

UNITED STATES DEPARTMENT OF LABOR

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ADVISORY BOARD ON TOXIC SUBSTANCES  
AND WORKER HEALTH

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MEETING

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WEDNESDAY

APRIL 27, 2016

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The Advisory Board met at the  
Department of Labor, 200 Constitution Ave, N.W.,  
Washington, D.C., at 8:30 a.m., Steven Markowitz,  
Chair, presiding.

**MEMBERS****SCIENTIFIC COMMUNITY:**

JOHN M. DEMENT  
MARK GRIFFON  
KENNETH Z. SILVER  
GEORGE FRIEDMAN-JIMENEZ  
LESLIE I. BODEN

**MEDICAL COMMUNITY:**

STEVEN MARKOWITZ, Chair  
LAURA S. WELCH  
ROSEMARY K SOKAS  
CARRIE A. REDLICH  
VICTORIA A. CASSANO

**CLAIMANT COMMUNITY:**

DURONDA M. POPE  
KIRK D. DOMINA  
GARRY M. WHITLEY  
JAMES H. TURNER  
FAYE VLIEGER

**DESIGNATED FEDERAL OFFICIAL**

ANTONIO RIOS

**PRESENTERS**

RHONDA CHAPPELLE, Branch Chief, Outreach and  
Technical Assistance, DEEOIC  
CURTIS JOHNSON, Unit Chief, Policy, Regulations,  
and Procedures, DEEOIC  
RACHEL LEITON, Director, DEEOIC

JOHN VANCE, Branch Chief, DEEOIC Policy,  
Regulations and Procedures

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

2 8:37 a.m.

3 CHAIR MARKOWITZ: So, let's begin.

4 This is our second day of the Advisory Board on  
5 Toxic Substances and Worker Health.

6 There are some people participating by  
7 WebEx and the internet. So, I thought we should  
8 introduce ourselves again in case there are some  
9 new people in the room or new people online.

10 So, George, do you want to start?

11 MEMBER FRIEDMAN-JIMENEZ: I'm George  
12 Friedman-Jimenez. I'm the Medical Director of  
13 the Occupational and Environmental Medicine  
14 Clinic at Bellevue Hospital, NYU School of  
15 Medicine.

16 MEMBER REDLICH: Carrie Redlich. I'm  
17 Professor of Medicine and Director of the Yale  
18 Occupational and Environmental Medicine Program  
19 and, also, a pulmonary physician.

20 MEMBER GRIFFON: Mark Griffon. I'm an  
21 Occupational Safety and Health Consultant.

22 MEMBER DEMENT: I'm John Dement. I'm

1 a Professor in the Division of Occupational and  
2 Environmental Medicine at Duke University and an  
3 industrial hygienist and epidemiologist.

4 MEMBER BODEN: I'm Les Boden. I'm  
5 Professor in the Environmental Health Department  
6 at Boston University School of Public Health. I  
7 have spent a lot of time looking at workers'  
8 compensation programs.

9 MEMBER CASSANO: Hi. I'm Tori  
10 Cassano. I'm a retired Navy occupational  
11 physician, industry medicine officer, radiation  
12 health officer. Did a lot of work at VA,  
13 environmental hazards and radiation compensation  
14 claims for VA, and now I do private consulting.

15 MEMBER SILVER: Ken Silver, Associate  
16 Professor of Environmental Health in the College  
17 of Public Health at East Tennessee State  
18 University.

19 CHAIR MARKOWITZ: Steven Markowitz.  
20 I'm an occupational medicine physician and  
21 epidemiologist and Professor at City University  
22 of New York.

1 MEMBER SOKAS: Rosie Sokas, a  
2 Professor and Chair of Human Science, Georgetown  
3 University School of Nursing and Health Studies.

4 MEMBER VLIEGER: Good morning. Faye  
5 Vlieger, Hanford worker/injured worker claimant.

6 MEMBER DOMINA: Kirk Domina, Employee  
7 Health Advocate for the Hanford Atomic Trades  
8 Council in Richland, Washington.

9 MEMBER WHITLEY: Garry Whitley.  
10 Worked in Oak Ridge for 42 years and worked with  
11 the Worker Health Protection Program in Oak Ridge  
12 for all plants.

13 MEMBER POPE: Duronda Pope. United  
14 Steelworkers, former Rocky Flats worker, 25  
15 years.

16 MEMBER TURNER: James Turner from  
17 Rocky Flat plant, Denver, Colorado, with the  
18 Beryllium Support Group since about 1992.

19 MEMBER WELCH: And Laurie Welch. I'm  
20 an occupational physician. I'm the Medical  
21 Director for the Building Trades Medical  
22 Screening Program, one of the DOE-funded Former

1 Worker Programs.

2 CHAIR MARKOWITZ: Okay. Thank you.

3 So, we will begin our first  
4 discussion. This is on the first area of the  
5 assigned tasks from our mission or charter of the  
6 Advisory Board. We will have John Vance, who is  
7 Branch Chief, Policy, Regulations, and Procedures  
8 of DEEOIC, and Rachel Leiton as well.

9 So, welcome back.

10 MR. VANCE: Hello, everybody. Can  
11 everybody hear me all right?

12 So, I don't expect everybody to careen  
13 over here to look at me in the corner. What I am  
14 going to do is I am walk through the Site  
15 Exposure Matrices. I have actually pulled up the  
16 public variant of the Site Exposure Matrices.

17 What we are going to do is I am going  
18 to talk a little bit about the history of the  
19 Site Exposure Matrices. I am going to talk a  
20 little bit about its functionality. This is a  
21 publicly-available resource through our website.  
22 So, this is something that I would encourage you

1 on the Board to go and play around with. It is a  
2 very interesting resource. It contains a huge  
3 amount of information about the information that  
4 we have collected over the years with regard to  
5 the toxic substances that are at the sites that  
6 are covered under Part E.

7 Many of you are probably familiar with  
8 this, but I want to give you a little bit of  
9 background if you do not. I had my folks work up  
10 a relatively-descriptive series of talking points  
11 or discussion points that I think are in your  
12 binders. So, I am not going to really go through  
13 it word by word, but I just want to touch on some  
14 of the functionality that I think is important  
15 for you to understand, some of the strengths, and  
16 some of the weaknesses that are contained in the  
17 Site Exposure Matrices.

18 So, it is a huge database. It is  
19 basically a database that contains information  
20 that organizes data about exposures at the  
21 different worksites. And if you could just take  
22 a look, you can look at just the basic initial



1 search criteria, which is basically predicated on  
2 the substances that were at these sites, the  
3 health effects which are the information about  
4 diseases that we know are linked to particular  
5 exposures and, then, work processes. But it gets  
6 more detailed than that.

7 This version of the Site Exposure  
8 Matrices, this public version, is not identical  
9 to the one that the claims staff used in the  
10 district offices, the reason being that, as our  
11 contractor, Paragon, is developing information  
12 relating to the Site Exposure Matrices, they are  
13 incorporating it into a version that is cleared  
14 for use by our claims examiners, but is not  
15 cleared for public release.

16 So, what ends up happening is you have  
17 a clearance process that every six months or so  
18 we will have basically a freeze of the internal  
19 Site Exposure Matrices for vetting by the  
20 Department of Energy. They are going to  
21 basically go in and evaluate the information to  
22 make sure it is okay for public release.

1           This is, of course, a publicly-  
2 available resource. So, of course, there are  
3 security concerns, and that is the issue that the  
4 Department of Energy is interested in making sure  
5 that there is no problems with any of the  
6 information that is available through the Site  
7 Exposure Matrices. We have users that are  
8 accessing this resource around the world. That  
9 is definitely a concern that we have to be aware  
10 of and conscious of.

11           It is a very large database. I think  
12 I had some information added in the discussion  
13 about some of the amount of information that we  
14 have in the Site Exposure Matrices. For example,  
15 the Hanford site, we have tens of thousands of  
16 rows of data of information about toxic  
17 substances that were at the site on page 3. So,  
18 huge volumes of information, 783 cells of data in  
19 2010. That has increased to 921,000 cells of  
20 data. This is just for the Hanford site.

21           Hanford, of course, is a very large  
22 site, but you can imagine that, if we have this

1 amount of information just on Hanford, think  
2 about some of these other large operations like  
3 Savannah River, the facilities at Oak Ridge, you  
4 know, Los Alamos, and some of these other  
5 locations.

6 A huge volume of information is being  
7 incorporated into the Site Exposure Matrices.

8 So, it is a very, very valuable tool in the sense  
9 that it does catalog a lot of data. Now, that  
10 being said, it does not catalog everything. It  
11 is basically a collection of information that our  
12 contractor has gone out to the site and  
13 collected.

14 So, basically, they have gone out, and  
15 we talk a little bit about it in the write-up  
16 here, the history of how they went about  
17 searching these records. They went out and did  
18 worker roundtable interviews. They met with  
19 workers. They tried to identify sources where  
20 the records were. They tried to get a framework  
21 or an understanding of some of the work that was  
22 occurring at the different sites. And then, the

1 contractor went off to contact the different  
2 sites and work with the Department of Energy to  
3 collect data relating to exposures and work  
4 processes at the sites. And so, this effort  
5 resulted in the culmination of the Site Exposure  
6 Matrices.

7 The data that is maintained in the  
8 Site Exposure Matrices is directly affiliated  
9 with documentation from the site. This is  
10 materials that the contractor, our contractor,  
11 Paragon, has collected and has assessed. They  
12 are evaluating that documentation to determine  
13 how best to report exposure data in the Site  
14 Exposure Matrices.

15 So, the Paragon folks that are doing  
16 this -- and we have a bio on the lead project  
17 manager, Keith Stalnaker -- many of the folks  
18 that are involved with the review and the  
19 collection of this material actually have site  
20 experience. There are experts in industrial  
21 hygiene and epidemiology that are involved with  
22 the SEM contractor and reviewing this material,

1 and they have internal processes for evaluating  
2 and assessing the documentation for use in the  
3 Site Exposure Matrices.

4 The Site Exposure Matrices itself is  
5 a collection of data that is primarily focused on  
6 chemical and biological materials at the sites.  
7 It is not intended to collect radiological  
8 information because that is generally viewed as  
9 being part of the dose reconstruction modeling  
10 that NIOSH does.

11 So, the Site Exposure Matrices really  
12 focuses on biological and chemical toxins. As  
13 you go through and look at some of the substances  
14 that you can see in the Site Exposure Matrices,  
15 you can just go see some of the thousands of  
16 different substances that we have in here. So,  
17 you can do very broad-based searches, and I will  
18 just direct you to the main screen or the screen  
19 over here in the front of the room.

20 Just huge amounts of information with  
21 all these different toxins. If you can think  
22 about the different types of materials that are

1 involved with making nuclear weapons. There is  
2 going to be a lot and there is going to be a lot  
3 of very unique materials.

4 And so, as the Paragon contractor was  
5 collecting data, they are looking for  
6 information, identifying specific toxins,  
7 tradename toxins and other types of things. And  
8 then, they will begin looking at how was this  
9 material used at a particular site.

10 And so, they will look for that data,  
11 and it has to be a primary source document. They  
12 are not going to be taking information without  
13 some sort of affirmation through documentation  
14 that they have collected.

15 Now, as we were talking about  
16 yesterday several times, the reality is, of  
17 course, there is missing documentation. If the  
18 documentation doesn't exist, it can't be used to  
19 populate data in the Site Exposure Matrices. So,  
20 this represents a reflection of data that we have  
21 been able to get our hands on.

22 And this effort is continuing. The

1 Site Exposure Matrices is not a static system.  
2 It is constantly being updated as the contractor  
3 identifies new sources of information, as they  
4 get additional information from either the  
5 Department of Energy or submitted through public  
6 channels.

7 We have a link on our website that  
8 allows the public to submit information in their  
9 possession for evaluation and consideration for  
10 additional data into the Site Exposure Matrices.  
11 And we do get a fairly good clip of information  
12 coming in. It is reviewed, catalogued, and it is  
13 assessed for inclusion in the Site Exposure  
14 Matrices.

15 As you can see, it is just thousands  
16 of different toxins. I mean, it is a very broad-  
17 based amount of information about toxic  
18 substances that were available.

19 What is nice about the Site Exposure  
20 Matrices, though, is the searching and filtering  
21 functionality. So, when you go up and you  
22 actually look at the different components of the

1 Site Exposure Matrices, the first thing you will  
2 notice is that there are different kinds of  
3 searches that you can do by DOE site, mines,  
4 mills, or ore-buying stations, or transport, or  
5 uranium transporting operations.

6 The main functionality, of course, is  
7 looking at the Department of Energy site. So,  
8 that is going to be your default option for  
9 searching the Site Exposure Matrices. As you can  
10 see, you can go into the Site Exposure Matrices  
11 and select what site it is that you are  
12 interested in doing research on. I am just going  
13 to use Hanford as an example because that is the  
14 one I used in the handout.

15 As soon as you select a site, you are  
16 going to immediately come up with additional  
17 information and search criteria that can be  
18 applied to the evaluation of a claim, right? And  
19 so, let's talk a little bit about that.

20 The information in the Site Exposure  
21 Matrices is a very broad collection of all the  
22 information that we have about toxins. The one



1 big feature it does not include is temporal data,  
2 which means we don't know and do have in the Site  
3 Exposure Matrices any information about when this  
4 material was utilized at the site, merely that at  
5 some point there was a material toxic substance  
6 that was utilized at the site and is going to be  
7 recorded in the Site Exposure Matrices. All  
8 right? And that is certainly a big issue for us  
9 because that is a degree of specificity that  
10 doesn't exist.

11 A lot of these toxins may have been  
12 utilized in historical operations and were ceased  
13 from use at certain periods of time. But that  
14 would not be reflected in the Site Exposure  
15 Matrices. We find, through our industrial  
16 hygiene referrals and looking at some things, in  
17 some instances toxic substances may have been  
18 used for a singular work activity that may have  
19 occurred at a singular point in time and was  
20 never utilized again.

21 But, in looking at the Site Exposure  
22 Matrices, you would think, okay, well, this was a

1 material that was at the site, but you really  
2 don't have any understanding or context as to the  
3 extent of the use of that material, merely that  
4 there was this material at the site at some point  
5 between whatever the operation period is at the  
6 facility you are doing research for. So, that is  
7 certainly something that the Board could be  
8 looking at with regard to specificity in the Site  
9 Exposure Matrices.

10 You can take a look and see all the  
11 different information that we have available on  
12 facility-wide searches. So, you can search by  
13 these different -- you can search by substance,  
14 if you so choose. The health effect data, which  
15 we will talk about, which is basically the  
16 information about the diseases we know are linked  
17 to particular toxins.

18 Work process is over here where you  
19 are talking about site history, areas, buildings.  
20 Work processes is very important, search  
21 criteria, labor categories. And then, we have  
22 this incident thing. We talked a little bit

1 about that yesterday.

2 The point, we were talking a little  
3 bit about that yesterday, and this is something  
4 else that you might want to jot as an asterisk.  
5 Again, the Site Exposure Matrices is focusing on  
6 biological or chemical exposures. If we have  
7 radiological incidents that occurred, that is  
8 probably not going to be something that we are  
9 going to regularly be seeing in the Site Exposure  
10 Matrices. Again, the context here is really  
11 chemical and biological exposures.

12 So, we are looking at Hanford. The  
13 claims examiner, once they have actually done --  
14 if you are going to go back to yesterday's  
15 discussion about the claim process, once they  
16 know what disease they are dealing with, they are  
17 going to start a correlation evaluation. They  
18 are going to go back and look at the exposure and  
19 employment history that has been presented by the  
20 employee, and they are going to try to match data  
21 that the employee or the case file has identified  
22 to information on the Site Exposure Matrices.

1           For example, if we are going to click  
2           on disease or health effect, we can go in and  
3           look for, let's use chronic obstructive pulmonary  
4           disease because that is a very common one. These  
5           are all the diseases the claims examiner can  
6           utilize as essentially we know that there is a  
7           toxic substance that causes or is affiliated with  
8           one of these diseases.

9           So, you know, we have quite a list of  
10          these things. This is information that is  
11          populated from Haz-Map. There is a brief  
12          discussion of that in the handout. This is also  
13          material that is vetted and evaluated by Dr. Jay  
14          Brown, who is basically the author or the editor  
15          of the Haz-Map. This is clearly an area where I  
16          think the Advisory Board could be instrumental in  
17          looking at additional expansion of health effect  
18          data in the Site Exposure Matrices and other  
19          sources of information we could utilize to  
20          populate the database.

21                 Getting back to this, though, if we  
22          look at chronic obstructive pulmonary disease, it

1 is going to pull up a relatively-broad list of  
2 data relating to the different kinds of things  
3 that we know are affiliated with chronic  
4 obstructive pulmonary disease.

5 As I scroll down, you will see the  
6 different categories that are listed. So, you  
7 can see the toxic substances that are linked to  
8 that disease. You can look at some of the  
9 disease links that are associated with that  
10 exposure or that health effect.

11 And then, we can do other types of  
12 search functionality. In other words, if a  
13 claims examiner is seeing something where it  
14 doesn't really match up very well with what is in  
15 the Site Exposure Matrices, they can do these  
16 alias searches where they are going to go in say,  
17 what is pulmonary fibrosis? Is that an alias of  
18 COPD? And they would generally see that that is.

19 So, it is a very interesting system in  
20 the sense that it does have a lot of data. The  
21 other neat feature about it that the claims  
22 examiners do you utilize quite a bit is the

1 filtering functionality. So, let's get out and  
2 see if we can get to that.

3 You can actually go in and do  
4 additional searching. So, let's say they want to  
5 look at somebody that was a welder. This is the  
6 example in your handout. So, they go in and they  
7 say, "Here, let me look at all of the information  
8 that we have about the different labor categories  
9 at Hanford." And what they would be looking for  
10 is information that correlates to data that the  
11 employee has reported.

12 So, let's say the employee has  
13 presented a claim saying, "Hey, I was a welder at  
14 Hanford for whatever period of time." Well, the  
15 first thing the claims examiner is going to do is  
16 they are going in and say, "Okay, let's take a  
17 look at welding or welders at Hanford and what we  
18 are able to sort of establish as a link between  
19 the welder labor category and the information  
20 being provided by the employee.

21 So, you can see right away we already  
22 have a list of toxins associated with welding.

1 Some of the ones that you would obviously know  
2 would be welders would be exposed to welding  
3 fumes and other types of things.

4 But the CE is, then, going to start  
5 trying to narrow that list down. Because we are  
6 operating in essentially the absence of reliable  
7 affirmative data specific to an employee, we are  
8 basically having to recreate their exposure  
9 history. This is the real challenge in this  
10 program, is the absence of individual-level data.

11 So, the Site Exposure Matrices and the  
12 functionality of the claims examiner is to try to  
13 identify and prioritize exposures that have the  
14 greatest likelihood of a positive outcome for the  
15 case. In this case, we have a welder. Let's say  
16 we are looking for welder who has made the claim  
17 and has established a diagnosed chronic  
18 obstructive pulmonary condition. So, the CE is  
19 going to go in and say, "Okay, these are my two  
20 filtering criteria." So, it would be "welder"  
21 and "obstructive chronic pulmonary disease".

22 You can immediately see they have

1 whittled this down to two toxins. Okay? This  
2 would be a relatively-good result because it is  
3 basically limiting it to two identified toxins.  
4 So, this is one where you would see this is where  
5 we would, then, turn to an industrial hygienist  
6 to the answer question, what would be the level  
7 and extent and duration of exposure for a welder,  
8 for whatever period of time, at Hanford working  
9 around these two specific toxins?

10 We would not go beyond that because  
11 this is affirmative data that we have been able  
12 to collect about welding at Hanford. Okay? So,  
13 of course, the question would be, you know, well,  
14 could there have been other toxins? There  
15 certainly could have been. But we are trying to  
16 identify the ones with the highest probability of  
17 the employee coming in contact with. This  
18 information would be based on specific data that  
19 we have about welders at Hanford. Okay?

20 So, this information would be based  
21 primarily on what the employee identified in  
22 their employment history or any other kind of



1 information in their DAR records, which is the  
2 information we get from the Department of Energy  
3 about their exposure history. We would also be  
4 looking at their occupational history  
5 questionnaire. All that information would also  
6 be something that would be considered by the  
7 industrial hygienist.

8 So, they would go and they would say,  
9 if I am welder and I have described my work  
10 activities as primarily welding, well, we can  
11 basically assume that that person is going to  
12 have a high level of exposure, but we are going  
13 to want to make sure that the industrial  
14 hygienist validates that kind of exposure.

15 I mean, this is a very good way of  
16 looking at it. You can search further by  
17 different kinds of work processes. Let's just  
18 select "welding" here. So, you know, we can also  
19 look at that.

20 So, let's say you have a laborer who  
21 identifies on their occupational history  
22 questionnaire, for example, that "Hey, I'm a

1 welder, too. My job classification is laborer,  
2 but I did a huge amount of welding at the site.  
3 I was a welder's assistant and I did a lot of  
4 work with them." Well, then, you can start  
5 searching by that labor category and, then, also  
6 add in additional filters for, say, welding.

7 Common ones we see, the laborer one is  
8 a good example because laborers are a very broad  
9 classification of labor category. You oftentimes  
10 have to search the labor category for a laborer,  
11 but, then, refine it by work process, so that you  
12 are limiting or trying to figure out which are  
13 the ones that are associated with a laborer doing  
14 that type of work activity. So, you could have a  
15 laborer who was perhaps doing like demolition  
16 activities, a laborer doing outside landscaping  
17 and that sort of work. So, those kinds of things  
18 are all captured in the Site Exposure Matrices.

19 So, it is a very good resource. I  
20 don't want to spend a lot of time on it. But I  
21 think it is definitely something that you all  
22 should take some time to just play around with

1 and have a good sense of the search-filtering  
2 capabilities.

3 One of the things that I do want to  
4 talk a little bit about is some of the things  
5 that are basically not going to give you good  
6 results. As I was talking about, as you filter  
7 these results, there is a fine balance between  
8 taking it too far or being too broad in your  
9 search criteria. In other words, if you apply  
10 every single one of the filters here up on your  
11 screen, it could be that you are going to exclude  
12 any data that is relevant to the case.

13 So, what we try to tell the CEs to do  
14 is to really use multiple different filtering  
15 techniques to try to identify those toxins that  
16 are coming up in different variances or different  
17 variables of a search criteria. In other words,  
18 if you are looking at labor category, health  
19 effect, facility, and let's say work process, and  
20 you are identifying toxins, and then, you do a  
21 similar search, but, then, are looking at a  
22 laborer category, if you are starting to see

1 replication of those toxins, replication in your  
2 search filter parameters are going to be ones  
3 that you will definitely want to identify.

4 Some of the things that are  
5 problematic -- somebody brought this up yesterday  
6 -- is the scope of the searches when you are  
7 talking about like building-level data. So, some  
8 of these locations were huge industrial  
9 operations. I am sure many of you are familiar  
10 with these sites where you had lots of different  
11 operations occurring in very large facilities.

12 One of the common misconceptions that  
13 we get is that, as soon as you walk onto a site  
14 and you go into the Site Exposure Matrices and do  
15 a search for, let's say, all the toxins that were  
16 at Hanford, does that necessarily mean that every  
17 employee was exposed to every single one of those  
18 toxins? No. We stress that a building-level  
19 search is not very reliable on its own. Simply  
20 because you have different operations that are  
21 occurring throughout the site, you have to bring  
22 the employee into contact with that material in

1 some way beyond just saying you were there.

2 So, when we are utilizing building-  
3 level searches and that sort of thing, what we  
4 are trying to do is add that into other filtering  
5 functionality. If you are talking about health  
6 effect, facility, work process, and building  
7 location, that is a good search. But, if you are  
8 simply saying, you know, this employee worked in  
9 Building X-10, or whatever the building  
10 designation is, we can't simply say, "Simply  
11 because you walked in that building you were  
12 exposed to every toxin that was in that site."

13 That has to do with the fact that, first of  
14 all, we don't have the temporal data on that.  
15 These locations were very large. Think about  
16 this building right now. We are in this room  
17 having a conference, but there are people  
18 upstairs doing work in the cafeteria that are  
19 doing things that are probably involving exposure  
20 to certain things that we will never be exposed  
21 to. So, I mean, that is just a reality of  
22 industrial operations, and that is something that

1 we generally say is not a very reliable source of  
2 information without additional filters, which is  
3 that building-level search.

4 The other big thing that I did mention  
5 before, you know, we are always looking for  
6 additional information. This is an area where I  
7 think the Board would be very helpful in looking  
8 at this. If we have sources of information that  
9 would be helpful to populate the data in the Site  
10 Exposure Matrices, that is definitely a source of  
11 information that we would be looking forward to  
12 getting.

13 We are always interested in  
14 information that I think would be helpful in  
15 utilizing this in our claims education process.  
16 This is a very complex system with regard to the  
17 development of these cases. As you can see,  
18 there are a lot of different ways to go about  
19 filtering and evaluating a case. That is what  
20 makes this so complicated, is that we have to  
21 utilize this data in a manner that corresponds  
22 with information that we have on an employee. If

1 we have not a lot of information about the work  
2 processes or the activities of the employee, this  
3 is not going to be very helpful. So, the Site  
4 Exposure Matrices can only really work when we  
5 have data about what the employee was doing at a  
6 site.

7 The Site Exposure Matrices is also not  
8 very helpful when we don't have a health effect  
9 that is listed in the database. So, if the CE  
10 cannot identify a linkage between the disease  
11 that has been diagnosed and something that is in  
12 the Site Exposure Matrices, this system can't be  
13 used. Okay. So, that is something that is an  
14 issue with the Site Exposure Matrices that I  
15 think that we would be looking for some input on.

16 The big drawback I think is the  
17 temporal data. We really don't have a lot of  
18 information about when these materials were  
19 there. The more specificity that we get, you  
20 know, that is a good thing. But, at the same  
21 time, you also have to be conscious of the fact  
22 that, as we get more data about the use of

1 materials, as we get more information about  
2 temporality in the system, then that could have  
3 an effect on claims adjudication in a sense that,  
4 if we are looking at cases and the Site Exposure  
5 Matrices includes temporal data saying this  
6 material was no longer at the site or utilized in  
7 industrial operations after 1960, well, that  
8 means that anybody that is filing a claim for  
9 employment at the site after 1960 is not going to  
10 be able to ever say that they were exposed to  
11 that toxin. So, there are always going to be  
12 pluses and minuses as you add additional  
13 information in the system.

14 The other thing that I want to also  
15 mention with regard to the addition of material,  
16 this system is always, the Site Exposure Matrices  
17 is always going to be changing with regard to how  
18 the information is presented. So, as  
19 clarification is obtained with regard to how  
20 materials were used at the site, this could  
21 change.

22 So, we have had instances where we



1 have added information. There are instances  
2 where we have taken information out as  
3 documentation becomes available to our contractor  
4 team and as they evaluate it. So, just because  
5 it goes in doesn't mean it is going to stay there  
6 forever.

7 For example, in your handout we talk  
8 a little bit about the work that is going on with  
9 tradenames where we talk about different types of  
10 tradenames for like window-cleaning agents. We  
11 talk about Windex and Clorox window-cleaner.  
12 Instead of calling them by tradenames, we have  
13 reduced that down to glass cleaners as a general  
14 search parameter.

15 In the handout we have also included  
16 several different things that we are interested  
17 in looking at. I have already touched on some of  
18 those. Let me just go through them. I'm not  
19 going to read through all this, but we definitely  
20 would be looking at input and assistance in  
21 identifying new health effect data to incorporate  
22 into the Site Exposure Matrices. The list of

1 items that you see here in your handout are items  
2 that we have struggled with, folks have mentioned  
3 in the past, and it is just issues that, from a  
4 policy perspective, we don't have clear answers  
5 for or there's lots of issues to consider with  
6 regard to those.

7 The effect of geriatric problems on  
8 these cases, you know, people are going to get  
9 sick. They are going to develop diseases as they  
10 get older. What is the connection between  
11 geriatric illnesses and occupational exposures  
12 that occurred in one's early working career?  
13 That is a very challenging topic for us to  
14 address, and it is one where we see individuals  
15 making claims for. So, you have individuals with  
16 heart disease, other types of problems that you  
17 would associate with age and that sort of thing,  
18 but the claims are being made that there is some  
19 effect of an occupational nature on those  
20 diseases. And how do we evaluate and consider  
21 those claims?

22 Yes?

1 MS. LEITON: There is a title in what  
2 he is reading from, and you are going to see this  
3 in most representations. It is advice and  
4 guidance, basically. I don't think it is called  
5 exactly that.

6 But, when he is talking about this  
7 list, this is the list of things that we think  
8 the Board might be able to help us with or the  
9 things that we struggle with the most that we  
10 think you guys might be able to take a look at,  
11 just for clarification in case anybody was  
12 confused.

13 Thanks.

14 MR. VANCE: Right. And then, as I was  
15 saying, you know, other types of things that are  
16 obvious here are the issues with the data itself,  
17 how it is presented in the Site Exposure  
18 Matrices, how it could be utilized more  
19 efficiently and effectively by our claims staff  
20 to avoid problems, to make sure that there is  
21 some sort of regimented process for doing this.

22 We have never been able to develop a

1 formulaic way of doing some searches, simply  
2 because there are just too many variables  
3 involved with these subsearches. So, if you  
4 prescribe a particular methodology for filtering,  
5 well, then, is that really going to apply to  
6 every single case that comes along and is it  
7 going to produce a good, valid outcome? So, we  
8 have struggled with that.

9           You know, just the mere categorization  
10 of information. Is there information in here  
11 that would be helpful to add in? Is there some  
12 topic or some sort of information that would be  
13 helpful to add to provide clarity to some of this  
14 information in the Site Exposure Matrices?

15           Improved data descriptions or just the  
16 general presentation of data or clarification of  
17 like, say, generic toxic profiles, which we do do  
18 to a certain extent in the Site Exposure  
19 Matrices, but could we apply that more broad-  
20 based across the board for certain labor  
21 categories? Could we apply that in certain  
22 temporal situations?

1           The site contractor or the SEM  
2 contractor, could we not identify areas where we  
3 could prioritize what their search functionality  
4 would be? Where should we be looking at data?  
5 You know, simply because we are out there  
6 collecting data doesn't necessarily mean it is  
7 going to be applicable to a lot of cases. The  
8 more information we have, obviously, the better  
9 off we will be, but does that necessarily mean  
10 that we should be expending a lot of time and  
11 resources trying to collect information on sites  
12 where we don't have a lot of claims? So, I mean,  
13 those are questions that I think certainly  
14 warrant some consideration.

15           I don't know, Rachel, if you have more  
16 to add to that?

17           MS. LEITON: No, I think you have  
18 covered it. You guys, obviously, when you start  
19 looking through the database, you will have ideas  
20 and thoughts about how it can be improved and  
21 that sort of thing. But these are just some of  
22 our struggle points.

1 MR. VANCE: So, questions at this  
2 point?

3 MEMBER VLIEGER: John, when looking  
4 through the example that you have on the screen,  
5 I notice that solvents are not included under the  
6 welders.

7 MR. VANCE: Uh-hum. Right. Like I  
8 was saying before, when you are doing a search,  
9 it is always going to produce data that relates  
10 to information on a document that the Paragon  
11 team has obtained in some way. So, in other  
12 words, somewhere it is saying, for somebody doing  
13 welding who has got -- let's use COPD and see  
14 what we get -- it is going to produce whatever  
15 information is available on a document that our  
16 contractor has obtained at the site.

17 So, you know, somewhere they have  
18 gotten information basically saying welding  
19 produces two types of toxic substances that we  
20 know are associated with that work process, and  
21 what we have is asbestos and welding fumes. If  
22 you are going to be talking about adding

1 solvents, we would have to look at, right now, if  
2 we were to be adding solvents, we would have to  
3 identify what are the solvents and what  
4 documentation exists to support that, or what  
5 information could you rely on to add that  
6 information to the Site Exposure Matrices.

7 MS. LEITON: John, isn't this, though,  
8 being filtered on COPD?

9 MR. VANCE: Yes.

10 MS. LEITON: So, if it was filtered on  
11 hearing loss, you might get a different result,  
12 correct?

13 MR. VANCE: Right.

14 MS. LEITON: But you still filter on  
15 COPD here.

16 MR. VANCE: Right.

17 MEMBER VLIEGER: I think the issue --  
18 excuse me -- I think the issue comes, John, from  
19 you have another statement in your presentation  
20 that, when there is a later development for a  
21 labor category, that that supersedes data in the  
22 SEM. But welding as a labor process has metal

1 cleaning in it, and that is where the solvents  
2 come in. Anybody in the room here who has worked  
3 on welding or welding projects knows that metal  
4 cleaning is part of it, and that is solvents.

5 MR. VANCE: Right. So, you could  
6 always look at whether or not this information  
7 would be something that you could look at welding  
8 fumes in general and just look at -- so, here's  
9 welding fumes as a description, "to describe the  
10 toxic materials that a person doing maintenance  
11 welding of carbon steel, aluminum, stainless  
12 steel would be exposed to. Thorium" -- and  
13 whatever this is -- "are also constituents of  
14 welding fumes."

15 So, you know, you are going to be  
16 looking at this as the general profile for  
17 welding. But, if you are talking about solvent  
18 exposure, well, then, maybe that would be a  
19 criteria you would apply separately, you know,  
20 saying, okay, was this welder exposed to --  
21 saying, "I was around all kinds of cleaning  
22 solvents" or other types of activities that were



1 going on.

2 It really depends on the profile, and  
3 that is what makes this so complicated, in the  
4 sense that you have got to look at what the  
5 employee is telling you. So, if the employee is  
6 saying, you know, "I did this type of work," or  
7 "I did this type of activity," then you have got  
8 it all applied in the Site Exposure Matrices. If  
9 that information isn't available, then the  
10 employee has no basis on which to do the  
11 filtering based on that data. And that is how  
12 this works. It is the absence of information is  
13 the challenge.

14 CHAIR MARKOWITZ: Dr. Redlich? And  
15 then, Dr. Friedman-Jimenez.

16 MEMBER REDLICH: Yes, I don't know  
17 where to begin, but it seems like you have got a  
18 lot of COPD claims. There is very extensive  
19 literature of occupational exposures increasing  
20 risk, causing COPD. And those exposures and  
21 those studies are generally vapors, gases, dust,  
22 and fumes. There is not identified the specific

1 exposure that a welder has that causes COPD.

2 So, if you knew someone was a welder  
3 for many years, stop, and none of this matrix is  
4 relevant because that is actually not what the  
5 occupational literature shows. It is extensive;  
6 there are multiple reviews. And the specific  
7 exposures that cause COPD have not been  
8 identified, but the types of, you know, general  
9 work in a dusty, dirty environment. So,  
10 something like COPD, if one were to look at the  
11 relevant literature, this just doesn't make  
12 sense.

