U.S. Department of Labor

Office of Workers' Compensation Programs
Washington, DC 20210

March 7, 2024

Dr. Steven Markowitz, Chair
Advisory Board on Toxic Substances
and Worker Health
Queens College, Remsen Hall
65-30 Kissena Boulevard
Flushing, NY 11367

Dear Dr. Markowitz:

Thank you for your letter dated January 16, 2024, transmitting recommendations adopted by the Advisory Board on Toxic Substances and Worker Health (Advisory Board or Board) during its meeting on November 15-16, 2023. On behalf of Acting Secretary of Labor Julie A. Su, to whom you addressed your letter, the Office of Workers' Compensation Programs (OWCP) responds to the recommendations herein.

The Board adopted the following recommendation regarding Assessing the Quality and Consistency of Consulting Physicians in Claims Evaluation in the Division of Energy Employees Occupational Illness Compensation (DEEOIC).

The ABTSWH recommends that the Department of Labor expand its quality assessment of [contract medical consultants (CMC)] performance by implementing independent peer review of the validity of the content and analysis reflected in a quarterly sample of an appreciable number of CMC reports. Such peer review would be conducted by a small panel (2 to 3 physicians) of medical experts in causation analysis of occupational diseases. The goals are multiple: 1) to estimate the frequency of impactful correctable errors in causation determinations contained in CMC reports; 2) to identify if there are systemic problems in CMC causation analyses; and 3) if so, to recommend effective and feasible solutions to reduce the frequency and impact of systemic errors in causation determination. The Board offers our assistance in planning for the implementation of this recommendation if accepted.

Supporting its request, the Board provided the following rationale.

The ABTSWH recognizes that the Energy Employees Occupation Illness Compensation Program (EEOICP) conducts a robust quality assurance program of multiple aspects of its claim evaluation process and that this process underwent a major enhancement in 2022.

The quality of the CMC reports is currently evaluated according to a number of factors, including timeliness, appropriateness of medical specialty, presence of "well- rationalized" discussion, responsiveness to questions posed by the claims examiners (CEs), and others.

In a letter to the Board (August 31, 2023), the Department of Labor stated that current EEOICP procedures and guidance safeguard against erroneous opinions expressed in CMC reports. This is achieved by giving claims examiners proper guidance. CEs determine whether well-rationalized opinions are offered by CMCs. To do so, per the EEOICP Procedure Manual (Version 8.0), CEs must determine that CMC opinions have a "proper foundation;" represent a "reasonable justification;" not contain "contradictory information;" and have "a compelling discussion supporting a particular conclusion." The Procedure Manual further defines for the CE that a well-rationalized opinion from a physician "applies reasonable medical judgement informed by relevant, creditable medical health science information, as to how the exposure(s) at least as likely as not significantly contributed to, caused, or aggravated the employee's claimed condition." (all quoted text is from the EEOICP Procedure Manual, Version 8.0).

The Department of Labor letter to the Board further states that quality assurance reviews are performed by dedicated staff and that CEs may demand further opinion evidence from physicians. These are positive features, but it is the opinion of the ABTSWH that there remain insufficient processes in place to identify erroneous CMC opinions.

Despite the aforementioned safeguards, we are left with the following questions. Was the CMC opinion, even when sufficiently well-rationalized, right or wrong? How are CEs, who are not required to have broad training in occupational medicine, medical diagnosis, clinical exposure assessment, epidemiology, toxicology, biostatistics or causation analysis equivalent to that required in training of occupational medicine and other physicians, supposed to recognize when a well-rationalized opinion by a physician is incorrect? Are the current procedures or quality review process sufficient to detect incorrect CMC opinions? The Procedure Manual points out that this is not a question that the CE is charged to address: "It is not the role of the assessor to agree or disagree with the conclusion; just to determine that the physician has offered a reasonable justification for how he or she responds to the referral question." But the Procedure Manual does not give guidance on how a CE should go about determining whether an apparently "reasonable" opinion is informed by relevant, creditable medical health science information, i.e. whether the opinion aligns with accepted medical knowledge. We reviewed the claims evaluation process to identify where this gap in quality assurance is addressed and could find no one who is assigned to identify CMC opinions and conclusions that do not reflect a generally held consensus within occupation medicine.

The essential problem is that neither the CEs nor the quality assessment personnel have the fund of knowledge of "relevant, creditable medical health science information" and an appropriate skill set to determine whether a CMC causation opinion is likely to reflect current consensus of medical opinion. This is not the fault of the CEs or quality assessors: their strengths lie elsewhere - in administration, communication, coordination, analysis, etc. And, in response to the Department's request of the Board, this essential problem cannot be addressed by pointing to "specific guidance or references to medical health science data." Such guidance or knowledge regarding occupational disease causation determination in individual patients is spread across textbooks, journal articles, and other forms of scientific communication, and is integral to the clinical experience of occupational medicine physicians and some other

occupational health professionals (for example, individual exposure determinations by industrial hygienists).

