The following topics were discussed at the in-person meeting with law firms held on August 9, 2017. The meeting covered important updates and reminders on the VCF. You can view the slides presented at the meeting here.

- **Announcements:**

  As all of you know, our long-time law firm liaison left the VCF in June to pursue other opportunities. Going forward, that role will be filled by Catherine Doctor in our New York Office and by one of our talented claim reviewers, Peter Offen. Given the nature of the questions being asked these days, we thought that having both Catherine and Peter working in tandem would bring the most benefit to you and to us.

- **General Updates on Claim Processing:**

  Claim Backlog: Since our last call in early March, we have rendered over 2,000 determinations. This includes eligibility and compensation determinations for new claims and amendments. Our team continues to work through the backlog with an eye towards opportunities to process claims more efficiently. We have made substantial progress in clearing the 2015 backlog and almost all non-economic loss claims filed in 2015 are completed. Approximately 425 claims that were submitted before Reauthorization and that are ready for compensation review remain to be decided. We are prioritizing older deceased claims, and hopefully you have seen more deceased claim awards in recent months. We are starting to turn our attention to claims where compensation was submitted in 2016. Under our prioritization plan, claims and amendments submitted in early to mid-2015 are currently receiving award determinations. Compensation submissions from mid-to late 2015 are under review, and compensation submissions from late 2015 and early 2016 will come under review soon.

  Non-Economic Loss: We have been concerned with the significant increase in the number of non-economic loss only claims that are being submitted. Since the claimant portal reopened in August 2016 with the new claim form functionality, we have seen the submission of over 7,000 new compensation claims (note, these are not amendments to existing claims, but new compensation submissions). The vast majority of those, over 5,000, have been submitted as non-economic loss only. As we've stated previously, it helps us process claims more quickly – and enables us to better predict and plan our resources – when you file one complete claim, including both non-economic loss and economic loss components. Or, at the very least, if you amend your claim for the economic loss component before we pick up the claim for review. The large numbers of non-economic loss only claims that we are seeing is very concerning because it implies we may then have a large number of economic loss amendments submitted at some point in the future.

  If you plan to later amend for economic loss on these claims, please understand that you are creating huge challenges for us in terms of processing claims as quickly as possible. Economic loss claims take a different skillset (and require significantly longer training for reviewers) than non-economic loss claims, and we cannot plan resources appropriately if we have a skewed perspective of how many economic loss versus non-economic loss claims are coming in. In addition, it hurts our processing capacity for all claims when we have to look at any individual's claim multiple times.

  **If you plan to file economic loss for a claimant, file it together with the non-economic loss claim**. If you know that you have filed a high number of non-economic loss only claims recently, please provide feedback to Catherine Doctor and Peter Offen about the percentage of these claims for which you plan to file an amendment for economic loss at a later date. If you have filed non-economic loss claims that are either under review or in queue for review, for which you plan to eventually file an economic loss amendment, please file those amendments now, before the claim is picked up for review and an award is issued, so we can review the claim in its entirety at one time.

  Because we are operating under the assumption that many of these claims will be amended, we are redirecting resources away from Fast-Track review. Fast-Track was created to quickly render award decisions in cases where claimants sought non-economic loss only – we did not want those claimants, whose claims we knew could be processed quickly, to have to wait in line behind significantly more

complicated claims. This process will not be used, however, to render a quick award decision when the end result may be that we will need to take the inefficient step of picking that claim up again once the economic loss amendment is filed. Given the pattern of claim filing that we are seeing, you will start to see a slow-down in Fast Track awards as we redirect resources to older compensation claims that have pending eligibility amendments.

Finally, a word about wrongful death claims and amendments. If you have filed a wrongful death claim and you know you need to amend the claim (for economic loss or other reasons), please submit those amendments now. If the claim is reviewed and we cannot issue anything other than the personal injury non-economic loss component, and if there are monetary limitations on the court order or Letters of Administration, you will end up in a situation where you may have to go back to the court multiple times to seek amended letters (once for the Personal Injury portion and then again for the Wrongful Death portion). If you submit the amendment late in the process – for example after the personal injury non-economic loss award has been issued but before payment is processed – it results in the claim being halted because we prefer to review the new information at that time rather than have to revisit the claim after it has been paid.

- **Policy Updates:** On May 18, we posted and circulated updates to our Policies and Procedures document. Many of the changes were discussed on our call held in March, and the updated version of the document includes a table highlighting the sections that were changed when compared to the prior version. Since the update was published, we have continued to evaluate our procedures and policies for reviewing certain types of claims and we have several new updates to share with you today. These updates will be incorporated into the Policies and Procedures document, as well. We are planning to post an updated version that incorporates these updates within the next few weeks.
  - **Private Physician Process:** The Private Physician process was originally created several years ago because the WTC Health Program could not meet the demand for appointments and we did not want claims to be held up while waiting for certifications – especially for those individuals who only needed the certification and not the treatment since they were being treated by their private physicians. The process was also important for those claimants who were being treated for their conditions by private physicians prior to the WTC Health Program being established, and for those individuals whose conditions were not yet covered for treatment. Since that time, many things have changed, including expanded capacity at the Clinical Centers of Excellence ("CCEs") and a desire to streamline the review process wherever possible. We have therefore agreed with our counterparts at NIOSH that it makes sense to limit the number of claims that go through the Private Physician process. The WTC Health Program has been working to expand outreach for the Nationwide Provider Network, and a claimant can continue to be treated by his or her "private" physician even if certified for treatment by the WTC Health Program. Seeking certification is the best way to demonstrate that a condition is eligible for compensation, and sending claimants to the WTC Health Program also expands their research base, which is a benefit to everyone.