13 CHAIR MARKOWITZ: So, is there a  
14 specific follow-up question to this on this  
15 track, Dr. Welch?

16 MEMBER REDLICH: I think it would be  
17 greatly simplified.

18 MEMBER WELCH: Well, I think that is  
19 an important point. And I was going to say, I  
20 mean, Steve asked me to chair the little  
21 Subcommittee, which I'm excited to do. Maybe  
22 you'll join?

1 MEMBER REDLICH: Which Subcommittee?

2 MEMBER WELCH: The SEM Subcommittee.

3 MEMBER REDLICH: Oh.

4 MEMBER WELCH: The one that talks  
5 about, well, it is really exposure  
6 identification, because, I mean, I think that is  
7 an important issue. I mean, I, for my life, have  
8 been diagnosing people with occupational disease  
9 without personal exposure information, sometimes  
10 with material safety data sheets. But you can  
11 tell by the occupational history the complex  
12 exposures that they have had. And the concern  
13 would be if this is leading the claims examiners  
14 to think that you need to identify specific  
15 exposures when, as Carrie was saying, the  
16 literature supports generic category of complex  
17 exposures.

18 And it is a problem that OSHA has  
19 dealt with and we dealt with in Health Effects,  
20 because many times it is hard to regulate  
21 something that is a complex exposure. It is hard  
22 to assess the components of a complex exposure,

1 and we don't want to get lost in the weeds or  
2 lost in the --- not see the forest for the trees  
3 kind of thing.

4 MR. VANCE: Yes, and welding itself,  
5 that is a fairly compensable labor category  
6 simply because welders are going to be welding  
7 and they are going to be exposed to a fairly high  
8 level of welding fumes. What you also have to  
9 consider is welding might be one where that would  
10 be very true with regard to the general  
11 information, but, then, you have to look at other  
12 types of labor categories across the board and  
13 how do you deal with that reality.

14 MS. LEITON: John, one thing you might  
15 just want to mention here is the work process  
16 search because the work process search is  
17 something that we will look at and it is okay.  
18 We know that they were involved in this  
19 particular job, this type of work. We are  
20 working currently, I believe, on a circular that  
21 will help the claims examiners say, well, if they  
22 were involved in this work process, and there is

1 a relation to a COP, or whatever it is, then we  
2 can make certain assumptions. But that is a  
3 different kind of filter that I think is a little  
4 bit more specific to the type of work that they  
5 were doing and might be relevant here.

6 MR. VANCE: Right. I mean, you know,  
7 Rachel raises a good point. So, what we would  
8 look for, too, is all the different kind of work  
9 processes that we have in the Site Exposure  
10 Matrices to further filter and resolve what do we  
11 know about the activities of the employee based  
12 on their information in their case file, based on  
13 what we have in the Site Exposure Matrices.

14 So, you can just see for Hanford, I  
15 mean, there is just a huge volume of different  
16 work processes that individuals could be  
17 associated with that we could, then, search  
18 further on health effects and looking to see if  
19 we can identify toxins that this person could  
20 have been potentially exposed to.

21 CHAIR MARKOWITZ: Dr. Friedman-  
22 Jimenez?

1                   MEMBER FRIEDMAN-JIMENEZ: I can see  
2 the huge amount of work and information that has  
3 gone into these Site Exposure Matrices. However,  
4 there is a lot of missing information here. And  
5 we understand that. We recognize that.  
6 Nevertheless, it is probably better than a lot of  
7 the information we get on many of our patients  
8 that we make decisions on based on job title and  
9 length/duration of exposure, et cetera.

10                   So, my question is, the claims  
11 examiners, a lot of this is going to depend on  
12 the judgment of the claims examiners, I think.  
13 It doesn't make sense to have a formulaic  
14 mathematical application of these to come up with  
15 a conclusion because there is a very high  
16 probability of getting a wrong answer.

17                   So, my question is, what is the level  
18 of training and the skill set of the claims  
19 examiners? Who are the claims examiners and how  
20 are they trained to use this information in a way  
21 that reduces that high likelihood of error?

22                   MR. VANCE: Well, the claims examiners

1 are exactly that; they examine information. They  
2 are examining data in the case file. They are  
3 trained to look at data. The way I have always  
4 explained it when I have done training is that,  
5 you know, our claims are words on paper. They  
6 are evaluating information that is contained in  
7 the case file. They don't necessarily have to  
8 have industrial hygiene experience.

9 I mean, they are going to have  
10 understanding of what the terms and terminology  
11 are on the cases. They are going to have an  
12 understanding of the facilities that they are  
13 looking at. But their functionality is really  
14 looking at and examining evidence. They are  
15 going to be looking at what information do they  
16 have about that employee in the case file and,  
17 then, comparing it to what they are able to  
18 obtain through the use of the Site Exposure  
19 Matrices to identify and prioritize those  
20 exposures.

21 MS. LEITON: And just to expand a  
22 little bit on that, the claims examiners are

1 going to be trained in looking at this. We go  
2 out and do a lot of training on how you filter  
3 what you are looking for and how you are going to  
4 categorize it in order to send it to an expert.  
5 That is why we do rely right now on the  
6 industrial hygienist to assist us in wrapping  
7 that into a statement that we can, then, use for  
8 a doctor to review, that we can say to the  
9 doctor, "This is what we have determined based on  
10 the evidence we have in the file that we have  
11 gathered and the opinion of the industrial  
12 hygienist." So, again, that is where they are  
13 not experts, but that is why we rely on some  
14 experts to help us with that.

15 CHAIR MARKOWITZ: So, I have a follow-  
16 up question on this topic. You described the use  
17 of this SEM as complicated. That was your word.  
18 Have you ever looked at the claims examiners'  
19 ability to do these searches, their  
20 repeatability? In other words, if a given claims  
21 examiner does a search multiple times over  
22 different time periods, or across claims



1 examiners, how different ones approach the same  
2 questions, to what extent do they actually come  
3 up with the same answers? Because it would be a  
4 way of looking at their ability to do this  
5 complicated task.

6 You probably haven't done that, but  
7 their ability to penetrate this data source in a  
8 way that is reliable is critical. And I don't  
9 think it is just a function of -- I mean,  
10 training and guidance and all that help, but  
11 somehow there needs to be a way of measuring  
12 that. Maybe you have done it. I don't know.

13 MR. VANCE: Well, let me make a couple  
14 of points, and I am sure Rachel is going to want  
15 to add something. Our claims process is designed  
16 to have this two-step process of making a  
17 recommended decision, having the employee present  
18 their point of view with regard to how the CE  
19 interprets this information, and then, having an  
20 independent review by the final adjudication  
21 board, where they are actually going to go in and  
22 they are required to go back and evaluate the

1 Site Exposure Matrices again because of the fact  
2 that it is constantly being updated. So, the  
3 mere process of evaluation of a claim  
4 necessitates two individuals looking at it and  
5 agreeing that the Site Exposure Matrices is being  
6 applied in an appropriate manner.

7 The other thing that I would like to  
8 point out is we do annual audits of all our  
9 district offices through our accountable review  
10 process, whereby we have an independent review  
11 team coming in and looking at -- one of the  
12 categories that we look at is Part E case  
13 adjudication, where we are looking at the quality  
14 of the Site Exposure Matrices application, the  
15 quality of the use of our medical physicians in  
16 coming to the certain claim outcomes.

17 And the last point I would have, just  
18 to make a mention, is that the GAO did just  
19 conduct an audit of this process and identified  
20 that we have done a fairly good job in keeping  
21 with the policies and procedures of this program  
22 with regard to the specific medical conditions

1 that they were looking at, which included some of  
2 these Part E conditions that we really have  
3 struggled with in the past.

4 I know Rachel might want to add  
5 something.

6 MS. LEITON: Just real quick, in terms  
7 of the Final Adjudication Branch review process,  
8 first, the claims examiners, depending on their  
9 journey level, whether they are new or not, they  
10 will often have a senior examiner look at this  
11 again before a decision will go out. And then,  
12 at the Final Adjudication Branch, you might have  
13 a CE doing an initial search and, then, a hearing  
14 rep doing a final search when they do their  
15 signoff.

16 And mentioning the GAO report, that is  
17 one of the processes we are going to put in place  
18 in terms of we are going to have another level of  
19 review before a recommended decision and before a  
20 final decision for hearing reps. That is one of  
21 the procedures we are putting into place.

22 When John mentioned an independent

1 review team for the accountability review, the  
2 team is made up of staff in the district office  
3 and our Policy Branch, but they are from a  
4 different district office looking at cases from  
5 other district offices, with the direction of our  
6 Policy Branch team.

7 CHAIR MARKOWITZ: Dr. Boden?

8 MEMBER BODEN: First, I wanted to  
9 comment on Dr. Markowitz's point, which is what  
10 you are talking about is good and I think  
11 important, but I want to emphasize I think what  
12 Steve was saying is something somewhat different,  
13 which is, if you actually have two people looking  
14 at the same case file independently -- that is,  
15 not one person reviewing another person's case  
16 file -- then how frequently they come up with the  
17 same answer is not only a measure of how  
18 consistent their reviews are, but it is a measure  
19 of how good the Site Exposure Matrix is in  
20 assisting them to do that. So, I would just say  
21 what you are talking about is not exactly the  
22 same thing.

1           But, getting back to where I was going  
2           to go originally, it seems to me that the Site  
3           Exposure Matrix has two features. One is that it  
4           helps us to learn something about potentially  
5           specific exposures at specific sites. But the  
6           other is it is kind of an expert system, right?  
7           Independent of all that, it is supposed to help  
8           people who are not occupational physicians or  
9           industrial hygienists figure out what people's  
10          likely exposure is.

11           It seems to me it would be an  
12          important thing to think about as this group  
13          reviews the Site Exposure Matrix, about whether  
14          the way it is being used now really helps the  
15          process. I kept thinking to myself, well,  
16          wouldn't it be better to have, let's say, the  
17          occupational physician who is interviewing the  
18          person have information about the potential  
19          exposures at the site, because, presumably, that  
20          person would know that a welder is exposed to  
21          solvents? And then, they could report to the  
22          claims examiner without having things sort of

1 filtered for them through the Site Exposure  
2 Matrix. At least I think that is something that  
3 we could try to think about as a group.

4 CHAIR MARKOWITZ: Dr. Dement?

5 MEMBER DEMENT: First of all, I think  
6 the Site Exposure Matrix is useful to an extent.  
7 The issue that we have always faced with  
8 exposures as an industrial hygienist, a labor  
9 category is a very rough first-level cut. The  
10 next cut really comes when we talk about specific  
11 tasks that the individual does. What we have  
12 found a lot of times is there's so much crossing  
13 between labor categories in terms of work that is  
14 actually done. Welding is a good example.

15 We have so many people on the DOE site  
16 who are not welders who actually do a lot of  
17 welding. And the same with the use of solvents,  
18 welding on coated materials. So, you have a  
19 metal exposure in addition to the welding thing.

20 So, my concern is how it is one thing  
21 to go into this SEM with a labor category, but  
22 how flexible is it for the person who is looking

1 at this information to say, "Well, this is a  
2 welder, but they said they did solvent  
3 cleaning."? Is there a way to actually put that  
4 together?

5 I mean, I see that welders don't have  
6 solvents as a potential exposure. If I go into  
7 solvent cleaning, you know, a welder is somebody  
8 who might have that.

9 MR. VANCE: Yes, it is going to depend  
10 completely on what is in the Site Exposure  
11 Matrices. So, if you --

12 MEMBER DEMENT: But, if it is not  
13 there, how would they use the information? If it  
14 is not in the SEM, how do they use that  
15 information that is given to them by the  
16 individual who is filing the claim?

17 MR. VANCE: Yes, well, I mean, they  
18 are going to look at it and say, okay, in what  
19 context is that information coming? So, in other  
20 words, let's say we have a welder who in the  
21 occupational history questionnaire is really  
22 providing a lot of data about solvent use. That

1 is also something that is affirmed in  
2 documentation that we have gotten from the  
3 employer. That could certainly be something that  
4 they could add into the profile documentation  
5 that goes to the industrial hygienist.

6 The Site Exposure Matrices, though,  
7 may not have that information because there is no  
8 primary source information that they have  
9 identified that specifies the use of solvents by  
10 that labor code category at the site. That would  
11 be --

12 MS. LEITON: But -- sorry.

13 MEMBER DEMENT: Go ahead.

14 MS. LEITON: But I think that the  
15 bottom line is that, yes, we are going to use  
16 this as a tool. Oftentimes, what we find is that  
17 the claimants don't know. When we talk to them  
18 or they have an occupational history  
19 questionnaire, as I said earlier, particularly  
20 survivors, they don't know this information.

21 So, we will look at whatever they have  
22 described, especially if it is an employee who



1 knows what they did, but they don't know what  
2 they were exposed to. That is where the work  
3 process can come in. And if there were a work  
4 process in here that said they were cleaning, you  
5 know, they were using solvents or there was a  
6 certain process, it may be in there that we would  
7 look under that process. But, if it is not in  
8 there and a person is specific, we can include  
9 that in our Statement of Accepted Facts that goes  
10 to the scientist or the doctor.

11 We are not going to exclude  
12 information, particularly information that the  
13 claimant does know and they are very specific.  
14 And we can say, "This is what this person says  
15 they did." That is something we can move forward  
16 to both the IH and/or the physician when we are  
17 making that assessment.

18 So, we are not trying to say we are  
19 going to ignore everything that the claimant  
20 says. We are just saying that a lot of times the  
21 claimants don't know very much. And so, it is a  
22 starting point.

1           MR. VANCE: Or there is conflicting  
2 information between what the claimant is saying,  
3 what our SEM is saying, and that raises issues  
4 about how we can decide, okay, is this an  
5 accurate portrayal of what the employer was  
6 doing.

7           I think we are running low on time,  
8 but I think that the Site Exposure Matrices is  
9 obviously ripe with a lot of different options  
10 for improvement, but I think that it is a good,  
11 useful starting place. And the question would  
12 be, where do we take this into the future in the  
13 application of this data in the claim process?

14           CHAIR MARKOWITZ: Dr. Cassano?

15           MEMBER CASSANO: Hi. Dr. Cassano.  
16 Sort of a follow-up to Dr. Boden's comment.

17           When I'm doing a claim, or many people  
18 that are doing a claim, I like to see all of the  
19 information that is available. What I see  
20 happening here -- and I don't know if it is true  
21 or not -- but what it looks like is that the  
22 information gets narrowed and pigeonholed to a

1 point that the industrial hygienist sees what the  
2 claims examiner has specified they need to see.  
3 So, if it is a welder, they say, "Well, according  
4 to SEM, they were exposed to asbestos and welding  
5 fumes," and you go from there. And then, the  
6 doctor sees even a more narrow view.

7 My first question, if somebody says  
8 they are a welder, I say, "Okay. What were you  
9 welding on and what was the flux?" And that  
10 isn't included in this discussion because the  
11 difference between galvanized steel and hard  
12 steel or chromate steel is very, very big.

13 So, what I am trying to find out is  
14 how much discretion does the industrial hygienist  
15 or the physician have to say, "No, this is not a  
16 nail. I can't hit it with a hammer. It's  
17 actually a different problem or a broader  
18 problem."

19 MS. LEITON: And I think that the  
20 industrial hygienists, they are given the  
21 occupational history questionnaire. They are  
22 given whatever information we have gathered on

1 exposure, whether it is from the claimant or from  
2 some other source. They are given that. So,  
3 they are provided the discretion to tell us those  
4 things.

5 Now, obviously, you guys have a lot of  
6 expertise? That, again, we think can really help  
7 in that process.

8 But the industrial hygienist does --  
9 it goes to a physician, and we do try to include  
10 as much as we can in that assessment or that  
11 Statement of Accepted Facts for the physician.

12 CHAIR MARKOWITZ: We are going to take  
13 one last question and, then, move to something  
14 else. But, after the break, we will continue  
15 this discussion.

16 But Mr. Turner?

17 MEMBER TURNER: James Turner.

18 Okay. I'm thinking about your cutoff  
19 dates, okay? I know you have to have a cutoff  
20 date sometime or another, but your cutoff date to  
21 me is not working.

22 Take, for instance, like at the Rocky

1 Flats Plant, they are destroying a lot of  
2 beryllium, supposedly destroyed, cleaning up, but  
3 beryllium is a very light metal. When it is  
4 machined, it goes wherever, the high beam areas,  
5 up in the ducts and ceilings. Years later when  
6 they was tearing down these buildings, the  
7 workers, they got exposures, okay? So, a few  
8 days, years down the road, people are going to  
9 come down with CBD, chronic beryllium disease.  
10 So, what are you going to do about that?

11 MS. LEITON: I'm not sure. We don't  
12 have a cutoff. So, I'm not cure what you mean by  
13 cutoff.

14 MEMBER TURNER: Well, you made mention  
15 earlier that --

16 MR. VANCE: Yes, what I was suggesting  
17 is that is something for the Board to consider.  
18 Now that information, we don't have cutoff dates  
19 in here now, but what you are raising is a very  
20 valid point. And that would be something that  
21 certainly would be considered.

22 The example that I tend to use is lead

1 paint. You know, they stopped using lead paint  
2 years ago, but that doesn't mean that somewhere  
3 at one of these sites there was a reserve of this  
4 stuff that somehow got back into production  
5 somehow. So, saying they stopped using it, or  
6 let's say that they prohibited the use of that  
7 material at a set period of time, doesn't mean  
8 that that, in reality, they stopped using it.  
9 There could be circumstances where it continued  
10 to be used, for whatever reason. Temporality is  
11 an issue that the Board should consider as part  
12 of this because it is not in the SEM right now.

13 CHAIR MARKOWITZ: Okay. We are going  
14 to just take a break from this discussion and  
15 hear from Dr. Rosemary Sokas, who served on the  
16 Institute of Medicine Committee several years ago  
17 which took a look at the SEM database and issued  
18 a report three years ago, which is accessible  
19 through our website. So, if you want to take a  
20 look at the IOM report, you can see it through  
21 our website.

22 Dr. Sokas, please.

1           MEMBER SOKAS: Thank you. And IOM  
2 reports, you can actually scroll through them  
3 pretty much anytime you want to. You don't have  
4 to actually purchase and download, but they will  
5 let you look at it.

6           So, the Institute of Medicine, which  
7 is now called something different which I don't  
8 recall, the National Academy of Medicine, okay,  
9 formed a committee in response to a DOL request  
10 that met five times in 2012. The first two times  
11 were public meetings and, then, the last three  
12 times were really writing the stuff up. And  
13 then, it got reviewed externally and, then, was  
14 published in 2013.

15           So, this Committee was chaired by Mark  
16 Utell. The staff person from the IOM was Rebecca  
17 Koehler, who is a radiation expert.

18           I did want to just take a moment and  
19 recall in gratitude the work of Julia Quint, who  
20 has since passed away, but who was an incredibly  
21 active contributory member to this Committee.

22           So, the background for the Committee,

1 which we were given actually before the first  
2 meeting, was a 2010 GAO report that talked about  
3 a number of things that will sound familiar.  
4 But, basically, what they recommended were to  
5 strengthen the independent review, the quality  
6 assurance and the independent review of the  
7 claims process. Then, the second thing that they  
8 wanted to do was to enhance the exposure input  
9 information in the SEM and make it publicly  
10 accessible and readily usable.

11 Then, they also wanted to create --  
12 and this was the comment that Mr. Nelson made  
13 yesterday -- that there had been an ombudsman  
14 report that was never publicly addressed by the  
15 Department of Labor. And so, that has changed  
16 directly, it seems, in response to this GAO  
17 report.

18 Those were the executive  
19 recommendations from that report. They also had  
20 a congressional recommendation, which was to form  
21 an independent review board similar to the one  
22 for radiation. So, that is why we are sitting



1 here now.

2 The second item that I would like to  
3 share that was presented at the first meeting to  
4 the Institute of Medicine, the first Committee  
5 meeting, was actually a presentation by Ms.  
6 Barrie and Dr. Fuortes from the Alliance of  
7 Nuclear Workers advocacy group. It was focused  
8 on Haz-Map really as a problem, because, as you  
9 have seen this whole SEM, there is one source of  
10 information for health outcomes and that is Haz-  
11 Map. So, to look at Haz-Map, just to step aside  
12 and take a look at it, Haz-Map was created by an  
13 occupational physician who had previously  
14 practiced for many years as a primary care  
15 clinician, was really developing a tool, an  
16 instrument for other primary care clinicians  
17 without occupational health training to deal with  
18 patients in their clinical practices.

19 And it is kind of like, if you look at  
20 the old -- those of us of a certain age will  
21 remember the old NIOSH Blue Book where you could  
22 look up the activity; you could look up the job

1 category; you could look up the disease; you  
2 could look up the exposure, and kind of work  
3 backwards and forwards if you had somebody who  
4 came up with something that you weren't quite  
5 sure about.

6 That was actually the starting point  
7 for this. And so, if you go to the National  
8 Library of Medicine, you will find the Haz-Map  
9 and it has got all these kinds of  
10 functionalities.

11 Now the problem is, when a clinical  
12 person sees someone in their office, they are  
13 mostly worried about not calling zebras if it is  
14 in North America and they hear hoof beats; they  
15 are looking for horses, right?

16 (Laughter.)

17 MEMBER SOKAS: They have zero interest  
18 -- zero, negative zero interest -- in any form of  
19 compensation system and will run out of the room  
20 screaming, typically, if anybody mentions that.  
21 So, it is apples and oranges.

22 So, having said that, the ANWAG group

1 gave a lovely presentation of all of the many  
2 problems that derive from using that as the  
3 single metric for health impact.

4 In addition, Rebecca Koehler sent  
5 everybody on the Committee a memo that is  
6 unsigned, but was, presumably, sent by Dr. Eugene  
7 Schwartz prior to his departure as, I believe,  
8 Medical Director for the program in 2009, where  
9 he laid out two densely-written or three pages of  
10 -- and I think I sent that link to Steve. So, it  
11 could be part of what we look at.

12 But it is a very detailed look at what  
13 all the different problems are with making use of  
14 Haz-Map, in addition to some other items, making  
15 use of Haz-Map for this particular purpose.

16 Okay. So now, getting into the IOM  
17 meeting, I am going to go into -- I think people  
18 have it. Wait a minute. Okay, the next one.  
19 Does it work? How do I get it to work? Oh, this  
20 is the one. Okay, this is the one. If you can  
21 expand that to just focus not on the front, not  
22 on the top, but on the little bullets there?

1       Okay.

2                       So, this is the task, and people have  
3       this in their books right now. The task list  
4       that was the negotiated scope of the work was  
5       really around these particular questions, right?  
6       So, these questions, the eight questions that you  
7       see in front of you -- and you can kind of like  
8       enlarge them -- were really what we were allowed  
9       even to ask about. So, if we strayed off into  
10      quality assessment for the claims examiners or  
11      for the review process or for anything else, we  
12      could ask those questions, but, basically, would  
13      be reminded by Rebecca that the Institute of  
14      Medicine had agreed to answer these questions.

15                      So, I am going to go through the task  
16      that was assigned to us and what we were able to  
17      do with that. In your handout, in the end of the  
18      first summary section, there are longer answers  
19      to each one of these questions, but I just wanted  
20      to frame the questions for you.

21                      One of the questions was, what are the  
22      diseases that aren't in the SEM? There were a

1 handful. Instead of going through -- at the time  
2 there were 1300 chemical exposures listed in the  
3 SEM; now there's something like 1700 -- so,  
4 instead of doing an expansive look at all of  
5 those chemicals, there were some sample ones done  
6 where you looked for exposure disease outcomes,  
7 where you thought that they should be there, and  
8 they weren't.

9           So, the first one is the diseases.  
10 The second one was what are the links that seem  
11 to be missing. And I am going to go into that in  
12 one second. Again, it was a kind of a sampling  
13 of, well, let's look at a few things and see what  
14 we think is missing. Is there additional  
15 information? And it was preferably from  
16 epidemiology. So, there were a number of  
17 epidemiologists on this panel, in addition to  
18 toxicologists that should be used.

19           What other databases might be  
20 included, and the Committee came up with a  
21 laundry list of additional databases that would  
22 have good information in them.

1                   What are the strengths and weaknesses  
2 of the NIH/NLM peer-review process? Now here,  
3 again, I mean, I am a little confused, I would  
4 say, about whether any of the -- so, the  
5 responses that I know got accepted from the  
6 Committee report were some of the critiques of  
7 the Haz-Map program for where it missed different  
8 things. The person who organizes that, who runs  
9 it, went back and included some. So, by the time  
10 the report appeared, some of the deficiencies in  
11 specific examples were corrected. But, apart  
12 from that, it is not clear to me that any of the  
13 other recommendations were actually acted upon.

14                   And I particularly want to point out  
15 this one about the NIH/NLM peer-review process  
16 because there the NLM, the National Library of  
17 Medicine, personnel responsible for putting up  
18 that program came to the Committee and said, "We  
19 do not do peer review on the content of this.  
20 All we do is an editorial review for language and  
21 missing links." So, there is no peer review.

22                   So, I am a little concerned that on

1 page 4 of the handout we just looked at from the  
2 SEM it still says that "Dr. Brown's work is then  
3 submitted to NLM for review and editing." While  
4 that is technically true, it has a completely  
5 different meaning to people who read it than what  
6 is actually the case.

7 So, that is technically true. They do  
8 review and editing, but it is for things like  
9 broken links and that is it. They don't do any  
10 content.

11 There was another question about  
12 synergistic effects. And so, there was a whole  
13 little report, mini-report, in the document  
14 about, well, what is the science behind  
15 synergistic effects? We do know that they occur.  
16 What do we think is -- but there is a lot of  
17 missing information on that. And so, it is a  
18 ripe area for further investigation.

19 And then, what consistent process or  
20 approach could be used to consider a disease or a  
21 cancer? In fact, the group got into some  
22 additional recommendations and suggestions.

1           I would like to move to the next one.  
2       What did I do with the thing, the slide changer?  
3       Here it is. Okay, great. So, again, does this  
4       change the slide? Yes. Okay, great. No, wait a  
5       minute. Hold it. This one. Okay, great.

6           So, this one, again, if we could maybe  
7       just expand the top piece, if people can see it?  
8       This is just an example. So, for example, the  
9       exposure cancer links in the Haz-Map -- which  
10      then are transported into SEM, right, so it is  
11      now the same thing -- are only IARC 1  
12      carcinogens, at least at that time, which is a  
13      very strict rule. I mean, an IARC 1 carcinogen  
14      doesn't include some of the OSHA standard  
15      carcinogens, for example, right?

16           And so, the IARC 1 carcinogens that  
17      were looked at, not all of those outcomes were  
18      made. So, these are the missing IARC 1 exposures  
19      and outcomes that were missing from Haz-Map;  
20      therefore, missing from the SEM.

21           There is a whole other -- and again,  
22      this is in the document itself -- there is a



1 whole other table of IARC 2As, for example, that  
2 are possibly human carcinogens for which there is  
3 a body of evidence that was not included.

4 And then, there is another table that  
5 shows just, again, as a random sampling, looking  
6 for exposure outcome links for cardiovascular  
7 outcomes -- and, for example, at that time,  
8 disulfide was missing as a cardiovascular  
9 outcome.

10 So, there were enormous gaps. And  
11 this is spot-checking. You know, we didn't have  
12 subcontractors. We didn't have somebody to go  
13 through 13,000 items.

14 So, this was kind of obvious  
15 immediately. And then -- all of which is  
16 documented earlier, but we kind of re-documented  
17 it -- the quality assurance for this database is  
18 that one individual with some subcontracting  
19 reviews a handful of journals periodically and,  
20 also, relies on textbooks which may be, as we all  
21 know, years out of date. Again, it makes sense  
22 if you are a primary care clinician who is trying

1 to figure out if this person's kidney disease  
2 might or may not be due to their work, but was  
3 shocking, in fact, to the members.

4 So, the clear recommendations are  
5 pretty obvious. And so, we will go to the next  
6 step, which if we can scroll down to the middle  
7 of that, there are just basically three  
8 recommendations.

9 If we go to those three  
10 recommendations, let's just see. The first one  
11 was to add supplemental sources of information on  
12 health effects to supplement Haz-Map, to either  
13 change Haz-Map and have it be the sole source of  
14 health effects or you could add stuff, you know,  
15 that somehow gets incorporated apart of Haz-Map.  
16 But you have to do something because, really, as  
17 it stands, it is insufficient and it is not  
18 appropriate.

19 Not saying that it is not a useful  
20 thing to have up on the NIH website, because  
21 primary care clinicians need this. You know, it  
22 is useful for a lot of people, but it is just not

1 useful for this purpose.

2 The other concern was that the  
3 structure and function of the SEM itself could be  
4 a little easier to do. For example, if you are a  
5 construction worker and you have worked at a  
6 bunch of different sites, you have to kind of  
7 flog through each one. This, again, was meant  
8 for the public.

9 And this was a really -- I don't want  
10 to speak for the industrial hygienists on the  
11 Committee -- but there was a sense among them  
12 that, through all of the DOE-funded studies that  
13 were done in collaboration with NIOSH or with  
14 other people, there should be a lot more  
15 information because it is not clear to me yet  
16 that the information that is in the SEM about  
17 exposures is anything more than kind of a  
18 purchase inventory and the MSDSS that go along  
19 with it.

20 I mean, although it is described that  
21 there are tons of sporadic, and often missing,  
22 but there are places where exposure has been

1 assessed and other kinds of assessments have been  
2 made. It is not clear how or whether that has  
3 been incorporated in the SEM. So, that I don't  
4 really understand.

5 And then, the third advice was use an  
6 external advisory group for the health  
7 information data on the SEM. So, it really was  
8 not the whole SEM; it was really, you know, this  
9 health information data. We don't think it is  
10 going to be fixed real easy. So, you are going  
11 to need a group.

12 By the way, 12 meetings, and et  
13 cetera, we are not that group, said the IOM  
14 Committee at the end of a year of doing this;  
15 somebody else is going to have to do this, right?

16 And so, then, the next couple of  
17 bullets I just wanted to go through. If we could  
18 just scroll down to that first set of bullets?  
19 These are just some of the thoughts that the  
20 Committee had about what an external advisory  
21 group could do.

22 Now, again, I don't want to belabor

1 this, but the GAO report was in 2010. That one  
2 memo was in 2009. This Committee met throughout  
3 2012 and reported in 2013. So now, we are in  
4 2016, but we are here.

5 So, these were the kinds of things  
6 that we thought might be useful. People can read  
7 through that. But it is you want to have  
8 criteria for causal linkages that could be used,  
9 and there was a lot of discussion about weight of  
10 the evidence, that you could develop something  
11 that is similar to IARC where you go from, yes,  
12 we know this is true to, you know, we think it is  
13 probably true, to, well, it could be true, and  
14 then, we are really sure it is not. So, those  
15 kinds of things the IOM has done in different  
16 places.

17 And also, look at different sources of  
18 information, again, beyond the handful of  
19 journals and bunch of textbooks that are put into  
20 the Haz-Map.

21 Develop some sort of a worksheet that  
22 could, then, assist in making these

1       determinations.  And then, there was some thought  
2       that maybe the exposure information might be able  
3       to be more robust through readily-available data,  
4       but that is not clear that that is true.  And I  
5       would defer to people here who have done those  
6       studies.

7                   And then, again, they wanted to have  
8       some other ongoing responsibility, which is peer  
9       review of the new links, assessing occupational  
10      diseases.  This, I think, is exactly what the  
11      list that we just saw kind of gets at, is where  
12      there may be more information about some of these  
13      exposure outcome relationships.

14                   And as well, look at the existing  
15      causal links.  It wasn't all sins of omission;  
16      there were actually one or two items where a link  
17      was in there that was not clear from the data  
18      where that link actually came from.  And so, when  
19      you see the word "link" here, it means really the  
20      exposure outcome, exposure link.  So, there was  
21      probably a false-positive around, I think it was  
22      hemolytic anemia that was in there.  And then, a

1 periodic review.

2 So, again, I don't want to beat this  
3 to death, but I think there were fair amounts of  
4 -- I mean, the IOM reports are always really  
5 consensus documents. There was no disagreement.  
6 There was no separate appendix where people got a  
7 chance to kind of say they didn't agree with it.

8 So, these recommendations were really  
9 consensus. I think the information in the  
10 document itself may be useful for people as the  
11 Subcommittee moves forward on this. Again, the  
12 list of some of the other databases that might be  
13 useful, if that is of any interest.

14 But, as someone who spent five  
15 meetings over a year when other stuff was going  
16 on in my life, you know, I would have hoped to  
17 have seen a little bit more specific responses to  
18 some of this, but we're here.

19 CHAIR MARKOWITZ: Laura?

20 Thank you. We are here.

21 So, are there questions or comments?

22 Laurie?

1                   MEMBER WELCH: Laurie Welch.

2                   It is partly a question for you, too,  
3 Steven. Some of the things that Rosie mentioned  
4 that the Committee had looked at, such as the  
5 report from ANWAG and that letter from Gene  
6 Schwartz, is that something that is available to  
7 us? I mean, we have the IOM report, but the  
8 background documents are generally not up on the  
9 IOM website.

10                  MEMBER SOKAS: They are publicly  
11 available through -- you know, they keep a file.  
12 So, anything that they have used is publicly  
13 available.

14                  MEMBER WELCH: So, we could just go  
15 back to the staff member and --

16                  MEMBER SOKAS: And the Schwartz memo  
17 is actually, when Rebecca sent it around, she  
18 actually gave a link. So, I was able -- she had  
19 accessed it in January of 2012. In preparation  
20 for this meeting, I used her link and found it  
21 again. So, it is out there. I emailed it to  
22 Steve. So, you have that link.



1 MEMBER WELCH: Okay.

2 CHAIR MARKOWITZ: Sure. I mean,  
3 whatever documents, we can just make a request of  
4 DOL to produce.

5 MEMBER SOKAS: Okay.

6 CHAIR MARKOWITZ: We have a few  
7 minutes on this before we break.

8 Yes, Dr. Boden?

9 MEMBER BODEN: So, maybe some of you  
10 have seen this, but I think it might be useful,  
11 to me at least, to see what the report that goes  
12 from the claims examiner to the evaluating  
13 physician looks like. If we could get some  
14 examples that are redacted adequately, so that  
15 they didn't identify, you know, we couldn't  
16 identify particular people, but we could get a  
17 picture of what the information is that is  
18 presented, I think that would be helpful.

