Guidance for District Medical Consultants

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I - PROGRAM OVERVIEW

A. What are the Objectives of the Program?

The Energy Employees Occupational Illness Compensation Program (EEOICP) provides benefits authorized by the Energy Employees Occupational Illness Compensation Program Act (EEOICPA or Act). Part B of the program went into effect on July 31, 2001 and Part E of the program went into effect on October 28, 2004. The Department of Labor's Office of Workers' Compensation Programs (OWCP) is responsible for adjudicating and administering claims filed by employees, former employees or certain qualified survivors under the Act.

1. EEOICP Roles

Under the Office of Workers' Compensation Programs, the Division of Energy Employees Occupational Illness Compensation (DEEOIC) is responsible for the adjudication and administration of claims. This division is composed of:

- Eleven (11) resource centers to assist workers and their families apply for benefits under the EEOICPA. These centers also conduct outreach activities to inform the public of benefits and requirements of the EEOICPA.
- Four (4) District Offices that process incoming claims. These offices are located in Cleveland, Ohio; Denver, Colorado; Jacksonville, Florida; and Seattle, Washington.
- The Final Adjudication Branch (FAB), which maintains a central office in Washington, DC as well as offices co-located in each district office. The function of the FAB is to review each recommended decision from the district offices to ensure adherence to the legal requirements enumerated under the EEOICPA and that the decisions are issued with proper regard to established program policy and procedures. The claimant has an opportunity to object to the recommended decision and request either an oral hearing or a review of the written record. Upon completion of the review and objection process, the FAB issues the final agency decision, based on the evidence in the case record.
- The National Office is located in Washington, DC and provides administrative leadership, policy guidance, planning, budgeting, etc.

The EEOICP is a specialized program within the US Department of Labor with specific regulations and causation criteria. The program was designed in response to the situation that arose early in the 1940s with the pressure to rapidly develop nuclear weaponry. The program was designed in recognition of the severe risk of work-related illnesses and:

1) The uniqueness of the type and extent of exposure(s);

2) Workers' general lack of information regarding workplace risks at the time of exposure necessitated by the secrecy of the weapons program;
3) The development of subsequent patterns of disease and death;
4) The unavailability of past employment and medical records; and
5) The numerous barriers imposed by state workers' compensation programs as well as past programs administered by the DOE.

In support of development of this program Congress noted the following (abstracted from the preamble to the Act):

(1) Since World War II, Federal nuclear activities have been explicitly recognized under Federal law as activities that are ultra-hazardous. Nuclear weapons production and testing have involved unique dangers, including potential catastrophic nuclear accidents that private insurance carriers have not covered and recurring exposure to radioactive substances and beryllium that, even in small amounts, can cause medical harm.

(2) Since the inception of the nuclear weapons program and for several decades afterwards, a large number of nuclear weapons workers at sites of the DOE and at sites of vendors who supplied the Cold War effort were put at risk without their knowledge and consent....

(3) Many previously secret records have documented unmonitored exposures to radiation and beryllium and continuing problems at these sites across the Nation...

(4) The policy of the DOE has been to litigate occupational illness claims, which has deterred workers from filing workers' compensation claims and has imposed major financial burdens for such employees...

(5) Over the past 20 years, more than two dozen scientific findings have emerged that indicate that certain of such employees are experiencing increased risks of dying from cancer and non-malignant diseases...

(6) ...studies indicate that 98 percent of radiation-induced cancers within nuclear weapons complex have occurred at dose levels below existing maximum safe thresholds.

The intent of Congress was to lower many of the barriers and reduce the delays encountered by energy workers who seek compensation. Thus, the legal standard for acceptance of a claim under the EEOICP is less stringent

than found in other venues that you may be familiar with (e.g., tort liability, most state workers' compensation programs).

B. Part B

1. Part B covers the following population:
    - Employees of the Department of Energy (DOE), its contractors or subcontractors, and atomic weapons employees with radiation–induced cancers.
    - Employees of the Department of Energy (DOE), its contractors and subcontractors, and designated beryllium vendors who worked at covered facilities where they were exposed to or may have been exposed to beryllium produced or processed for the DOE who developed chronic beryllium disease (Employees exposed to beryllium who develop beryllium sensitivity receive medical monitoring) under statutory diagnostic criteria.
    - Employees of the DOE, its contractors and subcontractors who worked at least 250 days during the mining of tunnels at underground nuclear weapons test sites in Nevada or Alaska and who developed chronic silicosis under statutory diagnostic criteria.
    - Uranium workers (or their survivors) previously awarded benefits by the Department of Justice under Section 5 of the Radiation Exposure Compensation Act (RECA).

Individuals found eligible receive a lump sum and payment of medical expenses. Survivor benefits are available for claims falling within each of these categories.

2. To determine whether the employee's cancer is at least as likely as not related to exposure to radiation at DOE sites, the program uses a set of probability of causation (POC) tables developed by and maintained by the National Institute for Occupational Safety and Health (NIOSH). A compensable POC is one of a 50% or greater probability that occupational radiation was the likely cause of the diagnosed cancer.

