

UNITED STATES DEPARTMENT OF LABOR

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ADVISORY BOARD ON TOXIC SUBSTANCES
AND WORKER HEALTH

+ + + + +

WORKING GROUP ON PRESUMPTIONS

+ + + + +

MEETING

+ + + + +

WEDNESDAY,
JUNE 21, 2017

+ + + + +

The Advisory Board met telephonically
at 1:00 p.m. Eastern Time, Steven Markowitz, Chair,
presiding.

MEMBERS

SCIENTIFIC COMMUNITY:

KENNETH Z. SILVER
LESLIE I. BODEN

MEDICAL COMMUNITY:

STEVEN MARKOWITZ, Chair
VICTORIA A. CASSANO

CLAIMANT COMMUNITY:

KIRK D. DOMINA
GARRY M. WHITLEY
FAYE VLIENER

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BOARD MEMBERS ALSO PRESENT:

KIRK DOMINA

DESIGNATED FEDERAL OFFICIAL:

CARRIE RHOADS

P-R-O-C-E-E-D-I-N-G-S

1:05 p.m.

1
2
3 MS. RHOADS: Hi everybody. My name's
4 Carrie Rhoads. I'd like to welcome you to today's
5 teleconference meeting of the Department of Labor's
6 Advisory Board on Toxic Substances and Worker
7 Health, the Presumptions Working Group.

8 I am the board's designated federal
9 officer or DFO for today's meeting.

10 First of all we appreciate the time and
11 the work of our board members in preparing for this
12 meeting and for their time spent working after.

13 I'll introduce board members and take
14 a quick roll call. Dr. Steven Markowitz is the
15 chair of this group and chair of the advisory board.

16 CHAIR MARKOWITZ: Here.

17 MS. RHOADS: And the members are Dr.
18 Victoria Cassano.

19 MEMBER CASSANO: Here.

20 MS. RHOADS: Ms. Faye Vlieger.

21 MEMBER VLIEGER: Present.

22 MS. RHOADS: Dr. Leslie Boden. Dr.

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1 Boden, are you on the line?

2 MEMBER BODEN: Here.

3 MS. RHOADS: Thanks. Mr. Garry
4 Whitley.

5 MEMBER WHITLEY: Here.

6 MS. RHOADS: Dr. Ken Silver.

7 MEMBER SILVER: Here.

8 MS. RHOADS: Dr. John Dement and Dr.
9 Laura Welch are both in this group but could not
10 make the call today. And Mr. Kirk Domina is also
11 on the line with us.

12 In the room with me is Melissa Schroeder
13 from SIDEM, our contractor.

14 Today's meeting is scheduled from 1
15 o'clock to 3:30 Eastern time. I don't know if we'll
16 take a break. If the discussion allows and Dr.
17 Markowitz wants to that is fine.

18 Copies of all meeting materials and any
19 written public comments are or will be available
20 on the board's website under the heading Meetings
21 and a listing there for this meeting.

22 The documents will also be up on the

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1 WebEx screen so everyone can follow along with the
2 discussion.

3 The board's website can be found at
4 dol.gov/OWCP/energy/regs/compliance/advisoryboard.htm.
5

6 When you visit the website after
7 clicking on today's meeting you'll see a page
8 dedicated entirely to the meeting.

9 The webpage contains publicly
10 available material submitted to us in advance and
11 we'll publish any materials that are provided to
12 this subcommittee.

13 There you should also find today's
14 PowerPoint presentation as well as instructions
15 for participating remotely.

16 If you are participating remotely and
17 you're having a problem please email us at
18 energyadvisoryboard@dol.gov.

19 If you're joining by WebEx please note
20 that the session is for viewing only and will not
21 be interactive.

22 The phones will also be muted for

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1 non-advisory board members.

2 If you're a speaker and you're not
3 speaking please mute your phone because we're
4 getting a lot of background noise right now.

5 Please note that we do not have a
6 scheduled public comment session today. The
7 call-in information has been posted on the website
8 so the public can listen in but not participate
9 in the discussion.

10 The advisory board voted at its April
11 2016 meeting that the subcommittee meeting should
12 be open to the public. A transcript and minutes
13 will be prepared from today's meeting.

14 During board discussions today as we're
15 on a teleconference line please speak clearly
16 enough for the transcriber to understand. When
17 you begin speaking especially at the start of the
18 meeting please state your name so we can get an
19 accurate record of the discussion.

20 And I'd like to ask our transcriber to
21 let us know if you're having any issues with hearing
22 or with recording.

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1 As the DFO I see that the minutes are
2 prepared and ensure they're certified by the chair.

3 The minutes of today's meeting will be available
4 on the website no later than 90 calendar days from
5 today.

6 If they're available sooner we'll
7 publish them sooner as well.

8 We'll also be publishing verbatim
9 transcripts which are obviously more detailed in
10 nature. Those transcripts should be available on
11 the website within 30 days.

12 I'd also like to remind the advisory
13 board members that there are some materials that
14 have been provided to you in your capacity as
15 special government employees and members of the
16 board which are not for public disclosure and can't
17 be shared or discussed publicly including in this
18 meeting.

19 Please be aware of this as we continue
20 with the meeting today. These materials can be
21 discussed in a general way which does not include
22 using any personally identifiable information such

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1 as names, addresses, specific facilities of the
2 cases being discussed.

3 And with that I convene the meeting of
4 the Advisory Board on Toxic Substances and Worker
5 Health, Presumptions Working Group. And I'm going
6 to turn it over to Dr. Markowitz.

7 CHAIR MARKOWITZ: Thank you, Carrie.
8 And actually, thank you Carrie for all the support
9 work and work you do with the board. It's extremely
10 useful.

11 I'd like to welcome people onto this
12 call from the Presumptions Working Group. I'd also
13 like to welcome any members of the public who are
14 listening in.

15 We don't have a public comment period
16 during this working group meeting or for that matter
17 any of the subcommittee calls as Carrie mentioned.

18 However, we do welcome always written
19 public comments which we read and try to take into
20 consideration in terms of our discussions and
21 decisions.

22 I think first we should probably just

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1 go around in case there are any members of the public
2 who aren't familiar with board members and just
3 very briefly identify ourselves.

4 I'm Steven Markowitz. I'm an
5 occupational medicine physician and
6 epidemiologist, and professor at the City
7 University of New York.

8 And Carrie, if you could just cite
9 peoples' names and then they can respond. That's
10 probably the easiest way.

11 MS. RHOADS: Okay. Dr. Cassano.

12 MEMBER CASSANO: This is Dr. Victoria
13 Cassano. I am also an occupational and
14 environmental medicine physician. Retired Navy
15 physician and also worked at VA in the central
16 office doing environmental health policy. And now
17 have my own company. Thank you.

18 MS. RHOADS: Okay. Ms. Vlieger.

19 MEMBER VLIEGER: Faye Vlieger, former
20 Hanford worker and worker advocate.

21 MS. RHOADS: Dr. Boden?

22 MEMBER BODEN: This is Les Boden. I'm

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1 a professor at Boston University School of Public
2 Health.

3 MS. RHOADS: Mr. Whitley?

4 MEMBER WHITLEY: Garry Whitley. I
5 worked at Y-12 National Security Complex Oak Ridge
6 for 42 years and worked with the worker health
7 protection program.

8 MS. RHOADS: Dr. Silver?

9 MEMBER SILVER: Ken Silver, associate
10 professor of environmental health at East Tennessee
11 State University.

12 MS. RHOADS: Mr. Domina.

13 MEMBER DOMINA: Kirk Domina. I'm the
14 employee health advocate for the Hanford Atomic
15 Metal Trades Council. We're from Washington.
16 I've been here 34 years and we represent
17 approximately 2,600 current workers.

18 MS. RHOADS: Okay. Go ahead, Dr.
19 Markowitz.

20 CHAIR MARKOWITZ: Thank you. So the
21 agenda for today really is to discuss the PowerPoint
22 which I prepared which really principally addresses

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1 one issue which are looking at the medical criteria
2 for the diagnosis or the use of medical information
3 for application to claims under EEOICPA with
4 relation to various asbestos related diseases.

5 And then at the end I open up the --
6 try and open up the discussion to consideration
7 of other issues for the future in terms of
8 presumptions.

9 Is there any other agenda item that
10 members of the board would like to propose or
11 discuss today?

12 Okay, well if something comes up I think
13 we're going to have time because I don't think the
14 agenda so far will occupy nearly all of our time,
15 although I always seem to underestimate how much
16 discussion is generated. But regardless.

17 And by way of taking a break we'll see
18 how things go. In an hour or an hour and 15 minutes
19 if it looks like we're going to go for quite a while
20 longer then I'll call for a break.

21 On the presumptions we've been dealing
22 with scientific technical medical issues that some

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1 members of the board are much more familiar with
2 than other members.

3 And I just want to reiterate that if
4 there are issues, terms, or comments that people
5 don't understand we can very quickly explain things
6 in a way that allows everybody to understand.

7 Because everybody makes important
8 contributions and I really don't want folks feeling
9 shut out in any sense because the doctors are
10 talking about medical stuff.

11 So we should be able to communicate in
12 a way where everyone understands and can
13 contribute. So I probably should have said that
14 before, but in any event I feel that reflects the
15 spirit of the board.

16 So let's go to the PowerPoint. And go
17 to the first slide.

18 Now, just to summarize, this is the work
19 we've already done on presumptions. And you see
20 listed the first four content, either diseases or
21 exposures.

22 We've mostly focused on exposure

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1 presumptions rather than on helping DOL make a
2 determination about how to recognize a diagnosis
3 of disease.

4 We did that for asthma but we didn't
5 really do that for COPD, for asbestos-related
6 diseases, and we didn't weigh in on how they should
7 look at hearing loss in terms of diagnosing hearing
8 loss.

9 We did, however, weigh in on the
10 exposure side. And then early on we had
11 recommended actually cessation of use of a
12 presumption for post-95 toxic exposures, a
13 presumption which is the recommendation that DOL
14 has accepted.

15 And then we earlier this week formally
16 endorsed as a board the current presumption, so
17 that's not a recommended change at all in how DOL
18 treats sarcoidosis and its equivalents with CBD
19 if a person is a covered beryllium employee. So
20 that's the work we've done so far.