19 MEMBER SOKAS: I agree, and that was  
20 outside the scope.

21 (Laughter.)

22 MEMBER SOKAS: But it's not.

1                   CHAIR MARKOWITZ: Okay. So, I am told  
2 we will have that tomorrow.

3                   I would just like to make a comment on  
4 the IOM report. It is extremely useful for us to  
5 have this review and critique. You should take a  
6 good look at this report. There are things that  
7 they call for that probably we could assist with.  
8 There are other changes we call for which are  
9 pretty fundamental and are probably beyond the  
10 ability of this Advisory Board to achieve.

11                  For those not familiar, the process of  
12 reviewing a single agent and its ability, say, to  
13 cause cancer, which is done routinely by or on a  
14 regular basis by IARC, also by the National  
15 Toxicology Program, is a multi-year process on a  
16 single agent for which there is a lot of evidence  
17 that it causes cancer. It is a protracted review  
18 process by a number of peers. It goes back and  
19 forth internal/external review. And so, it is  
20 very complicated, and that is for a single agent  
21 for a well-known outcome for which there are a  
22 lot of studies.

1           So, part of what the IOM report calls  
2 for is this kind of injection of this peer-review  
3 process into essentially what Haz-Map has taken  
4 on, these exposure/disease links, on an ongoing  
5 basis. That is an immense task. We are not  
6 going to do that, I think, because that is not  
7 really what we are capable of doing, but we could  
8 probably help point the direction in this.

9           Other comments or questions?

10           (No response.)

11           CHAIR MARKOWITZ: So, let's take a  
12 break. Oh, yes, Dr. Friedman-Jimenez?

13           MEMBER FRIEDMAN-JIMENEZ: Just a quick  
14 general question. Did treating physicians have  
15 access to this Site Exposure Matrix and all the  
16 information on exposure?

17           MEMBER VLIEGER: They do have access  
18 to it. Whether or not they want to take the time  
19 to learn the intricacies to find adequate data,  
20 although most of the physicians that I deal with,  
21 with claimants or on my own claim, their eyes  
22 glaze over as soon as I mention that there is a

1 source.

2 CHAIR MARKOWITZ: Okay. We will take  
3 a break for 15 minutes, and at 10:15 we will  
4 start up again. Thank you.

5 (Whereupon, the above-entitled matter  
6 went off the record at 9:58 a.m. and resumed at  
7 10:17 a.m.)

8 CHAIR MARKOWITZ: We are going to  
9 spend the next 45 minutes discussing the area of  
10 our assignment, which, according to the Act, is  
11 that we will advise the Secretary of Labor with  
12 respect to the Site Exposure Matrices of the  
13 Department of Labor.

14 For the next 45 minutes we would like  
15 to begin discussion or resume discussion of some  
16 of these issues among ourselves and, also, form a  
17 committee to carry on the work beyond this three-  
18 day meeting. We are going to form four  
19 committees, one corresponding to each of the four  
20 tasks given us by the Department of Labor.

21 So, think about which committee or  
22 committees you would like to serve on. It would

1 be good to have representation from the various  
2 communities represented on the Board, including  
3 the claimant or the worker community, the  
4 scientific community, and the medical community.  
5 You can serve on more than one committee if you  
6 want, and you can make an initial volunteer today  
7 and tomorrow as we form these committees, but we  
8 will also allow you to switch your committees  
9 over the next period of time, in case you change  
10 your mind, or whatever.

11 So, there will be some flexibility,  
12 but we would like to get to the point where we  
13 have committees because we would like to schedule  
14 committee meetings in the next couple of months  
15 to continue the work that we are starting here.

16 So, it is open for discussion now  
17 about the Site Exposure Matrices. I think there  
18 may have been maybe Dr. Redlich or some people  
19 from the previous session who had questions who  
20 weren't able to ask those questions. If not, I  
21 can --

22 MEMBER REDLICH: I'll wait.

1 CHAIR MARKOWITZ: Okay. Yes, Mr.  
2 Domina?

3 MEMBER DOMINA: I have a question for  
4 Mr. Vance, if we are going to have access to the  
5 SEM that the claims examiners have.

6 MR. RIOS: As I stated in the opening  
7 statement on day one, if you have any questions  
8 that require participation from the public,  
9 please go through the Chair. Thank you.

10 MS. LEITON: So, your question was  
11 that you want to know if you are going to get the  
12 one that the claims examiners have. I'm going to  
13 have to get back to you on that. I'll let you  
14 know for sure exactly what we can provide to you.

15 CHAIR MARKOWITZ: So, while we have  
16 Ms. Leiton and Mr. Vance here, any other  
17 questions, in particular, for them, carryover  
18 from the last session?

19 Go ahead, Dr. Boden.

20 MEMBER BODEN: Well, I just want to  
21 follow up on the question that I raised from Dr.  
22 Sokas' presentation, which is, is there a way

1 that we can have access to the claims examiner  
2 reports that go to the physicians who are, then,  
3 going to make initial decisions on the claims?

4 MS. LEITON: As part of our  
5 presentation tomorrow from Jeff Kotsch, who is  
6 our Industrial Hygienist, he is going to be --  
7 I'm sorry, our Lead Health Physicist -- he is  
8 going to be providing a sample of one of the  
9 referral packages. At least we can start there  
10 because he is going to have that redacted. He  
11 has already used it other things.

12 So, we are going to provide you both  
13 with the package that goes to the industrial  
14 hygienists as well as a sample of the industrial  
15 hygienist report that is written as a result of  
16 it. So, we can start there tomorrow with that.

17 MEMBER BODEN: Okay. Then, we may  
18 want to follow up with looking at more stuff to  
19 get a more general sense.

20 CHAIR MARKOWITZ: Sure.

21 MEMBER GRIFFON: Steve?

22 CHAIR MARKOWITZ: Yes, sir, Mr.

1 Griffon?

2 MEMBER GRIFFON: Yes, I just wanted --  
3 I will direct it to you, Steve. A question about  
4 the procedures that the claims examiners will use  
5 in putting all this together.

6 So, they have the SEM as, I won't call  
7 that a tool, but I am wondering if the procedures  
8 -- and I looked online. There is this Procedures  
9 Manual and there is a subsection on the SEM or  
10 using the SEM.

11 Are there other procedures or guidance  
12 that the claims examiners will use in compiling  
13 this information before it goes to the medical  
14 side?

15 I guess I am directing it to them.

16 CHAIR MARKOWITZ: Sure, sure. I'm not  
17 sure I'm going to give you an informed answer. I  
18 am going to turn that over to Mr. Vance and Ms.  
19 Leiton.

20 MS. LEITON: So, the Procedural Manual  
21 is the basis for what how they do their work. It  
22 outlines step by step exactly what we expect them



1 to do. So, that chapter in the SEM is how they  
2 are supposed to use the SEM. We have chapters on  
3 referrals to the IHS. We have got chapters on  
4 how they are going to write their recommended  
5 decisions. So, each step of the process there is  
6 an outline.

7 Outside of that, the training that has  
8 been conducted and is conducted yearly by our  
9 industrial hygienists and by our policy staff,  
10 that is where we get more into, okay, so here's  
11 where we're at; here's where you use it.

12 There are training resources out there  
13 for them to use, but that is why we do a lot of  
14 -- every year pretty much we go out and do hands-  
15 on training with them to ensure that they  
16 understand and that we are explaining things, and  
17 as things change, they have an understanding of  
18 that.

19 MR. VANCE: Yes, there is also on our  
20 website, if you go to the SEM initial page, there  
21 is also a SEM User Guide that will give you some  
22 more technical information about how to utilize

1 SEM.

2 MEMBER GRIFFON: Okay. So, I mean, I  
3 am just looking at those procedures. I mean,  
4 they are useful, but they are pretty broad. I am  
5 wondering, there is no site-specific guidelines?  
6 Say I work, I am a claims examiner and I'm in a  
7 region where I get a lot of claims from Savannah  
8 River. There is no site-specific guidelines that  
9 might help for the consistency issue?

10 I know this has come up on the  
11 radiation side. That is why they have a lot of  
12 guidance that isn't necessarily published as  
13 public procedures, but there are guidelines for  
14 the dose reconstructors to have when they are  
15 doing claims because there are areas of  
16 professional judgment, and they are trying to  
17 assure that there is at least some level of  
18 consistency in how people interpret certain  
19 pieces of evidence. So, I am wondering, is there  
20 any such thing? Any guidance for sites?

21 MS. LEITON: We haven't had the  
22 resources to have that kind of level of detail

1 for each site.

2 MEMBER GRIFFON: Okay. Yes.

3 MS. LEITON: But just keep in mind  
4 that our administrative costs that we get are for  
5 claims examiners and doing the claims process.  
6 And so, you know, Rosie talked a little bit about  
7 the recommendations that were made there. A lot  
8 of that would require a lot of resources that we  
9 weren't given.

10 And so, over the years we have tried  
11 to like get together either more IHs or a panel.  
12 First, we have got to get interest for a panel.  
13 This a lot of people don't want to touch, as you  
14 can imagine, because it is rather complicated.

15 In addition, we have been trying to  
16 get a contract, which now it looks like we are  
17 going to get, and we have got this Board. But,  
18 yes, it has taken years.

19 If we can get that level of detail,  
20 that would be fantastic. We just haven't had the  
21 resources to do that thus far.

22 MEMBER GRIFFON: Thank you.

1 CHAIR MARKOWITZ: Dr. Cassano?

2 MEMBER CASSANO: I have a process  
3 question and, then, I think a request for some  
4 information. So, I will direct it in both  
5 directions.

6 A claims examiner gets a statement  
7 from a claimant that says, "I was exposed to"  
8 this, this, this, and that, at such-and-such a  
9 site. "I have this disease." The claims  
10 examiner can't verify that in SEM.

11 I need to be closer. Usually, I can  
12 bellow pretty good.

13 (Laughter.)

14 MEMBER CASSANO: Does the claim get  
15 denied at that point or a recommendation for  
16 denial go up to the Final Adjudication Board at  
17 that point? Or does it go through an industrial  
18 hygienist and a physician at that point who can  
19 exercise a little bit more discretion or judgment  
20 on the case? Or does it get denied at that  
21 point?

22 MS. LEITON: If a claimant has

1 information, you know, it might not be in the  
2 SEM, but they might have very detailed  
3 information. And in some cases we have experts  
4 that will provide us with this saying, "I'm an  
5 industrial hygienist" or "I'm an HP" or "I have  
6 this level of expertise, and I know this is a  
7 process I was involved with." They can describe  
8 exactly what.

9 Like sometimes we have incidents.  
10 Well, those sorts of things we will move forward  
11 to NIH in some circumstances. Sometimes we get  
12 medical reports along with that where the doctor  
13 says, "I believe that these toxic substances this  
14 person was exposed to were related to...," and we  
15 will follow up on that. We are not going to just  
16 outright deny it because it is not in SEM.

17 But there are certain other  
18 circumstances where we have no, zero information,  
19 zero detail. At that level, if we can't get  
20 anything else, there will be circumstances where  
21 it will be moved to a recommended denial.

22 MR. VANCE: Yes, and let me give you

1 a quick example of a real-life situation we just  
2 encountered recently. Information in the  
3 document acquisition request that we get from the  
4 Department of Energy trumps any information that  
5 might be in the Site Exposure Matrices. So,  
6 recently, we had a case where there was some sort  
7 of chemical incident at one of the sites. There  
8 was no information in the Site Exposure Matrices  
9 about this, but the DAR itself contained  
10 information about this employee's exposure as  
11 part of this incident. And we ended up looking  
12 at that and saying, okay, well, that clearly is  
13 documentation of an exposure that, while it might  
14 not be in the Site Exposure Matrices, it is  
15 clearly probative enough to us to accept that  
16 that exposure occurred.

17 And because we already had the medical  
18 documentation linking that exposure to a skin  
19 problem, we ended up accepting that case. That  
20 entire process existed to acceptance without the  
21 use of the Site Exposure Matrices at all.

22 MEMBER CASSANO: And I think the

1 request for information, it would be nice to be  
2 able to see some data. It would be nice to be  
3 able to see some data at what point claims are  
4 denied and for what reasons. You know, if they  
5 were denied before the industrial hygienist,  
6 before the physician, at the claims examiner  
7 level, and for what reasons. And then, at each  
8 stage, what they were denied for.

9 CHAIR MARKOWITZ: We are keeping a  
10 list -- Steve Markowitz -- a list of the  
11 requests. And if anything is unclear after the  
12 meeting, then we will get back to you about some  
13 clarity.

14 Dr. Welch?

15 MEMBER WELCH: If you guys can  
16 clarify, it is my understanding that using the  
17 industrial hygienists as frequently as you are  
18 now is a relatively new procedure. I think that  
19 is a conversation we had when you were at our  
20 building trades meeting.

21 MS. LEITON: Yes, we have been using  
22 them more than we used to. As I tried to explain

1 yesterday a little bit, we are getting criticisms  
2 for our claims examiners not really having  
3 expertise to make any of these sorts of  
4 judgments. And so, we were trying to balance  
5 that with, okay, well, we don't want our claims  
6 examiners who aren't IHS and aren't scientists or  
7 doctors to be doing this. So, we started  
8 referring more cases to the industrial hygienists  
9 for their opinions. And as I indicated, I  
10 believe we are very close today; maybe with  
11 getting this contract tomorrow, we will know for  
12 sure.

13 CHAIR MARKOWITZ: I am sorry, what  
14 contract are you referring to?

15 MS. LEITON: We are getting a contract  
16 of industrial hygienists that can help us with  
17 the workload that we currently have. And so, we  
18 are hoping to have official word on that this  
19 week.

20 CHAIR MARKOWITZ: So, I have a follow-  
21 up question to this about contractors. It seems  
22 from the IOM report that one of the areas that



1 needs some attention is the Haz-Map part of the  
2 SEM. And we may be able to help in certain  
3 respects with that.

4 What is the relationship between the  
5 Haz-Map contractor, you know, creator,  
6 maintainer, and the Department of Labor? Is  
7 there a contract relationship?

8 MS. LEITON: Yes, we have a  
9 contractual relationship with them. I think it  
10 is a subcontract.

11 Tell them who you are.

12 MR. PENNINGTON: Sorry. Excuse me.  
13 My name is Douglas Pennington. I'm the Deputy  
14 Director of the Energy Program. I won't give you  
15 all the details I gave because I am going to make  
16 this quick.

17 We have an MOU with another agency,  
18 and Dr. Brown is a contractor with the other  
19 agency that we fund through this MOU in what is  
20 called an interagency agreement. And so, we do  
21 fund his work, but it isn't through a direct  
22 contract that we hold ourselves.

1 CHAIR MARKOWITZ: And what is the  
2 agency that you fund?

3 MR. PENNINGTON: It's HHS.

4 CHAIR MARKOWITZ: Oh, okay. Okay. Is  
5 that the NLM?

6 MR. PENNINGTON: Yes.

7 CHAIR MARKOWITZ: Okay. So, you  
8 contract with NLM who contracts with Jay Brown?

9 MR. PENNINGTON: Say it again?

10 CHAIR MARKOWITZ: You contract with  
11 NLM who contracts with Jay Brown?

12 MR. PENNINGTON: Yes.

13 CHAIR MARKOWITZ: And what other  
14 contractors are involved with the SEM? You  
15 mentioned Paragon. They deal with exposure data.  
16 Are there other contractors involved at all with  
17 the SEM?

18 MR. PENNINGTON: No.

19 MS. LEITON: Not currently.

20 CHAIR MARKOWITZ: Okay. Dr. Redlich?  
21 Thank you.

22 MEMBER REDLICH: I mean, obviously,

1 this is a huge, complicated task where you are  
2 trying to reconstruct years of historic  
3 exposures, and you have people now presenting  
4 with probably multiple chronic diseases. But I  
5 think people present with diseases and not with  
6 thousands of exposures. And so, I think more  
7 information about the actual data, the number of  
8 cases of COPD, cardiac disease, the major  
9 cancers, in terms of just where you spent your  
10 efforts. And then, for those major diseases,  
11 what percentage of claims are accepted, denied,  
12 reasons for denial? We would be able to at least  
13 focus, prioritize efforts.

14 Because there are certain diseases  
15 that there is just not a lot of association with  
16 occupational exposures and there are other  
17 diseases like the COPD where digging in the weeds  
18 is not supported at all by the literature. So,  
19 in terms of just where you would spend your  
20 efforts.

21 MS. LEITON: Yes, and I think I got  
22 that from you yesterday, and we have got it. We

1 are tracking what kinds of reports you want. We  
2 might have to come back and ask you to be  
3 specific, so we can build a report and get that  
4 information and see what we can provide. So, we  
5 will just have to further delve into those  
6 requests for data.

7 MR. VANCE: Yes, let me add, too, I  
8 want to share an experience for the Board because  
9 I think it is an important one for you all to be  
10 aware of. It relates specifically to your  
11 question or your comment.

12 We have tried to do that in the past  
13 by identifying -- you know, we have presumptive  
14 standards. We have worked on trying to develop  
15 information about health effect data.

16 We did have an experience where we  
17 tried to go back and do exactly what you  
18 suggested by identifying those diseases which  
19 science really doesn't have any information  
20 linking it to workplace exposures. And we  
21 actually created a list at some point where we  
22 said these are just conditions which we can't see

1 are in any way related to employment. And that  
2 ended up just creating a firestorm that we ended  
3 up having to rescind.

4 So, I just want to throw that out  
5 there as a lesson learned from the program, that  
6 while we did it for that very purpose, we got  
7 ourselves stuck in this reality of how to deal  
8 with that kind of a scenario.

9 MEMBER REDLICH: Yes, I would probably  
10 word it as less data and not no data.

11 CHAIR MARKOWITZ: Yes, Mr. Whitley?

12 MEMBER WHITLEY: So, what I think I  
13 just heard you say, a pipefitter that worked 25  
14 years at a plant passed away with lung cancer.  
15 The spouse comes in and all that client has is a  
16 death certificate that says lung cancer, and "I  
17 know he worked 25 years at Y-12." Okay? So,  
18 that is all the claims examiner is going to get.  
19 Where do they go from there? I mean, they have  
20 got very little information.

21 MS. LEITON: That's all they got from  
22 the claimant. That doesn't necessarily mean --

1 as I have tried to explain, we do a lot to try to  
2 develop a case like that. We will go to DOE  
3 first and, then, we will try to get DAR records.  
4 We will look at the SEM. The SEM in that case  
5 would probably give some more information. We  
6 will go to an IH, based on what we can get.

7 You know, there will be circumstances  
8 that there is nothing, but it is rare that we get  
9 absolutely nothing. I mean, we will do whatever  
10 we can to get more information on a case like  
11 that.

12 MEMBER REDLICH: But I think this is  
13 where some expert guidance -- you know, if a  
14 pipefitter, and I'm not an industrial hygienist,  
15 but was working in the fifties and sixties and  
16 seventies and has lung cancer, I think there is a  
17 high likelihood that there was asbestos exposure.  
18 And how much time and effort do you want to spend  
19 trying to tease that out?

20 MS. LEITON: True, we could --

21 MEMBER REDLICH: But I guess the other  
22 request as far as data, just because I am less

1 familiar with those whole program -- and maybe it  
2 is somewhere -- would be it sounds like these  
3 contractors are more challenging in terms of  
4 records as far as employment. It might just be  
5 helpful to have some summary idea of what the  
6 major categories of the subcontractors. I don't  
7 know if that is possible. You know, what are the  
8 most common sort of subcontractor types of jobs,  
9 if you have that or not?

10 The SEC, you know, the Special  
11 Exposure Categories that are listed, those are  
12 for the radiation and the cancers. That is  
13 actually helpful for that side. But, my  
14 understanding, that doesn't address the whole  
15 issue of all the other exposures and the  
16 subcontractors.

17 It does contractors? So, it is  
18 subcontractors at -- okay. But it is cancer?

19 MS. LEITON: Okay. We will evaluate  
20 the ask again and see what we have, what we can  
21 provide.

22 MR. RIOS: Right. You are asking the

1 agency for information, but I think your request  
2 is amorphous, and we need very specific  
3 parameters. If you are asking us to mine data  
4 from a system, we need specific parameters. So,  
5 I'm going to probably ask you, because you have  
6 asked a couple of times for this, I am going to  
7 ask you to actually write down your request, so  
8 we can work with you and tell you whether what  
9 you are requesting will get you what you need,  
10 and whether it is sufficient for us to actually  
11 mine data out of a system.

12 MEMBER REDLICH: Thank you.

13 CHAIR MARKOWITZ: Ms. Vlieger?

14 MEMBER VLIEGER: It may not help in  
15 all instances, but we are dealing with different  
16 departments' definition of what an incident is.  
17 The Department of Energy has very specific  
18 definitions of what an incident, accident, and  
19 off-normal occurrence is. Yet, in each state  
20 that they operate, an incident, an accident is  
21 defined by the state labor and industry  
22 definitions.



1                   What we are seeing on the Site  
2           Exposure Matrix mostly is the Department of  
3           Energy definition of a radiological incident.  
4           What I would like to see, and my specific  
5           request, is for the sites that are here -- and it  
6           may be a request to the Department of Energy --  
7           there is a database that they use to report, and  
8           it is a more recent database called CAIRS, for  
9           the accidents that actually occur onsite. And  
10          more accidents are chemically-related than  
11          radiologically-related.

12                   Wouldn't you agree? Would you agree  
13          with that, Kirk?

14                   So, what I would like to see is that  
15          lower-level reporting because we are dealing with  
16          Part E here, is that accident reporting with the  
17          chemicals, because that, I think, is what is not  
18          being reflected in the Department of Labor's  
19          data, whether it is on the SEM or anyplace else.  
20          And that data is not in the personnel records,  
21          nor will it be in the personnel records. And so,  
22          you can't even get it unless you know

1 specifically what to go ask the Department of  
2 Energy for. But the Department of Energy has  
3 those records because they report it to  
4 headquarters DOE.

5 CHAIR MARKOWITZ: Other questions or  
6 comments? Sure. Dr. Silver?

7 MEMBER SILVER: Having seen this  
8 program grow up, revisiting some fundamental  
9 assumptions, hearing the discussion. I think we  
10 heard yesterday that the SEM grew out of a  
11 statutory requirement for Site Profiles. No?

12 MS. LEITON: No.

13 MEMBER SILVER: No? How would you  
14 rephrase it?

15 MS. LEITON: Our statute does not  
16 require the Department of Labor to create Site  
17 Profiles. That is not where our expertise is.  
18 Our statute requires the Department of Labor to  
19 administer the program, to adjudicate claims, to  
20 write recommended decisions. But we were never  
21 provided with expert -- you know, the Site  
22 Profiles was a NIOSH mandate. They were required

1 to do that, but we didn't have -- that wasn't our  
2 mandate, is to create Site Profiles or the Site  
3 Exposure Matrices.

4 This is something we did on our own  
5 because we decided that, without it, we would be  
6 denying a lot more claims, frankly. That was our  
7 incentive for doing it.

8 So, you know, I will look into that  
9 statement that was made yesterday about that, but  
10 I know for a fact that we have never been  
11 mandated to either create Site Exposure Matrices  
12 or Site Profiles.

13 MEMBER SILVER: So, that's helpful, in  
14 that there was a statutory requirement to  
15 administer Part E for chemicals and the agency  
16 used its discretion to create the SEM. Equally,  
17 the agency could use its discretion to develop  
18 another approach to toxic chemical exposures.

19 And broad categorical solutions, as  
20 Dr. Redlich's remarks drive at, as Mr. Whitley's  
21 remarks drive at, might be something for the  
22 Committee to look at, back up out of the trees

1 and the weeds of the SEM and see if there is  
2 another way to address people by job title,  
3 location, and era.

4 MS. LEITON: I agree.

5 MEMBER SILVER: Okay.

6 CHAIR MARKOWITZ: Dr. Redlich?

7 MEMBER REDLICH: I won't ask for data  
8 again, but could you just tell us what sort of  
9 data systems you have? Like for the claims data,  
10 what variables you have entered? So at least I  
11 won't ask for something that doesn't exist.

12 And I think it is very important, even  
13 whatever data systems you have now, what you  
14 might want to put in place moving forward.  
15 Because to really sort of assess some of these  
16 issues, that would be helpful.

17 MS. LEITON: So, we created our case  
18 management system for the sole purpose of  
19 tracking our claims process. When a claim comes  
20 in, we are able to enter information about when  
21 that claim came in, when we started development  
22 on it, when that recommended decision is issued.

1 We do record, usually, what type of recommended  
2 decision it is; sometimes we have reasons behind  
3 it. Final decisions.

4 So that when we are looking at it for  
5 our purposes of managing a program full of claims  
6 examiners, we can say it took 30 days, it took 60  
7 days, it took 90 days. We can measure their  
8 performance that way, and we can actually track  
9 where we are in the process.

10 So, the database wasn't created for  
11 reporting purposes, other than reporting on how,  
12 for our purposes, because that's what our need  
13 was immediately. And it continues to be our  
14 need. We get a lot of requests for information.  
15 So, you know, we can go back and mine data in  
16 certain way, but we can't always get information  
17 for research purposes that is being requested at  
18 all times.

19 So, there is where the challenge lies,  
20 that the database is created for a different  
21 purpose than what a lot of people would like the  
22 data for. So that's kind of why it was created

1 and how we use it.

2 CHAIR MARKOWITZ: So, can you provide  
3 the variables in the database so we know what's  
4 easier to look for than not?

5 MS. LEITON: What might be easier, I  
6 mean, if you have a request, it might be easier  
7 for us to tell you whether or not we can do it.  
8 We have a very large number of variables. The  
9 data dictionary is humongous if you want to look  
10 at every code that we enter in the system.

11 So, we do track when it goes to a  
12 health physicist, when it goes to an industrial  
13 hygienist. There's a lot of things we put in the  
14 system. Whether we could pull a report on it is  
15 another question. That's why, for us, it would  
16 be a lot easier than to try to give you the  
17 litany of every single thing if you give us a  
18 request, and we can tell you yes or no and  
19 whether or not we can -- how we can --

20 CHAIR MARKOWITZ: That's fine. That's  
21 fine. Others? There were some hands over here  
22 on the left.

1 (No response.)

2 CHAIR MARKOWITZ: This is Steve  
3 Markowitz. One follow-up to the issue of the  
4 contractors. It would be useful to see the scope  
5 of work for the contractors in the SEM. I'm not  
6 interested in the administrative or financial  
7 arrangements, but I'm thinking, in particular,  
8 about the Haz-Map. If there's some interest in  
9 trying to improve the quality of that process,  
10 it'd be good to know what that contract -- well,  
11 in this case, NLM -- but, you know, is presently  
12 asked to do.

13 If you could find out, further,  
14 whether NLM has a different kind of contract with  
15 Jay Brown on a Haz-Map that the SEM would benefit  
16 from. So, your contract with NLM may say "X, Y,  
17 Z," but NLM has a broader set of tasks for Dr.  
18 Brown. If you could get that, that would be  
19 useful.

20 Where I am heading is that, in order  
21 to improve that piece of it, it'd be nice to know  
22 the extent to which the current vehicles can be

1 used to move ahead.

2 MS. LEITON: I'll find out what we can  
3 give to you.

4 CHAIR MARKOWITZ: And if you need  
5 greater specificity, let me know.

6 Okay. Any other comments or  
7 questions? Yes, Mr. Turner?

8 MEMBER TURNER: I've been a claimant.  
9 I went through the process. What happened when I  
10 would check with the claims examiners, each time  
11 that I checked with them, it was a different  
12 claims examiner. I would write their name down  
13 each time.

14 So, I was wondering, it seems like  
15 they have ones that they weren't currently  
16 familiar with my case. And then it would take  
17 time, it would take time, on and on and on and  
18 on.

19 And my thing is, I was wondering, is  
20 there a way that a claims examiner can take your  
21 case and keep it, like from the cradle to the  
22 grave? Is there such a thing?



1 MS. LEITON: Actually, no, that's not  
2 something we can do, because of the fact that we  
3 do have turnover of our claims staff. People  
4 leave. They retire. They come and go. So, we  
5 don't have a way that -- if somebody starts on  
6 your case and they leave, then we can't keep them  
7 there. We can't make them stay and continue to  
8 work on your case.

9 One of the things that we have talked  
10 about doing is trying to inform you first in  
11 advance when we change claims examiners. And I  
12 think that some of our offices have been able to  
13 come up with a mechanism for doing that.

14 And we do try to tell them, "Please  
15 become familiar with the claims if you get a new  
16 caseload." But, unfortunately, there is no way  
17 to control for people coming and going and  
18 fluctuations in staff.

19 MR. VANCE: Let me add, too, that in  
20 an imaged environment, we actually can have staff  
21 become very quickly familiar with material  
22 anywhere in the country. So, all of our cases

1 are fully scanned for the most recent ones. Some  
2 of our historical cases are hybrid between  
3 physical and imaged case files.

4 So, we have systems in place that  
5 allow people to completely understand what is  
6 going on in cases, but this is a concern that I  
7 think we've heard in the past and we try to  
8 mitigate. But the reality of case management is  
9 such that, when people leave or workloads shift,  
10 we've got to change personnel around to make sure  
11 that the work is distributed evenly amongst  
12 available staff. Or there could be specialized,  
13 prioritized case assignments that are, you know,  
14 shifting the workload around, so that we can get  
15 certain cohorts of cases processed quickly.

16 CHAIR MARKOWITZ: Other questions or  
17 comments? Mr. Whitley?

18 MEMBER WHITLEY: Rachel, in the law is  
19 there anything that says you can't have  
20 presumptions like you do for hearing? Like for  
21 chemical hearing loss, it says this many years,  
22 this group, these chemicals. Is there anything

1 in the law that says you can't have presumptions?

2 MS. LEITON: No. In fact, I've got a  
3 list of about a half a dozen bulletins or  
4 circulars here where we've made assumptions. We  
5 have been able to tell staff how to make those  
6 assumptions.

7 And that is why when we talked earlier  
8 about presumptions, if we can get this Board to  
9 help us come up with more, it's just that the  
10 statute doesn't give us any. They don't come out  
11 and say you can make assumptions here and there.  
12 So, we have to kind of make that up as we go  
13 along.

14 MR. VANCE: Well, let me also make  
15 sure everybody is clear. The presumptions that  
16 are enumerated in our policy are derived from the  
17 Part E causation standard. So, it is an  
18 interpretative question as far as what is the  
19 program determining that fits into allowing us to  
20 accept a case within that significant factor at  
21 least as likely as not standard.

22 So, our presumptions are basically

1 saying, if you meet these standards, you have  
2 satisfied that requirement. So, it's sort of a  
3 dichotomy that you need to understand exists.

4 All right?

5 CHAIR MARKOWITZ: Any other comments,  
6 questions? So, at this point, I would like to  
7 see who would like to serve on a subcommittee to  
8 deal with Site Exposure Matrices. So, there will  
9 be four subcommittees. They correspond to the  
10 four areas that we have been asked to address.  
11 This is in Section 2, I think. Section 2 of the  
12 briefing book, for the public on the phone and  
13 for the attendees. These are the four areas set  
14 out for us by the Department of Labor.

15 One is Site Exposure Matrices. Two is  
16 medical guidance for claims examiners. Three is  
17 evidentiary requirements for claims under  
18 Subtitle B related to lung disease. And the  
19 fourth is the work of the industrial hygienists  
20 and staff physicians and consulting physicians to  
21 ensure quality, objectivity, and consistency.

22 So, right now, we're talking about

1 Site Exposure Matrices. Okay. So, we've got  
2 here John Dement. In our first three volunteers  
3 -- Laurie Welch, John Dement, and Gary Whitley --  
4 we've covered all three communities represented  
5 on the Board. Okay. Mark Griffon. So far, I  
6 have Laurie Welch, John Dement, Gary Whitley, Mr.  
7 Domina, and Mark Griffon.

8 I intend, by the way, as Chair, to  
9 participate in all the committees as much as  
10 possible. So, you won't see me volunteer for any  
11 particular one, but I will be present as much as  
12 I can.

13 Okay, and, Laurie, you volunteered to  
14 be the chair? Excellent.

15 Now I thought that we might just think  
16 about what an agenda would be for the  
17 subcommittee, actually, a generic, if we could,  
18 agenda for the subcommittees as they move  
19 forward.

20 And the expectation is that these  
21 subcommittees will meet before the next in-person  
22 meeting of the entire Board once or twice,

1 depending on exactly how long it takes to get  
2 notices in the Federal Register.

3 But we have to actually come back to  
4 that point, which we will later, and make a  
5 decision about public access to those  
6 subcommittee meetings.

7 In any case, I thought as an initial  
8 agenda for each subcommittee, it would be to  
9 define the initial issues and scope, as we see  
10 it, of the particular area that DOL has asked us  
11 to look at.

12 Secondly, to begin to define data or  
13 information needs to understand that particular  
14 area better.

15 And thirdly, to draft an initial work  
16 plan for the committee with a timetable, so that  
17 we have some roadmap as to how that committee is  
18 proceeding.

19 And my question is, does that suffice  
20 or are there amendments to that? Or is it  
21 complete enough? It is certainly non-specific  
22 enough.

1           MEMBER SOKAS: So, I would make it a  
2 little more non-specific by saying data needs and  
3 review, and/or review.

4           CHAIR MARKOWITZ: Okay. So, we have  
5 the Committee here. We've got an agenda.

6           We've got a few minutes before 11  
7 o'clock, before our next speaker. So, I would  
8 like to return to the issue that we began to  
9 discuss yesterday about how we are going to  
10 conduct the subcommittee meetings and whether  
11 they will be open. We've learned from FACA that  
12 it's optional. We've learned from the Radiation  
13 Advisory Board this is what they have done from  
14 the beginning. We've learned from, I think, the  
15 Department of Labor that it's essentially up to  
16 us. And we also learned a little bit yesterday  
17 about what steps we have to go through in order  
18 to have a public meeting, meaning probably six  
19 weeks or so advanced notice published in the  
20 Federal Register.

21           So, it's open for discussion. I would  
22 like to, if we can get to a vote before 11:00,

1 fine; if not, we can resume this discussion. But  
2 I'd like to come back to this issue.

3 Thoughts? Dr. Welch?

4 MEMBER WELCH: I think Mark's  
5 discussion of what the Advisory Board does for  
6 radiation convinced me that -- I mean, I probably  
7 would have thought it anyway -- but I think the  
8 subcommittees should be open.

9 You know, I think that the public  
10 input, that people can listen to the conversation  
11 and then point us to things that we have missed,  
12 would be so valuable. Because, although we have  
13 representatives of the workers and the advocates  
14 on the Committee, there are so many people who  
15 have spent so long thinking about these issues, I  
16 would hate to miss some great ideas. And I think  
17 it is worth the work to make the subcommittees  
18 open.

