread to the district office FO, advising of a new, pending extended care facility request. All requests for extended care require prior authorization from the CE. Upon receipt of an authorization request for extended care from the BPA, the FO forwards the information to the appropriate CE for review and adjudication.

When a treating physician determines that extended care is required for an accepted condition, and provides a written statement to that effect, the CE may authorize the services. The claimant should remain under continuing medical supervision of a physician while residing in an extended care facility.

(1) Period of Service. Extended Care facilities may be authorized up to six months. Recertification is required for any period of time beyond six months. Recertification should be completed before the current authorization

expires, to allow for care to continue uninterrupted.

(2) Billing. Supporting documentation (i.e., medical notes and itemization of charges,) must be submitted with the bill to the DEEOIC's BPA. The DEEOIC's BPA then forwards supporting documentation to the district office for review. DEEOIC will reimburse the rates for standard accommodations according to the requirements of the medical condition. In assigning billing codes, the CE references the Current Procedural Terminology (CPT) manual.

6. Durable Medical Equipment. This section describes procedures to be followed when a claimant requests authorization for durable medical equipment (DME), appliances and supplies. All DME, appliances, and or supplies must be purchased from a DME supplier.

a. DME is primarily and customarily used to serve a medical purpose only. DME can withstand repeated use, and is appropriate for use in the home. Some examples of DME include hospital beds, walkers, wheel chairs, and oxygen tents.

b. The District Office has broad discretion in approving DME, appliances, or supplies provided under the EEOICPA.

(1) Most appliances, supplies and or DME purchases under $5,000.00 do not need CE approval and are automatically paid by the DEEOIC's BPA in accordance with the OWCP fee schedule.

(2) Requests for DME, appliances and or supplies equal to or over $5,000 (excluding mobility devices) must be approved by the CE, and that approval must be communicated to DEEOIC's BPA through the FO.

(3) Requests for mobility devices, such as a scooter or a motorized wheelchair, including its components and accessories, which are medically necessary to provide basic mobility, under $10,000, do not need approval and are paid automatically by DEEOIC's BPA.

(4) Requests for mobility devices equal to or over $10,000 must be approved by the CE, and that approval must be communicated to DEEOIC's BPA through the FO.

c. When authorizing purchase requests for DME equipment equal to or over $5,000 and mobility devices equal to or over $ 10,000, the CE must obtain the following information:

(1) From the treating physician:

(a) The treating physician must provide either a detailed letter of medical necessity or another means of justification for the medical equipment required, relating the need to the accepted condition.

(b) A full, specific description of the basic

equipment.

(c) The anticipated duration of the need for the item (to determine whether rental or purchase is appropriate).

(d) The full name and address of two suppliers.

(2) Claimant:

(a) Claimant must submit two estimates from two different DME suppliers. These estimates must be for exactly the same type of DME appliances and or supplies.

(3) From the Supplier:

(a) From each potential supplier, a signed statement describing in detail the DME equipment item, a breakdown of all costs including delivery and installation, and the current Healthcare Common Procedure System (HCPCS) code for each DME item needed.

e. Estimates. The CE must authorize the lowest estimate provided that no exceptional circumstances warrant the higher estimate, (e.g., inability to provide the equipment in a timely fashion).

f. Repair/Maintenance Cost: Cost for repairs and maintenance to DME equipment is covered.

g. DME add-ons or Upgrades: Add-ons or upgrades are not covered; when they are intended primarily for the claimant's convenience, and do not significantly enhance DME functionality.

h. Communicating the decision. Upon receiving a request for DME, appliances or supplies, the CE takes one of the actions below:

(1) Approval: If the CE approves the request, he/she writes a letter to the claimant advising him/her of the decision. The letter includes the following: the date DO received the request; the type of service or appliance being approved; and a statement that the reimbursement amount will be based on the OWCP fee schedule. The CE also communicates this decision to the DEEOIC's BPA, through the fiscal officer. The claimant should be instructed to submit a copy of this approval letter, along with the request for reimbursement or payment, to the DEEOIC's BPA.

(2) Additional Information: If upon review the CE determines that additional information is necessary, he/she writes to the claimant requesting specific documentation that is necessary to continue the processing of the payment.

(3) Follow-up. If the provider and/or claimant do not respond to the development letter, or if he/she fails to

provide sufficient documentation to support their request, the CE has the discretion to either take additional steps to develop the evidence, or to deny the request. The CE must review the evidence in accordance with the guidance in this chapter, properly weighing the medical rationale provided.

(4) Denials. If the CE denies the request he/she writes a detailed letter decision to the claimant detailing the reason(s) for the denial. The letter-decision must include a sentence at the end with language as follows:

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.

(5) Recommended Decision. If the claimant requests a recommended decision, the CE proceeds with a recommended decision.

7. Vehicle Modifications and Purchases. This section provides clarification with regard to the evidence needed to approve vehicle modifications and purchases; as well as procedural guidance with regard to the process for review, development, and authorization of vehicle modifications and purchases.

a. When it becomes necessary to provide the claimant with some form of private transportation, other than taxis or hired services, modification to, or replacement of the claimant's privately owned vehicle can be approved. Upon receipt of a letter of medical necessity from the treating physician, detailing the physical limitations involved, and the specific transportations needs of the claimant as related to the accepted medical condition. The CE must gather two estimates from certified or licensed dealers for the cost of vehicle modifications recommended by the claimant's treating physician. The CE has the latitude to approve an estimate that the claimant favors, if the estimates are reasonably similar in scope and cost.

(1) Criteria for Modifications. If the claimant's transportation needs can be met by modifying or adding accessories and equipment to the claimant's present vehicle, the CE explores this option first, before consideration is given to replacing the existing vehicle. When considering modifications to an existing vehicle, the CE takes into consideration the type of vehicle currently owned, its age, and condition. Modifications must be consistent with the claimant's pre-injury standard of living and should approximate that standard insofar as is practical.

(2) Proposals. If the CE determines that the claimant's needs warrant vehicle modification, the CE advises the

claimant in writing to submit a detailed written proposal containing the following information:

(a) The year, make, model, and body style of the vehicle to be modified, as well as current mileage, description of general mechanical condition, and any repairs currently needed or anticipated. The same applies regardless of whether the vehicle to be modified is new or used.

(b) An itemization of all vehicle modifications proposed, to include parts, labor and their respective costs. The itemization should also specify the amount of time required for the modifications.

(3) After considering the proposal for modification to an existing vehicle, the CE accepts or rejects the proposal, in writing, within a reasonable time frame.

(4) Approval. If upon review of the evidence the CE approves the request, the CE writes a detailed letter decision to the claimant advising of the approval.

(5) Notifying the BPA. Once the CE sends the letter of approval to the claimant, the CE prepares an email to the FO. In the email, the CE advises the FO of the approval, citing the appropriate homegrown code (e.g. VHMDF, VHPUM) for a vehicle modification or purchase and the amount approved. The fiscal officer communicates this approval to DEEOIC's BPA.

(6) Additional Information. If the CE determines that additional information is necessary, the CE sends a letter to the claimant requesting additional documentation that is necessary to continue with the review process.

(7) Follow-up. If the claimant does not respond to the development letter, or if he or she fails to provide sufficient documentation to support the request, after considering all relevant evidence, the CE issues a detailed letter decision informing the claimant of the denial. The CE also informs DEEOIC's BPA through the FO of this denial. The letter-decision must include a sentence at the end with language as follows:

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.

(8) Recommended Decision. If the claimant requests a recommended decision, the CE proceeds with a recommended decision.

(9) Purchase. If it is established that the claimant's currently owned vehicle is no longer acceptable for his or

her transportation needs, and if modifications to that vehicle are not possible or practical, then the CE reviews the case with a supervisor and may authorize the purchase of a suitable replacement vehicle, taking credit (see (e) below) for the value of the claimant's existing vehicle. Purchase options include the following:

(a) Purchase of a used vehicle, similar in quality to the claimant's existing vehicle, which is already equipped to accommodate the claimant's disability and transportation needs.

(b) Purchase of a used vehicle that is suitable for modification as described above.

(c) Purchase of a new vehicle, modified, or suitable for modification, to meet the transportation needs of the claimant, arising from an accepted condition.

(d) Whether a new or used vehicle is purchased, it must be a vehicle of similar quality as the vehicle that the claimant already owns (i.e. a vehicle in a price range that closely approximates the level of income and/or standard of living of the claimant).

For example if the claimant owns a mid-priced Chevrolet, Ford, Honda or Toyota, purchase of a Cadillac or Lincoln SUV, to be modified for their needs, would not be of comparable value. A vehicle of comparable value would have to be selected. Once the baseline cost of a comparable quality vehicle has been established, the claimant may (at his or her option) choose to upgrade the baseline model, by adding additional equipment, with the difference in cost being paid for by the claimant.

(e) After determining the baseline cost of a comparable vehicle, the CE must take credit for (deduct) the wholesale value of the claimant's existing car, when determining the allowance to be paid for a replacement vehicle. The wholesale value of the existing vehicle can be determined through a number of internet websites that make this information available free-of-charge. The CE should advise the claimant of the source of their information, once the wholesale value of the claimant's current vehicle has been determined.

(f) Sales Tax: State sales tax should be included in the cost of obtaining a replacement vehicle.

(g) Equipment that is medically necessary for the accepted condition should be factory-installed whenever possible.

(10) Maintenance Costs. The CE authorizes necessary maintenance on the specialized equipment in a modified vehicle, whether installed in a new or used vehicle.

a) Replacement cost of the specialized equipment, due to normal wear and tear, may be considered as well. Other parts of the vehicle will be maintained at the owner's expense, even if the vehicle purchase was reimbursed by DEEOIC.

(b) Replacement of the vehicle, and all authorized equipment, can be considered if the claimant can establish that the age, mileage, and condition of the vehicle warrant such replacement. Any residual value remaining in the vehicle to be replaced would be applied as a credit toward the cost of a replacement vehicle.

(11) Proof of Insurance. The claimant is required to obtain adequate insurance and to maintain current registration of the vehicle in the state of residence. Claimants are required to carry comprehensive (fire, theft, vandalism, etc.) and collision insurance on any vehicle for which DEEOIC has authorized reimbursement, unless the fair market value of the vehicle and its equipment is less than $2,500. The claimant may select the deductible of the insurance policy but will be responsible for any such deductible should an accident occur.

(12) Vehicle No Longer Needed. When the claimant no longer needs the vehicle, DEEOIC is entitled to recover the fair market value of the modified vehicle, less any percentage contribution the claimant made to the overall purchase price of the vehicle and its modifications. If the fair market value of the modified vehicle is less than $5,000, no reimbursement will be due DEEOIC.

(a) Example 1. The claimant owns a $10,000 vehicle that is *not* suitable for modification. The purchase price of a suitable replacement vehicle is $30,000. The claimant contributes $10,000 toward the purchase of the new $30,000 vehicle, as this represents the value of the vehicle he or she owned, which is being replaced. DEEOIC *then* pays an *additional* $20,000 in reimbursement toward the purchase price of the modified vehicle.

(b) Example 2. The claimant has a $30,000 vehicle, for which he or she has contributed one-third of the purchase price. At the time of sale, the claimant would be entitled to one-third of the proceeds and DEEOIC would recover two-thirds. However, if at the time of sale, the fair market value was determined to

be $4,995 (less than $5000); the DEEOIC would recover zero dollars.

8. Housing Modifications. This section provides clarification with regard to the evidence needed to approve housing modifications, as well as procedural guidance with regard to the process for review, development, and authorization of housing modifications.

a. Modifications must be prescribed by a treating physician whose medical specialty qualifies him or her to offer a medical opinion on the specific architectural needs of a medically disabled person. Modifications must be in conformity with applicable building codes and must conform to the standard of décor that existed prior to the disability.

(1) Modifications to Owned Property. Modifications to a house must be consistent with the claimant's pre-injury standard of living and should approximate that standard insofar as practical, with respect to the quality of construction materials and workmanship.

(a) Modifications may include certain additions where warranted. For example, if a ground-floor recreation room is converted to a bedroom, to accommodate a wheelchair-bound individual, and if no ground-floor bathroom facilities exist, then the addition of a bathroom on the ground floor could be approved. Similarly, if there is no suitable space for conversion to a bedroom on the ground floor, then the addition of a bedroom on the ground floor could be approved, if no other reasonable alternative exists.

(b) Modifications may include certain accessories. The addition of appliances such as air conditioning or air filtration equipment can be considered, if found to be medically necessary for the relief of certain accepted medical conditions.

For example, if the claimant suffers from respiratory or cardiac conditions that have been accepted, his or her physician may order that the claimant be kept in an air conditioned environment, in which case the expense for these modifications would be allowed.

(c) Maintenance expenses. The CE approves maintenance expenses for equipment furnished to the claimant, as well as replacement costs after normal wear and tear.

(d) The Government is entitled to reimbursement for the value of any special equipment that can be removed and sold separately, when no longer needed by the claimant. Reimbursement shall also be owed for any increase in overall value of the property resulting from permanently installed special equipment, or for

any architectural modifications of a permanent nature, that improve the value of the property.

The value of such permanent equipment or modifications may be determined in any reasonable, equitable manner, such as written estimates from real estate sources, or by comparing the recent sales prices of similar houses without the special equipment. No reimbursement to the claimant should be considered for any reduction in the value of the property resulting from modifications which may inconvenience prospective purchasers.

(2) Modifications to Non-Owned Property. Any modifications to property not owned by the claimant and his or her family are subject to approval by the landlord or owner. *This is in addition to the preceding guidelines established for owned property.* When presented with a request for modifications to non-owned property, the CE considers the following points:

(a) Rental property may be subject to federal (Americans with Disabilities Act), state or local statutes that mandate barrier-free accessibility for persons with disabilities. The claimant should discuss any change in housing needs with his or her landlord, who may be able to offer modifications or alternative accommodations better suited to the needs of the individual.

(b) If the landlord is unable or unwilling to pay for modifications, or offer other suitable accommodations, approval must still be obtained from the landlord prior to making any changes or alternations to the non-owned property. Any such changes must be made at the claimant's expense, and are subject to review and approval by DEEOIC, prior to any reimbursement.

(c) If the landlord/owner will not permit modifications, or if the costs are excessive, and if suitable housing arrangements are available elsewhere, it may be more cost-effective to consider paying relocation expenses rather than paying for modifications at the current location. If changing locations is the most cost-effective alternative, the CE may authorize a subsidy for any increase in rent, if warranted, in addition to the relocation expense. For example, if the claimant lives in an apartment with stairs, and is no longer able to climb stairs due to his or her accepted condition(s), DEEOIC would reimburse the claimant for the most nearly comparable apartment available that offers an elevator and any other accommodations required to fulfill the

claimant's medical needs arising from the claimant's accepted condition(s).

(d) The Government is entitled to reimbursement only for the value of special equipment that can be removed and sold separately, once the claimant no longer needs that equipment. Improvements or modifications, and any increase in property value resulting from such changes, accrue to the benefit of the owner.

(3) Proposals. If the CE determines that the claimant is eligible for housing modifications, the CE asks the claimant to submit a detailed written proposal for review and consideration.

The CE advises the claimant that the proposed housing modifications should be of a quality and finish consistent with his or her present residence, not superior to it. Further, the claimant should be cautioned that structural modifications must not compromise the integrity of the existing structure.

While the choice of modifications remains with the claimant, the CE does not authorize payment for any modifications that are structurally unsound.

Modifications will be no more expensive than necessary to accomplish the required purpose. For example, when remodeling a bathroom, it may be feasible to re-install an existing sink at wheelchair height, for less than the cost of discarding the sink and buying a new one.

Conversely, modifications must be in keeping with the standard of the décor of the current or pre-illness accommodations. For example, if the claimant's dwelling (owned or rented) requires that a sink or commode be changed for handicap accessibility, and if it is necessary to tear out and replace tile, then the tile in the entire bathroom or kitchen may have to be replaced with similar quality tile in order to maintain the architectural décor of the room.

Proposals must include the following information:

(a) A medical report detailing the physical limitations for which the requested modifications are necessary. This report should be prepared by a physician who is a recognized authority in the appropriate medical specialty. Reports from physical or occupational therapists may also be helpful in determining the nature of the modifications required.

(b) An itemization of all modifications proposed. Where substantial modifications are required, the detailed changes should be recommended by a medical or

rehabilitation professional familiar with the needs of the disabled.

(c) If the claimant lives in a rented or non-owned premise, a written statement from the landlord/owner must be obtained, approving and authorizing the specific plans and proposed modifications.

(d) The CE reviews the itemized proposal and determines if the specified modifications are warranted. If the CE identifies technical issues regarding implementation, the CE develops the issue further to identify alternate solutions.

b. Fees and Bids.

(1) Reasonable fees may be paid for the medical or rehabilitation professional's visit to the site, and for the preparation of the detailed report. The same applies to any architectural drawings that are required for significant structural changes.

(2) No fee will be paid for attorneys or similar representatives engaged by the claimant to assist with the proposal. Any fee charged by an Approved Representative remains the claimant's obligation.

(3) Two or more bids must be obtained by the CE for the proposed changes from licensed and/or certified contractors. These bids must be for exactly the same modifications so that a true comparison of the competitive bids can be obtained.

(a) If construction work is required, the bids obtained must be for binding estimates of the cost. No fees will be paid for the bids or estimates.

(b) If special accessories or devices are required, the CE stipulates that the price quoted by the vendor includes any necessary installation.

(4) The CE reviews the bids and selects the one which combines any acceptable alternative means of achieving the desired results with the lowest cost, unless there is a sound reason for a higher-cost alternative, such as increased durability.

(5) Approval. If upon review of the evidence the CE approves the request, the CE writes a detailed letter decision to the claimant advising of the approval.

(6) Notifying the BPA. Once the CE sends the letter of approval to the claimant, the CE prepares an email to the FO. In the email, the CE advises the FO of the approval, citing the homegrown code (e.g. HSMDF) for housing modifications and the amount approved. The fiscal officer

communicates this approval to DEEOIC's BPA.

(7) Additional Information. If the CE determines that additional information is necessary, the CE sends a letter to the claimant requesting additional documentation that is necessary to continue with the review process.

(8) Follow-up. If the claimant does not respond to the development letter, or if he or she fails to provide sufficient documentation to support the request, after considering all relevant evidence, the CE issues a detailed letter decision informing the claimant of the denial. The CE also informs DEEOIC's BPA through the FO of this denial. The letter-decision must include a sentence at the end with language as follows

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.

(10) Recommended Decision. If the claimant requests a recommended decision, the CE proceeds with a recommended decision.

9. Health Facility Membership/Spa Membership. This section describes procedures to be followed when a claimant requests authorization for reimbursement of fees to join a commercial health club or spa.

a. Authorization. Membership in a health club or exercise facility, or treatment at a spa, may be authorized when recommended by the treating physician as likely to treat the effects, cure or give relief from a covered illness. All requests for reimbursement of health facility and spa fees require prior authorization from the CE.

In all cases where such membership is requested, the CE determines whether the membership is likely to be effective and cost-efficient.

b. Payment. Whenever a request for payment of health club/spa membership is received, the CE obtains the following information:

(1) Information from Physician. The CE obtains the following information from the treating physician:

(a) A description of the specific therapy and or exercise routine needed to address the effects of the covered illness, including the frequency with which the exercises should be performed.

