

DEPARTMENT OF LABOR**Office of Workers' Compensation Programs****20 CFR Part 30**

RIN 1240-AA08

Claims for Compensation Under the Energy Employees Occupational Illness Compensation Program Act

AGENCY: Office of Workers' Compensation Programs, Department of Labor.

ACTION: Notice of proposed rulemaking.

SUMMARY: This document contains the changes to the regulations governing the administration of the Energy Employees Occupational Illness Compensation Program Act of 2000, as amended (EEOICPA or Act), being proposed by the Department of Labor (Department or DOL). Part B of the Act provides uniform lump-sum payments and medical benefits to covered employees and, where applicable, to survivors of such employees, of the Department of Energy (DOE), its predecessor agencies and certain of its vendors, contractors and subcontractors. Part B of the Act also provides smaller uniform lump-sum payments and medical benefits to individuals found eligible by the Department of Justice (DOJ) for benefits under section 5 of the Radiation Exposure Compensation Act (RECA) and, where applicable, to their survivors. Part E of the Act provides variable lump-sum payments (based on a worker's permanent impairment and/or qualifying calendar years of established wage-loss) and medical benefits for covered DOE contractor employees and, where applicable, provides variable lump-sum payments to survivors of such employees (based on a worker's death due to a covered illness and any qualifying calendar years of established wage-loss). Part E of the Act also provides these same payments and benefits to uranium miners, millers and ore transporters covered by section 5 of RECA and, where applicable, to survivors of such employees. The Office of Workers' Compensation Programs (OWCP) administers the adjudication of claims and the payment of benefits under EEOICPA, with National Institute for Occupational Safety and Health (NIOSH) within the Department of Health and Human Services (HHS) estimating the amounts of radiation received by employees alleged to have sustained cancer as a result of such exposure and establishing guidelines to be followed by OWCP in determining

whether such cancers are at least as likely as not related to employment. Both DOE and DOJ are responsible for notifying potential claimants and for submitting evidence necessary for OWCP's adjudication of claims under EEOICPA.

DATES: Comments on the regulations in this proposed rule must be submitted on or before January 19, 2016. Written comments on the information collection requirements in this proposed rule must be received on or before December 18, 2015.

ADDRESSES: You may submit comments on the regulations in this proposed rule, identified by Regulatory Information Number (RIN) 1240-AA08, by any ONE of the following methods:

Federal e-Rulemaking Portal: The Internet address to submit comments on the regulations in the proposed rule is www.regulations.gov. Follow the Web site instructions for submitting comments. Comments will also be available for public inspection on the Web site.

Mail or Hand Delivery: Submit written comments to Rachel P. Leiton, Director, Division of Energy Employees Occupational Illness Compensation, Office of Workers' Compensation Programs, U.S. Department of Labor, Room C-3321, 200 Constitution Avenue NW., Washington, DC 20210. The Department will only consider mailed comments that have been postmarked by the U.S. Postal Service or other delivery service on or before the deadline for comments.

Instructions: All comments must cite RIN 1240-AA08 that has been assigned to this rulemaking. Receipt of any comments, whether by Internet, mail or hand delivery, will not be acknowledged. Because the Department continues to experience significant delays in receiving postal mail in the Washington, DC area, commenters are encouraged to submit any mailed comments early.

In addition to having an opportunity to file comments on the regulations in this proposed rule, interested parties may file comments on the information collection requirements in this proposed rule with the Office of Management and Budget by mail, at Office of Information and Regulatory Affairs, Attn: OMB Desk Officer for DOL-OWCP, Office of Management and Budget, Room 10235, 725 17th Street NW., Washington, DC 20503; by Fax: 202-395-5806 (this is not a toll-free number); or by email: OIRA_submission@omb.eop.gov. Commenters are encouraged, but not required, to send a courtesy copy of their comments to the Department by

mail to Vincent Alvarez, U.S. Department of Labor, 200 Constitution Avenue NW., Room S-3201, Washington, DC 20210; by Fax to 202-693-1447; or by email to alvarez.vincent@dol.gov. In order to help ensure appropriate consideration, comments should mention at least one of the OMB control numbers mentioned in this preamble.

FOR FURTHER INFORMATION CONTACT: Rachel P. Leiton, Director, Division of Energy Employees Occupational Illness Compensation, Office of Workers' Compensation Programs, U.S. Department of Labor, Room C-3321, 200 Constitution Avenue NW., Washington, DC 20210, Telephone: 202-693-0081 (this is not a toll-free number).

Individuals with hearing or speech impairments may access this telephone number via TTY by calling the toll-free Federal Information Relay Service at 1-800-877-8339.

SUPPLEMENTARY INFORMATION:**I. Background**

The Energy Employees Occupational Illness Compensation Program Act of 2000, as amended (EEOICPA or Act), 42 U.S.C. 7384 *et seq.*, was originally enacted on October 30, 2000. The initial version of EEOICPA established a compensation program (known as Part B of the Act) to provide a uniform lump-sum payment of \$150,000 and medical benefits as compensation to covered employees who had sustained designated illnesses due to their exposure to radiation, beryllium or silica while in the performance of duty for DOE and certain of its vendors, contractors and subcontractors. Part B of the Act also provides for payment of compensation to certain survivors of these covered employees, and for payment of a smaller uniform lump-sum (\$50,000) to individuals (who would also receive medical benefits), or their survivors, who were determined to be eligible for compensation under section 5 of the Radiation Exposure Compensation Act (RECA), 42 U.S.C. 2210 note, by DOJ. Primary responsibility for the administration of Part B of the Act was assigned to DOL by Executive Order 13179 ("Providing Compensation to America's Nuclear Weapons Workers") of December 7, 2000 (65 FR 77487). On May 25, 2001, the Department issued interim final regulations (66 FR 28948) governing its administration of Part B of the Act, and issued final regulations on December 26, 2002 (67 FR 78874) that went into effect on February 24, 2003.

The initial version of EEOICPA also created a second program (known as

Part D of the Act) that 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. However, Congress amended EEOICPA in Subtitle E of Title XXXI of the Ronald W. Reagan National Defense Authorization Act for Fiscal Year 2005, Public Law 108-375, 118 Stat. 1811, 2178 (October 28, 2004), by abolishing Part D of the Act and creating a new Part E (codified at 42 U.S.C. 7385s through 7385s-15) that it assigned to DOL for administration. Part E established a new system of variable federal payments for DOE contractor employees, uranium workers covered by section 5 of RECA, and eligible survivors of such employees. On June 8, 2005, the Department issued interim final regulations (70 FR 33590) governing its administration of Part E of the Act, and issued final regulations on December 29, 2006 (71 FR 78520) that went into effect on February 27, 2007.

II. Discussion of Proposed Changes to the Regulations

A. Stakeholder Engagement

As part of the development of the proposed rule, the Department hosted a telephonic listening session during which interested parties provided their views, ideas and concerns to Departmental leadership on the provisions of the existing regulations. The Department found the listening session to be helpful and considered relevant information raised during the session in developing the proposed regulations.

B. Overview of the Proposed Rule

The Department is proposing to amend certain of the existing regulations governing its administration of Parts B and E of EEOICPA to conform them to current administrative practice, based on its experience administering the Act since 2001, and to bring further clarity to the regulatory description of the claims adjudication process, and to improve the administration of the Act. The following discussion describes the proposed changes to the existing regulations that currently appear in 20 CFR part 30. Since some of these

proposed changes involve moving existing text to new sections, please refer to those new sections when submitting comments on the proposed changes.

Subpart A—General Provisions

The proposed changes to the regulations in this subpart involve updating the language used in certain regulations in the introduction portion of subpart A, and both expanding upon existing definitional regulations and adding new definitions that memorialize programmatic determinations.

Introduction

The Department proposes to modify § 30.1 to update the Secretary's Order reference and delete the reference to the Assistant Secretary for Employment Standards, since that position, as well as the Employment Standards Administration, no longer exists. The proposed change to § 30.2 memorializes that HHS delegated its dose reconstruction responsibilities to NIOSH in 42 CFR 82.1. Consistent with this proposed change, the Department proposes to modify several other sections of the regulations, not otherwise discussed specifically below, to replace references to "HHS" in those sections with "NIOSH."

Definitions

The Department proposes to remove the language in the definition of a *beryllium vendor* in § 30.5(i) that references DOE's periodically published list of beryllium vendors in the **Federal Register**, since DOE no longer updates that list, and replace it with a reference to the final list of beryllium vendors that DOE published in the **Federal Register** on December 27, 2002. Based on the language of sections 73841(7)(A) and 7384n(a)(2) of EEOICPA, the Department seeks to define a *beryllium vendor facility* in proposed § 30.5(j) as "a facility owned and operated by a beryllium vendor." Proposed § 30.5(k) replaces the term "medical doctor" with "licensed physician."

The Department also proposes to update the existing definition of the *Department of Energy* or *DOE* in proposed § 30.5(w) to clarify that DOE's predecessor agencies date back to August 13, 1942, which is the date that the Manhattan Engineer District was established. In proposed § 30.5(x)(2)(iii), the Department adds language to bring this provision in line with programmatic policy, which states that a civilian employee of a state or federal government agency qualifies as a *Department of Energy contractor*

employee if the agency employing that individual is found to have entered into a contract with DOE for the provision of one or more services it was not statutorily obligated to perform and DOE compensated the agency for those services, and also that the delivery or removal of goods from the premises of a DOE facility does not constitute a service for the purposes of determining a worker's coverage under the Act. Proposed § 30.5(ee) removes an ambiguity in the statute by more clearly defining the term *physician*, while proposed § 30.5(gg) simplifies the definition of a *specified cancer* by deleting the unnecessary references to "RECA" and "EEOICPA."

Further, the Department proposes to expand upon the existing definition of *time of injury* in new § 30.5(ii) by adding text explaining that the *time of injury* in a survivor's claim is the date of the employee's death. Finally, the Department proposes to add a definition for *time of payment* or *payment* in proposed § 30.5(jj) to define those terms as the date that a paper check issued by the Department of the Treasury is received by the payee or by someone who was legally able to act for the payee, or the date the Department of the Treasury made an Electronic Funds Transfer to the payee's financial institution.

Subpart B—Filing Claims; Evidence and Burden of Proof; Special Procedures for Certain Cancer Claims

The Department proposes revisions to subpart B, including changes in §§ 30.100 and 30.101 to require claimants to sign their own written claims, and in §§ 30.112 and 30.113 to codify the Department's current policy for evaluating affidavits and statements submitted by claimants as proof of an employee's work history or medical condition. In addition, the Department proposes other revisions that are described below, which update references and language used in the regulations that have changed since these regulations were last revised.

Filing Claims for Benefits Under EEOICPA

The Department proposes to amend § 30.100 to remove language in paragraphs (a) and (c)(1) allowing someone other than the employee to sign a written claim with the Department on the employee's behalf, and instead require that the employee sign his or her own claim. The same amendments are proposed in paragraphs (a) and (d)(1) in § 30.101 to require survivors to sign their own written claims. The Department believes that

this requirement will improve its communications with claimants. Also in §§ 30.100 and 30.101, the Department seeks to add the words “or other carrier’s date marking” to the current language “by postmark” to reflect changes in delivery options, and to make that same change in several other sections of the regulations not otherwise discussed specifically below. In § 30.102(a), the Department proposes to remove the superfluous term “minimum impairment rating” and replace it with “impairment rating.” The term “minimum impairment rating” is an artifact left over from an early draft of what later was enacted as Part E of EEOICPA and has no intrinsic meaning in the scheme that Congress eventually passed. Due to the level of confusion its retention by Congress has caused, coupled with the fact that it serves no actual purpose because there is no “minimum” rating that is presumed, the Department seeks to remove that word when describing an employee’s impairment rating.

Evidence and Burden of Proof

Proposed § 30.110 updates cross-references in that section. The Department proposes to amend §§ 30.112(b)(3) and 30.113(c) to remove the term “self-serving” when referring to affidavits and documents submitted to establish either covered employment or a covered medical condition. In its place, the proposed language codifies the program’s practice of evaluating all employment and medical evidence in a claim when it decides if the claimant has met his or her burden of proof under § 30.111. The Department also proposes to amend § 30.114(b) to clarify that current paragraphs (b)(1) and (b)(2) pertain to Part B, and to add paragraph (b)(3) to provide that additional medical evidence, as described in other sections of the regulations, is required to establish claims for benefits under Part E.

Special Procedures for Certain Radiogenic Cancer Claims

Proposed § 30.115(a) deletes reference to HHS’s regulation at 42 CFR 81.30, since HHS published a final rule in the **Federal Register** on February 6, 2012 to remove 42 CFR 81.30 from part 81. The proposed change to § 30.115(a)(2) deletes language stating that HHS may complete further development of the employee’s work history and that it will provide DOE with a copy of the final dose reconstruction report for an employee, since HHS does not perform either of these actions.

Subpart C—Eligibility Criteria

The proposed changes in subpart C involve revising the existing regulations to better explain how the Department evaluates medical evidence submitted to establish a claim for chronic beryllium disease under Part B, and to provide the Department’s current requirements for establishing work-related toxic exposure and a covered illness under Part E. In addition to those changes, the Department proposes minor updates to the language in this subpart, as explained below.

Eligibility Criteria for Claims Relating to Covered Beryllium Illness Under Part B of EEOICPA

Proposed § 30.205 updates cross-references in that section. The Department further proposes to amend § 30.206(a) to remove the language “a facility owned, operated, or occupied by a beryllium vendor” and to instead reference proposed § 30.5(j), which defines a *beryllium vendor facility*. Also, the Department proposes to add paragraph (d) in § 30.207 to memorialize its current practices for determining whether to evaluate an employee’s medical evidence under either the pre- or post-1993 criteria outlined in section 7384l(13) of EEOICPA.

Eligibility Criteria for Claims Relating to Radiogenic Cancer Under Parts B and E of EEOICPA

Proposed §§ 30.210 and 30.211 update the cross-references in that section. Also, the proposed change in § 30.213(a) replaces the language “the employee’s radiation dose reconstruction” with “the employee’s final dose reconstruction report.”

Eligibility Criteria for Claims Relating to Chronic Silicosis Under Part B of EEOICPA

Proposed § 30.220 updates the cross-references in that section. Proposed § 30.222 also updates the cross-reference in that section, and replaces the term “medical doctor” with “licensed physician.”

Eligibility Criteria for Other Claims Under Part E of EEOICPA

Proposed § 30.230 updates the cross-references in that section. In addition, the Department proposes to amend § 30.231(a) to explain its current practice of evaluating affidavit evidence submitted by a claimant as proof of employment in conjunction with all evidence of employment to determine if the claimant has met his or her burden of proof under § 30.111. Proposed § 30.231(b) describes sources, in addition to the Site Exposure Matrices

that are currently listed in that paragraph, that the Department considers to be reliable sources of information to establish whether an employee was exposed to a toxic substance at a DOE facility or a RECA section 5 facility. Proposed § 30.232(a) deletes the former Part D requirements for establishing a covered illness, as Congress abolished Part D and those requirements are now irrelevant. In its place, the Department seeks to add language to describe its current requirements for establishing a covered illness under Part E. Proposed § 30.232(b) updates the cross-reference in that paragraph.

Subpart D—Adjudicatory Process

The Department proposes to update the regulations in subpart D with policies that it has developed and followed since the last time these regulations were updated, and to increase both clarity and transparency in the claim adjudication process for radiogenic cancer claims filed under Part B of EEOICPA.

General Provisions

In § 30.300, the Department proposes to add language to explain that a claimant may seek judicial review of a final decision issued by FAB by filing an action in federal district court, since the current regulations do not provide this explanation.