19 CHAIR MARKOWITZ: Okay. Other  
20 comments? Okay. So, I just need a proposal  
21 here, so we can vote on it.

22 MEMBER CASSANO: I move.



1 CHAIR MARKOWITZ: Well, what do you  
2 move exactly?

3 (Laughter.)

4 MEMBER CASSANO: I move to keep the  
5 subcommittee meetings open.

6 MEMBER BODEN: Second.

7 CHAIR MARKOWITZ: Okay. That was Dr.  
8 Cassano, and there is a second by Dr. Boden.

9 Okay. So, any further discussion?  
10 All those in favor, please raise your hand.

11 (Show of hands.)

12 CHAIR MARKOWITZ: And I will, for the  
13 people on the phone, indicate that everybody has  
14 raised their hands. So, it's unanimous. Thank  
15 you very much.

16 I think we are ready, actually, to go  
17 with the next speaker a few minutes early. So,  
18 we're moving on to the second area that the  
19 Department of Labor has asked us to address.

20 While she's setting up, let me just  
21 remind the people on the phone who may not have  
22 access to this: this second area, according to

1 our charter, is we would advise the Secretary of  
2 Labor with respect to medical guidance for claims  
3 examiners for claims under this Subtitle with  
4 respect to the weighing of the medical evidence  
5 of claims.

6 We'll start up in a minute. We are  
7 just waiting for the setup.

8 It's no problem. I'm just telling the  
9 people on the phone, that's all.

10 (Pause.)

11 CHAIR MARKOWITZ: So, let me introduce  
12 Ms. Rhonda Chappelle, who's the Branch Chief of  
13 Outreach and Technical Assistance in the Division  
14 of EEOICP. Welcome.

15 MS. CHAPPELLE: Good morning.

16 MR. RIOS: Rhonda, I'm sorry. Thank  
17 you. Yes, speak all the way into the microphone.  
18 Thank you. Or get it as close to you as  
19 possible.

20 MS. CHAPPELLE: Okay. Good morning.  
21 It is a pleasure to be here to talk to you this  
22 morning about weighing medical evidence in the

1 claims process.

2 I started with the program about 10  
3 years ago as a hearing representative, and then  
4 became the Assistant Branch Chief over at the  
5 Final Adjudication Branch, and then came here to  
6 the Branch of Outreach and Technical Assistance  
7 about four years ago.

8 So the first thing I would like to  
9 talk about: there are various sources of medical  
10 evidence when we are looking in a case file. So,  
11 the first source of medical evidence, of course,  
12 is the information that comes from the claimant's  
13 healthcare provider. That will include documents  
14 from the claimant's attending physician and any  
15 other consulting experts that the attending  
16 physician referred the claimant to, as well as  
17 reports from hospitals or medical facilities  
18 where there are laboratory tests or anything like  
19 that performed.

20 The second source of medical evidence  
21 in a file would be information from the  
22 Department of Energy's medical screening

1 programs. These programs are located throughout  
2 the country. And what they do, they maintain  
3 examination records and exposure data on their  
4 employees.

5 We also have information from the Oak  
6 Ridge Institute for Science and Education, which  
7 we refer to by the acronym of ORISE. And ORISE  
8 offers extensive testing for chronic beryllium  
9 disease and monitoring for people who've been  
10 diagnosed with a positive beryllium sensitivity.

11 Then there are three other sources of  
12 medical evidence, and those are usually from the  
13 Department of Labor. And I say they are from the  
14 Department of Labor because these are provided by  
15 our contractors.

16 So, the first would be the contract  
17 medical consultants, which I will talk a little  
18 bit more in detail about a little later. We also  
19 have contracts with physicians who render second  
20 opinion evaluations. And we refer to them as  
21 SECOP. So what they do, they will actually  
22 sometimes examine the patient and review all the

1 medical records before rendering a decision.

2 Then we have the referee specialists  
3 who are also contracted by the Department of  
4 Labor. And the referee specialist is chosen to  
5 actually resolve a conflict, usually between an  
6 attending physician and another physician, either  
7 another specialty or another contract medical  
8 consultant.

9 The referee specialists are chosen  
10 according to their specialty, and they are chosen  
11 at random. And they examine the employee, or  
12 they may just review the case file.

13 So, incongruent with the sources of  
14 medical evidence, I will talk a little bit about  
15 the actual types of medical evidence. As I said,  
16 the first source of medical records are records  
17 from the employee. And those are usually the  
18 records from the employee's treating physician,  
19 the attending physician's notes, charts, various  
20 things like that from actually examining the  
21 patient.

22 The treatment records can also consist

1 of records from physicians that the attending  
2 physician consulted, or, for instance, if the  
3 employee went to have a second opinion or  
4 independent evaluation.

5 Then the treatment records also  
6 consist of diagnostic testing, such as X-rays,  
7 EKGs, any other type of test. And then the  
8 records from any hospitals or in-home healthcare  
9 that's provided to the patient.

10 A second type of medical evidence  
11 would be medical evaluations that are done for  
12 reasons other than to actually treat or diagnose  
13 the patient. So, this would include things like  
14 reports from the Department of Energy's Former  
15 Worker Program, such as pre-employment physicals  
16 or termination physical exams.

17 These would also include examinations,  
18 for instance, like from the VA if a person  
19 applied for disability benefits with Social  
20 Security or VA, those or other types of medical  
21 evidence.

22 And then the third type of medical

1 evidence would be any type of medical report that  
2 a person is instructed to undergo in regards to  
3 the litigation of maybe a state or federal case.

4 A third type of medical evidence would  
5 be reports produced in response to the Department  
6 of Labor's referral to one of our contract  
7 specialists, either to the CMC or the SECOP  
8 position or to a referee specialist.

9 Then, lastly, we have a group that we  
10 call other types of evidence. Those consist of  
11 things like the Cancer Registry records, which we  
12 can use in some cases to establish a diagnosis of  
13 cancer or the date of diagnosis of cancer.

14 Also, one of those other types are  
15 death certificates. If the death certificate is  
16 signed by a physician, we can use that  
17 information to help establish a date of diagnosis  
18 on the death certificate or even a cause of  
19 diagnosis -- cause of disease or diagnosis --  
20 cause of death. I'm sorry.

21 Then we have secondary evidence, and  
22 this would be evidence that the actual attending

1 physician relies upon. And we call it secondary  
2 because it's not evidence that the physician  
3 himself finds, but he may have referred the  
4 patient to another doctor and he's relying on  
5 that information. So, it's secondary to that  
6 particular physician.

7 And then, lastly, we can use  
8 affidavits. Usually, these are used with regard  
9 to date of diagnosis.

10 So, I'll talk about the contract  
11 medical consultant referrals that we do. Of  
12 course, the first thing that we do is rely on, as  
13 I said, the evidence that is submitted by the  
14 claimant. But we realize that oftentimes the  
15 claimant isn't able to get the type of evidence  
16 that's needed to prove his case. So, what we  
17 did, we have a contract and we implemented this  
18 as a way of helping the claimant.

19 So, what we will do, we will refer the  
20 case to either a CMC or SECOP or the medical  
21 referee as a way of helping to develop the  
22 medical evidence in the case file.



1           So, some of the ways that the contract  
2 medical consultant can assist would be confirming  
3 a medical diagnosis, by assisting with providing  
4 medical causation, and impairment evaluations can  
5 be used so they can review the records and  
6 actually give the percentage of whole-person  
7 permanent impairment. We use them in wage loss  
8 claims, and we use them in that manner to  
9 determine the onset and the period of a specific  
10 illness that's related to wage loss.

11           We also use them if we are looking for  
12 medical treatment, if a person needs in-home  
13 healthcare. If they need durable medical  
14 equipment, we can use the CMCs for that purpose.

15           If a person has a consequential  
16 illness, we can refer the case. If it it's not  
17 clear, we can have a contract medical consultant  
18 render an opinion on whether or not a condition  
19 is a consequential illness to the originally-  
20 accepted condition.

21           And then sometimes we just need the  
22 CMC to give us clarification on a specific report

1 or test result.

2 And then, again, as I said, the last  
3 one we would need, if there's a conflict in  
4 medical opinion, we can use the CMC to resolve  
5 that conflict.

6 So, developing medical evidence. The  
7 initial responsibility -- or, actually, the total  
8 responsibility for developing medical evidence  
9 lies with the Department of Labor. The  
10 claimant's responsibility is to submit medical  
11 evidence that they have in their possession and  
12 to respond to any inquiries that the claims  
13 examiner may have. If the medical evidence on  
14 file is not sufficient to establish the claim,  
15 then the claims examiner's responsibility is to  
16 develop the medical evidence.

17 So, the first thing that they will do  
18 is look in the record. They will explain to the  
19 claimant what is lacking, what the deficiencies  
20 are, why the report isn't sufficient. If they do  
21 that, then they can assist the claimant by  
22 telling the claimant exactly what is needed to

1 help support their case. Oftentimes, the claims  
2 examiner will actually communicate directly with  
3 the treating physician. If he needs to reach out  
4 to get some clarification, he can reach out to  
5 the treating physician himself.

6 And if he is unable to get the  
7 information from the claimant or either from the  
8 treating physician, then that is when the CE  
9 would refer the case to a CMC, the contract  
10 medical consultant, or either for a second  
11 opinion or referee evaluation.

12 So, I want to talk a little bit about  
13 the contents of medical reports. As you know,  
14 all medical reports aren't the same. Usually, we  
15 say a medical report has added value if it  
16 follows the SOAP acronym, and that's S-O-A-P.  
17 Okay. So, if the report contains a subjective  
18 section which uses information that is relayed to  
19 the physician by the patient -- oh, I'm sorry.  
20 Yes, it should say SOAP, S-O-A-P.

21 So, the subjective section, as I said,  
22 is what the patient is actually telling the

1 physician. For instance, a subjective section  
2 might say, "The patient comes in today to have us  
3 look at a lump on his neck that has gotten larger  
4 over the last month." So, that's strictly what  
5 the patient is relaying to the physician.

6 The second section is the objective  
7 section. That records the physician's findings  
8 based on his or her observation. So, for  
9 example, the objective section might read, "The  
10 patient's breathing is labored and his X-ray  
11 shows a spot on his left lung," because it's  
12 actually what the physician himself is seeing and  
13 observing.

14 We usually say there are three  
15 different types of objective findings. The first  
16 would be laboratory findings, such as bloodwork  
17 or a tissue biopsy or what we use, like a  
18 beryllium lymphocyte proliferation test.

19 A second type of objective finding  
20 would be diagnostic procedures such as X-rays or  
21 ultrasounds, CT scans, MRIs.

22 And then the third would be the

1 physical findings that are actually noted by the  
2 physician upon either visual inspection or  
3 manipulation of the body. So, this would include  
4 the description of the demeanor and readings of  
5 temperature, pulse rates, respiration rates,  
6 those types of things.

7 The assessment section of the medical  
8 report contains the physician's opinions,  
9 suspicions, and diagnosis, along with any medical  
10 rationale.

11 And then, finally, the plan section  
12 describes exactly what it says, the treatment  
13 plan and the prognosis. So, the physician, for  
14 example, may refer the patient for additional  
15 testing or may prescribe medication.

16 We usually say that a good medical  
17 report is one that follows the SOAP, and most  
18 medical reports do, even if they don't  
19 necessarily spell it out. Some physicians will  
20 actually put "S" and then talk about the  
21 subjective. But most of them will follow this  
22 format even if they don't specifically say it is

1 in that format.

2 So, that gets us to weighing evidence,  
3 actually weighing medical reports. Some medical  
4 reports we consider are more probative than  
5 others. We would say that a medical report  
6 that's based on an accurate and complete medical  
7 and factual background has more probative value  
8 than a report that is incomplete, that is  
9 subjective, or is based on inaccurate  
10 information.

11 For instance, if a physician knows  
12 exactly where the employee worked, knew his job  
13 duties, knew his exposures, his opinion would  
14 generally be more probative or have more  
15 probative value than a physician who didn't know  
16 all of these things. An opinion that is based on  
17 the definitive test is considered to have more  
18 probative value than one that is incomplete or  
19 subjective.

20 We use the term "rationalized  
21 opinion," and you will sometimes hear the term  
22 "reasoned" or "rationalized." That simply means

1 that the report -- that the medical findings are  
2 supported, that the report is supported by the  
3 medical findings on examination through a  
4 thorough review of the medical records, and, if  
5 appropriate, references scientific articles.

6 We need more than just an affirmation.  
7 We need an explanation of a cause and  
8 relationship of the factors to the condition  
9 and/or disability.

10 Also, the opinion of an expert is  
11 usually considered to have more probative value  
12 than an opinion of a general practitioner. So, a  
13 board certification or an appropriate field  
14 carries more weight. So, if a physician is,  
15 like, a board-certified pulmonologist, his  
16 opinion would carry more weight in terms of a  
17 lung condition than just a general practitioner  
18 or an internist.

19 Then sometimes we see medical reports  
20 that use what we call vague or speculative  
21 language. So, an opinion that is unequivocal is  
22 given more weight than one that we consider vague

1 or speculative. So if the physician's offering a  
2 clear, unequivocal opinion, it's more probative  
3 value. And when you talk about vague or  
4 speculative terms, when the physician uses terms  
5 such as "could" or "may" or "might be". You  
6 know, like you may say, "Well, it could be caused  
7 by," "It might be caused by." If he says  
8 "probably," that is a little less speculative.  
9 And if he says "medical probability," that is a  
10 little better than if a doctor just says, "Well,  
11 it's medically possible."

12 So, the ways in which we could use the  
13 Board's assistance, we outlined four different  
14 things that we could probably use your assistance  
15 with. And that would be to help us to clarify  
16 and make recommendations regarding the assessment  
17 of medical opinions. For instance, if there are  
18 some standardized triggers for requiring an  
19 independent review or the review by a second  
20 opinion specialist or a contract medical  
21 consultant.

22 Another way would be to help us with



1 the methodologies for improving physician  
2 responsiveness to data requests, including  
3 reviewing development letters, outreach efforts,  
4 and any provider communication.

5 Another way that would help would be  
6 training resources for improving the quality of  
7 the medical review of medical evidence and  
8 weighing these conflicting medical opinions.

9 And then, lastly, any application or  
10 guidance relating to assessing that standard of  
11 contribution to, or aggravation of, toxic  
12 substance exposure.

13 CHAIR MARKOWITZ: So, thank you.

14 One comment I would have is that your  
15 review addresses, really, two issues. One is,  
16 does the claimant actually have the diagnosis.  
17 Set aside what caused it, but does that person  
18 have the diagnosis? And, secondly, what that  
19 disease is caused by.

20 And so, I was unclear, frankly, from  
21 the language in the charter, whether this  
22 particular issue actually covered the issue of

1 causation, contribution, aggravation, in addition  
2 to just weighing the medical evidence about  
3 coming to the diagnosis. So, I'm glad for some  
4 clarification about that. That's useful.

5 Comments? Questions? Dr. Silver?

6 MEMBER SILVER: Thank you very much  
7 for participating. On page 5, weighing the  
8 evidence, the first bullet gives an example.

9 One physician assumes a higher level  
10 of exposure, employment, and a causation analysis  
11 than the claimant actually had. So, what's the  
12 standard of actuality? The SEM? There is so  
13 little industrial hygiene monitoring data, I  
14 could see a claimant, a patient, telling the  
15 doctor, "Doc, I was covered from head to toe.  
16 Whenever we did this certain maintenance  
17 procedure, my kids called me the snowman." And  
18 the doctor would assume high-level exposure.

19 (Laughter.)

20 MEMBER SILVER: You look at the  
21 record. That doesn't say anything about the  
22 snowman, but the doctor says, "High-level

1 exposure." What do you compare that to to arrive  
2 at actual exposure?

3 MS. LEITON: I think that that  
4 actually is -- it's a really situation, kind of.  
5 I mean, you will have claimants that will go in  
6 and say, you know, "I was covered in all these  
7 things," and the doctor will say, "Well, you said  
8 you were. So, I'm going to assume that you  
9 were."

10 We will look at the evidence and say,  
11 "Well, actually, this person was employed there  
12 for a couple of years. We don't have a lot of  
13 evidence of exposure, heavy exposure to certain  
14 toxic substances this doctor might have said."

15 What we would normally do in that  
16 circumstance, especially if it was a treating  
17 doctor, is go back and say, "Here's the evidence  
18 that we have," if we have evidence to the  
19 contrary or we have specific evidence we can  
20 share with that doctor and say, you know, "This  
21 is the amount of exposure." Because oftentimes  
22 they'll assume they worked there for 20 years,

1 when maybe they only worked there for two.

2 That's one kind of very objective thing that we  
3 can tell them that we know.

4 So, we can go back to that treating  
5 and say we do know these X, Y, Z facts. That is  
6 where either they will come back and say, "Okay,  
7 well, that changes my opinion," or they won't  
8 come back at all. And maybe at that point we  
9 will go to a CMC to say, "Well, this doctor's  
10 made these assumptions. Here's what we know.  
11 Please provide us an opinion." But we'll first  
12 go back to that doctor, if it's their treating,  
13 and provide them with more information, if we  
14 have it.

15 CHAIR MARKOWITZ: Dr. Cassano?

16 MEMBER CASSANO: Yeah, I'm still a  
17 little bit confused about how you determine that  
18 one opinion is more correct than the other. But  
19 let's say, in the medical opinion the person says  
20 a higher level of exposure. If they give you a  
21 good rationale for, not even the guy saying that  
22 "I was covered in soot from head to toe," but

1 goes and gives you references of people that  
2 worked in that same industry and indicated over a  
3 certain period of time or what the dosing was at  
4 that point, would that convince you more than the  
5 evidence that you are getting from elsewhere?

6 MS. LEITON: If a doctor is going to  
7 come back and talk to that level of detail,  
8 oftentimes you might have doctors that actually  
9 treat this on a regular basis, people in Hanford  
10 or Oak Ridge. If we have that level of  
11 information, definitely that report's going to  
12 have more probative value than somebody that has  
13 no idea or doesn't reference anything at all.

14 CHAIR MARKOWITZ: Dr. Boden?

15 MEMBER BODEN: I have a question about  
16 what medical evidence means in this context. So,  
17 it seems to me that, in order to make causation  
18 decisions, you need evidence about employment,  
19 exposure, and then the kind of stuff that doctors  
20 normally do; that is, diagnosis.

21 Are we considering all three of those  
22 as being part of medical evidence? I think so,

1 but I just wanted a clarification on that.

2 Because if a doctor gives a report, presumably,  
3 he'll have to talk about all those things.

4 MS. LEITON: That's what we would hope  
5 out of an ideal report, is that the doctor would  
6 have those three elements in their reports. And  
7 if they don't, that's when we would usually go  
8 back and do something about it.

9 MEMBER BODEN: And there is something  
10 else that we haven't talked about yet, that,  
11 presumably, you need a doctor's input in also.  
12 And that's impairment. And so I'm wondering how  
13 you currently get the AMA guide's impairment  
14 information from physicians. I mean, most  
15 physicians don't use the AMA guides, haven't  
16 really been trained to use the AMA guides, and,  
17 also, may have to perform tests that wouldn't  
18 normally be covered by diagnosis or treatment of  
19 disease. And I'm wondering how those tests get  
20 paid for.

21 MS. LEITON: Okay. So, when an  
22 individual claimant files for impairment, they

1 have to make a choice. First, they make a choice  
2 whether they want this impairment rating to be  
3 done by a physician of their choosing, or whether  
4 they want us to have a contract medical  
5 consultant who has been trained in the guides to  
6 conduct it.

7 The first thing, if they choose their  
8 own treating doctor, is we just require that the  
9 doctor certify that they have knowledge of and  
10 experience with the guides or they have some sort  
11 of ABIME certification or AADEP certification.  
12 So, that's what we first ask.

13 And in some cases we already know  
14 which doctors have that. So, we don't keep  
15 asking it every time. And so those doctors that  
16 they're going to choose, they're going to have  
17 the knowledge to use the guides.

18 If they don't choose to do that, or  
19 they can't find a doctor in their area, we'll  
20 have the CMC do it. If we do, then we request  
21 certain -- there are certain tests, like,  
22 depending on the condition they are claiming, if

1 it is a lung condition, we are going to require  
2 them to have recent PFTs within the last year.  
3 And there are certain other tests that we outline  
4 for each condition that they are claiming. But  
5 then they would submit those results to our CMC  
6 who can evaluate them. And if additional  
7 information were to be required, that CMC would  
8 reach back out.

9 MEMBER BODEN: And if their insurance  
10 coverage doesn't pay for those tests, who would  
11 pay for them?

12 MS. LEITON: We pay for those.

13 MEMBER BODEN: Okay. Thank you.

14 CHAIR MARKOWITZ: Dr. Sokas?

15 MEMBER SOKAS: So, just clarification  
16 on that last, you only get to the limitations  
17 evaluation once you have been accepted, right?

18 MS. LEITON: Yes.

19 MEMBER SOKAS: My comment is really  
20 just a comment. It's, when I look at the  
21 language, I mean, physicians are actively taught  
22 in school to couch their language as "this person



1 may have lost their life due to" or their limb  
2 due to the earthquake that just happened. You  
3 know, so there is this -- I mean, I'm  
4 exaggerating -- but there is this presupposition  
5 in scientific research that there's always more  
6 information out there. And so you always couch  
7 it that way.

8           So, that's a little concerning, that  
9 that language would be a flag, as opposed to  
10 definitive, because, actually, people are taught  
11 that you are not supposed to come to premature  
12 conclusions. And so it's actually in conflict  
13 with the way many people are trained.

14           And in truth, I mean, a lot of the  
15 questions you have about getting good  
16 information, getting people to answer your phone  
17 calls, getting like all of this, it's like,  
18 golly, if we could figure that out, we would be  
19 in -- you know, it's a real hard nut to crack, as  
20 I'm sure you know. But that last bullet was a  
21 little concerning.

22           CHAIR MARKOWITZ: Dr. Friedman-

1 Jimenez?

2 MEMBER FRIEDMAN-JIMENEZ: Yeah, I want  
3 to agree with what Rosie just said. Having  
4 taught clinical epidemiology of diagnostic  
5 testing for 20 years in the medical school, we  
6 really focus on probabilistic diagnosis. And  
7 even in mainstream medicine, it's not that common  
8 that you get an unequivocal diagnosis or a  
9 definitive test or what we would consider  
10 completely accurate. In occupational medicine,  
11 there's less evidence available. And so we're  
12 even farther from these ideals.

13 So, I agree that setting ideals as the  
14 standard to be reached, it's not often going to  
15 be reached. In fact, I would expect diagnoses to  
16 be couched with words like "probably" or  
17 "possibly," and those subjective, non-  
18 quantitative terms are about all that we have,  
19 because we often don't have exact predictive  
20 values for specific tests, especially for  
21 causation. So, I think you're setting the  
22 standard a little high for your ideal situation.

1 CHAIR MARKOWITZ: Dr. Welch?

2 MEMBER WELCH: I have two comments,  
3 one of which is, I disagree with both of you  
4 guys, because I actually think they need  
5 something they can hang their hat on. And the  
6 language that the physician has to use is a  
7 little cumbersome, but it's not more likely than  
8 not. So that if we figure out a way during this  
9 process to let the examining physicians know that  
10 they basically have to say that the exposure was  
11 a substantial factor, as opposed to causative, I  
12 think that's enough of a "may." But it's a  
13 question of how to get that into the language. I  
14 mean, many treating physicians are not  
15 comfortable making a causation statement at all.  
16 So, that's a different question.

17 But the question I had put my flag up  
18 for was really now I think there is a lot of  
19 overlap between these task and No. 4, because so  
20 much of the weighing the medical evidence is  
21 using consulting medical physicians, consulting  
22 contract, the CMCs. I always forget what that

1 stands for, consulting medical consultants? I  
2 don't know.

3 (Laughter.)

4 MEMBER WELCH: Contract medical  
5 consultants. Okay, I finally got it.

6 And I don't know if we want to combine  
7 the two. We should probably think about that as  
8 a group, because there is the process of getting  
9 the diagnosis, and then there is the process of  
10 making the causation statement. I'm not sure  
11 that getting the diagnosis is all that hard for  
12 you guys.

13 But if you can't, I mean, it's really  
14 whether there are records or not, not so much how  
15 you necessarily weigh the records. I would  
16 imagine it's generally -- and it's easier to get  
17 physicians to make a statement about diagnosis  
18 that seems probative or definitive.

19 But, anyway, just at a point, and  
20 maybe some guidance from those of you who came up  
21 with those four tasks, is there a way --  
22 Congress?

1 (Laughter.)

2 MEMBER WELCH: But probably just some  
3 advice from within. You know, we're supposed to  
4 be doing what you guys need us to do.

5 MS. LEITON: Yeah. No, I appreciate  
6 that. What we will probably do is check with our  
7 lawyers to see if there are some distinguishing  
8 factors between the third and the fourth items,  
9 to just give you guys some clarification.

10 CHAIR MARKOWITZ: Do you want to  
11 respond? Dr. Sokas?

12 MEMBER SOKAS: Yeah. So, I mean, when  
13 I saw the title of "weighing the evidence,"  
14 again, it's, I think, what you said earlier. I  
15 assumed that it was going to be something totally  
16 different.

17 I mean, what you're saying is, how do  
18 you evaluate the way the medical people write the  
19 information? The weight of evidence that we  
20 talked about in the earlier committee was quite  
21 different. It was whether this toxic exposure  
22 causes this health outcome with what level of

1 reasonable possibility or probability. And I  
2 don't know if that question is getting addressed  
3 in the first working group with the SEM. It may  
4 not be.

5 And that's actually a question -- I  
6 would go back to, what did Congress mean then? I  
7 mean, did they mean what you are describing, or  
8 did they mean what the IOM meant when it was  
9 talking about weight-of-evidence discussion? And  
10 I don't know who wants to take that one.

11 CHAIR MARKOWITZ: If you want to  
12 respond, Dr. Welch, and then we'll move on.

13 MEMBER WELCH: Well, just that, in the  
14 end, what this program is doing is making a  
15 decision of whether to compensate somebody for a  
16 toxic exposure. So, it would seem that that  
17 question of causation would be something within  
18 the purview of this Board. And if we were to  
19 interpret each of the questions to exclude that,  
20 then maybe we're not going to be that valuable.

21 So, I think that either No. 2 or No.  
22 4 has to address that question of how the system

1 is using all its available information to come to  
2 a causation decision, in my opinion.

3 MS. LEITON: Right, and I think 4  
4 could do that.

5 CHAIR MARKOWITZ: Well, Steve  
6 Markowitz.

7 I agree that causation, contribution,  
8 aggravation has to be at the heart of what the  
9 Board does, because that's the most problematic,  
10 difficult issue to address, and probably much of  
11 what we have to offer, actually.

12 And I think weight of evidence means  
13 different things in different contexts. In the  
14 IOM report, it had to do with, you know, how do  
15 you approach the issue of causal criteria? But  
16 it means different things in terms of reviewing  
17 medical records and deciding what diagnosis  
18 people have.

19 But, Dr. Cassano?

20 MEMBER CASSANO: Tori Cassano again.

21 Laurie basically said most of what I  
22 wanted to say about having those specifics. When

1 you look at a claim, that is exactly what you  
2 see. But I also agree that most treating  
3 physicians don't know how to do that and they're  
4 uncomfortable doing it.

5 So, if the claimant is given some  
6 information and is told, "Hey, when you go to  
7 your treating physician, see if they can write  
8 these statements at less than likely, at least as  
9 likely as not," et cetera, as aggravating,  
10 causative, et cetera, et cetera, et cetera, that  
11 would be very helpful in setting that treating  
12 physician up. And if you can't do it, then you  
13 have to go to a CMC. But some might actually  
14 want to do the research and look at it.

15 CHAIR MARKOWITZ: Dr. Boden? Oh,  
16 yeah, sure. Oh, I'm sorry. Let me say that most  
17 people are putting their name placards upright to  
18 indicate.

19 MEMBER REDLICH: Mine is on the floor.

20 (Laughter.)

21 CHAIR MARKOWITZ: Okay. It's on the  
22 floor, but it is upright. So, I missed that.



1 (Laughter.)

2 CHAIR MARKOWITZ: I'm sorry about  
3 that.

4 MEMBER REDLICH: I think I had a  
5 related question that I think you were about to  
6 answer. So, maybe you should respond.

7 MS. CHAPPELLE: Actually, that's what  
8 I was going to say. When we talked about the  
9 Department of Labor having the responsibility of  
10 developing the medical evidence, we said that the  
11 claims examiner will often reach out to the  
12 claimant and explain the deficiencies and what is  
13 needed in the medical report. And sometimes if  
14 the claimant cannot adequately convey that to the  
15 physician, then the claims examiner will call the  
16 physician himself, call the treating physician,  
17 to try to clarify and explain what it is that we  
18 need.

19 And we do recognize that, you're  
20 right, most physicians are taught that they don't  
21 want to come out and say, "Well, this is 100  
22 percent caused by," you know, working at a

1 particular place. So, that's why we do use those  
2 terms like "probably" as opposed to "possibly".  
3 And, again, using the standard of the "at least  
4 as likely as not," and did it contribute to or  
5 did it aggravate? And it doesn't have to be a  
6 specific, medically-caused condition.

7 CHAIR MARKOWITZ: I have a question,  
8 actually. So, I co-direct one of the former  
9 worker medical screening programs. And we've  
10 done thousands of exams. And we don't routinely  
11 -- we rarely get requests, actually, for our  
12 report, our medical reports that we issue. Is  
13 that because it's up to the claimants to bring in  
14 the report that we give to them to the claims  
15 process? Meaning the claimant has to initiate,  
16 essentially, that transfer. It just doesn't  
17 seem, at least in our program, it's routinely  
18 done. I don't know about the other former worker  
19 programs. But we almost never get requests from  
20 DOL for these reports.

21 MS. LEITON: Usually, when we ask for  
22 DAR records from the Department of Energy, the

1 former worker programs screening or those reports  
2 would be included. Oftentimes, they are  
3 included. At least that's our assumption.

4 CHAIR MARKOWITZ: Let me clarify. So,  
5 these are the reports that we --

6 MS. LEITON: Okay. Well, that's --

7 MS. CHAPPELLE: You know, from our  
8 program, it's my understanding that the worker  
9 takes the letter to the resource center. And  
10 that is usually the basis of them filing a claim.  
11 But I don't know that it --

12 CHAIR MARKOWITZ: Right. Yeah, just  
13 to clarify, the Department of Energy wouldn't  
14 have our reports, just because these are  
15 individual personal medical records. The only  
16 person who gets them is the individual and their  
17 physician, if the individual requests it. So,  
18 those are the only parties who have it. So, I  
19 understand, it's up to the claimant --

20 MS. LEITON: Yeah, so I was  
21 misinformed. I was thinking about DAR records,  
22 and they mentioned former worker program, but I

1 think that's a different piece of the former  
2 worker program that we get automatically. So, it  
3 would be required that the claimant themselves  
4 provide us with that.

5 CHAIR MARKOWITZ: Thank you. Ms.  
6 Vlieger?

7 MS. CHAPPELLE: I mean, we do see a  
8 lot of them in the case files. So, perhaps the  
9 claimant is bringing them in, because there are a  
10 lot of them in the case files that I've reviewed.

11 CHAIR MARKOWITZ: I'm glad they end up  
12 there, actually.

13 (Laughter.)

14 MS. CHAPPELLE: Yes.

15 CHAIR MARKOWITZ: Ms. Vlieger?

16 MEMBER VLIEGER: So, a couple of  
17 things. I've read a lot of the claimants'  
18 records. I talk with a lot of the claimants.  
19 And many times, when those reports from the  
20 former worker program are presented, the claimant  
21 is told, "This will not be accepted as primary  
22 evidence. You must get a specialist of the

1 appropriate system or body part to opine on  
2 this."

3 So, then we run into the problem,  
4 particularly with the few number of specialists  
5 that will even talk to you for this program, we  
6 run into the issue of not having adequate medical  
7 insurance for the tests that are required.

8 And then, if you find a specialist who  
9 is willing to do this, the proximity to the  
10 worker is usually not there. So, the whole  
11 concept of saying that you are accepting the  
12 former worker records, I find to not be factual  
13 in all cases, or at least in the majority that I  
14 have seen.

15 I guess I go back to in our briefing  
16 book this page on weighing evidence. Did this  
17 come as kind of a mutation from FECA or another  
18 program? What is the basis for these  
19 presumptions of what evidence is adequate?

20 MS. LEITON: We do weigh medical  
21 evidence at all four of our -- or at least three  
22 of our Office of Workers' Compensation programs.

1 And so, yes, a lot of that language comes from  
2 the years, the hundred years of experience we  
3 have had in OWCP with evaluating medical evidence  
4 and weighing medical evidence. And that's where  
5 a lot of these standards came from.

6 CHAIR MARKOWITZ: Ms. Pope?

7 MEMBER POPE: Duronda Pope. I was  
8 just trying to envision the claimant submitting  
9 this information to their physician, their  
10 treating physician, and then how that claim --  
11 the CE calling the physician and asking them,  
12 "Did you mean, when you wrote down this  
13 diagnosis, did you mean this?" And do they say,  
14 "Well, you need to put this information in"?

15 MS. CHAPPELLE: I don't think it works  
16 exactly that way. The idea is that the claimant,  
17 the CE is advising the claimant what they need to  
18 prove their case, the type of medical evidence  
19 that is needed, and if they have medical  
20 evidence, for instance, they will tell them, you  
21 know, "Well, your doctor needs to at least render  
22 an opinion whether or not it is possible," or not

1 possible, "it's probably or at least as likely as  
2 not that your condition is related."

3 The CE can call the treating physician  
4 if the claimant is having a difficult time  
5 getting the medical evidence that is necessary.  
6 They don't always do that. That is why sometimes  
7 they may, and then, sometimes it is just easier  
8 to refer them to the contract medical consultant  
9 to have them to review all of the medical  
10 information that the claimant already has and  
11 then render an opinion.

12 CHAIR MARKOWITZ: Dr. Boden?

13 MEMBER BODEN: So, the way this is  
14 focused is you've got these different pieces of  
15 medical evidence and you need to figure out how  
16 to weigh them. But there is, I think, another  
17 way of thinking about the issue of weighing the  
18 medical evidence, which is providing a framework  
19 for the evidence that you get.

20 So, we have talked a little bit about  
21 the idea of possibly developing presumptions for  
22 certain cases. In fact, I think you have

1 developed some of them. Well, that is a way of  
2 -- a presumption can, also, then, be provided to  
3 the physician who is treating the person as a way  
4 of telling them what you need from them to  
5 fulfill your needs for the causation, right?