(b) The anticipated duration of the recommended regimen (i.e. weeks, months, etc.).

(c) An opinion as to the actual/anticipated effectiveness of the regimen, treatment, goals attained/sought, and frequency of examinations to assess the continuing need for the regimen.

(d) A description/list of the specific equipment and or facilities needed to safely perform the regimen.

(e) The nature and extent of supervision, if any, required for the safety of the claimant while performing the exercises.

(f) An opinion stating whether exercise can be performed at home, as part of a home exercise program, or a recommendation as to what kind of public or commercial facility could provide the prescribed exercise routine.

(2) Information from Claimant. In addition, the CE obtains the following information from the claimant:

(a) The full name, address, and distance from the claimant's home or work location, of any public facilities (no membership required) and those commercial facilities (membership required) able to accommodate the prescribed regimen.

(b) If applicable, the specific reason(s) membership in a commercial health club/spa is required when public facilities are available, and or where the doctor indicates the regimen can be performed at home.

(c) A signed statement from the health club/spa manager stating that the club/spa can fully provide the exercise regimen prescribed by the treating physician, and a breakdown of the fees and charges for various membership options and terms. The statement should describe all facilities, services, and special charges not included in the membership fee.

c. Approval.

(1) For all requests, if upon review of the evidence the CE approves the request, CE must write a letter to the claimant advising of the approval. The letter must include the following:

(a) The date the DO received the request.

(b) The period of time which the approval will cover.

(c) The amount approved (i.e. monthly or annual fee, etc.).

(d) The type of membership approved.

(e) Two copies of a blank OWCP-957

(2) Notifying the BPA. Once the CE sends the letter of approval to the claimant, the CE prepares an email to the FO. In the email, the CE advises the FO of the specific services being approved, citing the homegrown code (i.e.

GYMME) and the amount to be reimbursed. The FO communicates this approval to DEEOIC's BPA.

d. Additional Information. If the CE determines that additional information is necessary, the CE sends a letter to the claimant (with a copy to the treating physician) requesting additional documentation that is necessary to continue with the review process. In the letter, the CE provides 30 days for receipt of the requested information.

e. Follow-up. If the claimant does not respond to the development letter, or if he or she fails to provide sufficient documentation to support the request, after considering all relevant evidence, the CE issues a detailed letter decision informing the claimant of the denial. The CE also informs DEEOIC's BPA through the FO of this denial. The letter-decision must include a sentence at the end with language as follows:

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.

f. Recommended Decision. If the claimant requests a recommended decision, the CE proceeds with a recommended decision.

g. Reimbursement Request. If a request for reimbursement of a health facility membership or spa membership, not previously approved, is submitted for payment to DEEOIC's BPA, the DEEOIC's BPA communicates this to the DO through the FO, and waits for approval from the CE.

h. Period of Service. Health facility membership may be authorized for up to twelve months. Recertification is required for any period of time beyond twelve months.

10. Medical Alert Systems. This section describes procedures to be followed when a claimant requests authorization for medical alert system.

a. Definition. A Medical Alert system is an electronic device connected to a telephone line. In an emergency, the system can be activated by either pushing a small button on a pendant or pressing the help button on the console unit. When the device is activated, a person from the 24 hour central monitoring station answers the call, speaks to the claimant via the console unit, assesses the need for help, and takes appropriate action. A medical communication system qualifies as a Medical Alert system if it includes the following requirements:

(1) An in-home medical communications transceiver;

(2) A remote, portable activator (Personal Pendant, etc.);

(3) A central monitoring station staffed by trained attendants 24 hours a day, seven days a week (optional).

b. Authorization. All requests for medical alert systems require prior authorization from the CE. A request for a medical alert system must be documented with a letter of medical necessity from the treating physician, linked to the accepted condition, which includes a statement that the claimant has an acute or chronic condition which can require urgent or emergency care.

(1) Period of Service. The CE may authorize the medical alert system for up to twelve months at a time. The need for such equipment should be recertified by the prescribing physician prior to the expiration of the authorization period.

(2) Billing. Systems that require a one-time connection fee and monthly monitoring fee may be approved, based on the claimant's needs and the medical justification. The equipment provided is leased and must be returned when no longer needed to avoid further charges. DEEOIC is not responsible for any additional charges incurred for failure to return equipment or failure to timely return the equipment in a timely manner.

c. Approval.

(1) For all requests, if upon review of the evidence the CE approves the request, the CE writes a letter to the claimant advising of the approval. The letter includes the following:

(a) The date the DO received the request;

(b) The period of time which the approval will cover;

(c) The amount approved.

(2) Notifying the BPA. Once the CE sends the letter of approval to the claimant, the CE prepares an email to the FO. In the email, the CE advises the FO of the approval, citing the HCPS code for a medical alert system and the amount approved. The fiscal officer communicates this approval to DEEOIC's BPA.

d. Additional Information. If the CE determines that additional information is necessary, the CE sends a letter to the claimant (with a copy to the treating physician) requesting specific documentation that is necessary to continue with the approval process. In the letter, the CE provides 30 days for receipt of the requested information.

e. Follow-up. If the claimant does not respond to the development letter, or if he or she fails to provide sufficient medical documentation to support the request, the POC CE sends a detailed letter decision to the claimant. The CE also informs DEEOIC's BPA through the FO of this denial. The letter decision must include a sentence at the end with language as follows:

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.

f. Recommended Decision. If the claimant requests a recommended decision, the CE proceeds with a recommended decision.

g. Reimbursement Request. If a request for reimbursement of a medical alert system not previously approved is submitted for payment to DEEOIC's BPA, the DEEOIC BPA communicates this to the DO through the FO, and awaits approval from the CE.

11. Medical Expense Reimbursement for Extended Travel. This section describes procedures to be followed for authorizing medical travel requests over 200 miles round trip, and the process for approving claims for reimbursement, regardless of whether the claimant obtained prior approval for the trip.

a. Travel Claims. All claims for travel reimbursement must be sent to DEEOIC's BPA. Should the CE receive a reimbursement request directly from the claimant for an authorized trip, the CE forwards it immediately to DEEOIC's BPA to begin the reimbursement process. In the event the CE receives a claim for travel reimbursement that was not approved in advance, the CE immediately forwards the claim to the DEEOIC's BPA, and concurrently begins the process of approving or denying the trip. This ensures that all claims are adjudicated promptly and are properly recorded and tracked by DEEOIC's BPA, throughout the reimbursement process.

b. Authorization. DEEOIC requires pre-authorization for reimbursement of transportation, lodging, meals, and incidental expenses incurred when a claimant travels in excess of 200 miles round trip for medical care of an approved condition. DEEOIC's BPA processes reimbursement claims for claimant travel without pre-authorization when travel is less than 200 miles round trip.

c. Processing. DEEOIC's BPA processes reimbursement claims in accordance with GSA travel guidelines. Per diem rates for overnight stay and mileage reimbursement rates are published on GSA's website, and air fare reimbursement is based on actual ticket cost up to the amount of a refundable coach ticket (Y-Class airfare).

d. Approval. Upon acceptance of a medical condition, the claimant receives a medical benefits package from the DEEOIC that includes instructions on how to submit a written request for prior approval of medical travel when such extended travel (over 200 miles round trip) is required. Despite these instructions, it is not uncommon for claimants to submit their request for reimbursement after a trip has been completed, and without having obtained prior approval.

e. Travel Exceeding 200 Miles. Medical expense reimbursement for travel exceeding 200 miles round trip must be authorized by the CE. Claims that are submitted to DEEOIC's BPA, for reimbursement of

travel expenses arising from medical travel in excess of 200 miles roundtrip, will not be processed for payment unless authorization has been provided by the district office.

(1) Requests. Upon receipt of a travel authorization request from the claimant, the claims examiner (CE) takes immediate action to ensure that the request meets one basic requirement: that the medical treatment or service is for the claimant's approved medical condition(s). The medical provider's enrollment in the DEEOIC program is not a prerequisite to approving medical travel if the claimant chooses to receive medical services from a non-enrolled provider.

(2) Companion. If the travel request involves authorization for a companion to accompany the claimant, the claimant must provide medical justification from a physician. That justification must be in written form, relating the treatment to the accepted condition and rationalizing the need for the companion. If the doctor confirms that a companion is medically necessary, and provides satisfactory rationale, then the CE may approve companion travel. In the alternative, the CE can authorize the claimant to stay overnight in a hospital or medical facility, and can approve payment for a nurse or home health aide if a companion is not available. The CE must use discretion when authorizing such requests and may approve one of the above alternatives when there is a definite medical need, accompanied by written justification from the physician.

(3) Mode of Travel. The claimant is allowed to specify his/her desired mode of travel. It is the CE's role to authorize the desired mode of travel for the time period(s) requested. When a request is received from the claimant that does not identify the mode of transportation, the CE contacts the claimant by telephone and assists in determining the desired mode of travel. (Resource Center staff may be assist in this process.)

f. Approval. Once the basic requirements for travel over 200 miles are met, as outlined above, the CE prepares and sends the claimant a travel authorization letter following the guidelines below. The CE may approve an individual trip, or any number of trips within a specified date range, all in one letter to the claimant. Once an initial authorization letter has been sent, future visits to the same doctor or facility may be approved by telephone, and confirmed by a follow-up letter.

g. Authorization Letter. The authorization letter delineates the specifics of the trip being authorized, based upon the mode of travel

the claimant has selected. In the travel authorization letter, the CE advises the claimant that travel costs are reimbursable only to the extent that the travel is related to obtaining medical treatment. In the letter CE also invites the claimant to contact the nearest Resource Center for assistance prior to or upon completing any trip and to complete Form OWCP-957, Request for Reimbursement, in accordance with the information and conditions as outlined in Exhibit 6.

h. Adjudication. When adjudicating claims submitted after the trip has been completed, but for which prior approval was not obtained, the CE follows the same steps as for pre-authorized trips, to the point of sending an authorization package. At that point the CE sends only the authorization (or denial) letter to the claimant, not an entire authorization package.

i. Denials. If a travel request is denied (either before or after a trip), the CE notifies the claimant in writing, detailing the reason(s) for the denial. *The CE's unit supervisor must provide sign-off for all denials of claimant travel before the denial letter is sent to the claimant.* The following wording is included in the denial letter: "This is the final Program decision on your request for approval of travel expense reimbursement. *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."*

j. Recommended Decision. If the claimant requests a recommended decision, the CE proceeds with a recommended decision.

k. Notifying the BPA. In conjunction with sending the claimant an approval or denial of a travel request, the CE conveys his/her decision to DEEOIC's BPA via the office's Fiscal Officer (FO), who is the point of contact with DEEOIC's BPA for such issues. The CE prepares an email to the FO, who in turn generates an electronic thread to the BPA. In the email the CE provides the information specified below. The CE must *also* enter this information into the case notes field of ECMS (Select the note type of "T" for Travel Authorization):

(1) Approved dates for a single trip or in the alternative, a date range and number of trips authorized within that time frame.

(2) Approved mode of transportation

(3) Starting point and destination, e.g., claimant address and provider address (city & state at a minimum).

(4) Authorization for rental car reimbursement, if appropriate.

(5) Companion travel if approved.

l. Approval Package. The approval package must include the following:

(1) Two copies of the detailed authorization letter.

(2) Two copies of a blank OWCP-957.

(3) *A prepaid express mail envelope, addressed to DEEOIC's BPA*, for the claimant's use.

m. Prompt Pay. DEEOIC's BPA promptly pays any approved claims directly to the claimant, not to any other party. However, if the claimant completes the form in error or neglects to submit the proper information, DEEOIC's BPA attempts to resolve the issue by accessing the authorization letter or the pre-approval notification (thread) from the FO. If DEEOIC's BPA is unable to issue payment based on information provided in one of these two sources, DEEOIC's BPA contacts the FO, requesting clarification and/or assistance.

n. DO Review. The FO and responsible CE take immediate action to review the claim as submitted, contact the claimant when appropriate, make a determination as to the correct amount of reimbursement or denial, and send an authorization notification or correction (electronic thread) back to DEEOIC's BPA.

o. District office CEs and FOs responsible for travel authorization processing must keep management apprised of issues impacting prompt and accurate processing of travel authorizations and reimbursements. Claims staff should be especially vigilant to identify any real or perceived problems with the processing interfaces between and among the district office, the Resource Center and DEEOIC's BPA.

Problems must be elevated (reported via email) immediately to the National Office to the attention of the Branch Chief for Policy, with a copy of the notification to the Branch Chief for the Branch of ADP Systems (responsible for oversight of DEEOIC's BPA).

Exhibit 1: Sample Initial Medical Development Letter

Exhibit 2: Sample Follow-up Development Letter

Exhibit 3: Sample Authorization Letter

Exhibit 4: Billing Codes

Exhibit 5: Sample Recommended Decision to Deny Home Health Care

Exhibit 6: Sample Travel Authorization Letter

3-0400 Tort Action and Election of Remedies

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Exhibit

1 EEOICPA Parts B/E Benefits Offset Worksheet (with instructions). 09/09 09-10

1. Purpose and Scope. This chapter describes procedures to determine if a claimant is eligible to receive Part B benefits because of a lawsuit filed against a beryllium vendor or atomic weapons employer due to the "election of remedies" provision of the EEOICPA. It also describes procedures for offsetting (reducing) EEOICPA benefits if the claimant is eligible to receive EEOICPA benefits but received settlement from a lawsuit for injuries resulting from exposure to the same toxic substance for which EEOICPA benefits are payable.

2. Authority. 42 U.S.C. § 7385 requires the offset for certain EEOICPA payments. 42 U.S.C. § 7385d requires the election of remedies for Part B beryllium vendor and atomic weapons employer employees.

3. Signed Response Regarding Lawsuit, State Workers' Compensation Claim and Fraud. Before a claim can be accepted under the Act, the claimant must provide a signed response (affidavit) reporting whether a lawsuit had been filed for exposure to the same toxic substance for which EEOICPA benefits are payable, or whether a state workers' compensation (SWC) claim had been filed for the same medical condition(s), or whether the claimant has ever pled guilty to or been convicted of fraud in connection with an application for or receipt of any federal or state workers' compensation. This signed response must be obtained regardless of the information contained on the forms

EE-1 or EE-2 related to these three questions.

a. The CE may call the claimant to get an initial verbal response to the three questions. If the claimant confirms verbally or submits a signed response that he/she has not filed a lawsuit, SWC claim, or pled guilty to or been convicted of fraud, the CE may proceed with issuance of the Recommended Decision (RD).

Since a signed response from the claimant must be included in the case file before issuance of the Final Decision (FD), the CE follows up with a development letter requesting the signed response from each claimant before transferring the case to the Final Adjudication Branch (FAB). The development letter must be claim specific and clearly note that by signing the written response, the claimant agrees to report any changes to the information provided in the response, immediately, to DEEOIC. The CE also advises the claimant that failure to submit a signed response will result in administrative closure of the claim.

b. If the CE is unable to obtain a verbal response from the claimant or the claimant responds affirmatively to any one of the questions, or evidence in the case file indicates that a lawsuit, SWC claim or fraud was filed or committed, the CE cannot issue a RD without further development and clarification. The CE may consider administrative closure of the claim if the claimant is not responsive to the development request for clarification but only as a last resort, and after at least two development letters.

c. It is the responsibility of the FAB to obtain this signed response if a RD is issued without receipt of the signed response (i.e. the CE only received verbal confirmation). The FAB makes every effort to obtain this signed response including calling the claimant and sending a follow up development letter. However, if the FAB is unable to obtain the signed response after 30 days from the FAB's follow up development letter, the FAB remands the case to the district office for administrative closure of the claim. The FAB sends a letter advising the claimant of this course of action.

d. If the case is with the FAB, and there is evidence in the case file of a lawsuit, a SWC claim, or fraud in connection with an application for or receipt of workers' compensation that may impact the claimant's EEOICPA benefits, further development must be undertaken. If the matter could be clarified by a telephone call, the FAB takes this action. If the matter requires extensive development, the case is to be remanded to the district office for further development.

e. By signing the written response, the claimant agrees to notify DEEOIC of any changes in the information provided in regards to the lawsuit/SWC/fraud statement. It is not necessary to request this information again unless there is a new exposure or illness (including consequential) being accepted under EEOICPA. For instance, if the claimant had submitted a written response for lung cancer and

is now filing a claim for a consequential condition of bone cancer, a new written response regarding the bone cancer is required before this consequential condition may be accepted under the Act.

4. Developing for Lawsuit. If the claimant reports, or the evidence indicates, that a lawsuit was filed (regardless of what type, what happened, when it was filed or who filed it), the CE develops for verification of the lawsuit and lawsuit payments received.

a. Contact with Claimant. The CE confirms with the claimant as to whether a lawsuit was filed and requests documents related to the lawsuit if one was filed. The CE requests copies of any complaint, settlement document, award from a judge/jury, and settlement sheet from the legal proceeding. If the claimant states that he or she is not legally permitted to disclose the information, it may be possible to persuade him or her to do so based on the Privacy Act protections in place for claims filed under the EEOICPA.

b. Contact with Attorney/Law Firm. The CE advises the claimant to contact the attorney who filed the lawsuit to obtain copies of required documents if the claimant does not have them. If the claimant is elderly or he or she is confused as to the type of documents that are required, the CE may need to directly contact the attorney. If the attorney considers the release on the bottom of Form EE-1 or Form EE-2 to be legally insufficient to authorize the release of the required document, the CE requests a separate written release from the claimant. If the attorney is no longer with the law firm, the CE attempts to find out who in the law firm inherited the attorney's clients, or where the records are stored.

c. Information from Other Sources. If information is not available from the claimant or the law firm, the CE attempts to obtain it from other sources. Some information can be obtained from the court where the matter was litigated, such as the complaint, judge or jury award (if any), and pertinent court orders.

d. Initial Development Letter. The CE follows up with a development letter to the claimant explaining the need for the lawsuit documents and requesting a response within 30 days. The CE requests documents as noted in paragraph 4a. The letter indicates that failure to comply with the request may result in an administrative closure of the claim.

e. No Response. If there is no response to the initial development letter after 30 days, the CE sends a second development letter. The second development letter informs the claimant that the requested information must be submitted before the claim can be fully adjudicated, and the claim will be administratively closed if no response is received.

f. Administrative Closure. The CE may administratively close the file after two development letters are sent, if no response is

received from the claimant and the CE is unable to obtain the lawsuit documents from other sources.

5. Evaluating Lawsuit Documents. Once the CE has obtained the necessary documents regarding the lawsuit, he or she must review them to see what impact, if any, the lawsuit will have on the claim.

a. Complaint. A complaint is a legal document in which the plaintiff alleges that certain events took place involving exposures to toxic substances and that those events were the fault of the defendant(s). The complaint asks for certain remedies (payment for the resulting medical condition). From the complaint, the CE can discern the reason why the plaintiff filed the lawsuit, the identity of the plaintiff, the identity of the defendant and the date the lawsuit was filed.

(1) The CE determines if the alleged exposures raised by the plaintiff were the same as the exposures for which EEOICPA benefits are claimed. There may be some exposures alleged by the plaintiff in the complaint that are not exposures for which EEOICPA benefits can be paid (non-employment exposures).

(2) The CE must thoroughly understand the basis for the lawsuit (e.g., whether the plaintiff alleged that he or she was exposed as a worker rather than just as an individual who lived in a particular locale).

