U.S. Department of Labor

Office of Workers' Compensation Programs
Division of Energy Employees Occupational
Illness Compensation
P.O. Box 8306
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RELEASE – TRANSMISSION OF FEDERAL (EEOICPA) PROCEDURE MANUAL VERSION 9.0:

EEOICPA TRANSMITTAL NO. 25-01 October 28, 2024

EXPLANATION OF MATERIAL TRANSMITTED:

The Division of Energy Employees Occupational Illness Compensation (DEEOIC) is issuing this Transmittal to notify staff of the publication of Federal (EEOICPA) Procedure Manual (PM) Version 9.0 (v9.0), which replaces PM v8.0, effective the date of publication of this Transmittal. Following are the content edits that make up PM v9.0:

- **Chapter 1 – Definitions**

  - Exhibit 1-2, Forms, has been updated to remove reference to Form OWCP-957 and reference to Form OWCP-957 Part A: Medical Travel Refund Request – Mileage; and OWCP-957 Part B: Medical Travel Refund Request – Expenses. Additionally, Form EE-1A: Claim for Consequential Illness Benefits, has been added.

- **Chapter 6 – Processing Mail**

  - Ch. 6.2c has been edited to replace reference to Form OWCP-957 with Form OWCP-957 Part A, and Form OWCP-957 Part B. The language in v8.0 previously read:

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

    It has been updated in v9.0 to:

    c. Bills. Form OWCP-1500 is used to bill OWCP for medical services and supplies. Hospital bills are submitted on the Form OWCP-04. Form OWCP-915 is used for employee reimbursement of out-of-pocket medical expenses. Form OWCP-957 Part A is used for reimbursement of private auto mileage for covered medical travel. Form OWCP-957 Part B is used for reimbursement of medical travel expenses, including mileage requiring pre-authorization and any additional covered expenses, such as related transportation, meals, and lodging costs.

  - Exhibit 6-2, Date Release Form, has been updated to include a "Beginning/End Date of Response" field.

- **Chapter 7 – Case Creation**

  - Ch. 7.6 has been modified to instruct Claims Examiners (CEs) to contact a claimant or their Authorized Representative (AR) directly for clarification of unclear information on claim forms to facilitate timely adjudication. The language in v8.0 previously read:

    6. CE Review. Once a new claim is received from the CCC, but prior to initial development and adjudication, the assigned CE reviews the claim forms, any employment and/or medical evidence, the claimed employment and occupational history development conducted by the RC and ECS to ensure ECS contains accurate information. If the claim requires additional follow up action by the RC, the CE may assign additional tasks to the RC as necessary.

    It has been updated in v9.0 to:

    6. CE Review. Once a new claim is received from the CCC, but prior to initial development and adjudication, the assigned CE reviews the claim forms; any employment and/or medical evidence; the claimed employment and occupational history development conducted by the RC; and ECS to ensure ECS contains accurate information. To facilitate timely processing, if the CE identifies issues with the claim filing, including questions about the claimed illnesses or confusing information reported on the claim forms, the CE should contact the claimant, or their AR, by telephone to obtain verbal clarification about claimed conditions or other confusing features of information communicated on a claim form. The CE must document any clarifying information received in a telephone call record uploaded into OIS which will serve as a basis for proceeding with case adjudication. If the claim requires additional follow up action by the RC, the CE may assign additional tasks to the RC as necessary.

  - Ch. 7.8e has been added to require claimants to submit Form EE-1A: Claim for Consequential Illness Benefits, for all consequential illness claims. The language in v9.0 has been added to include Ch. 7.8e as outlined below:

    e. Consequential Illness Claims. A claimant must file a claim for consequential condition(s) by submitting a completed and signed Form EE-1A, Claim for Consequential Illness Benefits. In cases in which a claimant submits Form EE-1A that cannot be associated with an existing case record, the DO or RC must return the Form EE-1A to the claimant. No ECS record will be created for a new Form EE-1A which cannot be associated with an existing case.

- **Chapter 12 – Representative Services**

  - Exhibit 12-1, Authorization for Representation/Privacy Act Waiver, has been modified to include a field for a claimant phone number.

- **Chapter 13 – Establishing Covered Employment**

  - Ch. 13.2b has been updated to reflect a change in the Federal Register Notice that broadens the scope of coverage for some beryllium vendor sites. The language in v8.0 previously read:

    b. Beryllium Vendors. Beryllium Vendors are companies which are named in the Act, or DOE has determined processed or produced beryllium for sale to, or use by, DOE. The Act identifies some 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. DOE, through publication in the Federal Register, designated other beryllium vendors, which are location specific. DOE designated the final list of beryllium vendors on December 27, 2002.

    (1) Beryllium vendor coverage extends to direct employees of the vendor, its contractors, or subcontractors and to any Federal employee who may have been exposed to beryllium at a facility owned or operated 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 CBD.

