Proposed Revised Recommendation for Work-Related Asthma

The Board recognizes the modifications made by EEOICP in the provisions relevant to work-related asthma as reflected in the EEOICP Procedure Manual V2.3, Appendix 1. It is also cognizant of the statutory requirement that a compensable condition under EEOICPA must be aggravated, contributed to, or caused by a toxic substance.

However, there remains one section where the current language of the EEOICP Procedure Manual is so divergent from current medical guidelines and practice that the Procedure Manual requires correction. (bolded language below).

Appendix 1 (Exposure and Causation Presumptions with Development Guidance for Certain Conditions), Section 5c(ii) includes the following (bolding language of note):

> ii. After a period of covered employment, a qualified physician conducts an examination of either the patient or available medical records and he or she concludes that the evidence supports that the employee had asthma and that an occupational exposure to a toxic substance was at least as likely as not a significant factor in causing, contributing to or aggravating the condition. The qualified physician must provide a well-rationalized explanation with specific information on the **mechanism** for causing, contributing to, or aggravating the conditions. **The strongest justification for acceptance in this type of claims is when the physician can identify the asthmatic incident(s) that occurred while the employee worked at the covered work site and the most likely toxic substance trigger.** A physician's opinion that does not provide a clear basis for diagnosing asthma at the time of covered employment or the physician provides a vague or generalized opinion regarding the relationship between asthma and occupational toxic substance exposure will require additional development including the CE's request for the physician to offer further support of the claim. If the CE is unable to obtain the necessary medical evidence from the treating physician to substantiate the claim for work-related asthma, the CE will need to seek an opinion from a CMC. If a CMC referral is required, the CE will need to provide the CMC with the relevant medical evidence from the claim file and provide a detailed description of the employee's covered employment which must include each covered worksite, dates of covered employment, labor categories, and details about the jobs performed.

Physicians generally understand "mechanism of disease" to mean the cellular or physiologic processes and mediators that cause a disease. As with most disease processes, clinicians would not be able to identify a "mechanism" for work-related asthma, as clinical tools generally do not identify mechanisms of disease, and in addition, because the mechanisms of work-related asthma remain poorly defined. Thus,

the request that the physician identify the mechanism of disease is not feasible and should be deleted.

We also recommend revising the description of "the strongest justification." Most work-related asthma is caused by a toxic substance, so such cases satisfy the relevant statutory requirement noted above. However, in the great major of cases of work-related asthma there are usually multiple exposure events and toxic substances rather than a single specific incident, so that singling out the one incident and agent that is a "most likely trigger" would be arbitrary and not possible in the great majority of cases. Therefore, the scenario for the "strongest justification for acceptance" outlined above is unrealistic and suggests a standard that could only be met by a small minority of cases of work-related asthma. The effect will be to deny the claims of legitimate cases of work-related asthma. It is also not a standard recommended in any of the professional guideline documents related to work-related asthma.

The Board recommends the following revised wording for the Procedure Manual:

> ii. After a period of covered employment, a qualified physician conducts an examination of either the patient or available medical records and he or she concludes that the evidence supports that the employee had asthma and that an occupational exposure to a toxic substance was at least as likely as not a significant factor in causing, contributing to or aggravating the condition. The qualified physician must provide a well-rationalized explanation with specific supporting information, including the basis for diagnosing asthma or worsening asthma at the time of covered employment and the basis for the relationship between asthma and the covered workplace.* If the CE is unable to obtain the necessary medical evidence from the treating physician to substantiate the claim for work-related asthma, the CE will need to seek an opinion from a CMC. If a CMC referral is required, the CE will need to provide the CMC with the relevant medical evidence from the claim file and provide a detailed description of the employee's covered employment which should include each covered worksite, dates of covered employment, labor categories, and details about the jobs performed.

* Note: examples of supporting information could be provided here or in training materials.

The Board also notes that the Table entitled *Asthma, Occupational* (Procedure Manual 2.3, page 543; Appendix 18-1) has not been updated and requires revision to be consistent with the relevant text in the revised Procedure Manual.

References:

1. Jajosky RA, Harrison R, Reinisch F, Flattery J, Chan J, Tumpowsky C, Davis L, Reilly MJ, Rosenman KD, Kalinowski D, Stanbury M, Schill DP, Wood J. Surveillance of work-related asthma in selected U.S. states using surveillance guidelines for state health

departments--California, Massachusetts, Michigan, and New Jersey, 1993-1995. MMWR CDC Surveill Summ 1999; 48: 1-20.

2. Mazurek JM, Filios M, Willis R, Rosenman KD, Reilly MJ, McGreevy K, Schill DP, Valiante D, Pechter E, Davis L, Flattery J, Harrison R. Work-related asthma in the educational services industry: California, Massachusetts, Michigan, and New Jersey, 1993-2000. Am J Ind Med 2008; 51: 47-59.

3. White GE, Seaman C, Filios MS, Mazurek JM, Flattery J, Harrison RJ, Reilly MJ, Rosenman KD, Lumia ME, Stephens AC, Pechter E, Fitzsimmons K, Davis LK. Gender differences in work-related asthma: surveillance data from California, Massachusetts, Michigan, and New Jersey, 1993-2008. J Asthma 2014; 51: 691-702.

4. Talini D, Ciberti A, Bartoli D, Del Guerra P, Iaia TE, Lemmi M, Innocenti A, Di Pede F, Latorre M, Carrozzi L, Paggiaro P. Work-related asthma in a sample of subjects with established asthma. Respir Med 2017; 130: 85-91.

5. Anderson NJ, Fan ZJ, Reeb-Whitaker C, Bonauto DK, Rauser E. Distribution of asthma by occupation: Washington State behavioral risk factor surveillance system data, 2006-2009. J Asthma 2014; 51: 1035-1042.

6. Harber P, Redlich CA, Hines S, Filios M, Storey E. Recommendations for a clinical decision support system for work-related asthma in primary care settings. JOEM 2017: 59;11: e231–235.

7. Tarlo SM, Balmes J, Balkissoon R, et al. Diagnosis and management of work-related asthma: American College of Chest Physicians Consensus Statement. Chest. 2008;134:1S–41S.

8. Henneberger PK, Redlich CA, Callahan DB, et al. An official American Thoracic Society statement: work-exacerbated asthma. Am J Respir Crit Care Med. 2011;184:368–378.

9. Jolly AT, Klees JE, Pacheco KA, et al. Work-related asthma. J Occup Environ Med. 2015;57:e121–e129.