    Early last month, we published guidance on our website about the changes to the Private Physician process. We recognize there was some confusion about the impact and significance of the changes in the criteria and process, and based on feedback and questions we received, we posted updated guidance on July 25 in Section 7 of the FAQs that we believe addresses the questions raised.

    **In collaboration with NIOSH, we have agreed that going forward, we will only verify conditions through the Private Physician process in the following situations:**

    1) Deceased victims who were not certified for treatment by the WTC Health Program for the claimed condition;
    2) Individuals (personal injury or deceased) who were previously deemed eligible based on a certified condition and are seeking verification for cancer (which is easy to verify through the Private Physician process based on the pathology report); or

3) Individuals who are not able to go to a WTC Health Program center (either in the New York City metropolitan area or through the Nationwide Provider Network) to have their condition evaluated and certified for treatment without suffering significant hardship. If you believe that a claimant will suffer significant hardship in seeking certification by the WTC Health Program, you should upload a statement or letter to the claim explaining the circumstances and why the individual should be considered for the Private Physician process, **and** then call the Helpline to alert us to the request. This is similar to the process we use for expedite requests. Once the request is reviewed and a decision is made about whether to grant the request, a member of our Helpline team will call you to notify you of the decision. This will enable us to properly track all requests, and continue to review and respond to these requests in a timely manner. If we determine that a claimant is an appropriate candidate for the Private Physician process, once we call to notify you of that decision, you should complete and submit a Private Physician packet and the supporting documents. *In all other cases, we will not process the claim until we receive notification from the WTC Health Program that the claimant has been certified for at least one physical condition*.

We have been reviewing the claims that were previously submitted with a Private Physician packet and are taking one of the following actions depending on the claim:

- If the claimant **is** certified for at least one condition, we will continue the review of the claim and the next determination letter that is sent (either Eligibility or Compensation) will include text explaining that the Private Physician packet was not reviewed and the next steps to take if the claimant still wants the condition to be considered for compensation. As we have discussed before, please carefully consider whether certification of an additional condition will impact the amount of the award before advising your client to return to the WTC Health Program to seek additional certifications for purposes of the VCF.
- If the claimant does **not** have any certified conditions, we have updated the language in the Missing Information letters to explain that the submitted Private Physician packet is not being reviewed, and that the claimant should seek certification from the WTC Health Program. In these instances, the claim will be made inactive, but the 60-day timeframe prior to denial will not apply as we recognize it may take time for the claimant to schedule the appointment and receive the certification.

We are working on changes to the language in the claim form to reflect the updated policy. It will take longer to make changes to the online form due to the embedded logic regarding when to display the Private Physician questions, so in the meantime, please ONLY complete them if you are confident the claimant meets the new criteria.

We believe these changes will speed the review of claims as we will already have a certified condition when the claim is picked up for review. If you are preparing new claims to submit, we encourage you to wait for the certification before submitting the claim. As long as the claim has been timely registered, it is best to wait to submit the claim until the victim has been certified by the WTC Health Program. If you submit the claim *without* the individual first being certified, we will place the claim in Inactive status and it will remain in that status and will not be reviewed until the certification letter is submitted.

For those claims that have already been submitted and are impacted by the change in the Private Physician process, the claim's priority order will not be impacted as it is established based on the submission of the compensation claim. This means that waiting for the certification will not change the order in which the claim is processed. Once the certification is received, the claim will be prioritized for processing based on the date on which the compensation claim was submitted.

o **WTC Health Program Disability Process**: As a reminder, the WTC Health Program disability process is intended for claimants who do not already have a disability determination for an eligible

condition from a third-party entity (e.g., Social Security Administration, FDNY/NYPD, a state Workers' Compensation program, or insurance company).

We have been working with the WTC Health Program to ensure that the disability evaluation process meets our needs for purposes of calculating a claimant's loss, meets the WTC Health Program's needs for patient evaluation and care, and meets the needs of our claimants who rely on these evaluations as the only means of demonstrating a disability. With this in mind, we have refined the criteria to be eligible for an evaluation. Going forward, a claimant will only be considered for the program if he/she meets all of the following criteria:

1) **The claimant is a member of the WTC Health Program.**

2) **The VCF has deemed the claimant to be eligible for at least one certified physical condition.** If the claimant's only eligible conditions were verified through the Private Physician process, then the claimant is not eligible for this process. The claimant is also not eligible for this process if certified only for ineligible conditions.

3) **The claimant must not already have a disability determination for an eligible condition from a third-party entity or have a pending disability application with a third party.** This is a change from prior criteria, which allowed claimants into the process who had a partial disability determination for an eligible condition, if other criteria were met. *Under the updated criteria, claimants who have a full or partial disability determination based on an eligible condition are not eligible to enter the process as the VCF will rely on the existing determination*.

4) **The claimant's earnings must have decreased or stopped due to an eligible condition and there must be a reasonable basis to believe that the claimant's eligible condition is preventing his/her return to work.** To satisfy this component, there must be evidence that the claimant is currently not working or is earning materially less than he/she earned prior to the alleged disability. In other words, if the claimant is currently earning an amount that approximately equals or exceeds the amount he/she earned prior to the alleged disability, then the claimant will not be approved as a candidate for the process. In addition, there must be a reasonable basis to believe that the claimant's 9/11-related condition is what is preventing the return to work, either in whole or in part. This new limitation is intended to address situations where, even if there is a finding of an occupational disability through the WTC Health Program, the VCF would not assume any earnings loss.

