

Action items from July 12 subcommittee meeting:

- Discussing PM “Sources of Medical Evidence”
 - o “Consensus documents from learned bodies” – is it the CEs responsibility to gather these? Or the CMCs responsibility? – (PM2-0800.2) We are not clear where this phrase “consensus documents from learned bodies” comes from in the PM, but it is ultimately the claimants’ burden of proof to establish their cases; however the claims examiners are directed to obtain as much information as possible from many resources to assist in this task. Initial medical evidence of a condition is typically submitted by the claimant/treating physician, at which time the CEs will request additional information (if necessary) either directly from the claimant or from the treating physician (if there is one). If the information submitted by the claimant is sufficient to establish a diagnosis and there is evidence that the employee worked at a covered site, but there is additional evidence lacking (e.g. detailed exposure information, medical opinion on causation), then the CE may refer the case to a CMC, Industrial Hygienist or the Toxicologist. Any information submitted to the CMC, medical director, IH or Toxicologist’s review is gathered and submitted by the CE.
- Discussing PM “Types of Medical Evidence”
 - o Does all of the medical evidence get to the CMCs? For example, would a claimant’s submitted symptom diary get to a CMC? – Only medical evidence determined to be relevant to the questions being asked of the CMC is typically included. In some cases, that would be ALL medical evidence, but not in every case.
- Discussing PM “Developing Medical Evidence”
 - o Can the subcommittee get more background on the CE’s duty to assist? Are there any training documents on this? – There is no legal “duty to assist” written into the law as there is in other statutes. However, given that the DEEOIC is dedicated to accepting cases whenever appropriate, DEEOIC employees are directed to assist every claimant in attaining or providing the information necessary to adjudicate the claim. This includes obtaining information from DOE and the other sources of employment verification listed in the PM. It also includes assisting in obtaining exposure and causation information whenever possible through the use of SEM and referrals to IHS or CMCs. If DEEOIC didn’t use these tools, claimants would have less access to information necessary, which would likely result in more denials.
- Discussing PM “Deficient Evidence”
 - o How do doctors evaluate effect on “historical” wages? Is this appropriate for physicians to do? Physicians normally evaluate impairment, not wage loss from such impairment. – (PM2-0800.5.b) The section of the PM to which you are referring is one example of the various topics that may require evaluation of medical evidence. In this example, for wage loss claims, the claimant must establish that the employee lost time from work as a result of the accepted condition. In order to be eligible for wage loss, the claimant must first establish when the employee first began losing time from work in order for the DEEOIC to establish a baseline average annual wage with which to compare any ongoing or later years of lost wages. It is sometimes difficult for a claimant to discern 1) when the employee first lost time from work as a result of the condition and/or 2) whether later years of lost time were related to the accepted condition. Oftentimes, claimants will state that the employee began losing wages decades ago, and the DEEOIC requires medical evidence to establish that those lost wages were related to the condition. That is what is meant by “effect of historical wages” in the PM.

Discussing PM “Telephone Request”

- o Is there a paper trail for telephone requests to physicians? PM 2-0800 5.c(1) states that the CE must document the call in the Energy Compensation System (ECS). This call then becomes a part of the claimant’s permanent record.

Discussing PM “Unavailable Medical Records”

- o What does the CE do if no records are available? – (PM2-0800.5.e) Sometimes claimants have reported that the employee’s medical records have been destroyed due to record retention issues, closing of a facility, burning of a medical facility etc. In those cases when there is no medical evidence of a diagnosis or any treatment of the claimed condition but there is evidence that the employee was treated by a particular physician, the CE is directed to ask the physician to provide whatever evidence he/she may be able to provide based on his knowledge of the employee.
- o Does this section of the PM add much to the process? What is its goal? – The goal is to avoid denying a claim when there is a possibility the physician has enough knowledge to at least provide a history and diagnosis. There have been some cases in which this information has enabled the DEEOIC to further process the case without a denial.