21 And we've concentrated on I think
22 fairly common outcomes for which people make

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1 claims, especially on the respiratory disease side,
2 but also on the hearing loss. So the next slide.

3 So, I think it was in the last meeting
4 when we were discussing asbestos-related diseases
5 that someone suggested that maybe we should look
6 at the medical side, at the diagnostic side, and
7 see if there's some helpful suggestions that we
8 could make to DOL in terms of how they recognize
9 various asbestos-related disease.

10 Now, from their manual -- by the way,
11 if you haven't seen the updated procedures manual,
12 updated, the date was April 2017, you should take
13 a look. It's very nicely organized.

14 I don't think the content has been
15 changed, but it's organized in a way that makes
16 it much easier to locate things.

17 So as we actually discussed in April
18 that the current program recognizes a variety of
19 asbestos-related diseases including those not --
20 that don't represent cancer, and that's asbestosis
21 or scarring of the lung tissue itself due to
22 asbestos. Pleural plaques and pleural thickening,

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1 scarring of the covering of the lungs, the pleura.

2 They actually mentioned something
3 which is fairly uncommon and we haven't discussed
4 before, but sometimes asbestos after many years
5 causes a fluid to accumulate, fluid that's
6 elaborated by this covering of the lung, the pleura.

7 And it's called pleural effusion. Accumulates
8 at the bottom of the lung and then eventually
9 resolves.

10 It's not a malignancy. It usually
11 leaves behind some scarring, but it's something
12 actually that the program and the procedure manual
13 recognizes. So even though we didn't suggest it
14 in April it is part of the disease spectrum of the
15 program.

16 And then secondly, the various
17 malignancies that are recognized by the program
18 which are malignant mesothelioma, cancer of the
19 pleura.

20 Now, by the way, mesothelioma occurs
21 elsewhere in the body besides in the chest. It
22 occurs about 10 percent of the time in the abdomen

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1 where it's called peritoneal mesothelioma.

2 And then less than 1 percent of the time
3 at other locations.

4 And we're not going to discuss
5 mesothelioma outside of the chest today because
6 the procedure manual doesn't -- I don't think it
7 addresses mesothelioma of the abdomen or otherwise
8 known as peritoneal mesothelioma.

9 And so we're just sort of skipping over
10 that for now. It's extremely rare and there are
11 about 250 cases total in a year among Americans,
12 350 million people of which there are a total of
13 250 cases total per year of peritoneal
14 mesothelioma.

15 So we're not going to address that
16 today.

17 And then the other cancers including
18 lung cancer, and cancer of the ovary, and cancer
19 of the larynx. Next slide.

20 By the way, I'll occasionally take a
21 breath so jump in with comments, questions, or
22 interrupt me so that this isn't a monologue.

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1 At certain points I'll open it up for
2 specific comments.

3 Now on the next few slides what I do,
4 I simply abstracted the current language from the
5 procedure manual on how claims examiners and the
6 program as a whole view medical evidence of
7 asbestosis and other conditions.

8 So where at the top of the slide it says
9 the EEOICPA Procedure Manual Chapter 18 this is
10 the language that they use.

11 So the claims examiner is instructed
12 for a claim of asbestosis to look at a number of
13 different sources of evidence.

14 And they look for an opinion of a
15 qualified physician. This is presumably the
16 treating physician, at least initially. And that
17 that opinion is based on a chest X-ray finding,
18 a CAT scan finding, CT scan finding, an MRI which
19 is a fancier imaging study of the chest, pulmonary
20 function tests or breathing tests, or lung biopsy.

21 Or, and/or another source of evidence
22 is the physician report from the DOE's former worker

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1 program.

2 And/or another source of evidence is
3 the death certificate.

4 So, I have to say, and here I'm going
5 to open it up for comments, I have to say I'm a
6 little puzzled still about how this works.

7 The claims examiner is collecting
8 information the claimant has sent in. They get
9 hopefully some report from the treating physician
10 and the treating physician say in a case of
11 asbestosis might say this is asbestosis that the
12 person has and they may or may not cite the evidence
13 for that diagnosis.

14 And presumably the claims examiner gets
15 a report of the chest X-ray, or the CT scan, or
16 the biopsy.

17 And what I'm trying to understand is
18 does the claims examiner look at not just the
19 physician report, but they're looking at the chest
20 X-ray report and the CT report, the lung biopsy
21 report, and they're trying to see whether what they
22 are reading in those reports constitutes

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1 asbestosis, or there are findings that allow them
2 with some confidence to say yes, this person's claim
3 is for asbestosis.

4 Is that your -- speaking to the other
5 board members here -- your general impression of
6 the process of how the claims examiner works?

7 MEMBER CASSANO: Steve, I was kind of
8 confused as you know from my email about the --
9 I'm not quite sure whether it's all -- I guess that
10 they're saying that these are all the sources of
11 evidence, but I don't think any of them are used
12 definitively.

13 I think there's a lot of -- what's the
14 word I'm looking for. There's a lot of
15 interpretation allowed here.

16 So this is what I wrote you about, DOE
17 WP physician findings. And that's when I asked,
18 gee, does it mean that only -- that any other
19 qualified MD, there has to also be chest X-rays,
20 CT, MRI, before DOE from a worker program physician
21 all you need is that physician's statement that
22 it's asbestosis.

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1 So I don't know whether you need any
2 combination of these, or any one of these. To me
3 it's confusing and I presume then that it's probably
4 confusing for CEs as well. I don't know.

5 CHAIR MARKOWITZ: Right. Other
6 comments?

7 MEMBER VLIEGER: This is Faye. What
8 I find with asbestos diagnosis, unless it's one
9 of the former worker physicians who's actually
10 looking at it and saying that this is asbestosis
11 it's very hard to get a diagnosis from your
12 pulmonary physician because they feel unable to
13 make a diagnosis from what they see.

14 And so I'm not sure how to change that.
15 Maybe include the wording of what they're supposed
16 to be looking for more clearly.

17 But even at that if you show them the
18 document they say well, I don't know how to diagnose
19 asbestos. And this is from qualified
20 pulmonologists.

21 So I don't know if we can fix that or
22 not.

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1 My experience is that you have some
2 piece of evidence, not all of them, and then you
3 have to have a physician stating that this is what
4 this is.

5 In the past the former worker program
6 physicians were not accepted because it wasn't the
7 attending physician. That's considered a one-time
8 occupational medicine physician which I find
9 appalling, but that's what they've been doing.

10 CHAIR MARKOWITZ: And later I'm going
11 to show some slides of the former worker program's
12 language that they -- or basis for their decisions.

13 Other comments.

14 MEMBER WHITLEY: This is Garry. In
15 Oak Ridge our pulmonary doctors gives a diagnosis
16 and writes the letter, sends it -- gives the
17 claimant a letter and they send a letter that
18 they've been diagnosed with asbestosis.

19 And usually they don't question it
20 pretty much. And the doctors here in Oak Ridge,
21 if you've been working with asbestos in groups that
22 have, and they diagnose it, that's pretty much what

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1 all has to happen.

2 I had a friend this week that just told
3 me he got his claim of asbestosis and it hadn't
4 been probably three or four months since he filed.

5 MEMBER CASSANO: And that was because
6 the physician in the local area -- is that just
7 a local physician or is that within a former worker
8 program?

9 MEMBER WHITLEY: No, it's a local
10 pulmonologist in this area. We've got several
11 right here in Oak Ridge and they see a lot of people.
12 They diagnose asbestos pretty often.

13 MEMBER CASSANO: I think people that
14 are used to seeing individuals exposed to asbestos
15 don't have difficulty diagnosing it. Whether
16 you're an occupational physician, or a
17 pulmonologist, or an internist.

18 But even pulmonologists who don't see
19 it are uncomfortable diagnosing it I think. They
20 call it either pulmonary fibrosis or they --
21 whatever they're going to call the small -- I'm
22 not thinking straight for some reason, but whatever

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1 they're going to call what they see on a chest X-ray
2 they're uncomfortable calling it asbestosis.

3 A lot of times because they don't ever
4 ask for an occupational history so they don't know
5 the person's been exposed to asbestos.

6 CHAIR MARKOWITZ: For the transcriber
7 that interchange was between Garry Whitley and Dr.
8 Tori Cassano.

9 MEMBER CASSANO: Sorry about that.

10 CHAIR MARKOWITZ: That's okay. Garry
11 Whitley is the one with the attractive accent so
12 you can always recognize him.

13 MEMBER CASSANO: Yes, I'm the one that
14 speaks like a doctor.

15 CHAIR MARKOWITZ: Other comments?

16 MEMBER SILVER: This is Ken. This is
17 pretty interesting. We have two extremes laid out.

18 One is at Oak Ridge where the pulmonologists are
19 experienced and cooperative in making the
20 diagnosis.

21 And then we have Faye's experience
22 where they're not. And it seems an important

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1 question for us is how much discretion do the claims
2 examiners have between those two poles and how do
3 they exercise it.

4 And they qualified in the case of Oak
5 Ridge to overrule or are they qualified to construct
6 a diagnosis for a Hanford worker who didn't get
7 one from their pulmonologist.

8 MEMBER BODEN: This is Les Boden. I'm
9 wondering following up on this conversation whether
10 there ought to be some either information or
11 guidance for the pulmonologists who are treating
12 people.

13 So information might be providing them
14 with information about whether that person worked
15 on a job that DOE would consider to be potentially
16 asbestos exposed, or guidance about how to think
17 about what DOE is looking for from them which would
18 presumably include some information about exposure
19 to asbestos.

20 This is for Faye's physicians and not
21 for Garry's I guess.

22 MEMBER CASSANO: What I find with

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1 treating physicians a lot that are experienced at
2 either primary care or the (inaudible) doc is that
3 even if you give them all of that they're always
4 going to waffle. I see this all the time.

5 They're never going to say it's at least
6 -- it's most probably. That's the best you're
7 going to get. You're never going to get even an
8 at least as likely as not statement, or a definitive
9 statement that what they're seeing on chest X-ray
10 on the person's pulmonary function is due to
11 asbestos.

12 They're going to say is consistent with
13 asbestos, consistent with asbestos exposure,
14 probably due to asbestos, or possibly due to
15 asbestos.

16 I find that most of them aren't going
17 to pin etiologic certainty with something that does
18 not -- even with stuff that they are very familiar
19 with. A lot of times they won't do it.