A full and proper assessment of the validity of CMC opinions and the arguments they depend upon ultimately requires a review of these opinions by peers - occupational medicine and other physicians who focus on causation, medical diagnosis, etc. It is only through such a knowledge-based review that it can be determined whether the evidence cited and used by CMCs is correct and relevant and whether the synthesis of that evidence by the CMC and the conclusions they draw reflect generally accepted medical analysis and opinions.

It is hardly surprising that peers are required to weigh in on key aspects of performance of a peer reference group. Specialized areas of knowledge and their application – whether it be law, architecture, engineering, or medicine – require substantial periods of training, study and practice. The result is knowledge-based value added that improves decision-making. The Board's recommendation is intended to ensure that the claims evaluation process properly reflects high quality CE and CMC decision- making and will improve an already carefully considered quality assessment process that covers much, but still leaves an important gap.

DEEOIC recognizes the concerns raised and is committed to working with the Board to determine a process to review medical opinions. Below, we share issues to address in setting up such a review process. As the Board noted, one of the existing qualitative review elements relating to CMC work products is assessing if the opinion is well-rationalized. As discussed in the Federal (EEOICPA) Procedure Manual (Version 8.0), a well-rationalized opinion must provide "a convincing argument for a stated conclusion that is supported by the physician's reasonable justified analysis of relevant evidence."

DEEOIC retains services of CMCs who possess the necessary medical credentials and expertise to produce well-rationalized opinions. The CMC contract requires that all CMCs possess expertise in treating, diagnosing, or researching the illness claimed to be caused or aggravated by the alleged exposure. Additionally, all participating CMCs must be Board-certified in their specialty by a medical specialty board recognized by the American Board of Medical Specialties or by the American Osteopathic Association.

Although DEEOIC does not require CEs and other claims staff to have medical degrees, they are extensively trained as adjudicators and have experience in determining if a medical report, which includes CMC reports and medical reports submitted by the claimant, communicates a well-rationalized opinion. In particular, the CE will ensure that the CMC's discussion and opinion offers a compelling justification for the stated conclusion. As the CMC is a Board-certified professional, DEEOIC has an inherent expectation that the opinion expressed by a CMC is accurate, so long as the CMC provides sufficient discussion of the justification for a particular conclusion. If the CE questions the validity of a medical opinion due to a lack of compelling justification, the CE must request additional explanation from the CMC.

The question about judging CMC opinions as accurate or not is difficult to gauge because the opinion represents the outcome of a physician's individual interpretive analysis of available information and application of their professional medical judgment regarding causation. While

differences of opinion can and do occur between physicians, the suggestion that an opinion from a qualified physician is either "right or wrong" is difficult to quantify.

The Board states that DEEOIC can increase its quality assessment of CMC performance by implementing a panel of independent peer reviewers to review CMC reports to ascertain whether or not the CMC opinion arrives at an incorrect conclusion despite being well rationalized. It is unclear to DEEOIC as to what condition(s) would allow for the proposed panel to characterize a physician's professional judgment as producing an erroneous outcome versus a routine difference of medical opinion. The Board has not provided clarity on how an independent panel would address such a dilemma. In addition, the Board has not provided any evidence that would suggest that there is a problem with the CMC reports, much less a systemic problem, that necessitates this type of oversight. Therefore, DEEOIC seeks further information from the Board about the specific circumstances that would need to exist for a physician's opinion to be objectively characterized as an error or not. Of particular interest, DEEOIC requests that the Board identify any medical opinion(s) it has encountered in its case screenings that it can describe as erroneous, and provide its detailed reasoning for concluding that the opinion is in error. DEEOIC will evaluate those reports, and any other input the Board may offer, to arrive at a more definitive response to this recommendation.

The Board adopted the following recommendation regarding the processing of DEEOIC claims filed by claimants with a terminal prognosis.

The ABTSWH recommends that the EEOICP designate a single program staff person at each district office within 30 days of the date of this recommendation to serve as an initial point of contact for claims that involve people who report that they are terminally ill.

Supporting its request, the Board provided the following rationale.

The issue of timely and appropriate claims evaluations and decision-making with regard to claimants who are very ill has arisen several times before the ABTSWH and pertains to the Board's 5th assigned task: "the claims adjudication process generally, including review of procedure manual changes prior to incorporation into the manual and claims for medical benefits."

The Board notes that the EEOICP Procedure Manual (Version 8.0) has specific provisions in Chapter 11 and Chapter 30 to address claimants who may be terminally ill, including identification of such claimants, priority handling of claims from such claimants, describing a method to resolve uncertainties regarding status as terminally ill, and addressing the need for hospice care. It is clear that this issue has received considerable attention from the EEOICP.

Addressing the many needs of a very ill person facing death in a matter of months is a difficult challenge for all concerned – the ill person, family, other caregivers, advocates such as lawyers or authorized representatives, and physicians. Under such circumstances, enlisting help for needed medical care or compensation from a government agency, especially undertaking an effort that involves navigating a multi- step, complex administrative process, can feel daunting, at best, or insuperable, at worst.