3. The Act also created and provides procedures for the designation of Special Exposure Cohorts (SEC) for employees of certain DOE facilities (or its contractors and subcontractors) and certain atomic weapons employees who worked at specified facilities. Petitions for possible SEC designation are reviewed by NIOSH and submitted to the Advisory Board on Radiation and Worker Health. Upon receiving a recommendation from the Board, the Secretary of Health and Human Services can designate a class of employees as an SEC if it is not feasible to estimate with sufficient accuracy the radiation dose that the class received, and there is a reasonable likelihood that such radiation dose may have endangered the health of members of the class. Employees (or eligible survivors of a deceased employee) who are found to

be members of an SEC are eligible for benefits if, after beginning covered employment, they contracted:

- Bone cancer (including myelodysplasias and polycythemia vera)
- Renal cancer
- Leukemia (other than chronic lymphocytic leukemia) with a latency of at least 2 years
- Lung cancer (other than in situ discovered after an autopsy)
- *Multiple myeloma
- *Lymphomas (other than Hodgkin's disease)
- *Primary cancer of:
    - *Thyroid
    - *Breast (male or female)
    - *Esophagus
    - *Stomach
    - *Pharynx
    - *Small intestine
    - *Pancreas
    - *Bile ducts
    - *Gallbladder
    - *Salivary glands
    - *Urinary bladder
    - *Brain
    - *Colon
    - *Ovary
    - *Liver (except if cirrhosis or hepatitis B is indicated)

***Provided onset was at least 5 years after first exposure.**

4. Uranium workers and survivors, who have received a $100,000 lump sum award under sections of the Radiation Exposure Compensation Act (RECA), are entitled to file a claim for benefits under Part B. The employee or survivor will receive a $50,000 lump sum payment under Part B upon confirmation from the Department of Justice that a RECA award was approved for the claimant. RECA employees are also eligible for medical benefits in relation to their accepted covered condition.

C. Part E

1. Part E was created when Congress abolished Part D of the EEOICPA with an amendment signed into law by the President on October 28, 2004. Part D required DOE to establish a system by which DOE contractor employees (and their eligible survivors) could seek assistance from DOE in obtaining state workers' compensation benefits if a Physicians Panel determined that the employee in question had sustained a covered illness as a result of work-related exposure to a toxic substance at a DOE facility. A positive panel

finding that was accepted by DOE required DOE, to the extent permitted by law, to order its contractor not to contest the claim for state workers' compensation benefits. Now, Part E provides compensation in the form of medical benefits, wage loss, and impairment benefits to DOE contractors and subcontractors and certain Section 5 Radiation Exposure Compensation Act (RECA) workers. Covered survivors of deceased workers are also eligible to receive $125,000 in lump sum compensation if the covered illness aggravated, contributed to, or caused the employee's death. An additional survivor benefit is payable if the employee sustained wage loss prior to death. Congress assigned Part E administration to the Department of Labor (DOL).

2. An accepted Part E claimant may receive compensation for wage loss based on the number of years, as determined in relation to the Social Security retirement age, that an employee experienced a loss in wages due to his or her covered illness. Impairment benefits, based upon the amount of whole-person impairment of the employee due to an accepted covered illness, are paid to employees but not persons filing claims as a survivor. Covered employees will receive $2,500 for each percentage of whole-person impairment attributable to the accepted covered illness.

3. Any DOE contractor claimant whose claim had been accepted under Part B (including by way of the Special Exposure Cohort) is presumed to have the same covered condition under Part E. Atomic weapons employees and beryllium vendor employees are not eligible for Part E benefits.

4. Any claimant whose claim has been accepted by DOE as a result of a positive Physicians Panel is presumed to have a covered condition under E.

5. Other claimants must establish that it is at least as likely as not that exposure to a toxic substance at a covered facility was a significant factor in causing, contributing to, or aggravating an illness.

6. For survivors to receive benefits in most instances there must be a finding that it is at least as likely as not that exposure to a toxic substance was a significant factor in causing, aggravating, or contributing to the employee's death.

Note: DMCs should not use any reference materials provided to them by DOE (during the existence of Part D) in any Part E claim.

II - MEDICAL ISSUES

A. ROLE OF THE DMC

District Medical Consultants (DMCs) **assist** the DEEOIC by reviewing and evaluating the medical evidence of record and providing medical opinions regarding various aspects of selected compensation cases. DMCs do not review every case, rather medical input from DMCs is sought for selected cases identified by CEs. Such input may include:

- Causality issues involving the work relatedness of a given disease, the role of the covered illness in the death of a claimant; the appearance of secondary or consequential diseases or injuries, etc.
- The explanation of treatment modalities, the interpretation of clinical test results and the clarification of other physicians' reports.
- Determining the level of impairment in a given case in accordance with the AMA's Guides to the Evaluation of Permanent Impairment and DEEOIC's guidance.
- Assessing an individual's ability to work.

Ideally the medical opinion should be provided by a qualified physician with expertise in treating, diagnosing or researching the illness claimed to be caused or aggravated by the alleged exposure.

The DMCs' medical reports are evidence that enable the program's claims examiners (CEs) to reach adjudication decisions regarding causality, and/or impairment in compensation cases. Because of its programmatic and legal constraints, DEEOIC expects these medical opinions to be solidly based on the facts as accepted by the CE and expressed in the Statement of Accepted Facts (SOAF) and on state-of-the-art medical knowledge. Above all, these opinions should be as objective as possible. There will be instances where the DMC will have to make a determination based upon historically incomplete, vague, or contradictory evidence. In these instances, the DMC will have to accept the facts as provided by the CE and formulate a medical opinion based upon what is provided. It should be noted that the DMC's opinion, while critically important, is one of many pieces of evidence that is considered along with the totality of evidence in the case file.

B. CAUSATION

1. One of the major roles of the DMC is to provide the program with reports and opinions regarding causation. According to the program's legal requirements, a case can be accepted if the evidence in a particular case shows that there was a plausible relationship between the exposure at the workplace and the employee's illness or, in some cases, death.

DMCs may be asked to render their opinions regarding the causality of the specific occupational illnesses noted in Part B, including chronic beryllium disease, beryllium sensitivity and chronic silicosis. The statute provides specific diagnostic criteria for these conditions as well as the minimum

duration of employment and latency. Causality for covered radiogenic cancers is determined by a process of dose reconstruction as performed by NIOSH.

DMCs may also be asked their opinions regarding causality and impairment for covered illnesses noted in Part E. Clinical guidance regarding case definitions for some key conditions is found in E-500 (see, for example, Exhibit 2). Impairment determinations are made by specially qualified DMCs who will utilize the evaluation process set forth in the AMA's Guides to the Evaluation of Permanent Impairment.