20 So I think we need to find some way of
21 giving the CEs enough information. If they have
22 a definitive diagnosis then that's fine, but if

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1 they've got a chest X-ray that has fibrosis or has
2 B reading that shows one zero B read or something
3 like that.

4 I think it needs to go to a CMC.
5 Because I don't think for the most part without
6 something clear that says asbestosis that it goes
7 to radiology reports or MRI, CT, or whatever that
8 says definitively asbestosis.

9 They need that clinical
10 interpretation.

11 CHAIR MARKOWITZ: This is Steve. And
12 that's probably the way it works.

13 In fact, after this call I'll ask for
14 some clarification from DOL about how this works
15 in practice.

16 But we're going to get into some
17 specific language on medical evidence which I think
18 will help the process. Even if the process doesn't
19 change it'll help the CE by giving more specifics
20 about diagnosis.

21 It'll help the treating physician
22 because they'll be able to look at the specifics

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1 that by the way exist in some other aspects of the
2 program, some of the statutory, for instance,
3 beryllium and silica, actually in the act.

4 It's not in the act about asbestosis
5 nor in the procedure manual.

6 So let's continue with the next slide.

7 So this is cited from the procedures manual about
8 the opinion of the qualified physician who states
9 on any or all of the following, pulmonary
10 interstitial fibrosis with or without heart
11 enlargement, CT or MRI finding of lung scarring,
12 pleural thickening, heart enlargement, pulmonary
13 function test finding of restriction. That's
14 lower lung volumes. The person can't breathe
15 sufficiently.

16 And the PFT requires a physician
17 interpretation or lung biopsy. And it mentions
18 that lung biopsy sputum cytology which is simply
19 looking at cells in sputum or a bronchial lavage
20 which is putting fluid into the lung and then taking
21 it out and looking at cells. It often shows
22 asbestos bodies which are old asbestos fibers that

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1 are coated with protein and have a very distinct
2 appearance.

3 Those findings are helpful but not
4 definitive. So that's kind of a summary from the
5 manual as to how the CE and others look at the
6 information that the treating physician provides.

7 Next.

8 And/or the former worker program. And
9 the assessment. And the language of the procedure
10 manual says they accept the physician assessment
11 of asbestosis or asbestos related lung disease.

12 And from the language frankly looks
13 like the CE doesn't necessarily have to look at
14 the data that we just went over in the previous
15 slide, meaning chest X-ray, CT results or the like.

16 It looks like it can be based on the
17 FWP determination. And part of the logic of that
18 would be frankly the FWP determination is based
19 on the chest X-ray and occupational history which
20 we'll go over in a second.

21 And then the third source of evidence
22 -- next slide -- that the CE or the claimant process

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1 can examine is the death certificate.

2 And here they want to see asbestosis
3 on the death certificate as either the cause or
4 a contributing factor.

5 And if the death certificate says
6 something other than asbestosis because it very
7 easily could say pulmonary fibrosis, or fibrosis
8 of the lung, or interstitial fibrosis, or something
9 that is kind of equivalent but less specific than
10 asbestosis then the claims examination process
11 needs evidence, other evidence to support the
12 diagnosis of asbestosis which makes a lot of sense.

13 Next slide.

14 And moving onto cancers. The
15 procedure manual requires that the CE find
16 confirmation of the diagnosis of mesothelioma of
17 the pleura. And it's not specified exactly what
18 that is although in practice it's almost assuredly
19 it's going to be the pathology report, examination
20 of the tissue of the cancer.

21 Again, from the procedure manual, now
22 moving onto pleural plaques and pleural effusions

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1 this is in the non-malignant category, plaques
2 being the scarring of the pleura.

3 And then the supportive medical
4 evidence that is examined in the claims process
5 includes the physician diagnosis, some chest X-ray
6 or CT, in other words some imaging evidence of
7 pleural plaques or pleural thickening which is not
8 due to surgery or trauma.

9 And we've got rounded atelectasis which
10 is quite specific to asbestos. What happens is
11 that the pleura sits on top of the lung and when
12 it gets scarred, and the scarring can get exuberant
13 or kind of aggressive, it can envelop a section
14 of the nearby lung and kind of wrap -- the scarring
15 of the pleura wraps around that section, a small
16 section of the lung.

17 And it's called rounded atelectasis.

18 And it has the potential to appear in the chest
19 X-ray or CT scan as fairly specific for
20 non-malignant asbestos related disease.

21 And then finally the presence of
22 bilateral pleural effusions.

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1 So again, these are just the pieces that
2 are examined in the process of looking at a claim
3 for pleural plaques or pleural effusions.

4 By the way these are two separate
5 entities. This pleural plaque, the thickening,
6 the scarring is one thing, and the pleural effusion
7 is something separate, much less common.

8 MEMBER BODEN: This is Les Boden. Can
9 I interrupt just for a second to clarify for me?

10 So I see these various pieces of
11 supportive medical evidence. Is there any
12 guidance to the CE about how to use these various
13 pieces to come to a conclusion? And that would
14 hold clearly for the asbestos.

15 CHAIR MARKOWITZ: Yes. So if you go
16 to the previous slide just so we can look at what
17 we were looking at.

18 I don't know what exists outside the
19 procedure manual because I didn't really look at
20 the circulars, go around the circular bulletins
21 or any other sources of guidance. So there may
22 be something else somewhere else, but probably not

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1 much actually.

2 This is a summary of how the CE looks
3 at these cases for claims of information.

4 MEMBER BODEN: Right.

5 CHAIR MARKOWITZ: There's no more
6 specificity than this. Unless I somehow didn't
7 summarize these properly, but I think I got the
8 keywords right.

9 MEMBER BODEN: Okay. So I'm thinking,
10 I'm looking at this is like how many of the four
11 things on this list would I need before I was
12 convinced that I should approve the claim for
13 pleural plaques.

14 Or which ones are particularly
15 convincing to me. That's not part of this,
16 correct?

17 CHAIR MARKOWITZ: Not that I saw. I
18 mean, what probably happens, my guess is that
19 physician diagnosis, the physician cites an imaging
20 study or the CT scan as evidence.

21 That would be -- predominantly in
22 asbestos disease that would be the typical or the

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1 expected kind of scenario.

2 MEMBER BODEN: Right.

3 CHAIR MARKOWITZ: Now, if the CE just
4 sees a physician diagnosis without reference to
5 a chest X-ray I'm not sure what happens.

6 MEMBER BODEN: I would suspect not be
7 convincing.

8 CHAIR MARKOWITZ: Right. Nor frankly
9 should it.

10 MEMBER BODEN: Yes, appropriately so.

11 CHAIR MARKOWITZ: Right, right. So,
12 next slide.

13 And then there is instruction on these
14 specific plaques and effusions that the claims
15 examiner will consult either with the treating
16 physician or the CMC if evidence was inconclusive.

17 If the pleural thickening is in an area
18 of surgery or trauma, or if there's other --
19 evidence of other causes of a pleural effusion is
20 present.

21 I would just tell you pleural
22 thickening, if a person has a traumatic rib

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1 fracture, or if the person undergoes chest surgery
2 it would typically leave behind an area of pleural
3 thickening in which case you wouldn't really
4 ascribe that pleural thickening or plaque to
5 asbestos. You would say it's due to that trauma
6 or surgery. It's not necessarily -- all the time.

7 And then pleural effusions, this is
8 item number three, pleural effusions are very
9 common. Asbestos related, benign pleural effusion
10 is very uncommon and so it makes a lot of sense
11 to look for other more ready explanations for
12 pleural effusions. Next slide.

13 So, just to move to what the former
14 worker program does. These are surveillance case
15 definitions so these are not diagnostic. These
16 are how we identify for the purposes of reporting
17 to DOE in large populations that we screen how we
18 identify a case of asbestosis which is they have
19 a history of exposure to asbestos or a job title
20 in which it's reasonably likely to have exposure
21 to asbestos.

22 And we require a B reading which is a

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1 chest X-ray by a physician who is specially trained
2 and passed a test given by NIOSH for reading X-rays
3 for dust diseases.

4 The B reading of a standard chest film
5 demonstrating bilateral irregular opacities in the
6 lung tissue itself with a specific shape and size.

7 And stu means irregular.

8 And the profusion score meaning a
9 density of the lowest level or higher, the lowest
10 level being 150 which is a relatively slight
11 disease.

12 So there's some specificity. It can't
13 exactly be transferred over to the program, but
14 it's an example of how the former worker program
15 looks at it.

16 And notice that if she's not on the film
17 -- chest film, it doesn't discuss pulmonary
18 function tests or any other source of evidence.
19 Next slide.

20 MEMBER BODEN: Sorry, this is Les
21 again. So it appears to me, and I don't really
22 know this stuff that well, that this would be

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1 somewhat more restrictive than you might get from
2 using the other pieces of evidence that were talked
3 about before, more consistent maybe, but maybe also
4 more restrictive or not.

5 CHAIR MARKOWITZ: Well, it doesn't
6 address the death certificate obviously. The FWP
7 or screening program.

8 MEMBER BODEN: But putting the death
9 certificate aside. So the question is at least
10 in your opinion would it be -- would using this
11 definition only screen in fewer cases than.

12 CHAIR MARKOWITZ: So it depends on --
13 probably not many. It could be more restrictive.
14 It depends on how the current guidelines are
15 applied.

16 For instance, notice that in this
17 definition that it's nothing about breathing tests.

18 MEMBER BODEN: Right.

19 CHAIR MARKOWITZ: If the claims
20 examiner is looking at a case in which a person
21 reports asbestos exposure so that's off the table
22 -- has a normal X-ray, or X-ray findings that are

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1 a lot less specific than what we were looking at
2 on the screening here, but has restriction on
3 pulmonary function.

4 Would the claims examiner, the treating
5 physician, the claims examiner or the CMC consider
6 that to be sufficient to say it's asbestosis.

7 In practice they might. Would they be
8 right? Unlikely. But they could do that.

9 MEMBER BODEN: The other problem with
10 this for general use would be that you'd need to
11 have a B reader.

12 CHAIR MARKOWITZ: Oh yes, yes. This
13 is too restrictive in that sense because most people
14 aren't going to people who are B readers. Most
15 B readers are radiologists. They're not primary
16 care doctors, or pulmonary specialists.