(3) The CE also determines the identities of the parties to the lawsuit. To do so, the CE may need to inquire whether any later amended complaints were also filed.

b. Settlement Sheet. A settlement sheet is basically a billing document. It lists the amounts received from a defendant and attorney fees and other costs that are being charged against those amounts. However, there may not be a document entitled "Settlement Sheet." Instead, a CE may receive a document that simply lists the name of each defendant and the amount that the defendant paid to settle the suit. The CE needs to be able to determine how much the plaintiff/claimant actually received.

When a settlement sheet lists the amount of the "costs" of bringing the lawsuit (not the attorney fees that are being charged), the CE must insist on an itemized list of costs, if they are not already itemized on the settlement sheet. If the legal costs are not itemized, the CE may not deduct the legal costs in calculating the amount of offset.

c. Court Orders. If the lawsuit was not settled, the CE may be provided with an order of a judge, or a jury award, that states the amount that the defendant must pay to the plaintiff and the reason for payment of that amount.

d. Bankruptcy. If a claimant receives a settlement in a bankruptcy proceeding, such settlement is treated like any other settlement for

purposes of the offset. The CE requests the settlement sheet from the claimant's attorney, as outlined above

6. Election of Remedies, Part B. Depending on the circumstances of the lawsuit and the Part B claim, the claimant *may no longer be eligible* for EEOICPA Part B benefits based on the "election of remedies" provision under the Act. The election of remedies provision does not apply to Part E benefits. Different scenarios are discussed below:

a. Lawsuit against Atomics Weapons Employer (AWE) or Beryllium Vendor. The "election of remedies" provision applies only to Part B claimants who have filed a lawsuit against either an AWE or a beryllium vendor. To determine if this provision applies to a Part B claim involving a lawsuit, the CE must determine if the otherwise eligible claimant was the same person who filed the lawsuit, if the lawsuit was against an AWE or a beryllium vendor, and if the lawsuit was for employment-related exposure to either radiation or beryllium. If the answer to all three of these questions is yes, further development is required, based on the date that the lawsuit was filed.

b. Lawsuits Filed Before October 30, 2000, Terminated Prior to December 28, 2001. For lawsuits in this category, "terminated" means that the lawsuit was concluded in *any* way: the parties settled, after which the suit was dismissed by the judge; the claimant won the case; or even that the claimant lost the case (judgment was granted for the defendants). *This meaning of "terminated" applies to this time period only.* The CE must look for proof that the matter has been resolved, regardless of the outcome. If the CE finds that the matter was terminated before December 28, 2001, the claimant is not disqualified from receiving any Part B benefits. The CE must include a finding in the recommended decision that the lawsuit did not cause the claimant to be disqualified.

c. Lawsuits Filed Before October 30, 2000, Still Pending as of December 28, 2001. For lawsuits in this category, the CE will need to determine if the claimant dismissed all claims in the suit that arose out of the same employment-related exposure to either beryllium or radiation that is the basis for the Part B claim *by December 31, 2003*.

Unlike the situation discussed on paragraph 6b, the suit must be *dismissed*, rather than merely terminated. That means that there must not be a final judgment in the suit for either the claimant or the defendant. If the suit was not dismissed by December 31, 2003 or if there is a final judgment in the suit, the claimant is not entitled to any Part B benefits.

d. Lawsuits Filed Between October 30, 2000 and December 28, 2001. For lawsuits in this category, the claimant will not be eligible to receive Part B benefits, if the claimant does not dismiss all claims in the suit that arose out of the same employment-related exposure to

either beryllium or radiation that is the basis for the Part B claim by the *later* of April 30, 2003, or the date that is 30 months after the date the claimant either received a radiation dose reconstruction from National Institute for Occupational Safety and Health (NIOSH) *or* a diagnosis of either beryllium sensitivity or chronic beryllium disease (CBD), depending on the occupational illness being claimed.

e. Lawsuits Filed after December 28, 2001. For lawsuits in this category, the claimant will not be eligible for Part B benefits if a judgment is entered against the claimant (that is, the claimant loses the lawsuit). If the judgment is entered for the claimant (the claimant wins the lawsuit), the claimant is eligible for Part B benefits.

If judgment has not been entered against the claimant, the claimant will not be eligible to receive Part B benefits, if the claimant does not dismiss all claims in the suit that arose out of the same employment-related exposure to either beryllium or radiation that is the basis for the Part B claim by the *later* of April 30, 2003, or the date that is 30 months after the date the claimant either received a radiation dose reconstruction from NIOSH *or* a diagnosis of either beryllium sensitivity or CBD, depending on the occupational illness being claimed.

7. Tort Offset, Parts B and/or E. If the lawsuit has not adversely affected the claimant's eligibility under Part B due to election of remedies, an offset of the potential Part B and/or E award may still be needed. EEOICPA benefits are only offset if the basis for the lawsuit and the payable EEOICPA claim are due to injuries from exposure to the same toxic substance. For example, if the claimant filed a lawsuit for lung cancer based on exposure to asbestos and the Part E claim that is payable is also based on lung cancer due to exposure to asbestos, offset is required. As long as there is one exposure that would be compensable, offset is required even if the lawsuit or EEOICPA claim is based on several other different exposures.

a. Exceptions: There are several exceptions to the offset requirement.

(1) If the lawsuit alleges exposure that is clearly outside the time frame and/or location of exposure awarded under EEOICPA or if the lawsuit and EEOICPA claim are based on exposure to two different toxic substances, offset is not required. For example, if the EEOICPA claim is based on radiation exposure from 1952 to 1962 but the lawsuit is based on radiation exposure beginning in 1965, offset is not required.

(2) If the lawsuit alleges non employment exposures, offset is not required (nor is there an election of remedies requirement). For example, if a claimant alleges in a lawsuit that he was exposed to radiation because he lived

in proximity to a facility that produced radiation, not because he was exposed to radiation while working in a covered facility, offset is not required.

(3) If an employee and his or her spouse were both plaintiffs with causes of action in a lawsuit they brought together and they both signed releases to settle their case, but only the spouse received tort payment and the employee was alive at that time, no offset is required.

8. Pending Tort Settlement Payment. The requirement to offset EEOICPA benefits does not apply if the claimant has not received any payments from a lawsuit at the time of the EEOICPA payment. The CE does not defer issuing the Recommended Decision (RD) or the Final Decision (FD). The RD or the FD is issued without offset since the claimant has not yet received tort payment.

However, if the claimant receives tort payment that requires EEOICPA benefits to be offset, at any time after issuing the RD or FD, but before the issuance of EEOICPA payment, the EEOICPA payment cannot be issued until the following actions are taken.

a. Tort Payment Pending at the District Office (DO). If the tort payment is pending at the time of the RD, the CE issues the RD without an offset. However, the CE states in the RD's cover letter that if the claimant receives tort payment after the issuance of the RD, but before issuance of the FD, the claim will be remanded by the Final Adjudication Branch (FAB) for offset and a new RD.

b. Tort Payment Pending at the FAB. If the tort payment is pending at the time of the FD, the FAB Hearing Representative (HR) issues the FD without an offset. However, the HR states in the FD's cover letter that if the claimant receives tort payment after the issuance of the FD, but before issuance of the EEOICPA payment, the FD authorizing the payment will be vacated.

c. Tort Payment Pending at the time of EEOICPA Payment. Before issuing EEOICPA payment, the CE calls the claimant to verify that tort payment is still pending. If the claimant receives tort payment after issuance of the FD, but before issuance of the EEOICPA payment, the DO forwards the claim to the National Office for a reopening.

9. Required Tort Offset. After receipt of all relevant documents, the CE determines whether an offset is needed. If so, the CE completes the "EEOICPA Part B/E Benefits Offset Worksheet" (Exhibit 1).

The Worksheet includes detailed instructions for computing the amounts that the CE uses to calculate the amount of any offset. After completing the Worksheet, the CE staples it to the inside left cover of the case file jacket.

a. Complaint. While the complaint must be obtained if the claimant disputes the necessity of the offset, the CE may proceed with the offset without the complaint if the claimant does not dispute that

offset is necessary, and the CE has sufficient evidence to fill out the EEOICPA Part B/E Benefits Offset Worksheet. This step occurs after confirming that the election of remedies does not apply.

b. EEOICPA Benefits Greater than Offset. If the amount of EEOICPA benefits to which the claimant is currently entitled is *more than* the offset, the balance due the claimant will be the amount appearing on Line 7b of the Worksheet. This is the amount of EEOICPA benefits that must be referenced in the recommended decision (RD), along with an explanation of how this amount was calculated.

c. EEOICPA Benefits Less than Offset. If the amount of EEOICPA benefits currently payable is *less than* the offset, the amount of the "surplus" payment still to be offset will appear on Line 7c of the Worksheet. All future EEOICPA benefit payments for the same exposure(s) that formed the basis for the lawsuit are subject to the offset to absorb a surplus. Since additional EEOICPA benefits must first become payable before a surplus payment can be absorbed, no further action to offset the surplus payment is required for a survivor's Part B claim.

(1) If a surplus payment is to be absorbed in an employee's Part B claim, this must be noted in the RD, along with an explanation that DEEOIC will not pay medical benefits until the surplus is absorbed.

(2) If a surplus is to be absorbed in an employee's Part E claim, this same explanation must appear in the RD, plus an explanation that DEEOIC will also not pay any benefits for wage loss and/or impairment that may be due in the future until the surplus is absorbed.

(3) If a surplus is to be absorbed in a survivor's Part E claim and further monetary benefits may be payable based on the deceased employee's calendar years of qualifying wage loss, this must be noted in the RD, along with an explanation that DEEOIC will absorb the remaining surplus out of those benefits if and when they become payable.

d. FAB Award Letter. In situations involving a surplus, the FAB issues an award letter which accompanies the final decision and advises the claimant of the exact amount of the surplus. In the award letter, the FAB representative explains that the surplus will be absorbed out of medical benefits payable under EEOICPA (and lump-sum payments due in the future under Part E). The FAB representative instructs the claimant to submit proof of payment of medical bills to the District Office (DO) until notice is received that the surplus has been absorbed, and to advise medical providers to submit proof of payment of medical bills to the DO during this time.

e. ECMS Coding. Upon issuance of the final decision that concludes with a surplus, the FAB reviewer updates ECMS in the condition status field with the "O" (Offset) code for the affected medical

condition(s) on the medical condition screen for the employee's claim. The offset only applies to the employee's claim, even in the event that the employee died prior to adjudication of the case, and the survivor is entitled to compensation. The "O" code is entered only for the medical condition(s) that derived from the same exposure(s) that formed the basis for the tort claim. During the time in which the "O" code remains in the medical condition status screen, the bill processing agent (BPA) denies medical bills related to the medical condition coded as "O" and generates explanations of benefits that the bills are not payable due to a surplus. Once the surplus is absorbed, the CE replaces the "O" code with "A" (Accepted) code.

10. Actions to Absorb Surplus. Each District Director appoints a qualified individual to serve as the point of contact (POC) to monitor surplus situations for both tort settlements and state workers' compensation (SWC) benefits. Tort settlement and SWC benefit surpluses are absorbed until the surplus is exhausted and EEOICPA benefit disbursement can commence. The POC tabulates the amounts of proofs of payment, using the DEEOIC Offset Tracking Database, until they equal or exceed the surplus amount.

a. While the surplus is being absorbed, the POC temporarily places the affected case file in a red jacket denoting that a surplus exists. All case file contents are maintained in the red jacket throughout the process of surplus depletion.

b. No further payments related to the same toxic exposure(s) that formed the basis for the lawsuit are made on any case file contained in a red jacket until such time the offset has been absorbed. Should an unpaid bill be submitted to the POC during the surplus period, it must be forwarded to the BPA so an explanation of benefits can be generated.

c. During the time in which the surplus is being monitored for depletion, the POC continually tracks the offset using the DEEOIC Offset Tracking Database, which is accessible through the shared drive. Upon payment of impairment benefits, wage loss compensation, or proof of payment of medical bills, the POC enters the dollar amount being applied toward the offset into the appropriate field in the DEEOIC Offset Tracking Database, until such time the surplus has been absorbed.

d. While medical benefits are not being paid because of a surplus that is being absorbed, the CE may find it necessary to obtain a second opinion examination, a referee examination, or a medical file review. If so, DEEOIC pays the costs for these directed examinations or reviews and reimburses any reasonable expenses incurred by the employee, including medical travel expenses, without adding to the surplus. Therefore, offset does not apply to any prior approval medical conditions in ECMS, coded with a medical condition type of "PA." In such situations, the CE enters a comment into ECMS case notes authorizing the BPA to pay all bills related to the directed

medical examination or medical file review.

In a case with a surplus, BPA creates a thread for all medical travel refund requests to the POC requesting authority to deny or proceed with payment. Medical travel expenses related to a directed medical examination must be approved for payment and are not subject to offset.

e. Once the surplus is completely absorbed and EEOICPA benefits may commence, the POC removes the temporary red file jacket and returns the case contents to the original file jacket. Removal of the red file jacket signifies that future benefit payments may be made on the case. Once the surplus is absorbed, the CE also replaces the "O" in the condition status field in ECMS with "A" (Accepted) code. However, cases **are not** to be deleted from the DEEOIC Offset Tracking Database once the offset has been absorbed.

f. The POC sends a letter to the claimant that the surplus is absorbed. The letter provides the claimant with the address of the BPA and instructs him or her to submit all future unpaid medical bills to that address for processing. To avoid duplicate payment of medical bills that were applied toward the offset, BPA creates threads for all submitted medical bills with service dates prior to the date that condition status "O" was changed to "A" in ECMS. The CE reviews the threads and advises BPA if the medical bills can be paid by checking the DEEOIC Offset Tracking Database to determine if the medical bills were applied toward the offset.

Exhibit 1: EEOICPA Parts B/E Benefits Offset Worksheet (with instructions)

3-0500 Coordinating State Workers' Compensation Benefits

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1. Purpose and Scope. This chapter describes procedures for coordinating Part E benefits with state workers' compensation (SWC) benefits. "Coordination of benefits" occurs when the compensation payable under Part E of the Act is reduced to reflect certain benefits previously received by the claimant under a SWC program for the same covered illness.

2. Authority. 42 U.S.C. § 7385s-11 requires the Office of Workers' Compensation Programs (OWCP) to coordinate the Part E award(s) with the amount of certain benefits received from a SWC program for the same covered illness, after deducting the reasonable costs incurred by the claimant in obtaining those benefits.

3. State Workers' Compensation Benefits. SWC programs are no fault systems designed to provide injured workers or survivors benefits for work-related injuries or illnesses without having to sue their employers. SWC benefits may include payments for medical services, vocational services, cash payments to the injured worker for wage loss or reduction in earning capacity, as well as death and funeral benefits to the worker's survivor(s).

The laws creating these systems differ by state, but the cash benefits (whether for temporary total disability, temporary partial disability, permanent total disability, permanent partial disability, or death of a worker) are typically a calculated percentage of the injured worker's weekly earnings for a set number of weeks. SWC benefits can be administered directly by a state commission (as in Ohio). Another method is to have a state board supervise or adjudicate disputed claims and enforce the required payments made by private parties such as employers or insurance companies. Payments can be issued in a lump-sum award or settlement, on an ongoing basis

(weekly or monthly), or a combination of both.

4. When Coordination is Required. Coordination of Part E benefits (there is no coordination of Part B benefits) is required only if the EEOICPA beneficiary received benefits through a SWC program for the same covered illness for which that same EEOICPA beneficiary is eligible to receive benefits under Part E. This means the CE first determines the employee/survivor's eligibility to receive Part E benefits, then determines who the beneficiary of the SWC benefits was before determining whether coordination is required. For example, if the employee settles a SWC claim for asbestosis and the accepted covered illness for which the employee is entitled to Part E benefits is also asbestosis, coordination of the Part E award is required to reflect the amount of SWC benefits the employee has received.

Similarly, in cases where the employee had filed a Part E claim but died before payment could be issued, Part E medical benefits through the date of employee's death awarded to the survivor requires coordination if the employee had received SWC benefits for the same covered illness. Coordination of medical benefits is required in this case because the Part E medical benefits were based on the employee's entitlement to Part E benefits and the same employee received SWC benefits for the same covered illness.

However, if the employee or the deceased employee's estate (considered same as the employee) receives SWC benefits for asbestosis and the accepted covered illness for which the survivor is entitled to Part E benefits is also asbestosis, the CE will not consider this claim for coordination (unless that survivor also received some form of SWC benefits for asbestosis, such as death benefits).

5. Exceptions. The following are exceptions to the coordination requirement. Review Exhibit 1 for additional scenarios and determination as to whether coordination is required.

a. Multiple illness(s). If the claimant receives SWC benefits for a non-covered illness, or for both a covered and a non-covered illness arising out of and in the course of the same work-related exposure, the CE does not coordinate the Part E award.

For example, if the claimant settles a SWC claim for asbestosis and silicosis arising out of the same exposure and the amounts are not apportioned between the two illnesses, and the accepted covered illness for which the claimant is entitled to Part E benefits is only asbestosis, coordination of the Part E benefits is not required.

b. Covered illness. Because a "covered illness" is an illness resulting from exposure to a toxic substance, the same medical condition accepted by DEEOIC and a SWC program may not require coordination. For example, if the claimant settles a SWC claim for asbestosis in a **non-**DOE facility and is entitled to Part E benefits for asbestosis based on a separate and distinct exposure to asbestos

at a DOE facility, coordination of the Part E benefits is not required because it is not the same covered illness (not resulting from the same toxic exposure).

c. Waivers. DEEOIC may waive the requirement to coordinate Part E benefits with benefits paid under a SWC program, if it is determined that the administrative costs and burdens of coordinating Part E benefits in a particular case or class of cases justifies the waiver. A waiver is automatically granted if the total amount of SWC benefits the claimant received is under $200.

If a waiver is to be granted, the CE prepares a memo to the file, approved by the District Director, explaining that the requirement to coordinate the benefits is waived due to the dollar amount of the SWC benefits the claimant received.

d. Medical or Vocational Benefits Only Claims. Medical or vocational benefits paid by a SWC program do not require any coordination of benefits.

6. Signed Response Regarding SWC Claim, Lawsuit and Fraud. Before a Part E claim can be accepted under the Act, the claimant must provide a signed response (affidavit) reporting whether a SWC claim had been filed for the same covered medical condition(s), or whether a lawsuit had been filed for the same toxic exposure, or if the claimant has ever pled guilty to or been convicted of fraud in connection with an application for or receipt of any federal or state workers' compensation. This signed response must be obtained regardless of the information on the forms EE-1 or EE-2 as related to these three questions.

a. The CE may call the claimant to get an initial verbal response to the three questions. If the claimant confirms verbally or submits a written response that he/she has not filed a SWC claim, lawsuit, or pled guilty to or been convicted of fraud, the CE may proceed with issuance of the Recommended Decision (RD).