Recommended Decisions on Claims

The Department proposes to modify § 30.306 to make recommended decisions more understandable by mandating that they include a narrative discussion of the district office’s findings of fact and conclusions of law. The Department also proposes to move the provisions in current § 30.307 to § 30.308. Proposed § 30.307(a) describes the Department’s longstanding general policy of issuing a single recommended decision to all of the survivors who filed claims under Part B and/or Part E of EEOICPA relating to the same deceased employee. Proposed § 30.307(b) explains the exception to the policy, which is that if another individual subsequently files a survivor claim for the same award referenced in proposed § 30.307(a), the recommended decision on that claim will not address the entitlement of the earlier claimants if the district office recommended that the later survivor claim be denied. No changes were made to the language in proposed § 30.308.

Hearings and Final Decisions on Claims

The Department proposes amending § 30.314(a), which currently provides a

FAB reviewer with the discretion to conduct hearings by telephone or teleconference, to also allow the FAB reviewer to conduct hearings by videoconference or other electronic means. Proposed § 30.314(b) includes new language to provide the FAB reviewer with the discretion to mail a hearing notice less than 30 days prior to the hearing if the claimant and/or representative waives the 30-day notice period in writing. The Department believes this will provide FAB with more flexibility when it comes to scheduling oral hearings. Proposed § 30.315(a) adds a provision that prohibits a claimant or representative from making more than one request to reschedule a hearing, since repeated requests to cancel and reschedule hearings have resulted in an undue burden on the claim adjudication process.

Since the beginning of OWCP's administration of Part B of EEOICPA, FAB reviewers have struggled with their regulatory obligation in existing § 30.318 to consider objections to final dose reconstruction reports that have been prepared by NIOSH during its portion of the adjudication process for radiogenic cancer claims. Currently, a FAB reviewer must decide if an objection to a final dose reconstruction report concerns the "methodology" that NIOSH used to calculate the estimated doses in the report, which cannot be considered by the FAB reviewer because it is binding on FAB, or if the objection concerns the "application" of that methodology to the individual facts of the claim, in which case it *can* be considered by the FAB reviewer. Because it can be difficult to understand the differences between these two possibilities, FAB reviewers have had varying levels of success in making these distinctions. This experience has also been frustrating for claimants, and has convinced the Department that FAB reviewers are ill-suited to address objections that concern matters within the particular scientific expertise of NIOSH.

As part of its dose reconstruction process described in 42 CFR part 82, NIOSH confers with claimants prior to finalizing a dose reconstruction report; however, information regarding those discussions is not always included in the final dose reconstruction report. NIOSH has agreed to include information regarding how it considered and addressed claimant concerns in the final dose reconstruction report it sends to OWCP, and has also agreed to make personnel available to help FAB reviewers address any objections raised while the claim is pending before FAB.

Therefore, the Department proposes to modify § 30.318(a) to describe the potential for NIOSH to be more explicitly involved in FAB's consideration of objections to final dose reconstruction reports. By making these changes, the Department will be doing away with the current limitation on the scope of objections that can be raised before FAB. The Department also proposes to clarify its obligation to consider objections to how OWCP calculates the probability of causation in new § 30.318(b). All of the proposed changes to current § 30.318 are being proposed in an effort to be responsive to concerns expressed by claimants.

Lastly, the Department proposes to change §§ 30.310(b) and 30.319(b) to reflect recent changes in how the program receives and processes mail.

Reopening Claims

Proposed § 30.320(b)(2) allows claimants to request a reopening based on new medical evidence diagnosing a medical condition. The Department believes that this will afford claimants a greater opportunity to obtain additional review of their denied claim based on new medical evidence.

Subpart E—Medical and Related Benefits

The changes to subpart E consist of clarifying the Department's policies regarding paying for the treatment of covered medical conditions. Also in subpart E, the Department seeks to make changes relating to its payment for non-physician services, and to its ability to administratively close claims when an employee refuses to attend directed medical examinations. Other minor proposed changes are discussed below.

Medical Treatment and Related Issues

The Department proposes to move language in current § 30.400(a) to proposed new § 30.400(d) in order to bring attention to its longstanding policy regarding the payment of certain medical benefits to survivors. The Department also proposes to make a number of changes to § 30.400(c). First, the Department proposes to add new language in this paragraph to explain the current qualifications that must be met before hospitals and providers of medical services or supplies may furnish appropriate services, drugs, supplies and appliances to covered employees. In addition, the Department proposes to add authority for it to offset the cost of prior rental payments against the future purchase of an appliance or supply, and to provide refurbished equipment where appropriate. Further, the Department is adding language

recognizing its existing authority to pay for durable medical equipment and modifications to a home or vehicle that it deems necessary and reasonable. Lastly, the Department seeks to codify its authority to contract with specific providers to provide non-physician services and appliances. The Department believes that providing such services in this manner may aid in delivering some types of benefits.

The Department proposes to reorganize § 30.403 into three separate paragraphs, and to better focus the section on its payment of claims under section 7384t of EEOICPA for home health care, nursing home, and assisted living services, which comprise the bulk of services of this type being provided. Proposed § 30.403(a) incorporates the descriptive text in current § 30.403 with minor modifications, and proposed § 30.403(b) describes OWCP's general requirements for payment of a claim for nursing home and assisted living services. Furthermore, proposed paragraph (c) in § 30.403 sets out the particular pre-authorization process used to file an initial claim under section 7384t of EEOICPA for home health care, nursing home, and assisted living services. The proposed changes to paragraph (c) in § 30.405 clarify the Department's policy for approving or denying an employee's request to change treating physicians.

Directed Medical Examinations

The Department proposes to amend §§ 30.410(c) and 30.411(d) to memorialize the Department's existing authority to administratively close an employee's claim when he or she refuses to attend a second opinion examination or a referee medical examination, respectively.

Medical Reports

Proposed § 30.416(a) removes language that a physician's stamp will be accepted in lieu of his or her signature on such a report, and specifies that the physician's handwritten or electronic signature should be on his or her medical report.

Subpart F—Survivors; Payments and Offsets; Overpayments

The proposed changes to the regulations in this subpart involve memorializing the Department's policy determinations relating to the definition of a "child" under Parts B and E, and the eligibility requirements for a "covered child" under Part E.

Survivors

The Department proposes to amend the first sentence in § 30.500(a)(2) to

provide the Department's policy determination that a "child" under Parts B and E of EEOICPA means only a biological child, a stepchild or an adopted child of a deceased covered Part B or Part E employee. Also, the Department proposes to move the statutory definition of a "covered child" currently stated in the second sentence of § 30.500(a)(2) to its own new paragraph in proposed § 30.500(c). Proposed § 30.500(c) further provides that a child's marital status or dependency on the covered employee for support is irrelevant to his or her eligibility for benefits as a covered child under Part E, and that *incapable of self-support* means that the child must have been physically and/or mentally incapable of self-support at the time of the covered employee's death. The above new language codifies the Department's current policy and case law. See *Watson v. Solis*, 693 F.3d 620 (6th Cir. 2012). Finally, proposed §§ 30.501 and 30.502 update the cross-references in those sections.

Subpart G—Special Provisions

The Department proposes to modify § 30.600 to clearly state that a representative does not have the authority to sign either Form EE-1 or Form EE-2, to be consistent with proposed §§ 30.100 and 30.101. Proposed § 30.601 adds language to provide that a representative must comply with the Department's conflict of interest policy. Proposed § 30.603 clarifies that a representative may charge a claimant for costs and expenses related to a claim in addition to the fee limitations specified in § 30.603(b).

Subpart H—Information for Medical Providers

The majority of changes in this subpart update the regulations to take into account the Department's electronic bill processing and authorization system. In addition, the Department seeks to modify the method by which it excludes medical providers so that the Department of Labor's Office of Inspector General (DOL OIG) is involved in that process.

Medical Records and Bills

The Department proposes to amend § 30.700 to describe, for the first time, its provider enrollment process and automated bill processing and authorization system. Proposed § 30.701(a) recognizes that the Department may withhold payment for services until the required medical evidence described in § 30.700 is provided, and clarifies that charges for medicinal drugs dispensed in a

physician's office must be reported on Form OWCP-1500 or CMS-1500.

Proposed § 30.701(b) describes the Department's existing discretion to determine which codes to use in the billing process, and to create and supply specific codes to be used by providers. Proposed § 30.701(c)(1) clarifies the Department's current billing procedures for providers to follow when submitting charges, and alerts providers that the Department may adopt the Home Health Prospective Payment System, which was devised by the Centers for Medicare and Medicaid Services (CMS) within HHS. Proposed § 30.701(d) makes clear that providers must adhere to accepted industry standards when billing, and that billing practices such as upcoding and unbundling are not in accord with those industry standards. Proposed § 30.701(e) describes the Department's current practice of rejecting a bill that does not conform to the requirements in § 30.701, after which the rejected bill is returned to the provider to be corrected and resubmitted. Proposed § 30.701(e) also makes clear the Department's policy that a bill must contain the provider's handwritten or electronic signature when required by the pertinent billing form, and removes language that a provider's stamp will be accepted in lieu of his or her signature on the bill.

The changes to § 30.702 clarify how an employee currently seeks reimbursement for out-of-pocket expenses. Proposed § 30.702(a) adds a reference to Forms OWCP-04 and UB-04 to clarify that those forms are required for reimbursement of hospital charges. In addition, proposed paragraph (a)(1) in § 30.702 provides that the Department will reject a reimbursement request if a provider does not indicate the code or a description of the service, so that the employee can correct and resubmit the required information. The Department proposes to amend § 30.702(d), which currently provides that the Department's decision regarding reimbursement to an employee for out-of-pocket expenses is final, and to instead provide that the Department will issue a letter decision in such circumstances. A claimant who disagrees with the letter decision may request a formal recommended decision and utilize the adjudicatory process described in subpart D. Lastly, the Department seeks to add paragraph (h) to § 30.702 to require that an employee submit Form OWCP-957, along with proof of payment, with a request for reimbursement for the costs and expenses specified.

Medical Fee Schedule

The Department proposes to modify § 30.705 to provide that it may require nursing homes to abide by a fee schedule, and also proposes to update the indices used to determine maximum fees in §§ 30.706 and 30.707. The Department proposes to modify the introductory text in § 30.709 to provide the Department with the authority to contract for, or require the use of, specific providers for medicinal drugs, and proposed § 30.709(a) clarifies that the fee schedule for medicinal drugs applies whether the drugs are dispensed by a pharmacy or by a doctor in his office. Finally, proposed § 30.709(c) codifies the Department's authority to require the use of generic drugs, where appropriate.

Proposed § 30.710 changes the terminology used in that section to refer to the "Inpatient Prospective Payment System" devised by CMS, instead of the obsolete "Prospective Payment System." The Department also proposes to add new § 30.711 to explain its current practice of paying hospitals for outpatient medical services according to Ambulatory Payment Classifications based on the Outpatient Prospective Payment System devised by CMS.

To accommodate the proposed addition of new § 30.711, existing §§ 30.711, 30.712 and 30.713 appear below as §§ 30.712, 30.713 and 30.714. In addition, the Department proposes to change existing § 30.711(a), which appears below as new § 30.712(a), to clearly state that the Department will not correct procedure or diagnosis codes on submitted bills. Rather, those bills will be returned to the provider for correction because the responsibility for proper submission lies with the provider. The Department also proposes to amend existing § 30.712(b), which appears below as § 30.713(b), to reflect the current process used by providers to challenge a reduction of a fee based on a fee schedule.

Exclusion of Providers

The Department proposes to amend § 30.715 by adding paragraphs (i) and (j), which set out additional, reasonable bases for excluding providers. In proposed § 30.715(i), a provider may be excluded for failing to inform the Department of any change in their provider status, and in proposed § 30.715(j), a provider may be excluded for engaging in conduct related to care found by the Department to be misleading, deceptive or unfair. Proposed § 30.716(c) also adds language to clarify that a provider may voluntarily choose to be excluded

without undergoing the exclusion process. This clarification is meant to address situations where providers agree to be excluded when a provider may be faced with criminal charges. Most importantly, the Department proposes to amend § 30.717 to provide that the DOL OIG will be primarily responsible for investigating all possible exclusions of providers. This function was previously handled by OWCP; however, OWCP has no investigatory arm and lacks resources to carry out this responsibility. The Department also proposes amending §§ 30.718 through 30.721 in order to permit the Director for Energy Employees Occupational Illness Compensation to specify the deciding official, as appropriate. Proposed §§ 30.718 through 30.721 will recognize the new role of DOL OIG in this process.

The Department proposes revising §§ 30.723 through 30.724 to modify the manner in which the administrative law judge's recommended decision on exclusion becomes final. Currently, the decision becomes final if no objection is filed, and the proposed change states that no recommended decision regarding exclusion will become final until the Director for Energy Employees Occupational Illness Compensation issues the decision in final form. Finally, the Department proposes to amend § 30.725 to add language stating that it will notify the state or local authority responsible for licensing or certifying the excluded party of the exclusion, and also proposes revising § 30.726 to correct outdated terminology.

Subpart I—Wage-Loss Determinations Under Part E of EEOICPA

The proposed changes in this subpart involve both expanding upon existing definitional regulations and adding new definitions that memorialize programmatic determinations. Also, the Department proposes to reorganize existing §§ 30.805 through 30.806, and to add proposed § 30.807 in order to better describe the process it currently uses to evaluate evidence in a wage-loss claim.

General Provisions

In addition to updating the cross-references in proposed § 30.800, the Department proposes to use months instead of quarters in the definition of *average annual wage* in § 30.801(a), to conform with 42 U.S.C. 7385s–2(a)(2)(A)(ii) and its current practices. In proposed § 30.801(c), the Department seeks to add a definition of the term *month during which the employee was unemployed*, and adjusts the constant

dollars in the definition of a *quarter during which the employee was unemployed* to 2013 constant dollars in proposed § 30.801(e). Also, the Department proposes to define a *trigger month* in new § 30.801(f), consistent with the statute, as the calendar month during which a covered Part E employee first experienced a loss of wages due to exposure to a toxic substance at a DOE facility or RECA section 5 facility. The Department proposes to move the definition of *wages*, which is currently referenced in the last sentence of § 30.805(a), to its own new paragraph in proposed § 30.801(g), and to amend that definition to focus on earned income from regular employment, rather than just taxable income, and to provide examples of what the Department considers as *wages* for the purposes of this subpart.

Evidence of Wage-Loss

Proposed § 30.805(a) sets out in detail the criteria for establishing eligibility for wage-loss benefits under Part E. Proposed § 30.805(b) explains that the Department may discontinue development of a covered Part E employee's request for wage-loss benefits at any point when the claimant is unable to meet his or her burden of proof to submit factual and/or medical evidence to establish the criteria specified in proposed § 30.805(a). Proposed § 30.806 is substantially similar to current § 30.805(b), except that it provides an explanation of what the Department considers to be "rationalized" medical evidence, *i.e.*, medical evidence based on a physician's fully explained and reasoned decision, which a covered Part E employee must submit in order to establish that the wage-loss at issue was causally related to the employee's covered illness.

Additionally, proposed § 30.806 memorializes the Department's policy and federal district court jurisprudence that wage-loss sustained due to something other than a covered illness is not compensable wage-loss under Part E of EEOICPA. *See Trego v. U.S. Dep't of Labor*, 681 F.Supp.2d 894 (E.D. Tenn. 2009). Proposed § 30.807(a) is substantially similar to current § 30.805(a), except to state that the Department may rely upon annual, as well as quarterly wage information, that has been reported to the Social Security Administration (SSA). The current provision refers to only quarterly wage information reported to SSA; however, employers also report wages on an annual basis to SSA. Also, as discussed above, the Department seeks to remove language defining "wages" in current § 30.805(a) and place it in new

§ 30.801(g). Proposed § 30.807(b) is largely the same as current § 30.806.