2. Legal Standards of Certainty and Concepts

There is a wide range of legal standards and concepts for judging certainty depending on the specific venue (e.g., criminal convictions, arrests, searches, police stops, a range of administrative or civil actions, etc.). These range from:

a. Highest - beyond a reasonable doubt (e.g., used to determine guilt in criminal cases);

b. Clear and convincing evidence (e.g., used in special civil cases such as commitment determinations);

c. Mid – preponderance of evidence (usual standard in civil cases and usually means more likely than not)[1];

d. Low - reasonable suspicion[2];

e. Lowest - mere suspicion (hunch).

In the EEOICP the causation standard for Part E seems to fall between level c and d (above).

Specifically, under Part E of the EEOICPA, the criteria for a covered illness requires, in part, that "it is at least as likely as not that exposure to a toxic substance at a [covered] facility was a significant factor in aggravating, contributing to, or causing the [illness]."[3]

3. Cause, Contribute, Aggravate

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[1] For reasonable doubt, clear and convincing, and preponderance cite to *McCormick on Evidence*, sections 339-341 (K. Broun. ed. 6th ed West 2006).
[2] For probable cause and reasonable suspicion cite La Fave, et al, Criminal Procedure, sec 3.3 and 3.9(4th ed West 2004).
[3] 42 USC 7385s-3(a)(1)(B)

In establishing this relationship and developing the report, the DMC should take into consideration the following:

The program recognizes three types of causation: direct causation, contribution and aggravation.

a. Direct causation refers to a clear, linear, one-on-one relationship between the exposure and the illness or death in the absence of other diseases or conditions. A classic example of this type of causation is:

> A 67 year old male who never smoked worked at a covered DOE facility for 40 yrs where he was exposed to asbestos as a pipe fitter for a period no less than 15 years, beginning at age 30. He retired at age 65 and was in good health until age 67 when he developed a mass in the right upper lobe of the lung which was diagnosed as a poorly differentiated squamous cell carcinoma. A lobectomy was performed but the patient died 24 hours post surgery.

In this example, the only condition identified was the squamous cell carcinoma and the duration, intensity and latency of the asbestos exposure was likely sufficient to produce the carcinoma. Clinical literature amply supports such a relationship.

b. Contribute. The statute doesn't limit or restrict workplace exposure(s) as the "sole cause", "exclusive cause", "only cause", "primary cause" or the "sufficient cause". Workplace exposure(s) can contribute to an increased risk of illness, progression or acceleration (that "hasten") of the adverse outcome. A contributing cause may 1) increase the likelihood of suffering or harm, or 2) result in the earlier onset of a condition (hastening).

Two examples follow:

> Mr. B., a 56 year old male, worked at DOE facilities for 20 yrs as a heavy equipment operator and had extensive exposure to diesel fumes. He also smoked 1 pack/day for 20 years and now files a claim for COPD (chronic obstructive pulmonary disease).
>
> Mr. C., a 69 year old male, worked at a covered facility for 3 years. Beginning at age 30, he was a sheet metal worker and was exposed to asbestos. He was a heavy smoker with a 50 pack-year history of cigarettes. He claims his lung cancer, diagnosed at age 67, was related to his work as a sheet metal worker.

These cases exemplify how workplace exposure(s) may contribute to an illness, even though workplace exposure(s) might not be the sole or exclusive cause of the condition. In these cases the challenge is to determine if workplace exposures: 1) may have increased the risk of the claimed condition, or 2) may have hastened the onset of the condition.

c. Aggravation can be defined as the worsening of a previously existing disease, condition or physical impairment by a workplace exposure or event. Consider whether workplace exposure(s) worsen, intensify or exacerbate symptoms, increase the clinical severity or clinical complications or lead to adverse outcomes of a pre-existing condition. Also consider whether workplace exposures "light up" or activate a condition that may have remained latent or inactive (e.g., TB).

Examples of aggravation include: a) increased frequency or severity of asthmatic attacks resulting from exposure to workplace chemicals, b) greater liver damage resulting from workplace exposure to solvents in a worker with mild liver damage who is a recovered alcoholic.[4]

In these cases, the DMC should consider and explain in his/her report whether it was at least as likely as not that the claimant's workplace exposure(s) was a significant factor in aggravating the employee's illness or death.

An example of aggravation is as follows:

> Mr. D's claimed illness of asbestosis was accepted by the district office to have been caused by his employment at a DOE site. Mr. D, a 65 y/o man, died in 2004 and his death certificate mentions cardiopulmonary arrest, coronary artery disease, ischemic cardiomyopathy and congestive heart failure as the reasons for his death. Multiple notes from treating physicians indicate that from 2000-2004 Mr. D was diagnosed with asbestosis, developed several episodes of pneumonia and suffered from severe dyspnea at rest. He received supplemental O_2 and several medications including bronchodilators. PFTs (pulmonary function studies) were increasingly abnormal in 1996, 1998 and 2002.

In this case, the claims examiner may be asking the physician whether Mr. D's congestive heart failure and ischemic cardiomyopathy were aggravated by his accepted condition of asbestosis. It is apparent from the medical evidence that Mr. D suffered from cardiac disease and that this led to his demise. However, it is also apparent that asbestosis played

[4] For more examples of aggravation see, for example, "A guide to the work-relatedness of disease" pp 15-20 – NIOSH 1979

a significant role in his clinical course. Asbestosis is a chronic, progressive lung disease that impedes or restricts the intake of O_2 and its passage through the lungs to the blood stream. In Mr. D, this process was made obvious by the severe changes in the 1996 and 1998 PFTs. In turn, these abnormalities worsened the hypoxia (low oxygen) at the level of the cardiac muscle fibers which gave rise to the ischemic cardiomyopathy and contributed to its inexorable progression.

4. Consequential Conditions

In addition, the program accepts as work-related a condition, disease or injury that arises as a consequence of a condition previously accepted by the program. In some cases, the DMC is asked to provide a causal link between the two conditions. Neither the fact that the illness manifests itself after the accepted covered illness was diagnosed, nor the belief of the claimant that the illness was caused by the accepted covered illness, is sufficient in itself to prove a causal relationship.