6 And there are other things that I  
7 think we can probably think about that would help  
8 the Department of Labor process the evidence that  
9 they are getting. For example, providing the  
10 treating physicians with words that, if they use  
11 them, won't be helpful and words that, if they  
12 use them, will be helpful.

13 Unless somebody is a professional who  
14 does a lot of workers' compensation cases, they  
15 are not going to know that they need to use these  
16 kinds of words in order to get the response that  
17 they think they are going to get for their  
18 patient.

19 So, I think that, as part of this, we  
20 want to think about things that your organization  
21 can do to help you get the evidence that you can  
22 weigh appropriately, and not just passively take



1 in the evidence and, then, try to figure out what  
2 it means.

3 CHAIR MARKOWITZ: Dr. Welch?

4 MEMBER WELCH: I just wanted to have  
5 you guys clarify that, if a treating physician  
6 doesn't provide a causation statement, then the  
7 claims examiner can weigh the evidence and  
8 potentially make a decision him or herself or use  
9 the consultants? So, getting the information  
10 from the treating physician is not necessarily an  
11 impediment to the claim. It might make it easier  
12 because, then, you don't have to go out to your  
13 outside consultants. But you wouldn't turn down  
14 a claim because you can't get the physician to  
15 give a causation opinion, if you have got the  
16 diagnostic information?

17 MS. LEITON: It depends on what we  
18 have in the case file. If we don't have any  
19 information at all that would lead to any  
20 suggestion of causation, there was a limited  
21 amount of exposure, the doctor really might have  
22 said something else like "I believe that this is

1 related to" X, Y, and Z "that isn't related to  
2 this," sometimes the word "idiopathic" is an  
3 indication; we will follow up on it.

4 I am not going to tell you that we are  
5 not going to deny cases if we don't get enough  
6 something at the beginning to lead us in the next  
7 direction. But we will, if there is some  
8 indication there might be a causation link  
9 anywhere in the case, if we can't get it from the  
10 treating, we will go to a CMC.

11 CHAIR MARKOWITZ: Dr. Redlich?

12 MEMBER REDLICH: Just a related  
13 question. So, this back-and-forth that might go  
14 on between the claims administrator and a  
15 physician, is there a standard, templated letter  
16 or wording that is used? Because the way the  
17 question is framed can very much determine.  
18 Like, "Do you think that this was caused by...,"  
19 or "Do you think that there was a contributing  
20 factor?"

21 I'm just curious, because the doc is  
22 likely to get a standard letter that says, you

1 know, "Your patient has applied for" X. "We  
2 would like your opinion on...," and how it is  
3 actually worded. Or is this more verbal? If it  
4 is written, if there is an example of it --

5 MS. CHAPPELLE: We do have, when a  
6 case first comes in and when a claimant first  
7 files the claim, a development letter is sent to  
8 the claimant, and it will talk about the  
9 employment evidence that is needed, the medical  
10 evidence that is needed. And so, that kind of  
11 lays out exactly what is needed and it will talk  
12 about causation.

13 MS. LEITON: We do. We have given  
14 them examples on many occasions of, "Ask the  
15 doctor, is it at least as likely as not a  
16 significant factor in causing, contributing to,  
17 or aggravating?" That is language we use in our  
18 development letters. Sometimes that is to the  
19 claimant, but sometimes it is in a letter to the  
20 doctor where we say, "We understand you are the  
21 treating physician. Here's what we need in this  
22 case, and here's the question that we need

1 answered." We will send that out.

2 When you say "templates," I mean, we  
3 do try to cater our letters to the case at hand.  
4 So, I don't have like a form letter that we send  
5 out to them, but we do send out those letters.  
6 Our procedures lay out that we are supposed to be  
7 asking those sorts of questions.

8 CHAIR MARKOWITZ: Dr. Welch? No?  
9 You're done? That's good.

10 And Dr. Boden is done. That leaves  
11 Dr. Silver.

12 MEMBER SILVER: Do you have any  
13 success stories of specialists or GPs who don't  
14 have a lot of training in occupational medicine?  
15 A typical scenario around one of these DOE sites  
16 is a worker goes to see an oncologist, the best  
17 in the region. And the oncologist takes off  
18 their glasses, puts their pen down, and says,  
19 "You're from" fill in the blank, Los Alamos.  
20 "You are the fifth person I've seen. This is  
21 work-related."

22 A few weeks or months later, they ask

1 the doctor for a letter for this program.

2 Frankly, the letter stinks.

3 (Laughter.)

4 MEMBER SILVER: Have you cultivated  
5 anyone like that who is not an occ doc and  
6 brought them along and taught them how to be  
7 helpful, and now might be helpful to the medical  
8 community saying, "Hey, it's easy. I learned how  
9 to do it."?

10 MS. LEITON: Actually, I think that,  
11 since we are not located locally, I believe that  
12 some of the advocates have been able to cultivate  
13 those relationships with the physicians to help  
14 them understand what is needed and provide us  
15 with the evidence that we need. Also, we have  
16 authorized reps. We have attorneys that have  
17 done that and cultivated those relationships, and  
18 have been able to get, frankly, you know, some of  
19 these doctors who understand the program. And  
20 that happens.

21 MEMBER SILVER: I have worked with  
22 primary care folks in Tennessee. There isn't an

1       occ doc for miles around, at least not one who  
2       workers could trust. There are some who come to  
3       Tennessee periodically, but on a day-to-day basis  
4       I am thinking of a peer education approach.

5                 The primary care or rural  
6       practitioners talk to occ docs, and they get kind  
7       of overwhelmed with everything they ought to be  
8       doing. But from oncologist to oncologist or  
9       primary care doc to primary care doc, it might be  
10      easier to spread the word of how to get these  
11      cases done.

12                MS. CHAPPELLE: One of the things that  
13      we have done, we started back in 2012, was trying  
14      to reach out to the medical community, to  
15      physicians, to educate them. For instance, we  
16      went out to Shiprock and met with the hospital  
17      staff there to talk about things that we needed,  
18      because that is a very small and closed  
19      community. So, we talked about what it is that  
20      we need in terms of medical evidence, medical  
21      reports.

22                And we have been trying to expand that

1 throughout, and we have had several outreach  
2 events that we have focused on the physicians,  
3 trying to educate them and let them know what it  
4 is that we need.

5 We have what we call an email  
6 subscription medical blast that we send out  
7 monthly that we will take a specific topic and we  
8 talk about it. So, we have some various things,  
9 and we are always open to other ideas in terms of  
10 trying to reach the medical community, because  
11 that is one of the difficult things because they  
12 are busy. And so, just trying to get them and  
13 get them engaged, to let them know what we need  
14 and what would be helpful to the claimants.

15 CHAIR MARKOWITZ: So, I see there are  
16 a couple of more questions. But let me just ask  
17 whether, after lunch at 12:45, Ms. Chappelle and  
18 Ms. Leiton, are you available to return in case  
19 there are additional questions?

20 MS. LEITON: Sure.

21 CHAIR MARKOWITZ: Okay. So, that  
22 should relieve some of the pressure.

1                   Dr. Cassano, the last question before  
2 lunch.

3                   MEMBER CASSANO: I am still a little  
4 bit confused between what you stated about the  
5 development letter and the fact that you are very  
6 specific about the language that is needed by the  
7 physician. And then, what you said when you  
8 stated, "Well, we explain the deficiencies, and  
9 if the claimant can't still explain to the doc,"  
10 and I don't understand that piece.

11                   If you have gotten something that has  
12 been written out very specifically as to what is  
13 needed, and if you have explained the  
14 deficiencies in a letter, rather than a phone  
15 call to the claimant, why there is this seemingly  
16 disconnect between what is said to the claimant  
17 or written to the claimant? I mean, most of the  
18 time, the claimant just brings that letter from  
19 the agency to their doc and says, "This is what  
20 you have to do." So, I don't understand the  
21 disconnect.

22                   MS. LEITON: Usually, that is the



1 case, you're right. A letter that we send to the  
2 claimant saying, "This is the medical evidence we  
3 need." They will take it to their physician.

4 You know, in some cases, the claimant  
5 might not take it to their physician, and the  
6 physician, therefore, never got this information.  
7 We may follow up then and either write to the  
8 doctor, forward the letter to the doctor, or call  
9 the doctor.

10 MEMBER CASSANO: Okay.

11 CHAIR MARKOWITZ: Okay. Thank you.

12 Thank you.

13 It is 11:45. We are going to break  
14 for lunch. We will be back at 12:45.

15 (Whereupon, the above-entitled matter  
16 went off the record at 11:45 a.m. and resumed at  
17 12:56 p.m.)

18 CHAIR MARKOWITZ: We are going to get  
19 started. It's five of 1:00. We are missing one  
20 member, two members. I'm sorry. Three members.  
21 But let's get started anyway.

22 So, we are discussing weighing medical

1 evidence. We have another 35 minutes, actually,  
2 to ask questions or make comments, have  
3 discussion.

4 Anybody have anything they wanted to  
5 raise?

6 (No response.)

7 CHAIR MARKOWITZ: So, I can start off.  
8 I tend to ask "how frequently" questions, like  
9 how frequently does this occur, does that occur.  
10 I appreciate that that is not necessarily known  
11 or looked at.

12 But I am interested in the use not  
13 just of the contract medical physicians, but the  
14 second-opinion physicians and the referee  
15 specialists. So, the second-opinion physicians,  
16 how often do you use them? Under what  
17 circumstances do you use them? It is just not  
18 clear to me.

19 MS. LEITON: This is Rachel. So, we  
20 use the CMCs a lot more. I don't have numbers  
21 for you right now. We might be able to get those  
22 figures for you. But we use the CMCs a lot more

1 because there are more things that we will refer  
2 to a CMC. That would be like diagnoses and  
3 impairment and clarification on causation, things  
4 like that.

5 We go to a second opinion only when we  
6 really feel a physical examination is necessary.  
7 So, for example, there is a need for home  
8 healthcare, for example, and the treating hasn't  
9 really given us enough information to go by, but  
10 we know that we can't have a CMC evaluate a  
11 patient on an issue like that because they really  
12 need to see the patient to know what is going on  
13 with them. So, we will refer it to a second  
14 opinion if we feel it is necessary at that point.  
15 But it is rare that will go to a second opinion.

16 We will go to a referee when there is  
17 a conflict, only when there is a conflict in the  
18 evidence. So, let's say we have a treating  
19 doctor saying one thing, we have a second opinion  
20 saying another thing, and we might need to refer  
21 the claimant to another, a third independent  
22 doctor who looks at everything, looks at the

1 patient, and provides us with another opinion.  
2 And we can weigh the medical evidence between  
3 those three at that point. So, a referee is even  
4 more there than a second opinion, but it is  
5 occasionally something that we do.

6 CHAIR MARKOWITZ: And is the issue of  
7 causation, aggravation, contribution, is that a  
8 main reason for using second opinions or  
9 referees? Or is it more diagnosis and  
10 impairment?

11 MS. LEITON: So, I would say second-  
12 opinion referees are rarely used for those  
13 purposes. I mean, I would say probably  
14 aggravation/causation might be a second opinion,  
15 but the CMCs are usually used more for all those  
16 purposes.

17 But the impairment, we do have a lot  
18 of referrals for impairment because there aren't  
19 a lot of doctors out there that do impairments on  
20 their own or are qualified to do them. So, a lot  
21 of our claimants will opt to get a CMC to do  
22 impairment ratings. And so, a lot of our

1 business is there.

2 But, again, I don't have the  
3 specifics. I might be able to break out the  
4 reasons for all that. That would have to be  
5 something I would look into.

6 CHAIR MARKOWITZ: Dr. Friedman-  
7 Jimenez?

8 MEMBER FRIEDMAN-JIMENEZ: I have one  
9 concern. I think between probably five or six of  
10 us we have spent over 100 physician-years trying  
11 to teach doctors how to diagnose occupational  
12 diseases. And it is very difficult. I think  
13 everyone would agree with me it is very  
14 difficult, and the vast majority of physicians  
15 are not trained in any way to make causation  
16 judgments.

17 And the boards in internal medicine,  
18 in pulmonary, I don't think there are ever any  
19 questions on causation. And so, I think that the  
20 emphasis on board certification may not be in the  
21 claimant's favor because that doesn't in any way  
22 ensure that those physicians have the proper

1 knowledge and skills to make these judgments.

2           There are several specialties that do  
3 get trained in that. Occupational medicine is  
4 probably the main one, and I think there probably  
5 should be more emphasis on using people that have  
6 specific formal training in toxicology,  
7 epidemiology, and judgment of causation,  
8 epidemiology and biostatistics, as well as just  
9 the experience doing it. So, that is my concern  
10 about the language here in terms of weighing the  
11 evidence.

12           MS. LEITON: I understand your  
13 concern. It is really a challenge for us because  
14 there aren't a lot of people with those  
15 specialties. So, if we don't go to the treating  
16 doctor, you know -- and when you say "board-  
17 certified," I mean, most of them are board-  
18 certified, depending on the specialty, whatever.

19           I think that, as I said, our first  
20 avenue is going to go to a treating because the  
21 claimant chose that doctor to be their doctor or  
22 they have been treating them for a long time.

1 And so, our first avenue would be we want to  
2 allow them to go to that doctor if that is who  
3 they want to go to, instead of saying, "Well,  
4 we're going to ignore your doctor altogether and  
5 we are just going to go to an occ med doctor that  
6 we have contracted with."

7 That is where it gets a little tricky  
8 for us because we don't want to say, "Well, your  
9 medical evidence isn't good enough because your  
10 doctor isn't trained in doing this." So, that is  
11 where our balancing-act hat is with all that.

12 I don't know if that answers your  
13 question, but that is kind of where we are.

14 CHAIR MARKOWITZ: Dr. Cassano?

15 MEMBER CASSANO: Sort of along those  
16 lines, though, what is the expertise of your  
17 contract medical consultants? Are you going to  
18 those who are boarded in the particular body part  
19 specialty or disease specialty? Or you are going  
20 to people like occupational physicians that have  
21 more broad understanding of cause/effect?

22 MS. LEITON: The majority of our

1 contractors are occ med doctors, but there are  
2 questions that we have sometimes with regard to a  
3 cancer diagnosis or a pulmonary condition, CBD  
4 issues, that aren't necessarily about causation.  
5 And so, we will go to a specialist for those  
6 questions.

7 CHAIR MARKOWITZ: Other questions or  
8 comments?

9 (No response.)

10 CHAIR MARKOWITZ: So, thank you to Ms.  
11 Chappelle and, also, Ms. Leiton on this issue.

12 We need to form a Committee. There  
13 was, I think, some discussion about whether there  
14 was a lot of overlap between this task and the  
15 fourth task on our list. Maybe we should discuss  
16 that for a moment to try to clarify. My  
17 preference, I think, is to try to keep two  
18 separate Subcommittees, so at least we can make  
19 sure at the end of the day we actually respond to  
20 DOL's requests of us.

21 But the one we are discussing now is  
22 medical guidance for claims examiners for claims



1 under this Subtitle with respect to the weighing  
2 of the medical evidence of claimants. And the  
3 fourth task is, quote, "The work of industrial  
4 hygienists and staff physicians and consulting  
5 physicians of the Department and reports of such  
6 hygienists and physicians to ensure quality,  
7 objectivity, and consistency."

8 I see No. 4 as really focusing on the  
9 use of experts and how they operate, how their  
10 opinions enter the process, how their opinions  
11 are relied upon in the process, and specifically  
12 looking at the validity of their work,  
13 objectivity, and consistency. So, that is pretty  
14 easy for us to at least identify, not easy to do,  
15 but easy to identify as a relatively specific  
16 thing to look at.

17 Whereas, this Item No. 2, looking at  
18 providing medical guidance for claims examiners,  
19 weighing the medical evidence, is a broader issue  
20 into which the industrial hygiene and the  
21 occupational or the contract medical physicians,  
22 whatever, that is a subset. That is a piece of

1 the weighing of the medical evidence, as defined  
2 here, "medical evidence" meaning not just  
3 addressing diagnosis, but also aggravation,  
4 contribution, and causation.

5 So, thoughts about that?

6 Ken?

7 MEMBER SILVER: I think the intuitive  
8 appeal of combining them is that we spent time  
9 this morning discussing the Site Exposure Matrix  
10 and Haz-Map which not entirely, but they kind of  
11 smack of general causation. Can X cause Y on a  
12 hypothetical worker who was exposed to X?  
13 Whereas, B and C are more specific causation.  
14 Does DOL in deciding in a particular case? That  
15 is just my intuition on why B and D tend to fit  
16 together.

17 CHAIR MARKOWITZ: Dr. Cassano?

18 MEMBER CASSANO: I think there is some  
19 overlap in those two, as I think I said to you  
20 earlier, between 2 and 4. But I also see them as  
21 more distinct tasks. As you just said, I think 2  
22 is a little bit broader in that we are focusing

1 more on the claims examiner and how they should  
2 be looking at the evidence and what that evidence  
3 should be. And I think No. 4 is more about where  
4 should some experts be inserted into this system.

5 I think maybe there is a way,  
6 obviously, to keep the two Committees separate,  
7 but even before it gets to the -- and I don't  
8 know if this is allowed -- but even before those  
9 two Committees report to the main Committee,  
10 maybe they deconflict or combine their  
11 recommendations or not and, then, move it  
12 forward, because there is some overlap between  
13 the two.

14 CHAIR MARKOWITZ: Other thoughts?  
15 Comments?

16 Dr. Redlich?

17 MEMBER REDLICH: Well, it just seems  
18 that these two activities are so intertwined, but  
19 I am not sure it would either create more work or  
20 it seems to me that putting them together might  
21 make more sense. I mean, I realize that they are  
22 separate, but they are so dependent on each other

1 and the information that exists. Maybe after we  
2 learn more about everything, we would at that  
3 point decide that there was a need for a smaller  
4 group to work on a specific area. But I feel  
5 like at least it would be premature.

6 CHAIR MARKOWITZ: Dr. Welch?

7 MEMBER WELCH: I think I might, even  
8 though I was the one who suggested combining  
9 them, I might say keep them separate and then see  
10 if they come together. Because there are many  
11 different steps in the process from when the  
12 medical diagnosis information starts to come in  
13 to when the final adjudication is made. If one  
14 group starts with the role of the experts and  
15 kind of moves backwards, and one starts with the  
16 medical information coming in and moves forwards,  
17 you come together where it overlaps. I think it  
18 would make sure that everything is getting  
19 covered to keep it in two different groups,  
20 because there are so many pieces in there.

21 MEMBER REDLICH: Well, assume there  
22 will be fewer pieces when we are done.

1 (Laughter.)

2 MEMBER WELCH: Well, or more ways to  
3 move quickly through some parts of it anyway.

4 CHAIR MARKOWITZ: Dr. Friedman-  
5 Jimenez?

6 MEMBER FRIEDMAN-JIMENEZ: I think the  
7 unifying theme here is judgment of causation,  
8 causation used in its broader meaning to include  
9 aggravation, contributing to, and what is usually  
10 thought of as cause. And then, the two subsets  
11 of this are as done by the treating physician,  
12 medical practitioners, consultants, and as done  
13 by the claims examiners, which the logic is  
14 similar, but they are somewhat different  
15 processes because there are different information  
16 sets available to them.

17 So, you might think about structuring  
18 the Committees both around the concept of  
19 judgment of causation, but one focusing on the  
20 claims examiners and one focusing on the treating  
21 physicians and consultants.

22 CHAIR MARKOWITZ: Comments?

1 I agree with you George, that both  
2 areas have to address/include aggravation,  
3 contribution, and causation. My feeling about  
4 Task No. 4 is that that group is likely to zero-  
5 in on the experts; whereas, No. 2 is larger and  
6 looks at how the claims examiner is going to use  
7 that expert information, and how it is integrated  
8 with SEM or with other information.

9 Many of us, being experts, will zero-  
10 in on what is easy for us, which is the  
11 expertise, right, and then, neglect the process.  
12 That is the reason I would like to at least start  
13 with two separate Committees, to make sure that  
14 the larger process gets sufficient attention.

15 Ms. Vlieger?

16 MEMBER VLIEGER: I agree with you, Dr.  
17 Markowitz, it needs to be two separate areas. We  
18 are dealing with a set of lay people who do not  
19 have medical expertise, and we need to provide  
20 them the guidance of how to review the things,  
21 what is important and what is not. Because what  
22 is important to one claims examiner may not

1 actually seem important to another claims  
2 examiner.

3 And this is not just in reviewing the  
4 medical evidence, but it is the evidence of the  
5 file that is provided to them from the Document  
6 Acquisition Request, called the DAR, and from  
7 their records that they provide of their own work  
8 experience.

9 So, I think the guidance to the claims  
10 examiners for what they are looking at and  
11 whether or not it is relevant, and what the  
12 different names could be, because it is different  
13 from site to site. There is a lot of jargon,  
14 too. And so, I think it is important to keep  
15 them separate.

16 CHAIR MARKOWITZ: So, there are a  
17 couple of people with vertical name tags, but --

18 (Laughter.)

19 CHAIR MARKOWITZ: Other comments,  
20 questions?

21 (No response.)

22 CHAIR MARKOWITZ: So, should we move

1 on this issue of two separate Committees or one  
2 Committee, not necessarily for the record, but  
3 just to make it clear where people stand? Is  
4 there a motion?

5 MEMBER VLIEGER: I move to keep the  
6 Committees separate.

7 CHAIR MARKOWITZ: Second?

8 MEMBER BODEN: Second.

9 CHAIR MARKOWITZ: Oh, Dr. Boden, okay.  
10 All right. Any further discussion?

11 (No response.)

12 CHAIR MARKOWITZ: So, all in favor of  
13 keeping two separate Committees to address B and  
14 D raise your hand.

15 (Show of hands.)

16 CHAIR MARKOWITZ: So, for the record,  
17 it is unanimous, yes. Yes, I think it is almost  
18 unanimous, but it is certainly the majority. I  
19 can't see everybody's hands.

20 So, let's form a Committee now. Who  
21 is interested in addressing this?

22 Ms. Vlieger. Let's get this down



1 here. Okay. We have got Les Boden, Ken Silver,  
2 Tori Cassano, Ms. Vlieger.

3 And do we have anybody who would like  
4 to actually chair this Committee? Okay. Thank  
5 you, yes.

6 Again, we have sort of set out the  
7 generic agenda for this Committee, as we did for  
8 the last one.

9 We should move on now. We are a  
10 little bit ahead, which is great.

11 I am hoping Mr. Curtis Johnson is  
12 here.

13 We are going to be discussing, while  
14 he sets up, we are going to be discussing Area 3,  
15 which I will read to you from our charter, which  
16 is, "Advise the Secretary of Labor with respect  
17 to evidentiary requirements for claims under  
18 Subtitle B related to lung disease."

19 And so, I would like to welcome Mr.  
20 Curtis Johnson, who is the Unit Chief of Policy,  
21 Regulations, and Procedures in the Division, and  
22 welcome back, Mr. Vance.

1 MR. JOHNSON: Thank you very much.

2 Thank you.

3 Good afternoon, everyone.

4 Just a little bit about my background  
5 before we get started, my background is pretty  
6 much similar to that of John Vance and Rachel  
7 Leiton. I started with OWCP in October of 1994  
8 at the FECA office in New York. Since 1996, I  
9 worked as a claims adjudicator, as a claims  
10 examiner, senior claims examiner, and supervisory  
11 claims examiner. In June of 2005, I came to the  
12 Energy Program as a hearing representative for  
13 the Final Adjudication Branch, worked in that  
14 capacity until October of 2013, into the current  
15 position that I am working in now.

16 One issue/concern that I just had the  
17 Board -- and I am really relieved to see that  
18 Part B is something that the Board is going to  
19 initiate or take action on right now -- Part B is  
20 really the legacy of our program. As Rachel  
21 mentioned in her presentation before, if it  
22 wasn't for Part E and the work that we did on

1 Part E, Part E actually wouldn't have come to our  
2 program. So, I am really grateful that the Board  
3 is really going to be taking some action  
4 immediately to look at the Part B aspects of our  
5 claim.

6 During the EEOICPA 101 presentation  
7 yesterday, you were all given the conditions that  
8 are covered under Part B. What I am going to do  
9 today is talk a little bit more specifically  
10 about chronic beryllium disease and silicosis.

11 Before I start with those particular  
12 items, I really need to include one other  
13 condition that is covered under Part B, beryllium  
14 sensitivity. The reason why it is important to  
15 discuss beryllium sensitivity is because there is  
16 obviously a link between beryllium sensitivity  
17 and chronic beryllium disease and, also, our  
18 procedures and our statute really mandate that a  
19 discussion of beryllium sensitivity take place.

20 So, first, we are going to start off  
21 with beryllium sensitivity. Basically, beryllium  
22 sensitivity is simply an allergic reaction to the

1 immune system that is the result of the presence  
2 of beryllium in either the blood or based on  
3 exposure to beryllium.

4 The requirements for beryllium  
5 sensitivity, the exposure requirements, you  
6 simply need one day of employment at either a  
7 Department of Energy facility or with a covered  
8 beryllium vendor.

9 Mr. Turner, you had an issue earlier  
10 today regarding beryllium at the Rocky Flats  
11 Plant. I don't know if your question was  
12 answered, but let me just reassure you of one  
13 thing. The Department of Energy Covered Facility  
14 List does acknowledge that beryllium was present  
15 at Rocky Flats as well as all Department of  
16 Energy facilities. And beryllium was present not  
17 only during the operation of the plant, but also  
18 during the residual period of the plant and  
19 during the decontamination process of the plant.

20 So, as long as an individual worked at  
21 Rocky Flats, as long as they have one day of  
22 employment, we know for sure without a doubt that

1 there is evidence of beryllium exposure. So, I  
2 just wanted to make sure that you understand that  
3 part of the deal.

4 As far as diagnostic evidence for  
5 beryllium sensitivity, the statute requires one  
6 abnormal beryllium test. That test can come in  
7 the form of a lymphocyte proliferation test or a  
8 lymphocyte transformation test.

9 Once again, I just want to reiterate  
10 that the statute allow one, only one, test, and  
11 it only has to be an abnormal test. It doesn't  
12 have to be borderline normal. It has to be  
13 abnormal.

14 In addition to the testing that I  
15 mentioned, we would also accept beryllium skin  
16 patch testing. If there is a positive skin patch  
17 test for beryllium, we would accept that as  
18 medical evidence as well.

19 Once we establish the medical, the  
20 employment criteria for beryllium sensitivity, if  
21 a claim is accepted for beryllium sensitivity, we  
22 would pay for medical treatment. Unlike other

1 Part B conditions where there is lump-sum  
2 compensation, we would only pay for medical  
3 monitoring for beryllium sensitivity.

4 Although the requirements for  
5 accepting claims for beryllium sensitivity are  
6 straightforward, there are still issues and  
7 concerns that we would like for the Board to take  
8 into consideration.

9 The first issue that we have is the  
10 consistency in testing results from different  
11 facilities. This may be simply due to the  
12 calibration of equipment or monitoring data, but  
13 that sometimes has an issue or concern where one  
14 site might consider something normal and another  
15 site may not consider something normal. So, that  
16 is one issue that we would like for the Board to  
17 consider.

18 Another issue we would like for the  
19 Board to consider is what happens in instances  
20 when one physician interprets the results of a  
21 beryllium test as normal and another physician  
22 reviews those tests and finds that they are

1 abnormal. Once again, this issue might even be  
2 related to the calibration or the methods that  
3 are used in the testing, but, once again, that is  
4 something that we also have a concern and issue  
5 about as well.

6 The next issue that we have is whether  
7 or not there is any new scientific data that is  
8 used to establish a diagnosis of beryllium  
9 sensitivity. The lymphocyte proliferation test  
10 is pretty much the gold standard, so to speak,  
11 and we know those testing methods are out there.  
12 We just don't know if there are any other  
13 specific testing mechanisms that are out there  
14 that would help us in determining a diagnosis of  
15 beryllium sensitivity.

16 The last item that we have is  
17 basically what should we consider as medical  
18 monitoring for beryllium sensitivity. We would  
19 pay for any treatment that we feel is going to be  
20 related to establishing a diagnosis of chronic  
21 beryllium disease. That would include any chest  
22 x-rays, any lung biopsies, any type of testing

1 that would be done. We are just interested in  
2 seeing if there are any other topics or issues of  
3 concern that we should be considering for a  
4 medical.

5 And that is everything for beryllium  
6 sensitivity. Before I go on to chronic beryllium  
7 disease, are there any questions? Any questions?

8 CHAIR MARKOWITZ: Yes. Steve  
9 Markowitz.

10 I have a question. I didn't quite  
11 understand the last item, definition of beryllium  
12 medical monitoring. If people are sensitive now,  
13 and their claim is accepted, they are in a  
14 monitoring program, which is determined probably  
15 mostly by the physicians they are seeing. So,  
16 what exactly are you asking for here?

17 MR. JOHNSON: We are really looking at  
18 this point for testing to show whether or not an  
19 individual will develop chronic beryllium  
20 disease. Beryllium sensitivity is really one of  
21 the main monikers that is used to determine  
22 whether or not an individual is diagnosed with



1 chronic beryllium disease or some other form of  
2 pulmonary illness. So, at that point, our  
3 efforts are really focused on testing to make  
4 sure that we detect chronic beryllium disease as  
5 soon as possible.

6 MR. VANCE: Yes, this is John Vance.

7 The thing that we see with medical  
8 monitoring is what are the expected tests and  
9 diagnostic regimen to follow for an individual  
10 who has been sensitized to beryllium. What is  
11 the frequency of that testing?

12 We really get a wide, diverse range of  
13 suggestions about, well, this should be done  
14 annually, biannually. And so, you have  
15 individuals with beryllium sensitivity going all  
16 over the country to different facilities to have  
17 different types of tests performed. And so, we  
18 take a very liberal approach right now with  
19 regard to what is defined as medical monitoring,  
20 but we can certainly be looking for, you know,  
21 what is a good course of care for somebody with  
22 beryllium sensitivity with regard to what do we

1 mean by medical monitoring. Right now, it is a  
2 very broad meaning, and there are lots of  
3 different interpretations about what that means.

4 So, I hope that adds some clarity to  
5 that issue.

6 CHAIR MARKOWITZ: Right. So, you are  
7 looking for advice on an appropriate monitoring  
8 protocol for progression to disease?

9 MR. JOHNSON: Correct.

10 CHAIR MARKOWITZ: Thank you.

11 MR. JOHNSON: The next condition I am  
12 going to talk about is chronic beryllium disease.  
13 From a claims adjudication standpoint, chronic  
14 beryllium disease is probably one of the, if not  
15 the, most difficult claims to adjudicate.  
16 Normally, it is claims examiners, when we are  
17 establishing a diagnosis for a medical condition,  
18 we are normally keying on a specific medical  
19 report or some type of specific medical evidence  
20 where we could say this is what we are going to  
21 use to establish a diagnosis of beryllium  
22 sensitivity.

1           Actually, the way that the statute  
2 reads -- and we will go into the specifics a  
3 little bit later -- for the Part B aspects of the  
4 program, you don't necessarily have to have a  
5 diagnosis of chronic beryllium disease per se.  
6 It is based on the concept, if it looks like CBD  
7 and it talks like CBD, we assume, assumption of  
8 causation, that it is CBD.

9           First of all, the requirements for  
10 establishing a diagnosis of chronic beryllium  
11 disease, similar to the criteria for beryllium  
12 sensitivity, one day of exposure to beryllium at  
13 a Department of Energy facility or with a  
14 beryllium vendor. Once that information is  
15 established, the statute mandates that the  
16 criteria are reviewed based on a diagnosis  
17 chronic beryllium disease either before or after  
18 1993. Once again, this is something that the  
19 statute set in place.

20           MR. VANCE: Let me interject real  
21 quick. Let me make a point of clarification  
22 here. When Curtis is talking about a

1 presumption, what we are talking about is the  
2 statute lays out very strict requirements for  
3 what constitutes the establishment of chronic  
4 beryllium disease. And you will notice I am  
5 saying "the establishment of chronic beryllium  
6 disease," not necessarily the diagnosis of  
7 chronic beryllium disease.

8 So, I just want to make that clear,  
9 that the statute lays out specific diagnostic  
10 criteria for establishing chronic beryllium  
11 disease, dependent on whether or not an  
12 individual has a pre- or post-1993 evidence of a  
13 chronic -- there is a test that goes into  
14 determine whether you are going to apply the  
15 criteria for a pre-1993 standard for chronic  
16 beryllium disease or a post-1993 standard. Okay?  
17 And we'll talk about that because that is an  
18 important function of making a determination of  
19 the establishment of chronic beryllium disease.

20 MR. JOHNSON: For establishing the  
21 pre- or post-1993 standard, normally, what we  
22 would look at first is the actual claim form

1 where the claimant will actually identify when  
2 they were diagnosed or when they believe that  
3 they were diagnosed with the illness. That would  
4 be the first marker that we are looking for to  
5 determine whether or not we are going to use the  
6 pre- or post-1993 standards.

7 If there is no identifying factor as  
8 to when the diagnosis took place, what we would  
9 be looking at, we would make a determination  
10 based on the medical evidence of when an  
11 individual was first treated or received  
12 treatment for a chronic respiratory disorder.

13 If we establish that the treatment  
14 took place before 1993, we would use the pre-1993  
15 criteria. If it is established after 1993, we  
16 would use the post-1993 criteria.

17 The pre-1993 criteria, it is based on  
18 five particular elements. In order to have an  
19 acceptable claim, you must meet three of those  
20 particular five elements.

21 The first element that we are looking  
22 at is the characteristics of the chest

1 radiographs. This includes any chest x-rays, any  
2 CT scans, any CAT scans. The claims examiner  
3 reviews that particular element, and we are  
4 looking for, as John mentioned, we are looking  
5 for specific findings or criteria in those chest  
6 x-rays.

7           And what I want to make sure that it  
8 is really clear is that this is something where  
9 the claims examiner does not make an  
10 interpretation on their own. If the evaluation  
11 report does not identify these particular items  
12 and terms, then we make the determination that  
13 this information may need to go to the treating  
14 physician to ask whether the characteristics are  
15 similar to or found in CBD, or we would go to a  
16 CMC to get that information.

17           There are some target words that we do  
18 look at. One of the biggest terms is "non-  
19 caseating granulomas". That is one term that we  
20 determined that is synonymous or consistent  
21 characteristics with chronic beryllium disease.  
22 If those findings are noted in the x-ray report,

1 then the claims examiner should feel comfortable  
2 in stating this particular piece of criteria is  
3 met.