Determinations of Average Annual Wage and Percentages of Loss

The Department proposes to revise § 30.810 to state that it will calculate the average annual wage of a covered Part E employee using months instead of quarters, to be consistent with proposed § 30.801(a). Proposed § 30.811(a) combines the text from paragraphs (a) and (b) in current § 30.811, since the Department believes that the current language in those paragraphs is repetitive.

Subpart J—Impairment Benefits Under Part E of EEOICPA

The Department proposes to revise subpart J to update obsolete terminology and clarify its requirements for impairment rating determinations. Also in subpart J, the Department proposes to include in the regulations its existing policy for reducing the amount of an impairment award that is subject to any required offset and/or coordination of benefits.

General Provisions

Proposed §§ 30.901 and 30.902 replace the term "minimum impairment rating" with "impairment rating," since the earlier term has no meaning in the Act. The Department also proposes to add text in new § 30.902(b) regarding its current policy of proportionately reducing an impairment award in circumstances when such award is payable based on a whole person impairment rating and at least one of the impairments is subject to a reduction under §§ 30.505(b) and/or 30.626.

Medical Evidence of Impairment

Proposed § 30.908 also replaces the term "minimum impairment rating" with "impairment rating," to be consistent with the changes in §§ 30.102(a), 30.901 and 30.902.

III. Statutory Authority

Section 7384d of EEOICPA provides general statutory authority, which E.O. 13179 allocates to the Secretary, to prescribe rules and regulations necessary for administration of Part B of the Act. Section 7385s–10 provides the Secretary with the general statutory authority to administer Part E of the Act. Sections 7384t, 7384u and 7385s–8 provide the specific authority regarding medical treatment and care, including authority to determine the appropriateness of charges. The Federal Claims Collection Act of 1966, as amended (31 U.S.C. 3701 *et seq.*), authorizes imposition of interest charges

and collection of debts by withholding funds due the debtor.

IV. Executive Orders 12866 and 13563

E.O. 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including distributive impacts, equity, and potential economic, environmental, public health and safety effects). E.O. 13563 is supplemental to and reaffirms the principles, structures, and definitions governing regulatory review as established in E.O. 12866.

Section 3(f) of E.O. 12866 defines a “significant regulatory action” as an action that is likely to result in a rule that: (1) Has an annual effect of \$100 million or more, or adversely affects in a material way a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities (also referred to as economically significant); (2) creates serious inconsistency or otherwise interferes with an action taken or planned by another agency; (3) materially alters the budgetary impacts of entitlement grants, user fees, or loan programs, or the rights and obligations of recipients thereof; or (4) raises novel legal or policy issues arising out of legal mandates, the Presidents priorities, or the principles set forth in E.O. 12866.

The Department believes that the proposed rule is needed to update the existing regulations to reflect the program’s current processes, and to incorporate the policy and procedural changes that have been implemented since the existing regulations were issued in 2006.

The Department has considered the benefits and costs that would result from the proposed rule. As discussed in the Overview of the Proposed Rule below, proposed § 30.318 will benefit claimants by providing better and more transparent responses to objections to final dose reconstruction reports provided by NIOSH in claims for radiogenic cancer, because NIOSH is the agency with scientific expertise in the relevant field. Proposed §§ 30.700 through 30.726 will benefit private sector providers of medical services and supplies by clarifying and bringing the program’s billing and exclusion regulations into conformance with the current practices of other benefit programs administered by OWCP. And finally, proposed § 30.403 will benefit claimants by standardizing the current process for requesting pre-authorization for in-home health care services and realigning that process to better serve

the needs of the program’s beneficiaries. The Department does not believe that any of the above significant policies in the proposed rule will result in increased or decreased administrative costs to either the program or the public, or any increase in benefits paid.

This rule has been designated a “significant regulatory action” although not economically significant under section 3(f) of E.O. 12866. The rule is not economically significant because it will not have an annual effect on the economy of \$100 million or more. Accordingly, the rule has been reviewed by the Office of Management and Budget.

V. Regulatory Flexibility Act

This proposed rule has been reviewed in accordance with the Regulatory Flexibility Act of 1980, as amended by the Small Business Regulatory Enforcement Fairness Act of 1996, 5 U.S.C. 601–612. The Department has concluded that the rule does not involve regulatory and informational requirements regarding businesses, organizations, and governmental jurisdictions subject to the regulation.

VI. Paperwork Reduction Act

The Paperwork Reduction Act of 1995 (PRA), 44 U.S.C. 3501 *et seq.*, and its implementing regulations, 5 CFR part 1320, require that the Department consider the impact of paperwork and other information collection burdens imposed on the public. A Federal agency generally cannot conduct or sponsor a collection of information, and the public is generally not required to respond to an information collection, unless it is approved by OMB under the PRA and displays a currently valid OMB Control Number. In addition, notwithstanding any other provisions of law, no person shall generally be subject to penalty for failing to comply with a collection of information that does not display a valid Control Number. See 5 CFR 1320.5(a) and 1320.6.

This notice of proposed rulemaking contains information collection requirements subject to the PRA. The information collection requirements set out in §§ 30.700, 30.701 and 30.702 of this proposed rule, which relate to information required to be submitted by claimants and medical providers in connection with the processing of bills, were both submitted to and approved by OMB under the PRA, and the currently approved collections in OMB Control Nos. 1240–0007 (expires January 31, 2016), 1240–0019 (expires January 31, 2016), 1240–0021 (expires January 31, 2016), 1240–0044 (expires December 31, 2015) and 1240–0050 (expires January

31, 2016) were not affected by any of the substantive changes that have been made in this proposed rule.

The information collection requirements in §§ 30.100, 30.101, 30.102, 30.103, 30.112, 30.113, 30.206, 30.207, 30.213, 30.222, 30.231, 30.232 and 30.416 of this proposed rule were also previously submitted to and approved by OMB under the PRA, and were assigned OMB Control No. 1240–0002 (expires December 31, 2016). This second group of information collection requirements was also not affected by any of the substantive changes that have been made in this rule. However, this rule revises the currently approved collection in OMB Control No. 1240–0002 by adding two new information collection requirements and by moving one existing information collection requirement; this revision of a currently approved collection will be submitted to OMB for review under the PRA on the date of publication of this rule. The new information collection requirements in this rule are in §§ 30.114 and 30.403 and relate to information required to be submitted by or on behalf of claimants as part of the EEOICPA claims adjudication process. While the information collection requirements in § 30.807(b) relating to information to be submitted by claimants in support of claims for wage-loss benefits are not new and have been approved under the PRA in OMB Control No. 1240–0002 (as 20 CFR 30.806), they have been moved in this proposed rule, without substantive change, to new § 30.807(b); this new location will be incorporated into OMB Control No. 1240–0002 in this revision. The Department is proposing to create two new forms to implement one of the new collections (see sections C and D below). The remaining new collections will be implemented by adding them to existing Forms EE/EN–11A and EE/EN–11B (see sections A and B below).

A. Letter to Claimant About Claiming for Impairment Benefits Under Part E, Sent With Enclosure EN–11A: Form EE–11A (§§ 30.114(b)(3), 30.905 and 30.907)

Summary: Employees and/or survivors claiming for the first time that a covered illness has resulted in permanent impairment must submit a narrative medical report from a physician that conforms to the methodology of the 5th Edition of the American Medical Association’s *Guides to the Evaluation of Permanent Impairment* (AMA’s *Guides*) and provides a rating of whole-person impairment. In order to obtain the necessary type of medical report, Form EE–11A explains the requirements for

that report to covered Part E employees (or their survivors), and enclosure EE-11A provides them with the opportunity to choose their own physician to submit the report, or to ask OWCP to arrange for the report.

Need: Proper medical evidence of permanent impairment is necessary to establish entitlement to benefits for permanent impairment under Part E of EEOICPA.

Respondents and proposed frequency of response: It is estimated that 3,767 Part E respondents annually will submit this collection of information once.

Estimated total annual burden: The time required to review instructions, search existing data sources, gather the data needed, and complete and review each collection of this information is estimated to take an average of 15 minutes per response for a total annual burden of 942 hours.

B. Letter to Claimant About Claiming for Wage-Loss Benefits Under Part E, Sent With Enclosure EE-11B: Form EE-11B (§§ 30.114(b)(3) and 30.807(b))

Summary: Employees and/or survivors claiming for the first time that a covered illness has resulted in wage-loss must submit both earnings information and a narrative medical report from a physician that shows a causal relationship between the claimed wage-loss and the accepted "covered illness." In order to obtain the necessary earnings information and medical report, Form EE-11B explains the type of factual and medical evidence that is required to support an initial claim for wage-loss benefits, and enclosure EN-11B collects information on the period of time for which the claim for wage-loss benefits is being made.

Need: Factual and medical evidence of wage-loss is necessary to establish entitlement to benefits for wage-loss under Part E of EEOICPA.

Respondents and proposed frequency of response: It is estimated that 520 Part E respondents annually will submit this collection of information once.

Estimated total annual burden: The time required to review instructions, search existing data sources, gather the data needed, and complete and review each collection of this information is estimated to take an average of 30 minutes per response for a total annual burden of 260 hours.

C. Claim for Home Health Care, Nursing Home or Assisted Living Benefits Under the Energy Employees Occupational Illness Compensation Program Act: Form EE-17A (§ 30.403)

Summary: Covered Part B and covered Part E employees who have

been awarded medical benefits for treatment of accepted illnesses by OWCP may file claims for Home Health Care, Nursing Home, or Assisted Living Benefits; all of these specific medical benefits require pre-authorization by OWCP and a Letter of Medical Necessity. In order to obtain the name and contact information for the beneficiary's treating physician, Form EE-17A requires covered Part B and Part E employees to provide the name, address and telephone number of the physician that OWCP should contact to obtain the Letter of Medical Necessity when they make their first claim for these benefits.

Need: A Form EE-17A claiming for Home Health Care, Nursing Home, or Assisted Living Benefits is necessary to initiate OWCP's first adjudication process for these specific pre-authorized medical benefits filed by covered Part B and covered Part E employees.

Respondents and proposed frequency of response: It is estimated that 3,286 respondents annually will file one Form EE-17A.

Estimated total annual burden: The time required to review instructions, search existing data sources, gather the data needed, and complete and review each Form EE-17A is estimated to take an average of five minutes per respondent for a total added annual burden of 274 hours.

D. Physician's Certification of Medical Necessity for Home Health Care, Nursing Home or Assisted Living Benefits Under the Energy Employees Occupational Illness Compensation Program Act: Form EE-17B (§ 30.403)

Summary: Covered Part B and covered Part E employees who have been awarded medical benefits for treatment of accepted illnesses by OWCP may file claims for Home Health Care, Nursing Home, or Assisted Living Benefits; these specific medical benefits require both pre-authorization by OWCP and a Letter of Medical Necessity from the treating physician that supports the need for the claimed benefits. In order to obtain the required Letter of Medical Necessity the first time a claim is filed, OWCP will send the beneficiary's treating physician a Form EE-17B requesting this required medical evidence. The Form EE-17B also asks the physician to verify that a face-to-face physical examination was conducted, which is required by OWCP procedures.

Need: A Form EE-17B requesting a Letter of Medical Necessity to support an initial claim for Home Health Care, Nursing Home, or Assisted Living Benefits filed by a covered Part B or covered Part E employee is needed so

OWCP can adjudicate the initial claim for these pre-authorized medical benefits.

Respondents and proposed frequency of response: It is estimated that 3,286 respondents annually will file one Form EE-17B.

Estimated total annual burden: The time required to review instructions, search existing data sources, gather the data needed, and complete and review each Form EE-17B is estimated to take an average of 30 minutes per respondent for a total annual burden of 1,643 hours.

E. Information Collection Request (ICR) Submissions to OMB and Request for Comments

Consistent with requirements codified at 40 U.S.C. 3506(a)(1)(B), (c)(2)(b) and 3507(a)(1)(D), and 5 CFR 1320.11, the Department has submitted a series of ICRs to OMB for approval under the PRA, in order to update the information collection approvals to reflect this rulemaking and provide interested parties a specific opportunity to comment under the PRA. Allowing an opportunity for comment helps to ensure that requested data can be provided in the desired format, reporting burden (time and financial resources) is minimized, collection instruments are clearly understood, and the impact of collection requirements on respondents can be properly assessed. OMB and the Department are particularly interested in comments that:

- Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;
- Evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;
- Enhance the quality, utility, and clarity of the information to be collected; and
- Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submission of responses.

F. Burden Summaries

The information collections in this rule may be summarized as follows. The number of responses and burden estimates listed are not specific to the Energy program; instead, the estimates

are cumulative for all OWCP-administered compensation programs that collect this information.

1. *Title of Collection:* Energy Employees Occupational Illness Compensation Program Act Forms.

OMB Control Number: 1240-0002.

Total Estimated Number of Responses: 67,325 (1305 due to this rulemaking).

Total Estimated Annual Time Burden: 23,746 hours (556 due to this rulemaking).

Total Estimated Annual Other Costs Burden: \$31,503 (\$3,414 due to this rulemaking).

2. *Title of Collection:* Claim for Medical Reimbursement Form.

OMB Control Number: 1240-0007.

Total Estimated Number of Responses: 38,480.

Total Estimated Annual Time Burden: 6,388 hours.

Total Estimated Annual Other Costs Burden: \$68,879.

3. *Title of Collection:* Uniform Billing Form (OWCP-04).

OMB Control Number: 1240-0019.

Total Estimated Number of Responses: 221,992.

Total Estimated Annual Time Burden: 25,503 hours.

Total Estimated Annual Other Costs Burden: \$0.

4. *Title of Collection:* Provider Enrollment Form.

OMB Control Number: 1240-0021.

Total Estimated Number of Responses: 31,979.

Total Estimated Annual Time Burden: 4,252 hours.

Total Estimated Annual Other Costs Burden: \$16,629.

5. *Title of Collection:* Health Insurance Claim Form.

OMB Control Number: 1240-0044.

Total Estimated Number of Responses: 2,777,034.

Total Estimated Annual Time Burden: 260,873 hours.

Total Estimated Annual Other Costs Burden: \$0.

6. *Title of Collection:* Pharmacy Billing Requirements.

OMB Control Number: 1240-0050.

Total Estimated Number of Responses: 1,453,300.

Total Estimated Annual Time Burden: 24,421 hours.

Total Estimated Annual Other Costs Burden: \$0.

VII. Unfunded Mandates Reform Act

Title II of the Unfunded Mandates Reform Act of 1995 (2 U.S.C. 1531 *et seq.*) directs agencies to assess the effects of federal regulatory actions on state, local, and tribal governments, and the private sector, “other than to the

extent that such regulations incorporate requirements specifically set forth in law.” For purposes of the Unfunded Mandates Reform Act, this proposed rule does not include any federal mandate that may result in increased annual expenditures in excess of \$100 million by state, local or tribal governments in the aggregate, or by the private sector.

VIII. Executive Order 13132 (Federalism)

The Department has reviewed this proposed rule in accordance with E.O. 13132 regarding federalism, and has determined that it does not have “federalism implications.” The proposed rule does not “have substantial direct effects on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government.”

IX. Executive Order 13175 (Consultation and Coordination With Indian Tribal Governments)

The Department has reviewed this proposed rule in accordance with E.O. 13175 and has determined that it does not have “tribal implications.” The proposed rule does not “have substantial direct effects on one or more Indian tribes, on the relationship between the Federal government and Indian tribes, or on the distribution of power and responsibilities between the Federal government and Indian tribes.”

X. Executive Order 12988 (Civil Justice Reform)

This regulation has been drafted and reviewed in accordance with E.O. 12988, Civil Justice Reform, and will not unduly burden the Federal court system. The regulation has been written so as to minimize litigation and provide a clear legal standard for affected conduct, and has been reviewed carefully to eliminate drafting errors and ambiguities.