17 And if you send their X-ray over to
18 Methodist Hospital in Oak Ridge, or Baptist over
19 in Paducah there's no B reader in sight. So yes,
20 in that sense in particular it's different.

21 And then the other thing in the current
22 guidelines is lung biopsy, and obviously former

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1 worker program isn't looking at a lung biopsy.
2 They don't do that as part of a screening program.

3 Any other comments at this moment?
4 Okay, so just moving on FWP for pleural disease.

5 I'm sorry, go back to the previous slide. For
6 pleural disease due to asbestos.

7 What we require in the former worker
8 program is a history of exposure to asbestos or
9 a job title which we expect has exposure to
10 asbestos.

11 And again, a B reading notation of the
12 presence of unilateral or bilateral pleural
13 thickening consistent with pneumoconiosis.
14 Pneumoconiosis just means dust disease of the lung.

15 So mind you, we're talking about an
16 expert looking at films, just films for
17 occupational lung diseases.

18 And it's most likely that if that person
19 sees a single pleural plaque on a side where they
20 also see rib fractures they're probably not going
21 to call that a pleural thickening consistent with
22 pneumoconiosis.

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1 So embedded in this process is an issue
2 that the current program is more explicit about
3 which is this issue of pleural thickening due to
4 trauma or surgery. That's how that's dealt with.

5 So if we could go to the next slide.

6 So, the next series of slides just is
7 proposed language subject to change of course.
8 It's a first draft about ways in which defining
9 these entities, the kinds of evidence they're based
10 on what would be helpful to the process.

11 The way I think about them is maybe --
12 some of these criteria may be within the reach of
13 the claims examiner. They would certainly be in
14 the reach of many of the treating physicians.

15 And this kind of specificity should
16 certainly be helpful to the CMCs in making decisions
17 about who has and doesn't have any of these
18 entities.

19 And so that's what -- it's not supposed
20 that a claims examiner will necessarily be able
21 to understand and apply all of these criteria by
22 way of their background. But to some extent they

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1 probably could.

2 But in any case the intent is to give
3 some greater specificity.

4 And so for asbestosis there are three
5 slides that mimic the current procedure. One is
6 the radiography. The other is the lung biopsy,
7 et cetera.

8 But the first one is obviously history
9 of asbestos exposure. We dealt with that in our
10 previous recommendations so I'm not going to focus
11 on that.

12 Remember we went over 30 days for
13 mesothelioma, 250 days for the other entities.
14 And then we sent out various job titles or the like
15 to address exposure.

16 But on the disease side what we see is
17 the chest X-ray or the CT scan which is the presence
18 of bilateral diffuse interstitial fibrosis which
19 affects any combination of the mid and lower lung
20 zones. And that's what asbestosis is.

21 And that definition, you can look at
22 a chest X-ray and identify whether the person has

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1 it or not, or the CT scan.

2 And that's in fact what the B reader
3 is doing. But it's also what the radiologist is
4 doing and what the pulmonary specialist is doing
5 in looking. And for that matter even the primary
6 care doc should be able to do this if they have
7 some experience in reading films.

8 They may not call it asbestosis, but
9 they should be able to -- the definition should
10 be able to be used in looking at the X-ray report
11 and seeing whether it's bilateral, is it only in
12 the upper zones which wouldn't be asbestosis, and
13 is it a diffuse process as opposed to a specific
14 scar in the mid left lung.

15 And then if the ILO score is used, and
16 this is the appropriate definition, it's not
17 expected that the ILO score is going to be used,
18 but it should be in there as a guideline. Question,
19 comment?

20 MEMBER CASSANO: Tori Cassano. I
21 think the ILO scoring can only be used on B readings.

22 I think it should just be changed if

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1 a B read chest X-ray is used then ILO scoring
2 upgraded in one, zero, just, you know, s, t, or
3 u, or passing for clarity.

4 Because should the ILO scoring on a CT
5 scan or a regular chest X-ray.

6 CHAIR MARKOWITZ: Okay, so you're
7 saying if a B reading is performed rather than if
8 ILO scoring --

9 MEMBER CASSANO: Yes. If the B
10 reading is performed then ILO scoring greater than
11 one dash zero adds to your, you know, opacity.

12 CHAIR MARKOWITZ: Right. I changed it
13 in my version. I mean, I'm not a B reader, but
14 I will use the ILO scoring. So, that's a little
15 odd, but we can address that.

16 Other comments? Next slide. So this
17 mimics current language which is the second
18 diagnostic criteria is what comes out of the FWP
19 program which we went over before is very similar
20 to what the previous slide showed.

21 The next slide is -- here this addresses
22 pathology.

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1 Now, most people who have scarring in
2 the lung tissue don't come to biopsy. So this,
3 I'm showing the current program and the future is
4 going to be quite uncommon.

5 But sometimes if a person has severe
6 fibrosis scarring, or if it's progressed very
7 quickly which usually asbestosis doesn't then they
8 may come to biopsy to see if they have something
9 that can be treated.

10 So to be complete we need a criterion
11 for that. And it's a simple definition which is
12 when you look at cells what you see is a diffuse
13 interstitial process in the lung.

14 I should say that there are -- the
15 pathologists argue about some other things which
16 mainly center on whether they see asbestosis fibers
17 or asbestosis bodies and how much of that do you
18 need.

19 But there's general agreement on at
20 least the histologic evidence when you look at cells
21 under a microscope that there needs to be a diffuse
22 interstitial process, scarring process seen. So

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1 that's what is here.

2 If you could look to the next slide.

3 Here we favor a history of asbestos exposure.
4 We identify exposure.

5 But actually when you have lung tissue
6 you have the opportunity on asbestos to actually
7 look at whether there are fibers or not.

8 Just parenthetically, this is a
9 complicated subject because some fibers stick
10 around and some fibers don't.

11 Mind you, most people with asbestosis
12 are 20 or 30 years from their initial exposure to
13 asbestos.

14 One type of asbestos, the most common
15 type tends not to concentrate in the lung but to
16 move onto the pleura and elsewhere.

17 So these are kind of complicated
18 topics.

19 But if there is tissue and it can be
20 used to support a claim then you can document
21 exposure, meaning if you're not sure a person has
22 a history of asbestos exposure then you can use

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1 tissue burden of either fibers or asbestos bodies
2 to identify the exposure.

3 But the history comes first. The
4 history of asbestos exposure is sufficient. And
5 we should probably say this actually that it is
6 recognized as being sufficient to relate the
7 finding of diffuse scarring for the diagnosis of
8 asbestosis, but that in the absence of a history
9 that exposure can be documented through finding
10 of fibers or asbestos bodies.

11 Now, what you're looking at here on the
12 slide says consistent with excessive asbestos
13 exposure. John Dement wrote in and suggested that
14 phrase consistent with excessive asbestos exposure
15 be replaced by compatible with asbestosis.

16 Because the examining laboratories
17 vary one to the next. And what one considers
18 excessive is different from what others consider
19 excessive. So he's just suggesting and I think
20 he's right that we should simply say that they find
21 the concentrations of asbestos fibers or asbestos
22 bodies compatible with asbestosis by that very same

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1 examining laboratory.

2 That lab has evidence. Relatively few
3 labs do this counting of fibers and so they would
4 have experience with asbestos related disease.

5 So, any comments or questions on that?

6 MEMBER CASSANO: I have just one
7 comment. The only fear I have with this is that
8 a CE in the absence of history of asbestos exposure
9 is going to tell somebody -- that they cannot accept
10 the finding or something.

11 CHAIR MARKOWITZ: Right. So --

12 MEMBER CASSANO: We're not even saying
13 go get a chest X-ray, or go get a CT scan or whatever.

14 The only alternative to the word here of asbestos
15 exposure is a chest X-ray or CT scan according to
16 what we're putting here is a lung biopsy.

17 CHAIR MARKOWITZ: Right, right. So I
18 think it should be clear that the history is
19 sufficient.

20 I don't think -- I find it hard to
21 believe that claims examiners can direct the
22 medical care of each individual.

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1 But I see what you're saying. They
2 could not fully appreciate what it means to have
3 a lung biopsy.

4 So I think I should change the language
5 here to make it clear that the history of asbestos
6 exposure is sufficient, and that in the absence
7 of that history.

8 Well, you know, if you really don't have
9 a history of exposure, even if you have diffuse
10 interstitial fibrosis it's hard to prove your case.

11 MEMBER CASSANO: I agree.

12 CHAIR MARKOWITZ: By the way, let me

13 --

14 (Simultaneous speaking)

15 MEMBER CASSANO: -- exposure is a
16 history of disease that finds it before, correct?

17 (Simultaneous speaking)

18 MEMBER CASSANO: -- working at a job
19 it's presumed to have had asbestos exposure,
20 correct?

21 CHAIR MARKOWITZ: My thinking is that
22 if they accept our expanded definition of asbestos

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1 exposure that we recommended previously that that
2 should capture everybody who's got exposure.

3 MEMBER CASSANO: Okay.

4 CHAIR MARKOWITZ: Mind you, asbestosis
5 in particular takes a fair amount of exposure.
6 It's not occult exposure that causes asbestosis.
7 Mesothelioma, but not asbestosis.

8 MEMBER CASSANO: Right.

9 CHAIR MARKOWITZ: Yes. But it should
10 be clear. Yes, other comments?

11 MEMBER BODEN: Yes, this is Les.
12 First of all, I think that changing excessive
13 asbestos exposure in the way that you suggested
14 is a very sound idea.

15 Also, I'm just wondering whether when
16 we talk about a history of asbestosis exposure that
17 in -- if we're writing a presumption that someplace
18 in the presumption we refer specifically to what
19 we mean by that.

20 CHAIR MARKOWITZ: The history?

21 MEMBER BODEN: Yes.

22 CHAIR MARKOWITZ: Yes.

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1 MEMBER BODEN: And presumably the
2 history also includes -- I'm trying to remember
3 how it was worded before because I thought the
4 wording was good, that it was a history, or having
5 a job or task that was considered to be exposure,
6 to have exposure to asbestos.

7 (Simultaneous speaking)

8 MEMBER CASSANO: So you could actually
9 have two presumptions. You could have a
10 presumption of exposure and we could list it as
11 a presumption of exposure which is sort of what
12 we did when we talked about history of asbestos
13 exposure.