Generally, consequential illnesses and injuries fall into the following categories: recognized complications of the disease accepted by the program, complications of the treatment for the accepted condition, and injuries or diseases arising from unforeseen occurrences when the claimant is seeking or undergoing medical treatment for the accepted condition. Classic examples of consequential illnesses and injuries include: the development of pulmonary hypertension in a case of COPD; the development of osteoporosis and hypertension because of the long term use of steroids to treat chronic beryllium disease; and a traumatic fracture of the distal tibia and fibula which occurred upon falling on the sidewalk while walking to the doctor's office.

5. Framework: Basic Elements to Determine Causality - 5 steps

Address the specific questions posed by the CE and consider the following 5 steps:

a. Exposure. The CE will make sure that the claimant is a "covered worker" by documenting employment. For Part E, for example, eligible claimants are limited to DOE contractors, subcontractors, certain workers covered by sections of RECA, and certain survivors. The CE will check for "possible", "potential" or documented exposures and may utilize available records, including but not limited to:

- Records regarding specific work-sites;
- Known exposures for specific job titles or work areas;
- Industrial hygiene or other monitoring data (e.g., medical monitoring records);
- Plant records (e.g., incident or accident reports);
- The site exposure matrices (SEM); and/or

- Consultations with the EEOICP's specialists in industrial hygiene and/or toxicology.

In addition, at the time a claim is filed, the worker or survivor is asked to complete an Occupational History Questionnaire.

Consider the "nature, frequency and duration of exposure" as well as the intensity and route of exposure if this information is available. Given the need to rely on historical data, the complete and specific information regarding all aspects of exposure may not be available. The question may require you to rely on "accepted" facts as found in the statement of accepted facts (SOAF).

The regulations note, "Proof of exposure to a toxic substance may be established by the submission of any appropriate document or information that is evidence that such substance was present at the facility in which the employee was employed and that the employee came into contact with such substance." "The OWCP site exposure matrices may be used to provide probative factual evidence that a particular substance was present at either a DOE facility or RECA section 5 facility."

b. Health Effect (Outcome). Consider the claimed health condition. Medical evidence as found in medical records, including hospital and clinic records, lab tests and imaging reports may be provided. Complete specific medical information may not be available and you may have to rely on less than perfect information to infer a diagnosis or clinical condition (e.g., from death certificates).

Guidance regarding covered diseases and illnesses and disease criteria for case definitions are specified in program regulations, bulletins and manuals for various conditions including, but not limited to:

1. Specified cancers
2. Chronic Beryllium Disease (CBD) – based on year of diagnosis (the statutory criteria for CBD under Part B do not apply to Part E)
3. Beryllium sensitivity
4. Chronic Silicosis
5. Asbestosis
6. Pneumoconiosis
7. COPD
8. Other conditions (see Exhibit 2, E-500)

c. Plausible Linkage. Consider the "plausible" connection between workplace exposure(s) and the claimed health outcome, based on the facts of the case. The program does not require 100% certainty, rather the conclusion of work-relatedness turns on the plausibility of the exposure/disease association.

Evaluating work-relatedness should be "evidence-based", grounded in scientific evidence, when available. Identifying and evaluating scientific evidence most often requires a review of the current epidemiologic literature regarding:

- The health effects of relevant occupational groups;
- The health effects of the claimed or established toxic exposures; and
- The known epidemiologic characteristics of the claimed illness.

Due diligence required to draw a conclusion regarding the plausible existence of an association between workplace exposures and the claimed illness will generally require a review of the current peer-reviewed literature on the specific topic. Due diligence (taking due care) will often require a search using the National Library of Medicine data-base (www.pubmed.gov) as well as:

- A review of the key journal articles identified by the pubmed search (a review of abstracts is not sufficient).
- A review of the relevant authoritative textbooks.
- A review of professional society and government agency opinions, reports and guidelines.[5]

d. Judge Each Causal Element. Make individual determinations based on the totality of the evidence. Weigh the available evidence for each causal element including:

- "Cause" – "direct cause", "the cause", "sufficient cause";
- "Contribute" – consider increased risk or harm, or hastening;
- "Aggravate" – consider impact on the clinical severity (i.e., worsening) of a pre-existing condition.

Except in unusual situations it is almost always impossible to determine which person's disease was caused by a workplace exposure with 100% certainty.[6] Most diseases have multiple causes and each person may also be exposed to multiple exposures or may have other risk factors for the condition. While epidemiologic data may provide guidance for evaluating the risk of groups, individual determinations often rely on an expert opinion because of the methodological complexity, compounded by imperfect knowledge and incomplete evidence.

Consider any unusual features of the clinical condition including, but not limited to:

- The clinical course (e.g., rapid progression, aggressive disease, unusual pathology);

[5] See Section IV below for additional references and resources for DMCs.
[6] Samet JM: Improving Presumptive Disability Decision-making for Veterans. NAS, Washington, DC 2008

- Age at onset (e.g., early age of onset);
- Rarity of the condition in the general population;
- The known clustering or likelihood of occurrence among workers similarly exposed;
- Latency – note specific program criteria and any unusual patterns;
- The possibility of interaction arising from multiple exposures.[7]

e. Consider Alternative Explanations. Weigh the likelihood that other factors may have caused, contributed or aggravated the clinical condition including genetic susceptibility, life-style factors or non-occupational exposures.

Suggestion: Consider the plausibility of the purported association between the exposure and outcome and then consider if the plausibility meets the "at least as likely as not" threshold.

6. Selected Knotty Issues in Causation

- People differ substantially in their response to noxious exposures.

- Many diseases of occupational origin are multifactoral (multicausal), with non-occupational and occupational factors playing contributory roles.