XI. Executive Order 13045 (Protection of Children From Environmental, Health Risks and Safety Risks)

In accordance with E.O. 13045, the Department has evaluated the environmental health and safety effects of this rule on children, and has determined that it will have no effect on children.

XII. Executive Order 13211 (Actions Concerning Regulations That Significantly Affect Energy Supply, Distribution, or Use)

In accordance with E.O. 13211, the Department has evaluated the effects of this rule on energy supply, distribution or use, and has determined that it is not likely to have a significant adverse effect on them.

List of Subjects in 20 CFR Part 30

Administrative practice and procedure, Cancer, Claims, Kidney diseases, Leukemia, Lung diseases, Miners, Radioactive materials, Tort claims, Underground mining, Uranium, Workers' compensation.

Text of the Rule

For the reasons stated in the preamble, the Department of Labor proposes to amend subchapter C consisting of part 30 as follows:

SUBCHAPTER C—ENERGY EMPLOYEES OCCUPATIONAL ILLNESS COMPENSATION PROGRAM ACT OF 2000

PART 30—CLAIMS FOR COMPENSATION UNDER THE ENERGY EMPLOYEES OCCUPATIONAL ILLNESS COMPENSATION PROGRAM ACT OF 2000, AS AMENDED

■ 1. The authority citation for part 30 is revised to read as follows:

Authority: 5 U.S.C. 301; 31 U.S.C. 3716 and 3717; 42 U.S.C. 7384d, 7384t, 7384u and 7385s–10; Executive Order 13179, 65 FR 77487, 3 CFR, 2000 Comp., p. 321; Secretary of Labor's Order No. 10–2009, 74 FR 58834.

■ 2. Revise § 30.1 to read as follows:

§ 30.1 What rules govern the administration of EEOICPA and this chapter?

In accordance with EEOICPA, Executive Order 13179 and Secretary's Order No. 10–2009, the primary responsibility for administering the Act, except for those activities assigned to the Secretary of Health and Human Services (HHS), the Secretary of Energy and the Attorney General, has been delegated to the Director of the Office of Workers' Compensation Programs (OWCP). Except as otherwise provided by law, the Director of OWCP and his or her designees have the exclusive authority to administer, interpret and enforce the provisions of the Act.

■ 3. Amend § 30.2 by revising paragraph (b) to read as follows:

§ 30.2 In general, how have the tasks associated with the administration of EEOICPA claims process been assigned?

* * * * *

(b) However, HHS has exclusive control of the portion of the claims process under which it provides reconstructed doses for certain radiogenic cancer claims (see § 30.115), which it delegated to the National Institute for Occupational Safety and Health (NIOSH) in 42 CFR 82.1. HHS also has exclusive control of the process for designating classes of employees to be added to the Special Exposure Cohort under Part B of the Act, and has promulgated regulations governing that process at 42 CFR part 83. Finally, HHS has promulgated regulations at 42 CFR part 81 that set out guidelines that OWCP follows when it assesses the compensability of an employee's radiogenic cancer (see § 30.213). DOE and DOJ must, among other things, notify potential claimants and submit evidence that OWCP deems necessary for its adjudication of claims under EEOICPA (see §§ 30.105, 30.112, 30.206, 30.212 and 30.221).

■ 4. Amend § 30.5 as follows:

- a. Revise paragraphs (c)(2)(i) and (i);
- b. Redesignate paragraphs (j) through (hh) and paragraphs (ii) and (jj) as paragraphs (k) through (ii) and (kk) and (ll), respectively;
- c. Add paragraphs (j) and (jj);
- d. Revise newly designated paragraphs (k)(2) introductory text and (w);
- e. In newly designated paragraph (x)(2)(ii), remove the period at the end of the paragraph and add “; or” in its place;
- f. Add paragraph (x)(2)(iii) to newly designated paragraph (x);
- g. Revise newly designated paragraphs (ee) and the introductory text to (gg); and
- h. Revise newly designated paragraph (ii) introductory text, further redesignate paragraphs (ii)(1), (2) and (3) as paragraphs (ii)(1)(i), (ii) and (iii), respectively, and add paragraphs (ii)(1) and (2).

The revisions and additions read as follows:

§ 30.5 What are the definitions used in this part?

* * * * *

(c) * * *

(2)(i) An individual employed at a facility that NIOSH reported had a potential for significant residual contamination outside of the period described in paragraph (c)(1) of this section;

* * * * *

(i) *Beryllium vendor* means the specific corporations and named predecessor corporations listed in section 7384l(6) of the Act and any of

the facilities designated as such by DOE on December 27, 2002.

(j) *Beryllium vendor facility* means a facility owned and operated by a beryllium vendor.

(k) * * *

(2) A written diagnosis of silicosis is made by a licensed physician and is accompanied by:

* * * * *

(w) *Department of Energy* or *DOE* includes the predecessor agencies of DOE back to the establishment of the Manhattan Engineer District on August 13, 1942.

(x) * * *

(2) * * *

(iii) A civilian employee of a state or federal government agency if the agency employing that individual is found to have entered into a contract with DOE for the provision of one or more services it was not statutorily obligated to perform, and DOE compensated the agency for those services. The delivery or removal of goods from the premises of a DOE facility does not constitute a service for the purposes of determining a worker's coverage under this paragraph (x).

* * * * *

(ee) *Physician* means surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors and osteopathic practitioners, within the scope of their practice as defined by state law. The services of chiropractors that may be reimbursed are limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by x-ray to exist.

* * * * *

(gg) *Specified cancer* means:

* * * * *

(ii) *Time of injury* is defined as follows:

(1) For an employee's claim, this term means:

* * * * *

(2) For a survivor's claim, the date of the employee's death is the time of injury.

(jj) *Time of payment* or *payment* means the date that a paper check issued by the Department of the Treasury was received by the payee or by someone who was legally able to act for the payee, or the date the Department of the Treasury made an Electronic Funds Transfer to the payee's financial institution.

* * * * *

■ 5. Amend § 30.100 by revising paragraphs (a), (c) introductory text, (c)(1) and (d) to read as follows:

§ 30.100 In general, how does an employee file an initial claim for benefits?

(a) To claim benefits under EEOICPA, an employee must file a claim in writing with OWCP. Form EE-1 should be used for this purpose, but any written communication that requests benefits under EEOICPA will be considered a claim. It will, however, be necessary for an employee to submit a Form EE-1 for OWCP to fully develop the claim. Copies of Form EE-1 may be obtained from OWCP or on the Internet at <http://www.dol.gov/owcp/energy/index.htm>. The employee must sign the written claim that is filed with OWCP, but another person may present the claim to OWCP on the employee's behalf.

* * * * *

(c) Except as provided in paragraph (d) of this section, a claim is considered to be “filed” on the date that the employee mails his or her claim to OWCP, as determined by postmark or other carrier's date marking, or on the date that the claim is received by OWCP, whichever is the earliest determinable date. However, in no event will a claim under Part B of EEOICPA be considered to be “filed” earlier than July 31, 2001, nor will a claim under Part E of EEOICPA be considered to be “filed” earlier than October 30, 2000.

(1) The employee shall affirm that the information provided on the Form EE-1 is true, and must inform OWCP of any subsequent changes to that information.

* * * * *

(d) For those claims under Part E of EEOICPA that were originally filed with DOE as claims for assistance under former section 7385o of EEOICPA (which was repealed on October 28, 2004), a claim is considered to be “filed” on the date that the employee mailed his or her claim to DOE, as determined by postmark or other carrier's date marking, or on the date that the claim was received by DOE, whichever is the earliest determinable date. However, in no event will a claim referred to in this paragraph be considered to be “filed” earlier than October 30, 2000.

■ 6. Amend § 30.101 by revising paragraphs (a), (d) introductory text, (d)(1) and (e) to read as follows:

§ 30.101 In general, how is a survivor's claim filed?

(a) A survivor of an employee must file a claim for compensation in writing with OWCP. Form EE-2 should be used for this purpose, but any written communication that requests survivor benefits under the Act will be considered a claim. It will, however, be necessary for a survivor to submit a

Form EE-2 for OWCP to fully develop the claim. Copies of Form EE-2 may be obtained from OWCP or on the Internet at <http://www.dol.gov/owcp/energy/index.htm>. The survivor must sign the written claim that is filed with OWCP, but another person may present the claim to OWCP on the survivor's behalf. Although only one survivor needs to file a claim under this section to initiate the development process, OWCP will distribute any monetary benefits payable on the claim among all eligible surviving beneficiaries who have filed claims with OWCP.

(d) Except as provided in paragraph (e) of this section, a survivor's claim is considered to be "filed" on the date that the survivor mails his or her claim to OWCP, as determined by postmark or other carrier's date making, or the date that the claim is received by OWCP, whichever is the earliest determinable date. However, in no event will a survivor's claim under Part B of the Act be considered to be "filed" earlier than July 31, 2001, nor will a survivor's claim under Part E of the Act be considered to be "filed" earlier than October 30, 2000.

(1) The survivor shall affirm that the information provided on the Form EE-2 is true, and must inform OWCP of any subsequent changes to that information.

(e) For those claims under Part E of EEOICPA that were originally filed with DOE as claims for assistance under former section 7385o of EEOICPA (which was repealed on October 28, 2004), a claim is considered to be "filed" on the date that the survivor mailed his or her claim to DOE, as determined by postmark or other carrier's date marking, or on the date that the claim was received by DOE, whichever is the earliest determinable date. However, in no event will a claim referred to in this paragraph be considered to be "filed" earlier than October 30, 2000.

■ 7. Amend § 30.102 by revising paragraph (a) to read as follows:

§ 30.102 In general, how does an employee file a claim for additional impairment or wage-loss under Part E of EEOICPA?

(a) An employee previously awarded impairment benefits by OWCP may file a claim for additional impairment benefits. Such claim must be based on an increase in the employee's impairment rating attributable to the covered illness or illnesses from the impairment rating that formed the basis for the last award of such benefits by OWCP. OWCP will only adjudicate

claims for such an increased rating that are filed at least two years from the date of the last award of impairment benefits. However, OWCP will not wait two years before it will adjudicate a claim for additional impairment that is based on an allegation that the employee sustained a new covered illness.

■ 8. Amend § 30.103 by revising paragraph (b) to read as follows:

§ 30.103 How does a claimant make sure that OWCP has the evidence necessary to process the claim?

(b) Copies of the forms listed in this section are available for public inspection at the U.S. Department of Labor, Office of Workers' Compensation Programs, Washington, DC 20210. They may also be obtained from OWCP district offices and on the Internet at <http://www.dol.gov/owcp/energy/index.htm>.

■ 9. Amend § 30.110 by revising paragraphs (a)(1) and (4) and (b) to read as follows:

§ 30.110 Who is entitled to compensation under the Act?

(a) A "covered beryllium employee" (as described in § 30.205(a)) with a covered beryllium illness (as defined in § 30.5(p)) who was exposed to beryllium in the performance of duty (in accordance with § 30.206).

(4) A "covered uranium employee" (as defined in § 30.5(t)).

(b) Under Part E of EEOICPA, compensation is payable to a "covered Part E employee" (as defined in § 30.5(q)), or his or her survivors.

■ 10. Amend § 30.112 by revising paragraph (b)(3) to read as follows:

§ 30.112 What kind of evidence is needed to establish covered employment and how will that evidence be evaluated?

(3) If the only evidence of covered employment is a written affidavit or declaration subject to penalty of perjury by the employee, survivor or any other person, and DOE or another entity either disagrees with the assertion of covered employment or cannot concur or disagree with the assertion of covered employment, then OWCP will evaluate the probative value of the affidavit in conjunction with the other evidence of employment, and may determine that the claimant has not met his or her burden of proof under § 30.111.

■ 11. Amend § 30.113 by revising paragraph (c) to read as follows:

§ 30.113 What are the requirements for written medical documentation, contemporaneous records, and other records or documents?

(c) If a claimant submits a certified statement, by a person with knowledge of the facts, that the medical records containing a diagnosis and date of diagnosis of a covered medical condition no longer exist, then OWCP may consider other evidence to establish a diagnosis and date of diagnosis of a covered medical condition. However, OWCP will evaluate the probative value of such other evidence to determine whether it is sufficient proof of a covered medical condition.

■ 12. Amend § 30.114 as follows:
■ a. Revise paragraphs (b)(1) and (2);
■ b. Redesignate paragraph (b)(3) as paragraph (b)(4); and
■ c. Add paragraph (b)(3).

The revisions and addition read as follows:

§ 30.114 What kind of evidence is needed to establish a compensable medical condition and how will that evidence be evaluated?

(1) For covered beryllium illnesses under Part B of EEOICPA, additional medical evidence, as set forth in § 30.207, is required to establish a beryllium illness.

(2) For chronic silicosis under Part B of EEOICPA, additional medical evidence, as set forth in § 30.222, is required to establish chronic silicosis.

(3) For covered illnesses under Part E of EEOICPA, additional medical evidence, as set forth in § 30.232, is required to establish a covered illness.

(i) For impairment benefits under Part E of EEOICPA, additional medical evidence, as set forth in § 30.901, is required to establish an impairment that is the result of a covered illness referred to in § 30.900.

(ii) For wage-loss benefits under Part E of EEOICPA, additional medical evidence, as set forth in § 30.806, is required to establish wage-loss that is the result of a covered illness referred to in § 30.800.

■ 13. Amend § 30.115 by revising paragraphs (a) introductory text, (a)(2) and (b) to read as follows:

§ 30.115 For those radiogenic cancer claims that do not seek benefits under Part B of the Act pursuant to the Special Exposure Cohort provisions, what will OWCP do once it determines that an employee contracted cancer?

(a) Other than claims seeking benefits under Part E of the Act that have

previously been accepted under section 7384u of the Act or claims previously accepted under Part B pursuant to the Special Exposure Cohort provisions, OWCP will forward the claim package (including, but not limited to, Forms EE-1, EE-2, EE-3, EE-4 and EE-5, as appropriate) to NIOSH for dose reconstruction. At that point in time, development of the claim by OWCP may be suspended.

* * * * *

(2) NIOSH will then reconstruct the radiation dose of the employee and provide the claimant and OWCP with the final dose reconstruction report. The final dose reconstruction record will be delivered to OWCP with the final dose reconstruction report and to the claimant upon request.

(b) Following its receipt of the final dose reconstruction report from NIOSH, OWCP will resume its adjudication of the cancer claim and consider whether the claimant has met the eligibility criteria set forth in subpart C of this part. However, during the period before it receives a reconstructed dose from NIOSH, OWCP may continue to develop other aspects of a claim, to the extent that it deems such development to be appropriate.

■ 14. Amend § 30.205 by revising paragraphs (a)(1) and (a)(3)(i) to read as follows:

§ 30.205 What are the criteria for eligibility for benefits relating to beryllium illnesses covered under Part B of EEOICPA?

* * * * *

(a) * * *

(1) The employee is a “current or former employee as defined in 5 U.S.C. 8101(1)” (see § 30.5(u)) who may have been exposed to beryllium at a DOE facility or at a facility owned, operated or occupied by a beryllium vendor; or

* * * * *

(3) * * *

(i) Employed at a DOE facility (as defined in § 30.5(y)); or

* * * * *

■ 15. Amend § 30.206 by revising paragraph (a) to read as follows:

§ 30.206 How does a claimant prove that the employee was a “covered beryllium employee” exposed to beryllium dust, particles or vapor in the performance of duty?

(a) Proof of employment or physical presence at a DOE facility, or a beryllium vendor facility as defined in § 30.5(j), because of employment by the United States, a beryllium vendor, or a contractor or subcontractor of a beryllium vendor during a period when beryllium dust, particles or vapor may have been present at such facility, may

be made by the submission of any trustworthy records that, on their face or in conjunction with other such records, establish that the employee was employed or present at a covered facility and the time period of such employment or presence.