14 We might actually call it a presumption
15 of exposure. It should be presumed that a person
16 is exposed to asbestos if they have worked in
17 whatever facilities, or done whatever jobs over
18 a period of seven years for asbestosis.

19 MEMBER BODEN: Right.

20 CHAIR MARKOWITZ: Well, yes, in April
21 we approved the exposure presumptions.

22 MEMBER BODEN: We just want to make

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1 sure we incorporate it in this document.

2 MEMBER CASSANO: Maybe we should say
3 an alternative for history, and we tell that history
4 of exposure here we should say as per whatever the
5 document is that contains our previous
6 recommendation on how you define history of
7 asbestos exposure.

8 CHAIR MARKOWITZ: Right. That's
9 good. In fact, we might even repeat it here. I
10 have a slide with -- in case they don't accept our
11 previous recommendations, right?

12 (Laughter)

13 CHAIR MARKOWITZ: And that could
14 happen, that could happen.

15 MEMBER BODEN: Right, in which case you
16 can't refer back to it.

17 CHAIR MARKOWITZ: Exactly. Rejected
18 recommendations. Okay, fine.

19 MEMBER WHITLEY: Garry here. What
20 they're going to do -- a claims examiner going to
21 do automatically is they're going to go to the SEM
22 database. That's where they're going to get their

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1 history of exposure.

2 So if you were a pipefitter, asbestos
3 worker, that stuff, you're fine. If you look at
4 the buildings that says they contain asbestos, they
5 show all of them in the whole plant.

6 You go down to a supervisor or even
7 though he worked in that building with a crew every
8 day, if you go down to a supervisor and look up
9 to see if he was exposed to asbestos even though
10 he's in that building it will say no. No, no.

11 Claims examiners are going to use the
12 SEM database to help you, but they're also going
13 to use it against you if you're not listed in it.

14 CHAIR MARKOWITZ: Yes, I'm just trying
15 to bring up our recommendation on asbestos
16 exposure.

17 This is from our recommendation from
18 April which is on the exposure side. We
19 recommended at least 250 days of exposure, job
20 title, on the presumption side any maintenance or
21 construction worker. And this would be exposure
22 prior to 2005 with a minimum of 15 years.

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1 Anybody who doesn't make that
2 presumption would be individually evaluated.

3 So I don't know, Garry, if that
4 addresses the scenario that you raised here or not.

5 But that was our discussion of documenting
6 asbestos exposure previously, at least for
7 asbestosis.

8 MEMBER WHITLEY: Garry here. I think
9 the only way you can do it properly because you're
10 going to be fighting against the SEM database.
11 So, if you're not listed there you're going to have
12 to prove it otherwise.

13 CHAIR MARKOWITZ: Right. You know,
14 again, for asbestosis you need a fair amount of
15 exposure to asbestos. So it should be provable.

16 And I'm not talking about industrial
17 hygiene data. I'm talking about description of
18 tasks, description of work that a person did, job
19 title. In this one we're okay.

20 So let's move onto the next slide.

21 MEMBER SILVER: Before we move on, this
22 is Ken. The lung tissue burden can also be

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1 demonstrated on autopsy tissue.

2 CHAIR MARKOWITZ: Yes. It's not
3 specific here. It could be a biopsy or autopsy.

4 MEMBER SILVER: Thank you.

5 CHAIR MARKOWITZ: Next slide. Here's
6 for asbestos pleural disease, a history of asbestos
7 exposure. Again that harkens back to our previous
8 recommendation.

9 And then finding on chest X-ray or CT
10 a unilateral or bilateral pleural thickening, or
11 plaques that's not readily explained by another
12 cause.

13 And that should be sufficient for most
14 doctors to be able to make a decision as to whether
15 it's asbestos related pleural thickening or not.

16
17 It gets tricky when a person has had
18 heart surgery and you see diffuse or relatively
19 extensive pleural thickening at the bottom of the
20 lung on one side, and was that asbestos exposure
21 or was that the surgery.

22 And doctors may disagree, but no amount

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1 of definition is going to resolve that. That's
2 just judgment.

3 MEMBER CASSANO: Going back to the
4 prior slide. You don't have to go back, but just
5 thinking about the prior slide -- why can't somebody
6 -- if somebody has fibrosis but no history of
7 asbestos exposure and they have pleural plaques
8 with no other explanation for them.

9 I mean I have always been told and have
10 always considered pulmonary fibrosis and pleural
11 plaque as sort of capping -- or asbestosis.

12 So why can't we use the presence of
13 pleural plaque with the fibrosis as definitive of
14 asbestosis?

15 I know there's some other things that
16 can do that, but not a whole heck of a lot.

17 CHAIR MARKOWITZ: Yes. That's a good
18 idea. Let me -- I will draft some language that
19 addresses that.

20 Again, it takes a lot of asbestos
21 exposure to get asbestosis.

22 MEMBER CASSANO: Yes.

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1 CHAIR MARKOWITZ: And so it's unlikely
2 to be occult, you know, or not noticed. But if
3 a person really isn't in the right job title,
4 doesn't report it, but has pleural plaques and
5 interstitial fibrosis then I would probably lean
6 towards asbestosis as you say.

7 So let me add some language to reflect
8 that. Which we don't have to draft here because
9 we're just working this up, but when we meet.

10 I'll circulate another version of this
11 before the meeting in October or November.

12 MEMBER CASSANO: I could give you some
13 language, but you probably will be better at it
14 than I.

15 CHAIR MARKOWITZ: I mean, I'll draft
16 it and everybody can look at it and chime in. Or
17 if you want to send over language that's fine too.
18 Whichever. That works. Other comments?

19 Okay, so let's go -- let's see, we're
20 at pleural disease. Any comments on this
21 particular slide? You notice we're not
22 quantifying how much pleural thickening. We are

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1 leaving it open as whether it's one side or both
2 sides. And I think that's appropriate to not get
3 any more specific than this.

4 MEMBER VLIEGER: This is Faye. I have
5 a question and it comes from the fact that I have
6 a recent claimant that went through the IH in D.C.
7 who we interviewed at our meeting there.

8 And this person was an asbestos
9 insulator, but not for 15 years. He was there for
10 17, 18 months, but he was an asbestos insulator.

11 During the time period where they
12 weren't required to wear masks or alternative air.

13 And the IH said that his exposures would
14 have been incidental and infrequent and thereby
15 sending it to a CMC who of course was not going
16 to disagree with the IH.

17 And of course the answer came back that
18 his lung condition, not asbestos disease, but his
19 lung condition was not caused or contributed to
20 his asbestos exposure.

21 How are we going to get away from this
22 being sent to the IH who presumes, or has to presume

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1 that the person worked or was exposed to asbestos?

2 I don't know how we're going to get away from that
3 part of the law that says you have to prove exposure.

4 You know, you have to prove exposure.

5 CHAIR MARKOWITZ: This is Steven.
6 Again, if our prior recommendation is accepted for
7 that outcome, either pleural thickening, or pleural
8 plaques, or asbestosis, if a person has 250 days
9 of exposure certainly that person was an insulator,
10 so they're like number one on the job title list.

11 If they had 18 months of work then they
12 would make it as a matter of presumption.

13 MEMBER VLIEGER: You would think that,
14 but the other thing that of course they threw out
15 there again was, well, you know, smokers have this
16 happen to them too, therefore that in a short period
17 of work this couldn't have happened.

18 I don't know how we can get away from
19 an IH and a CMC doing the same song and dance that
20 they haven't already done here. If it gets sent
21 to a CMC.

22 CHAIR MARKOWITZ: Well, there's no

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1 amount of guidelines that we can recommend that
2 would get around the problem of misapplication or
3 incorrect decisions.

4 Although, another recommendation that
5 we're going to take a look at, there are a number
6 of CMC decisions or recommendations or opinions
7 and then look at their level of accuracy.

8 MEMBER VLIEGER: Okay, well I'm just
9 trying to figure a way in this wording that it
10 doesn't have to go out to an outside source. So
11 far these are still recommendations I understand,
12 but somewhere in the wording it's like well, I know
13 this is presumptive, but we haven't said don't do
14 the other things.

15 They still always have the option of
16 doing the other things.

17 CHAIR MARKOWITZ: Yes, but we've also
18 in other conversations have been circumspect about
19 the claims examiner making decisions that they're
20 not really qualified to make.

21 But you know, the idea of adding more
22 specific diagnostic criteria would also help the

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1 treating physician because there are guideposts
2 the treating physician could -- this is how the
3 program looks at evidence for these entities. It's
4 now more specific than it was previously.

5 And then they in their letter if it's
6 true or cite that, okay, my decision on asbestosis
7 is based on review of the chest X-ray which showed
8 bilateral and diffuse interstitial fibrosis in mid
9 and lower lung zones.

10 And the CE then should be able to match
11 up what the treating physician has said with the
12 evidence that we're recommending and say yes,
13 that's the case. No need to send to the IH or CMC.
14 We're done.

15 I think the added specificity would
16 allow both the treating physician get a better sense
17 of what's required, but also allow the CE to make
18 a decision and not do what you're worried about
19 which is sending it to an IH or CMC who's going
20 to make the wrong decision. Does that make sense?

21 MEMBER VLIEGER: It does. I guess
22 part of my frustration is we work on these things

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1 and it's all logical and good, and then back in
2 the trenches we're still dealing with the idiocy.

3 CHAIR MARKOWITZ: Well, you know, the
4 application, should they accept these
5 recommendations, the application, we should get
6 around to figuring out how to help monitor the
7 application of these things so that they're applied
8 appropriately.

9 MEMBER SILVER: Ken Silver here. We
10 might start generating a list of issues that we
11 want to remark upon with great emphasis in our
12 accompanying rationale.

13 The pathogenicity of plaques in
14 asbestos, what smoking does and does not contribute
15 to lung cancer and fibrosis as I understand it.

16 And maybe the phenomenon of short-term
17 high-level exposure causing chronic asbestosis
18 years later.

19 I think findings back from the late
20 seventies, early eighties of lung bumps in an
21 amosite plant you know, still cited.

22 So if you put a big emphasis on that

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1 in the rationale at least advocates can say look,
2 we told you so.

3 CHAIR MARKOWITZ: Also the rationale
4 would be accessible to the physicians who are part
5 of the process meaning the treating physician and
6 the CMC. So it would be useful.

7 Yes, I haven't transferred the
8 rationale but when I do and send it around, if it
9 doesn't have those points, Ken, throw them in there.