- The clinical and pathologic expression of most occupational diseases are indistinguishable from those of non-occupational origin.

a. Duration of exposure intensity and latency. It is acknowledged that brief and intense exposures can be associated with adverse health effects, for example, accidental inhalations.

In general, there is no known threshold for many carcinogens.

Latency may be shortened by more intense or higher cumulative exposures.

The program provides some guidance for the minimum duration of exposure and latency for specific medical conditions.[8]

b. Smoking and Workplace Exposures. A history of smoking does not negate the role of workplace exposures in making a supportive determination.

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[7] Samet 2008.
[8] See, PM E-500 Exhibit 2.

The American Thoracic Society (ATS) statement on the Occupational Contribution to the Burden of Airway Disease (2003) notes: "Despite the difficulty of disentangling the effects of cigarette smoke from those of other exposures, an increasingly impressive body of scientific literature is available demonstrating that specific occupational exposures contribute to the development of COPD." p 788.[9]

"Overall, the magnitude of effect of occupational exposures appears consistent with that of cigarette smoking." P 788.[10]

Henrick notes (Thorax, 1996) that only 15-20% of smokers actually develop COPD. "There is evidence, however, that when smokers additionally work with noxious respirable agents, COPD occurs with unusual frequency and/or severity."
This "...indicates interaction between smoking and working environment."[11]

7. DMC Check-list

The most common problems with DMC reports fall into the following 5 categories:

1. The reports don't answer the specific question that was posed and/or the exact language used in the program was not used.
2. The correct causal criteria were not used.
3. Rationale is incomplete, vague, inconsistent, inaccurate or not well developed.
4. No references were provided to support the rationale.
5. Reports were not timely.

DMC reports must:

- Address the specific question(s) posed in the request.
- Use the specific language used by the DEEOIC
- Provide a fully developed ("fully rationalized") report.
- Perform a search of the relevant peer-reviewed literature.

In an effort to improve the quality of DMC reports consider the following check-list before submitting your report:

1. Have I answered the specific questions posed?
2. Have I used the specific program criteria?

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[9] ATS: American Thoracic Society Statement: Occupational Contribution to the Burden of Airway Disease. Am J Resp Care Med 167:787-797 2003. Found at http://www.thoracic.org/sections/publications/statements/pages/eoh/burden1-11.html.
[10] Id.
[11] Hendrick DJ. Occupation and chronic obstructive pulmonary disease (COPD). Thorax 51:947-955 1996.

3. Have I considered each aspect of causation: "cause", "contribute" and "aggravated"?
4. Is the rationale fully developed?
5. Have I performed a literature search to assure due diligence?
6. Have I included supportive references?
7. Have I submitted my report within the 21 day time frame?
8. Have I signed the conflict of interest statement?
9. Have I clearly stamped the report "medical confidential"?

III - ADMINISTRATIVE ISSUES

A. DMC QUALIFICATIONS

Physicians working as DMCs must have a valid medical license on record with the program and must be currently certified by one of the American Medical Boards. Because of its claimant population, the program frequently utilizes physicians with expertise in pulmonology, oncology, hematology, neurology, and other internal medicine specialties as well as occupational medicine.

To perform impairment ratings for the program, a physician must also meet at least one of the following criteria: certification by the American Board of Independent Medical Examiners (ABIME); certification by the American Academy of Disability Evaluating Physicians (AADEP); or possession of the requisite professional background and work experience to conduct such ratings. Documentation in support of the above criteria is gathered by DEEOIC National Office when evaluating a physician for participation in the District Medical Consultant program. The DEEOIC National Office maintains current licensure and Board certification data, and physicians selected as DMCs are responsible for updating this information as needed.

B. REFERRALS

1. Sources of referrals

DMCs receive referrals from the DEEOIC district offices located in Jacksonville, FL; Cleveland, OH; Denver, CO; and Seattle, WA. Each district office employs a Medical Scheduler, who has the responsibility to process and track all DMC referrals and to ensure prompt payments of bills. There is also a National Office Coordinator who maintains a DMC database and works with the district offices to assign case referrals.

The Medical Schedulers are:

District Office 1 – Jacksonville, FL (877) 336-4272
John D. Shepard: 904-357-4795 x74143 ShepardIII.John@dol.gov

Back-up: Athanase Jones: 904-357-4795 x74467;
Jones.Athanase@dol.gov

District Office 2 – Cleveland, OH (888) 859-7211
Terri Hlad: 216-802-1306; hlad.terri@dol.gov
Back-up: Angelito Gregorio: 216-802-1304; gregorio.angelito@dol.gov

District Office 3 – Denver, CO (888) 805-3389
Norma Johnson: 720-264-3175; johnson.norma@dol.gov
Back-up: Eudocio Garcia: 720-264-3092; garciajr.eudocio@dol.gov

District Office 4 – Seattle, WA (888) 805-3401
Edith C. Adekoya: 206-373-6729; adekoya.edith@dol.gov
Back-up: Gordon Alton: 206-373-6787; alton.gordon@dol.gov

The National Office Coordinator is Jewel Pearson, who can be reached at (202) 693-0214 or via email at Pearson.Jewel@dol.gov

2. Types of DMCs

In general, there are two types of DMCs providing case reports, those who actually come to the district offices to perform the reviews, and those who review claims outside of the office. Although the cases referred to both types of DMCs are similar, the referral process and timetables are different.