* * * * *

■ 16. Amend § 30.207 as follows:

■ a. Revise paragraph (a);

■ b. Redesignate paragraph (d) as paragraph (e); and

■ c. Add paragraph (d).

The revision and addition read as follows:

§ 30.207 How does a claimant prove a diagnosis of a beryllium disease covered under Part B?

(a) Written medical documentation is required in all cases to prove that the employee developed a covered beryllium illness. Proof that the employee developed a covered beryllium illness must be made by using the procedures outlined in paragraph (b), (c), (d) or (e) of this section.

* * * * *

(d) OWCP will use the criteria in either paragraph (c)(1) or (2) of this section to establish that the employee developed chronic beryllium disease as follows:

(1) If the earliest dated medical evidence shows that the employee was either treated for or diagnosed with a chronic respiratory disorder before January 1, 1993, the criteria set forth in paragraph (c)(2) of this section may be used;

(2) If the earliest dated medical evidence shows that the employee was either treated for or diagnosed with a chronic respiratory disorder on or after January 1, 1993, the criteria set forth in paragraph (c)(1) of this section must be used; and

(3) If the employee was treated for a chronic respiratory disorder before January 1, 1993 and medical evidence verifies that such treatment was performed before January 1, 1993, but the medical evidence is dated on or after January 1, 1993, the criteria set forth in paragraph (c)(2) of this section may be used.

* * * * *

■ 17. Amend § 30.210 by revising paragraph (a)(1) to read as follows:

§ 30.210 What are the criteria for eligibility for benefits relating to radiogenic cancer?

(a) * * *

(1) The employee has been diagnosed with one of the forms of cancer specified in § 30.5(gg); and

* * * * *

■ 18. Revise § 30.211 to read as follows:

§ 30.211 How does a claimant establish that the employee has or had contracted cancer?

A claimant establishes that the employee has or had contracted a specified cancer (as defined in § 30.5(gg)) or other cancer with medical evidence that sets forth an explicit diagnosis of cancer and the date on which that diagnosis was first made.

■ 19. Amend § 30.213 by revising paragraph (a) to read as follows:

§ 30.213 How does a claimant establish that the radiogenic cancer was at least as likely as not related to employment at the DOE facility, the atomic weapons employer facility, or the RECA section 5 facility?

(a) HHS, with the advice of the Advisory Board on Radiation and Worker Health, has issued regulatory guidelines at 42 CFR part 81 that OWCP uses to determine whether radiogenic cancers claimed under Parts B and E were at least as likely as not related to employment at a DOE facility, an atomic weapons employer facility, or a RECA section 5 facility. Persons should consult HHS’s regulations for information regarding the factual evidence that will be considered by OWCP, in addition to the employee’s final dose reconstruction report that will be provided to OWCP by NIOSH, in making this particular factual determination.

* * * * *

■ 20. Amend § 30.220 by revising paragraph (a) to read as follows:

§ 30.220 What are the criteria for eligibility for benefits relating to chronic silicosis?

* * * * *

(a) The employee is a civilian DOE employee, or a civilian DOE contractor employee, who was present for a number of workdays aggregating at least 250 workdays during the mining of tunnels at a DOE facility (as defined in § 30.5(y)) located in Nevada or Alaska for tests or experiments related to an atomic weapon, and has been diagnosed with chronic silicosis (as defined in § 30.5(k)); or

* * * * *

■ 21. Amend § 30.222 by revising paragraph (a) introductory text to read as follows:

§ 30.222 How does a claimant establish that the employee has been diagnosed with chronic silicosis or has sustained a consequential injury, illness, impairment or disease?

(a) A written diagnosis of the employee’s chronic silicosis (as defined in § 30.5(k)) shall be made by a licensed physician and accompanied by one of the following:

* * * * *

■ 22. Amend § 30.230 by revising paragraphs (a) and (d)(1) introductory text to read as follows:

§ 30.230 What are the criteria necessary to establish that an employee contracted a covered illness under Part E of EEOICPA?

* * * * *

(a) That OWCP has determined under Part B of EEOICPA that the employee is a DOE contractor employee as defined in § 30.5(x), and that he or she has been awarded compensation under that Part of the Act for an occupational illness;

* * * * *

(d)(1) That the employee is a civilian DOE contractor employee as defined in § 30.5(x), or a civilian who was employed in a uranium mine or mill located in Colorado, New Mexico, Arizona, Wyoming, South Dakota, Washington, Utah, Idaho, North Dakota, Oregon or Texas at any time during the period from January 1, 1942 through December 31, 1971, or was employed in the transport of uranium ore or vanadium-uranium ore from such a mine or mill during that same period, and that he or she:

* * * * *

■ 23. Amend § 30.231 by revising paragraphs (a) and (b) to read as follows:

§ 30.231 How does a claimant prove employment-related exposure to a toxic substance at a DOE facility or a RECA section 5 facility?

* * * * *

(a) Proof of employment may be established by any trustworthy records that, on their face or in conjunction with other such records, establish that the employee was so employed and the time period(s) of such employment. If the only evidence of covered employment is a written affidavit or declaration subject to penalty of perjury by the employee, survivor or any other person, and DOE or another entity either disagrees with the assertion of covered employment or cannot concur or disagree with the assertion of covered employment, then OWCP will evaluate the probative value of the affidavit in conjunction with the other evidence of employment, and may determine that the claimant has not met his or her burden of proof under § 30.111.

(b) 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 where the employee was employed and that the employee came into contact with such substance. Information from the following sources may be considered as probative factual evidence for purposes

of establishing an employee's exposure to a toxic substance at a DOE facility or a RECA section 5 facility:

(1) To the extent practicable and appropriate, from DOE, a DOE-sponsored Former Worker Program, or an entity that acted as a contractor or subcontractor to DOE;

(2) OWCP's Site Exposure Matrices; or
(3) Any other entity deemed by OWCP to be a reliable source of information necessary to establish that the employee was exposed to a toxic substance at a DOE facility or RECA section 5 facility.

■ 24. Amend § 30.232 as follows:

■ a. Revise paragraphs (a)(1) and (2);

■ b. Remove paragraphs (a)(3) and (4) and (b); and

■ c. Redesignate paragraph (c) as paragraph (b) and revise newly designated paragraph (b).

The revisions read as follows:

§ 30.232 How does a claimant establish that the employee has been diagnosed with a covered illness, or sustained an injury, illness, impairment or disease as a consequence of a covered illness?

(a) * * *

(1) Written medical evidence containing a physician's diagnosis of the employee's covered illness (as that term is defined in § 30.5(s)), and the physician's reasoning for his or her opinion regarding causation; and

(2) Any other evidence OWCP may deem necessary to show that the employee has or had an illness that resulted from an exposure to a toxic substance while working at either a DOE facility or a RECA section 5 facility.

(b) An injury, illness, impairment or disease sustained as a consequence of a covered illness (as defined in § 30.5(s)) must be established with a fully rationalized medical report by a physician that shows the relationship between the injury, illness, impairment or disease and the covered illness. Neither the fact that the injury, illness, impairment or disease manifests itself after a diagnosis of a covered illness, nor the belief of the claimant that the injury, illness, impairment or disease was caused by the covered illness, is sufficient in itself to prove a causal relationship.

■ 25. Add an undesignated center heading preceding § 30.300 and revise § 30.300 to read as follows:

General Provisions

§ 30.300 What administrative process will OWCP use to decide claims for entitlement, and how can claimants obtain judicial review of final decisions on their claims?

OWCP district offices will issue recommended decisions with respect to claims for entitlement under Part B and/

or Part E of EEOICPA that are filed pursuant to the regulations set forth in subpart B of this part. In circumstances where a claim is made for more than one benefit available under Part B and/or Part E of the Act, OWCP may issue a recommended decision on only part of that particular claim in order to adjudicate that portion of the claim as quickly as possible. Should this occur, OWCP will issue one or more recommended decisions on the deferred portions of the claim when the adjudication of those portions is completed. All recommended decisions granting and/or denying claims for entitlement under Part B and/or Part E of the Act will be forwarded to the Final Adjudication Branch (FAB). Claimants will be given an opportunity to object to all or part of the recommended decision before the FAB. The FAB will consider objections filed by a claimant and conduct a hearing, if requested to do so by the claimant, before issuing a final decision on the claim for entitlement. Claimants may request judicial review of a final decision of FAB by filing an action in federal district court.

■ 26. Amend § 30.301 by revising paragraph (b)(1) to read as follows:

§ 30.301 May subpoenas be issued for witnesses and documents in connection with a claim under Part B of EEOICPA?

* * * * *

(b) * * *

(1) Submit the request in writing and send it to the FAB reviewer as early as possible, but no later than 30 days (as evidenced by postmark or other carrier's date marking) after the date of the original hearing request;

* * * * *

■ 27. Amend § 30.305 by revising paragraph (a) to read as follows:

§ 30.305 How does OWCP determine entitlement to EEOICPA compensation?

(a) In reaching a recommended decision with respect to EEOICPA compensation, OWCP considers the claim presented by the claimant, the factual and medical evidence of record, the dose reconstruction report prepared by NIOSH (if any), any report submitted by DOE and the results of such investigation as OWCP may deem necessary.

* * * * *

■ 28. Revise § 30.306 to read as follows:

§ 30.306 What does the recommended decision include?

The recommended decision shall include a discussion of the district office's findings of fact and conclusions of law in support of the recommendation. The recommended

decision may recommend acceptance or rejection of the claim in its entirety, or of a portion of the claim presented. It is accompanied by a notice of the claimant's right to file objections with, and request a hearing before, the FAB.

§ 30.307 [Redesignated as § 30.308]

- 29a. Redesignate § 30.307 as § 30.308.
- 29b. Add § 30.307 to read as follows:

§ 30.307 Can one recommended decision address the entitlement of multiple claimants?

(a) When multiple individuals have filed survivor claims under Part B and/or Part E of EEOICPA relating to the same deceased employee, the entitlement of all of those individuals shall be determined in the same recommended decision, except as described in paragraph (b) of this section.

(b) If another individual subsequently files a survivor claim for the same award, the recommended decision on that claim will not address the entitlement of the earlier claimants if the district office recommended that the later survivor claim be denied.

- 30. Revise § 30.310 to read as follows:

§ 30.310 What must the claimant do if he or she objects to the recommended decision or wants to request a hearing?

(a) Within 60 days from the date the recommended decision is issued, the claimant must state, in writing, whether he or she objects to any of the findings of fact and/or conclusions of law discussed in such decision, including NIOSH's reconstruction of the radiation dose to which the employee was exposed (if any), and whether a hearing is desired. This written statement should be filed with the FAB at the address indicated in the notice accompanying the recommended decision.

(b) For purposes of determining whether the written statement referred to in paragraph (a) of this section has been timely filed with the FAB, the statement will be considered to be "filed" on the date that the claimant mails it to the FAB, as determined by postmark or other carrier's date marking, or on the date that such written statement is actually received, whichever is the earliest determinable date.

- 31. Amend § 30.313 by revising paragraph (c) to read as follows:

§ 30.313 How is a review of the written record conducted?

* * * * *

(c) Any objection that is not presented to the FAB reviewer, including any objection to NIOSH's reconstruction of

the radiation dose to which the employee was exposed (if any), whether or not the pertinent issue was previously presented to the district office, is deemed waived for all purposes.

- 32. Amend § 30.314 by revising paragraphs (a) introductory text and (b) to read as follows:

§ 30.314 How is a hearing conducted?

(a) The FAB reviewer retains complete discretion to set the time and place of the hearing, including the amount of time allotted for the hearing, considering the issues to be resolved. At the discretion of the reviewer, the hearing may be conducted by telephone, teleconference, videoconference or other electronic means. As part of the hearing process, the FAB reviewer will consider the written record forwarded by the district office and any additional evidence and/or argument submitted by the claimant. The reviewer may also conduct whatever investigation is deemed necessary.

* * * * *

(b) The FAB reviewer will mail a notice of the time and place of the hearing to the claimant and any representative at least 30 days before the scheduled hearing date. The FAB reviewer may mail a hearing notice less than 30 days prior to the hearing if the claimant and/or representative waives the above 30-day notice period in writing. If the claimant only objects to part of the recommended decision, the FAB reviewer may issue a final decision accepting the remaining part of the recommendation of the district office without first holding a hearing (see § 30.316). Any objection that is not presented to the FAB reviewer, including any objection to NIOSH's reconstruction of the radiation dose to which the employee was exposed (if any), whether or not the pertinent issue was previously presented to the district office, is deemed waived for all purposes.

* * * * *

- 33. Amend § 30.315 by revising paragraph (a) to read as follows:

§ 30.315 May a claimant postpone a hearing?

(a) The FAB will entertain any reasonable request for scheduling the time and place of the hearing, but such requests should be made at the time that the hearing is requested. Scheduling is at the discretion of the FAB, and is not reviewable. In most instances, once the hearing has been scheduled and appropriate written notice has been mailed, it cannot be postponed at the claimant's request for any reason except

those stated in paragraph (b) of this section, unless the FAB reviewer can reschedule the hearing on the same docket (that is, during the same hearing trip). If a request to postpone a scheduled hearing does not meet one of the tests of paragraph (b) and cannot be accommodated on the same docket, or if the claimant and/or representative cancels or fails to attend a scheduled hearing, no further opportunity for a hearing will be provided. Instead, the FAB will consider the claimant's objections by means of a review of the written record. In the alternative, a teleconference may be substituted for the hearing at the discretion of the reviewer.

* * * * *

- 34. Revise § 30.318 to read as follows:

§ 30.318 How will FAB consider objections to NIOSH's reconstruction of a radiation dose, or to OWCP's calculation of the recommended probability of causation, in a Part B claim for radiogenic cancer?

(a) If the claimant objects to NIOSH's reconstruction of the radiation dose to which the employee was exposed, either in writing or at the oral hearing, the FAB reviewer has the discretion to consult with NIOSH as part of his or her consideration of any objection. However, the HHS dose reconstruction regulation, which provides guidance for the technical methods developed and used by NIOSH to provide a reasonable estimate of the radiation dose received by an employee, is binding on FAB. Should this consultation take place, the FAB reviewer will properly document it in the case. Whether or not NIOSH is consulted, and as provided for in § 30.317, the FAB reviewer may decide to return the case to the district office for referral to NIOSH for such further action as may be appropriate.

(b) If the claimant objects to OWCP's calculation of the recommended probability of causation in a Part B radiogenic cancer claim, the FAB reviewer has the discretion to consider if OWCP used incorrect factual information when it performed this calculation. However, the statute requires that OWCP use a particular methodology, established by regulations issued by HHS at 42 CFR part 81, when it calculates the recommended probability of causation.

- 35. Amend § 30.319 by revising paragraph (b) to read as follows:

§ 30.319 May a claimant request reconsideration of a final decision of the FAB?

* * * * *

(b) For purposes of determining whether the written request referred to

in paragraph (a) of this section has been timely filed with the FAB, the request will be considered to be "filed" on the date that the claimant mails it to the FAB, as determined by postmark or other carrier's date marking, or on the date that such written request is actually received, whichever is the earliest determinable date.

* * * * *

■ 36. Amend § 30.320 by revising paragraph (b) to read as follows:

§ 30.320 Can a claim be reopened after the FAB has issued a final decision?

* * * * *

(b) At any time after the FAB has issued a final decision pursuant to § 30.316, a claimant may file a written request that the Director for Energy Employees Occupational Illness Compensation reopen his or her claim, provided that the claimant also submits new evidence of a diagnosed medical condition, covered employment, or exposure to a toxic substance. A written request to reopen a claim may also be supported by identifying either a change in the PoC guidelines, a change in the dose reconstruction methods or an addition of a class of employees to the Special Exposure Cohort. If the Director concludes that the evidence submitted or matter identified in support of the claimant's request is material to the claim, the Director will reopen the claim and return it to the district office for such further development as may be necessary, to be followed by a new recommended decision.