10 MEMBER SILVER: Okay.

11 CHAIR MARKOWITZ: Other comments on
12 this? So let me see. It's 2:15. Do people want
13 to take a five-minute break? I have three or four
14 more slides. But if people want to take a break
15 we can.

16 MEMBER BODEN: I'm okay going on, but
17 maybe other people --

18 MEMBER CASSANO: I'm okay.

19 CHAIR MARKOWITZ: Okay. So let's
20 continue then. Okay, next slide then.

21 So this is for pleural effusion. This
22 is a very uncommon condition and I'm a little

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1 surprised actually to see it in the language of
2 the manual.

3 But there's no definitive way of making
4 the diagnosis. You need the history of exposure
5 and then you need an unexplained pleural effusion.

6 Even in such a population 9 times out
7 of 10 that pleural effusion is going to be caused
8 by something else like heart failure, or
9 inflammation, or very common causes.

10 So this definition should be
11 sufficient. I don't think the claims examiner is
12 really likely to be able to make this call, but
13 treating physician and the CMC certainly could.

14 Because if a person has inflammation
15 infection or a heart failure that should be pretty
16 apparent from the medical record or from examining
17 the person.

18 More than a dozen claims for this I'd
19 be surprised. It's a very unusual condition
20 especially these days.

21 Any comments on this? Okay. So let's
22 go on to the next slide.

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1 Okay, so this is important because
2 these are common outcomes. And these are all the
3 cancers that are recognized as being related to
4 asbestos.

5 So how do we want the claims examiner
6 to look at a case. Generally they are looking
7 probably at present and they should look for
8 pathology reports because there's either a biopsy,
9 or autopsy, or surgery in which they've taken a
10 whole bunch of tissue.

11 And it says on the pathology lung cancer
12 it says mesothelioma or cancer of the ovary or
13 larynx. It won't say asbestos, but that's not
14 needed for this process.

15 The history of exposure comes from
16 different kind of evidence.

17 There are some instances, particularly
18 in older people, who aren't well enough to undergo
19 a biopsy, or surgery, or there's no point in doing
20 surgery.

21 They may not come to autopsy. And it
22 doesn't happen very often but it does happen in

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1 which case the physician is left trying to make
2 the best judgment without having tissue whether
3 the person has a cancer and what the cancer is cancer
4 of.

5 And I think the claims process -- I'm
6 not sure how it works now in terms of these claims,
7 but it has to recognize this group of presumed
8 diagnosis.

9 And this is not something that the
10 claims examiner would do. It is something that
11 the physician would do.

12 And that is just by way of example if
13 a person comes in, they've lost weight, they're
14 short of breath, they have fluid in their chest
15 and they have a big mass coming from the pleura
16 then chances are that's mesothelioma.

17 Or they have a big mass in the lung and
18 no one's going to do surgery, it's too risky to
19 do biopsy, that's going to be a lung cancer with
20 90 percent certainty.

21 So this group should be specified in
22 the claims examination process.

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1 Or a death certificate that mentions
2 one of these entities somewhere on the death
3 certificate. Usually not very far down because
4 at least for mesothelioma, cancer of the lung,
5 cancer of the ovary people usually die of those
6 entities.

7 MEMBER CASSANO: Do we need to say
8 something about with or without looking for a
9 history of smoking? Just because I see a lot of
10 times that the person smoked, they've got lung
11 cancer, it's due to smoking, it's not due to
12 asbestos.

13 CHAIR MARKOWITZ: Yes, we should put
14 that in the rationale. Rachel has told us that
15 the process doesn't recognize or take into account
16 smoking, but CMCs presumably read this.

17 We're not quite sure whether they
18 follow everything in the program. And the treating
19 physicians wouldn't be downed by this either.

20 So in the rationale it should be
21 explicit. Smoking does not contribute to
22 mesothelioma. Smoking does to lung cancer, but

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1 in a way that exacerbates the asbestos exposure,
2 et cetera. We'll put that in the rationale.

3 MEMBER CASSANO: Okay, thanks.

4 CHAIR MARKOWITZ: So my question
5 overall about these, is this added level of
6 specificity and pointing out the relative utility
7 of different ways of diagnosing or sources of
8 evidence, would this represent an improvement over
9 the current process.

10 MEMBER CASSANO: I think if they enlist
11 the doc -- I mean, the doctor would be able to
12 determine that.

13 MEMBER VLIEGER: I'm sorry, are we on
14 slide 20? This is Faye.

15 (Simultaneous speaking)

16 MEMBER VLIEGER: -- on the WebEx.

17 CHAIR MARKOWITZ: Yes, we're on 20.
18 We're on the cancer list. Yes.

19 MEMBER VLIEGER: So as far as all of
20 this it looks pretty much normal the way it runs
21 right now. I don't see any problem with it.

22 We don't usually have pathology. We

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1 could make a comment on it on the death certificate.

2 But there again we run into the same problem on
3 death certificates as we do with diagnostic
4 paperwork from the physicians here. Unless it's
5 been heavily charted and documented they're not
6 going to make any asbestos diagnosis on a death
7 certificate unless there's been an autopsy and
8 those are not common.

9 CHAIR MARKOWITZ: So Faye, does that
10 mean if a person has a documented history of
11 asbestos exposure it's recognized by the claims
12 process, but then has lung cancer on the death
13 certificate but it doesn't say anything about
14 asbestos related lung cancer, that that wouldn't
15 necessarily be accepted?

16 MEMBER VLIEGER: That's correct.
17 That's correct. I have a case right now where the
18 person was in the hospital, had recently been
19 diagnosed with multiple myeloma, had one chemo
20 treatment, went to the hospital with a blood clot
21 and the death certificate says he died from a blood
22 clot. Does not mention the mesothelioma. So the

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1 death certificate is not useful at all unless it's
2 specific.

3 Even if it's secondary or tertiary
4 cause, it has to be on the death certificate.

5 But we have the physicians at the
6 largest hospital in the area here for the Tri-Cities
7 that they only put the most immediate cause of death
8 and then to try and get a death certificate amended
9 they refuse. So you have to go through the coroner
10 and that can take up to a year because the coroner
11 is busy with the most recently dead, not the more
12 longer dead.

13 And in the two cases I had to have death
14 certificates amended it took more than a year.

15 CHAIR MARKOWITZ: Right. Wow. Well,
16 the problem is not DOL or the program, the problem
17 is the healthcare system that doesn't get the death
18 certificate right.

19 MEMBER VLIENER: Well, yes, that's the
20 problem. What I see more of a problem is that DOL
21 has the physicians running scared because the
22 program guidelines are not clear.

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1 And there are no pamphlets out to the
2 doctors that say this is what I accept for
3 mesothelioma. This is what we accept for COPD.
4 This is what we accept for asthma.

5 The department has failed to do that
6 probably to their own benefit. So the doctors take
7 two steps back for a couple of reasons.

8 First of all they did not go to school
9 to play legal beagle.

10 Secondly, the state labor and
11 industry's claims system has all of them running
12 scared that they're going to have to spend a day
13 of clinic time in depositions.

14 So the Department of Labor program
15 because it doesn't specify and it doesn't provide
16 an easy way for them to understand what's going
17 on, they think it's like every other worker
18 compensation program which is going to require them
19 to not have office time for patients, but to have
20 to do legal maneuvers.

21 So, I think the department could do some
22 things to improve this, but right now no, they don't

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1 make it easy.

2 And by the same token as when we look
3 on the CMC side of things the CMCs are barely vetted.

4 And as you saw in the decisions we reviewed don't
5 even follow program guidelines because there's no
6 clear program guidelines given to them either.

7 CHAIR MARKOWITZ: If we can develop
8 some consensus diagnostic criteria I think it will
9 be useful by all elements, the treating physicians,
10 the CMCs, the claims examiners.

11 This should provide some greater basis
12 for making decisions and more uniform as well.

13 Doctors not wanting to participate in
14 legal processes, compensation systems and the like,
15 that is a huge problem everywhere in relation to
16 workers compensation, any federal compensation
17 program, tort litigation, you name it. It's just
18 universal.

19 You lecture first-year medical
20 students and mention lawyers and they boo you.
21 It's a problem.

22 MEMBER CASSANO: Steve, tangential to

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1 this. A recommendation that we could make is that
2 in these areas where there's large numbers of
3 claimants, et cetera, that there should be some
4 program, it doesn't have to be -- somebody should
5 be going to the hospitals and maybe doing grand
6 rounds, or even a lunch and learn if you will on
7 some of these issues for the local physicians inside
8 -- how to fix it.

9 It's obviously outside of our purview,
10 but maybe it's not. Maybe it's something we could
11 do when we do one of these meetings. Have a
12 two-hour session for local docs in a meeting to
13 talk about some of these issues.

14 CHAIR MARKOWITZ: The Department of
15 Labor --

16 MEMBER CASSANO: I don't know if that's
17 in our purview or not, but it should be done by
18 somebody.

19 CHAIR MARKOWITZ: The Department of
20 Labor has a joint task force with NIOSH and with
21 DOE. I think it was the Ombudsman's Office to do
22 these public meetings to discuss compensation

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1 program, former worker program and other things.

2 And conceivably they could engage the
3 former worker programs to do this kind of medical
4 education.

5 MEMBER CASSANO: Yes.

6 CHAIR MARKOWITZ: Part of the problem
7 is frankly we don't think the doctors would show
8 up because they're not all that interested.

9 MEMBER CASSANO: Well, unless somebody
10 gave them CME credits. Then they would.

11 MEMBER SILVER: This is Ken Silver.
12 Going back to this slide. Faye if this were adopted
13 the connecting word is "or." Would you have been
14 able to use number 2 in your mesothelioma case where
15 the death certificate said blood clot? Would you
16 be able to win the claim based on number 2 on this
17 slide?

18 MEMBER VLIEGER: If there's clinical
19 evidence then they would be eligible for Part E.

20 But under Part E the death certificate wouldn't
21 match the clinical.

22 And so in order to qualify for survivor

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1 benefits the death certificate, the reason they
2 died has to be a covered condition or a later covered
3 condition.

4 And the death certificate would not
5 match in this case and therefore there wouldn't
6 be no survivor benefit.

7 The only caveat to that is if there was
8 a claim in place at the time of death and the
9 department was dawdling and the person died, then
10 the Russero ruling would come into play with the
11 survivor claim where they would be eligible for
12 benefits.