4           There are also other conditions. Once  
5 again, this is something that really the Board  
6 would really, really be able to give us help on:  
7 what other characteristics in chest radiographs  
8 should we be looking at to establish  
9 characteristics of CBD?

10           MR. VANCE: Yes. So, in the handout  
11 -- I think we don't need to re-read each one of  
12 these -- but the test for the pre- and the post-  
13 are laid out. So, what Curtis is talking about  
14 is, you know, this is an interpretation of  
15 evidence by a physician looking to the diagnostic  
16 test results and applying the criteria from the  
17 statute. So, in other words, you know, are we  
18 looking at x-ray results that are characteristic  
19 with chronic beryllium disease? Again, you are  
20 looking at an interpretative question that a  
21 physician evaluating the evidence makes an  
22 opinion as to whether or not this particular test

1 is showing you a result that he or she feels is  
2 consistent with chronic beryllium disease. And  
3 that sort of runs throughout here.

4 So, the pre-1993 standard is a little  
5 bit more generalized; whereas, the post-1993  
6 standard is a little bit more specific as to what  
7 evidence needs to exist to establish chronic  
8 beryllium disease.

9 And so, it is not a matter of the CE  
10 looking at diagnostic evidence and saying, "Hey,  
11 this is characteristic with chronic beryllium  
12 disease. It is a physician's determination. So,  
13 a physician has to look at this information and  
14 make that judgment based on what it is that they  
15 have seen or see in the evidence of record.

16 And then, what the claims examiner is  
17 doing is basically saying, do I have the  
18 diagnostic results or the interpretation of the  
19 evidence that satisfies these three of the five  
20 criteria for the pre- or the criteria for the  
21 post-? So, they are looking for a physician who  
22 has opined on these things and do the diagnostic



1 test results correspond with what is required by  
2 the statute.

3 And what we have as issues here is, of  
4 course, the genuine question that we always have,  
5 which is interpretative differential, where you  
6 have one physician who can look at it and say,  
7 "This is clearly characteristic of chronic  
8 beryllium disease." Another physician says,  
9 "Well, that really is just characteristics of  
10 obstructive pulmonary disease, pulmonary  
11 fibrosis." And it is impossible to differentiate  
12 between that type of a disease and chronic  
13 beryllium disease.

14 So, what we would be looking for is  
15 help in saying, what are the markers that can  
16 consistently be seen for chronic beryllium  
17 disease? Or is that even possible? Or other  
18 types of clarifications for how we can apply the  
19 evidence in a way consistently to always say this  
20 is what you will see if you are talking about the  
21 establishment of chronic beryllium disease.  
22 These are the types of diagnostic findings or

1 other types of x-ray results that you would see  
2 with that. It is really a question of what would  
3 be the standard of creating consistency in that.

4 Some of the other quick things are  
5 that this test of the pre- or post-1993 standard  
6 is dependent on the definition of what we mean by  
7 chronic respiratory disorder. Okay? It is  
8 purely a definitional question, because the  
9 statute basically says that the test is evidence  
10 of a chronic respiratory disease prior to 1993.  
11 And so, we have to know, well, what does that  
12 mean? Does that mean one x-ray result that has  
13 an abnormal finding or is it truly a situation  
14 where a doctor has identified a chronic disease  
15 process?

16 So, we get questions, you know, where  
17 we get claims where people are saying, "Hey,  
18 here's my occupational x-ray that was performed  
19 in 1974 where it shows a mild restrictive  
20 problem." Does that equate into a chronic  
21 respiratory disorder that turns the program on  
22 having to apply the pre-1993 standard or not?

1 So, that is one area that I think is really kind  
2 of an issue for us to try to figure out how to  
3 apply that in a consistent manner that is  
4 medically-valid. And we have struggled with that  
5 for quite some time.

6 On your handout, we talk about  
7 clarification of the diagnostic interpretative  
8 meaning of characteristic of CBD. This also sort  
9 of plays into No. 4 there, obtaining clarity on  
10 the specific diagnostic markers required for the  
11 establishment of chronic beryllium disease,  
12 whether it is pre- or post-.

13 And then, we have in the past had  
14 issues with regard to how we look at sarcoidosis  
15 and how that can be commonly misinterpreted as  
16 CBD. So, in other words, somebody is presenting  
17 with pulmonary sarcoidosis. How do you treat  
18 that, where a lot of physicians would opine that  
19 a diagnosis of pulmonary sarcoidosis in the  
20 presence of an exposure to beryllium could  
21 actually be masking a true chronic beryllium  
22 disease situation.

1           And then, we also have this question  
2 of the beryllium LPT issue, which is that the  
3 statute requires the presentation of an abnormal  
4 beryllium lymphocytic proliferation test when you  
5 are dealing with a post-1993 diagnosis of or the  
6 establishment of chronic beryllium disease.

7           So, we have commonly seen a lot of  
8 physicians contesting the use of the beryllium  
9 lymphocytic test to do that, and a lot of times  
10 that test can be masked by the use of different  
11 kinds of steroidal medications and other reasons  
12 where you would end up with a situation where a  
13 positive or a normal test result is being masked  
14 by medication. And can we not create better  
15 rules or processes for evaluating that? And what  
16 are some of the considerations that can be used  
17 to say, in this scenario where you do have a  
18 normal BeLPT, you know, a beryllium lymphocytic  
19 test, what are the characteristics that would  
20 allow us to say that is actually, that is really  
21 an abnormal result, due to other factors or other  
22 considerations?

1 MR. JOHNSON: This is Curtis Johnson  
2 again.

3 After the chest radiographs, the next  
4 criteria that we look at after the chest  
5 radiograph, we look for evidence of restrictive  
6 or obstructive lung physiology. This is  
7 basically a review of the pulmonary function  
8 test. Once again, the interpretation for the  
9 pulmonary function test, it specifically has to  
10 state that there is either a restrictive  
11 disorder, an obstructive lung disorder, or some  
12 sort of diffused lung effect. And once again,  
13 this is something that the claims examiner does  
14 not make that interpretation their own. This  
15 actually has to be in the results of the test  
16 itself.

17 Okay. And what we are going to do, we  
18 are going to continue on because the next issues  
19 that we talk about, the lung pathology, the  
20 clinical course, all that information we have  
21 really already discussed. And we are going to go  
22 through it again in the post-1993 criteria.

1 MR. VANCE: What we are going to do is  
2 I am assuming you guys can read the criteria for  
3 the pre- and the post, so we are not going to  
4 rehash that whole thing.

5 What I did want to say is, are there  
6 any questions at this point about the Part B CBD  
7 criteria?

8 CHAIR MARKOWITZ: It is Ms. Vlieger.

9 MEMBER VLIEGER: One of the things  
10 that I wrestle with with the medical providers  
11 and for the claimants is that the doctors are  
12 taught the Beryllium Case Registry criteria as  
13 part of their studies. And when it comes to this  
14 program, it is more lenient criteria number than  
15 Beryllium Case Registry.

16 And so, is there any explanation given  
17 to the CMCs in detail, that they have to  
18 acknowledge that they understand there is a  
19 difference, and to the medical providers that you  
20 are in contact with, that there is a distinct  
21 difference between the criteria under this  
22 program and what is defined as chronic beryllium

1 disease under the Beryllium Case Registry  
2 criteria?

3 MR. VANCE: Now, what we would do is  
4 communicate and convey the information that is  
5 statutorily required under our provision, under  
6 our statute. So, in other words, if we are going  
7 to be developing a case where we are going out to  
8 a treating physician, we are going to say, "This  
9 is what our statute stipulates as the  
10 requirement." So, therefore, we would be seeking  
11 information relating to the statutory  
12 requirements. We are not going to go out and  
13 compare other types of provisions that may exist  
14 with regard to the assessment of chronic  
15 beryllium disease.

16 So, this is what is unique about this  
17 particular condition in a Part B claim, is that  
18 the statute identifies specific diagnostic  
19 criteria. So, any other legal provisions really  
20 have no effect on our test for chronic beryllium  
21 disease. We have to apply this standard.

22 And where we can have wiggle room is

1 the definition of certain things such as, what do  
2 you mean by a chronic respiratory disorder for  
3 determining whether you are going to apply the  
4 pre- or post- standard?

5 CHAIR MARKOWITZ: I have a question.  
6 Steven Markowitz.

7 So, when you say that a physician --  
8 the claims examiner isn't making the  
9 determination of the presence of each of these  
10 items? It is from a physician report or the  
11 like. Is it the case that the physician has to  
12 say that, yes, there are three of these five  
13 items present and specify what they are? So, the  
14 physician is essentially putting the case  
15 together and calling this CBD according to your  
16 definition? Or is it that the physician merely  
17 needs to indicate that, yes, barometry shows  
18 restriction; chest x-ray shows interstitial  
19 fibrosis, or whatever?

20 And then, the claims examiner says,  
21 "Yes, I see the physician said restriction. I  
22 see basic chest x-ray finding compatible with,



1 and I see a history of chronic respiratory  
2 disorder." And the claims examiner, then, is  
3 putting those three pieces together and saying  
4 this is CBD?

5 MR. VANCE: No. It has to be the  
6 doctor evaluating the evidence, identifying the  
7 characteristics of the test results that are  
8 abnormal, and that in the opinion of that  
9 physician can be interpreted as being consistent  
10 with chronic beryllium disease.

11 MS. LEITON: But I think the  
12 expression, we ask the doctor, "Is this  
13 characteristic of...?"

14 MR. VANCE: Right.

15 MS. LEITON: And the doctor says yes.  
16 Then, we put three pieces together.

17 MR. VANCE: Right. Well, right. So,  
18 what Rachel was saying is that, basically, you  
19 know, we will advise the doctor, "These are the  
20 requirements." And then, the doctor is going to  
21 respond, and we are going to get information  
22 relating to different components of the chronic

1 beryllium disease standard.

2 As long as the doctor is providing an  
3 opinion that is characterizing the interpretation  
4 of the test to meet that standard, whatever the  
5 criteria around the statute, then, yes, we would  
6 have the CE looking at that and accepting that,  
7 as long as the doctor has interpreted that  
8 evidence in a way that satisfies the statutory  
9 requirement.

10 CHAIR MARKOWITZ: All right. So, the  
11 assembling of the pieces, the doctor-certified  
12 pieces, can be done by the examiner to include?

13 MR. VANCE: Yes.

14 CHAIR MARKOWITZ: Thank you.

15 MR. VANCE: So, basically, the CE is  
16 making sure do we have the pieces that allow us  
17 to accept it, but the source of that material  
18 needs to come from the physician and the  
19 interpretation of that evidence needs to be done  
20 by the physician.

21 CHAIR MARKOWITZ: Okay. Thank you.

22 Dr. Welch?

1                   MEMBER WELCH: Are you still getting  
2 claims where the pre-1993 applies?

3                   MS. LEITON: Oh, yes.

4                   MR. VANCE: Oh, yes, I think that is  
5 the most common ones we are seeing now. A lot of  
6 our cases are -- the pre-standard is a little bit  
7 more liberal. So, of course, that is where you  
8 are going to have a lot of people trying to  
9 persuade the program that that is the applicable  
10 standard to apply in their case. So, we see a  
11 lot of that. I think a majority of our cases now  
12 are more pre-1993 than post-.

13                   MEMBER WELCH: So, are you seeing  
14 people who are having their first BeLPT in 2016,  
15 and that is positive, but they have a long  
16 history of chronic respiratory disease that  
17 predates the 1993 date?

18                   MR. VANCE: No. The LPT now is  
19 negative, and they are trying to argue that the  
20 evidence of a chronic respiratory disorder that  
21 started way before 1993 allows for the  
22 application of the pre-1993 standard.

1 Rachel was saying that we are seeing  
2 it; we are seeing both, but because it is an  
3 easier standard, that is where the claims are  
4 going to go to.

5 CHAIR MARKOWITZ: Dr. Redlich?

6 MEMBER REDLICH: Yes, I understand  
7 some of the problems. I am quite familiar with  
8 many of the issues around beryllium.

9 So, in the post-1993, for people who  
10 aren't familiar with all of these issues, there  
11 are multiple reasons why someone may not end up  
12 getting a tissue diagnosis or a lavage in terms  
13 of being too sick. There are also reasons why  
14 the BeLPT might be false, the blood one might be  
15 false or negative, depending on medications or  
16 even whether the person had the opportunity to  
17 have it done, or if something happened in the  
18 sample when it went out to National Jewish.

19 But how many labs are you using for  
20 the tests now?

21 MR. VANCE: We don't actually specify  
22 or prescribe particular testing facilities. And

1 that relates back to the question or the issue  
2 that Curtis was mentioning before.

3 MEMBER REDLICH: Okay.

4 MR. VANCE: It is that different  
5 testing facilities where claimants can go to may  
6 have different standards by which they apply to  
7 say this is a normal versus an abnormal test.  
8 And so, we end up, you know --

9 MEMBER REDLICH: Yes. No, I'm aware,  
10 yes.

11 MR. VANCE: So, we don't have specific  
12 testing facilities that are utilized by the  
13 program. Claimants are free to pick and choose  
14 which facilities that they would like to go to.

15 MEMBER REDLICH: Okay. So, there  
16 aren't a ton.

17 And how strict is this? I was looking  
18 for wiggle room in terms of the -- you know, you  
19 sort of have the problem, the potential problem,  
20 that the pre-1993, since it is three of those  
21 five criteria, you don't have to actually have  
22 sensitization, and there is a lot of lung disease

1 in people, given how common COPD and lung disease  
2 is. So, I could understand --

3 MR. VANCE: You're absolutely correct,  
4 yes.

5 MEMBER REDLICH: I understand that.

6 And then, you have almost the reverse  
7 issue with the post-1993 in terms of being maybe  
8 overly-strict in that it isn't leaving a lot of  
9 leeway in terms of wanting some either lavage or  
10 tissue.

11 MR. VANCE: Right. And that will  
12 never change unless they change the law itself.  
13 So, what I need to really stress is these can't  
14 be changed without a legislative change. These  
15 are specifically enumerated in the statute  
16 itself, rightly or wrongly.

17 (Laughter.)

18 MEMBER REDLICH: Okay. But someone  
19 could conceivably write, a physician could give  
20 an opinion that they think this is CBD, based on  
21 A, B, and C, despite the fact that there was  
22 never a biopsy, or not?

1 MR. VANCE: It depends on the  
2 combination. As long as the doctor can provide  
3 the information that is statutorily required --  
4 so, in other words, if you have the positive  
5 beryllium test and you have a biopsy showing this  
6 on the first one that the doctor has interpreted  
7 as saying, yes, this is showing a bronchial or  
8 interstitial lung tissue problem that they can  
9 interpret as being chronic beryllium disease.

10 MEMBER REDLICH: Okay. But I have  
11 just diagnosed CBD without tissue, but that  
12 doesn't seem to be in --

13 MR. VANCE: Yes, and I think the  
14 statute allows for that to occur.

15 MS. LEITON: Blood testing.

16 MEMBER REDLICH: No, no, but it is  
17 lavage.

18 MR. VANCE: Right. It can be a lung  
19 biopsy. It can be a lavage.

20 MEMBER REDLICH: I know, but that is  
21 still an invasive procedure.

22 MR. VANCE: Oh, yes, and that is one

1 of the issues that we have on our list --

2 MEMBER REDLICH: Okay.

3 MR. VANCE: -- is the fact that that  
4 reality exists.

5 MEMBER REDLICH: Yes, I'm saying I've  
6 made the diagnosis absent of those, because one  
7 was unable to obtain them. But you are saying  
8 that, right now, there isn't wiggle room for  
9 that? Okay.

10 MR. VANCE: No, not under the post-  
11 1993 criteria. It basically is exactly this.  
12 You have got to meet these criteria. You know,  
13 it is just statutorily required.

14 CHAIR MARKOWITZ: Dr. Welch?

15 MEMBER WELCH: Could someone, if they  
16 don't meet the Part B criteria, pursue it under  
17 Part E, a claim for CBD? Or is it excluded under  
18 E?

19 MR. VANCE: No, it would be something  
20 we could consider under Part E.

21 MEMBER WELCH: So, then, your kind of  
22 case is where you might have a CT scan that shows



1 characteristic CBD and you have sensitization.  
2 It could potentially go under Part E without a  
3 biopsy?

4 CHAIR MARKOWITZ: So, I have a  
5 question. Is this a follow-up?

6 MEMBER VLIEGER: Yes.

7 CHAIR MARKOWITZ: Oh, go ahead. Go  
8 ahead.

9 MEMBER VLIEGER: Just a clarification  
10 on the information in our briefing book. It  
11 doesn't exactly follow the wording from the  
12 statute. So, my question is, just for  
13 clarification for the other Board members, could  
14 you enumerate the quantity of criteria needed  
15 under a post-1993 diagnostic definition for the  
16 Department?

17 MR. JOHNSON: First, you would need a  
18 diagnosis of beryllium sensitivity. That is No.  
19 1. And the second component is that you would  
20 need lung pathology consistent with chronic  
21 beryllium disease.

22 We will come back to it.

1                   CHAIR MARKOWITZ: Steve Markowitz.  
2                   Since you have chronic respiratory  
3 disorder, so it must be potentially confusing for  
4 claims examiners because it encompasses a broad  
5 range of illnesses and, also, is a fairly non-  
6 specific term. So, is there written guidance for  
7 the claims examiners on what is a chronic  
8 respiratory disorder or when it needs to have  
9 appeared, or the like?

10                  MR. VANCE: Yes. In our Procedure  
11 Manual, we define it as a problem that is chronic  
12 in nature, which means that it is something that  
13 exists for a period of time, that a physician is  
14 interpreting as being a chronic disease process.

15                  I am not sure of the exact wording,  
16 but we do talk about the fact that, you know, a  
17 single diagnostic test may not necessarily  
18 establish chronic respiratory disease. It is a  
19 question that a physician needs to address.

20                  So, we have that language in our non-  
21 cancer condition chapter in our Procedure Manual,  
22 and we do try to spell that out. But, again, we

1 are still left with the question of, is that  
2 definition that we have in our procedures too  
3 strict, too conservative, or too liberal? And  
4 that is why we would certainly be looking for the  
5 Board to assist with helping in clarifying that  
6 issue, because a lot of people are really  
7 concerned about that, simply because, then, that  
8 sort of sets in motion whether we are going to  
9 apply that pre-1993 standard, which is a little  
10 bit more easier to do than the post-.

11 So, that is the focus of a lot of  
12 stakeholders and a lot of claimants, is, how do  
13 you want to define that? And the words are  
14 "chronic respiratory disorder". So, our program  
15 has sort of taken the view that it is something  
16 that is diagnosed as a long-term respiratory  
17 problem.

18 CHAIR MARKOWITZ: Thank you.

19 Dr. Silver?

20 MEMBER SILVER: If I understood your  
21 question a little while ago, there is a Beryllium  
22 Case Registry that many of the leading physicians

1 in this area participate in, and it has certain  
2 criteria that are above and beyond DOL's.

3 I am reminded of an early nuclear  
4 worker advocate, before there were many, Bob  
5 Alvarez, who at the inception of this program  
6 went around the country reinforcing the idea that  
7 a program like this is social policy first,  
8 informed by science. And the scientists are in  
9 the backseat giving a little bit of advice, but  
10 Congress decided on a claimant-friendly program.

11 And one of the things we have been  
12 doing all along is reminding people that  
13 scientists, when among themselves, can apply  
14 their normal standards of proof. But, for a  
15 program like this which is mainly social policy,  
16 different standards apply.

17 So, because the group of doctors who  
18 do beryllium disease as a specialty is so small,  
19 I really think this is an opportunity for us to  
20 put out an explicit reminder that, fine, you  
21 know, the NIH study section, when you are  
22 figuring out who is going to get money to do the

1 next molecular marker in the Case Registry, apply  
2 your sky-high criteria, but a little tap on the  
3 shoulder here: when you are seeing people for  
4 the purposes of compensation, the standards are  
5 different. Is that kind of the issue that you  
6 are getting at?

7 MEMBER VLIEGER: Yes, and then, we see  
8 it chronically because physicians aren't taught  
9 this standard according to this program. So,  
10 they rely on their education, which is what they  
11 do; it is their job.

12 But the requirements under this  
13 program, when the worker says, "Well, I think I u  
14 qualify," and the doctor goes, "No, that's not  
15 what I was taught," that is what they write to.

16 MEMBER SILVER: Are there specific  
17 items that are on the doctors' scientific list of  
18 criteria that get injected into determinations  
19 for this program inappropriately?

20 MEMBER VLIEGER: From time to time,  
21 the doctors will say, "Well, I'm not going to do  
22 a biopsy because I don't think you have it.

1 Well, that's not required."

2 And then, on the post-1993 diagnoses,  
3 it is not required at all, but the doctors were  
4 not trained to opine on something less than  
5 definitive evidence from a biopsy or from  
6 something, a lavage.

7 And I agreed with Dr. Redlich; the  
8 intrusive procedures in many cases are  
9 unwarranted, and in older patients you just can't  
10 do them. So, with the post-1993 criteria, which  
11 is what we see a lot of from the Hanford site,  
12 the doctors don't understand that there is a  
13 less-restrictive criteria they can write to.

14 MEMBER REDLICH: But, actually, the  
15 problem is also that the 1993 criteria are  
16 actually stricter than the American Thoracic  
17 Society recently, or in 2004, came out with  
18 official guidelines, and theirs are actually less  
19 strict than this 1993 because they leave some  
20 wiggle room. What it says is that, basically, a  
21 probably diagnosis of CBD can be based on imaging  
22 consistent with sarcoidosis or a BAL

1 lymphocytosis, meaning you could have a  
2 positive -- so, it is actually this is a stricter  
3 criteria than the current ATS guidelines.

4 I think that was -- I was involved in  
5 reviewing this whole document -- because for  
6 physicians seeing these patients, realizing that  
7 there are times when one is unable, for various  
8 reasons, to get the sampling that would be  
9 needed.

10 And even something like a biopsy, you  
11 can have three pathologists look at a biopsy and  
12 come up with a different description of that  
13 pathology; the same with a CT scan.

14 CHAIR MARKOWITZ: So, that kind of  
15 raises the issue of something you mentioned  
16 before, whether Part E might actually solve a  
17 little bit of this problem, where the doctors  
18 have a different set of criteria for CBD diagnose  
19 than the Congress people. If somebody doesn't  
20 meet Part B requirements, they don't have the  
21 biopsy, and you could under Part E compensate  
22 them, do you move them over? Can you move them?

1 Is that a solution to the problem?

2 MR. VANCE: Well, this is where it  
3 gets fascinating. Under Part E, we do require  
4 for a Part E claim for chronic beryllium disease  
5 that they have to have a positive beryllium  
6 lymphocytic test.

7 The issue there is that, you know,  
8 then you are no longer dealing with a pre- or  
9 post- standard anymore. So, you could have  
10 someone who is trying to get a claim through on  
11 Part B for the pre-1993 standard. But, then,  
12 when you flip over, and let's say that gets  
13 denied, then you flip over to the E side. They  
14 might change the story and say, "Well, it was  
15 always chronic obstructive pulmonary disease,"  
16 and that is where they go with their case. So,  
17 it really depends.

18 So, under Part E, it is a little bit  
19 different. This is where you get this  
20 differential between what happens under Part B  
21 and E, because the standards are different. So,  
22 it depends on how an individual is going to



1 pursue their case.

2 CHAIR MARKOWITZ: But the post-1993  
3 cases, right, in which there is no biopsy, so it  
4 can't go under B, it won't be recognized under B.  
5 No biopsy, but Dr. Redlich certifies it is CBD.  
6 Could that come under -- this is post-1993 --  
7 could that come under Part E and be compensated?

8 MR. VANCE: Yes. Yes, it can.

9 CHAIR MARKOWITZ: Thank you.

10 MS. LEITON: You can't go backwards,  
11 though. You can't go E back to B.

12 CHAIR MARKOWITZ: Okay. Okay.

13 MR. VANCE: So, Rachel was just adding  
14 an elaboration that it can't go from E to B, but  
15 it can go from B to E. I love that combination,  
16 by the way, the E-B.

17 MEMBER REDLICH: So, it solves part of  
18 the problem. It solves the scenario of the  
19 positive BeLPT where you don't have tissue --

20 MR. VANCE: Correct.

21 MEMBER REDLICH: -- where you, let's  
22 say, have a CT scan that is classic and a

1 positive BeLPT and a history of exposure, and it  
2 solves that problem.

3 MR. VANCE: Right.

4 MEMBER REDLICH: The one problem it  
5 doesn't solve is where you might have tissue that  
6 is classic and a good exposure story, and the  
7 person on a lot of steroids and stuff, and then,  
8 they get a BeLPT. So, that little thing isn't  
9 solved, but it is solves part of it? Is that  
10 right?

11 MR. VANCE: I think you have a pretty  
12 good read on it.

13 MEMBER REDLICH: There is every  
14 combination, permutation of these.

15 (Laughter.)

16 MR. VANCE: Right. There's lots of  
17 different combinations of how this can play out.

18 MEMBER REDLICH: Yes.

19 MR. VANCE: And that is what makes  
20 this component of the Part B lung disease, that  
21 is what makes it so entertaining, is just there's  
22 lots of different issues that are buried in a

1 very clear statutory provision. And so, that is  
2 what we are pointing out here.

3 MEMBER REDLICH: How many new claims  
4 a year do you get?

5 MR. VANCE: So, the question is how  
6 many new claims we get, and I can't answer that.

7 MEMBER REDLICH: Or getting tortured  
8 by the old claims that keep coming back?

9 MR. VANCE: Yes, we would have to get  
10 back to you on that.

11 MEMBER REDLICH: Okay.

12 MR. VANCE: I just don't know.

13 MEMBER REDLICH: I was just trying to  
14 get a sense of it, because part of how you  
15 address it is really what the magnitude of the  
16 problem is.

17 CHAIR MARKOWITZ: Dr. Boden?

18 MEMBER BODEN: So, you may have  
19 answered this, but I can't remember if you did or  
20 not. Under Part B, if you have a physician  
21 report that meets your criteria, but the  
22 physician says it doesn't say that they think

1 that it is CBD, do you act in a positive way on  
2 that claim?

3 MR. VANCE: Could you restate that?  
4 I didn't hear the first part.

5 MEMBER BODEN: Oh, okay. So, you got  
6 a physician's report. The physician gives you a  
7 report with specifics that meet your Part B  
8 criteria, but they say it doesn't meet their  
9 standard for being chronic beryllium disease. Do  
10 you pay that claim?

11 MR. VANCE: Yes, as long as the doctor  
12 is fulfilling the requirements of the statute, we  
13 will pay it.

14 MEMBER BODEN: So, even if they say  
15 it's not --

16 MR. VANCE: So, let's say, for  
17 example, you have a doctor that says, "The  
18 standard that is being applied here is completely  
19 wrong. I have no idea what Congress was doing  
20 when they put this in here, but I am going to  
21 opine that this patient does meet the post-1993  
22 standard," the case will be paid.

1           MEMBER BODEN: But if they give you  
2 the test results that meet the standard --

3           MR. VANCE: Yes, as long as the  
4 standard in the statute is satisfied --

5           MEMBER BODEN: -- they just don't say  
6 it --

7           MR. VANCE: -- the justification of  
8 that from a physician, or whatever their opinion  
9 is about that --

10          MEMBER BODEN: Good.

11          MR. VANCE: -- it is really sort of  
12 inconsequential.

13          CHAIR MARKOWITZ: Other questions,  
14 comments?

15          Are you moving on to silicosis or --

16          MR. JOHNSON: When you are ready to.

17          CHAIR MARKOWITZ: Okay. So, I have a  
18 question.

19          I'm sorry, there are a couple of name  
20 cards that are vertical.

21          There are some proposed rule changes  
22 that are relevant to this issue of pre- and post-

1 1993. I couldn't understand the importance of --  
2 I'm not sure I even understood the change, but I  
3 didn't understand the importance of the change.  
4 So, what was happening that caused you to propose  
5 changes to the regulations and what are these  
6 changes exactly?

7 MR. VANCE: Well, yes, unfortunately,  
8 I am not in a position to be able to comment on  
9 the regulations at all. I think that is going to  
10 be something that you are going to have to  
11 deliberate on your own to decide what your  
12 feelings are on that issue as a deliberative  
13 body.

14 MEMBER REDLICH: The pre-1993 is much  
15 more liberal.

16 CHAIR MARKOWITZ: Right. No, I get  
17 that. Okay, fine. Okay. Thank you. I forgot,  
18 actually. Other questions or comments?

19 (No response.)

20 CHAIR MARKOWITZ: Okay. So, let's  
21 proceed.

22 MR. JOHNSON: And the last condition

1 that we are going to talk about is chronic  
2 silicosis. Once again, the statute mandates that  
3 under Part B chronic silicosis is the only  
4 silicosis that is covered.

5 The exposure requirements are simply  
6 an individual must have 250 days of employment  
7 during the mining of tunnels or exposure to  
8 silica, I should say, 250 days of exposure to  
9 silica as a result of mining in the tunnels of a  
10 DOE facility in Nebraska -- I'm sorry; in  
11 Nebraska? In Nevada or Alaska. Excuse me.

12 (Laughter.)

13 MR. JOHNSON: The medical requirements  
14 -- and once again, this is strictly for chronic  
15 silicosis -- there has to be a latency period of  
16 10 years between the initial date of exposure to  
17 silica and the date of diagnosis for chronic  
18 silicosis.

19 As far as the diagnostic criteria  
20 goes, what we see mostly is the results of a  
21 B-reader chest, a NIOSH B-reader chest x-ray.  
22 The results of those x-rays have to note the

1 existence of pneumoconiosis at a level of 1 over  
2 zero or higher. That is what we see in most  
3 instances as the determining medical evidence.  
4 We would also accept if we receive some sort of  
5 pathology or chest x-ray evidence of, evidence  
6 consistent with chronic silicosis. We would  
7 accept claims for silicosis on that basis as  
8 well.

9 One particular issue that we would  
10 like for the Board to consider regarding chronic  
11 silicosis is the validity of the B-reader x-rays.  
12 The x-ray form itself does not have a particular  
13 field, or whatever you want to call it, for a  
14 physician to sign the form and identify himself  
15 as the actual B-reader. The only requirement is  
16 that the physician's initials appear on the form  
17 and that the address of the physician appears on  
18 the form.

19 Our question is, how do we determine  
20 what the validity of that B-reader's credentials  
21 are and how do we actually identify that  
22 particular physician as a B-reader physician?



1           MR. VANCE: This is an issue that just  
2 pops up periodically, as far as making sure that  
3 we know that that is a valid B-read and that it  
4 can be applied in the case. It might not be that  
5 complicated, but we just get ourselves into this  
6 situation where we get B-reads where there is  
7 some question as to whether or not that is a true  
8 B-read or is that a reinterpretation of a B-read,  
9 or what have you?

10           So, it is just a question of, what it  
11 is that marks a valid B-reading? And that is  
12 sort of the issue. Silicosis is not one where we  
13 have a lot of issues, and that was one that we  
14 looked at. We were trying to look at what are  
15 some issues that we could identify for  
16 consideration, and that is just one that  
17 periodically pops up with discussions with  
18 external stakeholders.

19           Any other questions at this point  
20 regarding beryllium sensitivity, chronic  
21 beryllium disease, or silicosis?

22           MEMBER VLIEGER: Dr. Markowitz?

1 CHAIR MARKOWITZ: Yes?

2 MEMBER VLIEGER: I know that sites for  
3 this, I believe that sites for the silicosis are  
4 determined by NIOSH, is that correct?

5 MR. VANCE: You mean silicosis --

6 MEMBER VLIEGER: Where silicosis  
7 applies? Because silicosis doesn't apply to all  
8 of the sites.

9 MR. VANCE: Well, again, we are  
10 talking about Part B lung disease. So, silicosis  
11 is specifically named as a statutory provision,  
12 and the statute, just like chronic beryllium  
13 disease, sets out specific criteria that have to  
14 be satisfied.

15 Under Part E, it can apply to  
16 anything. So, silicosis can be claimed and does  
17 not have to meet the same standard that exists  
18 under Part B.

19 MEMBER VLIEGER: Okay. And so, the  
20 explanation for why some sites that could have  
21 silicosis claims at them that are not considered  
22 to have silicosis under B, is that still a NIOSH

1 determination?

2 MR. VANCE: No. I mean, that is a  
3 determination of our normal exposure analysis for  
4 a Part E case. In other words, if you are a  
5 miner who is filing a claim under Part E, you  
6 know, it doesn't matter. Any mine where you are  
7 working where there could be silica -- the same  
8 thing could be applied at any of the DOE  
9 facilities under Part E, you know, where there  
10 was a silica exposure and an employee has  
11 silicosis.

12 MEMBER VLIEGER: Okay. Thank you.

13 CHAIR MARKOWITZ: Dr. Welch?

14 MEMBER WELCH: I actually didn't go  
15 back and look at the statute, but does the  
16 statute say they had to be exposed to silica for  
17 an aggregate of 250 days? And how do you accept  
18 a demonstration of silica exposure at the site?

19 MR. VANCE: It is 250 days of  
20 exposure, and we just presume that if you were  
21 there at one of these sites, you are going to  
22 have that exposure.

1 MEMBER WELCH: Okay.

2 MR. VANCE: And I think Amchitka  
3 Island it is even a lesser standard. I think it  
4 is only like one day, were you at Amchitka  
5 Island.

6 MEMBER WELCH: Okay. Okay. Good.

7 CHAIR MARKOWITZ: Other comments or  
8 questions?

9 (No response.)

10 CHAIR MARKOWITZ: Okay. Thank you  
11 very much, Mr. Vance and Mr. Johnson.

12 MR. VANCE: Thank you.

13 CHAIR MARKOWITZ: So, is there any  
14 discussion on these issues that the Board would  
15 like to have before we designate a Committee,  
16 volunteer for a Committee, and the like?

17 Dr. Cassano?

18 MEMBER CASSANO: I just have one  
19 question on it. They talked about the fact that  
20 this was a congressional mandate. And so, I  
21 don't know if it is within the purview of the  
22 Board that if after deliberation we find that

1 there is no good way to squeeze this lemon from  
2 Part B to Part E, if it is within the purview of  
3 the Board to recommend that DOL ask for some  
4 statutory relief in changing the standard and the  
5 statute.

6 CHAIR MARKOWITZ: Dr. Welch?

7 I mean, I think just to comment on  
8 that, if we are looking at this issue, these  
9 couple of issues, we can make certainly  
10 observations about weaknesses or deficiencies.  
11 We could probably make some recommendations in  
12 general, though not necessarily to the Secretary,  
13 about how such a situation might be improved.