  It has been updated in v9.0 to:

    b. Beryllium Vendors. Beryllium vendors are companies which are named in the Act, or DOE has determined processed or produced beryllium for sale to, or use by, DOE. The Act identifies some beryllium vendors by corporate name, and these are known as statutory beryllium vendors. A complete list of statutory beryllium vendors can be found within the text of the Act, specifically under 42 U.S.C § 7384l(6). Additionally, DOE, through publication in the Federal Register, has designated a list of beryllium vendor facilities. 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 the vendor facility location. Should claims staff identify claimed employment at a statutory beryllium vendor, including, but not limited to Brush Wellman Inc. predecessors and successors, that is not listed in the DOE covered facility list and/or in EPOD, they should refer those cases to the National Office Policy Branch for review.

    (1) Beryllium vendor coverage extends to direct employees of the vendor, its contractors, or subcontractors and to any Federal employee who may

have been exposed to beryllium at a facility owned or operated 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 CBD.

- Ch. 13.8c has been edited to update the Secure Electronic Record Transfer System (SERT) Process The language in v8.0 previously read:

c. Once the request is sent through the SERT, the CE bronzes a copy of the request in the case file.

It has been updated in v9.0 to:

c. Designated contract staff monitor the DEEOIC SERT RESPONSES mailbox for SERT email notifications. When email notifications are received, the designated contract staff bronze the SERT response into the case file with the appropriate corresponding category and subject in OIS. The CE will then receive the DOE SERT response as unreviewed mail in OIS and is responsible for entering the associated correspondence received date in OIS.

- Ch. 13.11c has been updated to correct the omission of additional DEEOIC personnel who may use the BtComp resource, including the Final Adjudication Branch (FAB). The language in v8.0 previously read:

c. *Requests for supporting documentation. In cases where the CE conducts a search of BtComp, finds positive results, and needs a copy of the supporting documentation, the DOE POC sends the request to the to the NO, to submit the request to CPWR. In its request, the DO references the BtComp Document-ID number and the reason for the request. CEs request this documentation if it is being used to resolve a discrepancy in the case file, or if the documentation is needed for litigation purposes. The processing of this type of request will be at the discretion of the NO. The CPWR will respond with a copy of the documentation within 5 business days of the receipt of the request.*

It has been updated in 9.0 to:

c. Requests for supporting documentation. In cases where DEEOIC staff conducts a search of BtComp, finds positive results, and needs a copy of the supporting documentation, the CE, FAB representative, or other appropriate DEEOIC staff person, sends a request to the Contract Officers Representative (COR) overseeing the BtComp contract. The COR will evaluate the request and decide whether it is appropriate to submit to the contractor. In its request, the requestor must reference the BtComp Document-ID number and the reason for the request. Claims Staff may request this documentation for a variety of reasons, including, but not limited to, if it is being used to resolve a discrepancy in the case file, or if

the documentation is needed for litigation purposes. The contractor must respond with a copy of the documentation within 5 business days of the receipt of the request.

- **Chapter 14 – Establishing Special Exposure Cohort Status**

  - Ch. 14.7h has been edited to eliminate the requirement that Claims Examiners (CEs) seek clarification from the Policies, Regulations, and Procedures Unit (PRPU) to determine whether a diagnosed cancer is a "specified cancer." The language in v8.0 previously read:

    h. Identifying Specified Cancers. For cases where there is uncertainty as to whether a diagnosed cancer is a specified cancer, the CE is to refer the case file to PRPU for consideration. The examination of the record by PRPU will determine whether the diagnosed cancer originates within the anatomic structure of one of the listed "specified cancer" locations within the body, and conforms to the pertinent latency period, if any.

    It has been updated in v9.0 to:

    h. Identifying Specified Cancers. For cases where there is uncertainty as to whether a diagnosed cancer is a specified cancer, the CE must obtain a well-rationalized medical opinion from a qualified physician, including either the claimant's physician or a CMC, that interprets available pathology to opine whether a diagnosed cancer originates within the anatomic structure of one of the "specified cancer" locations within the body, and conforms to the pertinent latency period, if any.

  - Exhibit 14-2, Sample Letter to Claimant Granted Medical Benefits for Unaccepted Reverse Consequential Condition (Medical Treatment of Underlying Primary Cancer), has been removed. It is now available in the Correspondence Creation and Tracking System (CCAT).

- **Chapter 15 – Establishing Toxic Substance Exposure and Causation**

  - Ch. 15.12b has been updated to clarify the role of a DEEOIC Health Physicist (HP) about characterizing occupational radiation for non-cancer claims. The language in v8.0 previously read:

    b. Non-cancerous conditions linked to radiation exposure will not undergo the dose reconstruction process by NIOSH but will need a review by the NO HP if there is a medical or scientifically based link between the condition and radiation exposure.

    (1) Submission of HP referral. If the Supervisor or other office designee grants approval for the referral, the CE prepares a SOAF along with a set

of questions relating to the issue(s) for determination. The CE prepares an e-mail to the designated Program Specialist within the MHSU. The CE also includes a copy of any radiation exposure records available. The CE images the referral package into OIS.

(2) HP response. The Program Specialist assigns the question to the HP. The HP prepares a formal written response that describes the review and offers a well-rationalized opinion regarding causation.