13 But that only applies if there is a
14 claim in process that the Department of Labor has
15 administratively dawdled on. And then Russero
16 would come in play because the family would be
17 eligible for the claims that would have been
18 eligible while the claimant was alive.

19 In most cases when you're dealing with
20 a claim filed posthumously and the death
21 certificate does not match for a condition covered
22 under Part E, and that's what asbestos would be,

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1 then you would either have to get an autopsy done,
2 or you would have to have your death certificate
3 changed.

4 And both of those are similar to having
5 baby elephants.

6 MEMBER SILVER: I believe diagnostic
7 criteria would work for causation for like a wage
8 loss claim, or coverage in medical benefits, but
9 then for survivors claims someone would have to
10 administratively extend our logic and override the
11 death certificate requirement.

12 MEMBER VLIEGER: Exactly.

13 MEMBER SILVER: Okay.

14 CHAIR MARKOWITZ: This language we're
15 looking at actually would provide the basis for
16 that, a rational medical basis for that decision.

17 MEMBER SILVER: Right.

18 MEMBER VLIEGER: Yes. If there's
19 enough medical evidence that it's pretty clear-cut
20 the coroner doesn't have any problem doing the
21 change. But we have to have the documented
22 medical.

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1 I haven't had to use an autopsy result
2 to change a death certificate. I have one pending
3 right now and I don't know what the outcome's going
4 to be.

5 MEMBER CASSANO: So if it requires a
6 medical opinion working with a -- if I'm
7 understanding this right it works like the ABD I
8 work with it would be a medical opinion that states
9 that if it doesn't at the cause of death then the
10 mesothelioma despite what -- that the contributory
11 cause of death was mesothelioma despite what is
12 on the death certificate. Am I correct, Faye?

13 MEMBER VLIENER: That or enough
14 evidence that they were diagnosed with it prior
15 to their death. And as long as it was being
16 actively treated it should have been listed on the
17 death certificate.

18 MEMBER CASSANO: If it wasn't on the
19 death certificate then -- we may be able to come
20 up with some language that basically says if there
21 is current evidence yada yada yada at the death
22 certificate that's not included as a contributory

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1 -- secondary or contributory cause then the claims
2 examiner should forward it to the CMC for a
3 decision.

4 I think that would work. And then we'd
5 give the CMC guidance on that.

6 MEMBER BODEN: Can I just ask a
7 question about this last slide just to clarify.
8 So these are diagnostic criteria for example for
9 cancer of the lung, not necessarily asbestos
10 related cancer of the lung.

11 CHAIR MARKOWITZ: Right.

12 MEMBER BODEN: Right? Okay. So if
13 then one wanted to tie it to occupation one would
14 need additional exposure evidence.

15 CHAIR MARKOWITZ: Right.

16 MEMBER BODEN: Yes? Okay. Just to
17 clarify for me. I wasn't sure I understood that
18 right.

19 CHAIR MARKOWITZ: Right. And for the
20 other conditions in every instance we mentioned
21 the history of asbestos exposure because they were
22 asbestos specific conditions like asbestosis,

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1 pleural disease or the like.

2 But here I could have added a slide to
3 say related to asbestos requires fulfilment of the
4 criteria plus a history of exposure.

5 MEMBER CASSANO: Well, what about
6 mesothelioma just for relevance.

7 CHAIR MARKOWITZ: You know, actually
8 in our recommendation for mesothelioma we said 30
9 days and a minimum of the right job title or a
10 history of exposure or the like.

11 So there should be some documentation
12 of the asbestos exposure. But it usually doesn't
13 require much.

14 MEMBER CASSANO: Okay.

15 CHAIR MARKOWITZ: Tori, getting back
16 to your point, your suggested language, if you want
17 to draft something and send it to me.

18 MEMBER CASSANO: I believe that's about
19 what I was going to say. Oh it was about pleural
20 plaque plus sarcoidosis.

21 CHAIR MARKOWITZ: No, this was about
22 the issue that Faye was raising about the use of

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1 clinical information --

2 MEMBER CASSANO: Okay, so --

3 CHAIR MARKOWITZ: -- for a physician
4 to opine on a cause of death when the death
5 certificate doesn't mention.

6 MEMBER CASSANO: Okay. I will do
7 that.

8 CHAIR MARKOWITZ: Yes. I mean, it's
9 a bit of a tough hurdle because you're seen as sort
10 of second guessing the doctor who actually attended
11 the death and filled out the death certificate,
12 but it's worth putting in there I think.

13 MEMBER CASSANO: You know, I see a lot
14 all the time it's cause of death heart attack.
15 Well, the heart attack is secondary to the fact
16 that the person had pleural -- or whatever, but
17 the final event is always the heart stops.

18 So, I don't think it's difficult and
19 I think once it's explained, the claims examiners
20 and to the agency that it could be -- I don't think
21 it's going to be difficult to make it happen.

22 CHAIR MARKOWITZ: The other thing of

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1 course is that frequently the physician filling
2 out the death certificate is the person who happens
3 to be in the hospital when the person died. And
4 they're typically being a resident.

5 So they may be covering for somebody
6 else and may not even know the patient or what the
7 patient's illnesses are.

8 So that's not apparent to the outside
9 world, but it generally happens.

10 MEMBER CASSANO: Yes. Okay, so I can
11 do that.

12 CHAIR MARKOWITZ: Okay, so if we're
13 done with asbestos let's move onto the last slide.

14 And here I'm not expressing an opinion,
15 I'm just raising issues. I went through the claims
16 -- the procedure manual for other conditions that
17 it mentions.

18 It does mention at the end of chapter
19 2 or whatever the new chapter is Parkinsonism
20 without saying much about it other than treating
21 the various synonyms for Parkinsonism meaning
22 Parkinson's disease, Parkinson syndrome,

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1 Parkinsonism to treat them as the same.

2 It doesn't weigh in in terms of
3 exposures.

4 And then there's an exhibit which is
5 an attachment or an appendix to the manual which
6 lists -- which is an old thing I think from the
7 beginning of the program which lists a number of
8 different entities including peripheral
9 neuropathy, damage to the nerves of the arms and
10 legs caused by a toxin.

11 It also mentions something called toxic
12 encephalopathy, chronic toxic encephalopathy which
13 is brain damage due to chronic exposure to certain
14 toxins such as metals or solvents in particular.

15 But it doesn't really go into any detail.

16 And then also it just very briefly
17 mentions chronic kidney disease.

18 I don't know that there are many claims
19 for these conditions so it's hard -- we can ask
20 DOL if there are, because if there are not I don't
21 think there's any rationale for trying to design
22 presumptions.

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1 MEMBER CASSANO: Well, I just wonder
2 if the reason there aren't any claims for them is
3 that people don't know that organic solvents, toxic
4 encephalopathy or Parkinson's disease.

5 And the literature is pretty replete
6 now with both epidemiologic and toxicologic studies
7 that tend to prove that association.

8 I think the other one might be -- and
9 again, organic solvents, specifically benzene --
10 I don't know how many of these people were exposed
11 to benzene, and acute myelogenous leukemia.

12 I don't think we should use how many
13 claims are there. I mean, I don't want to open
14 up another can of worms for the agency either, but
15 people that have diseases that are related to their
16 work should be compensated.

17 But I don't think we should start with
18 how many claims. I think we should look at the
19 form and see what the major toxicants are in the
20 workplace. And if we see major toxicants that we
21 know definitively cause disease then those are
22 easily turned into presumptions.

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1 And I just mentioned the two of them.

2 There's benzene in AML and Parkinson's and both
3 manganese -- if there's an extension of manganese,
4 I don't know if there is.

5 So, primarily two to use.

6 MEMBER VLIEGER: This is Faye. DIAB,
7 the board that I still chair on though it's gone
8 kind of dark did a list of diseases most likely
9 denied by the department. I can resurrect that
10 list and send it.

11 But of the things that were more
12 routinely denied was peripheral neuropathy,
13 Parkinsonism, dementia, chronic encephalopathy,
14 toxic encephalopathy.

15 So I can resurrect that list. But what
16 we had done was look at the statistics from the
17 Department of Labor and look at the things that
18 were most likely denied.

19 So if you want I can resurrect that and
20 send it out.

21 CHAIR MARKOWITZ: Sure.

22 MEMBER VLIEGER: All right, thank you.

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1 CHAIR MARKOWITZ: The issue of whether
2 they should come to presumptions depends on a number
3 of factors like is there enough information to make
4 decisions.

5 There may be that a number of these
6 different conditions, either a high denial rate,
7 or a fair number of denials, not referring to rate,
8 that the issue of not lack of presumptions but the
9 issue is that the SEM is incomplete or inaccurate,
10 or the claims process doesn't recognize certain
11 aspects of these diseases.

12 Or if a person has diabetes the
13 neuropathy is always chalked up to the diabetes
14 and never to the toxin.

15 That's separate from the issue of
16 whether there should be presumptions.

17 So I guess we may need to figure out
18 what the particular issues for these conditions
19 are first before deciding whether they're
20 appropriate to try to elaborate presumptions.

21 MEMBER CASSANO: You mean as far as DOL
22 is concerned, as far as the exposure is concerned,

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1 or what?

2 CHAIR MARKOWITZ: Well, it could be
3 exposure, it could be the diagnostic criteria.
4 It can be any aspect of the process.

5 MEMBER CASSANO: Okay.

6 CHAIR MARKOWITZ: But that may involve
7 -- I mean, if we believe that toxic neuropathy might
8 be an issue that's not -- that there is some
9 suspicion it isn't being addressed properly then
10 we could look at a certain number of cases of toxic
11 neuropathy denied and accepted and see how the
12 decisions are made and whether we think there's
13 any room for improvement.

14 And that's what occurred before the
15 issue of developing presumptions.

16 MEMBER CASSANO: Yes. We could look
17 at the Parkinson's disease too because I don't know.

18 I mean, I'm not -- organic solvents have to be
19 a huge exposure issue in this area. I am assuming
20 that. I don't know if that's true.