Since a signed response from the claimant must be included in the case file before issuance of the Final Decision (FD), the CE must follow up with a development letter requesting the signed written response from each claimant before transferring the case to the FAB. The development letter must be claim specific and clearly note that by signing the written response, the claimant agrees to report any changes to the information provided in the response, immediately, to DEEOIC. The CE must also advise the claimant that failure to submit a signed response will result in administrative closure of the claim.

b. If the CE is unable to obtain a verbal response from the claimant or the claimant responds affirmatively to any one of the questions, the CE cannot issue a RD without further development and clarification. The CE may consider administrative closure of the claim if the claimant is not responsive to the development request for clarification. This action is taken only as a last resort, and

after at least two development letters.

c. It is the responsibility of the FAB to obtain this signed response if a RD is issued without receipt of the signed response (i.e. the CE only received verbal confirmation). Every effort should be taken by the FAB to obtain this signed response including calling the claimant and sending a follow up development letter. However, if the FAB is unable to obtain the signed response after 30 days from the FAB's follow up development letter, the FAB remands the case to the district office for administrative closure of the claim.

d. If the case is with the FAB, and there is evidence in the case file of a SWC claim, lawsuit, or fraud in connection with an application for or receipt of workers' compensation that may impact the claimant's EEOICPA benefits, further development must be undertaken. If the matter could be clarified by a telephone call, the FAB should take this action. If the matter requires extensive development, the case is to be remanded to the district office for further development.

e. By signing the written response, the claimant agrees to notify DEEOIC of any changes in the information provided in regards to the SWC/lawsuit/fraud statement. It is not necessary to request this information again unless there is a new exposure or illness (including consequential) being accepted under EEOICPA. For instance, if the claimant has submitted a written response for lung cancer and is now filing a claim for a consequential condition of bone cancer, a new signed response regarding the bone cancer is required before this consequential condition is accepted under the Act.

7. Verifying State Workers' Compensation Claims. If the claimant reports, or the evidence indicates a SWC was filed, the CE verifies the illness and SWC benefits received, but only after the CE determines Part E eligibility.

Once the CE determines that there is qualifying employment, covered illness, and a SWC claim for the same illness, the CE sends the claimant a development letter. The development letter states that a decision under the EEOICPA cannot be rendered until the claimant provides evidence from the state commission, board, payment-issuing agency, or from an attorney who settled his or her SWC claim verifying the total amount and type of SWC benefits paid to date.

a. Benefit Categories. The evidence from the state commission, board, payment-issuing agency or attorney must specify the total amount in benefits the claimant received as of the date of the reply, and an itemized account of the total benefits paid for each benefit category, such as: medical benefits; disability benefits; death benefits; burial/funeral benefits; settlement amount; attorney fees; vocational rehabilitation; and the amount of any disability payment issued during vocational rehabilitation training.

b. No Response or Insufficient Response. If the claimant does not

respond to the request or the material submitted is not sufficient to coordinate benefits, the claim is administratively closed and the claimant is advised that no additional action will be taken until the required documentation is provided.

In some limited cases, the claimant, the SWC board, commission, payment-issuing agency or attorney may no longer have the SWC records. If the CE independently confirms with the SWC board, commission, payment-issuing agency or attorney that the SWC record is no longer available, the CE may accept a signed affidavit from the claimant attesting to the amount of the SWC benefit. As a last resort, this affidavit can be used to determine the amount of coordination.

8. Pending SWC Payment. Coordination of benefits is tied to the dollar value of the SWC benefits the claimant received for the same covered illness. Therefore, the requirement to coordinate benefits does not apply if the claimant has not received SWC benefits as of the time of the Part E payment.

If payment of SWC benefits for the same covered illness is pending at the time of the Part E payment, the CE does not defer issuing the RD or the FD. The RD or the FD is issued without coordination since the claimant has not actually received SWC benefits yet.

However, if the claimant receives payment on the pending SWC claim at any time after issuing the RD or FD, but before the issuance of the Part E payment, the Part E payment cannot be issued until the following actions are taken.

a. SWC Payment Pending, Prior to RD. If the claimant filed a SWC claim for the same covered illness, but SWC payment is pending at the time of the RD, the CE issues the RD without any coordination. However, the CE states in the RD's cover letter that if the claimant receives SWC payment after the issuance of the RD, but before issuance of the FD, the claim will be remanded by the FAB for coordination of benefits and a new RD.

b. SWC Payment Pending While the Case is at the FAB. If the SWC payment is pending while the case is in posture for the FD, the FAB Hearing Representative (HR) issues the FD without coordination. However, the HR states in the FD's cover letter that if the claimant receives SWC payment after the issuance of the FD, but before issuance of the Part E payment, the FD authorizing the payment will be vacated.

c. SWC Payment Pending at the Time of EEOICPA Payment. Before issuing the Part E payment, the CE calls the claimant to verify that payment of the SWC benefits is still pending. If the claimant receives SWC payment after issuance of the FD, but before issuance of the Part E payment, the DO forwards the claim to the National Office for a reopening.

9. Calculate Amount to Coordinate. Once the CE receives the

documentation which verifies the amount of SWC benefits the claimant received for the same covered illness, the CE completes the "EEOICPA/SWC Coordination of Benefits Worksheet" (Exhibit 2). This Worksheet (and its detailed instructions) is to be used by the CE to make the calculations necessary to determine how much to coordinate a claimant's EEOICPA Part E benefits to reflect benefits received from a SWC program for a covered illness compensable under Part E. After completing the Worksheet, the CE staples it to the inside of the case file jacket.

a. Maximum Aggregate Compensation. The amount of monetary compensation provided under Part E (impairment and wage-loss compensation), excluding medical benefits, cannot exceed $250,000. In determining the aggregate compensation, reduction of compensation based on state workers' compensation coordination or tort offset is not taken into consideration. For example, if the employee is awarded benefits for impairment in the amount of $100,000 but his compensation is reduced because of coordination of SWC benefits to $60,000, the amount of compensation used to determine the maximum aggregate compensation is $100,000.

b. Periodic SWC Benefits. Some claimants receive ongoing periodic SWC benefits, such as a worker's or widow's annuity that can make calculation of the proper amount of coordination difficult. For cases with such SWC payments, the FAB is to use the same cut-off date for determining the amount of SWC received that was used by the CE at the DO.

c. Part E Benefits Greater than SWC Benefits. If the amount of EEOICPA Part E benefits (which may consist of lump-sum payments and/or post-filing and ongoing medical benefits) to which the claimant is currently entitled is MORE than the amount of the SWC requiring coordination, the balance due the claimant (i.e., a positive amount) will be listed on Line 7 of the Worksheet. This is the amount of Part E benefits that must be referenced in the RD, together with an explanation of how this amount was calculated.

d. Part E Benefits Less than SWC Benefits: If the amount of Part E benefits is LESS than the amount of the SWC requiring coordination, the amount of the "surplus" (i.e., a negative amount) is listed on Line 7 of the Worksheet. Because a surplus can only be absorbed from EEOICPA Part E benefits due an employee currently or in the future, no further action is required for a survivor claim.

If there is a surplus to be absorbed in an employee's Part E claim, this must be noted in the RD, along with an explanation that OWCP will not pay medical benefits and will apply the amount it would otherwise pay (directly to a medical provider, or to reimburse an employee for ongoing medical treatment) to the remaining surplus until it is absorbed. In addition, the CE explains in the RD that OWCP will not pay any further lump-sum payments for wage-loss and/or impairment due in the future until the surplus is absorbed.

e. FAB Award Letter. In situations involving a surplus, the FAB issues an award letter to the claimant containing special language. The FAB award letter accompanies the final decision and advises the claimant of the exact amount of the surplus.

(1) The FAB explains in the award letter that the surplus will be absorbed out of medical benefits payable and further lump-sum payments due in the future (i.e. wage loss and impairment) under Part E of the EEOICPA.

(2) The award letter further instructs the claimant to submit proof of payment of medical bills to the DO until notice is received from the DO that the surplus has been absorbed.

(3) In addition, the award letter instructs the claimant to advise medical providers to submit proof of payment of medical bills to the DO during this time.

10. Actions to Absorb Surplus. Each District Director appoints a qualified individual to serve as the point of contact (POC) to monitor surplus situations for both tort settlements and SWC benefits. Tort settlement and SWC benefit surpluses are absorbed until the surplus is exhausted and EEOICPA benefit disbursement can commence. The POC tabulates the amounts of proofs of payment and further lump-sum awards for wage loss and impairment benefits using the DEEOIC Offset Tracking Database, which is accessible through the National Office Shared Drive, until they equal or exceed the surplus amount.

a. While the surplus is being absorbed, the POC temporarily places the affected case file in a red file jacket denoting that a surplus exists. All case file contents are maintained in the red file jacket throughout the process of surplus depletion.

b. No further payments are made on any case contained in a red file jacket. Should an unpaid bill be submitted to the POC during the surplus period, it must be forwarded to the medical bill processing agent (BPA) so an explanation of benefits can be generated.

c. During the time in which the surplus is being monitored for depletion, the POC continually tracks the offset using the DEEOIC Offset Tracking Database until the surplus has been depleted. Proofs of payment amount and further lump-sum awards for wage loss and impairment benefits will be entered into the appropriate fields in the DEEOIC Offset Tracking Database, until they equal or exceed the surplus amount.

d. Once the surplus is completely absorbed and EEOICPA benefits may commence, the POC removes the temporary red file jacket and returns the case contents to the original file jacket. Removal of the red file jacket signifies that future benefits may be provided on the case. Cases are not to be deleted from the DEEOIC Offset Tracking Database

e. The POC sends a letter advising the claimant that the surplus is absorbed. The letter provides the claimant with the address of the BPA and instructs him or her to submit all future medical bills to that address to review for payment.

f. While medical benefits are not being paid because of a surplus that is being absorbed, the CE may find it necessary to obtain a medical examination, second opinion examination, a referee examination, or a medical file review. If so, DEEOIC will pay the costs for these directed examinations or reviews and will reimburse any reasonable expenses incurred by the employee, including medical travel expenses, without adding to the surplus. Therefore, the coordination of benefits will not apply to any prior approval medical conditions in ECMS, coded with a medical condition type of "PA." In such situations, the CE enters a comment into ECMS case notes authorizing the BPA to pay all bills related to the directed medical examination or medical file review.

In a case with a surplus, BPA creates a thread for all medical travel refund requests to the POC requesting authority to deny or proceed with payment. Medical travel expenses related to a directed medical examination must be approved for payment and are not subject to coordination.

11. ECMS Coding. The CE/HR must review the EEOICPA Procedure Manual for specific ECMS coding instructions for cases with SWC payment. Accurate and prompt ECMS coding is important because on surplus cases, the condition status field for the medical condition(s) must be updated to "O" (Offset) on the Employee Medical Condition screen to suspend medical bill payment until the surplus is absorbed and the "O" code is replaced by "A" (Accepted). During the time in which the "O" code remains in the medical condition status screen, the BPA denies medical bills related to the medical condition coded as "O" and generates explanations of benefits that the bills are not payable due to a surplus.

12. Contact with State Workers' Compensation Office. Due to privacy and disclosure regulations, the CE can not disclose any information regarding a claim filed by a claimant to a SWC office unless:

a. CE Requires Information from the SWC Office. If the CE requires information from a SWC office to process an EEOICPA claim, the CE can disclose to that SWC office that the claimant filed for benefits under the EEOICPA.

b. The SWC Office Requests Evidence. If a SWC office requests evidence to establish that the EEOICPA claimant should not receive benefits from a SWC claim, the request should be submitted to the National Office for review. The National Office will provide instructions for responding to the request after reviewing all information.

Exhibit 1: Do Not Coordinate Table

Exhibit 2: EEOICPA/SWC Coordination of Benefits Worksheet

3-0600 Compensation Payments

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1. Purpose and Scope. This chapter describes the policies and procedures to be used in the processing of compensation payments, and defines the roles of the various personnel in the District Office (DO) and the Final Adjudication Branch (FAB) who are involved in the compensation payment process. At the discretion of the District Director (DD), the procedures outlined below may vary in terms of sequence or assigned roles.

2. Responsibilities. When a final decision is issued awarding lump-sum compensation, the FAB Claims Examiner (CE) or Hearing Representative (HR), the District Office CE, Senior Claims Examiner (SrCE) or Supervisory CE (SCE), Fiscal Officer (FO), and DD all ensure that the payment is processed in a timely manner. The role of SCE may be designated as an alternate to the SrCE, at the discretion of the DD. The payment process begins at the FAB office, and continues at the DO, upon return of the Form EN-20. Signatures from each of the DO individuals above, provides for a separation of functions.

3. Form EN-20. Upon issuing a final decision advising a claimant of an award of compensation, FAB enters the Acceptance of Payment (AOP) Amount and the AOP Sent Date (the date the decision was issued

and mailed) into ECMS. In conjunction with the final decision, the CE prepares and mails the Form EE-20 (award letter), accompanied by Form EN-20 (the acceptance form), to the claimant for completion.

a. Routing. Upon receipt of the completed Form EN-20 at the DO, the completed form is date-stamped (AOP Received Date) in the mail room. Mail room staff match the EN-20 with the case file, update ECMS to show the file location, and deliver the case file and EN-20 to either the FO or the Payee Change Assistant (PCA), depending upon established procedures within that DO. The mail room updates ECMS to record the file location at the time of transfer.

b. FO Review. The FO reviews the EN-20 and the associated payment information in the case file. Once the FO has determined that all information on Form EN-20 is correct, the record has been reviewed, and the payment is ready for processing by the CE or the PCA, the FO delivers the case file with Form EN-20 to the responsible CE or PCA, and changes the location of the file in the ECMS. (At the discretion of the DD, this process may be reversed, with the PCA performing data entry prior to FO review.)

c. Facsimile and Photocopies. Facsimile copies of Form EN-20 will not be accepted for processing of ECMS payments. However, a photocopy of the EN-20 may be accepted, as long as the copy bears the claimant's original signature.

d. EN-20 Signed by Power of Attorney (POA). If, upon review, the PCA or FO notes that the EN-20 has been signed by a POA, the AOP Received Date is completed in ECMS and the file is returned to the FO (or to the responsible CE) for review of the documents and POA signature. The DD has discretionary authority to assign this task to the FO, or to the responsible CE assigned to the file.

The FO/CE reviews the file to determine that a POA document has been received, and if so, makes copies of that document, along with Form EN-20, and writes a brief cover memo. The FO/CE sends the memo, the EN-20 and the POA documents (via facsimile) to the National Office (NO) Policy Branch. The Policy Branch is responsible for routing all POA requests to the Office of the Solicitor for review and response. Responses from the Office of the Solicitor are forwarded directly to the requesting DO. At the time of referral to the Policy Branch, the FO/CE enters a call-up in ECMS for seven days. The Policy Branch acts as the NO point-of-contact for any follow-up inquiries from the DO.

Upon receipt of the Office of the Solicitor's determination, the FO/CE proceeds as follows:

(1) If the Solicitor's Office approves the POA, normal processing of the payment continues.

(2) If the Solicitor's Office determines that the POA is invalid, the CE sends a letter to the claimant, with a copy to the holder of the POA, advising that the Office of the Solicitor has determined the POA to be invalid, and stating

the reason why. A copy of the Office of the Solicitor's opinion is not sent to the claimant or the holder of the POA. At this time the "AOP received date" is removed. Upon receipt of a valid POA, the "AOP received date" is then re-entered.

4. Electronic Funds Transfer.

a. Data Entry. If the claimant requests electronic funds transfer (EFT), the PCA enters the following items in the ECMS payment screen:

(1) AOP received date (i.e., date the EN-20 was date-stamped as received at the DO).

(2) Information pertaining to the recipient's Financial Institution (bank or credit union).

(a) Address (No Post Office Boxes allowed).

(b) Zip Code.

(c) State.

(d) Country (USA only – no foreign banks).

(e) ACH (Federal Reserve Bank) Routing Number, which can be verified at: http://www.fedwiredirectory.frb.org/).

(f) Recipient's account number.

(g) Type of account: Checking or Savings. (Payments may also be made to money market accounts, as long as no third party routing system is involved and the account type can be classified as checking or savings.)

(h) Telephone number.

(3) Names listed on Form EN-20 for all account holders.

b. PCA Verification. After completing these entries, the PCA verifies that the information entered is correct and prints out a copy of the input screen. The PCA initials the screen print and returns it, along with the file, to either the FO or the CE for continued processing of the payment. The file location is updated in ECMS.

c. Verification with Financial Institution. The FO, (or at the discretion of the DD, the PCA) calls the financial institution and verifies the routing number, account number, and account type. All phone calls and the information obtained is documented in ECMS. (Note: It is extremely important to verify the routing number on the EN-20 for ACH transactions. Most rejected funds transfers result from either wrong account numbers, or wrong routing numbers on the EN-20).

d. FO Review. It is the FO's responsibility to review and verify the following information in the case file and on the payment documents:

(1) Correct file number on Form EN-20 header.

(2) Correct payee name on Form EN-20 header.

(3) Correct payee Social Security Number on Form EN-20 header.

(4) Payment Amount on Payment Transaction Form (PTF), matching the amount on the EN-20.

(5) EFT or paper check is selected on Form EN-20.

(6) If EFT is selected, the "type account" block is checked ("C" for checking, "S" for savings) and the routing number and account number are listed correctly, with no trace-overs or corrections.

(7) Form EN-20 is signed and dated (if the holder of a POA signs the form, see POA process above).

(8) Phone number for the financial institution is correct and matches the number in ECMS.

(9) Address in ECMS is correct and matches the address in the paper file.

e. International Payments.

(1) Electronic Funds Transfer (EFT). Because international EFTs are not part of the U.S. Treasury/bank routing system, EEOICPA payments can only be made to U.S. banks that participate in the Treasury Department's ACH network. (See Federal Reserve E-Payments Routing Directory website at http://www.fedwiredirectory.frb.org/ for a list of ACH and FedWire participants.) A claimant living outside of the U.S. can open a bank account with a U.S. bank and arrange for withdrawal or transfer of funds, once payment has been made.

(2) Checks. When preparing a payment request in ECMS, for a check to be mailed outside the U.S., the entire mailing address must be entered on the three address lines provided on the payment screen. It is also necessary to enter 5 zeros in the Zip Code field, and Xs in the City and State fields.

5. Paper Check. After completion of the FO review, requests for payment by check are routed directly to the CE, who reviews the claimant's address as reported on Form EN-20, and verifies this address against case file documents, change of address requests in the case file, and the current address displayed in ECMS.

If the claimant provides a different address on Form EN-20 from the current address of record, the CE contacts the claimant via telephone to verify if the change of address is permanent, or if it is a temporary payment address only.

a. Permanent Change. If the payment address on the EN-20 is a permanent change of address, the CE instructs the claimant to submit a separate signed letter requesting a permanent change of address. The CE documents the telephone call in ECMS, then proceeds with payment processing using the address provided on the EN-20.

b. Temporary Change. If the payment address is a temporary address for that payment only, the CE verifies the address provided on the EN-20 through a telephone call to the payee, advises the payee that the address will only be used as a temporary address for that payment, and documents the telephone call in ECMS. The CE then proceeds with processing of the payment. (See Step 6 below for additional instructions on noting the ECMS Payment Screen when using a Payment Address Only.)

6. Payment Setup and Payment "CREATION" by the CE. Upon receipt of the EN-20 for processing, the PCA enters the AOP received date on the payee screen in ECMS. The CE verifies the AOP amount on the ECMS payee screen matches the payment amount on the signed EN-20. The CE also generates a Payment Transaction Form, or PTF (see Exhibit 1) for each Part B or Part E payment. Part B and E payments cannot be combined on one PTF. The PTF cannot contain any cross-outs, white-outs, alterations, or erasures.