* * * * *

■ 37. Amend § 30.400 by revising paragraphs (a) and (c) and adding paragraph (d) to read as follows:

§ 30.400 What are the basic rules for obtaining medical treatment?

(a) A covered Part B employee or a covered Part E employee who fits into at least one of the compensable claim categories described in subpart C of this part is entitled to receive all medical services, appliances or supplies that a qualified physician prescribes or recommends and that OWCP considers necessary to treat his or her occupational illness or covered illness, retroactive to the date the claim for benefits for that occupational illness or covered illness under Part B or Part E of EEOICPA was filed. The employee need not be disabled to receive such treatment. If there is any doubt as to whether a specific service, appliance or supply is necessary to treat the occupational illness or covered illness, the employee should consult OWCP prior to obtaining it through the automated authorization process

described in § 30.700. In situations where the occupational illness or covered illness is a secondary cancer, such treatment may include treatment of the underlying primary cancer when it is medically necessary or related to treatment of the secondary cancer; however, payment for medical treatment of the underlying primary cancer under these circumstances does not constitute a determination by OWCP that the primary cancer is a covered illness under Part E of EEOICPA.

* * * * *

(c) Any qualified physician may provide medical services, appliances and supplies to the covered Part B employee or the covered Part E employee. A hospital or a provider of medical services or supplies may furnish appropriate services, drugs, supplies and appliances, so long as such provider possesses all applicable licenses required under State law and has not been excluded from participation in the program under subpart H of this part. OWCP may apply a test of cost-effectiveness when it decides if appliances and supplies are necessary to treat an occupational illness or covered illness, may offset the cost of prior rental payments against a future purchase price, and may provide refurbished appliances where appropriate. Also, OWCP may authorize payment for durable medical equipment and modifications to a home or vehicle, to the extent that OWCP deems it necessary and reasonable. With respect to prescribed medications, OWCP may require the use of generic equivalents where they are available. OWCP may contract with a specific provider or providers to supply non-physician medical services or supplies.

(d) In circumstances when a covered employee dies after filing a claim but before such claim is accepted, OWCP will pay for medical treatment for all accepted illnesses, retroactive to the date that the employee filed the claim, if the deceased employee's survivor(s) files a claim that is accepted under Part B and/or Part E of EEOICPA. If this occurs, OWCP shall only pay either the provider(s) or the employee's estate for medical treatment that the employee obtained after filing his or her claim.

■ 38. Revise § 30.403 to read as follows:

§ 30.403 Will OWCP pay for home health care, nursing home, and assisted living services?

(a) OWCP will authorize and pay for home health care claimed under section 7384t of the Act, whether or not such care constitutes skilled nursing care, so long as the care has been determined to be medically necessary. OWCP will pay

for approved periods of care by a registered nurse, licensed practical nurse, home health aide or similarly trained individual, subject to the pre-authorization requirements described in paragraph (c) of this section.

(b) OWCP will also authorize and pay for periods of nursing home and assisted living services claimed under section 7384t of the Act, so long as such services have been determined to be medically necessary, subject to the pre-authorization requirements described in paragraph (c) of this section.

(c) To file an initial claim for home health care, nursing home, or assisted living services, the beneficiary must submit Form EE-17A to OWCP and identify his or her treating physician. OWCP then provides the treating physician with Form EE-17B, which asks the physician to submit a letter of medical necessity and verify that a timely face-to-face physical examination of the beneficiary took place. This particular pre-authorization process must be followed only for the initial claim for home health care, nursing home, and assisted living services; any subsequent request for pre-authorization must satisfy OWCP's usual medical necessity requirements. If a claimant disagrees with the decision of OWCP that the claimed services are not medically necessary, he or she may utilize the adjudicatory process described in subpart D of this part.

■ 39. Amend § 30.405 by revising paragraphs (b) and (c) to read as follows:

§ 30.405 After selecting a treating physician, may an employee choose to be treated by another physician instead?

* * * * *

(b) OWCP will approve the request if it determines that the reasons submitted are credible and supported by probative factual and/or medical evidence, as appropriate. Requests that are often approved include those for transfer of care from a general practitioner to a physician who specializes in treating the occupational illnesses or covered illnesses covered by EEOICPA, or the need for a new physician when an employee has moved.

(c) OWCP may deny a requested change of physician if it determines that the reasons submitted are not both credible and supported by probative evidence. If a claimant disagrees with such an informal denial, he or she may utilize the adjudicatory process described in subpart D of this part.

■ 40. Amend § 30.410 by adding paragraph (c) to read as follows:

§ 30.410 Can OWCP require an employee to be examined by another physician?

* * * * *

(c) OWCP may administratively close the claim and suspend adjudication of any pending matters if the employee refuses to attend a second opinion examination.

■ 41. Amend § 30.411 by adding paragraph (d) to read as follows:

§ 30.411 What happens if the opinion of the physician selected by OWCP differs from the opinion of the physician selected by the employee?

* * * * *

(d) OWCP may administratively close the claim and suspend adjudication of any pending matters if the employee refuses to attend a referee medical examination.

■ 42. Amend § 30.416 by revising paragraph (a) to read as follows:

§ 30.416 How and when should medical reports be submitted?

(a) The initial medical report (and any subsequent reports) should be made in narrative form on the physician's letterhead stationery. The physician should use the Form EE-7 as a guide for the preparation of his or her initial medical report in support of a claim under Part B and/or Part E of EEOICPA. The report should bear the physician's handwritten or electronic signature. OWCP may require an original signature on the report.

* * * * *

■ 43. Amend § 30.500 by revising paragraph (a)(2) and adding paragraph (c) to read as follows:

§ 30.500 What special statutory definitions apply to survivors under EEOICPA?

(a) * * *

(2) *Child* of a deceased covered Part B employee or deceased covered Part E employee means only a biological child, a stepchild or an adopted child of that individual.

* * * * *

(c) For the purposes of paying compensation to survivors under Part E of EEOICPA, OWCP will use the following additional definitions:

(1) *Covered child* means a child that is, as of the date of the deceased covered Part E employee's death, either under the age of 18 years, or under the age of 23 years and a full-time student who was continuously enrolled in one or more educational institutions since attaining the age of 18 years, or any age and incapable of self-support. A child's marital status or dependency on the covered employee for support is irrelevant to his or her eligibility for benefits as a covered child under Part E.

(2) *Incapable of self-support* means that the child must have been physically and/or mentally incapable of self-

support at the time of the covered employee's death.

■ 44. Amend § 30.501 by revising paragraphs (a) introductory text and (b) introductory text to read as follows:

§ 30.501 What order of precedence will OWCP use to determine which survivors are entitled to receive compensation under EEOICPA?

(a) Under Part B of the Act, if OWCP determines that a survivor or survivors are entitled to receive compensation under EEOICPA because a covered Part B employee who would otherwise have been entitled to benefits is deceased, that compensation will be disbursed as follows, subject to the qualifications set forth in § 30.5(hh)(3):

* * * * *

(b) Under Part E of the Act, if OWCP determines that a survivor or survivors are entitled to receive compensation under EEOICPA because a covered Part E employee who would otherwise have been entitled to benefits is deceased, that compensation will be disbursed as follows, subject to the qualifications set forth in § 30.5(hh)(3):

* * * * *

■ 45. Revise § 30.502 to read as follows:

§ 30.502 When is entitlement for survivors determined for purposes of EEOICPA?

Entitlement to any lump-sum payment for survivors under the EEOICPA, other than for "covered" children under Part E, will be determined as of the time OWCP makes such a payment. As noted in § 30.500(c)(1), a child of a deceased Part E employee will only qualify as a "covered" child of that individual if he or she satisfied one of the additional statutory criteria for a "covered" child as of the date of the deceased Part E employee's death.

■ 46. Amend § 30.509 by revising paragraph (c) to read as follows:

§ 30.509 Under what circumstances may a survivor claiming under Part E of the Act choose to receive the benefits that would otherwise be payable to a covered Part E employee who is deceased?

* * * * *

(c) OWCP only makes impairment determinations based on rationalized medical evidence in the case file that is sufficiently detailed and meets the various requirements for the many different types of impairment determinations possible under the 5th Edition of the American Medical Association's *Guides to the Evaluation of Permanent Impairment* (AMA's *Guides*). Therefore, OWCP will only make an impairment determination for a deceased covered Part E employee pursuant to this section if the medical

evidence of record is sufficient to satisfy the pertinent requirements in the AMA's *Guides* and subpart J of this part.

■ 47. Amend § 30.600 by revising paragraph (c)(2) to read as follows:

§ 30.600 May a claimant designate a representative?

* * * * *

(c) * * *

(2) A representative does not have authority to sign the Form EE-1 (described in § 30.100(a)) or the Form EE-2 (described in § 30.101(a)) for his or her client. A representative also does not have authority to sign the Form EN-20 (described in § 30.505(c)) for his or her client.

■ 48. Amend § 30.601 by revising the introductory text to read as follows:

§ 30.601 Who may serve as a representative?

A claimant may authorize any individual to represent him or her in regard to a claim under EEOICPA, unless that individual's service as a representative would violate any applicable provision of law (such as 18 U.S.C. 205 and 208) or the standards regarding conflicts of interest adopted by OWCP. A federal employee may act as a representative only:

* * * * *

■ 49. Amend § 30.603 by revising paragraph (a) to read as follows:

§ 30.603 Are there any limitations on what the representative may charge the claimant for his or her services?

(a) Notwithstanding any contract, the representative may not receive, for services rendered in connection with a claim pending before OWCP, more than the percentages of the lump-sum payment made to the claimant set out in paragraph (b) of this section, exclusive of costs and expenses.

* * * * *

■ 50. Amend § 30.617 by revising paragraph (b)(2) to read as follows:

§ 30.617 What happens if this type of tort suit was filed during the period from October 30, 2000 through December 28, 2001?

* * * * *

(b) * * *

(2) The date that is 30 months after the date the claimant or claimants first became aware that an illness of the covered Part B employee may be connected to his or her exposure to beryllium or radiation covered by EEOICPA. For purposes of determining when this 30-month period begins, "the date the claimant or claimants first became aware" will be deemed to be the date they received either a reconstructed

dose from NIOSH, or a diagnosis of a covered beryllium illness, as applicable.

■ 51. Amend § 30.618 by revising paragraph (c)(2) to read as follows:

§ 30.618 What happens if this type of tort suit was filed after December 28, 2001?

* * * * *

(c) * * *

(2) The date that is 30 months after the date the claimant or claimants first became aware that an illness of the covered Part B employee may be connected to his or her exposure to beryllium or radiation covered by EEOICPA. For purposes of determining when this 30-month period begins, “the date the claimant or claimants first became aware” will be deemed to be the date they received either a reconstructed dose from NIOSH, or a diagnosis of a covered beryllium illness, as applicable.

■ 52. Revise §§ 30.700 through 30.702 to read as follows:

§ 30.700 In general, what responsibilities do providers have with respect to enrolling with OWCP, seeking authorization to provide services, billing, and retaining medical records?

(a) All providers must enroll with OWCP or its designated bill processing agent (hereinafter OWCP in this subpart) to have access to the automated authorization system and to submit medical bills to OWCP. To enroll, the provider must complete and submit a Form OWCP-1168 to the appropriate location noted on that form. By completing and submitting this form, providers certify that they satisfy all applicable federal and state licensure and regulatory requirements that apply to their specific provider or supplier type. The provider must maintain documentary evidence indicating that it satisfies those requirements. The provider is also required to notify OWCP immediately if any information provided to OWCP in the enrollment process changes. Federal government medical officers, private physicians and hospitals are also required to keep records of all cases treated by them under EEOICPA so they can supply OWCP with a history of the claimed occupational illness or covered illness, a description of the nature and extent of the claimed occupational illness or covered illness, the results of any diagnostic studies performed and the nature of the treatment rendered. This requirement terminates after a provider has supplied OWCP with the above-noted information, and otherwise terminates ten years after the record was created.

(b) Where a medical provider intends to bill for a procedure where prior

authorization is required, authorization must be requested from OWCP.

(c) After enrollment, a provider must submit all medical bills to OWCP through its bill processing portal and include the Provider Number/ID obtained through enrollment or other identifying number required by OWCP.

§ 30.701 How are medical bills to be submitted?

(a) All charges for medical and surgical treatment, appliances or supplies furnished to employees, except for treatment and supplies provided by nursing homes, shall be supported by medical evidence as provided in § 30.700. OWCP may withhold payment for services until such report or evidence is provided. The physician or provider shall itemize the charges on Form OWCP-1500 or CMS-1500 (for professional charges or medicinal drugs dispensed in the office), Form OWCP-04 or UB-04 (for hospitals), an electronic or paper-based bill that includes required data elements (for pharmacies) or other form as warranted, and submit the form or bill promptly to OWCP.

(b) The provider shall identify each service performed using the Physician’s Current Procedural Terminology (CPT) code, the Healthcare Common Procedure Coding System (HCPCS) code, the National Drug Code (NDC) number, or the Revenue Center Code (RCC), with a brief narrative description. OWCP has discretion to determine which of these codes may be utilized in the billing process. OWCP also has the authority to create and supply specific procedure codes that will be used by OWCP to better describe and allow specific payments for special services. These OWCP-created codes will be issued to providers by OWCP as appropriate and may only be used as authorized by OWCP. For example, a physician conducting a referee or second opinion examination as described in §§ 30.410 through 30.412 will be furnished an OWCP-created code. A provider may not use an OWCP-created code for other types of medical examinations or services. When no code is submitted to identify the services performed, the bill will be returned to the provider and/or denied.

(c) For professional charges billed on Form OWCP-1500 or CMS-1500, the provider shall also state each diagnosed condition and furnish the corresponding diagnostic code using the “International Classification of Disease, 9th Edition, Clinical Modification” (ICD-9-CM), or as revised. A separate bill shall be submitted when the employee is discharged from treatment or monthly,

if treatment for the occupational illness or covered illness is necessary for more than 30 days.

(1)(i) Hospitals shall submit charges for both inpatient and outpatient medical and surgical treatment or supplies promptly to OWCP on Form OWCP-04 or UB-04.

(ii) OWCP may adopt a Home Health Prospective Payment System (HHPPS), as developed and implemented by the Centers for Medicare and Medicaid Services (CMS) within HHS for Medicare, while modifying the allowable costs under Medicare to account for deductibles and other additional costs that are covered by EEOICPA. If adopted, home health care providers will be required to submit bills on Form OWCP-04 or UB-04 and to use Health Insurance Prospective Payment System codes and other coding schemes.

(2) Pharmacies shall itemize charges for prescription medications, appliances or supplies on electronic or paper-based bills and submit them promptly to OWCP. Bills for prescription medications must include all required data elements, including the NDC number assigned to the product, the generic or trade name of the drug provided, the prescription number, the quantity provided, and the date the prescription was filled.

(3) Nursing homes shall itemize charges for appliances, supplies or services on the provider’s billhead stationery and submit them promptly to OWCP. Such charges shall be subject to any applicable OWCP fee schedule.

(d) By submitting a bill and/or accepting payment, the provider signifies that the service for which payment is sought was performed as described and was necessary, appropriate and properly billed in accordance with accepted industry standards. For example, accepted industry standards preclude upcoding billed services for extended medical appointments when the employee actually had a brief routine appointment, or charging for the services of a professional when a paraprofessional or aide performed the service. Also, industry standards prohibit unbundling services to charge separately for services that should be billed as a single charge. In addition, the provider thereby agrees to comply with all regulations set forth in this subpart concerning the rendering of treatment and/or the process for seeking payment for medical services, including the limitation imposed on the amount to be paid for such services.