5) **The claimant's eligible WTC Health Program certified condition is one that could reasonably be found to be disabling.** Whether there is a "reasonable" basis could be based on the nature of the condition (for example, a very serious pulmonary condition or a cancer that is in active treatment), medical records documenting consistent emergency room visits, consistent acute episodes of the manifestation of the disease, recurring surgeries or serious side effects of medication needed to control the eligible condition, etc. A credible personal statement may also provide sufficient support for this requirement.

6) **The claimant is not eligible for WTC retirement or WTC reclassification by the FDNY, NYPD, or NYCERS, with limited exceptions.** If a claimant did not apply for WTC retirement or reclassification or was denied WTC retirement or reclassification, and the claimant is claiming lost earnings based on FDNY, NYPD, or NYCERS employment, s/he is generally not eligible for this process. Because there is an alternative, formal process available to those claimants to seek a disability determination due to eligible conditions, they do not qualify for a separate disability evaluation through the WTC Health Program. An exception may be made in those cases where a claimant already has a WTC retirement or WTC reclassification, but it is due solely to an ineligible condition, if all of the other eligibility criteria are met.

We posted updated guidance to our website on July 6 reflecting these changes and will also be

updating the relevant section in the Policies and Procedures document.

We are also making a few changes to the way we process claims when the claimant has been deemed eligible for the disability evaluation. After being notified by the VCF that the individual is eligible, the claim will be placed in an "On Hold" status pending the outcome of the disability evaluation. If after 4 months we have not received the disability evaluation report, we will remove the claim from the hold and render a determination based on what is in the file at that time. We have discussed the average timeframes with the CCEs for scheduling the appointment, performing the exam, and providing the report, and 4 months appears to be more than adequate if the claimant takes action once we confirm he/she is approved for the process. If there is something that delays the claimant's ability to get the exam, you can notify us and we will hold our review of the claim beyond the 4 months if appropriate.

We also have a few important reminders that will help this process move more smoothly:

- Please submit the WTC Health Program disability evaluation request as a *compensation* amendment, as opposed to an eligibility amendment. If you have not yet filed a compensation claim for the individual, you need to do so before submitting the disability evaluation request.
- You must submit a sufficient Exhibit 1 with the disability evaluation request if it was not already submitted with the compensation claim.
- Please also submit medical records relating to severity of the condition and/or records that support that the condition is reasonably disabling. PFTs and/or other objective records related to respiratory conditions should be submitted, if available.

We have updated the disability evaluation form and the updated form has been shared with the CCEs. If a claimant submitted an evaluation using the prior form, he/she should NOT go back to the CCE to request another evaluation using the new form. If there is sufficient reason to believe that additional information from the evaluating physician would allow us to award lost earnings, we will contact the CCE directly to get this information.

- **Medical Expense Claims**: In May, as part of the update to the Policies and Procedures document, we posted updated guidance to our website regarding claims for out-of-pocket medical expenses. As a reminder, we will now only accept medical expense claims filed as a compensation amendment after the initial award determination has been issued. This allows us to issue the initial award determination more quickly, since we are not spending time during our initial review to verify each claimed medical expense. In addition, we will only consider medical expense claims if the total amount of claimed medical expenses incurred due to eligible conditions exceeds $2,000. Establishing this minimum threshold is consistent with the reauthorization requirement to prioritize funding to those claimants with the most debilitating conditions.

  We will consider requests for exceptions to this policy, but they truly must be worthwhile requests. For example, if you have a claimant who is under financial strain and who paid for a surgery out of pocket, you can submit the request for consideration. We will review the request as part of our review of the claim; the award letter will include language addressing the request, and whether and to what extent such claimed expenses were compensated.

- **Replacement Services:** We have received questions from some of you regarding why your claims for replacement services are not being awarded. Replacement services are awarded at the Special Master's discretion. They were originally designed to account for the contributions of, for example, a stay at home parent. As noted in VCF regulations, replacement services are typically considered to be a component of loss in claims where the victim did not have prior earned income or only worked part-time outside the home. For that reason, under current policy, it is rare that we will award replacement services in a personal injury claim where we are also awarding lost earnings, even if there is documentation in the claim file showing that the claimant performed certain services before

the onset of eligible conditions and can no longer perform those services as a result of eligible conditions. The value of replacement services is a substitute for valuing economic loss in those cases where lost income could not serve as the way to value that loss; it is not intended to be additive in cases where lost earnings can be, and are being, compensated.

When we do award replacement services, we look for a statement from the claimant about the services he/she provided before the eligible condition, the amount of time spent on those services (per week or month), and the amount of time he/she is able to spend on those services now (i.e., with the eligible conditions). The claim must also be supported by medical records that clearly show that the claimant cannot perform household services because of an eligible condition.

- **Claim Review Process:** Many of you have repeatedly asked us what you can do to help us process claims more efficiently. We very much appreciate you asking these questions and we have taken your requests to heart. We have identified two specific areas in our review of claims where getting the information from you in a different format could positively impact our review: claims where pension information is needed and claims that are seeking compensation for a discrete period of past lost earnings. We have also made some changes to our loss calculation addendums that we hope will provide more clarity for you and your clients regarding how loss calculations are done.

  New Worksheets**:** We have created new worksheets for you to use when submitting claims with defined benefit pension loss or a discrete period of past lost earnings. These are now posted to our website under Forms and Resources. Your use of these worksheets will be of great benefit to us in getting claims processed faster, and we hope that you will find them useful in identifying the key information that we need in these types of claims.