14 Dr. Dement?

15 MEMBER DEMENT: Yes, it looks like  
16 Task No. 3 is very specific to Subpart B. So, we  
17 are not dealing with what I think is a much  
18 broader issue, and that is all the other lung  
19 diseases that occur beyond the very few we  
20 discuss here. Where do we get to those? Do we  
21 get to those in Task 2? I mean, where does this  
22 come in? For example, where do we consider

1 criteria for COPD?

2 CHAIR MARKOWITZ: Dr. Welch?

3 MEMBER WELCH: Well, I think that in  
4 some ways it could go into 1 or 2 because,  
5 really, the issue with COPD is how much exposure,  
6 what kind of exposures and how much exposure do  
7 you need, and what documentation for that do you  
8 need, to determine that it is work-related under  
9 the statute? I see the discussion of SEM as  
10 really the discussion of exposure assessment  
11 rather than the SEM as part of that. So, that  
12 could go there.

13 It is kind of where would you put, if  
14 we were going to help the agency write a  
15 presumption for COPD, where would that go? But  
16 that probably goes under 2.

17 CHAIR MARKOWITZ: Yes. Yes, probably  
18 2.

19 Dr. Redlich?

20 MEMBER REDLICH: Well, I was hoping  
21 John wouldn't raise that question because I was  
22 going to offer to see with the more limited

1 version of addressing beryllium and sarcoid, but  
2 it is --

3 CHAIR MARKOWITZ: But I think what Dr.  
4 Welch was saying is that C is more limited.  
5 Subtitle B, lung disease issues. And I think  
6 John wanted to make sure that we didn't forget  
7 about the rest more than where we were going to  
8 put it. It is not going to be in C. So, you  
9 shouldn't be discouraged.

10 (Laughter.)

11 MEMBER VLIEGER: Dr. Redlich, you  
12 could volunteer for more than one Committee.

13 (Laughter.)

14 CHAIR MARKOWITZ: Mr. Whitley?

15 MEMBER WHITLEY: Yes. It is Garry  
16 Whitley.

17 From a medical side of the house, is  
18 there anything besides the LPT test that -- I see  
19 it is kind of like, he said, the gold standard.  
20 But we have people that have eight inconclusives.  
21 You never get an abnormal, but they got eight  
22 inconclusives. I was just talking to Kirk. He

1 said they had the same thing, eight or nine  
2 times. They never get a negative; they never get  
3 a positive. Is there anything else? I mean, I  
4 don't know.

5 MEMBER DEMENT: Yes, people with CBD  
6 will never get a positive BeLPT.

7 CHAIR MARKOWITZ: Dr. Welch?

8 MEMBER WELCH: Well, it is kind of a  
9 technical question. But, if what they are  
10 getting is an indeterminate result, then the  
11 people at ORISE recommend you do a test with  
12 autologous serum, as opposed to just continuing  
13 to do the same test. You do a different kind of  
14 test. And that should come out positive or  
15 negative and not indeterminate. So, those people  
16 could talk to the ORISE experts or I can tell you  
17 how. Because we have a process where, if we get  
18 two indeterminates, we don't run the test again.  
19 We do a whole different system.

20 CHAIR MARKOWITZ: Other comments?

21 MEMBER REDLICH: I think there have  
22 been issues with some of the different labs.



1 MEMBER WELCH: Yes, that's true.

2 CHAIR MARKOWITZ: So, who would like  
3 to serve on this Committee, besides Dr. Redlich?

4 MEMBER REDLICH: Laura has a lot of  
5 experience.

6 CHAIR MARKOWITZ: That covers the  
7 medical side.

8 MEMBER REDLICH: Someone on the  
9 exposure side, I think. No, I think I would like  
10 some input on what issues --

11 MEMBER DOMINA: Just for your  
12 information, back in June of 2008, the Department  
13 of Energy told Hanford, "You need to have one  
14 beryllium program." We are in 2016 and we are  
15 still fighting with the contractors to come up  
16 with what that program is going to be.

17 And we do have a different standard to  
18 be more protective for the worker, and that is  
19 why I am kind of concerned, based on the rewrite  
20 of 10 CFR 850, of doing something here, and then,  
21 850 saying something different. And that is why  
22 I asked Pat Worthington yesterday, just like I

1 did a month ago in Denver, about it, because this  
2 rewrite was supposed to come out three years ago.  
3 And so, I have a concern with that.

4 MEMBER REDLICH: Not to keep going on  
5 with beryllium, but how many of the actual  
6 workers are machinist type? Are there many or  
7 not?

8 MEMBER DOMINA: No.

9 MEMBER REDLICH: Okay.

10 MEMBER DOMINA: We have janitors. We  
11 get, right now, at Hanford over the last couple  
12 of years, we have been getting like three, two to  
13 three, four newly-diagnosed workers a month  
14 sensitized, some CBD, and these are not long-term  
15 workers. These are workers that are 10 to 15  
16 years. Okay?

17 And that is one of the other issues we  
18 are having, especially in the D&D world, where  
19 they are saying, you know, that we believe that  
20 the exposure that people can get needs to be a  
21 lot lower than what it has been previously,  
22 because of all the sensitization and the CBD that

1 we are getting.

2 CHAIR MARKOWITZ: You know, I think if  
3 Ms. Leiton could actually just review the  
4 statutory requirements for us, it would help.

5 MS. LEITON: Sorry, I just want to  
6 clarify. Ms. Vlieger made a good observation  
7 there, and I apologize that the slides themselves  
8 probably should have specifically outlined what  
9 is in the statute in terms of pre- and post-.

10 For post-1993 beryllium disease, the  
11 statute requires any of the following: so, it is  
12 basically beryllium sensitivity together with  
13 lung pathology consistent with chronic beryllium  
14 disease, including the three things. And we will  
15 replace your slides.

16 But, first, it is lung biopsy showing  
17 granulomas or lymphocytic process consistent with  
18 CBD and a CT -- or, no -- a Computerized Axial  
19 Tomography scan showing changes consistent with  
20 chronic beryllium disease, or pulmonary function  
21 or exercise testing showing pulmonary deficits  
22 consistent with CBD. So, those are the three.

1 One of the three, the lung biopsy, the CT scan,  
2 or a PT test showing pulmonary deficit consistent  
3 with CBD. That is post-1993, and that is where  
4 it specifically says it has to be consistent with  
5 CBD.

6 So, our question is, right now, we go  
7 to the doctor. The doctor has to come back to us  
8 and say, "This lung pathology is consistent with  
9 CBD."

10 MEMBER REDLICH: I get it. We can  
11 define that.

12 MS. LEITON: So, how do we get them to  
13 help us do that?

14 MEMBER REDLICH: That is a fixable  
15 problem.

16 MS. LEITON: So, that is what I am  
17 thinking. I just want to make sure, those are  
18 the statutes we have to abide by, but we have the  
19 wiggle room where, how do we get that definition  
20 from the doctor?

21 So, for pre-1993, you have to have the  
22 presence of the history, the epidemiological

1 evidence, beryllium exposure, which we pretty  
2 much assume, and any three of the following  
3 criteria: characteristic chest radiograph or  
4 Computed Tomography, CT, abnormalities. And I  
5 think this is right on the slides, but just to  
6 reiterate: restrictive or obstructive lung  
7 physiology testing or diffusing lung capacity  
8 defect, lung pathology consistent with chronic  
9 beryllium disease, clinical course consistent  
10 with a chronic respiratory disorder,  
11 immunological tests showing beryllium  
12 sensitivity, which could be a skin patch or a  
13 beryllium blood test preferred.

14 So, here's where some of this says  
15 specifically lung pathology consistent with CBD.  
16 But, if you don't have that, if the doctors  
17 aren't going to tell you that, this gets back to  
18 your point, Dr. Boden, where you said, if the  
19 doctor doesn't say that, that you could have  
20 three of the other ones, like restrictive lung  
21 physiology testing, clinical course consistent  
22 with a chronic respiratory disorder, and

1 immunological tests showing beryllium  
2 sensitivity. Those three don't say anything  
3 about CBD necessarily.

4 But, then, you have got the lung  
5 pathology consistent with CBD and you have  
6 characteristic chest radiograph. What does that  
7 mean? How do we define "characteristic"? What  
8 do we look for in the reports from the doctor?  
9 And how can the doctors help us with those  
10 criteria when we are actually trying to outline  
11 what that means?

12 So, that is where we think you guys  
13 might be able to really help us figure out, as a  
14 claims examiner, what do we say to the doctor?  
15 Well, is this characteristic of CBD? Are they  
16 going to come back and say, "Yes, it is  
17 characteristic of CBD."? That is where the use  
18 of the term "CBD" or just "characteristic chest  
19 radiograph," where is our wiggle room? What do  
20 we really need to be looking at? What specific  
21 objective findings can we use to apply these  
22 tests?

1           Now we have procedures; we have ways  
2 of doing it now. But this is why I believe that  
3 this was one of the topics they wanted the Board  
4 to look at, because it is so restrictive, but it  
5 is also like, where can we find the middle ground  
6 somewhere in these two statutory criteria that we  
7 really can't change?

8           So, I hope that like clarifies.

9           CHAIR MARKOWITZ: Thank you.

10          Dr. Welch?

11          MEMBER WELCH: But now I am a little  
12 confused because I think you just said that the  
13 post-1993 criteria are completely different than  
14 what is written here.

15          MS. LEITON: Yes.

16          MEMBER WELCH: Okay. So, I would like  
17 this page --

18          MS. LEITON: I apologize for that. We  
19 are going to fix it. We are fixing it.

20          MEMBER WELCH: -- corrected and  
21 replaced in everybody's book.

22          MS. LEITON: We will. We are doing

1 it.

2 MEMBER WELCH: Because if this starts  
3 to float, I mean --

4 MS. LEITON: We will have it replaced  
5 by tomorrow.

6 MEMBER WELCH: Then, you could  
7 sometime explain to me how someone could possibly  
8 have done that.

9 MS. LEITON: I think a lot of that  
10 came from our Procedure Manual in terms of how we  
11 were interpreting some of the tests or what some  
12 of the tests mean and what we could be looking at  
13 in those test results to come up with pathology  
14 or the definition.

15 So, I will correct that tonight --

16 MEMBER WELCH: Okay.

17 MS. LEITON: -- make sure you have the  
18 correct page. But I apologize.

19 MEMBER REDLICH: So, it actually is  
20 pretty consistent with the ATS guideline and  
21 there is some --

22 MS. LEITON: But it is still kind of



1 restrictive.

2 MEMBER VLIEGER: If I might?

3 CHAIR MARKOWITZ: Sure.

4 MEMBER VLIEGER: This just goes to  
5 show you the different problems we have when we  
6 approach the positions, because they have read an  
7 article somewhere; they have read a study that is  
8 not accepted yet. It just makes this whole  
9 process of CBD claims and the discussion with the  
10 medical community and the discussion with the  
11 unions about protecting the workers so much more  
12 difficult because we don't have a level playing  
13 field of understanding.

14 CHAIR MARKOWITZ: Are there any  
15 additional comments or questions on this topic?

16 On the Committee we have Dr. Redlich,  
17 Dr. Welch, and Mr. Domina. And if other  
18 volunteers appear, that's great. I see some  
19 negotiations over there.

20 (Laughter.)

21 CHAIR MARKOWITZ: Okay. So, what we  
22 are going to do, we need to set up for the next

1 session. All right. We are going to take a  
2 five-minute break, just so we can set things up.  
3 So, please be back in five minutes. Thanks.

4 (Whereupon, the above-entitled matter  
5 went off the record at 2:16 p.m. and resumed at  
6 2:30 p.m.)

7 CHAIR MARKOWITZ: We are going to  
8 start the next session here.

9 So, this is the Board's opportunity --  
10 we also have a session tomorrow -- to provide DOL  
11 with input on proposed changes in regulations.  
12 Let me give a little bit of background. The  
13 Board knows this because you have participated in  
14 our discussions on Subcommittees so far, but I  
15 think the other attendees and the public who  
16 might be on the phone aren't aware. So, let me  
17 just give a little bit of background.

18 Several weeks ago the Department of  
19 Labor reopened the record for comments on the  
20 proposed rules. And part of that reopening was  
21 essentially an invitation to us to look at the  
22 proposed rules and make comments on proposals

1 that related, in particular, to the Scope of Work  
2 that has been assigned to the Board.

3 The way we went about that was we  
4 received a briefing on the phone by the Associate  
5 Solicitor -- thank you -- here at the Department  
6 of Labor, who essentially just went over the  
7 proposed changes with us. It was not a  
8 discussion, if you recall. It certainly wasn't a  
9 discussion among the Board. It was really just  
10 letting us know what the proposed changes were.

11 We, then, scheduled a number of phone  
12 calls and had these transient Subcommittees which  
13 were formed not by theme or by particular  
14 proposed changes, but just by convenience, who  
15 could be on the phone at what time. And so, we  
16 had three phone calls, different sized groups  
17 among the Board, in which we discussed the  
18 proposed changes and ideas about those changes.  
19 And each group had a scribe and recorded our  
20 thoughts about the proposed changes. There was a  
21 lot of similarity among the different groups in  
22 terms of the thinking.

1           Our task now is to look at those  
2 changes again and, if we can, come to some  
3 consensus about recommendations we would make or  
4 input we would make to the Department of Labor  
5 about the proposed changes.

6           The comment period is open until May  
7 9th. So that, essentially, if we don't provide  
8 input today or tomorrow, then we are not  
9 providing input as a Board, because to meet again  
10 as a Board before May 9th by phone requires six  
11 weeks' notice, as we know.

12           (Laughter.)

13           CHAIR MARKOWITZ: And let me count the  
14 days. It is not six weeks until May 9th.

15           So, that means we basically have today  
16 and tomorrow in order to consider changes as a  
17 group, as a Board, and then, make  
18 recommendations, if we want.

19           Now I should say that Board members,  
20 as individuals, are certainly free to submit  
21 comments to the record by May 9th regarding  
22 proposed changes. That is apart from your Board

1 activity. But, as members of the public, they  
2 are entitled to do that.

3 So, if, say, we vote on something and  
4 you feel very strongly otherwise, or if there is  
5 something that we haven't covered that you think  
6 should be covered, by all means, that is up to  
7 you whether you want to submit the comment or  
8 not.

9 Another consideration, I would just  
10 say that this is a fairly challenging task for us  
11 to do in a number of ways. One is the Board, we  
12 started talking about these proposed changes  
13 before even the Board had met, before we had been  
14 oriented by DOL about the program. The education  
15 we have gotten over the past day and we will  
16 continue to get.

17 So, the Board has members of varying  
18 levels of knowledge about the program. And we  
19 are all, though, even those more knowledgeable  
20 are still very much getting up-to-speed about  
21 this. We are providing input, making changes in  
22 a program that we are just learning about. I

1 consider that to be challenging.

2 The other aspect is that it is a very  
3 compressed timeframe for looking at these  
4 changes. We have done what we could to look at  
5 the changes considered relevant and are going to  
6 provide input, I hope, by consensus.

7 One piece of the process I neglected  
8 to mention is that the Department of Labor did  
9 provide us with some unofficial guidance, I would  
10 say, about proposed changes that were within the  
11 scope of the charter of the Board and those that  
12 were not within the scope.

13 But that was not entirely  
14 prescriptive. We could certainly take changes  
15 from the second list, the list that was not  
16 considered to be within our scope, and move them  
17 over to within our scope. It was very clear that  
18 we could do that. In fact, we did that. So,  
19 that was helpful, but not in any way mandated to  
20 us, just to be transparent about the process.

21 Tony, anything I forgot about the  
22 process?

1 MR. RIOS: No.

2 CHAIR MARKOWITZ: Okay. So, what we  
3 would like to do now is --

4 MEMBER REDLICH: What has prompted the  
5 changes at this time? Or is there some reason  
6 for the timing right now?

7 CHAIR MARKOWITZ: I can't answer that.  
8 I don't know the answer to that question.  
9 Because of the rules under the Administrative Act  
10 regarding the proposed rulemaking process, there  
11 can be very limited information that we can at  
12 this point get out of DOL about the proposed  
13 rules. That is just the matter of what the  
14 governing rules are about the rulemaking process.

15 Now whether DOL can answer that  
16 question, I don't know, but I would turn that  
17 over to Mr. Rios.

18 MEMBER REDLICH: When was the last  
19 time? How often are these rules changed?

20 MR. RIOS: Yes. So, we are very much  
21 ahead of schedule right now. I had asked that  
22 the Associate Solicitor, who gave you all the

1 briefing -- if you remember, Tom GIBLIN -- I  
2 asked him to be present for this part of the  
3 conversation. But, because we are so ahead of  
4 schedule and he was scheduled in other meetings,  
5 I am trying to pull him out of the meeting that  
6 he is in right now. So, he will be here in less  
7 than five minutes. He can tell you the  
8 Department's position.

9 CHAIR MARKOWITZ: So, any other  
10 comments or questions?

11 (No response.)

12 CHAIR MARKOWITZ: All right. So, the  
13 way this is going to work is that we are going to  
14 identify certain issues. We are going to put  
15 them up on the screen. Well, first, we are going  
16 to show you the language from the proposed  
17 changes. It is in blue, and the black is the  
18 current regulations.

19 We will simply describe what provision  
20 we are looking at, so it is understood. Then,  
21 each of the three groups from the scribe will  
22 give us summary comments about that particular



1 proposed change. We will have some discussion  
2 about that change.

3 And then, I have taken it upon myself  
4 to actually draft, in the interest of time, draft  
5 written recommendations based on the three  
6 groups' discussions, which we will, then, put on  
7 the screen and further discuss, alter, and,  
8 ultimately, decide whether we want to endorse  
9 those recommendations or not. So, is that  
10 reasonably clear?

11 Now I would say, for the people who  
12 are sitting way back, I have asked on the screens  
13 for the text to be large as much as possible.  
14 You may not be able to see it. You may have to  
15 move up, if you want to see it. But, as opposed  
16 to maybe some of the other things we have shown  
17 on the screen, it will be hard to follow along  
18 unless you are able to see what we have on the  
19 screen. Okay?

20 Board members have, if you want, in  
21 your books, in your briefing books you have a  
22 tracked-change version of the proposed changes.

1 It is in Section 7. So, if it is any easier,  
2 then you can follow along in the written form.

3 MR. RIOS: Just entering into the room  
4 is Tom Giblin, the Associate Solicitor.

5 Tom, you can have a seat. And if you  
6 will hold the microphone, that would be better.

7 Thanks.

8 MR. GIBLIN: All right.

9 MR. RIOS: Okay. He is ready for  
10 questions. No, I'm kidding.

11 (Laughter.)

12 MR. GIBLIN: Fire away. I'll give you  
13 my best lawyer answer.

14 MR. RIOS: Carrie, do you want to ask  
15 your question again?

16 MEMBER REDLICH: Well, I was just  
17 wondering what prompted changes at this time.

18 MR. GIBLIN: Well, the last two  
19 changes occurred as a result of statutory  
20 changes. You know, we got the EEOICPA statute in  
21 2001 and got Part E in 2004. So, we have been in  
22 the program now for close to 10 years. So, it

1 was a process of going through and looking at our  
2 regs again to see what we thought could be  
3 changed or needed to be changed. So, it was just  
4 good government, I guess would be the best way to  
5 describe it.

6 CHAIR MARKOWITZ: Are there other  
7 questions?

8 (No response.)

9 CHAIR MARKOWITZ: Let me say -- this  
10 is Steve Markowitz -- I mistakenly asked before  
11 when you were here about the rationale a certain  
12 particular change that was being proposed, and I  
13 was told that at this point it really can't be  
14 discussed by the Department of Labor. We are  
15 free to discuss it among ourselves. So, I just  
16 wanted to clarify that point, if there is  
17 anything else that I need to know?

18 MR. GIBLIN: No. I mean, we really,  
19 because we are in the open comment period, we  
20 really have to stick with providing the  
21 information that we have already provided to the  
22 public; in particular, the preamble to the NPRM.

1 That really sets out the basis for the changes.

2 CHAIR MARKOWITZ: Okay. Thank you.

3 MR. GIBLIN: Thank you.

4 CHAIR MARKOWITZ: And another comment  
5 I forgot to mention is that we are going to  
6 review about 10 proposed changes that we have  
7 identified as relevant to us, to our charter. I  
8 have invited Board members on other proposed  
9 changes over the last few weeks to bring them to  
10 our attention, so we could look at them and think  
11 about them. That hasn't been done, which is  
12 fine. We have until tomorrow, if there are  
13 additional changes. I'm not inviting; I'm just  
14 saying that that is the timetable. But, again, I  
15 would remind you they really have to fall within  
16 the scope of what we are supposed to do.

17 So, let's turn to the first one. I  
18 think that probably the easiest way of doing this  
19 is if one of us reads, actually. This is on page  
20 40, for those of you looking at the print. It is  
21 Section 30.231. It is about approving employment  
22 and, ultimately, exposure.

1 I just want to read the first one.

2 (a), the current language is, quote, "Proof of  
3 employment may be established by any trustworthy  
4 records that on their face, or in conjunction  
5 with other such records, establish that the  
6 employee was so employed and the written time  
7 periods of such employment."

8 And so, the new language, which  
9 doesn't replace but augments the current  
10 language, is, quote, "If the only evidence of  
11 covered employment is a written affidavit or a  
12 declaration, subject to penalty of perjury by the  
13 employee, survivor, or any other person, and DoD  
14 or another entity either disagrees with the  
15 assertion of covered employment or cannot concur  
16 or disagree with the assertion of covered  
17 employment, then OWCP will evaluate the probative  
18 value of the affidavit in conjunction with the  
19 other evidence of employment, and may determine  
20 that the claimant has not met his or her burden  
21 of proof under Section 30.111."

22 So, the recorder for each of the

1 groups, Laurie Welch, maybe you could start?

2 MEMBER WELCH: Okay. When our little  
3 group discussed this, we had some kind of  
4 specific concerns, one of which was in the new  
5 highlighted evidence. In one place it says, "If  
6 the only evidence of covered employment," et  
7 cetera, et cetera, "then OWCP will evaluate the  
8 probative evidence of the affidavit in  
9 conjunction with the other evidence of  
10 employment."

11 So, it is internally inconsistent  
12 because it is talking as if there is only an  
13 affidavit, but, then, refers to other evidence of  
14 employment.

15 Overall, we understand this change to  
16 make a worker's affidavit less valuable or it  
17 implies that the affidavit is less valuable by  
18 describing it that way. And I think it was this  
19 section, of our group, we felt that the  
20 claimant's occupational history in affidavit form  
21 should be an item that can be used to demonstrate  
22 exposure and employment. Essentially, that a

1 detailed affidavit about employment, job tasks,  
2 activities, should be considered a valuable piece  
3 of information. And our understanding of this  
4 change is it is a way to discount an affidavit if  
5 it is the only thing available. That is in (a).

6 So, do we want to discuss (a)'s --

7 CHAIR MARKOWITZ: We are just  
8 discussing (a).

9 MEMBER WELCH: -- separately from the  
10 SEM groups? Okay.

11 CHAIR MARKOWITZ: Yes.

12 Mark?

13 MEMBER GRIFFON: Yes. Our group,  
14 which was me and John Dement and Steve, a very  
15 small group, came up with similar stuff.

16 I mean, one specific question in (a)  
17 that we asked for further information was there  
18 is also a phrase "another entity" which refers, I  
19 think, to -- it says, "DOE or another entity  
20 demonstrate or challenge the employment in that  
21 time period". And we just wanted to know what  
22 "another entity" would be.

1           And then, defining "probative value,"  
2 I think that comes up in several sections as we  
3 went on. I think that came up again.

4           And can the OWCP give further  
5 guidelines on what elements should be included in  
6 an affidavit to improve its utility? So,  
7 overlapping, I guess.

8           MEMBER WELCH: Similar.

9           MEMBER GRIFFON: Yes.

10          CHAIR MARKOWITZ: And Ken?

11          MEMBER SILVER: Yes. We had a fairly  
12 large subcommittee. And now, for something  
13 completely different, our consensus I think was  
14 that the proposed change represents a slight  
15 improvement for claimants because consideration  
16 of affidavits is made explicit. Affidavits are  
17 not mentioned in the old language. It may be  
18 that our subcommittee was just kind of finding  
19 its legs. This is the first issue we brought up.

20          CHAIR MARKOWITZ: So, other comments  
21 from Board members on this?

22                   (No response.)



1                   CHAIR MARKOWITZ:  Actually, if you  
2                   could switch to the draft recommendation?  Let me  
3                   read this.  So, it will give you a moment to  
4                   understand it.

5                   "The Board finds that the proposed new  
6                   language is vague and contradictory.  The Board  
7                   recommends that DOL specify what is meant by" --  
8                   quote -- "`another entity'" -- end of quote --  
9                   "that the term `probative value' may be further  
10                  defined, and that the term `disagrees' be more  
11                  readily understandable.

12                  "The Board notes that the proposed new  
13                  language contradicts Section 30.111(c) in a  
14                  manner that limits the value of affidavits.  If  
15                  the goal is to increase the likelihood that  
16                  affidavits are valid, then guidelines on what  
17                  elements need to be included in an affidavit  
18                  should be issued to clarify the claimant's task  
19                  of proving an employment history in the absence  
20                  of other evidence.

21                  "The Board further recommends that the  
22                  apparent contradictions in the proposed rule

1 changes be resolved. That is, the proposed  
2 language sets out conditions when the affidavit  
3 is" -- quote -- "`the only evidence'" -- end of  
4 quote -- "and later states that OWCP will  
5 evaluate the" -- quote -- "`affidavit in  
6 conjunction with the other evidence of  
7 employment.'" End of quote.

8 So, comments, corrections?

9 Dr. Redlich?

10 MEMBER REDLICH: Well, just from an  
11 occupational physician point of view and  
12 occupational history, especially when you are  
13 dealing with many, many years of exposure and  
14 more chronic disease, is really considered  
15 probably the best available way to assess  
16 exposure. So, I wouldn't want any wording that  
17 minimized that evidence, as Laura said.

18 CHAIR MARKOWITZ: If you turn to page  
19 26, I just want to point out 30.111, Section (c),  
20 because it is directly relevant to this.  
21 Frankly, the new language appears to contradict  
22 it. So, let me just read it, although in the

1 near future there should be some other readers  
2 here.

3 I'm not sure, can you go back?

4 Actually, it is page 26 and it is 30.111(c). Go  
5 down a little, a few paragraphs. There, you are  
6 almost there. Okay. Let's see. Yes.

7 So, it says, quote, "Written  
8 affidavits or declarations, subject to penalty  
9 for perjury by the employee, survivor, or any  
10 other person, will be accepted as evidence of  
11 employment history and survivor relationship for  
12 the purposes of establishing eligibility and may  
13 be relied on in determining whether a claim meets  
14 the requirements of the Act for benefits if, and  
15 only if, such person attests that due diligence  
16 was used to obtain records in support of the  
17 claim, but that no records exist."

18 So, this paragraph addresses the value  
19 and the conditions under which affidavits will be  
20 accepted without really any limitation, except  
21 for the fact that the claimant has to exercise  
22 due diligence in finding the appropriate records,

1 unless I misunderstand this paragraph.

2 And so, the proposed change appears to  
3 move away from that and appears to set some  
4 optional restrictions on the use of affidavits.

5 Dr. Boden?

6 MEMBER BODEN: So, a couple of  
7 comments. One is, actually, the last line or two  
8 of the proposed change is also odd in that it  
9 sort of limits it to ignoring the affidavit  
10 rather than saying that they could either approve  
11 or disapprove of the affidavit.

12 I would actually suggest a different  
13 approach to this, a simpler approach, that says,  
14 maybe with some preamble, that we would suggest  
15 that that change be eliminated, and maybe with  
16 the same preamble. But it just seems to me, now  
17 that we have taken a second look at it, that it  
18 really doesn't enhance the ability of DOL to  
19 either accept or reject on a reasonable basis the  
20 affidavit. But it puts the affidavit in a rather  
21 negative light.

22 CHAIR MARKOWITZ: Other comments,

1 questions?

2 Yes, Dr. Cassano.

3 MEMBER CASSANO: Tori Cassano.

4 I agree with Dr. Boden and the comment  
5 about the internal inconsistency. If they wanted  
6 to make any kind of qualification about the  
7 affidavit, my suggestion would, basically, be to  
8 take out that whole middle part and, essentially,  
9 say after "subject to penalty of perjury by the  
10 employee," yada, yada, yada, take out all the  
11 rest and just say, "then OWCP will evaluate the  
12 probative value of the affidavit." Period. And  
13 be silent on the biased statement about disagree  
14 versus agree or deny versus accept.

15 CHAIR MARKOWITZ: Dr. Welch?

16 MEMBER WELCH: The problem with your  
17 suggestion is, then, it is just really clearly in  
18 contrast or in opposition to the 30.111(c)  
19 because that says an affidavit is sufficient.

20 MEMBER CASSANO: Yes.

21 MEMBER WELCH: And then, you're saying  
22 OWCP could decide, if it is the only evidence,

1 that it is not sufficient. So, I think I am  
2 coming down to going with Les' suggestion.

3 I mean, what this is saying is that,  
4 if the affidavit is the only evidence and DOE  
5 disagrees, then the claims examiner can make some  
6 decision. Well, maybe that is okay, I mean if  
7 there is contradictory evidence. But it goes on  
8 to say "disagrees or cannot concur," you know,  
9 which is different. That's different, right,  
10 cannot occur or disagree, meaning DOE has no  
11 evidence. So, I think the simplest thing would  
12 be to eliminate it because, under the statute,  
13 the examiners and the agency have the ability to  
14 weigh conflicting evidence, if there is  
15 conflicting evidence with the affidavit. But we  
16 would have to get concurrence on that idea from  
17 everybody.

18 CHAIR MARKOWITZ: So, other comments?

19 (No response.)

20 CHAIR MARKOWITZ: So, we need a  
21 motion, actually.

22 MEMBER BODEN: Can you go back to the

1 original change?

2 CHAIR MARKOWITZ: Sure.

3 MEMBER WELCH: Les, if you want to  
4 read it, it is in your briefing book.

5 MEMBER BODEN: I mean, our suggestion.

6 MEMBER WELCH: Or our suggestion?

7 Yes.

8 CHAIR MARKOWITZ: The draft  
9 recommendation?

10 MEMBER BODEN: The draft whatever that  
11 was called.

12 MR. RIOS: So, you want what Steve  
13 wrote? Okay. That was up there, yes. There it  
14 is right there.

15 MEMBER BODEN: So, I would recommend  
16 that we keep the initial paragraph. Well, let's  
17 see. Let's read it again. That we keep the  
18 initial two sentences of the paragraph and simply  
19 say that the Board recommends that the changes --  
20 I'm not quite sure of the wording, but that the  
21 changes, recommends that the changes not be made.  
22 So, maybe somebody can help me with the wording

1 on that.

2 CHAIR MARKOWITZ: Dr. Friedman-  
3 Jimenez?

4 MEMBER FRIEDMAN-JIMENEZ: If you  
5 remove the change and go back to the original  
6 language, essentially, what it says is, "Proof of  
7 employment may be established by any trustworthy  
8 records that established that the employee was so  
9 employed." It is kind of redundant and it  
10 doesn't really say much. And I think that we are  
11 trying to give some specificity to it. So, maybe  
12 we might want to suggest some more clear way of  
13 specifying what kind of records will prove  
14 employment.

15 CHAIR MARKOWITZ: Well, you know,  
16 that's really a different issue. The proposed  
17 change really focuses on the issue of the  
18 affidavit and how they are going to look at the  
19 affidavit. It is not on the whole set of sources  
20 they go to, which we have heard about, to prove  
21 employment.

22 So, it is recommending detail here on



1 the other sources is not on the table. I  
2 understand your point, and it is in the  
3 documentation that DOL provides, but it doesn't  
4 relate to the proposed change.

5 MEMBER FRIEDMAN-JIMENEZ: What I am  
6 saying is that we should keep something in it  
7 that includes mentioning the affidavit.

8 MEMBER WELCH: Yes, that's in the  
9 previous section, 30.111 and 30.112.

10 MEMBER FRIEDMAN-JIMENEZ: One eleven.

11 MEMBER WELCH: And 112.

12 CHAIR MARKOWITZ: Yes, which is on  
13 page 26.

14 CHAIR MARKOWITZ: Dr. Cassano?

15 MEMBER CASSANO: Actually, taking up  
16 what was just said and trying to revise what I  
17 said before, actually, if you take that first  
18 sentence, put a comma after "such employment,"  
19 and say -- I'm sorry. If you took that first  
20 sentence under "Proof of Employment," and put a  
21 comma after that first sentence, "including an  
22 affidavit as defined under 30.111(c) and 30." --

1 or whatever else it is. And that is all you  
2 need.

3 MEMBER WELCH: I don't think you need  
4 it.

5 MEMBER CASSANO: I don't know. I  
6 think you do because somebody may decide that it  
7 is not a trusted record. I don't know.

8 CHAIR MARKOWITZ: Dr. Welch?

9 MEMBER WELCH: So, what this paragraph  
10 30.231 is about is proving employment-related  
11 exposure to a toxic substance. That is the  
12 heading. So, to do that, first, they have to  
13 demonstrate they were employed. And then, they  
14 have to demonstrate there was proof of toxic  
15 substances.

16 So, one option for (a) is to refer  
17 back to the previous section where it talk about  
18 how they demonstrate that they are employed,  
19 which would solve what, George, I think you were  
20 thinking that first paragraph (a) was a little,  
21 the first sentence in (a) was kind of redundant  
22 and unnecessary. But it is defined previously,

1 you know. So, proof of employment may be  
2 established as specified under 30.111. Because  
3 this paragraph is really, the heading is really  
4 about (b), but, obviously, you can't prove toxic  
5 exposure unless you first prove that you were  
6 employed. I mean, it is stepwise.

7 CHAIR MARKOWITZ: So, let me ask Mr.  
8 Giblin a question here about what we are  
9 permitted to do. We're looking at the proposed  
10 changes and trying to provide input on specific  
11 new language. Are we also permitted to provide  
12 input on existing language which is not up for  
13 revision or add language such as being proposed  
14 here? Add language which is, again, not already  
15 in the proposed changes?

16 MR. GIBLIN: The comments really need  
17 to be limited to the proposed changes. I mean,  
18 that is the purpose of the exercise under the  
19 APA, is that we notify folks of what changes we  
20 are making and let people comment on those. If  
21 you were to comment on changes that were made  
22 and, then, we agreed with them, we would probably

1 have to go through another rulemaking because,  
2 see, people wouldn't have notice that we made the  
3 change. And so, it is kind of circular.