(3) Upon receipt of the completed HP response, the CE images the response into OIS. The CE reviews the response and moves forward with the claim based on the outcome.

It has been updated in v9.0 to:

b. Non-cancerous conditions linked to radiation exposure will not undergo the dose reconstruction process by NIOSH but will need a review by the NO HP to estimate the extent of occupational exposure to radiation to the effected organ or body part.

(1) Submission of HP referral. The CE prepares a referral package of documents for the HP to assess the likely extent of occupational radiation sustained by the employee. The CE is to prepare a SOAF along with a request for the HP to characterize the level of occupational radiation exposure incurred by the employee that relates to the claimed, diagnosed non-cancer condition. Attached to the SOAF, the CE includes a copy of available radiation exposure records (radiological or dose records) and copies of other pertinent records, including Form EE-3; OHQ; relevant DAR records, such as job/work process description data; records providing a description of work area or location; employee-completed letters about radiation exposure or work duties; affidavits, or other similar documents completed by other sources; any email traffic or documented phone calls between the CE and HP regarding the claim; and any narrative medical letters prepared by a physician that opine as to a potential linkage between the claimed condition and occupational radiation exposure. The CE will transmit the completed referral package to the designated POC within the Policy Branch in accordance with internal guidance. The CE images the referral package into OIS.

(2) HP response. Once a referral is received, the Policy Branch POC assigns the question to the HP. The HP prepares a formal written response that describes their review of available evidence and applies their subject matter expertise to communicate a well-rationalized opinion characterizing the likely extent of occupational exposure to radiation incurred by the employee during covered employment. The HP will characterize the exposure to the effected organ, organ system, or body

part relating to the non-cancer condition(s) under review. If the diagnosis date is prior to the end of the covered employment, the HP's radiation dose estimate will run through the date of diagnosis as opposed to running through the employment end date. The role of the HP is to characterize the extent of occupational radiation exposure, not to communicate any position about the causal nexus between the extent of estimated occupational radiation exposure and the claimed condition serving as the basis for the referral.

(3) Upon receipt of the completed HP radiation dose estimate, the CE images the response into OIS. The CE must then use the estimate to obtain a well-rationalized opinion from a qualified physician about causal relationship. Per staff procedure, the CE will initially provide the HP dose estimate to the claimant's chosen physician and request a well-rationalized opinion about whether the extent of occupational radiation exposure was at least as likely as not a significant factor in causing, contributing to, or aggravating the claimed non-cancer condition. In the absence of a response, or receipt of an opinion that the CE cannot weigh as being well-rationalized, the CE must forward the matter to a CMC for review.

- Exhibit 15-4.18, Organ Transplants, has been updated to clarify the adjudication steps and coding roles in claims for organ transplants. The language in v8.0 previously read:

  *18. **Organ Transplants**: To ensure appropriate reimbursement of medical treatment costs including prescription medications, any organ transplant accepted by the Medical Benefits Branch as medically necessary due to a previously accepted condition is to be presumed as an accepted consequential condition and coded as such in ECS.*

  It has been updated in v9.0 to:

  *18. **Organ Transplants.** To ensure appropriate reimbursement of medical treatment costs including prescription medications, any organ transplant accepted by the Medical Benefits Branch as medically necessary due to a previously accepted condition is to be presumed as an accepted consequential condition. The MBE is responsible for providing email notice to the assigned CE regarding the acceptance. Upon receipt of notice, the CE is to update ECS in accordance with coding instruction for adding a consequential illness to the claim.*

- **Chapter 16 – Developing and Weighing Medical Evidence**

  - Exhibit 16-3, Sample Letter to Claimant Regarding Second Opinion/Referee Physician, has been edited to replace reference to Form OWCP-957 with new Forms OWCP-957 Part A and OWCP-957 Part B.

- **Chapter 17 – Development of Radiogenic Cancer Claims**

  - Ch. 17.6c has been updated to incorporate EEOICPA Bulletin No. 24-02: Categorization of basal cell carcinoma (BCC) and squamous cell carcinoma (SCC) as non-melanoma skin cancers. The language in v8.0 previously read:

    c. Multiple Skin Cancers. When a claimant provides evidence that the covered employee has a large number of skin cancers, the CE will proceed as follows:

    (1) The CE considers each malignant skin neoplasm (e.g., basal, or squamous cell cancer) as a separate primary cancer, unless the medical records state 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. The CE must include this information in the medical section of the NRSD.

  It has been updated in v9.0 to:

    c. Multiple Skin Cancers. When a claimant provides evidence that the covered employee has a large number of skin cancers, the CE will proceed as follows:

    (1) The CE considers each malignant skin neoplasm (e.g., basal, or squamous cell cancer) as a separate primary cancer, unless the medical records state 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. The CE must include this information in the medical section of the NRSD.

    (3) There may be situations where a claim is filed for a non-melanoma skin cancer [basal cell carcinoma (BCC) or squamous cell carcinoma (SCC)] and there is a previous Part E acceptance for a BCC or SCC skin cancer based on a positive causation determination for a toxic substance other than radiation. The previous positive causation determination for a BCC or SCC skin cancer will apply to any other BCC or SCC skin cancer that the employee is diagnosed with, and the claim for the additional BCC or SCC skin cancer will be in posture for acceptance by letter decision.