  - **NYCRES and NYSLRS Pension worksheets:** Defined benefit pensions are retirement benefits that are awarded based on the number of years of credited service with an employer or union – they are different from a 401(k), for example, in which it is the employer's contribution to the retirement plan that is defined rather than the benefit. If a victim stopped accruing credited services toward his pension earlier than expected because he died or became disabled due to an eligible condition, we will try to compensate that pension loss. In some cases, the benefits may increase because of death or disability, and in that case we would need to offset the amount of the increase.

    **We have created two worksheets that will help you – and us – gather the information we need to calculate these amounts.** One is designed for victims who had pensions through the New York City Employee Retirement System (NYCERS) or through the New York State and Local Retirement System (NYSLRS). Whenever you have a victim who worked for a state or local government in New York, you should be on the lookout for a defined benefit pension. We created a separate worksheet for all other defined benefit pensions, including those administered by unions for their members.

    The Policies and Procedures document on our website provides specific information about each pension plan we have encountered, including a list of the information and documentation we need. FDNY, NYPD, NYCERS, and federal employees, including military personnel, are discussed in section 2.2. Unions and other employers, including NYSLRS, Con Ed, and Verizon are discussed in Appendix G. Section 2.2 also addresses what we will need if your client's claim involves a defined benefit pension that we have not previously encountered. The starting point will always be the Summary Plan Description (often referred to as the "SPD").

    Because our statute requires us to offset collateral source benefits, if we have any reason to believe that your claimant may be receiving a disability or survivor pension, we cannot award lost earnings until we obtain information about that pension, or confirm that there is no benefit. If there is no disability or survivor pension benefit, we can award lost earnings without complete information about the pension plan, but we will apply our standard default values for retirement benefits, which is a 401(k) employer contribution equal to 4% of base salary.

    **The third new worksheet is for a discrete period of lost earnings.** It is an Excel spreadsheet similar to the Medical Expenses worksheet: there is a tab of instructions and a tab of examples. The

tab titled "worksheet" is the one that you complete. A typical scenario is a claimant who misses a substantial amount of work while undergoing treatment for an eligible condition but then recovers and returns to work. There is no ongoing disability, but there may be lost earnings. Establishing this claim requires that you prove two things: (1) there was a loss of earnings; and (2) the loss was connected to an eligible condition. The different pieces of information that establish these two elements must overlap in time. For example, you might have medical records showing an extended period of hospitalization for an eligible condition, plus earnings records showing a significant decrease in earnings during the same time period. Or you might have a doctor's note excusing the claimant from working on certain dates due to an eligible condition, plus paystubs or a letter from the employer that establish an unpaid leave of absence on those dates, and the rate of pay the claimant would have received had s/he worked. You might enter each day as a separate row, if your evidence is that specific. Or if you have a document that covers a longer period, such as a hospital record for a long stay, or a doctor's letter covering a long period, you could enter a longer span of time in one row. ***Please do not enter the entire span of time on one row and point us to thirty pages of documents*** as that defeats the point of the worksheet!

- **Application of Offsets:** As discussed on our phone call in March, we no longer require that you withdraw an economic loss claim when the non-economic loss award is higher than the total award after applicable offsets. We are also calculating the personal injury and wrongful death portions of a deceased claim separately so that the two portions will not offset each other. These two changes are essentially a clarification of how we apply offsets to the different types of losses in a claim and we want to provide some additional insight regarding this topic. Slides 23-25 of the slides presented during the meeting include charts that summarize this information.

  Award letter Addenda: We have talked in the past about adding details to the loss calculation breakdown that is included in award letters, to better explain the calculations used. We have made several changes to the addenda to further clarify the calculation of the award. Slides 27-29 of the slides presented during the meeting include samples of the new addenda. Initially, you will see the new addenda format only in claims with wrongful death losses.

  The addendum now separates out the different categories of collateral source offsets to clarify how we are applying them. The offsets applicable to lost earnings and benefits are just below the lost earnings total. If the offsets are greater than lost earnings, a negative total is shown, but there is an additional row below it that shows the $0.00 that actually gets included when we add everything together. The other types of economic loss and the non-economic loss are added after the earnings-related offsets are applied. Then, any lawsuit settlement or PSOB award are subtracted at the bottom.

  For a wrongful death claim, the first page of the addendum will look similar to the personal injury addendum, but you will notice the lawsuit settlement and PSOB award will be included on the second page, after the personal injury portion of the claim is combined with the wrongful death portion. On the second page, the wrongful death losses and offsets will be shown. The earnings-related offsets are taken off the lost earnings before the other economic losses and non-economic loss are added. Then, the offsets that apply only to the wrongful death claim are taken. Finally, any PSOB award, prior lawsuit settlement, or previously paid personal injury award are deducted from the combined total of personal injury and wrongful death. These changes to the addenda are designed to provide more clarity about how we calculate the award.

  One final word about the addenda – many of you have contacted us about claims with Letters of Administration with monetary limitations and have asked if the addendum can be included in the Missing Information-Loss Calculation letter ("MILCs") so you know the award amount at that time, can assess whether or not your client will appeal, and can then decide whether to seek amended Letters of Administration at that time or wait for the full award letter to be issued and then seek amended letters following the appeal. We appreciate that no one wants to go back to the courts multiple times and as of August 7, we have added the addendum to all MILCs – Personal Injury and Wrongful Death – so you will start to see that change in the letters.