Discussing PM “Weighing Medical Evidence”

- How are the CEs trained to weigh medical evidence? This is a difficult task for a non-medical person, how does it work in practice? Is it out of the scope of a CE’s job to “weigh” medical evidence, and should only the CMCs be doing this? – (PM2-0800.6) The CEs are trained to evaluate all evidence that is submitted in a case file. This not only includes medical evidence, but any evidence, such as employment documentation. There are often complex employment issues related to whether an employee was on site at a covered part of a DOE facility – and various different documents are submitted to assist in making this determination. The CE must use critical analysis in these cases to determine what the facts are and how to apply the documentation. The CEs apply similar logic in weighing medical evidence. The PM is very specific as to what methods to apply when undergoing this analysis when it comes to medical evidence. Usually this situation occurs when there are conflicting medical reports in the case file (e.g. a treating physician and a CMC). The CEs are trained in conducting this analysis, and historically this has been through a hands-on approach (trainers evaluating specific cases and situations in a classroom setting). This analysis can often be straight-forward: for example, the treating physician provides a diagnosis and a statement that he/she believes that the condition is related to toxic substances in the work environment, without any detailed information regarding the type of exposure or any rationale as to how the physician came to this conclusion. In contrast, another treating physician, an occupational or some other sort of specialist, may submit a report with a detailed discussion of the employee’s exposure, the specific toxins he/she was exposed to, the length of exposure, and an opinion, with rationale, as to whether the exposure caused, contributed to or aggravated the exposure. The PM advises that CEs should provide the historical, exposure information to the treating physician (based on a SOAF or specific questions) before moving on to a CMC. If the CE determines that the reports between a treating physician and a CMC (or second opinion physician) are too similar to be weighed one over the other, the CE is to refer the case to a referee medical examiner for a new opinion, as outlined in the PM.

- o Can the subcommittee have a sort of “focus group” with 4 or 5 CEs to ask questions? Would the subcommittee members be allowed to sit down with a CE and go through claims as a CE

would? – We would be happy to compile a group of individuals to discuss the step by step procedures.

o Are treating physicians compensated for their reports by DOL? How? Is payment whether accept or deny? – Treating physicians are paid for any examination and supporting reports that they submit as long as they are signed up as a Provider in the OWCP payment system and the treatment is for the accepted condition. Treating physicians do not accept or deny cases; this is completed by the DEEOIC.

o Could the subcommittee speak to treating physicians? – I don't have any objections to it, but we are not clear as to how we would do this logistically, since there are hundreds of physicians enrolled in the Program, we would have to get their permission and determine how to pick the physicians to talk to.

· Discussing PM "Reviews by CMC" (PM2-0800.9)

o The CE looks to be in tough spot for weighing medical evidence if they have no medical training. Does the CE ever confer with the CMC if there are questions? Can they get different physicians on a conference call or do they need to do "shuttle diplomacy" between everyone? As indicated above in response to the weighing of medical evidence questions, the CEs are trained in weighing all medical evidence. The PM outlines the types of information to be reviewing. If follow-up or clarification is necessary, the CE does go back to the CMC for clarification. There are no conference calls between multiple physicians and the CE's.

o Request to look at (1) what materials the CMC gets with a referral, and (2) how they evaluate it, and (3) whether they interact with the CEs – I believe we provided a sample referral package to a CMC, but if not, we can provide a couple of examples. The CMC's evaluate the evidence using their expertise and professional judgment. CEs follow-up with the CMCs in writing, in order to ensure that the case file is documented appropriately.

o Can anyone (CEs, supervisors) question the validity of the CMC reports? Can the CEs question the treating physician's? Do the CEs actually "weigh" the CMC report or just accept it? – CMC reports are supposed to be evaluated like any other report and the CE may question any report submitted. As outlined in the PM, the CEs are expected to weigh the evidence submitted by the treating physician (and any other medical evidence in the file) with that the submitted by the CMC (if the opinions differ). CE's are NOT expected to simply accept the CMC's recommendations; however oftentimes the reason a case is referred to a CMC is that the CE was unable to obtain the necessary documentation from the treating physician. The CE's can and do question the treating physicians – the CEs are supposed to obtain the evidence from the treating physician first whenever possible, before any referral to a CMC. When there is a question or issue raised by the CMC that the treating physician may be able to answer, the CE is expected to question the treating physician. There are occasions when the CMC report is not used when a treating physician is able to sufficiently respond to a concern.