- **Chapter 18 – Eligibility Criteria for Non-Cancerous Conditions**

  - Ch. 18.5 has been modified to incorporate EEOICPA Bulletin No. 24-01: Updated Criteria for Establishing Beryllium Sensitivity. The language in v8.0 previously read:

    5. <u>Beryllium Sensitivity</u>. Beryllium sensitivity is an allergic reaction of the immune system to the presence of beryllium in the body because of contact with beryllium dust

particles or fumes. The evidence required to establish beryllium sensitivity is described under 42 U.S.C. §7384l(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 BeLPT or one 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. The DEEOIC requirement to accept beryllium sensitivity is one abnormal test.

b. Evaluation. A physician is required to validate the results of an abnormal BeLPT/BeLTT or beryllium patch test 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 CMC).

It has been updated in v9.0 to:

5. <u>Beryllium Sensitivity</u>. Beryllium sensitivity is an allergic reaction of the immune system to the presence of beryllium in the body because of contact with beryllium dust particles or fumes. The evidence required to establish beryllium sensitivity is described under 42 U.S.C. §7384l(8)(A), as updated by Public Law No. 118-31, the National Defense Authorization Act (NDAA) for FY 2024 on December 22, 2023. In developing claims for beryllium sensitivity, the CE must verify 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 BeLPT or one BeLTT, performed on blood or lung lavage cells, which shows abnormal or positive findings; or three borderline BeLPT/BeLTT, performed on blood cells, conducted over a period of three consecutive years. A claimant can also establish beryllium sensitivity by submitting the results of one beryllium patch test, which shows a positive reaction.

b. Evaluation. A physician is required to validate the results of an abnormal or borderline BeLPT/BeLTT, or a beryllium patch test which shows a positive reaction, with his or her findings specifically outlined (e.g., abnormal, or borderline response to beryllium). 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 CMC).

- **Chapter 23 – Consequential Conditions**

  - Ch. 23.3 has been modified to remove references to Forms EE-1/2 being used to claim consequential illness and to refer to the use of Form EE-1A: Claim for Consequential Illness Benefits. The language in v8.0 previously read:

    3. <u>Claims for Consequential Conditions</u>. The claimant must file a claim for all consequential condition(s) in writing and may use any method of written notification, so long as the claimant signs the submission. However, while documents containing written words of claim for a consequential condition(s) are acceptable, the CE is to obtain a completed and claimant signed Form EE-1/2 associated with the consequential claim before issuing a decision. A signed claim form is also required for all metastatic cancers. Ideally, the claimant should concurrently send a written statement identifying the specific nature of the consequential condition claimed, along with a signed EE-1/2. A signed EE-1/2 is required because it provides notice to the claimant of his or her responsibilities in filing for benefits under the Act.

    a. For each distinct medical condition claimed as a consequence of a previously accepted condition, the CE undertakes a careful examination of the evidence presented in support of the claim. If the evidence demonstrates the existence of a diagnosed consequential illness and the CE decides that the medical justification is sufficient to link reasonably the condition to a previously accepted condition, he or she proceeds with issuing a letter decision of acceptance (refer to 10a on acceptances). In those claims situations where insufficient evidence exists, after development, to establish a consequential claim, the CE issues a RD of denial.

    There may be instances where a claimant files words of claim or an EE-1/2 for a condition but it is not clear whether the claimant's intent was to file the condition as resulting from toxic substance exposure or as a consequential condition. In most cases, the condition will be processed as a primary diagnosed condition resulting from toxic substance exposure. However, if the medical or factual information provided with the words of claim or the EE-1/2 alludes to the fact that the condition may be a consequence of a previously approved condition, the CE is to contact the claimant to obtain clarification on whether he or she wants the claim to be processed as a primary condition or as a consequential condition. Once the CE obtains clarification, he or she documents the claimant's intent in ECS and begins appropriate development for that condition.

In those cases where only words of claim were filed, the CE requests that the claimant submit a completed and signed EE-1/2 clearly indicating that the condition is consequential, prior to issuing any decision. (Note: if a completed and signed EE-1/2 was already submitted and the CE just needed to seek clarification of the claimant's intent, a new updated EE-1/2 is not needed).