A separate PTF must be completed for each payee, and each payee's Social Security number must be entered on the PTF.

Upon entry of the AOP received date and completion of the PTF, the CE creates the compensation transaction in ECMS. The CE selects "Compensation" from the main menu at the top of the screen, followed by "Create Compensation Transaction" from the corresponding drop down menu. The CE then enters the employee and payee SSN and pushes the "Search" button. The employee and payee information should appear on the "Add Payment Transaction" screen.

The CE highlights the desired AOP record and selects "Create Payment." When the "Create Payment" button is clicked, the system requires the CE to confirm the allocation amounts by entering the amounts for impairment, wage-loss, and lump sum, and then and clicking "OK." The CE is then routed to the compensation screen, where he or she will have the option of selecting an EFT payment or a paper check. For an EFT, the CE proceeds with entering the routing number, account number, account type, and payment amount. For a paper check, the CE enters only the payment amount. If the payee has requested a check be sent to a "Payment Address Only" on the EN-20, the CE must check the box labeled "Payment Only Address" in the Payee Address section of the payment screen. Otherwise, this box is left unchecked. The CE then "Saves" the record on the compensation screen.

This completes Step 1, "Creation" of the payment.Upon completion, the CE signs and dates the PTF and transfers the case to the SrCE/SCE for continued processing.

a. Differing Allocation Amounts. If the allocation amounts do not match the amounts entered by the FAB CE/HR, an error message will appear stating: "The allocation amounts entered do not match the AOP allocation." If this occurs, the CE checks the amounts entered, for accuracy. If it is determined that FAB has entered an incorrect amount, the case file is returned to the FAB office, accompanied by a case transfer sheet, requesting correction of the allocation error. The FAB CE/HR treats a request for correction of AOP information as a high-priority task. ECMS allows the FAB CE/HR to change the allocation amounts in the impairment, wage-loss, and lump sum fields at any time prior to the creation of the payment. After the payment has been created, the FAB CE/HR has the ability to redistribute the allocation amounts, as long as the total AOP amount for the payment does not change. After the requested corrections are made, the case file is immediately transferred back to the DO, and the CE then completes the payment process.

b. Payment Limits. The ECMS system will reject payments keyed for more than: $150,000 on a non-RECA Part B case; $50,000 on a RECA Part B case; and $250,000 on a Part E case. (ECMS does not count cancelled payments in these cumulative totals.)

c. Minor Child. If payment for a minor child is to be made through EFT, the funds are deposited into the parent's or legal guardian's bank account. If payment is by paper check, the check is made out in care of the parent or legal guardian. For example, the address field would be keyed in ECMS as follows:

Marian Smith

For John Smith, Jr.

7. Payment "CERTIFICATION" BY THE SrCE or SCE. The SrCE or SCE reviews the electronic record, ensuring that the payment information from the EN-20 has been input correctly, that the PTF has been completed correctly, and that the PTF matches the electronic record. The SrCE/SCE then signs and dates the PTF in the certification section and completes Step 2, "Certification" in the ECMS payment screen. Once certified, the SrCE/SCE updates the case file location in ECMS, and delivers the file to the FO for continued processing.

When the payment is certified, ECMS automatically locks the record so that no changes can be made. If an error is detected by the SrCE/SCE, prior to his/her certification, the SrCE/SCE selects the "REJECT" option which erases the payment creation and returns the case to the CE, in ECMS.

If an error is discovered after certification by the SrCE/SCE, only the Chief of Operations, FO, Assistant DD, or DD can unlock the record.

Unlocking the payment record erases the electronic signature and date for the "Creation" and "Certification" status blocks, and returns the payment record to the CE, in ECMS. The certifier returns the case

file and the PTF to the CE. The CE corrects the payment record by modifying the payment. This can be done by selecting the 'Update Compensation' menu option in ECMS and making the necessary changes. After errors are corrected, the process begins again with creation of the payment.

8. Payment "VERIFICATION" by the FO. Upon receipt of the certified PTF, the FO reviews the electronic record, the EN-20 and the PTF to ensure that all payment information is correct on the fiscal documents and in ECMS. If all information is correct, the FO completes Step 3, "Verification" on the ECMS payment screen, and signs and dates the PTF in the verification blocks. The FO then updates the case file location in ECMS and delivers the case file to the DD (or designated alternate), for final authorization.

If an error is detected after the payment is verified, only the FO, Chief of Operations, Assistant DD, or DD can unlock the record. Unlocking the payment record erases the electronic signature and date for the "Creation", "Certification", and "Verification" status blocks on the compensation screen and the payment record is returned to the CE in ECMS. The CE corrects the payment record by modifying the payment. This can be done by selecting the 'Update Compensation' menu option in ECMS and making the necessary changes.

9. Payment "AUTHORIZATION" by the DD. Upon receipt of the PTF and the case file, the DD (or designated alternate) reviews the file documents to ensure that the PTF is accurate and complete. If so, the DD completes Step 4, "Authorization" on the ECMS payment screen. The DD signs and dates the PTF, and updates the file location in ECMS, and returns the case file to the FO.

If an error is detected after the payment is authorized, but before it is transmitted to the Department of the Treasury, only the DD (or designated alternate) can unlock the record from its authorized status. If unlocked by the DD, the electronic signature and dates are erased for the "Creation," "Certification," "Verification," and "Authorization" status blocks on the compensation screen, and the electronic record is automatically returned to the CE. The DD returns the case file and the PTF to the CE for corrective action. After taking corrective action, the CE starts the payment process over again, using a new PTF Form, if required. The CE corrects the payment record by modifying the payment. This can be done by selecting the 'Update Compensation' menu option in ECMS and making the necessary changes.

At any time during the payment process, if an error is discovered which requires a change in the PTF, the person canceling the transaction completes the "Transaction Cancelled" section at the bottom of the PTF, indicating the reason for the cancellation. The certifier and authorizer do not correct the PTF or the on-line data, but instead, return the file and the PTF to the CE for corrections and to start the payment process over again.

10. Payment Reports. Once the CE, the SrCE/SCE, the FO, and the DD have signed the PTF and the file has been returned to the FO, the PTF is copied. Each week, usually by close of business Thursday, the NO will batch and forward all payments that have been approved in the electronic file system for processing. A weekly report is generated by the FO and forwarded to the NO which lists the payments by Part (B or E) and by payment mode (EFT or paper check) which have been approved for that weekly payment cycle.

Once the report has been forwarded, the FO places a copy of the completed PTF in the file and reassigns the file to the proper location. The FO then runs the ECMS reports, which generate an automated copy of the PTF form for each payment approved that cycle. The two PTFs (computer-generated and signed original) are collated and placed in a locked file cabinet. These documents are filed chronologically, oldest to most current.

11. Substitutions Among Staff. If the creator, certifier, verifier, or authorizer is not available to perform his or her payment function, alternate persons in those same roles can substitute for them. Any CE, SrCE, or SCE can create the payment. Any SrCE or SCE can certify the payment as long as he or she did not create it.

The DD should be notified when an FO is unavailable to verify payments. Either the DD or the Chief of Operations can, in the absence of a FO, verify payments. However, if they verify payments, they will not be allowed to authorize those same payments.

If the DD or Assistant DD is unavailable to authorize payments, the NO must be advised. In those situations, the NO will assign a temporary role to either the Regional Director or the Chief of Operations, so that they may authorize payments on a temporary basis. Any request for a temporary role assignment should be sent via email to the Policies Regulations and Procedures Unit Chief, or the Policy Branch Chief, at the NO.

12. Processing Exception Payments. In any case in which a payment must be expedited or cannot be processed by the DO as outlined above; e.g. terminal claimants or a second Part B payment, the PTF for Exception Processing (Exhibit 2) is used in place of the standard PTF, and is forwarded to the NO according to established procedures.

13. Processing Payment Cancellations. Recording a cancelled payment is critical to maintaining an accurate and comprehensive accounting of all funds disbursed by DEEOIC. The cancellation process is also necessary in cases where a compensation payment is being cancelled so that it may be redistributed, or paid in its entirety to another claimant. Multi-level reviews, concurrence by DEEOIC management and documentation of the actions taken by all parties (claimants, financial institutions, and DEEOIC claims staff) are essential to safeguarding the integrity and security of DEEOIC’s financial accounting processes.

a. Cancellation Initiated by Treasury. The Department of Treasury transmits an electronic Cancellation Report to DEEOIC when either an EFT payment has been rejected/returned by a recipient bank, or when a paper check is returned to Treasury for any reason. These reports are sent to the DEEOIC National Office Fiscal Officer (NOFO), who then notifies the appropriate DO of the cancelled payment.

b. Cancellation Initiated by Claimant. Once compensation payments have been authorized by the DO and transmitted to Treasury for payment (either check or EFT), if payment is not received, the claimant may initiate an inquiry regarding non-receipt. The DO takes the following steps upon notification by a claimant that his or her compensation payment has not been received:

(1) The claimant notifies the CE, who documents the call or the correspondence in ECMS case notes.

(2) If a claimant reports non-receipt of payment by telephone, the CE advises the claimant to document the non-receipt in a letter to DEEOIC.

(3) Upon receipt of either a telephone call or letter, the CE transfers the case file to the FO.

(4) The FO notifies the NOFO via email, of the non-receipt of funds.

(5) The NOFO initiates an inquiry in the Treasury Department's online PACER system, to determine the status of the payment, and advises the FO of one of the following:

(a) Check outstanding (not yet negotiated).

(b) Check Cancelled (returned to Treasury).

(c) EFT transaction completed.

(d) EFT funds returned to Treasury (Cancelled).

(e) Check negotiated (funds disbursed).

(6) The NOFO provides the FO with a copy of the payment status in PACER, via email.

(7) The FO advises the claimant of the payment status, as delineated above.

(8) In the case of a check that is still outstanding, the FO requests that the NOFO initiate a "stop pay" order with Treasury (through the PACER online system) if requested by the claimant.

(9) Once a check has been negotiated, stolen check claims can be initiated with the Treasury Department, by the NOFO, but funds cannot be re-issued until authorized by Treasury.

14. Payment Cancellations at the NO. Once it is determined that an EFT payment has been returned to Treasury, or that a paper check has either been returned or had a "stop pay" order placed on it, the FO

proceeds with a Payment Cancellation request to the NOFO.

a. Payment Cancellation Process.

(1) The DO transfers the case file out to "NAT" in ECMS, and mails the case file via overnight mail to the NOFO.

(2) Upon receipt, the NO transfers the file in to "NAT" in ECMS.

(3) The NOFO initiates a Payment Transaction Form for Exception Processing (Exhibit 2), and signs item #1, then forwards the case file to the Policy Unit Chief for review and signature (item #2). Upon completion, the Unit Chief forwards the case file to the Director or Deputy Director for review, signature, and completion of Step 1, in the Void Transaction screen of ECMS.

15. Void Transaction by DEEOIC Director. ECMS only allows the Director or Deputy Director to "Initiate" the on-line payment cancellation process. If upon review of the cancellation request, the Director or Deputy Director agrees that the ECMS payment record needs to be voided, the payment cancellation is initiated in ECMS.

a. Void Transaction Process.

(1) In ECMS, select "Initiate Void Compensation Transaction" from the Compensation menu.

(2) At the Search Payment Record screen, enter the case SSN or name.

(3) Click the "Initiate" button at the bottom of the Payment Update screen.

(4) Click "YES" to confirm the Void Initiation.

(5) After the void is reviewed and initiated in ECMS, the Director or Deputy Director checks off #3 and #4, and signs and dates the "Payment Cancellation" form (Exhibit 3). The case file is transferred out to the DO in ECMS, and returned via overnight mail.

16. Void Transaction by DD. Upon receipt of the case file in the DO, the ECMS file location is updated and the file is forwarded to the DD.

a. Only Authorized by DD. ECMS only allows the DD (or designated alternate) to "Authorize" (complete) the payment cancellation process in ECMS. If upon review, the DD agrees that the ECMS payment record should be voided, the payment cancellation is authorized by the DD.

(1) In ECMS, select "Authorize Void Compensation Transaction" from the Compensation menu.

(2) At the Search Payment Record screen, all pending check cancellations, pending authorization, will appear in a grid view.

(3) Highlight the record to be authorized, and click "Select."

(4) If no re-issue of the payment to that claimant is to be made (e.g. employee died before payment process was completed), check the "No Repayment To This Claimant" box.

(5) If repayment is to be made to that payee, the box is left blank.

(6) Click the "Authorize" button at the bottom of the Payment Update screen.

(7) Click "YES" to confirm the Void Authorization. After the payment cancellation is authorized in ECMS, the DD checks off #5 and #6 on the Payment Cancellation form, signs and dates the form, then updates the file location in ECMS and delivers the case file to the FO.

Note: If an error is detected by the DD, the Transaction Cancelled section of the "Payment Cancellation" form is filled out. The case file is returned to the FO for review.

17. DO Actions After Void Transaction Has Been Completed in ECMS.

a. Re-Issuing Payments. If the compensation payment is to be re-issued, the FO routes the case file to the CE and advises that the payment cancellation process has been completed and that payment is to be re-issued.

(1) If the EN-20 is insufficient to process the re-issued payment, i.e. the bank routing/account numbers for EFT, or address for check, are incorrect, the CE sends a letter of explanation to the claimant, along with a copy of the original EN-20 prepared by FAB. Upon receipt of the new EN-20, the Compensation Payment process begins again with either Paragraph 4 (EFT) or Paragraph 5 (paper check) above.

(2) If the EN-20 is sufficient to process a re-issue of the payment (e.g. the bank routing/account numbers for EFT, or address for check, are correct, but were incorrectly entered in ECMS; or the original check was lost in the mail and payment was stopped), the Compensation Payment process begins again with either Paragraph 4 (EFT) or Paragraph 5 (paper check) above, using a new PTF with new authorization dates.

b. Voided Transactions. If the compensation payment is not being re-issued, the FO confirms that the Void Transaction has been completed, and that the "No Repayment To This Claimant" box is checked on the View Comp. Transaction screen, under the "Void Transaction" tab. The case file is returned to the DO file room, and transferred to "FIL" in ECMS on the Case screen, or is returned to

the CE for survivor development, if applicable.

18. Claims for Non-Receipt of Compensation Payments When Paper Check Has Been Negotiated. If the payee calls or writes the DO to advise that he or she did not receive his or her compensation check, the FO requests that the payee provide immediate written notification of non-receipt of payment. Upon receipt of written notification, the FO forwards such notice to the NOFO, who takes the following actions:

a. Non-Receipt of Compensation Payments Process.

(1) Payment status is reviewed in the Treasury Department PACER system.

(2) If payment status in PACER shows "Negotiated" (check cashed), the National Office FO creates a claim in the PACER system, for that payment and selects Option #2 – Entitlement After Status.

(3) After 24 hours, the NOFO contacts Treasury and verifies that the claim has been recorded in the Treasury Department's "T-SIS" system.

(4) Upon receipt of the claim in T-SIS, Treasury forwards a stolen check claim packet to the payee, and investigates the circumstances surrounding the claim.

(5) Only after Treasury notifies of resolution can the payment be re-issued by DEEOIC.

19. Issuing Multiple Payments To The Same Payee in ECMS E. Under Part E, claimants can receive compensation from three types of awards: lump sum compensation (specifically awarded to a survivor if the employee's covered illness was a significant factor in aggravating, causing, or contributing to the employee's death); wage-loss; and impairment. Unlike Part B, ECMS-E contains a field for the subsequent allocation of the Acceptance of Payment (AOP) amount into three categories. These three categories are labeled in ECMS-E as: "Wage-Loss Alloc," "Impairment Alloc," and "Lump Sum Alloc" the sum of which will be equal to the AOP Amount, and the corresponding final decision.

Because Part E cases may also require multiple decisions awarding various amounts of compensation, each AOP amount can be allocated to a sub-category as is appropriate. This section provides written guidance on the proper procedures for issuing multiple payments to the same payee in ECMS E.

a. After Issuance of a Final Decision. When the FAB issues a Final Decision awarding compensation under Part E, the FAB CE or HR must complete the AOP information on the payee screen in ECMS E. The AOP information consists of the AOP sent date, which is the date the EN-20 is sent out, and the AOP allocation amounts. The AOP allocation amounts coincide with the final decision that is being issued. These amounts include lump sum compensation, wage-loss, and impairment.

The default amount for these blank fields is $0.00. Therefore, if no award is granted or if benefits are denied in one of the three areas, in that decision, no input is needed for the relevant field. The procedure for entering the AOP information in Part E is outlined below.

(1) To add new AOP information for a payee, the FAB CE/HR must go to the payee screen in ECMS E, click on any field in the AOP section, and click "Insert." This accesses the AOP information screen where the FAB CE/HR has access to the AOP sent date and allocation amounts (impairment, wage-loss, and lump sum). The FAB CE/HR accurately completes these fields to coincide with the final decision. Once the allocated amounts are entered, ECMS automatically totals the allocations and populates the (total) AOP amount. The AOP amount cannot exceed $250,000 in ECMS E. The AOP amount field should match the amount on the EN-20, and the amount awarded under that particular final decision. For example, a final decision awards a widow $125,000 because the employee's lung cancer (an accepted condition) was a significant factor in aggravating, causing, or contributing to the employee's death. She also receives $25,000 for his wage-loss under the same decision. The EN-20 reflects a payment amount of $150,000. The AOP screen shows "$125,000.00" in the lump sum compensation field, "$25,000.00" in the wage-loss field, and no amount paid in the impairment field. ECMS totals the amounts in the allocation fields and shows "$150,000.00" in the AOP Amount field, which is the same amount on the EN-20.

b. Subsequent Decisions. If subsequent decisions are issued awarding additional compensation (such as additional wage-loss), a new AOP record is created following the process discussed above. This is a new/separate AOP entry that reflects the amount of compensation awarded in the corresponding final decision. All of the AOP records are retained and are accessible through the payee screen in ECMS, by highlighting the associated AOP record and pressing enter, or double-clicking on the record. ECMS displays the cumulative total of AOP amounts paid on the Case Screen. This total does not include payments that have been cancelled. The Total Compensation Allocated, on the case screen, cannot exceed $250,000 in ECMS-E.

(1) When the completed EN-20 is received in the district office, it is routed to the CE if payment is to be made via paper check, or routed to the PCA if payment is to be made via EFT. For an EFT, the PCA accesses the EFT tab on the payee screen to enter the EFT data. If there are any changes to the EFT banking information (i.e. the claimant has changed bank names, account numbers, or account types since the last EFT payment), the PCA edits/changes the

information currently displayed on the EFT screen. The EFT information includes the bank name, bank address, routing number, account number, account name, account type, contact name, and contact phone number. The account number, routing number, account name, and account type are verified with the bank, to the fullest extent possible, and documented in the case file.

(2) Upon receipt of an EN-20 for processing, the CE must first enter the AOP received date. To do this, the CE accesses the payee screen in ECMS, highlights the associated AOP record (which will have a blank AOP received date), and presses the enter key, or double-clicks on the record. This allows access to the AOP information line. The CE can only add/edit the AOP received date. The CE cannot add/edit the AOP sent date, or the AOP amount. The CE inputs the receipt date of the EN-20 from the date stamp showing receipt of the document at the DO. Once the CE saves the AOP received date, he/she closes out of the case in ECMS.