3. Referral process.

a. Referrals to a DMC who visits a district office. The particular district office and the DMC agree upon the frequency of visits and the timeline for completion of reports based on the number of case files available for review. However, in-house DMCs are generally expected to submit their reports within 21 days.

b. Referrals to a DMC outside the district office. Referrals are distributed on a nationwide rotational basis by specialty or expertise and availability. For this reason, it is important that DMCs notify the National Office Coordinator whenever he or she will not be able to accept cases for a period lasting two weeks or longer.

i. Upon receipt of a referral from a claims examiner (CE), the Medical Scheduler in the district office contacts the National Office Coordinator to obtain the name of the next DMC in the rotation. The Medical Scheduler sends the referral package to the DMC. Referral packages are always express mailed.

ii. The DMC has 21 days from the date of receipt of the referral package to return a completed report accompanied by a bill to the Medical Scheduler in the responsible district office. The DMC should always use the return express mail envelope provided by the Medical Scheduler.

iii. The DMC keeps the case information provided in the referral package in a secure location and maintains confidentiality regarding the personal information contained in these documents. When the report is accepted by the district office and the DMC receives payment, he or she should destroy the case materials by the use of a shredder or burning if shredding is not an option. It is expected that this period will not be longer than 30 days.

iv. If the district office determines that the report submitted by the DMC is not properly responsive to the questions posed, is incomplete or incorrect, the District Director or CE may return the report and request the DMC to provide an additional report to correct the situation. The DMC should provide the additional report within 15 days of receipt of this request.

4. Contents of referral package.

To obtain a medical opinion, the DEEOIC district offices will forward the following material to the DMC:

a. A completed DMC referral form. This form is placed on top of the referral package from the district office.

b. The medical evidence. The district office will forward all pertinent medical reports contained in the case file to the DMC.

c. The Statement of Accepted Facts (SOAF). The SOAF contains the structural limits of the case. The DMC cannot consider data that are not in keeping with this document. For this reason, it is of vital importance that the SOAF be complete and correct. If the DMC believes that the SOAF is incomplete or finds information in the case file that is contradicted in the SOAF, he or she should discuss these issues with Medical Scheduler before proceeding with the review. If the Medical Scheduler is unavailable, or if s/he cannot answer the specific questions, then the DMC should contact the claims examiner. Keep in mind, however, that where there is conflicting factual information, the claims examiner is responsible for deciding the facts that are accepted.

Cases involving toxic exposures and related diseases where the CE asks causation questions but the SOAF fails to identify the chemical

substances to which the claimant was exposed, should be returned to the district office for clarification.

d. The questions to be addressed by the physician. The DMC must answer all the questions posed by the claims examiner using his/her medical rationale when providing an opinion. When appropriate, the DMC should reference any reference materials, tables, charts, and page numbers to substantiate any conclusions. Keep in mind that the DMC's responses should be easily understood by a lay person without the need for further clarification and/or interpretation. The amount of reference material documented in the report is at the discretion of the DMC.

e. A Form OWCP – 1500 for billing purposes. The district office will include a partially completed Form OWCP- 1500 for use when billing for services rendered. Section IV (Fees and Billing) provides additional discussion on billing.

f. An addressed express mail envelope. The DMC should use the provided express mail envelope to return his/her report and bill.

g. Return case immediately if not qualified. The DMC should contact the medical scheduler and return the case immediately if the referral is inappropriate. Inappropriate referrals include cases that:

1) May not be within the DMC's clinical specialty;
2) Where an impairment rating is required and the DMC is not qualified to perform impairment ratings; or
3) When the DMC rnay have a conflict of interest.

h. Communicating with the MS and CE. If the DMC has questions regarding the case, s/he should contact the medical scheduler (MS). If the medical scheduler is unable to answer the DMC's question, the DMC should contact the CE. The MS and CE should document all communications with the DMC in writing.

C. DMC REPORTS

DMC reports must be typed and contain the physician's name, signature, address, phone number and state medical license number.

Because of its importance, the medical report should be clear and convincing to medical and non-medical personnel. It should follow a logical progression from premise to evidence and conclusions, leaving the reader clear on what was said and convinced of the conclusions. It should be thorough and well rationalized. In writing a report, the DMC should use the following outline:

1. Case Identification. The DMC should identify the case using the name and case number of the employee. In addition, the conditions or diagnoses accepted by the program (if any) should be mentioned. This information is found in the SOAF.

2. Clinical history or summary. The DMC should include a brief clinical summary of the case based on the medical evidence on file and the SOAF.

3. Response to the CE's Questions. The DMC should write the opinion clearly, explaining complex medical terminology, using only standard abbreviations and defining any abbreviations used. When the CE asks more than two questions, it would be very helpful if the DMC numbers and answers each question separately.

4. Conclusions. The responses to the CE's questions almost always involve medical conclusions. Such conclusions should be developed from the available medical data in a logical, step-by-step manner and written in a fashion that allows a non-medical staff person to follow the DMCs reasoning. In addition, conclusions should be as definite as possible, given the available data. The physician should avoid such terms as "perhaps", "rule out", etc. If the medical evidence is insufficient to reach a more definitive conclusion, the DMC should ask the CE to request additional medical information from the claimant or the treating physician. The DMC should ask the CE for specific reports or information.

5. The use of references. The DMC should cite published studies to make a point or support a conclusion. When doing so, the DMC should be aware that saying "according to current medical literature..." is not sufficient. (See also section II.B.5 Framework – Basic Elements to Determine Causality – 5 steps, above). In addition to such a phrase, the physician should include some specific references in the body of the report or in a separate list of references. Modern Language Association (MLA) citation style can be used to reference the pertinent medical literature. In addition, the DMC should reference all documents used in decision making, either in the text of the report or in a separate list.

6. Signed Potential Conflicts of Interest Statement

Each DMC report must include the following certification regarding potential conflicts of interest:

> "I certify that I am an expert in the required areas of medical expertise for the issues raised in this case and this is my objective medical opinion provided in accordance with the DEEOIC program procedures and guidelines. I also certify that I neither have now, nor have had in the past, any relationship with the claimant, his/her physicians, their attorneys,

representatives or any employee, employer, manufacturer or entity that may be connected with this case that would influence my opinion in any way. I also certify that my opinion was not influenced by any financial consideration that may benefit me, my family or my heirs".