(1) For any consequential condition(s) where the CE has requested a completed and signed Form EE-1/2, the CE allows a period of 30 days for the claimant to submit the required documentation. After 30 days, the CE administratively closes the claim if the claimant has not submitted a signed EE-1/2 claim form. The CE is to mail a notice to the claimant(s) that no further action will occur on the claim for that medical condition until receipt of a completed and signed claim form.

b. In some situations, the CE may find evidence contained in a case record that suggests that an unclaimed medical condition is consequential to an accepted condition. If there is sufficient reason to discern that the evidence of record communicates the existence of a likely consequential condition, the CE is to contact the claimant to ascertain whether he or she wants to claim that condition as consequential to a previously accepted illness. If the claimant states that he or she wants to file a claim for that condition, the CE instructs the claimant to submit a completed and signed EE-1/2 form. The mere fact that the CE identifies an unclaimed condition in the medical evidence is not sufficient reason to seek a new claim. Evidence has to be present in the case record to lead the CE to a reasonable conclusion that the condition is consequential to an approved primary condition.

c. Where a claimant previously filed Form EE-1/2 for a condition due to toxic substance exposure that was denied, but later claims that the denied condition is consequential to an accepted condition, the claimant is to file a new Form EE-1/2 claiming the condition as a consequential illness. In this scenario, the CE treats it as new claim filed under the EEOICPA. As this is a new claim filed under the EEOICPA, a Director's Order vacating the prior denial of the same condition based on toxic substance exposure is unnecessary.

It has been updated in v9.0 to:

3. <u>Claims for Consequential Conditions</u>. The claimant must file a claim for consequential condition(s) using Form EE-1A, Claim for Consequential Illness Benefits. A Form EE-1A is required because it communicates a claimant's intent to file a consequential illness claim, rather than an illness associated with an occupational toxic substance exposure, and provides guidance to the claimant about his or her

responsibilities in filing for a consequential illness under the Act. When a Form EE-1A is received but cannot be associated with an existing case file, the DO or RC must return the form to the submitter for correction. Once a properly completed Form EE-1A is received and a Case Create Clerk creates the claim in ECS, the system will assign the form to the responsible CE.

a. *For each distinct medical condition claimed as a consequence of a previously accepted condition, the CE undertakes a careful examination of the evidence presented in support of the claim. If the evidence demonstrates the existence of a diagnosed consequential illness and the CE decides that the medical justification is sufficient to link reasonably the condition to a previously accepted condition, he or she proceeds with issuing a letter decision of acceptance (refer to 10a on acceptances). In those claims situations where insufficient evidence exists, after development, to establish a consequential claim, the CE issues a RD of denial.*

b. *In some situations, the CE may find evidence contained in a case record that suggests that an unclaimed medical condition is consequential to an accepted condition. If there is sufficient reason to discern that the evidence of record communicates the existence of a likely consequential condition, the CE is to contact the claimant to ascertain whether he or she wants to claim that condition as consequential to a previously accepted illness. If the claimant states that he or she wants to file a claim for that condition, the CE instructs the claimant to submit a completed and signed Form EE-1A. The fact that the CE identifies an unclaimed condition in the medical evidence is not sufficient reason to seek a new claim. Evidence has to be present in the case record to lead the CE to a reasonable conclusion that the condition is consequential to an approved primary condition.*

c. *Where a claimant previously filed a claim for a condition due to toxic substance exposure that was denied, but later claims that the denied condition is consequential to an accepted condition, the claimant is to file Form EE-1A claiming the condition as a consequential illness. In this scenario, the CE treats it as new consequential illness claim filed under the EEOICPA. As this is a new claim filed under the EEOICPA, a Director's Order vacating the prior denial of the same condition based on toxic substance exposure is unnecessary before issuing a decision about the consequential illness.*

d. *Adjudication of a consequential illness cannot occur unless a properly completed Form EE-1A is received. During adjudication, if an existing claimed condition is reclassified as a consequential illness, the CE must obtain a Form EE-1A for the condition. The claim for that condition is closed until receipt of a properly completed Form EE-1A.*

- Ch. 23.11a(2) has been modified to remove all references to using Forms EE-1/2 to claim a consequential illness and instead will now reference Form EE-1A: Claim for Consequential Illness Benefits. The language in v8.0 previously read:

> *(2) For situations where a new consequential illness is accepted after an initial impairment rating has occurred, the CE proceeds with a new impairment rating if the consequential condition affects an organ system that was not previously evaluated for impairment. For example, the primary accepted condition is lung cancer. FAB issued a FD one year ago to award a 50% impairment due to whole person impairment rating to the pulmonary system.*
>
> *A consequential illness is accepted for stomach ulcers as a result of medication required to treat the cancer. The CE may immediately proceed with a new impairment assessment because the consequential illness effects an organ system (digestive) that was not included in the prior impairment assessment.*
>
> *If the claimant's treating physician or a CMC identifies a consequential illness during an impairment evaluation that is not included in the SOAF as an accepted condition (regardless of whether or not it is included in the impairment), the CE contacts the claimant and asks if he or she wants to file a claim for the condition (refer to paragraph 3). If the claimant answers in the affirmative, the CE instructs him/her to submit a completed and signed Form EE-1/2. The processing of the impairment claim should not be delayed if the condition is for the same organ/body system.*

It has been updated in v9.0 to:

> *(2) For situations where a new consequential illness is accepted after an initial impairment rating has occurred, the CE proceeds with a new impairment rating if the consequential condition affects an organ system that was not previously evaluated for impairment. For example, the primary accepted condition is lung cancer. FAB issued a FD one year ago to award a 50% impairment due to whole person impairment rating to the pulmonary system.*
>
> *A consequential illness is accepted for stomach ulcers as a result of medication required to treat the cancer. The CE may immediately proceed with a new impairment assessment because the consequential illness effects an organ system (digestive) that was not included in the prior impairment assessment.*
>
> *If the claimant's treating physician or a CMC identifies a consequential illness during an impairment evaluation that is not included in the SOAF as an accepted condition (regardless of whether or not it is included in the impairment), the CE contacts the claimant and asks if he or she wants to file a claim for the condition. If the claimant answers in the affirmative, the CE instructs him/her to submit a completed and signed Form EE-1A. The processing of the impairment claim should not be delayed if the condition is for the same organ/body system.*

- **Chapter 24 – Recommended Decisions**

  - Ch. 24.7a(5) has been edited to remove the requirement that the signature block of a recommended decision (RD) include a location and office. The language in v8.0 previously read:

    (5) The signature block must include the name, job title, and location and office of the person who prepared the recommendation, and the date of issuance.

    It has been updated in v9.0 to:

    (5) The signature block must include the name and job title of the person who prepared the recommendation, and the date of issuance.

  - Ch. 24.9b has been modified to require any report that justifies findings contained within an RD to be included in the RD packet uploaded into the OWCP Imaging System (OIS), and to remove Ch. 24.9b(3), as the recording of the action in ECS renders this step unnecessary. The language in v8.0 previously read:

    b. Mailing the RD. The signed and dated RD is mailed to the claimant's established address of record, and a copy is sent to the claimant's designated representative, if any. Notification to either the claimant or the representative is considered notification to both parties.

    (1) A signed and dated copy of the RD is imaged into the electronic case file.

    (2) The decision issuance is to be appropriately recorded in ECS.

    (3) The CE then forwards the case record to the appropriate FAB office.

    It has been updated in v9.0 to:

    b. Mailing the RD. The signed and dated RD is mailed to the claimant's established address of record, and a copy is sent to the claimant's designated representative, if any. Notification to either the claimant or the representative is considered notification to both parties.

    (1) A signed and dated copy of the RD is imaged into the electronic case file. The imaged RD added to OIS must include all required attachments (HP, IH, TOX, and/or CMC reports) that provided justification or support for the claim's acceptance or denial.

    (2) The decision issuance is to be appropriately recorded in ECS.

- Ch. 24.10g has been updated to incorporate guidance from EEOICPA Bulletin No. 24-02: Categorization of basal cell carcinoma (BCC) and squamous cell carcinoma (SCC) as non-melanoma skin cancers. The language in v8.0 previously read:

  g. For any primary skin cancer that is accepted under Part E for toxic substance exposure other than radiation (e.g., chemical, or biological exposure), DEEOIC may accept by letter decision any subsequent claim of the same type of primary skin cancer diagnosed at a different anatomical location.

  It has been updated in v9.0 to:

  g. *For any primary skin cancer that is accepted under Part E for toxic substance exposure other than radiation (e.g., chemical, or biological exposure), DEEOIC may accept by letter decision any other claim of the same type of primary skin cancer diagnosed at a different anatomical location. In administrating this standard, the CE will accept that the non-melanoma skin cancers (BCC and SCC) are considered the same type of primary skin cancer. A positive causation determination for BCC skin cancer based on exposure to a toxic substance other than radiation shall apply to any other BCC or SCC skin cancers (and vice versa), that have been diagnosed and claimed under Part E. However, melanoma skin cancers are a distinct primary cancer type as compared to non-melanoma, and therefore melanoma is not the same type of primary skin cancer as BCC or SCC.*

- Exhibit 24-1, Uniform Formatting Guidelines for Decision Writing, has been modified to remove the requirement that the signature block of decisions issued by a district office, or the Medical Benefits Adjudication Unit (MBAU), include a location and office.

- Exhibit 24-3, Notice of Recommended Decision has been updated to include DEEOIC's toll-free number for customer service inquiries.

- **Chapter 26 – FAB Decisions**

  - Exhibit 26-4, Sample Medical Benefits Letter, has been updated to replace reference to Form OWCP-957 with new Forms OWCP-957 Part A and OWCP-957 Part B. In addition, all forms that are to be attached to the medical benefits letter have been removed, as those forms are available on the DEEOIC website.

- **Chapter 29 – Ancillary Medical Benefits**

  - Ch. 29.5f(3)(a) has been modified to communicate the responsibility of MBEs to coordinate with the assigned CE to ensure accurate ECS coding regarding the acceptance of an organ transplant. The language in v8.0 previously read:

    (a) Approval by DEEOIC Medical Officer. Upon approval by the Medical Officer for an organ transplant or experimental treatment, the MBE updates ECS Notes, and

prepares a decision letter of authorization to the claimant, with a copy to the prescribing physician, containing the following information and special limitations pertaining to organ transplants and experimental treatment plans:

It has been updated in v9.0 to:

(a) Approval by DEEOIC Medical Officer. Upon approval by the Medical Officer for an organ transplant or experimental treatment, the MBE updates ECS Notes and prepares a decision letter of authorization to the claimant, with a copy to the prescribing physician, containing the following information and special limitations pertaining to organ transplants and experimental treatment plans. The decision letter serves as the acceptance of the organ transplant as a consequential condition to a previously accepted work-related illness. After the MBE issues the decision letter, the MBE will provide email notice to the CE regarding the organ transplant acceptance. Once notified, the CE must complete the coding in ECS related to the organ transplant approval as a consequential condition. The MBE issued authorization decision must include the following information:

- Ch. 29.5i(3) has been edited to provide additional guidance regarding the adjudication of reimbursement requests for extended travel. The language in v8.0 previously read:

(3) Upon receipt of a travel authorization request from the claimant, for medical travel in excess of 200 miles round-trip, the MBE first determines whether the claimant has provided justification for extended travel to obtain medically necessary evaluation or treatment relating to an accepted medical condition. Medical justification will normally consist of evidence of a scheduled appointment with a medical provider and a description of the planned or scheduled treatment. The medical provider's enrollment in DEEOIC's program is not a prerequisite for approving extended medical travel if the claimant chooses to receive medical services from a non- enrolled provider. The claimant may choose the desired mode of transportation when making travel plans for medically necessary travel. In any instance where the purpose of extended travel is unclear, or a request does not properly document the medical necessity for the travel, the MBE initiates development with the claimant or the claimant's physician.

It has been updated in v9.0 to:

(3) Upon receipt of a travel authorization request from the claimant, for medical travel exceeding 200 miles round-trip, the MBE first determines whether the claimant has provided justification for extended travel to obtain medically necessary evaluation or treatment relating to an accepted medical condition. Medical justification will normally consist of evidence of a scheduled appointment with a medical provider and a description of the planned or scheduled treatment. The medical provider's enrollment in DEEOIC's program is not a prerequisite for approving extended medical travel if the claimant chooses to receive medical

services from a non- enrolled provider. The claimant may choose the desired mode of transportation when making travel plans for medically necessary travel. In any instance where the purpose of extended travel is unclear, or a request does not properly document the medical necessity for the travel, the MBE initiates development with the claimant or the claimant's physician.

In addition to reviewing the medical evidence supporting a travel request, the MBE reviews the request to determine if it meets the "prudent person" test, meaning the request is not deemed to be inappropriate, unreasonable, unnecessary, and/or unjustified with respect to the claimant's need to travel to obtain necessary medical treatment for an accepted medical condition. DEEOIC will not reimburse travelers for costs associated with an indirect or circuitous travel route; unnecessary delays or extended travel time; or luxury accommodations and services that are not essential to obtaining necessary medical treatment. Nor will travelers be reimbursed for fees, fines, and other costs incurred by travelers that are in non-compliance with DOL travel policies.

- Ch. 29.5i(5) has been updated to replace reference to Form OWCP-957 with reference to new Forms OWCP-957 Part A and OWCP-957 Part B. The language in v8.0 previously read:

(5) Approval for Extended Travel Reimbursement. Once the basic requirements for extended medical travel are met, the MBE prepares and sends the claimant a travel authorization letter. The MBE's authorization letter describes the specifics of the trip being authorized based upon the mode of travel the claimant has selected. The authorization letter includes a statement that travel costs are reimbursable only to the extent that the travel relates to obtaining medical treatment for an accepted medical condition. Additionally, the letter advises that the DEEOIC BPA processes travel reimbursement claims in accordance with Government Services Administration (GSA) travel guidelines. Per Diem rates for overnight stay and mileage reimbursement rates are published on the GSA website, and airfare reimbursement is based on actual ticket cost up to the amount of a refundable coach ticket (Y-Class airfare).

Lastly, the MBE's letter advises that the claimant may contact the nearest DEEOIC Resource Center for assistance prior to making a trip, or for assistance in completing Form OWCP-957, Request for Reimbursement, upon completion of a trip. The MBE may approve an individual trip, or multiple trips within a specified date range, in one letter to the claimant. In addition to the authorization letter, the MBE also includes attachments for the claimant to use when submitting their reimbursement claim.

It has been updated in v9.0 to:

(5) Approval for Extended Travel Reimbursement. Once the basic requirements for extended medical travel are met, the MBE prepares and sends the claimant a travel authorization letter. The MBE's authorization letter describes the specifics

of the trip being authorized based upon the mode of travel the claimant has selected. The authorization letter includes a statement that travel costs are reimbursable only to the extent that the travel relates to obtaining medical treatment for an accepted medical condition. Additionally, the letter advises that the DEEOIC BPA processes travel reimbursement claims in accordance with Government Services Administration (GSA) travel guidelines. Per Diem rates for overnight stay and mileage reimbursement rates are published on the GSA website, and airfare reimbursement is based on actual ticket cost up to the amount of a refundable coach ticket (Y-Class airfare).

Lastly, the MBE's letter advises that the claimant may contact the nearest DEEOIC Resource Center for assistance prior to making a trip, or for assistance in completing OWCP-957 Part A and Part B reimbursement forms upon completion of a trip. The MBE may approve an individual trip, or multiple trips within a specified date range, in one letter to the claimant. In addition to the authorization letter, the MBE also includes attachments for the claimant to use when submitting their reimbursement claim.