Life Insurance: If the victim had a life insurance policy, you **must** identify the life insurance policy and payments received (and by whom) when filing the claim. We will be following up to confirm for all claims where a "no" answer is provided specific to life insurance. We have had a few claims recently where the claim form indicated there was no life insurance but when we called to confirm, we were told there was in fact a policy and a payment. Please be careful to answer this question correctly – it saves us the confirmation call and enables us to move forward with the claim.

- **Appeals:** We have been very pleased to see that questions about when to amend and when to appeal have decreased considerably since the end of last year, and that the issues that ultimately do go to appeal are appropriately raised and addressed in that context. We recognize that not all circumstances fit squarely within the published guidance and appreciate your patience and willingness to work through certain claims prior to scheduling to determine how a particular issue should be handled – on appeal or via an amendment.

  We have, however, seen an increasing trend in appeals where you or your clients have attempted to raise issues on appeal that were not asserted in the claim. **If you did not claim a particular issue in your submission, you may not address it on appeal. Instead, you will need to file an amendment.** For example, if you did not claim replacement services in your submission, you cannot raise it for the first time on appeal. Also, please continue to be diligent about tracking down additional documentation well before the eligibility determination is issued so that we avoid using resources to plan, coordinate, and prepare for hearings that need not happen.

  As we have previously stated on our website and at these meetings, we set a goal back in November to have post-hearing decisions rendered approximately 45 days after a hearing. After working through the backlog and managing a continuing high volume of appeals, we are pleased to report that we are currently meeting that target (apart from a few claims where we are still awaiting additional information). We expect to continue rendering decisions post-appeal within 45 days after the hearing on a regular basis. As we meet the 45-day mark, please remember that if the Hearing Officer advises you to file certain information following an appeal within a specified time period, the appeal will be reviewed once that time period has elapsed. If you reasonably believe you need more time, please be sure to let us know (via a call to the New York Office) so that we can add a note in the claim that we should hold a decision on the appeal for some additional period of time.

- **New Forms and Resources:** We have a few new forms and resources, some of which were introduced on the call in March but were not available until after the call.

  Updated guidance for Surrogates and Probate courts regarding treatment of Letters of Administration or other Court Order that limit the authority of a Personal Representative. In response to hearing from many of you about the challenges in getting updated letters without limitations, we posted updated guidance to our website on July 6. We hope this document is one you can take to the courts to help explain what is needed and why. For those who have not had a chance to review the document, it includes information on limitations related to:

  - The authority to file, prosecute, and/or compromise any action or claim on behalf of a decedent – with information specific to the handling of the claim based on the cause of death (9/11-related vs. not), as well as information specific to letters issued in New York State vs. those issued outside of New York. This particular limitation is the one that could prevent us from even beginning to process the claim so please review the information carefully.
  - The following limitations apply regardless of the state in which the letters or court order are issued and regardless of the cause of death:
    - Limitations restricting the amount of funds the Personal Representative can collect on behalf of the decedent's estate. As you know, with these limitations, we can process the claim but can only issue payment up to the limitation amount.
    - Limitations restricting the Personal Representative's authority to specific actions. If the

Letters of Administration or court order authorizes the Personal Representative to take only a specific action(s) with respect to the estate, such as open an estate bank account or empty a storage locker owned by the decedent, then the VCF generally will not process the claim until amended letters are received.

- Time-limited letters: If the Letters of Administration or court order contains an expiration date, the VCF will require revised Letters of Administration or a court order that extends the Personal Representative's authority to collect assets or administer the estate if the letters or order expire prior to the payment being issued on the claim.

We are also working to schedule a call or visit with the various courts to discuss the VCF and the processing of claims for deceased victims. We will keep you posted as we determine how best to make sure the courts understand what the VCF needs and why you are asking for the amended letters.

Claim Information Resolution Form and Change of Attorney Form: We know many of you have already started using these forms and we hope you have found them to be as helpful to you as they have been for us. Getting the Claim Information Resolution Form forms makes it much easier for us to resolve the data discrepancies and multiple claim number issues that can hold up claims, and the Change of Attorney Form makes it much easier for us to ensure the correct law firm is associated with the claim and online access is granted to the proper individual.

We realize that in some cases, you are not able to upload these forms to the claim as you may not have online access to the claim until we process the form. Or, in some cases, we know you prefer to fax the form, which we have seen in our increased fax volume! We have put in place a new special email box to allow you to email **just these forms** to the VCF. This helps us in reducing our hard copy document handling and we hope you will find it easier than faxing.

If emailing the forms, we ask that you follow this protocol:

- Save the forms as individual, separate documents using the claim number in the file name. You may attach multiple forms to a single email, and may attach forms for more than one claim, but each form should be a distinct PDF file.
- You will receive an automated reply confirming receipt of the email. Our goal is to process these requests within 48 hours (2 business days) or receipt.
- If there is a discrepancy in the form, we will contact you to provide the correction. In these cases, the file with the discrepancy will not be made visible on the claimant portal.

*Please do not use the new email address for any other documents as they will not be reviewed or processed.*

- **Online claims system updates:** We continue to look for ways to improve the online claims system and appreciate your positive comments about the recent changes. We hope the tip sheets and resources on the website provide you with sufficient instruction on how to use the system to its maximum potential, but if you have questions, or if some additional training for your staff would be helpful, please let us know.