(e) In summary, bills submitted by providers must: Be itemized on Form

OWCP-1500 or CMS-1500 (for physicians), Form OWCP-04 or UB-04 (for hospitals), or an electronic or paper-based bill that includes required data elements (for pharmacies); contain the handwritten or electronic signature of the provider when required; and identify the procedures using HCPCS/CPT codes, RCCs or NDC numbers. Otherwise, OWCP may deny the bill, and the provider must correct and resubmit the bill. The decision of OWCP whether to pay a provider's bill is final when issued and is not subject to the adjudicatory process described in subpart D of this part.

§ 30.702 How should an employee prepare and submit requests for reimbursement for medical expenses, transportation costs, loss of wages, and incidental expenses?

(a) If an employee has paid bills for medical, surgical or other services, supplies or appliances provided by a professional due to an occupational illness or a covered illness, he or she must submit a request for reimbursement on Form OWCP-915, together with an itemized bill on Form OWCP-1500 or CMS-1500 prepared by the provider, or Form OWCP-04 or UB-04 prepared by the provider, and a medical report as provided in § 30.700, to OWCP for consideration.

(1) The provider of such service shall state each diagnosed condition and furnish the applicable ICD-9-CM code, or as revised, and identify each service performed using the applicable HCPCS/CPT code, with a brief narrative description of the service performed, or, where no code is applicable, a detailed description of that service. If no code or description is received, OWCP will deny the reimbursement request and correction and resubmission will be required.

(2) The reimbursement request must be accompanied by evidence that the provider received payment for the service from the employee and a statement of the amount paid. Acceptable evidence that payment was received includes, but is not limited to, a signed statement by the provider, a mechanical stamp or other device showing receipt of payment, a copy of the employee's canceled check (both front and back), a copy of the employee's credit card receipt or a provider billing form indicating a zero balance due.

(b) If a pharmacy or nursing home provided services for which the employee paid, the employee must also use Form OWCP-915 to request reimbursement and should submit the request in accordance with the provisions of § 30.701(a). Any such

request for reimbursement must be accompanied by evidence, as described in paragraph (a)(2) of this section, that the provider received payment for the service from the employee and a statement of the amount paid.

(c) OWCP may waive the requirements of paragraphs (a) and (b) of this section if extensive delays in the filing or the adjudication of a claim make it unusually difficult for the employee to obtain the required information.

(d) Copies of bills submitted for reimbursement must bear the handwritten or electronic signature of the provider when required, with evidence of payment. Payment for medical and surgical treatment, appliances or supplies shall in general be no greater than the maximum allowable charge for such service determined by OWCP, as set forth in § 30.705. OWCP will issue a letter decision on whether to reimburse an employee for out-of-pocket medical expenses, and the amount of any reimbursement. A claimant who disagrees with OWCP's letter decision may request a formal recommended decision and utilize the adjudicatory process described in subpart D of this part.

(e) An employee will be only partially reimbursed for a medical expense if the amount he or she paid to a provider for the service exceeds the maximum allowable charge set by OWCP's schedule. If this happens, OWCP shall advise the employee of the maximum allowable charge for the service in question and of his or her responsibility to ask the provider to refund to the employee, or credit to the employee's account, the amount he or she paid which exceeds the maximum allowable charge. The provider that the employee paid, but not the employee, may request reconsideration of the fee determination as set forth in § 30.712.

(f) If the provider fails to make appropriate refund to the employee, or to credit the employee's account, within 60 days after the employee requests a refund of any excess amount, or the date of a subsequent reconsideration decision which continues to disallow all or a portion of the disputed amount, OWCP will initiate exclusion procedures as provided by § 30.715.

(g) If the provider does not refund to the employee or credit to his or her account the amount of money paid in excess of the charge which OWCP allows, the employee should submit documentation of the attempt to obtain such refund or credit to OWCP. OWCP may authorize reasonable reimbursement to the employee after

reviewing the facts and circumstances of the case.

■ 53. Revise §§ 30.705 through 30.707 to read as follows:

§ 30.705 What services are covered by the OWCP fee schedule?

(a) Payment for medical and other health services, devices and supplies furnished by physicians, hospitals and other providers for occupational illnesses or covered illnesses shall not exceed a maximum allowable charge for such service as determined by OWCP, except as provided in this section.

(b) The schedule of maximum allowable charges does not apply to charges for services provided in nursing homes, but it does apply to charges for treatment furnished in a nursing home by a physician or other medical professional. In the future, OWCP may also decide to implement a fee schedule for services provided in nursing homes.

(c) The schedule of maximum allowable charges also does not apply to charges for appliances, supplies, services or treatment furnished by medical facilities of the U.S. Public Health Service or the Departments of the Army, Navy, Air Force and Veterans Affairs.

§ 30.706 How are the maximum fees for professional medical services defined?

For professional medical services, OWCP shall maintain a schedule of maximum allowable fees for procedures performed in a given locality. The schedule shall consist of: An assignment of a Relative Value Unit (RVU) to procedures identified by HCPCS/CPT code which represents the relative skill, effort, risk and time required to perform the procedure, as compared to other procedures of the same general class; an assignment of Geographic Practice Cost Index (GPCI) values which represent the relative work, practice expenses and malpractice expenses relative to other localities throughout the country; and a monetary value assignment (conversion factor) for one unit of value for each coded service.

§ 30.707 How are payments to providers calculated?

Payment for a procedure, service or device identified by a HCPCS/CPT code shall not exceed the amount derived by multiplying the RVU values for that procedure by the GPCI values for services in that area and by the conversion factor to arrive at a dollar amount assigned to one unit in that category of service.

(a) The "locality" which serves as a basis for the determination of cost is defined by the Bureau of Census Metropolitan Statistical Areas. OWCP

shall base the determination of the relative per capita cost of medical care in a locality using information about enrollment and medical cost per county, provided by CMS.

(b) OWCP shall assign the RVUs published by CMS to all services for which CMS has made assignments, using the most recent revision. Where there are no RVUs assigned to a procedure, OWCP may develop and assign any RVUs it considers appropriate. The geographic adjustment factor shall be that designated by GPCI values for Metropolitan Statistical Areas as devised for CMS and as updated or revised by CMS from time to time. OWCP will devise conversion factors for each category of service as appropriate using OWCP's processing experience and internal data.

(c) For example, if the RVUs for a particular surgical procedure are 2.48 for physician's work (W), 3.63 for practice expense (PE), and 0.48 for malpractice insurance (M), and the conversion factor assigned to one unit in that category of service (surgery) is \$61.20, then the maximum allowable charge for one performance of that procedure is the product of the three RVUs times the corresponding GPCI values for the locality times the conversion factor. If the GPCI values for the locality are 0.988(W), 0.948 (PE), and 1.174 (M), then the maximum payment calculation is:

$$[(2.48)(0.988) + (3.63)(0.948) + (0.48)(1.174)] \times \$61.20$$

$$[2.45 + 3.44 + .56] \times \$61.20$$

$$6.45 \times \$61.20 = \$394.74$$

■ 54. Revise §§ 30.709 and 30.710 to read as follows:

§ 30.709 How are payments for medicinal drugs determined?

Unless otherwise specified by OWCP, payment for medicinal drugs prescribed by physicians shall not exceed the amount derived by multiplying the average wholesale price of the medication by the quantity or amount provided, plus a dispensing fee. OWCP may, in its discretion, contract for or require the use of specific providers for certain medications.

(a) All prescription medications identified by NDC number will be assigned an average wholesale price representing the product's nationally recognized wholesale price as determined by surveys of manufacturers and wholesalers. OWCP will establish the dispensing fee, which will not be affected by the location or type of provider dispensing the medication.

(b) The NDC numbers, the average wholesale prices, and the dispensing fee

shall be reviewed from time to time and updated as necessary.

(c) With respect to prescribed medications, OWCP may require the use of generic equivalents where they are available.

§ 30.710 How are payments for inpatient medical services determined?

(a) OWCP will pay for inpatient medical services according to pre-determined, condition-specific rates based on the Inpatient Prospective Payment System (IPPS) devised by CMS. Using this system, payment is derived by multiplying the diagnosis-related group (DRG) weight assigned to the hospital discharge by the provider-specific factors.

(1) All inpatient hospital discharges will be classified according to the DRGs prescribed by CMS in the form of the DRG Grouper software program. On this list, each DRG represents the average resources necessary to provide care in a case in that DRG relative to the national average of resources consumed per case.

(2) The provider-specific factors will be provided by CMS in the form of their IPPS Pricer software program. The software takes into consideration the type of facility, census division, actual geographic location of the hospital, case mix cost per discharge, number of hospital beds, intern/beds ratio, operating cost to charge ratio, and other factors used by CMS to determine the specific rate for a hospital discharge under their IPPS. OWCP may devise price adjustment factors as appropriate using OWCP's processing experience and internal data.

(3) OWCP will base payments to facilities excluded from CMS's IPPS on consideration of detailed medical reports and other evidence.

(4) OWCP shall review the pre-determined hospital rates at least once a year, and may adjust any or all components when OWCP deems it necessary or appropriate.

(b) OWCP shall review the schedule of fees at least once a year, and may adjust the schedule or any of its components when OWCP deems it necessary or appropriate.

§§ 30.711 through 30.713 [Redesignated as § 30.712 through 30.714]

■ 55a. Redesignate §§ 30.711 through 30.713 as §§ 30.712 through 30.714.

■ 55b. Add § 30.711 to read as follows:

§ 30.711 How are payments for outpatient medical services determined?

(a) OWCP will pay for outpatient medical services according to Ambulatory Payment Classifications (APC) based on the Outpatient

Prospective Payment System devised by CMS.

(b) All outpatient medical services will be classified according to the APC prescribed by CMS for that service in the form of the Outpatient Prospective Payment System Grouper software program. Each payment is derived by multiplying the prospectively established scaled relative weight for the service's clinical APC by a conversion factor to arrive at a national unadjusted payment rate for the APC. The labor portion of the national unadjusted payment rate is further adjusted by the hospital wage index for the area where payment is being made.

(c) If a payable service has no assigned APC, the payment will be derived from the OWCP Medical Fee Schedule.

(d) OWCP shall review the pre-determined outpatient hospital rates at least once a year, and may adjust any or all components when OWCP deems it necessary or appropriate.

■ 55c. Revise newly designated §§ 30.712 and 30.713 to read as follows:

§ 30.712 When and how are fees reduced?

(a) OWCP shall accept a provider's designation of the code to identify a billed procedure or service if the code is consistent with medical reports and other evidence, and will pay no more than the maximum allowable fee for that procedure. If the code is not consistent with the medical and other evidence or where no code is supplied, the bill will be returned to the provider for correction and resubmission.

(b) If the charge submitted for a service supplied to an employee exceeds the maximum amount determined to be reasonable according to the schedule, OWCP shall pay the amount allowed by the schedule for that service and shall notify the provider in writing that payment was reduced for that service in accordance with the schedule. OWCP shall also notify the provider of the method for requesting reconsideration of the balance of the charge. The decision of OWCP to pay less than the charged amount is final when issued and is not subject to the adjudicatory process described in subpart D of this part.

§ 30.713 If OWCP reduces a fee, may a provider request reconsideration of the reduction?

(a) A physician or other provider whose charge for service is only partially paid because it exceeds a maximum allowable amount set by OWCP may, within 30 days, request reconsideration of the fee determination.

(1) The provider should make such a request to the district office with jurisdiction over the employee's claim. The request must be accompanied by documentary evidence that the procedure performed was either incorrectly identified by the original code, that the presence of a severe or concomitant medical condition made treatment especially difficult, or that the provider possessed unusual qualifications. In itself, board certification in a specialty is not sufficient evidence of unusual qualifications to justify a charge in excess of the maximum allowable amount set by OWCP. These are the only three circumstances that will justify reevaluation of the paid amount.

(2) A list of district offices and their respective areas of jurisdiction is available upon request from the U.S. Department of Labor, Office of Workers' Compensation Programs, Washington, DC 20210, or at <http://www.dol.gov/owcp/energy/index.htm>. Within 30 days of receiving the request for reconsideration, the district office shall respond in writing stating whether or not an additional amount will be allowed as reasonable, considering the evidence submitted.

(b) If the district office issues a decision that continues to disallow a contested amount, the provider may apply to the Regional Director of the region with jurisdiction over the district office. The application must be filed within 30 days of the date of such decision, and it may be accompanied by additional evidence. Within 60 days of receipt of such application, the Regional Director shall issue a decision in writing stating whether or not an additional amount will be allowed as reasonable, considering the evidence submitted. This decision is final, and shall not be subject to further review.

■ 56. Amend § 30.715 by adding paragraphs (i) and (j) to read as follows:

§ 30.715 What are the grounds for excluding a provider from payment under this part?

* * * * *

(i) Failed to inform OWCP of any change in their provider status as required in § 30.700.

(j) Engaged in conduct related to care of an employee's occupational illness or covered illness that OWCP finds to be misleading, deceptive or unfair.

■ 57. Amend § 30.716 by adding paragraphs (c) to read as follows:

§ 30.716 What will cause OWCP to automatically exclude a physician or other provider of medical services and supplies?

* * * * *

(c) A provider may be excluded on a voluntary basis at any time.

■ 58. Revise §§ 30.717 through 30.721 to read as follows:

§ 30.717 When are OWCP's exclusion procedures initiated?

(a) Upon receipt of information indicating that a physician, hospital or provider of medical services or supplies (hereinafter the provider) has or may have engaged in activities enumerated in paragraphs (c) through (j) of § 30.715, OWCP will forward that information to the Department of Labor's Office of Inspector General (DOL OIG) for its consideration. If the information was provided directly to DOL OIG, DOL OIG will notify OWCP of its receipt and implement the appropriate action within its authority, unless such notification will or may compromise the identity of confidential sources, or compromise or prejudice an ongoing or potential criminal investigation.

(b) DOL OIG will conduct such action as it deems necessary, and, when appropriate, provide a written report as described in paragraph (c) of this section to OWCP. OWCP will then determine whether to initiate procedures to exclude the provider from participation in the EEOICPA program. If DOL OIG determines not to take any further action, it will promptly notify OWCP of such determination.

(c) If DOL OIG discovers reasonable cause to believe that violations of § 30.715 have occurred, it shall, when appropriate, prepare a written report, *i.e.*, investigative memorandum, and forward the report along with supporting evidence to OWCP. The report shall be in the form of a single memorandum in narrative form with attachments.

(1) The report should contain all of the following elements:

(i) A brief description and explanation of the subject provider or providers;

(ii) A concise statement of the DOL OIG's findings upon which exclusion may be based;

(iii) A summary of the events that make up the DOL OIG's findings;

(iv) A discussion of the documentation supporting DOL OIG's findings;

(v) A discussion of any other information that may have bearing upon the exclusion process; and

(vi) The supporting documentary evidence including any expert opinion rendered in the case.

(2) The attachments to the report should be provided in a manner that they may be easily referenced from the report.

§ 30.718 How is a provider notified of OWCP's intent to exclude him or her?

Following receipt of the investigative report, OWCP will determine if there exists a reasonable basis to exclude the provider or providers. If OWCP determines that such a basis exists, OWCP shall initiate the exclusion process by sending the provider a letter, by certified mail and with return receipt requested (or equivalent services from a commercial carrier), which shall contain the following:

(a) A concise statement of the grounds upon which exclusion shall be based;

(b) A summary of the information, with supporting documentation, upon which OWCP has relied in reaching an initial decision that exclusion proceedings should begin;

(c) An invitation to the provider to:

(1) Resign voluntarily from participation in the EEOICPA program without admitting or denying the allegations presented in the letter; or

(2) Request a decision on exclusion based upon the existing record and any additional documentary information the provider may wish to furnish;

(d) A notice of the provider's right, in the event of an adverse ruling by the deciding official, to request a formal hearing before an administrative law judge;

(e) A notice that should the provider fail to respond (as described in § 30.719) the letter of intent within 60 days of receipt, the deciding official may deem the allegations made therein to be true and may order exclusion of the provider without conducting any further proceedings; and

(f) The address to where the response from the provider should be sent.