(3) The CE completes the Payment Transaction Form (PTF) in accordance with Paragraph 6, above.

(4) Upon entry of the AOP received date and completion of the PTF, the CE is ready to create the compensation transaction in ECMS-E. The CE selects "Compensation" from the main menu at the top of the screen, followed by "Create Compensation Transaction" from the corresponding drop down menu. The CE then enters the employee and payee Social Security number and pushes the "Search" button. The employee and payee information should appear on the "Add Payment Transaction" screen.

(5) The process of certifying, verifying and authorizing payments for the SrCE/SCE, FO and DD, proceeds as delineated in Paragraph 4, above.

20. Re-Issuing Payments After Payment Cancellation. If a previously voided payment, that is eligible for re-issue exists, (e.g. check was cancelled, EFT was returned because of erroneous banking information, etc.) the "Create Payment" button will change to a "Re-issue Payment" button that can be selected when the corresponding AOP record is highlighted. As always, if information needs to be corrected on the payee screen, such as routing number or street address, the PCA must complete this prior to the payment being re-issued.

Exhibit 1: Payment Transaction Form (PTF)

Exhibit 2: Payment Transaction Form for Exception Processing (PTF)

Exhibit 3: Payment Cancellation Form

3-0700 Post-Award Administration

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1. Purpose and Scope. This chapter outlines the actions Claims Examiners (CE) take on Part E cases after a claim has been approved for benefits. This chapter also describes the procedures used by the National Office (NO) to ensure that payment of medical benefits to covered Part E employees is fully coordinated with any state workers' compensation benefits received by those employees or their survivors.

2. Authority. Section 7385s-11(a) requires that compensation to an individual under Part E be coordinated with state workers' compensation benefits, other than medical benefits and benefits for vocational rehabilitation, that the individual has received for the same covered illness. The Director of DEEOIC has been delegated the authority to request information from state workers' compensation authorities concerning state workers' compensation benefits that covered Part E employees receive.

3. Claims Examiner Responsibilities. The CE sends a Form EE-12 letter, accompanied by Form EN-12 enclosure (Exhibit 1), to each covered Part E employee who receives medical benefits under Part E for a covered illness. These forms are sent on the one-year anniversary of the latest award of any type of Part E benefits, and every year thereafter in which the employee continues to receive medical benefits. The employee must complete and return the EN-12 questionnaire within 30 days.

If the employee has not responded after 30 days, the CE attempts to verify the employee's contact information in the case file and send another Form EE/EN-12 and provide the employee with an additional 30 days to in which to respond.

Upon receipt of a completed Form EN-12 from an employee, the CE reviews the employee's responses and takes the appropriate action as noted below.

a. Change of Address. If the employee lists a new address or telephone number, the CE notes the new information in the case file. The CE also ensures that the new contact information is reflected in the ECMS.

b. Treatment Concerns. If the employee identifies concerns about the treatment that he or she is receiving for a covered illness, the CE acknowledges these concerns by letter and advises that they are being referred to the appropriate person for further action.

c. Additional Impairment or Wage Loss. If the employee indicates that he or she wishes to claim additional Part E compensation due to increased permanent impairment as a result of an accepted covered illness, or additional compensation for another calendar year of qualifying wage-loss, the CE follows established procedures for facilitating these claims.

d. State Workers' Compensation. If the employee indicates that he or she has filed for or received state workers' compensation benefits after the receipt of an award of Part E benefits, the CE ensures that all of the information requested concerning the state workers' compensation benefits filed for or received has been provided.

e. Tort Awards or Settlements. If the employee indicates that, since receiving an award of benefits under Part E, he or she has received a tort award or settlement (other than for a claim for workers' compensation) in connection with a lawsuit alleging exposure to a toxic substance for which the Part E award was received, the CE ensures that all of the information requested concerning the tort award or settlement has been provided.

4. National Office Responsibilities. At the beginning of each fiscal year, the NO Fiscal Officer sends a Form EN-13 information request (Exhibit 2) to each state's workers' compensation authority advising of the requirement under EEOICPA that any state workers' compensation benefits received by a covered Part E employee for an accepted covered illness must be coordinated with Part E benefits received for that same illness, and requesting information about workers' compensation benefits paid to employees who have been awarded Part E benefits.

Upon receipt from the states, the NO Fiscal Officer sends copies of the information gained to each District Office Fiscal Officer for comparison against the information contained in the claims files for listed individuals.

a. Initial Requests. Form EE-13 lists employees who worked at DOE facilities in the state in question whose claims for compensation under Part E were accepted during the 12 months preceding issuance of the Form EE-13. For each employee, the list contains the following

information:

(1) Name(s) of the claimant(s);

(2) Whether the claimant is the employee or the employee's survivor;

(3) Social Security number of the employee;

(4) Employee's accepted medical condition; and

(5) Date the claimant's eligibility for Part E benefits began.

For each employee listed, the state agency is asked to provide information about state workers' compensation claim(s) that have been filed on behalf of the same worker, including the name(s) of the claimant(s), whether the claim was accepted, and if so, the medical condition accepted and the effective date of the award.

b. Subsequent Requests. Form EE-13 also contains a second list of employees for whom information has already been requested by a prior Form EE-13. For each employee on the second list, the state agency will be asked to indicate whether any information provided in response to the initial request has changed.

Exhibit 1: Form EE-12, Letter Enclosing EN-12 Questionnaire

Exhibit 2: Form EE-13, Letter from National Office With Blank EN-13

3-0800 Overpayment Process

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1. Purpose and Scope. This chapter describes how the Office of Workers' Compensation Programs (OWCP), through the Division of Energy Employees Occupational Illness Compensation (DEEOIC), identifies, evaluates, provides notification of, waives, issues final decisions regarding, and recovers overpayments under both Parts B and E of the EEOICPA.

2. Legislative Authority and Directives. The instructions in this part of the procedure manual derive from the following regulations and authority:

a. The Energy Employees Occupational Illness Compensation Program Act (EEOICPA) at 42 U.S.C. 7385j-2 authorizes the Secretary of Labor

to recover overpayments because of an error of fact or law, except when an incorrect payment has been made to an individual who is without fault and the adjustment or recovery would defeat the purpose of the Act or would be against equity and good conscience. With respect to recovery, the EEOICPA authorizes OWCP (as designee of the Secretary of Labor) to recover the overpayment pursuant to regulations prescribed by the Secretary.

b. Public Law 89-508, Federal Claims Collection Act of 1966 (80 Stat. 308), amended by Public Law 900-904 (2000), assigns the Secretary responsibility for the collection of debts arising from the activities of the Department of Labor. It also provides the authority to compromise, terminate, or suspend collection action on debts not in excess of $100,000 (exclusive of interest, penalties, and administrative costs and after partial payments have been deducted). In such cases, there must be no indication of fraud, and it must appear that:

(1) The debtor is unable to pay the full amount in a reasonable time, as verified through credit reports or other financial information;

(2) The Government is unable to collect the debt in full within a reasonable time by enforced collection proceedings;

(3) The cost of collecting the debt does not justify the enforced collection of the full amount; or

(4) There is significant doubt concerning the Government's ability to prove its case in court.

The Department of Labor Manual Series (DLMS) 6, Chapter 1100, Debt Management, provides that Department of Labor Agency Heads are delegated the authority to compromise, suspend or terminate collection action on debts stemming from program activities not in excess of $100,000, and that Agency Heads may re-delegate this authority to officials in their agencies with approval of the Chief Financial Officer. DLMS6-1111b (1),c (2).

c. Public Law 97-365, Debt Collection Act of 1982, amended several statutes, including the Federal Claims Collection Act of 1966. The Debt Collection Act authorizes Federal agencies to collect certain charges on outstanding debts, to use salary offset or administrative offset to collect claims and to use the services of private collection agencies.(Note: The Federal Claims Collection Act of 1966 as amended by the Debt Collection Act of 1982 has been codified as 31 USC 900-904.)

d. Public Law 104-134, Debt Collection Improvement Act of 1996 also amended several statutes, including the Debt Collection Act of 1982. The Debt Collection Improvement Act provides that any non-tax debt or claim owed to the United States that has been delinquent for a period of 180 days be turned over to the Secretary of the Treasury, who will

determine whether to collect or terminate collection actions on the debt or claim.

e. 31 CFR Parts 900-904 (Federal Claims Collection Standards) describes standards for the collection and compromise of debts, termination of agency collection, and referral of civil claims to the Department of Justice. In particular, 31 CFR 902.1(b) and 903.1(b) provide that the Department of Justice has the exclusive authority to compromise, suspend or terminate claims in excess of $100,000, exclusive of interest, penalties and administrative costs. Consequently, even if OWCP believes that compromise, suspension or termination of recovery of such a debt is appropriate, the matter must be referred to the Department of Justice, through the Department of the Treasury, for determination.

f. 31 CFR Part 285 includes the provisions for transferring delinquent debt to the Department of the Treasury.

g. In a case involving criminal fraud on the part of the debtor or any other party having an interest in the claim, instructions regarding compromise, suspension or termination of recovery do not apply. As provided by 31 CFR 900.3(a), only the Department of Justice has authority to compromise, suspend or terminate collection action on such claims.

h. In cases referred to the Office of the Inspector General or the U.S. Attorney for reasons other than collection of the debt, the OIG should be advised before collection action is initiated in order to evaluate whether collection action would jeopardize an ongoing investigation or a legal action in progress.

3. Definition of Overpayment. An overpayment is any amount of compensation paid under 42 U.S.C. §§ 7384s, 7384t, 7384u, 7385s-2 or 7385s-3 to a recipient that, at the time of payment, is paid where no amount is payable or where payment exceeds the correct amount of compensation determined by DEEOIC.

4. Notification of Payment. DEEOIC provides claimants with narrative descriptions of benefits paid or payable. Claimants who receive compensation payments are required to sign an acceptance of payment form. Payments made by check clearly indicate the reason for payment. Payments made by Electronic Funds Transfer (EFT) appear on the claimant's financial institution statement listing the amount and date of payment. Such advice is considered due notice of payment absent affirmative evidence to the contrary. The claimant is responsible for notifying DEEOIC of any discrepancy between the amount paid and the amount stated as paid on a check or bank statement.

5. Identifying Overpayments. Aside from the requirement that the claimant inform DEEOIC of any overpayment that he or she discovers, the primary responsibility to identify overpayments rests with claims staff. The Final Adjudication Branch (FAB) must issue a final

decision with respect to eligibility *before* the overpayment is officially identified.

a. Initial Screening. Claims staff initially screen for overpayments, which occur for various reasons, such as:

(1) A claimant was paid compensation in error. This might result from a final decision overturning an award of compensation. A final decision should not overturn a previous award of compensation based on a change in policy, if payment was made based on a policy that is now obsolete.

(2) The required tort offset or coordination with state workers' compensation benefits was either improperly applied or never applied.

(3) A lump sum award requires adjustment because additional eligible survivors emerge after payment, resulting in overpayments to the original eligible payees.

(4) Medical reimbursements to claimants in excess of actual medical bills result in overpayments.

b. Referral to National Office (NO). Once an overpayment is identified, the matter is referred to the District Office Chief of Operations (COP) or FAB Manager for transfer to the NO.

The Claims Examiner (CE) identifying the overpayment prepares a memorandum identifying and evaluating the overpayment for review by and signature of the COP/Manager. In the memorandum, the CE describes the circumstances of the overpayment.

If the COP/Manager agrees that an overpayment exists, the file is transferred to the Chief of Policies, Regulations, and Procedures Unit (PRPU), where it is assigned to a Policy Analyst (PA).

6. Compensation Paid After Claimant's Death. No overpayment is declared when compensation is paid by EFT for direct deposit to the decedent's bank account.

a. Standard Form 1184. When the NO discovers that compensation has been paid after the death of the claimant, and the payment is not returned, the Fiscal Officer immediately notifies the Department of the Treasury of the erroneous payment by completing the electronic Standard Form 1184 (Unavailable Check Cancellation), available at http://contacts.gsa.gov/webforms.nsf/0/A7422A589D29E2E1852570BC004ADC27/$file/sf1184_e.pdf, indicating the claimant's name and date of death in the appropriate boxes on the form.

b. Time Limitations. The Department of the Treasury has a twelve-month time limit from the date of the EFT to initiate recovery of the improper payment. Therefore, the PA acts promptly upon learning that a payment was issued after the date of the claimant's death. Once the Department of the Treasury has been advised of the erroneous payment, the PA monitors the case for receipt of the payments.

c. Recoupment. The Department of the Treasury recoups the money from the bank which received the EFT and restores the funds to DEEOIC. If for any reason the Department of the Treasury cannot recoup the erroneous payment, DEEOIC has no redress against the bank and the PA simply drafts a memorandum to the case file concerning the matter.

7. Review and Initial Notification. The PA reviews the overpayment memorandum and all available evidence to verify the existence of an overpayment, then calculates the exact amount of the overpayment. The PA creates and maintains an accounts receivable log in a spreadsheet to be stored on the shared drive to record overpayments and their disposition over time. The PA tracks overpayments separately by district office.

Once the overpayment is established, the PA determines whether the claimant bears any fault in the creation of the overpayment.

a. Determination of Fault. The PA's determination of fault depends on the circumstances surrounding the overpayment. The claimant must show good faith and exercise a high degree of care in reporting events which may affect entitlement to or the amount of benefits. Degree of care may vary with the complexity of circumstances and a claimant's capacity to realize an overpayment has occurred. While this is not an exhaustive list, the following can be construed as fault in creating an overpayment:

(1) Claimant made an incorrect statement as to a material fact he or she knew or should have known to be incorrect.

(2) Claimant failed to provide information he or she knew or should have known to be material in nature.

(3) Claimant accepted payment that he or she knew or should have known to be incorrect.

b. Initial Notification. After making a determination of fault, the PA generates a letter bearing the Unit Chief's (UC) signature informing the claimant that an overpayment exists. Initial notification is required before DEEOIC can take any final action to recover an overpayment or adjust benefits.

Exhibit 1 is a sample initial overpayment notification letter used when the claimant is without fault. Exhibit 2 is a sample initial overpayment notification letter used when the claimant is with fault. [However, in situations warranting administrative write-off (see paragraph 7c below), no overpayment notification is sent to the claimant.] The notification letter serves to:

(1) Notify the claimant that an overpayment exists and the exact amount of the overpayment.

(2) Provide the result of the preliminary finding of fault.

(3) Advise the claimant of his or her rights. The claimant

has 30 days following the date of the overpayment notification letter to invoke the rights to:

(a) Inspect and copy DEEOIC records relating to the overpayment.

(b) Present written evidence challenging existence or amount of the overpayment.

(c) Request a telephone conference.

(d) Challenge any finding of fault.

(e) Request waiver of recovery of the overpayment.

The filing date of the claimant's challenge to the overpayment is determined by the postmark date, the date the request is received in the office, or the Resource Center, whichever is the earliest determinable date.

c. Administrative Write-Off. If the amount of the overpayment is equal to or less than $2,500, the PA recommends administrative write-off, regardless of the claimant's fault, since the cost of recovery action will exceed the expected recovery amount. The PA prepares a brief memorandum to the UC describing the reasons for recommending termination of collection actions.

Once the UC approves an administrative write-off, the PA creates an accounts receivable record of the overpayment in the accounts receivable spreadsheet. The overpayment is then cancelled without giving any notice of the overpayment to the overpaid party, and no final decision is issued. Exhibit 3 is a sample memorandum to file for this process.

8. Telephone Conferences. When requested by the claimant, the PA holds a telephone conference within 30 days of the date of the overpayment notification letter. The PA also holds telephone conferences in cases where the financial data in the file is not clear or adequate to make a decision about waiver or repayment.

a. Pre-conference Call. The PA holds a pre-conference call to give the claimant a clear picture of the purpose and process of the conference and the obligations of all parties, and to schedule a time for the call. The PA:

(1) Explains the issues that will be addressed during the conference call (i.e., income, expenses, assets, transfer of assets, and liabilities). If a preliminary finding of "with fault" was issued, the PA explains how the decision was made and its implications, and invites the claimant to provide any information that could affect the preliminary determination;

(2) Describes the criteria used to make key decisions in the case (i.e., with fault finding, criteria for waiver, interest charges);

(3) Describes the evidence the claimant needs to collect in preparation for the conference call;

(4) Gives the claimant a chance to ask questions;

(5) Determines the best time for the conference; and

(6) Prepares the pre-conference checklist (Exhibit 4), which verifies that the conference agenda items were discussed.

b. During the Conference Call. The PA:

(1) Identifies him- or herself;

(2) References the pre-conference call;

(3) States the purpose of the call;

(4) Advises the claimant that he or she will be taking notes and for that reason there will be periodic pauses while he or she is writing;

(5) Describes the specific focus of the call;

(6) Obtains the claimant's acknowledgement that he or she understands what the conference issues are and what the conference is about;

(7) Listens carefully to what is being said;

(8) Probes responses that are too general or not credible, or which conflict with other statements given or the evidence of file;

(9) Takes notes complete enough to capture the necessary information; and

(10) Confirms the accuracy of the statements recorded by reading them back to the participant(s) for confirmation.

c. After the Conference. The PA:

(1) Prepares a neutral Memorandum of Conference, without findings, describing what transpired during the conference. (See Exhibit 5 for a sample Memorandum of Conference.) The language of the memorandum must be clear and non-technical. A sound Memorandum of Conference should:

(a) Identify and describe the issues that were discussed during the conference;

(b) Identify the PA who conducted the conference and who participated in the conference;

(c) Describe the position of DEEOIC and the claimant coming into the conference;

(d) Describe the explanation provided in the

conference that is relevant to the issue;

(e) Describe what was said in the conference that is relevant to the issue;

(f) Describe the method used to confirm the accuracy of the information collected in the conference that is recorded in the Memorandum of Conference; and

(g) Describe any agreements reached in the conference.

(2) Sends the Memorandum of Conference to the conference participant(s) for review and comments. Exhibit 6 is a sample letter to the claimant. Fifteen days from the date of the conversation, should be allowed for comments. After receipt of any comments, the PA makes findings on the issues for resolution and documents these findings in the final letter decision.

9. Burden of Proof. DEEOIC has the right to require that the overpaid claimant submit whatever financial information the PA deems necessary to determine whether to waive recovery of an overpayment. Form OWCP-20 financial questionnaire (Exhibit 7) is designed to obtain financial information. Extensive documentation of assets and expenses in support of the statements made on the OWCP-20 are required. The burden rests solely on the overpaid claimant to establish the grounds for a waiver.

10. Waiver. DEEOIC may waive recovery of all or part of an overpayment. (See paragraph 10(b)(2)(b)(Example 2) for further explanation of a partial waiver.) A determination to waive recovery of an overpayment is based on the PA's review of any documentation or argument submitted by the claimant within 30 days after the initial notification letter is issued, evidence obtained during the telephone conference, or evidence received within a timely period after the claimant's receipt of the Memorandum of Conference.

The burden of proof rests with the claimant to prove the conditions necessary to grant a waiver. DEEOIC requires the claimant to submit information specified on Form OWCP-20 and supporting documentation. If this information is not submitted within 30 days of the request, waiver will be denied until such time as the requestor documentation is furnished. Where it is determined that the overpaid claimant is not at fault in the creation of the overpayment, repayment will still be sought unless adjustment or recovery either would defeat the purpose of the Act or would be against equity and good conscience.

a. Recovery Would Defeat the Purpose of the EEOICPA.