D. FEES AND BILLING

1. Fees. The billing arrangement and other issues regarding the agreement between the OWCP and the DMC are outlined in the Memorandum of Agreement (MOA). As stated in the MOA, the program's basic fee for review of the file and a narrative medical report is $300 per hour (see Table 1 at the end of this section). The program does not reimburse for the costs associated with creating the report, such as typing, and computer maintenance expenses, or basic professional expenditures (i.e. travel to medical conferences, license costs, etc.).

The program has established 8 hrs and $2400 as limits for a case review with the understanding that most of the reviews will be completed in well under 8 hours. However, the program also recognizes that the review of a particularly complex case may require additional time and effort. Upon receipt of a case review and bill in the district office that exceeds the program limits, the Medical Scheduler will refer the materials to the District Director for review. The District Director may approve or deny the additional amount based on the degree of complexity of the case, the comprehensiveness of the report and the extent of the research performed by the DMC. If the District Director approves the additional fee; he or she instructs the Medical Scheduler to forward the bill to the Bill Processing Agent. If the District Director does not approve the additional fee, only the program's maximum of $2400 will be paid. Most reviews should be completed in 1-3 hours.

2. Billing. The DMC completes the partially completed OWCP-1500 billing form supplied by the Medical Scheduler for each case reviewed. This form should be returned to the district office along with the medical review. Bills containing errors or omissions will be returned to the DMC for correction.

The following instructions may assist the DMC in correctly completing the OWCP-1500:

- Complete block 24A with the dates of service (month, day and year);
- Complete block 24F with the amount billed (total charge);
- Complete block 24G with the number of time units spent on the case. Each time unit is 15 minutes. (See Table I to translate the time spent into units);
- Complete block 25 with your Federal Identification Number (FIN) or Social Security Number (SSN) and check the appropriate block. Use

the same ID number that was used to enroll as a medical provider with the program;

- Complete block 28 with total billed amount (same as block 24F);
- Complete block 30 with balance amount due (same as block 28);
- Complete block 31 with signature and date;
- Complete block 33 with name, address and 9 digit ACS provider number (9 digit provider enrollment number).

3. Unresponsive, Incomplete or Deficient Reports. As stated in the MOA, "If the District Director determines that a report from a physician is not properly responsive to the questions posed, is incomplete or incorrect, the District Director may return the case file for a rework to the physician for correction at no additional cost to the government." Correction of an unresponsive, incomplete or deficient report should be promptly submitted, no later than 15 days after notice. If the corrected report is deemed unresponsive, incomplete or deficient the government may withhold payment for any billable units related to the case.

Note: If the tirne spent and dollar amount payable is greater than $2400 the OWCP-1500 must contain more than one service line. For example, if the total amount payable for the review is $3000, the bill should contain two service lines with the same date(s) of service. The first service line should include procedure code FR001 (case file review in 15 minute increments – maximum of 32 units) in block 24D with the dollar amount listed as $2400 in block 24F along with the number 32 listed in block 24G. The second service line should use procedure code FR002 (Supplement code for case file review) in block 24D with the additional amount of $600 listed in block 24F along with number 2 listed in block 24G. The total amount of both service lines should be listed in block 28 and block 30.

TABLE 1

Translation of Time Spent into Units and Dollars

Time	Units	Dollars
15 min	1	$75.00
30 min	2	$150.00
45 min	3	$225.00
1 hour	**4**	**$300.00**
1 hr 15 min	5	$375.00
1 hr 30 min	6	$450.00
1 hr 45 min	7	$525.00
2 hours	**8**	**$600.00**
2 hrs 15 min	9	$675.00
2 hrs 30 min	10	$750.00
2 hrs 45 min	11	$825.00
3 hours	**12**	**$900.00**
3 hrs 15 min	13	$975.00
3 hrs 30 min	14	$1050.00
3 hrs 45 min	15	$1125.00
4 hours	**16**	**$1200.00**
4 hrs 15 min	17	$1275.00
4 hrs 30 min	18	$1350.00
4 hrs 45 min	19	$1425.00
5 hours	**20**	**$1500.00**
5 hrs 15 min	21	$1575.00
5 hrs 30 min	22	$1650.00
5 hrs 45 min	23	$1725.00
6 hours	**24**	**$1800.00**
6 hrs 15 min	25	$1875.00
6 hrs 30 min	26	$1950.00
6 hrs 45 min	27	$2025.00
7 hours	**28**	**$2100.00**
7 hrs 15 min	29	$2175.00
7 hrs 30 min	30	$2250.00
7 hrs 45 min	31	$2325.00
8 hours	**32**	**$2400.00**

E. MISCELLANEOUS

1. Confirmation of payments. Payments for DMC services are processed by the Treasury every week and the paid amounts are forwarded electronically to the account number provided by the DMC. In addition, the Bill Processing Agent sends out the Remittance Voucher (RV) which contains a record of all the bills paid and denied during the payment cycle. Questions regarding payments should be referred to the Medical Scheduler in the district office responsible for the case.

2. Provider enrollment. DMCs must enroll as providers with the program's Bill Processing Agent to receive payment for services rendered. Enrollment information is included in the materials sent when the physician is accepted as a DMC. The National Office Bill Payment Manager, Sharon Hill, may assist in completing the enrollment process. Ms. Hill may be reached on (202) 693-0457 if there are questions or concerns with the enrollment process or if there are any billing issues, address changes or banking information changes that the Medical Scheduler is unable to resolve.

3. Confidentiality and Security of files. As stated in the MOA, the claimant's personal information is protected under the Privacy Act. The Privacy Act not only obliges us to protect their information, but provides for civil and criminal penalties (against organizations and individuals) for not doing so. This information includes medical data as well as the protected personally identifiable information (PII) such as name and Social Security number. The DMC must handle the documents provided in the referral in the manner described in the MOA and in accordance with the OWCP policy that updates and formalizes the responsibilities of every OWCP federal and contracted staff member's responsibilities in protecting PII.

The policy is found at:

http://esa/owcp/Bulletin/OWCPBULLETIN08-2.pdf

The DMCs must destroy the case materials once the report is accepted. Paper files need to be shredded and under no circumstance should they be discarded whole. All electronic records are to be deleted. In addition, the information contained in the files is the property of OWCP, and DMCs cannot use or publish this information without the consent of OWCP.