  As a reminder, if you experience any problems using the system, your first point of contact should be the Helpline. This is for several reasons, including that they are always there to answer the phone, but more importantly, they are able to quickly escalate – when needed – to our systems team for assistance. You should also call the Helpline for the following requests or issues:

  - If you experience any problems using the system, including password resets
  - To request a change in online ownership of a single claim or for questions about changing the attorney on a claim
  - To request that an individual on your team be granted the ability to delegate claims to other users
  - For general claim status questions or to confirm the registration date for a specific claim

- Questions about requests for missing information or to confirm a document has been received
- Questions about payments or to request expedited status for claim
- Data discrepancy questions and multiple claim number issues

For requests to deactivate a user account or requests that require "bulk" changes, such as changing the *ownership* on a large number of your claims, please contact Amy Whitman-Hall or Stefanie Langsam and they will work with the team to make sure the request is properly handled.

***As a reminder, you should notify us each time a member of your staff leaves the firm or is no longer working on VCF claims so we can deactivate their account***.

- **Miscellaneous Items and Reminders:**

Important update re: Payment Processing: We were notified recently that the DOJ budget office that processes our payments will be shut down from September 27 – October 11 for implementation of a new financial management system. This is mandated by the Justice Management Division ("JMD") and impacts all payments and financial transactions within the DOJ Civil Division, not just VCF payments. Although the system shutdown does not begin until September 27, the budget office has informed us that September 22 is the cutoff date for payments to be authorized in time to process the payment prior to September 27. This means the last payments prior to the shutdown will be for claims with award letters dated in mid-August (assuming the claimant does not appeal).

For claims that are impacted by the shutdown – meaning those claims that would have been paid during that timeframe – we will send a letter once the claim reaches the payment stage that explains the delay and provides some expected timeframe for when the payment will be processed. We will also post a special message on our website explaining the shutdown period and impact to VCF payments.

We have been in discussions with JMD about expedited claims and there will be a process in place to pay these claims during the shutdown. Other than expedites, however, you will not receive any payments during the shutdown period. We will continue to authorize payments and send them to the budget office during the shutdown, and they are planning for the increase in activity once the system is online in mid-October, but we do expect a delay as they work through their backlog.

If you have a claim for which you are planning to request expedited processing, please submit the request ASAP. If approved for expedited processing, we will do our best to review the claim and authorize the payment prior to the budget office shutdown.

Amendments for claims at NEL cap: We have seen many instances where a conditions amendment is filed for a claimant who has already received an award at the non-economic loss cap. In this scenario, a new condition will not change the award – unless it is for a cancer where one was not previously considered in the award – and you should not seek additional non-economic loss. In order to keep these amendments from slowing down claims processing, we will disposition *upfront* any amendments where it is clear that the amended condition is not going to result in any additional non-economic loss, i.e. without doing a substantive review. You will start to see letters with new language specific to these amendments. Eligibility letters for new, amended conditions will include language explaining that a corresponding compensation amendment for non-economic loss should not be submitted. If a compensation amendment was submitted with the eligibility amendment, both will be dispositioned in the same letter.

Missing client authorizations for payment: When we send you a Missing Information-Loss Calculation ("MILC") letter and the missing item is a Client Authorization to make payment to your law firm account, please send us the document as soon as possible! We want to pay the claim and it takes time for us to continue to call you (and document the calls) to try and get the document. Rather than continuing to call to check status, we will send a second/duplicate MILC (including copying the claimant) if it has been 30 days since the last one and we still don't have the authorization. If it has been more than 60 days

without resolution, we will contact the claimant directly. Please help us by sending these documents in with the initial claim submission.

Wrongful death claim registration deadlines: Please remember that the deadline to submit a timely wrongful death claim is two years from the date of death. If a claimant was never treated by the WTC Health Program, and a wrongful death claim was not filed within two years of the date of death, a personal injury claim may be timely based on verification through the Private Physician process. In these instances, the loss associated with the Personal Injury claim will cut off at the date of death.

As a reminder, the "Registration Start Date," is based on the *earlier* of two dates: (1) the date of the WTC Health Program Certification Letter, or (2) the date on which another government entity determined that the physical injury or condition was 9/11-related. If we base a claimant's timeliness on a WTC Health Program certification letter date, and when reviewing compensation we see a disability determination for the same condition with an earlier date that makes the registration untimely, the eligibility determination could be rescinded. This is of particular concern for non-economic loss only claims for which we do not have a disability evaluation at the time the eligibility is determined. Once an economic loss amendment is filed, it can cause issues if we then have a disability determination with an earlier date for the same condition, because we must then rescind both the eligibility decision and a previously issued non-economic loss award. Please carefully review the dates on documents applicable to the claimant to confirm the registration is timely. There are several FAQs on our website related to timeliness – with examples – and we encourage you to review these to understand the various nuances associated with determining the proper "Registration Start Date" based on each claimant's circumstances.

Expedited claims: Please do not request expedited status until you have filed a complete claim with all supporting documentation. It is hard to expedite a claim if we don't have the claim form and the necessary information to render a decision on the claim and it also creates an unnecessary burden on the many entities from which we seek information (e.g., SSA, FDNY, NIOSH), if we ask them to expedite their response only to have to hold the claim because all the information necessary to calculate an award was not filed. If we have to hold a claim beyond 60 days because we do not have the information necessary to decide it, we may revoke its expedited status, so please only ask for us to expedite the claim once all necessary information has been filed.

Social Security disability information: We have heard requests from many of you about making the Social Security disability information we receive from SSA viewable in the claim. We recognize that it helps you to see the code and/or condition that was the basis for the SSA decision. We are pleased to report that we have been in communication with SSA and we are making changes to display this information in the claimant portal. This will take some time, so please bear with us and know that it is underway. We will, of course, keep you posted as the information begins to be displayed in the claims.