Streamlining the entry, re-entry, or monitoring of the claims process by assigning a single person within each EEOICP District Office to identify, monitor, and facilitate the claims of terminally ill people would be a very useful and compassionate addition to the efforts that the program already makes to accommodate such claimants. It would give the families and advocates a point of contact, which, in and of itself, would help forestall frustration and anxiety that may accompany the claims evaluation process. This person would have the experience and authority to monitor these claims to facilitate their resolution and overcome any "sticking points" that claims sometimes encounter in their flow. In addition, this person would assess whether the current provisions of Chapters 11 and 30 in the EEOICP Procedure Manual are being followed or require modification.

If this recommendation is accepted, the Board would appreciate a report on how it is implemented and whether it has resulted in improvements in facilitating claims of terminally ill claimants.

DOL does not agree with the Board's assessment that assigning a single individual staff person at each district office to serve as a point of contact for terminal claimants would tangibly enhance the ability to bring terminal claims to timely and accurate resolution. Currently, procedures are in place to provide expedited assistance to claimants with a terminal prognosis. Additionally, as is discussed below, DOL has concerns that assignment of a single point of contact within the District Offices could potentially impede the ability of claims staff to bring terminal claims to an expedited resolution.

DOL agrees that it is of vital importance to streamline and expedite the processing of terminal claims to the maximum extent possible. From DOL's perspective, existing processes and procedures ensure that terminally designated claims are expeditiously developed, evaluated, adjudicated, and paid (when applicable). Internal review of the terminally designated claims does not reveal any systemic problems about efforts taken to expedite processing when possible. Program staff are empowered to provide priority handling regarding terminal claims, and there are systems in place within the District Offices and Final Adjudication Branch (FAB) to ensure backup coverage in the event that the assigned staff person is unavailable. Moreover, claimants and their authorized representatives can always request to speak with a supervisor/manager, District Director, or Assistant District Director if an issue arises that requires escalation.

Throughout the case adjudication life cycle there are established methodologies to expedite case processing once the DEEOIC ascertains that a claimant is terminal. This includes mechanisms for obtaining prioritized responses to referrals and requests for essential claim data from the Department of Energy (DOE) employment verification site offices, National Institute for Occupational Safety and Health, CMCs, Industrial Hygienists (IH), Toxicologists, and Health Physicists. For example, for terminal cases, CMC and IH reviews can often be expedited to allow for a 48-hour (two business days) turnaround time, as compared to the standard 21-day timeframe.

We can highlight numerous examples of situations where program staff have successfully processed terminal claims in an expedited manner.

- An employee filed a claim for pancreatic cancer on June 30, 2023. The claimant's authorized representative submitted notification of terminal status on July 10, 2023. The CE immediately requested employment verification from DOE and advised of the terminal status. The District Office received the employment verification on July 31, 2023, confirming that the employee was a member of a Special Exposure Cohort class. The District Office then issued a recommended decision to accept the claim under Parts B and E on August 10, 2023, the final decision was issued on August 11, 2023, and the $150,000 Part B payment was processed that same day via wire transfer. An impairment report (100% rating) for the employee was received on August 22, 2023, and the Part E recommended decision, final decision, and $250,000 payment were all processed that same day.

- An impairment rating physician advised the District Office on February 9, 2023, that an employee was in terminal status. The District Office issued its Part E recommended decision on February 10, 2023, recommending an award of $250,000. The final decision was issued on February 17, 2023, and the $250,000 payment was processed that same day.

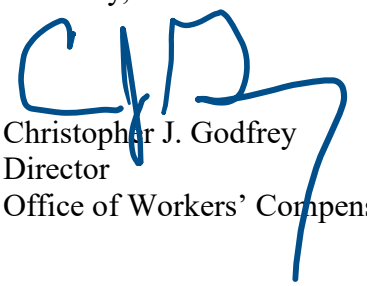
- A claimant provided documentation indicating a terminal status on March 2, 2023, and the CE sent a letter to the claimant's chosen physician the next day authorizing the physician to perform an impairment evaluation. The District Office issued its recommendation to approve the claim that same day, recommending an award of $202,500. The recommendation was finalized by the FAB one day later, and the payment was deposited into the employee's bank account the next business day.

These are just a few examples of the effort undertaken by DEEOIC to expedite the handling of terminally designated claimants. Prioritizing terminal cases is an important goal of the DEEOIC, and its staff expend significant effort to ensure that such cases are handled expeditiously. While a terminal status does not absolve the DEEOIC of its responsibility to complete necessary developmental steps and obtain evidence to support claim outcomes, it is a procedural and management prerogative to expedite terminal cases in whatever manner will produce a timelier outcome.

DOL has reviewed the current process for handling terminal claims. Each claimant has an assigned CE who has familiarity with the case status and is empowered to expedite claims processing for terminal claims. Assigning one person as a single point of contact in each office (even with a backup) could result easily in actual delays for processing terminal claims if the point of contact or backup are unavailable. While DOL believes that the current process works well, we are open to further dialogue with the Board, including specific problems they have heard about and how we can improve the process.

On behalf of the Department, OWCP, the Division of Energy Employees Occupational Illness Compensation, and the communities we serve, I look forward to the Board's continued efforts.

Sincerely,



Christopher J. Godfrey
Director
Office of Workers' Compensation Programs