21 Can somebody educate me on that?

22 CHAIR MARKOWITZ: Solvents?

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1 MEMBER VLIEGER: I'm sorry, is the
2 question that we're --

3 MEMBER CASSANO: Solvent exposure has
4 to be there in these facilities.

5 MEMBER VLIEGER: So I don't know if
6 anyone goes home and plays with them on purpose.

7 MEMBER CASSANO: Excuse me?

8 MEMBER VLIEGER: Yes, it would have to
9 be occupational. Like I said, I don't know of
10 anybody that goes home and plays with these things
11 on purpose.

12 MEMBER CASSANO: Yes, I mean people
13 work on their own cars, they use degreasers, they
14 ship furniture at home, et cetera. So some of it
15 can be from home, but usually that's incidental.
16 It's not chronic low-level or chronic moderate
17 level.

18 So, I think we need to know how -- I
19 think looking -- and that's something I guess
20 Rosie's group and my group could do once we get
21 past our next meeting is start looking at these
22 neuropathy and the Parkinson's disease claims and

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1 see whether the evaluation specifically by the CMC
2 and/or the industrial hygienist are appropriate.

3 I hate to make more work for Rosie.

4 CHAIR MARKOWITZ: I think that makes
5 sense. I think we need to understand some of the
6 issues better with some of these entities before
7 deciding which recommendations we might make.

8 MEMBER CASSANO: I was only looking at
9 it from out of these things what is the definitively
10 proved as a causal. That's all I was looking at.

11 I wasn't looking at it from the perspective of
12 the agency.

13 MEMBER SILVER: Kidney disease is
14 interesting. This is Ken Silver. In that there's
15 a lot of diabetes out there and there's a lot of
16 uranium at these sites and many organic chemicals
17 have been shown to cause various kinds of kidney
18 damage in animals in particular.

19 And there's evidence of synergistic
20 effects.

21 So if the statistics from DOL suggest
22 that kidney disease looms large, the issue is them

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1 getting people to take a look at that.

2 MEMBER CASSANO: Well, certainly, yes,
3 kidney disease and adrenal carcinoma is another
4 one related to organic solvents. Specifically
5 CTE.

6 MEMBER SILVER: And we did look at a
7 claim that was pretty much a slam dunk a few months
8 ago. It was paid, but -- teasing apart kidney
9 disease due to diabetes versus uranium exposure.

10 There were two cases at Los Alamos.
11 Both had happy endings for the claimants. But it's
12 a very small sample.

13 A much larger n in the DOL system.

14 MEMBER CASSANO: That's part of the
15 problem with how we look at these cases is that
16 they're not randomly picked. And I think we saw
17 that when we went to Seattle.

18 So, I'm not sure if there's some way
19 to get a list of what's been adjudicated this month
20 and randomly pick rather than having each district
21 office pick the ones they want to send to us.

22 Faye, you may want to elaborate on that

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1 a little bit more based on our meeting in Seattle.

2 But we'll deal a lot more with that on Tuesday
3 I think is when we meet, correct?

4 MEMBER VLIEGER: The 27th, isn't that
5 Monday?

6 MEMBER CASSANO: The 27th.

7 CHAIR MARKOWITZ: That's Tuesday,
8 11:30 a.m.

9 MEMBER VLIEGER: Yes, Tuesday. This
10 seems, and I don't know how random random is when
11 you're doing a specific district office and we're
12 looking at claims from that district office.

13 It just seems that the claims process
14 is becoming so convoluted that anything we can do
15 to keep it from becoming as convoluted as it is.

16 Maybe taking out as much as possible
17 the individual decision-making.

18 I agree that when we went to Seattle
19 -- the people seemed to generally know what they
20 were doing. What we were working with was pretty
21 picked.

22 CHAIR MARKOWITZ: Pretty what?

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1 MEMBER CASSANO: Yes, there wasn't
2 anything really controversial that we saw. It was
3 one case that they actually agreed was adjudicated
4 incorrectly and they were going to take another
5 look at it.

6 So I'm not sure if we saw the best of
7 what there was, or whether -- I know it wasn't a
8 random sample because they picked them based on
9 their medical interests from the supervisor's
10 position.

11 I don't know that we could get really
12 down and dirty in looking at these, other than to
13 say send me a list of numbers of all the Parkinson's
14 disease cases who have been adjudicated this month
15 and I'll just randomly pick numbers.

16 I don't need the files initially, I just
17 need the case numbers and I'll just randomly pick
18 numbers, or somebody will randomly pick numbers.

19 And that's a little bit better than somebody --
20 I'm hoping they're not cherrypicking them, but they
21 probably are a little bit.

22 MEMBER WHITLEY: This is Garry. If

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1 you do Parkinson's you need to do current cases
2 because if you go back three to five years ago they
3 didn't pay for Parkinson's at all.

4 MEMBER CASSANO: Right. Because
5 there was not a lot of definitive evidence that
6 organic solvents caused it.

7 MEMBER WHITLEY: Right. But recently
8 they have been paying for a few at least in our
9 area that I see Parkinson's.

10 Neuropathy they used to not pay at all.
11 Now they're paying some neuropathy cases if
12 there's no signs of diabetic even in the family
13 -- of diabetes even in the family.

14 If there's any signs of diabetes
15 they'll throw it out in a hurry.

16 The one they won't touch is pancreatic
17 cancer. I don't know anybody that's been paid for
18 pancreatic cancer. I could be wrong, but everybody
19 I know, they get back a letter that says there's
20 no evidence of any chemicals that cause pancreatic
21 cancer.

22 MEMBER VLIEGER: To clarify, that's

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1 only under E for toxic exposure, not Part B.

2 MEMBER CASSANO: There is some limited
3 evidence for I forget what it is, an association,
4 but it's pretty darn weak for pancreatic cancer.

5 Unless -- could arguably disagree I don't think
6 with not compensating pancreatic cancer. There's
7 just not enough -- there's nothing practically out
8 there about toxic etiology of pancreatic cancer.

9 From what I've been able to see.

10 CHAIR MARKOWITZ: I agree.

11 MEMBER SILVER: So in terms of a
12 process we could ask DOL for more systematic
13 sampling, or counts of cases where these issues
14 may come up.

15 Another thing we might do is if the
16 advocates who are listening to weigh in with, you
17 know, helpful one-page emails to flesh out where
18 we might be useful on developing new presumptions.

19 MEMBER VLIEGER: I want to agree with
20 Garry that Parkinson's disease even with adequate
21 information is a hit or miss entity to get it
22 accepted.

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1 And recently I had a case accepted that
2 had been pending for more than a year.

3 I cannot tell you the difference
4 between the information provided in that claim and
5 the other claims that got accepted and five others
6 got denied.

7 It just seems very eclectic with what
8 they accept and don't accept. And it hinges on
9 the contract medical consultant report.

10 MEMBER CASSANO: Probably hinges a lot
11 on the knowledge of the CMC.

12 MEMBER VLIENER: I'm not willing to
13 cast any aspersions but I totally agree with you.

14 MEMBER CASSANO: Because -- and it
15 changes every month practically.

16 CHAIR MARKOWITZ: So we have just five
17 minutes left, and I wanted to try to see if we could
18 figure out what our next steps are.

19 And I would actually think that the
20 report that Faye talked about a while back which
21 was cases frequently denied, even though it would
22 -- you couldn't publish the results in a journal

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1 it might actually be useful to us.

2 Because we certainly want to try to pick
3 up on diseases that were controversial but where
4 there were enough cases that our presumption would
5 help more than a couple of people.

6 And then if we pick diseases that we
7 want to look at next that we ask for a listing of
8 all the cases in a certain time period where this
9 disease was at issue, just the case numbers, and
10 then we pick a random sample and take a look.

11 MEMBER CASSANO: I think that's a good
12 idea.

13 MEMBER VLIEGER: This is Faye. I have
14 a copy of the data that was assembled by the
15 Institute of Medicine for the program under -- by
16 request from the Department of Labor.

17 And I'm going to be sending that to
18 Carrie shortly.

19 In the top 10 are a number of malignant
20 neoplasms of different places. But something that
21 is commonly denied as emphysema. I've seen a
22 turnaround in that.

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1 So I will send this out. And this is
2 from -- IOM was contracted by the Department of
3 Labor. So this is from 2011 but I know I've got
4 another list that DIAB and NTAC put together as
5 part of what we would need to recommend things to
6 the Department of Labor.

7 I'm sorry, I'm still looking for that
8 one.

9 MEMBER CASSANO: I can get the full IOM
10 report as well. I mean, anybody can. It's nid.edu
11 and just send it out.

12 MEMBER BODEN: One other thing that we
13 have to remember is it may be that particular
14 entities that are frequently denied are actually
15 denied for good reason. So it is an -- we have
16 to keep in mind.

17 CHAIR MARKOWITZ: And we should ask or
18 re-ask DOL if they have a list of the frequency
19 of denied conditions.

20 I think we've asked that before but I
21 don't recall the specifics. But we should at least
22 try or try again if they have information on that.

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1 So, is there anything -- I think we've
2 pretty much discussed most of the things that are
3 relevant and even other things. No? Talk is good.

4 Are there any other things relating to
5 presumptions that we need to discuss today?
6 Otherwise we should adjourn.

7 Okay. So I'm going to -- let's see,
8 I think Tori is going to send me some suggested
9 language. I'm going to modify some of the things
10 based on comments on the call. Then John Dement's
11 written comment.

12 I'll draft a rationale to go along with
13 this and then circulate this before our fall
14 meeting.

15 I don't think that we have enough
16 business to call for another presumptions working
17 group meeting prior to our fall meeting. Does
18 anybody think otherwise?

19 MEMBER SILVER: Is following up with
20 DOL to see how they're receiving our
21 recommendations something for the working group
22 or something for the full board?

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1 CHAIR MARKOWITZ: That's for the full
2 board. Doug gave us a brief report on Monday that
3 things are either within the program being worked
4 on or in the Secretary's office. And that's all
5 we know at this point.

6 But we'll continue to monitor it. And
7 continue to send in new recommendations.

8 MEMBER BODEN: Okay, well Steven, your
9 fear of not having to end well before our designated
10 time has been allayed.

11 CHAIR MARKOWITZ: Okay, that's good.
12 Okay, thank you and we'll continue to communicate
13 around this particular presumption medical section
14 for asbestos related disease.

15 And then we're going to set the schedule
16 for the full meeting in October or November so
17 you'll hear from Carrie. Thank you.

18 (Whereupon, the above-entitled matter
19 went off the record at 3:00 p.m.)

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