Social Security survivor and dependent benefits: You may be receiving requests for Exhibit 1s for the beneficiaries of deceased victims. We need the Exhibit 1 in order for SSA to provide us information about survivor and minors receiving SSA dependent benefits. Please respond to those requests promptly and keep in mind that it is NOT that we need another copy of the Exhibit 1 already submitted with the claim. It is a *separate* Exhibit 1 for the surviving spouse and/or minor children.

Compensation memos and the claim form: Some of you submit compensation memos that lay out the factors and considerations applicable to a claim for economic loss compensation. As a general rule, we find these memos helpful and we appreciate the time you take to compile them for us. But, please do not point to the memo as a substitute for claim form responses. We use the answers on the claim form to help us categorize claims, make appropriate assignments, and identify missing information. So, please fill out the claim form completely, even if you plan to submit a supplemental memo.

Cover letters identifying multiple claimants: We continue to receive hard copy mail from law firms that include documents for multiple claims in a single envelope, with a cover letter that lists each claim for which there is a document in the mailing. In these instances, because of privacy issues, we need to

redact the names and/or claim numbers of the other claimants, essentially creating a different version of the cover letter for each claim that was listed in the letter. We then upload redacted versions to each claim. As you can imagine, this takes quite a bit of time for our Intake team. We understand your temptation to provide a cover letter identifying all of the claims for which you are submitting information in a mailing, but the practice is actually unnecessary for our purposes and results in additional work, so please do not submit these "multiple claim" cover letters in the future. As long as the documents are clearly marked for their respective claim, or you include a cover memo for each claim's materials, the general cover letter is not needed.

Medical records: We frequently receive large (huge) files full of medical records submitted in support of non-economic loss claims, with little or no guidance provided to help us identify the relevant information in those records. When you are submitting medical records, please include a cover page directing us to specific pages and explaining why the information on those pages is relevant, please highlight specific information within the records, and please organize the records in chronological order so that we can clearly see the progression of the condition over time. Remember that there are circumstances where there is no need to submit medical records in support of a claim, for example when a claimant's condition is clearly at the cap for a non-economic loss award.

"Determination Made: Processing" status on claimant portal: We hope you find the new claimant portal statuses to be helpful and more informative. As you know, this particular status displays when the award determination on a claim has been entered into the system and we are doing a final quality check before sending the award letter. Please note that the quality check process may take several weeks depending on the complexity of the claim. We are increasing the size of our Quality Review team, but it does take significant training before new team members are fully productive. Please also note that this status also includes claims where we have sent a Missing Information-Loss Calculation letter and are waiting for the requested documentation to be submitted.

- **Additional Announcements:**

  We also want to let you know about a new resource that was made available to us that we found quite helpful and would like to make available to you. The Department of Justice's Office for Victims of Crime has put together what it calls a Vicarious Trauma toolkit that is intended to provide tools and resources to help those who, in turn, provide assistance to those who have suffered a traumatic event, such as exposure to an act of terrorism or its aftermath. There is an initial training presentation that we have tailored for our team as an introduction to what vicarious trauma is, how it can affect those who are exposed to it on a daily basis, and how to ameliorate some of these effects. We're happy to make that slide set available to you as well and, if you are interested, we also encourage you to take a look at the extensive tools and resources available on the OVC website.

- **Questions: The following questions and answers were discussed:**

  1. **Can the Missing Information-Loss Calculation ("MILC") letters include a breakdown of the award so we can go to the Surrogates Court once to get any restrictions lifted?**

     Yes. Starting this past Monday, August 7, all of the MILC letters now include the addenda we discussed today with the more detailed breakdown of the award. We're hoping this helps you to decide with your client whether you intend to appeal once the award letter is issued, which will then help you decide the right time to go back to the court. If you have claims with a MILC that did not include the detailed addendum and would like one, please let us know and we will generate a new one. Please remember that you cannot appeal the award based on the MILC. You can only appeal once the award letter is issued.

  2. **One of my clients has an award letter that includes economic loss for the personal injury portion of the award. Is it the VCF's position that the economic loss associated with the personal injury claim passes to the estate?**

     When calculating claims, we treat economic loss prior to death as personal injury. If a claimant was

out on disability prior to death and therefore incurred economic loss because he or she could not work, that is calculated as part of the personal injury claim. The VCF does not take any position as to whether these losses pass through the victim's estate. Rather, the VCF defers to a court of competent jurisdiction to determine the appropriate distribution of the various components of the award.

3. **I have several claimants who are impacted by the change in the Private Physician process and now need to get certified by the WTC Health Program. Some of them also have proof of presence deficiencies. Because of the backlog in getting appointments for survivors, in particular, can we request a proof of presence hearing now?**

   We have ended the process of presence-only hearings. We now only schedule hearings where all components of eligibility have been reviewed and eligibility has been denied. This means we will not render a decision until we know if the claimant has been certified. The real issue for us in these hearings, and one of the reasons the certification is so helpful to us, are the NIOSH exposure requirements. If we don't have a certification, then we need to establish those exposure requirements up front and that has become very difficult. Please submit any presence information you have for the claimant, but we won't review it until the certification is received.

4. **If we submit the presence information without the certification, will we receive a Missing Information letter for the certification?**

   Yes, if your claim is in an inactive status and you upload new presence documents, we will send you a letter acknowledging the new documents along with a missing information request for the outstanding request for the certification. This helps you to know what is missing from the claim and ensures we are properly tracking any unresolved missing information requests.