· The program asked for assistance:

o "Rationalization" – How complex a rationalization is considered adequate? Do not understand why a set of standardized triggers are necessary. – As indicated above, the CEs use the guidelines outlined in the PM to evaluate and weigh medical evidence. "Rationalized medical evidence" can be fairly straight forward; however when reviewing issues such as aggravation, contribution and causation, it is sometimes difficult to determine what level of rationalization should be required. The Program just thought if the Board had additional recommendations for the CEs to analyze the reports, that may be helpful, particularly in these more grey areas.

- Development letters – can the program supply some types of letters/communications it would like to see improved? What is the background for the second bulleted request for assistance? – In our presentation on this subject, we requested assistance in the following: “Methodologies for improving physician responsiveness to data requests including review of development letters, outreach efforts, and provider communications.” The background behind this is that we find it difficult to get the treating physicians to respond to detailed development letters. Oftentimes, we find that the physicians believe that if they have submitted a blanket statement of causation, without additional detail, that should be sufficient. We would like to be able to avoid going to CMCs and be able to rely on a claimant’s treating physician, but we have difficulty obtaining the reports that would enable us to do so. Therefore, we were hoping that perhaps the Board could assist us by providing best practices for obtaining this type of information. We can supply the Board with some samples of development letters written to claimants/their physicians when the Program needs additional information (e.g. more discussion on the relationship between the claimant’s actual established exposure and the accepted conditions) – they are often lengthy and physicians may not have the time or inclination to respond. Claimants also find it difficult to find physicians who are willing to enroll in the Program due to paperwork issues. Therefore, over the past several years, the Program has conducted regular outreach meetings throughout the country targeting physicians and other Providers, but we have had very low attendance from the physician community. We have a news blast email that goes out regularly that physicians or their assistants have subscribed to, and we are just now starting to host conference calls for physicians or their staff to call into. We are open to ideas from the Board as to how best to get physicians to enroll in the Program and to communicate with them about the requirements of the Program. We will provide some development letters to the Board.

- Training resources – what is out there on weighing medical evidence? The subcommittee would like to see the available materials in order to see how they could be improved – The PM is the starting point of weighing medical evidence and oftentimes the District Offices will develop classroom training around that. As indicated above, the National Office has conducted hands-on training on this issue using examples from real cases (for both the District and FAB offices), but I don’t believe we had a particular curriculum. If the Board is aware of guidance documents or training to assist in this effort, that would be helpful. We will provide some examples of training resources we have used in our offices.

- “Contribution or aggravation” – this is a huge issue in the medical world, “aggravation” versus natural progression of a disease; how does the program handle it now? What does the program expect the sub-committee to address? This is a difficult task for physicians to tease out, not sure it’s appropriate for a CE. What is the background on this request for assistance? – For Part E, the statute is very specific that exposure to toxic substances in the workplace must have been a “significant factor in causing, contributing to or aggravating” the claimed condition. Right now, the program relies on the medical opinions of the treating physicians or CMC physicians. As you indicate, it is a difficult task for physicians to tease out, but the role of the CE is to assess evidence that is submitted in support of a claim. If we had a guideline, or thresholds, or matrices that the physicians could follow with regard to what constitutes a “significant factor,” and how to apply this complex statutory definition, that would enhance the ability of the physicians to respond and the CEs ability to apply the definition.

- o Could the program assign a CE to attend the subcommittee calls in the future? – We can definitely assign a Program person to attend the subcommittee calls – we are not sure whether it is appropriate for bargaining unit employees to fulfill this role, but we will work with the Board on it.
- Request the Quarterly Management Reports (referred to in the CMC Statement of Work) for the last four quarters – Checking to see if we can give without QTC permission
- What are the exposures/diseases that claimants are claiming often? The subcommittee thought that the frequency of diseases had been requested by someone else; add also frequency of exposure – I thought this had been given, but will check and if not, can provide a list of top claimed conditions. We have no way to cull out the “frequency of exposure” from our database.
- Schedule another subcommittee meeting in September (DONE Tuesday, Sept. 13, 1:00 to 3:00 Eastern time)