DMCs must take all necessary measures to assure that confidential information is maintained in a manner that ensures its privacy including, but not limited to:

a. Stamp or watermark all identified reports as "Medical Confidential";
b. Maintain all records in a secure location.
c. Utilize passwords and encryption to limit access to computerized documents.

d. Return or destroy all records or materials containing personally identifiable information after you have completed your review.
e. Use trackable carriers when sending medical records or reports.
f. Do not copy records with personally identifiable information.
g. Report any breach of confidentiality to Jerry Delo (Chief, Branch of ADP Systems) at 202-693-0192.
h. Assure that the information provided shall only be used for the intended purpose as provided by the EEOICPA and shall not be shared or disclosed to any person or entity outside the DEEOIC.
i. PII shall not be communicated by email. Information containing or referring to PII should be faxed using a "Medical Confidential" cover page.

4. Terminations. The DMC agreement may be cancelled by either party for any reason upon thirty (30) days' written notice and the return of all OWCP materials by the DMC. Reasons for termination of the MOA by OWCP include, by are not limited to, situations when:

- The DMC consistently provides reports that are late and/or incomplete and/or unresponsive to the CE's questions.
- The DMC consistently bills excessive amounts.
- When a breach of the Privacy Act is noted.
- The DMC loses his/her license for cause or is debarred from participation in other Federal programs, such as Medicare or the VA.
- The DMC does not provide documentation of up to date credentials.
- The DMC fails to disclose potential conflicts of interest.

5. Credentials

DMCs are responsible for assuring that their credentials are up to date.

Current copies of the following information must be on file with the DEEOIC:

- State Medical License
- Board certification status
- Certification status for impairment evaluations
- Malpractice, Lawsuit, Adverse License Actions (submit all information)

The DEEOIC may require additional documentation regarding the DMC's education, past employment and/or hospital affiliations. The DEEOIC may review periodic reports on DMCs from the National Practitioner Data Bank.

IV - Selected Resources for DMCs

A. Procedure Manual – Part E-600 (DEEOIC website); Exhibit 2, E-500

B. Selected DEEOIC Bulletins

- Bulletin 2-04, Rectal Cancer;
- Bulletin 2-15, Chondrosarcoma of the cricoid cartilage of the larynx as a specified primary cancer;
- Bulletin 2-16, Uterine cancer as a specified primary cancer;
- Bulletin 2-28, Tonsil cancer;
- Bulletin 3-32, Certification by NCI of Certain Primary Cancers;
- Bulletin 6-13, Establishing causation for specific medical conditions under the Program – attachment 1 lists minimum duration of employment and latency for presumption of causation for selected conditions such as asbestosis, mesothelioma, laryngeal cancer, hemangiosarcoma and leukemia;
- Bulletin 8-15, Adjudication of Part E Claims for Parkinsonism.

C. Selected web-sites

1. National Library of Medicine

   http://www.pubmed.gov

2. ATSDR Toxicological Profiles

   http://www.atsdr.cdc.gov/toxpro2.html

3. National Toxicology Program (NTP) – Report on Carcinogens (RoC)

   http://ntp.niehs.nih.gov/?objectid=EF215565-F1F6-975E-7BEF7505A220D573

4. International Agency for Research on Cancer (IARC) – List of all agents evaluated

   http://monographs.iarc.fr/ENG/Classification/crthallalph.php

5. NIOSH

   http://www.cdc.gov/niosh/pubs/type.html

   Criteria Documents

   http://www.cdc.gov/niosh/pubs/criteria_date_desc_nopubnumbers.html

   Current Intelligence Bulletins

http://www.cdc.gov/niosh/pubs/cib_date_desc_nopubnumbers.html

6. OSHA

http://www.osha.gov/html/a-z-index.html#B

7. Toxnet – Toxicology Data Network

http://toxnet.nlm.nih.gov/

8. Hazmap

http://hazmap.nlm.nih.gov/

http://www.haz-map.com/

Brown, JA. "An internet database for the classification and dissemination of information about hazardous chemicals and occupational disease." Am J Ind Med 51:428-435, 2008.

D. Selected Textbooks

Textbook of Occupational and Environmental Medicine. Linda Rosenstock, Mark Cullen, Brodkin & Redlich
Saunders-Elsevier 2nd ed. 2005.

Environmental and Occupational Medicine. William Rom & Steven Markowitz. Lippincott 4th ed. 2006.

E. American Thoracic Society Position Statements

Found as PDF documents at:
http://www.thoracic.org/sections/publications/statements/pages/eoh/burden1-11.html

1. "The Occupational Contribution to the Burden of Airway Disease"
Am J Resp Crit Care Medicine 167:787-797 2003.

2. "The Adverse Effects of Crystalline Silica Exposure"
Am J Resp Crit Care Medicine 155:761-765 1997.

3. "Diagnosis and Initial Management of Non-malignant Diseases Related to Asbestos"
Am J Resp Crit Care Medicine 170:691-715 2004.

V – Selected Terms

Consequential illness or condition occurs as a result of, or treatment of, an accepted covered condition. A consequential illness or condition requires an accepted primary condition as well as medical evidence of a causal connection between the consequential condition and accepted covered condition. The mere fact that an illness arises subsequent to the acceptance of a covered condition is insufficient unless there is an obvious link. Examples may include conditions secondary to radiation therapy (burns, radiation pneumonitis, depression, diabetes, osteoporosis, hip fractures, chronic pain, secondary primary cancer, metastatic cancer, etc).

Toxic substance means "a material that has the potential to cause illness or death because of its radioactive, chemical, or biological nature".[12]

Sample DMC Reports

Sample 1 – Asbestos and Mesothelioma

Sample 2 – Smoking, Asbestos and COPD

[12] 20 CFR 30.5(ii).