- **Chapter 30 – Home and Residential Health Care**

  - Ch. 30.5a(11) has been updated to expand on the definition of period of required care. The language in v8.0 previously read:

    (11) Period of Required Care. The length of time for which the HRHC care is required to address the effect of an accepted condition(s). For example, an assistive health care individual is prescribed to provide care for a period of 6 months. For assisted living or nursing home requests, the physician must describe the relative permanency of the claimant's medical need for such care.

  It has been updated in v9.0 to:

    (11) Period of Required Care. The length of time for which the HRHC care is expected to be required to address the effect of an accepted condition(s) up to a period not to exceed one year. For example, an assistive health care individual is prescribed to provide care continuing for a one-year period, as the patient is unlikely to gain functional ability to perform ADLs on their own. For assisted living or nursing home requests, the physician must describe the relative permanency of the claimant's medical need for such care.

  - Ch. 30.8 has been updated to incorporate EEOICPA Bulletin No. 24-03, which increased the maximum allowable authorization for Home Health Care (HHC) from a duration of 6 months to 12 months.

  - Exhibit 30-1, Form EE-17A: Claim for Home Health Care, Nursing Home, or Assisted Living Benefits under the EEOICPA; and Exhibit 30-2, Form EE-17B: Physician's

Certification of Medical Necessity under the EEOICPA, have been removed. These forms are now available on the DEEOIC website.

- Based on these changes, all remaining exhibits of Chapter 30 have been renumbered accordingly.

- **Chapter 31 – Tort Action and Election of Remedies**

  - Ch. 31.9 has been edited to remove outdated language pertaining to paper case files and to provided updated procedures for tracking a surplus. The language in v8.0 previously read:

    9. Actions to Absorb Surplus. Each DD appoints a qualified individual to serve as the 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, 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 SECOP 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.

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 DEEOIC has recorded the absorption of any calculated surplus, normal payment of benefits must commence. 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.

It has been updated in v9.0 to:

9. <u>Actions to Absorb Surplus</u>. The NAFO is responsible for designating staff whose responsibility will be to tabulate surplus amounts arising from tort settlements. Tort settlement surpluses are absorbed until the surplus is exhausted and EEOICPA benefit disbursement can commence. Designated staff will tabulate the amount of medical benefits paid out of pocket, and lump-sum awards for wage-loss and impairment benefits, until they equal or exceed the assigned surplus amount.

a. No further payments related to the same toxic exposure(s) that formed the basis for the lawsuit are made on any case file in which a surplus exists until such time the offset has been absorbed. Should an unpaid bill be submitted to the designated staff person during the surplus period, it must be forwarded to the BPA so an explanation of benefits can be generated.

b. During the time in which the surplus is being monitored for depletion, designated staff will track the offset. Upon payment of impairment benefits, wage-loss compensation, or proof of payment of medical bills, the POC subtracts the dollar amount being applied toward the offset until such time the surplus has been absorbed.

c. While medical benefits are not being paid because of a surplus that is being absorbed, the CE may find it necessary to obtain a SECOP 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. Medical travel expenses related to a directed medical examination must be approved for payment and are not subject to offset.

d. Once the DEEOIC has recorded the absorption of any calculated surplus, normal payment of benefits must commence.

e. The designate staff person is responsible for sending 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.

- **Chapter 32 – Coordinating State Workers' Compensation Benefits**

  - Ch. 32.9 has been updated to remove outdated language pertaining to paper case files and to provided updated procedures for tracking a surplus. The language in v8.0 previously read:

    9. <u>Actions to Absorb Surplus</u>. Each DD appoints a qualified individual to serve as the 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 NO 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 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 those 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.

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.

It has been updated in v9.0 to:

9. <u>Actions to Absorb Surplus</u>. The NAFO is responsible for designating staff whose responsibility will be to monitor surplus situations for SWC benefits. SWC benefit surpluses are absorbed until the surplus is exhausted and EEOICPA benefit disbursement can commence. Designated staff will tabulate the amount of medical benefits paid out of pocket and lump-sum awards for wage-loss and impairment benefits, until they equal or exceed the assigned surplus amount.

a. No further payments are made on any case in which a surplus exists due to the receipt of SWC benefits that requires coordination. Should an unpaid bill be submitted to the designated staff person during the surplus period, it must be forwarded to the medical BPA so an explanation of benefits can be generated.

b. During the time in which the surplus is being monitored for depletion, including payments for medical benefits made out of pocket, and lump-sum awards for wage-loss and impairment benefits, the designated staff person tracks the offset until the surplus has been depleted. Once the surplus is completely absorbed, payment of EEOICPA benefits may commence.

c. The designated staff person is responsible for sending 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.

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 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. Medical travel expenses related to a directed medical examination must be approved for payment and are not subject to coordination.

- **Appendix 1 – Exhibits**

  - In conjunction with the change to signature block requirements in Chapter 24 – Recommended Decisions, outlined above, all sample decisions and letters affected by this change throughout Appendix 1 – Exhibits, have been edited to remove the office location from their signature blocks.

Rachel Pond

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