Where it is found that recovery will defeat the purpose of the EEOICPA, no recovery will be sought. To defeat the purpose of the EEOICPA, it must be found that the claimant requires substantially all current income to meet current ordinary and necessary living

expenses *and* that the claimant's assets do not exceed a specified amount as determined by DEEOIC from data furnished by the Bureau of Labor Statistics (BLS).

When a claimant exceeds the limit for either disposable current income or assets, a basis exists for establishing a reasonable repayment schedule over a reasonable, specified period of time. It is the claimant's burden to show otherwise by submitting evidence that recovery of the overpayment would cause hardship of a nature sufficient to justify waiver.

(1) The PA determines the claimant's income based upon documents submitted. An individual's total income includes any funds which may reasonably be considered available for his or her use, regardless of the source. A spouse's income will not be considered available to the claimant unless the spouse was living in the household both at the time the overpayment was incurred and at the time waiver is considered. Income to be considered includes, but is not limited to:

(a) Government benefits.

(b) Wages and self-employment income.

(c) Regular payments (rent or pension).

(d) Investment income and alimony or child support payments.

(2) The PA reviews claimed ordinary living expenses. It is the claimant's burden to show that such expenses are reasonable and necessary. An individual is deemed to need substantially all of his or her current income to meet current ordinary and necessary living expenses if monthly income does not exceed monthly expenses by more than $50. The following can be considered as ordinary and necessary living expenses:

(a) Food, clothing, household and personal hygiene supplies, rent, mortgage payments, property taxes, utilities (e.g., electricity, gas, fuel, telephone, water), insurance (e.g., vehicle—one or two allowable, life, accident, and health), expenses for one or two vehicles (e.g., loan payments with the date each will be paid off, gas, oil, maintenance), transportation expenses not included under vehicle expenses, and creditor payments (e.g., credit card debt or other debt made in monthly installments).

(b) Medical, hospitalization and similar expenses not reimbursed by insurance or other sources.

(c) Church and charitable contributions made on a regular basis. This does not include large one-time

gifts made after receipt of the preliminary notice of the overpayment.

(d) Miscellaneous expenses (e.g., haircuts, newspapers) not to exceed $50 per month.

A finding that a *type* of expense is ordinary and necessary does not mean that the *amount* is ordinary and necessary. The burden is on the claimant to show that the expenses are reasonable and needed for a legitimate purpose.

If the PA determines that the amount of certain expenses is not ordinary and necessary, particularly regarding significant expenses for food, clothing, and vehicles, the PA must state in writing the reasons for the finding. The finding must be supported by rationale, which may include reference to recognized research data (such as current statistics from BLS) that show that the claimant's expenses exceed the average or range of expenses for the general population relevant to the claimant's circumstances.

The PA evaluates only the minimum periodic payment as determined by the creditor. The minimum amount is verified by copies of the claimant's monthly billing(s) for consumer debt.

(3) An individual's assets should not exceed the resource base of $5,500 for an individual or $9,200 for an individual with a spouse or one dependent, plus $1,100 for each additional dependent, based on information from BLS. A spouse's assets will not be considered available to the claimant unless the spouse was living in the household both at the time the overpayment was incurred and at the time waiver is considered.

(a) Liquid assets may include (but are not limited to) cash, the value of stocks, bonds, savings accounts, mutual funds, and certificates of deposit.

(b) Non-liquid assets may include (but are not limited to) the fair market value of an owner's equity in property such as a camper, boat, second home and furnishing/supplies, vehicle(s) (i.e., any vehicles above the two allowed per immediate family), and jewelry.

Assets do not include the value of household furniture (primary residence), clothing, one or two vehicles, a home which the person maintains as the principal family domicile, or income-producing property, if the income from such property has been included in income.

b. Recovery Would Violate Equity and Good Conscience. If the claimant is not entitled to waiver under the "defeat the purpose of the EEOICPA" clause, the PA considers the "against equity and good

conscience" clause. Even if the claimant does not raise the "equity and good conscience" reason in the claim for waiver, the PA addresses this issue in the waiver memorandum.

The PA reviews all pertinent financial information to determine if recovery of the overpayment will violate the concept of "equity and good conscience." This clause is divided into two parts, financial hardship and relinquishing a valuable right. To demonstrate such a violation it must be established that either:

(1) Recovery will cause the claimant to experience severe financial hardship. The PA evaluates financial records and compares income with expenses similar to the review conducted under paragraph 10(a) to determine if repayment will cause severe financial hardship.

Recovery will be found to be "against equity and good conscience" when an individual who was not entitled to benefits would experience severe financial hardship in attempting to repay the debt. The criteria to be applied in making this determination are the same as those stated above in paragraph 10(a).

(2) The claimant has relinquished a valuable right or changed position for the worse. The PA must review pertinent financial and other evidence to determine either of the following:

(a) Based chiefly or solely on notification of payment, the claimant relinquished a verifiably valuable right and such right cannot be regained (e.g., left a job that cannot be regained, sold a business, retired, or other major life-changing financial decisions). When a claimant gives up a valuable right, his or her current ability to repay is not taken into consideration, as the forfeiture of the right is in itself the grounds for waiver.

Example: After being advised of entitlement to compensation, the claimant resigned his job and withdrew his contributions to his retirement fund, under the assumption that he was entitled to a lump sum award of $150,000. Three years later it was discovered that his award was erroneous. The claimant had lost his retention rights, was unable to get his old job back, and could not secure other employment. Recovery of any of the overpayment would be "against equity and good conscience" in this situation because the individual gave up a valuable right.

(b) A decision was made resulting in a loss that verifiably worsened the claimant's condition, and such decision would not have been made but for the receipt

of benefits. The claimant must show that if required to repay the overpayment, he or she would be in a worse position after repayment than would have been the case if the benefits had never been received in the first place.

Converting the overpayment into a different form, such as food, consumer goods, real estate, etc., from which the claimant derived some benefit, is not considered a loss. Converting the overpayment into a different form for the benefit of another person, such as a child or relative, may be considered as a loss if the claimant retains no ownership interest in the proceeds and has no ability to reclaim the proceeds.

Example 1: A claimant received a lump sum award. Later the entire award is declared to be an overpayment. The claimant contends that he has changed his position for the worse, as he used the entire award to make a down payment on a larger home. The claimant has not met his burden in showing that he changed his position for the worse, since he has not established that he suffered any loss. He has simply converted the money into a different form. Conversion of a liquid asset into real or tangible property does not constitute a loss.

Example 2: A claimant is notified that he is entitled to $30,000. Upon receipt of the money, the claimant signs a lease to rent a larger apartment and pays a $2,000 security deposit. He places the remainder of the award in a savings account. Before the claimant moves in, he is notified that the entire award is an overpayment. As a result, the claimant fails to make the first month's rent, forfeits the security deposit, and does not move to the new apartment.

Since the claimant would not have entered into the lease to rent the apartment but for his receipt of benefits, it would be inequitable to recoup the entire $30,000 overpayment. The claimant clearly suffered a $2,000 loss and repayment would put him in a worse position than if he had not received the initial award.

Given that the claimant suffered a $2,000 loss, and not a $30,000 loss, a partial waiver is a legitimate action is this case. The claimant does not have the money to rent a larger apartment and had no intention of doing so until he received his award. Thus, the claimant relied on DEEOIC's action and it would be inequitable to recover that part of the overpayment to

the extent of his reliance. It would not be inequitable to recover that part of the overpayment that the claimant deposited in the bank. However, if the claimant were faced with additional expenditures arising out of the lease, those expenses would also be deducted from the

Example 3: Suppose a claimant receives a $150,000 award and loaned a relative $25,000 to buy a house *before* he received notice of an overpayment. Since the claimant has not suffered a loss, equity and good conscience do not require waiving of this $25,000.

However, it would be inequitable to tell the claimant to recall the loan at once (further, the terms may not allow such action), and it would not be inequitable to count the $25,000 as currently available assets. Thus, the interest the claimant receives on the loan as well as any sum he may receive on the principal should be considered income when determining the claimant's ability to repay the overpayment.

11. Overpayment Decisions. After weighing all the evidence and considering all the circumstances surrounding the overpayment, the PA drafts an overpayment decision. The decision outlines his or her findings and whether recovery is to be pursued. The UC reviews, signs, and issues the overpayment decision to the claimant. Authority to issue overpayment decisions rests solely with the PPRU. As noted above, overpayment decisions are not issued where an overpayment is administratively terminated.

a. First Demand Letter. Where the overpayment decision holds that a collectible overpayment (debt) exists, the overpayment decision serves as the first demand letter. In the overpayment decision, the PA outlines the facts surrounding the overpayment, provides a rationale as to why the overpayment is recoverable, and informs the claimant of the exact amount owed and the collection strategy to be used (i.e., monthly payment, collection from future entitlement).

The decision advises the claimant that referral to the Department of the Treasury or the Department of Justice is possible and includes the due process requirements outlined by the Department of the Treasury. The decision advises the claimant that he or she has 30 days from the date of issuance of the overpayment decision to resolve the recoverable debt. Exhibits 8, 9, and 10 are samples of final letter decisions.

b. Issuing Waiver. If the PA determines that a waiver is warranted, the overpayment decision definitively waives the full amount of the overpayment in question. No further action is required on the part of the overpaid claimant or the PA, other than updating the spreadsheet. (See Exhibit 8, option 1.)

(1) Where it is determined that the claimant is at fault in the creation of the overpayment, no waiver may be granted and recovery will proceed as outlined in this chapter.

Exhibit 1: Sample Initial Overpayment Notification Letter (Without Fault)

Exhibit 2: Sample Initial Overpayment Notification Letter (With Fault)

Exhibit 3: Sample Memorandum to File for Administrative Write-Off of Debt Less Than $2000

Exhibit 4: Sample Pre-Conference Checklist

Exhibit 5: Sample Memorandum of Conference

Exhibit 6: Sample Conference Letter to Claimant

Exhibit 7: OWCP-20 Overpayment Recovery Questionnaire

Exhibit 8: Sample Final Decision (With Fault Preliminary Incorrect)

Exhibit 9: Sample Final Decision (With Fault Preliminary Correct)

Exhibit 10: Sample Final Decision (Without Fault Waiver Denied)

3-0900 Debt Liquidation

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1. Purpose and Scope. EEOICPA PM 3-800 addresses the identification and establishment of debts to the point of finding a specific debt amount to be due and payable (i.e., collectible). The purpose of this chapter is to provide guidance for managing debts by collection, compromise and termination. Included are procedures for the assessment of charges, collection actions, salary offset, administrative offset, compromise, referral to the Department of the Treasury, and termination (write-off) of collection efforts.

2. Responsibilities. The collection and settlement of debts are handled by:

a. Claims Staff. Claims Examiners identify the potential overpayments and initially compute the debts.

b. National Office Fiscal Point of Contact (POC). National Office Fiscal POC employees are authorized to compromise claims and to suspend or terminate collection action, subject to the approval of the Chief of the Policies, Regulations, and Procedures Unit (PRPU), on claims of $1 to $100,000 (exclusive of interest, penalties, and administrative costs). The POC also recommends referral of claims of more than $100,000 to the Director, Division of Energy Employees Occupational Illness Compensation (DEEOIC), for such action.

(1) If there is any indication of fraud on the part of the claimant or any other party with an interest in the claim, the POC refers the claim to the Director of DEEOIC, who in turn refers the claim to the Department of Justice (DOJ). POC has no authority to compromise, suspend or terminate recovery on such claims.

A case involves fraud if an investigation is ongoing which is likely to lead to an indictment, if an indictment is pending, or if there has been a conviction in connection with the debt claim. Cases where the DOJ has declined to seek an indictment, or the criminal case has been dismissed, or an acquittal has occurred are not considered fraud cases.

(2) The POC also takes preliminary and final actions with respect to waiver of recovery, establishing and maintaining accounts receivable actions in a spreadsheet, pursuing collection of the debt, and monitoring accounts receivable to determine if and when referral to the Department of the Treasury or termination of collection action may be appropriate.

c. An overpayment of compensation does not become a "debt" and is not subject to recoupment until established due process procedures have been provided and a final decision on waiver of recovery has been issued. Until that time, the POC may accept payment against the overpayment but may not assess any charges, take any action to collect from compensation owed, or issue requests for offset by any other agency.

3. Recovery. overpayment decision serves as the first demand letter to a claimant. If there is no response from the claimant, or the claimant has responded but failed to agree to a reasonable collection strategy as outlined by DEEOIC, the PA generates a second demand letter within 30 days of the issuance of the overpayment decision (see Exhibit 1). If the claimant does not respond or resolve the overpayment within 30 days of the issuance of the second demand letter, a third and final demand letter is sent (see Exhibit 2).

a. Means of Recovery. DEEOIC may employ various means of recovery where an overpaid claimant has been made aware of the overpayment (via the overpayment decision described above) but fails to refund

the overpayment within 60 days of the issuance of the third and final demand letter.

(1) Where the claimant has failed to refund the overpayment, DEEOIC recovers the overpayment by reducing any further lump sum payments due (current and future).

(2) Should the claimant die prior to repaying the overpayment, DEEOIC shall decrease future payments to any eligible survivors with respect to the underlying occupational illness or covered illness.

(3) If no element of fraud on the claimant's part is present, the PA refers the debt to the Department of the Treasury when a recoverable overpayment exists and the claimant fails to refund the full amount within 60 days of the final demand letter, and DEEOIC is unable to recover from any future or current compensation.

(a) Due to cross-servicing requirements of the Debt Collection Improvement Act of 1966, debts that are delinquent for more than 180 days should be referred to the Department of the Treasury for further debt collection action on the agency's behalf. Agencies may also refer debts that have been delinquent for less than 180 days to the Department of the Treasury to ensure efficient, cost-effective debt collection.

(b) If there is sufficient reason to conclude that full or partial collection of the debt would be best achieved through litigation, the Department of the Treasury referral should include a recommendation to forward the debt to the Department of Justice for litigation [see DLMS 6 § 1162(a)].

(c) However, no claim should be referred for litigation until DEEOIC's collection efforts and administrative processes are completed and the debt remains delinquent and legally enforceable. All referrals of this type should have the concurrence of the Office of the Solicitor of Labor.

(d) The overpayment is subject to the provisions of the Federal Claims Collection Act of 1966, as amended (31 U.S.C. 3701 et seq.), and may be reported to the Internal Revenue Service as income.

(4) Where there is an indication of fraud, a false claim being made, or misrepresentation on the part of the claimant, the PA refers the debt to the Department of Justice for recovery if no overpayment refund is made in full at the end of the recovery process.

The PA follows the current fraud procedures and promptly refers the claim to the Office of Inspector General for

investigation. However, a debt would not be referred to the Department of Justice if the debt is less than $2,500, which is the minimum amount necessary for referring debts to the Department of Justice for litigation.

4. Assessment of Charges. Debt Collection Act of 1982 authorizes the assessment of interest, administrative costs, and penalties on delinquent debts.

a. Final Decision. Charges are assessed on any debt where a final decision has been issued, beginning on the date the claimant was notified that charges may apply to the debt, or the date of the final decision, whichever is later.

b. Court Order. In cases of court-ordered restitution, the Court Order takes precedence over the Debt Collection Act. Unless stipulated in the Court Order, charges may not be assessed on the part of the debt corresponding to the restitution amount set by the court (see paragraph 16 below).

c. Interest. Interest is assessed at the rate in effect on the date of the final decision (unless the claimant has defaulted on a previous agreement). The rate of interest assessed shall be the rate of the current value of funds to the United States Treasury as published in the Federal Register. The Treasury Current Value of Funds Rate is posted on the U.S. Treasury website at: http://www.fms.treas.gov/cvfr/index.html.

d. Administrative Costs. When a debt is found to be delinquent and is referred to the Department of the Treasury for collection, a charge is added to the principal and interest as an administrative cost of collection.

5. Waiver of Interest and Other Charges. Interest charges may be waived under three circumstances. Waiver of these charges is mandatory under the provisions outlined in the first two subparagraphs below, and discretionary under the provisions outlined in the third subparagraph.

a. Full Payment Within 30 Days. If the principal is repaid in full within 30 days of the notification (final decision) that charges are applicable, then charges are waived. This may be extended for one additional 30-day period on a case-by-case basis for good cause shown. Acceptable reasons for the 30-day extension include (but are not limited to) situations where the claimant needs the additional time to liquidate assets or arrange financing to pay the debt, or where the claimant does not receive the final decision in a timely manner (e.g., because of absence from home due to vacation).

b. Claimant Without Fault. Where the claimant is without fault in the creation of the debt and a repayment agreement has been established, interest charges are waived if:

(1) The monthly payment is so small that it does not cover the interest, or

(2) There is so little left after interest that the debt will not be paid off within the lifetime of the claimant as determined by actuarial tables.

The POC determines whether charges are waived under this provision by completing the Waiver of Charges Worksheet (Exhibit 3).

If the claimant should later default on the repayment agreement, interest charges will again apply.

c. Cost of Recovery Exceeds Accrued Charges. If the full amount of the principal is paid after charges have accrued, and the additional cost of recovering the charges is greater than the amount of the accrued charges, then the DEEOIC may, at its discretion, waive the charges.

6. Compromise. Compromise differs from waiver of recovery of an overpayment. Waiver is accomplished by formal decision negating the overpayment before it becomes a debt, while compromise is an administrative means of disposing of a debt by accepting a partial settlement. claimant has no legal right to settlement or compromise. Also, the claimant need not be without fault for compromise to be considered.

a. Compromise to Limit Repayment Period. This method of compromise is addressed more fully in paragraph 7 below.

b. Compromise Due to Legal Issues. A debt may also be compromised if the Office of the Solicitor notifies the POC that significant doubt exists as to whether the Government could establish its claim in court, and the claimant has offered partial repayment. This may occur because of a dispute about the law or facts of the case. However, the POC does not make a judgment about legal enforceability without the Office of the Solicitor's specific advice after review of the case. (limitations noted in subparagraph c below also apply here.)

c. Resolution of Debt. Once a compromise letter explaining the reasons for, and amount to be compromised, is issued by the National Office and the agreed-upon portion of the debt has been refunded to DEEOIC, the debt is fully resolved. POC annotates the accounts receivable records to reflect resolution by compromise and the amount repaid.

(1) The POC also sends a letter to the claimant confirming that the debt has been discharged. Unless the compromise was for reasons of economic hardship, the POC also advises in this letter that the amount compromised will be reported as income to the IRS and may be subject to taxation under IRS rules.

(2) At the end of each year, the National Office POC files IRS Form 1099G in cases where the debt has been compromised for reasons other than economic hardship, and a copy of the form is forwarded to the claimant’s case file.

7. Compromise to Limit Repayment Period. Compromise of the principal amount owed is an established tool for collecting existing overpayments. However, compromise for the application of additional charges is different from compromise of principal. Compromise of additional charges is mandatory where the repayment period must be limited. Compromise to limit the repayment period may be due to hardship, or based on life expectancy. In such cases, a specific mathematical formula is used to determine the amount to be compromised.