§ 30.719 What requirements must the provider's response and OWCP's decision meet?

(a) The provider's response shall be in writing and shall include an answer to OWCP's invitation to resign voluntarily. If the provider does not offer to resign, he or she shall request that a determination be made upon the existing record and any additional information provided.

(b) Should the provider fail to respond to the letter of intent within 60 days of receipt, the deciding official may deem the allegations made therein to be true and may order exclusion of the provider.

(c) The provider may inspect or request copies of information in the record at any time prior to the deciding official's decision by making such request to OWCP within 20 days of receipt of the letter of intent.

(d) OWCP shall have 30 days to answer the provider's response. That

answer will be forwarded to the provider, who shall then have 15 days to reply. Any response from the provider may be forwarded to DOL OIG, should OWCP deem it appropriate, to obtain additional information which may be relevant to the provider's response.

(e) The deciding official shall be the Regional Director in the region in which the provider is located unless otherwise specified by the Director for Energy Employees Occupational Illness Compensation.

(f) The deciding official shall issue his or her decision in writing, and shall send a copy of the decision to the provider by certified mail, return receipt requested (or equivalent service from a commercial carrier). The decision shall advise the provider of his or her right to request, within 30 days of the date of the adverse decision, a formal hearing before an administrative law judge under the procedures set forth in § 30.720. The filing of a request for a hearing within the time specified shall stay the effectiveness of the decision to exclude.

§ 30.720 How can an excluded provider request a hearing?

A request for a hearing shall be sent to the deciding official and shall contain:

(a) A concise notice of the issues on which the provider desires to give evidence at the hearing;

(b) Any request for the presentation of oral argument or evidence; and

(c) Any request for a certification of questions concerning professional medical standards, medical ethics or medical regulation for an advisory opinion from a competent recognized professional organization or federal, state or local regulatory body.

§ 30.721 How are hearings assigned and scheduled?

(a) If the deciding official receives a timely request for hearing, he or she shall refer the matter to the Chief Administrative Law Judge of the Department of Labor, who shall assign it for an expedited hearing. The administrative law judge assigned to the matter shall consider the request for hearing, act on all requests therein, and issue a Notice of Hearing and schedule for the conduct of the hearing. A copy of the hearing notice shall be served on the provider by certified mail, return receipt requested. The Notice of Hearing and the schedule shall include:

(1) A ruling on each item raised in the request for hearing;

(2) A schedule for the prompt disposition of all preliminary matters,

including requests for the certification of questions to advisory bodies; and

(3) A scheduled hearing date not less than 30 days after the date the schedule is issued, and not less than 15 days after the scheduled conclusion of preliminary matters, provided that the specific time and place of the hearing may be set on 10 days' notice.

(b) The provider is entitled to be heard on any matter placed in issue by his or her response to the notice of intent to exclude, and may designate "all issues" for purposes of hearing. However, a specific designation of issues is required if the provider wishes to interpose affirmative defenses, or request the certification of questions for an advisory opinion.

■ 59. Amend § 30.723 by revising paragraph (b) to read as follows:

§ 30.723 How will the administrative law judge conduct the hearing and issue the recommended decision?

* * * * *

(b) The administrative law judge shall receive such relevant evidence as may be adduced at the hearing. Parties to the hearing are the provider and OWCP. Evidence shall be presented under oath, orally or in the form of written statements. The administrative law judge shall consider the notice and response, including all pertinent documents accompanying them, and may also consider any evidence which refers to the provider or to any claim with respect to which the provider has provided medical services, hospital services, or medical services and supplies, and such other evidence as the administrative law judge may determine to be necessary or useful in evaluating the matter.

* * * * *

■ 60. Revise § 30.724 to read as follows:

§ 30.724 How does a recommended decision become final?

(a) Within 30 days from the date the recommended decision is issued, each party may state, in writing, whether the party objects to the recommended decision. This written statement should be filed with the Director for Energy Employees Occupational Illness Compensation.

(b) For the purposes of determining whether the written statement referred to in paragraph (a) of this section has been timely filed with the Director for Energy Employees Occupational Illness Compensation, the statement will be considered to be "filed" on the date that the provider mails it to the Director, as determined by postmark or other carrier's date marking, or the date that such written statement is actually

received by the Director, whichever is earlier.

(c) Written statements objecting to the recommended decision may be filed upon one or more of the following grounds:

(1) A finding or conclusion of material fact is not supported by substantial evidence;

(2) A necessary legal conclusion is erroneous;

(3) The decision is contrary to law or to the duly promulgated rules or decisions of the Director;

(4) A substantial question of law, policy, or discretion is involved; or

(5) A prejudicial error of procedure was committed.

(d) Each issue shall be separately numbered and plainly and concisely stated, and shall be supported by detailed citations to the record when assignments of error are based on the record, and by statutes, regulations or principal authorities relied upon. Except for good cause shown, no assignment of error by any party shall rely on any question of fact or law upon which the administrative law judge had not been afforded an opportunity to pass.

(e) If a written statement of objection is filed within the allotted period of time, the Director for Energy Employees Occupational Illness Compensation will review the objection. The Director will forward the written objection to DOL OIG, which will have 14 calendar days from that date to respond. Any response from DOL OIG will be forwarded to the provider, which will have 14 calendar days from that date to reply.

(f) The Director for Energy Employees Occupational Illness Compensation will consider the recommended decision, the written record and any response or reply received and will then issue a written, final decision either upholding or reversing the exclusion.

(g) If no written statement of objection is filed within the allotted period of time, the Director for Energy Employees Occupational Illness Compensation will issue a written, final decision accepting the recommendation of the administrative law judge.

(h) The decision of the Director for Energy Employees Occupational Illness Compensation shall be final with respect to the provider's participation in the program, and shall not be subject to further review.

■ 61. Amend § 30.725 by revising paragraph (a) to read as follows:

§ 30.725 What are the effects of non-automatic exclusion?

(a) OWCP shall give notice of the exclusion of a physician, hospital or

provider of medical services or supplies to:

- (1) All OWCP district offices;
- (2) CMS;
- (3) All employees who are known to have had treatment, services or supplies from the excluded provider within the six-month period immediately preceding the order of exclusion; and
- (4) The state or local authority responsible for licensing or certifying the excluded party.

* * * * *

■ 62. Amend § 30.726 by revising paragraph (c) to read as follows:

§ 30.726 How can an excluded provider be reinstated?

* * * * *

(c) A request for reinstatement may be accompanied by a request for oral presentation. Oral presentations will be allowed only in unusual circumstances where it will materially aid the decision process.

* * * * *

■ 63. Amend § 30.800 by revising paragraph (c) to read as follows:

§ 30.800 What types of wage-loss are compensable under Part E of EEOICPA?

* * * * *

(c) Whether the employee's inability to earn at least as much as his or her average annual wage was due to a covered illness as defined in § 30.5(s).

■ 64. Amend § 30.801 as follows:

- a. Revise paragraph (a);
- b. Redesignate paragraphs (c), (d) and (e) as paragraphs (d), (e) and (h), respectively;
- c. Add paragraph (c);
- d. Revise newly designated paragraph (e); and
- e. Add paragraphs (f) and (g).

The revisions and additions read as follows:

§ 30.801 What special definitions does OWCP use in connection with Part E wage-loss determinations?

* * * * *

(a) *Average annual wage* means 12 times the average monthly wage of a covered Part E employee for the 36 months preceding the month during which he or she first experienced wage-loss due to exposure to a toxic substance at a DOE facility or RECA section 5 facility (referred to as the "trigger month"), excluding any months during which the employee was unemployed. Because being "retired" is not equivalent to being "unemployed," months during which an employee had no wages because he or she was retired will not be excluded from this calculation.

* * * * *

(c) *Month during which the employee was unemployed* means any month during which the covered Part E employee had \$250 (in constant 2013 dollars) or less in wages unless the month is one during which the employee was retired.

* * * * *

(e) *Quarter during which the employee was unemployed* means any quarter during which the covered Part E employee had \$750 (in constant 2013 dollars) or less in wages unless the quarter is one during which the employee was retired.

(f) *Trigger month* means the calendar month during which the employee first experienced a loss in wages due to exposure to a toxic substance at a DOE facility or RECA section 5 facility.

(g) *Wages* mean all monetary payments that the covered Part E employee earns from his or her regular employment or services that are taxed as income by the Internal Revenue Service. Salaries, overtime compensation, sick leave, vacation leave, tips, and bonuses received for employment services are considered wages under this subpart. However, capital gains, IRA distributions, pensions, annuities, unemployment compensation, state workers' compensation benefits, medical retirement benefits, and Social Security benefits are not considered wages.

* * * * *

■ 65. Revise § 30.805 to read as follows:

§ 30.805 What are the criteria for eligibility for wage-loss benefits under Part E?

(a) In addition to satisfying the general eligibility requirements applicable to all Part E claims, a claimant seeking benefits for calendar years of qualifying wage-loss has the burden of proof to establish each of the following criteria:

- (1) He or she held a job at which he or she earned wages;
- (2) He or she experienced a loss in those wages in a particular month (referred to as the "trigger month" in this section);
- (3) The wage-loss in the trigger month was caused by the covered Part E employee's covered illness, *i.e.*, that he or she would have continued to earn wages in the trigger month from that employment *but for the covered illness*;
- (4) His or her average annual wage;
- (5) His or her normal retirement age and the calendar year in which he or she would reach that age;
- (6) Beginning with the calendar year of the trigger month, the percentage of the average annual wage that was earned in each calendar year up to and including the retirement year;

(7) The number of those calendar years in which the covered illness caused the covered Part E employee to earn 50% or less of his or her average annual wage; and

(8) The number of those calendar years in which the covered illness caused him or her to earn more than 50% but not more than 75% of his or her average annual wage.

(b) OWCP will discontinue development of a request for wage-loss benefits, during which the claimant must meet his or her burden of proof to establish each of the criteria listed in paragraph (a) of this section, at any point when the claimant is unable to meet such burden.

■ 66. Revise § 30.806 to read as follows:

§ 30.806 What kind of medical evidence must the claimant submit to prove that he or she lost wages due to a covered illness?

OWCP requires the submission of rationalized medical evidence of sufficient probative value to convince the fact-finder that the covered Part E employee experienced a loss in wages in his or her trigger month due to a covered illness, *i.e.*, medical evidence based on a physician's fully explained and reasoned decision (see § 30.805(a)(3)). A loss in wages in the trigger month due solely to non-covered illness matters, such as a reduction in force or voluntary retirement, is not proof of compensable wage-loss under Part E.

■ 67. Add § 30.807 to read as follows:

§ 30.807 What factual evidence does OWCP use to determine a covered Part E employee's average annual wage?

(a) OWCP may rely on annual or quarterly wage information reported to the Social Security Administration to establish a covered Part E employee's presumed average annual wage (see § 30.810) and the duration and extent of any years of wage-loss that are compensable under Part E of the Act (see § 30.811). OWCP may also rely on other probative evidence of a covered Part E employee's wages, and may ask the claimant for additional evidence needed to make this determination, if necessary. For the purposes of making these two types of determinations, OWCP will consider all monetary payments that the covered Part E employee received as wages (see § 30.801(g)).

(b) A claimant who disagrees with the evidence OWCP has obtained under paragraph (a) of this section and alleges a different average annual wage for the covered Part E employee, or that there was a greater duration or extent of wage-loss, may submit records that were

produced in the ordinary course of business due to the employee's employment to rebut that evidence, to the extent that such records are determined to be authentic by OWCP. The average annual wage and/or wage-loss of the covered Part E employee will then be determined by OWCP in the exercise of its discretion.

■ 68. Amend § 30.810 by revising paragraphs (a), (b), (c), and (d) to read as follows:

§ 30.810 How will OWCP calculate the average annual wage of a covered Part E employee?

* * * * *

(a) Aggregate the wages for the 36 months that preceded the trigger month, excluding any month during which the employee was unemployed;

(b) Add any additional wages earned by the employee during those same months as evidenced by records described in § 30.807;

(c) Divide the sum of paragraphs (a) and (b) of this section by 36, less the number of months during which the employee was unemployed; and

(d) Multiply this figure by 12 to calculate the covered Part E employee's average annual wage.

■ 69. Amend § 30.811 as follows:

■ a. Revise paragraph (a);

■ b. Remove paragraph (b); and

■ c. Redesignate paragraphs (c) and (d) as paragraphs (b) and (c), respectively.

The revision reads as follows:

§ 30.811 How will OWCP calculate the duration and extent of a covered Part E employee's initial period of compensable wage-loss?

(a) To determine the initial calendar years of wage-loss, OWCP will use the evidence it receives under §§ 30.805 through 30.807 to compare the calendar-year wages for the covered Part E employee, as adjusted, with the average annual wage determined under § 30.810 for each calendar year beginning with

the calendar year that includes the trigger month, and concluding with the last calendar year of wage-loss prior to the submission of the claim or the calendar year in which the employee reached normal retirement age (as defined in § 30.801(b)), whichever occurred first.

* * * * *

■ 70. Amend § 30.901 by revising paragraphs (a) and (b) to read as follows:

§ 30.901 How does OWCP determine the extent of an employee's impairment that is due to a covered illness contracted through exposure to a toxic substance at a DOE facility or a RECA section 5 facility, as appropriate?

(a) OWCP will determine the amount of impairment benefits to which an employee is entitled based on one or more impairment evaluations submitted by physicians. An impairment evaluation shall contain the physician's opinion on the extent of whole person impairment of all organs and body functions of the employee that are compromised or otherwise affected by the employee's covered illness or illnesses, which shall be referred to as an "impairment rating."

(b) In making impairment benefit determinations, OWCP will only consider medical reports from physicians who are certified by the relevant medical board and who satisfy any additional criteria determined by OWCP to be necessary to qualify to perform impairment evaluations under Part E, including any specific training and experience related to particular conditions and other objective factors.

* * * * *

■ 71. Revise § 30.902 to read as follows:

§ 30.902 How will OWCP calculate the amount of the award of impairment benefits that is payable under Part E?

(a) OWCP will multiply the percentage points of the impairment

rating by \$2,500 to calculate the amount of the award.

(b) An employee's impairment rating may be comprised of multiple impairments of organs and body functions due to multiple covered illnesses. If an impairment award is payable based on a whole person impairment rating in which at least one of the impairments is subject to a reduction under §§ 30.505(b) and/or 30.626, OWCP will reduce the impairment award proportionately.

■ 72. Amend § 30.908 by revising paragraphs (b) and (c) to read as follows:

§ 30.908 How will the FAB evaluate new medical evidence submitted to challenge the impairment determination in the recommended decision?

* * * * *

(b) The employee shall bear the burden of proving that the additional impairment evaluation submitted is more probative than the evaluation relied upon by the district office to determine the employee's recommended impairment rating.

(c) If an employee submits an additional impairment evaluation that differs from the impairment evaluation relied upon by the district office, the FAB will review all relevant evidence of impairment in the record, and will base its determinations regarding impairment upon the evidence it considers to be most probative. The FAB will determine the impairment rating after it has evaluated all relevant evidence and argument in the record.

Signed at Washington, DC, this 20th day of October, 2015.

Leonard J. Howie III,

Director, Office of Workers' Compensation Programs.

[FR Doc. 2015-27121 Filed 11-17-15; 8:45 am]

BILLING CODE 4510-CR-P