5. **What do we do in cases where there is a WTC Health Program disability evaluation that does not include the date of onset of disability due to an eligible condition? How do you handle claims where the claimant was previously found disabled for an ineligible condition, in terms of apportioning disability between the eligible and ineligible conditions? We have seen claims recently where there was a WTC Health Program disability evaluation report but the economic loss claim was denied.**

   The new disability evaluation form specifically asks the CCE physician for the date of disability. This was one of the deficiencies in the old forms that has been changed in the updated version. If we are missing information that is needed specific to the disability evaluation forms, such as the date of disability, and there is no other medical evidence in the record from which we can determine that date with some level of certainty, we will, consistent with our longtime practice, reach out to the CCE physician to try to obtain this information. If no disability date is provided, but there is otherwise a basis to award economic loss, we will use the date of the WTC Health program evaluation report as the default date of disability.

   With respect to claimants who are already disabled due to an ineligible condition and are now coming in with a disability determination from the health program or somewhere else arising from their eligible conditions, it is really difficult for us to try to partition how much of the earnings loss is related to their eligible conditions, as opposed to how much of it is because they have already been out of the workforce for a number of years. We have been looking at those claims very carefully, particularly in those instances where claimants are out of the workforce due to mental health issues, where we are statutorily precluded from compensating for loss. If we can't very specifically tie the loss of earnings to the eligible conditions, we will deny the claim for economic loss, for example, if the claimant had already reached retirement age by the time the determination was made, or if their ineligible conditions contributed to the disability. An appeal hearing may be a way to provide more information to help us make that connection.

6. **If SSA has determined that an individual is disabled for a condition that is not related to 9/11, and the individual then passes away from a 9/11-related condition, and the only income coming into the home is the SSA benefit payment, would the VCF consider that disability payment as lost earnings?**

   We do not have an answer to this question yet, but it has been raised previously and we recognize the issue and are thinking through how these claims will be handled. We also have received similar questions when the pension payment following retirement is the only household income. It helps us to see more of these claims to better understand the arguments being made, so if you receive an award that does not include these payments as income, and you believe it should, we encourage you to appeal.

7. **The WTC Health Program recently sent a letter to each of their members informing them of the existence of the VCF. This is the first significant notification the WTC Health Program has ever sent specifying that WTC Health Program registration is different from VCF registration. Some patients of the WTC Health Program had no idea the VCF existed and the letter could be viewed as the first time the individual was notified of eligibility to file a claim, even if he/she had multiple past certifications. Many members of the WTC Health Program were seen and certified early – before the VCF was re-opened. Could the recent letter sent by the WTC Health Program be used as the "registration start date" for claimants who did not know the VCF existed?**

   We understand and recognize that there are circumstances where people simply did not know about the VCF. We have mentioned in past meetings, and reinforced in our written guidance, that these sorts of claims should come to us on appeal so we can assess whether or not there is a credible reason to find an equitable exception in these cases.

   Please remember that if someone is certified with a new eligible condition, the two-year registration period restarts. And, if the spouse of a deceased victim was unaware of the VCF, if the claim goes through the Private Physician process, it would be timely for the personal injury award with loss calculated through the date of death.

8. **We have noticed the VCF's recent focus on issuing wrongful death claims. It looks as though the VCF is working on the early 2015 backlog, but what about the early 2014 wrongful death claims? It would be helpful if the VCF published guidance specific to the effort being made on 2014 wrongful death claims so we can share that with our clients to help set expectations that these claims take more time to move through the process.**

   The oldest claims have been a significant priority. We have been working very hard to issue decisions on claims where compensation was submitted in 2015 or earlier. We still have a number of those claims in the system, but we are processing claims in order based on compensation submission dates. If you are not seeing awards on claims that were submitted in 2014, it is very possible that we are missing a critical piece of information needed to calculate the award. If you have an older claim for which you have submitted all the requested information, please let Catherine and Peter know so they can research what is happening with the claim.

9. **If a personal injury claim has an offset for SSA benefits, but the claimant passes away before the end of the projected benefit offset period, are the SSA offsets added back to the wrongful death claim?**

   If the personal injury claim has already been paid, and a wrongful death claim is then filed, we will recalculate the award, including the additional and revised offsets, and subtract the portion that has already been paid under the personal injury claim.

**10. When you file a deceased claim for an individual who had a prior personal injury claim, is it an amendment to the personal injury claim or is it a new claim?**

In these situations, if the claimant died of his or her 9/11-related illness, you should submit a new wrongful death claim. If the individual died of causes unrelated to 9/11, you should amend the personal injury claim to add a Personal Representative. Detailed information on the steps to take when a personal injury claimant passes away can be found under "Forms and Resources" on our website.

**11. In making the changes to the Private Physician criteria, why wasn't there a grace period for claims that were submitted before the implementation of the new policy?**

This was a policy decision made in an effort to increase efficiency in overall claims processing and make it easier for claimants to demonstrate eligibility. It is much simpler and more efficient for a claimant to demonstrate they have a valid claim when they are certified by the WTC Health Program. This is a change we wanted to make immediately across all claims, instead of having some claims under an old process that would require additional tracking and resources.

If you have a claim where the claimant would face a significant hardship in going to the WTC Health Program, please request an exception by uploading a statement to the claim **and** calling our Helpline to alert us to the request.

**12. If a cancer patient is now in remission, does that bar them from seeking certification and filing a claim?**

No. If the date of diagnosis of the primary cancer meets the latency requirements and the member's exposure requirements are adequate, the WTC Health Program will certify the cancer regardless of whether the cancer is in remission at the time of certification. And, if the certification was made appropriately (latency and exposure requirements met), the WTC Health Program will not decertify a member's cancer just because the cancer went into remission.