Under this policy, the POC considers compromising additional charges in all cases at the time the repayment agreement is established, unless charges are waived pursuant to paragraph 5(c) of this chapter. If charges are waived under that provision, then compromise will not be considered under this policy.

a. Effect of Charges. If charges cannot be waived and a repayment schedule (either initial or re-negotiated) is being established, compromise must be considered in cases where the POC has determined that a certain amount is the most the claimant can afford to repay.

For example, if the POC determines, by review of detailed financial information, that the maximum amount the claimant can afford per installment and the period required for repayment of the debt at this rate is extended by more than 35% due to the application of the charges, then the amount of the principal must be compromised so that the period required for repayment of the debt is not extended by more than 35%.

b. Information Needed. The following information is needed to determine whether compromise of accrued charges and/or principal is required: the amount of the principal, the amount of the monthly payment, and the interest rate.

c. General Calculation Rule. Some cases may be eliminated from consideration for compromise by applying the following rule: divide the current principal balance (plus any accrued charges) by the monthly payment and multiply the result by the annual interest rate.

If the result is less than 5.5%, no compromise is necessary, and the POC so indicates on the Compromise of Principal Worksheet (Exhibit 4). If the result is 5.5 or greater, the POC completes the Compromise of Principal Worksheet in its entirety to determine the amount to be compromised.

d. Compromise Order. If the principal must be compromised under this provision, the principal (before compromise) does not exceed $100,000, and no indication of fraud is present, the Chief of the PRPU certifies the Compromise of Principal Worksheet and the POC issues a compromise order to the claimant. The compromise order, which includes the information outlined below, does not carry the

right to a hearing. Exhibit 5 is a sample compromise order.

If the repayment period is sufficiently reduced by compromising only accrued charges, the PRPU Chief certifies the Compromise of Principal Worksheet and the POC issues a compromise order to the claimant, regardless of the principal amount. The compromise order includes:

(1) The amount of each component of the debt (with separate amounts specified for principal, accrued administrative costs, accrued penalty, and accrued interest, as applicable);

(2) The rationale for the determination that the debt cannot be waived;

(3) The rationale for any determination with respect to fraud (see paragraph 2b above);

(4) A brief explanation of the rationale for compromise (the Compromise of Principal Worksheet may be incorporated by reference);

(5) The amount to be accepted in full settlement of each component of the debt (with separate amounts specified for principal, accrued administrative costs, accrued penalty, and accrued interest, as applicable);

(6) The time and manner of payment; and

(7) A statement that the debt is not compromised or settled until full payment of the specified amount has been made.

e. Principal Over $100,000. If any amount of the principal must be compromised under this provision and the principal amount (before compromise) exceeds $100,000, the case is referred to the Director of DEEOIC for further action after the Chief of the Policies, Regulations and Procedures Unit (PRPU) certifies the Compromise of Principal Worksheet.

f. Compromise Not Approved. If neither accrued charges nor principal are compromised under this provision, the POC files the Compromise of Principal Worksheet in the case file.

8. Compromise in Consideration of Partial Payment. Regardless of whether it is required under the provisions of this chapter, compromise may be further considered as a means of disposing of debts where collection would be extremely difficult or expensive. The claimant need not be without fault for compromise to be considered, however, the claimant has no legal right to settlement or compromise to dispose of an overpayment.

a. Proposal. The claimant may propose that DEEOIC be satisfied with partial recovery on the debt, or DEEOIC may propose a compromise to the claimant. For example, compromise might occur if the claimant reported a liquid asset that exceeded the resource base, but was

insufficient to cover the debt, and otherwise had only enough income to meet expenses. compromise would provide for recovery of the amount available and forgiveness of the remainder.

However, in judging whether repayment would cause hardship, the POC assesses the claimant's income and assets according to the criteria provided in EEOICPA PM 3-0800. claimant should be required to submit a current financial report (OWCP-20), if one has not been provided within the previous six months. Also, the POC informs the claimant that under certain circumstances the compromised portion of the debt will be reported to IRS as income.

b. Repayment Within Reasonable Time. Compromise should be considered if the Government cannot collect the full amount because the claimant is unable to pay it within a reasonable time, or the claimant refuses to pay the claim in full and the Government cannot enforce collection by court action within a reasonable time. In determining inability to pay, the OWCP may consider:

(1) The age and health of the claimant;

(2) Current and potential income;

(3) Inheritance prospects;

(4) The possibility that the claimant has concealed or transferred assets to avoid recoupment; and

(5) The availability of assets or income for enforced collection.

If the POC finds that compromise is warranted, he or she prepares a memorandum to the file which describes the financial circumstances of the claimant, the proposed compromise, and the considerations which led to the compromise recommendation. Exhibit 6 is a sample compromise memorandum.

c. Limitations. The compromise limitations described earlier in this chapter also apply here. If compromise of the debt principal appears warranted but the original principal amount is more than $100,000, or where there is an indication of fraud (see paragraph 2b above), then the compromise memorandum and the case file should be referred to the Director of DEEOIC for further action.

d. Compromise Order. If compromise appears warranted and the limitations noted above do not apply, the POC issues a compromise order which includes the items listed in paragraph 4a above. POC incorporates the information noted in the compromise memorandum in the compromise order to explain the basis for the compromise to the claimant. compromise order does not carry the right to a hearing. Exhibit 5 is a sample compromise order.

e. Contractual Agreement. When a debt is compromised, the agrees to be satisfied with partial repayment. Even if the claimant's circumstances change, such that the reasons for the compromise are no

longer valid, OWCP has officially forgiven the remainder of the debt and may not press for additional repayment unless the claimant defaults on the repayment agreement. refore, compromise should be undertaken only after the claimant's financial circumstances are known.

9. Collection Strategies. Strategies for collection of a debt are generally pursued in the following order, as appropriate:

a. Recovery of Entire Debt. This may occur by reducing any further compensation payment due currently or in the future for which there is direct statutory authority under 42 U.S.C. 7385j-2. Such recoupment, either in a lump sum or in installments, is addressed in paragraph 9 below.

b. Voluntary Repayment in Lump Sum. Such repayments are addressed in paragraph 10 below.

c. Voluntary Deduction from Retirement Benefits. Such deductions are made in installments from periodic payments.

d. Involuntary Offset of Retirement Benefits. Also, refund of retirement contributions may be pursued.

e. Voluntary Installment Payments. Payments made directly by the debtor are addressed in paragraph 10 below.

f. Compromise. This action is addressed in paragraph 6 above. Where a debt exceeds $100,000, a recommendation is made to forward the debt to the Department of Justice for litigation or for compromising, suspending or terminating debt collection.

g. Termination or Suspension. These actions, also termed write-offs, are addressed in paragraph 13 below.

10. Recovery from Compensation Entitlement. If further compensation is owed to the claimant, the POC recovers the debt from any lump-sum payment due currently or in the future. Collection action cannot begin until after the POC issues a final overpayment decision. If a sufficiently large lump-sum payment of compensation is due, the debt is recovered in full by a single deduction from compensation owed. POC sends the claimant a letter explaining the recovery method. The POC establishes an accounts receivable on the accounts receivable spreadsheet to track the balance due, interest incurred, and/or payments received.

11. Recovery in Cases With No Compensation Entitlement.

a. Lump Sum Preferable. Debts are collected in one lump sum whenever possible. If the claimant cannot pay in this manner, payment may be accepted in regular installments. POC determines the size and frequency of the installment payments by the size of the debt and the claimant's ability to repay.

b. Claimant's Resources. The POC evaluates the claimant's

resources for repayment as soon as a final overpayment decision is made (see EEOICPA PM 3-0800) and sets or negotiates an appropriate repayment plan with the claimant.

If detailed information about the claimant's financial status is not already in the case file, it should be obtained. This information may include: Form OWCP-20 Overpayment Recovery Questionnaire; information provided on Forms EE-1 and EE-2; information provided by the Social Security Administration in response to requests from the DEEOIC; and other documents concerning the claimant's financial status.

c. Detailed Financial Information Not Available. If the claimant refuses to submit detailed financial information, or has not yet had time to reply to a request for such information, the POC may accept voluntary installment payments in an amount determined by the claimant, until detailed financial information becomes available.

However, the POC should not enter into a formal agreement with the claimant, and should not consider waiver of charges (see paragraph 4) or compromise of principal (see paragraphs 5 and 6), unless and until the claimant provides detailed financial information and agrees to installment payments in an amount which reasonably represents the maximum he or she can afford.

d. Schedule of Payments. If the claimant offers to repay on a set schedule or requests a change in a schedule already established, the POC evaluates the proposed repayment plan for reasonableness on the basis of the claimant's resources as documented in the case file. The Department of Labor's regulations concerning debt collection recommend that debt repayment be scheduled to recover the entire amount (including any interest or penalties) in three years, but this may not be practical if the claimant does not have appreciable income (29 C.F.R 20.33(a)).

(1) If the repayment plan is not reasonable, the POC asks the claimant, in writing, to contact the POC or the Chief, PRPU to discuss an accelerated repayment plan.

(2) If the repayment plan is reasonable, the POC obtains a signed statement from the claimant which specifies the terms of repayment. This statement constitutes a legally enforceable agreement. POC annotates the accounts receivable spreadsheet and diaries the next payment.

e. Unreasonably Small Payments. If the claimant unilaterally makes installment payments in amounts so small that the debt will never be repaid, or will be repaid in an unreasonably long period (such that the claimant will become a "perpetual debtor"), and the claimant refuses to increase the payments or submit detailed financial information justifying the size of the payments, the POC refers the debt to the Department of the Treasury with a recommendation that the

debt be forwarded to the Justice Department for resolution, if appropriate.

f. No Response to Demand Letters. If no response is received to the demand letters, the POC attempts to contact the claimant by telephone. POC explains who is calling and refers to the decision that stated the amount and terms of collection. POC asks what arrangements the claimant would like to make to effect repayment.

If the claimant does not suggest a repayment plan, the POC should be prepared, based on review of the case file, to propose a weekly or monthly amount. The POC ensures that the details of the telephone call are documented in the ECMS Telephone Messaging System. When agreement is reached, the POC drafts a follow-up letter referring to the telephone call and the terms discussed, and requesting the first installment payment.

g. Further Action. If the telephone call is unsuccessful, or if the claimant does not begin the agreed-upon payments, the POC evaluates the debt for referral to the Department of the Treasury, with a recommendation that it be forwarded to the Department of Justice, if appropriate, for termination of collection action.

12. Referring Debts to Department of Treasury. Debt Collection Improvement Act of 1996 provides that any non-tax debt or claim owed to the that has been delinquent for a period of 180 days be turned over to the Secretary of the Treasury for appropriate action to collect or terminate collection actions on the debt or claim. To further this goal, the Department of the Treasury (DOT) has created the Debt Management Services (DMS), a division of the Financial Management Services Branch.

DMS provides government-wide debt collection services through the Treasury Offset Program (TOP) and Cross-Servicing Program. TOP involves offsets of payments from a variety of federal programs and includes offset of income tax refunds. Cross-Servicing Program includes skip trace services, administrative wage garnishment, referral of debts to the Department of Justice (DOJ) for litigation, and referral of debts to private collection agencies.

The DOT oversees all collection activity on all referred debts, and all debts more than 180 days delinquent must be referred for either TOP or Cross-Servicing or both. All debts related to overpayment of benefits under the EEOICPA are referred for both.

a. Notice to Claimant. At least 60 days prior to referral to the DOT, the POC sends a letter advising the claimant that referral for collection action is possible. notice includes specific advice that the claimant can:

(1) Inspect and request copies of records about the debt;

(2) Enter into a mutually agreeable written repayment

agreement; and

(3) Request review of the amount of the debt, its past-due status, and whether the debt is legally enforceable.

Sample letters shown as Exhibits 1 and 2 include language for this purpose, so issuance of either or both at 30-day intervals after the debt becomes final provides adequate due process. DOT will not accept debts where such notice has not been given.

b. Referral. When a debt is 180 days delinquent, it is eligible for referral to the DMS at DOT. If the POC has made no progress in collection efforts through recoupment of compensation benefits or voluntary repayment actions, the POC refers the debt to the DOT.

The POC ensures that all due process requirements have been met and that the debt is appropriate for referral to the DOT. DOT will not accept debts that are not final, covered by bankruptcy, already in private collection, in litigation, or with the Department of Justice (DOJ).

The POC refers the case to the DOT using the automated Debt Management System on the DOT's website. POC completes the DMS Agency Profile for each debt referred for servicing. profile information includes:

(1) Claimant/Debtor's Social Security number;

(2) Agency Points of Contact;

(3) The method(s) by which DEEOIC wants the DMS to service their debts (refer to TOP, refer to credit bureaus);

(4) Payment agreement parameters (e.g., will interest during payment agreements); and

(5) Whether the administrative fee is added to the debt or charged to DEEOIC.

c. Return of Debt. The DOT may return a debt to DEEOIC if it has been collected in full, found to be uncollectible, or covered by a bankruptcy filing, or if compromise has been reached. Returned debts are sent to the POC for further action as necessary.

d. Debt and Transaction Tracking. DMS tracks all debts and payments using Fed Debt, a debt and debtor based system which allows:

(1) DMS to better handle joint and several debts;

(2) A demand letter to be sent to each debtor;

(3) Users to update debt and/or debtor information;

(4) Multiple payment agreements for a debt;

(5) Removal of a debtor/claimant from the debt

without closing the entire debt;

(6) Records of transactions, including how payments are applied (i.e., administrative fees, penalties, interest and principal);

(7) Federal agencies to report payments, adjustments and reversals they receive in their offices.

The POC has access to the DMS Fed Debt System and uses it to track the status of the debt until it is resolved.

e. Referral to Department of Justice (DOJ). A component of DOT's Cross Servicing is referral of debts in excess of $100,000 to the DOJ for litigating, compromising, suspending and terminating collection. The DOJ has the exclusive authority to compromise, suspend or terminate collection activity on debts in excess of $100,000, unless it decides, in its discretion, to return the debt to the agency for such purposes.

The POC ensures that all DOT referrals for debts in excess of $100,000, exclusive of interest, include recommendations to forward the debt to DOJ for permission to compromise, suspend or terminate collection action.

(1) While the DOJ is considering a case, the POC carries the accounts receivable record as open and annotates it as referred to DOJ.

(2) When collecting a debt under a DOJ agreement, DEEOIC cannot charge interest or send billing notices.

(3) The POC cancels the accounts receivable record on a case referred for collection when notified by the DOJ that it will not take further action.

13. Termination of Collection Action (Write-off). When DOT directs DEEOIC to write off the debt, the POC removes the account from DEEOIC's receivables.

a. Potential for Litigation. National Office managers periodically review the accounts receivable spreadsheets to identify cases in which aggressive collection action has brought no result. Each case is examined to determine whether litigation would lead to collection of the debt.

Cases in which collection is not likely to succeed are terminated. They include situations where the claimant appears to have no assets or income which could be attached by a court; where the claimant's financial circumstances are such that hardship would result from recoupment; or where the Office of the Solicitor or the U.S. Attorney's Office states that DEEOIC has a poor legal case against the debtor.

The POC prepares a memorandum regarding termination of collection action where collection actions have brought no results. In the

memorandum, the POC states the nature and amount of the debt, the efforts made to collect it, and the financial circumstances of the claimant, explaining why termination of collection action is warranted.

If the debt exceeds $100,000, or is between $2500 and $100,000 and there is an indication of fraud (see paragraph 2b above), the Chief of the PRPU signs the memorandum. Debts of $2500 or less which cannot be collected by administrative means, including referral to the DOT, must be written off, since the DOT will not accept them.

b. Suspension of Collection Action. Occasionally a claimant may ask that the debt be forgiven due to financial hardship. POC may suspend collection action because of financial hardship, but reserves the right to resume collection action in the event of future claims or a change in the claimant's circumstances. Exhibit 7 shows a sample letter advising a claimant of this action.

c. Termination of Collection Action. When collection action is terminated, the POC documents and closes the accounts receivable record. Termination of collection action, or the "write-off" of a bad debt, is an administrative action which differs from waiver or compromise. Termination of collection action does not forgive the debt, since DEEOIC may collect it at a later date. Generally, however, once a debt has been written off, collection actions are never resumed.

At the end of each year, DOT files IRS Form 1099G for each case where the debt has been written off for reasons other than economic hardship, and a copy of the form is sent to the POC for inclusion in the case file. Once Form 1099G has been filed, the POC documents the accounts receivable record accordingly, and DEEOIC may not collect the debt at a later date.

14. Recovery from Deceased Claimant's Estate. If the claimant dies before the debt is completely recovered, the POC acts quickly to obtain pertinent information about the estate. Prompt action is essential because creditors who have not properly asserted a claim before the estate is closed are generally precluded from any recovery. Once the estate has been closed and the proceeds distributed, collection action must be terminated. The information to be requested and the action to be taken are described in EEOICPA PM 3-0800 and are the same for an established debt as for a newly discovered debt.

15. Credit Reporting. Under the Debt Collection Act of 1982, claimants whose accounts become delinquent are subject to reporting to private credit reporting bureaus. The DOT refers delinquent DEEOIC debts to one or more credit bureaus based on information the POC places in the DOT's Debt Management System. The credit bureaus maintain credit information on individuals and provide the information upon request to lenders. POC points out the possibility of credit reporting to individuals who refuse to cooperate in the

debt collection process.

If a claimant disputes the information in a credit bureau's file, the DOT will contact the National Office to verify the information. POC verifies the information and responds to the DOT within seven business days.

If DOT fails to respond to the credit bureaus within a given time limit (generally 30 days), the credit bureau will accept the claimant's version of the facts.

If the information held by the credit bureau was incorrect, the POC notifies the DOT and corrects the information in the office's overpayment tracking system. POC also updates the Treasury's online debt system, so that the error is not repeated in the next transmission to the credit bureau.

16. Court Ordered Restitution in Fraud Cases. When a claimant has been convicted of filing a false claim which resulted in an overpayment/debt due the government, the court often orders the defendant/claimant to make restitution to the as a condition of probation. amount of restitution may or may not be the full amount of the debt owed to OWCP.

a. "Global Settlement". If the Court Order states that the restitution amount will be in full satisfaction of the debt owed the (a "Global Settlement"), the Court Order takes precedence over the OWCP's administrative debt collection process.

In such cases, if the restitution amount is less than the outstanding debt principal balance, the principal balance must be reduced to the restitution amount set by the court. Also, interest may not be applied to such debts unless stipulated in the Court Order. However, if the probation period ends and the claimant fails to make full restitution, the POC pursues collection of the full original debt amount.

b. Other Than "Global Settlement". If the Court Order does not represent a "Global Settlement," the POC continues to pursue collection of the full amount of the debt, taking credit for any restitution amounts received. Unless the Court Order stipulates assessment of interest, interest may not be applied to the restitution amount and any restitution payments received should be applied directly to the debt principal.

In criminal cases, OWCP is sometimes asked to assist the DOJ in calculating the loss to the government in accordance with federal sentencing guidelines. This may involve calculating how benefits would have been paid if the claimant had fully advised OWCP. The POC processes all such requests.

Exhibit 1: Sample Second Demand Letter

Exhibit 2: Sample Third and Final Demand Letter

Exhibit 3: Waiver of Charges Worksheet

Exhibit 4: Compromise of Principal Worksheet
Exhibit 5: Sample Compromise Order
Exhibit 6: Sample Compromise Memorandum
Exhibit 7: Sample Letter Terminating Collection Actions