4 MEMBER WELCH: Right. Right. That  
5 makes sense.

6 CHAIR MARKOWITZ: Okay. So, that is  
7 very helpful because it restricts our attention  
8 to new language. So, that's good.

9 What are we back to? Take a step back  
10 here.

11 MEMBER REDLICH: Could we just make  
12 sure that whatever change, because this is also  
13 referred to on page 27, and I'm having a little  
14 trouble telling what's new and what's crossed out  
15 between the blue color and the line through the  
16 blue color. I'm a little confused. But, if  
17 someone just can make sure it is consistent?

18 MR. RIOS: Yes, that is how tracked-  
19 changes works.

20 CHAIR MARKOWITZ: Right. So, looking  
21 at this language on page 27, it's Section 30.112,  
22 paragraph (3), or I don't know what you call

1 these subsections. But it contains the same  
2 contradictory language; whereas, the only  
3 evidence it starts off of is a written affidavit.  
4 Then, skipping down, "OWCP will evaluate the  
5 probative value of the affidavit in conjunction  
6 with other evidence of employment."

7 Okay. Well, let's decide first on  
8 231(a) and, then, we can go back to that language  
9 and provide input.

10 MEMBER BODEN: I had to write it down  
11 first. It is better that way.

12 So, my suggestion is, going back to  
13 the changes that were proposed, the  
14 recommendation that we would make is to keep the  
15 first two sentences of that recommendation and to  
16 follow those sentences with "The Board recommends  
17 that the proposed changes not be made."

18 CHAIR MARKOWITZ: I'm sorry, is that  
19 a motion?

20 MEMBER BODEN: That's motion.

21 CHAIR MARKOWITZ: Okay. So, I need a  
22 second.

1 (Seconded.)

2 CHAIR MARKOWITZ: So, discussion?

3 If you strike the new language,  
4 proposed language, then what sense is it to  
5 retain the second sentence of that  
6 recommendation, that the Board recommends that  
7 DOL specify what is meant by another entity --

8 MEMBER BODEN: No, I'm sorry. I guess  
9 I counted the sentences wrong. The first four  
10 lines; the first sentence, not the first two  
11 sentences.

12 CHAIR MARKOWITZ: Retain the first  
13 sentence?

14 MEMBER BODEN: No, there are the first  
15 two sentences. The first sentence is "The Board  
16 finds that the proposed new language is vague and  
17 contradictory." Oh, right, and that would be the  
18 only sentence that we would keep. And then, we  
19 would say, "The Board recommends that the changes  
20 not be made."

21 CHAIR MARKOWITZ: Excuse me. Dr.  
22 Welch?

1           MEMBER WELCH: I think including the  
2 first three sentences there, going down through  
3 "notes the proposed language contradicts Section  
4 30.111(c)," that is our reason for recommending  
5 that the language be eliminated --

6           MEMBER BODEN: Okay.

7           MEMBER WELCH: -- is those first  
8 three. So, I would do the first three and, then,  
9 put your language in.

10          MEMBER BODEN: I totally agree.

11          MEMBER WELCH: Friendly amendment to  
12 your proposal?

13          MEMBER BODEN: Friendly, very  
14 friendly.

15          MEMBER WELCH: Okay. Thank you.

16          (Laughter.)

17          CHAIR MARKOWITZ: I'm not quite  
18 understanding. You would retain the second  
19 sentence? "The Board recommends that DOL specify  
20 what is meant by `another entity'" and the term  
21 "probative value" be further defined?

22                 That is language which the motion is

1 to eliminate that language. So, it wouldn't make  
2 any sense to retain the second sentence.

3 MEMBER BODEN: Okay. So, the first  
4 and the third sentences.

5 CHAIR MARKOWITZ: Thank you. Okay.

6 MEMBER BODEN: We got it.

7 (Laughter.)

8 CHAIR MARKOWITZ: Yes, Mr. Griffon?

9 MEMBER GRIFFON: Yes, I just want to  
10 bring our attention back to page 27 because, I  
11 mean, I just want to be careful what I'm voting  
12 on here. I mean, if you go back to the old  
13 language, if we are saying we want to eliminate  
14 this, we would probably have to do the same thing  
15 in this section.

16 CHAIR MARKOWITZ: Yes.

17 MEMBER GRIFFON: And so, Section 3  
18 would then read, "If the only evidence for the  
19 covered employment is a self-serving affidavit,  
20 and DOE or another entity either disagrees or,"  
21 duh-duh-duh-duh-duh, "then the OWCP may reject  
22 the claim based upon a lack of evidence of



1 covered employment." That's the old language.

2 CHAIR MARKOWITZ: Okay. So, we will  
3 get --

4 MEMBER GRIFFON: Okay. Okay. All  
5 right. All right. We'll get to that.

6 CHAIR MARKOWITZ: We will get to that.

7 MEMBER GRIFFON: I just want to make  
8 sure we know. Okay.

9 CHAIR MARKOWITZ: We will get to that  
10 next.

11 MEMBER GRIFFON: All right. Sorry.

12 MEMBER WELCH: That was my concern  
13 over here.

14 MEMBER GRIFFON: Yes, yes, yes. Okay.  
15 Yes.

16 CHAIR MARKOWITZ: So, if we could go  
17 back to the -- question: since retaining the  
18 first sentence and the third sentence has  
19 something to do with providing some rationale for  
20 our recommendation, right, the fourth sentence,  
21 should we consider retaining that?

22 I quote: "If the goal is to increase

1 the likelihood that affidavits are valid, then  
2 the guidelines of what elements need to be  
3 included the affidavit should be issued to  
4 clarify the claimant's task of proving an  
5 employment history in the absence of other  
6 evidence." Or is that not really necessary?

7 Dr. Welch?

8 MEMBER WELCH: Well, I think we can't  
9 do that because that would be adding language to  
10 the statute, adding new changes that aren't  
11 there.

12 CHAIR MARKOWITZ: No, I'm sorry. This  
13 is part of the --

14 MEMBER WELCH: Oh, you talking about  
15 guidance?

16 CHAIR MARKOWITZ: -- rationale for our  
17 proposal. This would be in line with sentences  
18 one and three.

19 MEMBER WELCH: Right, but it says, it  
20 is suggesting guidelines. But I guess the  
21 guidelines could be not in the statute.

22 CHAIR MARKOWITZ: Right.

1 MEMBER WELCH: Not statutory.

2 CHAIR MARKOWITZ: Well, it could be  
3 procedural, not regulatory.

4 MEMBER WELCH: Right.

5 CHAIR MARKOWITZ: We could add, then,  
6 procedural guidelines or something, which  
7 actually already exist, right, to some extent?

8 MEMBER WELCH: I think that is  
9 reasonable.

10 CHAIR MARKOWITZ: So, we are on the  
11 friendly amendment phase, I think.

12 MEMBER BODEN: Yes.

13 CHAIR MARKOWITZ: So, one friendly  
14 amendment was to include the first sentence and  
15 the third sentence. And the next is to include  
16 this sentence which was just highlighted, the  
17 fourth sentence, amended to say, then,  
18 "procedural guidelines" under what elements, to  
19 make it clear that we are not talking about  
20 regulatory guidelines. Does that capture it?

21 MEMBER BODEN: How about just saying,  
22 then, "information on what elements need to" --

1 because procedural guidelines is also maybe, it  
2 is not clear what that means.

3 CHAIR MARKOWITZ: Yes, yes. Okay.

4 MEMBER SILVER: I think, as someone  
5 who has spent time around the Federal Register  
6 and administrative law, knows that there are  
7 regulations that are binding and, then, there are  
8 guidelines, guidance, that are just suggestive.  
9 So, I think it is fine the way it is.

10 CHAIR MARKOWITZ: Any other comments  
11 on that sentence?

12 (No response.)

13 CHAIR MARKOWITZ: And we look at the  
14 next paragraph, which is unnecessary because we  
15 are recommending that the whole section be  
16 struck. Okay.

17 So, I am going to just ask Kevin if  
18 you could delete the second sentence and the last  
19 paragraph? Right. Or you could strike through  
20 it, whichever it. You can delete it. Okay. And  
21 then, delete the last paragraph. Okay.

22 Okay. And we can add now Les' motion,

1 which is, "The Board recommends that" --

2 MEMBER BODEN: "The proposed changes  
3 not be made."

4 CHAIR MARKOWITZ: Okay.

5 MEMBER BODEN: "The proposed changes  
6 not be made."

7 CHAIR MARKOWITZ: Okay. So, we're now  
8 looking at the language of the motion with its  
9 rationale or preamble. Any further comments or  
10 discussion on this before we take a vote?

11 Sure. Mark?

12 MEMBER GRIFFON: I just have a process  
13 question. Do we want to vote on these one at a  
14 time or are we going to vote on a set of comments  
15 that we're submitting as the Board to DOL? I  
16 mean, it might be worth going through all of them  
17 and sort of drafting, getting the sense of the  
18 Board and, then, saving our votes for tomorrow.  
19 That way, we can look over them if we have any  
20 final thoughts or deliberations tomorrow. Just a  
21 thought, you know --

22 CHAIR MARKOWITZ: Right, right, right,

1 right.

2 MEMBER GRIFFON: -- in terms of  
3 process.

4 CHAIR MARKOWITZ: Right. Yes.

5 Anybody have any thoughts about that?

6 I think the question is hold off on the vote  
7 until tomorrow --

8 MEMBER GRIFFON: Yes. I guess two  
9 questions. One is I don't know if we are going  
10 to submit comments from the Board, if I vote on  
11 each individual one and I disagree with one, what  
12 does that mean?

13 CHAIR MARKOWITZ: Right, right.

14 MEMBER GRIFFON: Are we just going to  
15 vote on one set of recommendations or are we  
16 going to --

17 CHAIR MARKOWITZ: Right. I think we  
18 should vote on them individually because there  
19 may be difference of opinions.

20 MEMBER GRIFFON: But the plan is  
21 saving the votes for tomorrow.

22 CHAIR MARKOWITZ: Right, right.

1           MEMBER GRIFFON: Getting the sense of  
2 our language today and, then, maybe sort of  
3 emailing it to everyone, so we can look at it,  
4 look it over tonight before we do our final  
5 votes.

6           CHAIR MARKOWITZ: Mr. Rios is simply  
7 saying that, yes, we could, when we reconvene  
8 tomorrow, go over these and vote. We can't meet  
9 tonight and discuss them as the Board.

10          MEMBER VLIEGER: I think the intent of  
11 the comment was assigning us homework tonight,  
12 separately and individually in our own little  
13 rooms with our own little computers, not to have  
14 a meeting. So, I have to contradict the intent  
15 that we are going to try to have a meeting.

16          MR. RIOS: He asked me if that was  
17 okay, and I told him as long as you don't go back  
18 to the hotel and review these in groups. So,  
19 there was no intent behind that.

20                   (Laughter.)

21          MR. RIOS: It was a response to a  
22 question.

1                   CHAIR MARKOWITZ:  So, we interrupted  
2                   the vote or the discussion on this to consider  
3                   another question.  Fine.  A question of process.  
4                   And that is, should we delay votes until tomorrow  
5                   to give people time to think and consider?  Any  
6                   comments on that?

7                   Yes, Ken?

8                   MEMBER SILVER:  Bonus, we get to hear  
9                   from folks during the public comment period with  
10                  our draft comments up there.

11                  CHAIR MARKOWITZ:  The only thing I  
12                  would say is that tomorrow we have an hour-and-a-  
13                  half scheduled for this, beginning at 10:45.  So,  
14                  Ms. Pope is going to be speaking downstairs  
15                  tomorrow at around 10:40, 10:45, as part of  
16                  Workers' Memorial Day.  There is a half-hour of  
17                  speeches, and whatnot, in recognition of Workers'  
18                  Memorial Day between 10:30 and 11:00.  And she  
19                  couldn't attend part of this.  And so, if we can  
20                  afford the time, we will take that half-hour to  
21                  be downstairs and participate, which would leave  
22                  -- it's a half-hour -- leave us an hour tomorrow.



1                   So, from my point of view, the only  
2                   consideration is a practical one. Can we take  
3                   all the votes tomorrow on all the issues?

4                   Dr. Cassano?

5                   MEMBER CASSANO: Can we split the  
6                   difference and sort of, if there's still some  
7                   question, then maybe we will table a vote on any  
8                   one issue until tomorrow? But, if we are pretty  
9                   much in concurrence and we feel that we can go to  
10                  a vote on an issue today, we do that.

11                  CHAIR MARKOWITZ: I do think that  
12                  there are about 10 items on our list, but many of  
13                  them are fairly straightforward, on which we  
14                  could take the vote and not feel a need to think  
15                  about it, and others on which it would be good to  
16                  have some time.

17                  So, I guess the proposal, then, is to  
18                  decide, with each proposed change that we look  
19                  at, whether we want to discuss it today, settle  
20                  on language, but, then, vote on it tomorrow.

21                  Les?

22                  MEMBER BODEN: Just one alternate

1 suggestion, if this would work procedurally,  
2 which is, we vote on them today, and if there are  
3 any we want to reconsider tomorrow, we bring them  
4 up.

5 CHAIR MARKOWITZ: Well, that is a  
6 variation.

7 (Laughter.)

8 CHAIR MARKOWITZ: That is noted.

9 MEMBER BODEN: I just prefer moving  
10 along and voting --

11 CHAIR MARKOWITZ: Right.

12 MEMBER BODEN: -- on things, but I  
13 appreciate the concern.

14 CHAIR MARKOWITZ: Right, right.

15 MEMBER BODEN: So, I was just trying  
16 to figure it out.

17 CHAIR MARKOWITZ: Right. Dr. Welch?

18 MEMBER WELCH: Well, I would want to  
19 make some more comments on this tomorrow after I  
20 read all the sections before, because I think we  
21 are going to have to edit this based on the  
22 previous -- what I am just reading now. So, I

1 would like to hold off on this one, but let's  
2 maybe move on.

3 Some little nuances. I mean, I would  
4 still say that we wouldn't want to make the  
5 proposed changes, but --

6 CHAIR MARKOWITZ: Okay.

7 MEMBER GRIFFON: I think I can live  
8 with that compromise, that some might be really  
9 straightforward. This one, I want to make sure  
10 we have got the language correct, yes. Yes.

11 CHAIR MARKOWITZ: Okay. So, I guess  
12 the motion is whether we vote on them  
13 individually, whether we are going to decide them  
14 today or tomorrow, right? So, is there any  
15 further discussion on that?

16 (No response.)

17 CHAIR MARKOWITZ: All in favor of,  
18 when we visit each of these proposed changes,  
19 that we simultaneously decide whether we are  
20 going to vote today or tomorrow. All those in  
21 favor of that?

22 (Show of hands.)

1 CHAIR MARKOWITZ: Okay, it is in  
2 favor. Okay. So now, let's revisit this  
3 proposed change. The question, I guess, is, the  
4 motion is to --

5  
6 MEMBER CASSANO: Motion to table.

7 CHAIR MARKOWITZ: Second?

8 (Seconded.)

9 CHAIR MARKOWITZ: Okay. Any further  
10 discussion on this?

11 (No response.)

12 CHAIR MARKOWITZ: Okay. All those in  
13 favor?

14 (Show of hands.)

15 CHAIR MARKOWITZ: Okay, it is the  
16 majority. All those opposed, I guess?  
17 Abstentions?

18 So, we have this language which we  
19 will revisit tomorrow.

20 Let's move on. Now I think we should  
21 go to this page 27, to this language. It is very  
22 closely related. It wasn't discussed separately

1 by each of the committees that met on this. And  
2 it is Item No. 3.

3 Does someone want to read this aloud,  
4 just for people in the back who can't see it or  
5 people on the phone who don't have access to it?

6 Dr. Cassano?

7 MEMBER CASSANO: "If the only evidence  
8 of covered employment is" -- and I am going to  
9 read the new language, not the old language --  
10 "is a written affidavit or declaration, subject  
11 to penalty of perjury by the employee, survivor,  
12 or any other person, and DoD or another entity  
13 either disagrees with the assertion of covered  
14 employment or cannot concur or disagree with the  
15 assertion of covered employment, then OWCP will  
16 evaluate the probative value of the affidavit in  
17 conjunction with the other evidence of  
18 employment, and may determine that the claimant  
19 has not met his or her burden of proof under  
20 Section 30.111."

21 CHAIR MARKOWITZ: Dr. Welch?

22 MEMBER WELCH: But I think, for

1 purposes of our work, we need to also read the  
2 old language because the old language -- I guess  
3 what it is is --

4 CHAIR MARKOWITZ: Could you read that?

5 MEMBER WELCH: The way it was read  
6 before was, "If the only evidence of covered  
7 employment is a self-serving affidavit, and DOE  
8 or another entity either disagrees with the  
9 assertion of covered employment or cannot concur  
10 or disagree with the assertion of covered  
11 employment, then OWCP may reject the claim based  
12 on a lack of evidence of covered employment."

13 CHAIR MARKOWITZ: Dr. Boden?

14 MEMBER BODEN: So, I have a suggestion  
15 about a rewording of the change. All right?  
16 Which would be -- and I will read this. So, it  
17 starts out the same.

18 "If the only evidence of covered  
19 employment is a" -- cross out "self-serving" --  
20 "written affidavit or declaration, subject to  
21 penalty of perjury by the employee, survivor, or  
22 any other person," then continue down to "then

1 OWCP will evaluate the probative value of the  
2 affidavit in conjunction" -- well, it can't be in  
3 conjunction -- "will evaluate the probative value  
4 of the affidavit." Period.

5 CHAIR MARKOWITZ: Okay.

6 MEMBER BODEN: So, that is a change.  
7 It strikes the "self-serving" from the old  
8 language. It includes the declaration subject to  
9 the penalty of perjury, and then, it doesn't say  
10 that it may determine that it is bad. It just  
11 says it will evaluate it, which seems all that is  
12 really necessary.

13 And then, it is consistent, I think,  
14 with the change that we recommended in the  
15 section that we just discussed.

16 CHAIR MARKOWITZ: So, I think it is  
17 important that we see what Les has proposed. So,  
18 I've just asked for this section to be copied,  
19 moved over to the draft recommendations, and  
20 then, we can review those changes --

21 MEMBER BODEN: Okay.

22 CHAIR MARKOWITZ: -- so we can all

1 look at the language that we are discussing.

2 MR. RIOS: I would like to make a  
3 request. Since you're putting together your  
4 write-ups that you are going to submit, as my  
5 role as a DFO, I am required to ensure that the  
6 Board stays within the objectives and the  
7 statutory scope, specifically, the four subject  
8 matter areas.

9 So, if you are going to make any  
10 recommendations on a particular reg, I would like  
11 for the Chair to describe how the particular reg  
12 on which you're going to make a recommendation  
13 falls within your statutory authority.

14 CHAIR MARKOWITZ: You want me to do  
15 that now with regard to this proposal, or you are  
16 saying in general?

17 MR. RIOS: So, each one of these, if  
18 you can evaluate which of the four subject matter  
19 areas it falls under, it would be helpful.

20 CHAIR MARKOWITZ: Okay. Well, I can  
21 tell you this issue of covered employment  
22 certainly relates to SEM and it relates to the



1 evaluation of medical evidence used to judge  
2 claims.

3 MEMBER BODEN: So, would you like me  
4 to go over my proposal with you?

5 So, we start the same. "If the only  
6 evidence of covered employment is a" -- cross out  
7 "self-serving".

8 (Pause.)

9 MEMBER BODEN: Okay. So, "If the only  
10 evidence of covered employment is a" -- cross out  
11 "self-serving". Then, it would say, "written  
12 affidavit or declaration, subject to penalty of  
13 perjury by the employee, survivor, or any other  
14 person," and then, cross out everything until  
15 "then OWCP". "Then, OWCP" -- and then, cross out  
16 "may reject the claim based upon a lack of  
17 evidence of covered employment". Yes. And then,  
18 keep "will evaluate the probative value of the  
19 affidavit." Period, and cross out the rest.

20 That's it.

21 MEMBER WELCH: Les, weren't you going  
22 to leave in the part about the old language, "DOE

1 or another entity agrees or disagrees"? Because  
2 I don't know that we can strike that.

3 MEMBER BODEN: Oh, no, sorry. I'm  
4 sorry.

5 MEMBER WELCH: I think we have to  
6 leave that in because it's not a change. I would  
7 love to strike it, but I don't think we can.

8 (Laughter.)

9 MEMBER BODEN: Yes, okay. I think we  
10 can't. I think you are right. I think we can't  
11 strike it, as much as I would like to, yes.  
12 Thank you, Laura.

13 Take out "may reject the claim based  
14 on a lack of evidence of covered employment,"  
15 right.

16 "Then OWCP will evaluate the probative  
17 value of the affidavit in conjunction with the  
18 other evidence of employment." But it is the  
19 only evidence. So, there can't be any other  
20 evidence, right? So, take that out. Period.

21 CHAIR MARKOWITZ: No, you took out not  
22 only the citation of the other evidence, you also

1       took out -- just clarifying whether you meant to  
2       do this -- take out the language that says, "may  
3       determine that the claimant has not met his or  
4       her burden of proof under 30.111."

5               MEMBER BODEN:  Yes, I did, because I  
6       think that is -- so, if that is unnecessary  
7       because it is already evaluating the probative  
8       evidence --

9               CHAIR MARKOWITZ:  Okay.

10              MEMBER BODEN:  -- the probative  
11       value --

12              CHAIR MARKOWITZ:  I wasn't asking why.  
13       I was just asking --

14              MEMBER BODEN:  Yes, but I do want to  
15       say, I actually do want to say why, right?  
16       Because this, again, gives it that negative  
17       twist, right, that says -- because if it says,  
18       "may evaluate the probative evidence," that means  
19       it could be good; it could be bad.  We'll have to  
20       decide.  But if you say, "will determine that it  
21       hasn't met," then it is pushing you in the  
22       direction of, well, it would be bad.

1                   MEMBER CASSANO: Just a friendly  
2 amendment which I think might solve the problem  
3 of getting the language about 30.111 in there is  
4 to say "as it relates to Section 30.111."  
5 Because, without that, you don't know what the  
6 probative evidence you have there is being used  
7 to do.

8                   MEMBER BODEN: Okay. Right. So, we  
9 could, then, put back in, "under paragraph  
10 30.111" --

11                   MEMBER CASSANO: Or "as it relates to  
12 30.111".

13                   MEMBER BODEN: Well, I think we should  
14 leave their language as much as possible.

15                   MEMBER CASSANO: Okay.

16                   MEMBER BODEN: So, that is their  
17 language.

18                   So, it would read then, "the probative  
19 value of the affidavit"

20                   MEMBER WELCH: "Under" --

21                   MEMBER BODEN: -- "under paragraph" or  
22 "Section 30.111".

1 MEMBER WELCH: Yes.

2 MEMBER BODEN: I am just trying to  
3 keep their language as much as we can.

4 CHAIR MARKOWITZ: Okay. So, we need  
5 a motion. We will discuss this some more, but we  
6 do need a motion around this.

7 Yes?

8 MEMBER WELCH: One little amendment.  
9 We have to reference where we are editing the  
10 document because we didn't have that in our -- I  
11 mean, this isn't a heading that we had before.  
12 So, we have to be sure to add the 30.112 --

13 MEMBER BODEN: .112.

14 MEMBER WELCH: -- heading there.

15 MEMBER BODEN: Yes, yes. So, I think  
16 we replaced the 30.231(b) there with 30.112.

17 MEMBER WELCH: But it has a different  
18 title, too.

19 MEMBER BODEN: Right.

20 CHAIR MARKOWITZ: 30.112(b)(3), right?

21 MEMBER BODEN: Yes, (b)(3).

22 CHAIR MARKOWITZ: And if you just take

1 out the title, I'll replace it.

2 MEMBER WELCH: Okay. Yes. Okay. And  
3 do you want to highlight it, so you remember that  
4 you need to change it?

5 CHAIR MARKOWITZ: Sure.

6 MEMBER BODEN: Just delete it.

7 CHAIR MARKOWITZ: You can delete that,  
8 but just highlight the 30.112(b). Okay. Thanks.

9 So, I'm sorry, what is the motion?

10 MEMBER CASSANO: The motion is to  
11 accept the proposed language unless there is a  
12 motion to table, I guess, first.

13 CHAIR MARKOWITZ: Okay. The motion is  
14 to recommend this language with the changes,  
15 right?

16 MEMBER CASSANO: Yes.

17 CHAIR MARKOWITZ: Okay. Is there a  
18 second?

19 (Seconded.)

20 CHAIR MARKOWITZ: Okay. So now,  
21 discussion? Further discussion?

22 (No response.)

1 CHAIR MARKOWITZ: Okay. So now, let's  
2 decide whether we want to vote on this today or  
3 tomorrow. Is there a motion to table this until  
4 tomorrow, as in the previous one?

5 I'm sorry, I'm not making myself  
6 clear. We have a motion. We can vote on this  
7 proposed change or we can table the vote and vote  
8 on it tomorrow.

9 And my question is whether you want to  
10 vote on now or whether you want to table it and  
11 vote on it tomorrow.

12 MEMBER TURNER: I was thinking about  
13 earlier we had made mention that we ought to let  
14 the public have their comments and, then, we can  
15 kind of get some more thoughts and vote on it  
16 tomorrow.

17 MEMBER VLIENER: Dr. Markowitz, I move  
18 that we table it until tomorrow.

19 MEMBER TURNER: Second.

20 CHAIR MARKOWITZ: Okay. So, the  
21 motion is to table. Fine. Any discussion on  
22 that motion?

1 (No response.)

2 CHAIR MARKOWITZ: If not, let's vote  
3 on whether -- the motion is to table the vote on  
4 this particular recommendation until tomorrow.  
5 All those in favor raise your hand.

6 (Show of hands.)

7 CHAIR MARKOWITZ: All those opposed?  
8 And any abstentions?

9 Okay. So, that passes. So, that is  
10 tabled. Let's move on to the next. We finished  
11 the first one. That's good.

12 (Laughter.)

13 CHAIR MARKOWITZ: The first is the  
14 toughest or maybe the second. I'm not sure.  
15 Maybe the third. But they do get easier; I will  
16 say that.

17 Anyway, this is the following item.  
18 It is on page 40, for the Board members, if you  
19 are looking at the print copy. Otherwise, it is  
20 coming up on the screen. It is proof of exposure  
21 to a toxic substance. If you are online or on  
22 the phone, it is Item (b) under 30.231.



1           And I think, again, it would probably  
2 help if we have someone read this.

3           MEMBER CASSANO: I will be the  
4 designated reader then.

5           CHAIR MARKOWITZ: Okay.

6           MEMBER CASSANO: And I'll read both  
7 languages, old and new, if it makes any sense.

8           "Proof of exposure to a toxic  
9 substance may be established by the submission of  
10 an appropriate document or information that is  
11 evidence that such substance was present at the  
12 facility" -- strike "in which"; substitute  
13 "where" -- "the employee was employed and that  
14 the employee came into contact with such  
15 substance." Strike "OWC Site Exposure Matrices,"  
16 is stricken out. And then, "Information from the  
17 following sources may be -- strike out "used to  
18 provide" and substitute "considered" -- "as  
19 probative factual evidence" -- strike out "that"  
20 -- "for purposes of establishing an employee's  
21 exposure to a toxic substance". And then, it  
22 says, "was present at a DOE facility or a RECA

1 Section 5 facility".

2 Do you want me to go through the 1, 2,  
3 and 3?

4 CHAIR MARKOWITZ: Yes.

5 MEMBER CASSANO: No. 1, "To the  
6 extent" -- and this is new language -- "To the  
7 extent practicable and appropriate from DOE, a  
8 DOE-sponsored Former Worker Program, or an entity  
9 that acted as a contractor or subcontractor to  
10 DOE;"

11 Two, "OWPC Site Exposure Matrices;"

12 Or, three, "any other entity deemed by  
13 OWPC to be a reliable source of information  
14 necessary to establish that the employee was  
15 exposed to a toxic substance at a DOE facility or  
16 RECA Section 5 facility."

17 CHAIR MARKOWITZ: Okay. So, we have  
18 just the comments from each of the three groups.

19 Laura, do you want to go first?

20 MEMBER WELCH: Sure. Our discussion,  
21 what I would summarize from our discussion was  
22 that we were unhappy with the vague -- Item No. 3

1       seemed to be vague, and we wanted the whole  
2       Committee to discuss it.

3               My opinion, now that I am reading it,  
4       the fact that it is very open, which is a good  
5       thing, but it allows other sources to come in.  
6       So, I personally don't have the same concern we  
7       had when we discussed it on the phone.

8               CHAIR MARKOWITZ:   Mark?

9               MEMBER GRIFFON:   Yes, we had the same  
10       comment, although I think we also said that  
11       guidelines, either regulatory or procedural  
12       guidelines, should be established to identify  
13       what other reliable sources of information might  
14       be.  And in my own opinion on that, it might be  
15       better to put that sort of in a procedure, rather  
16       than a regulation, because it might be involved;  
17       it is probably going to change anyway.

18              CHAIR MARKOWITZ:   Ken?

19              MEMBER SILVER:   Before the meeting, I  
20       grabbed the law dictionary off the shelf and saw  
21       that the word "entity" doesn't apply to  
22       individuals.  But, as a group, our recommendation

1 was in (b)(3) to drop the word "entity". So, it  
2 reads, "any other source of information deemed  
3 reliable".

4 CHAIR MARKOWITZ: Okay. So, if you  
5 could put up the draft recommendation, which is  
6 what I drafted from the various subcommittee  
7 comments?

8 I forgot to say, are there other  
9 comments at this point that people wanted to  
10 make?

11 (No response.)

12 CHAIR MARKOWITZ: Okay. Yes, Dr.  
13 Friedman-Jimenez?

14 MEMBER FRIEDMAN-JIMENEZ: A very quick  
15 grammatical question. After Item 1, is it  
16 understood that there is an "or" there?

17 CHAIR MARKOWITZ: Yes, I don't know.  
18 I don't know the answer to that.

19 I neglected to say why the Board is  
20 justified in looking at this proposed change in  
21 terms of our mandate, and this particular issue  
22 of proof of exposure to toxic substances relates

1 to (a) and (b) really, both the Site Exposure  
2 Matrices, because this is the information that is  
3 used, well, it actually specifies Site Exposure  
4 Matrices, but also the medical values which  
5 includes information about exposures.

6 So, let me read this language of this  
7 draft recommendation.

8 "The Board recommends that DOL  
9 change," quote, "`entity'", end of quote, "to",  
10 quote, "`entity or other information source'",  
11 end of quote, "guidelines (regulations or  
12 procedures) on how OWCP determines reliability of  
13 the sources of information should be established.  
14 The occupational history from the claimant or an  
15 affidavit with relevant exposure information from  
16 a coworker should be considered evidence of  
17 exposure. In addition, exposure information  
18 obtained from an occupational or other health  
19 provider who is not affiliated with a Former  
20 Worker Program should be accepted."

21 So, let me comment on this, actually.  
22 The changes recommended under this section expand

1 and specify the sources of information used to  
2 obtain evidence of exposure. The old language is  
3 less specific and the new language now goes and  
4 lists the sources of information for proof of  
5 exposure. Those that are listed are DOE, the  
6 Former Worker Program, other entities that were  
7 contractors or subcontractors of DOE. It adds  
8 the Site Exposure Matrices, and then, it adds any  
9 other entity deemed by OWCP to be a reliable  
10 source of information.

11 It doesn't, however, recognize that  
12 the claimant himself and coworkers have this  
13 exposure information. That is actually where we  
14 normally get it from in conducting an  
15 occupational medicine evaluation. So, I  
16 understand that there may be a wish to complement  
17 that information with other sources, but its  
18 absence here I think is problematic.

19 And then, the last sentence of this  
20 recommendation relates to naming other health  
21 providers other than those at the Former Worker  
22 Program as having useful information.

1 Dr. Boden?

2 MEMBER BODEN: I like this. I wonder  
3 if -- and this is sort of my thinking, trying to  
4 think like a lawyer, which is hard for me --  
5 whether saying "should be considered as evidence"  
6 should be changed to "may be considered as  
7 probative", which is what the rest of the  
8 language is. I don't know for sure, but saying  
9 "should be considered as evidence" means that you  
10 take it as valid in all circumstances, which may  
11 be limiting.

12 CHAIR MARKOWITZ: So, I have to ask  
13 Mr. Giblin a question I have already asked, but  
14 appear to have forgotten the answer. This  
15 recommendation, this draft recommendation,  
16 actually proposes new language. For instance, it  
17 revises "entity" to "entity or other information  
18 source". That would be new proposed change in  
19 the regulation. And at this point, you can't add  
20 that language to the regulation, can you?

21 MR. GIBLIN: I am not quite sure I  
22 understand your question, but looking at this

1 change here --

2 MEMBER WELCH: Right now, it says  
3 "entity".

4 MR. GIBLIN: You can change, you can  
5 suggest changes to the language, yes, within the  
6 -- yes, you certainly can.

7 CHAIR MARKOWITZ: So, we are not  
8 limited to revisions or suggested deletions of  
9 the new language or reversals of struck language?

10 MR. GIBLIN: No, you're not.

11 CHAIR MARKOWITZ: Okay. Thank you.  
12 Dr. Welch?

13 MEMBER WELCH: I think one way to  
14 format those insertions of specific other  
15 information sources would to be add them in the  
16 numbered list. Because says, "Information from  
17 the following sources may be considered as  
18 probative factual value." And so, we have one,  
19 two, three. So, in between two and three, we  
20 could insert "the activation list of the  
21 claimant, an affidavit of relevant exposure  
22 information", and sort of add those to the list.



1 Then, we are basically using the language that is  
2 already proposed in the statute.

3 CHAIR MARKOWITZ: Dr. Cassano?

4 MEMBER CASSANO: I would recommend  
5 that we do that as an "e.g." rather than as  
6 examples. Because if you put it in as the list,  
7 then if it is not on the list, then it is  
8 excluded. So, in parentheses, we could say  
9 "e.g.", such-and-such and such-and-such.

10 CHAIR MARKOWITZ: Dr. Dement, do you  
11 have a comment on Dr. Cassano's remark?

12 MEMBER DEMENT: If I can get the  
13 microphone on.

14 (Laughter.)

15 MEMBER DEMENT: It's hard to see the  
16 light. Yes, it's on. Button-pushing 101 is not  
17 my forte.

18 (Laughter.)

19 CHAIR MARKOWITZ: I think it seems to  
20 be limited to this side of the room.

21 (Laughter.)

22 MEMBER DEMENT: Yes, we are very

1 limited on this side.

2 (Laughter.)

3 CHAIR MARKOWITZ: Okay. Dr. Dement  
4 has the floor.

5 MEMBER DEMENT: I think we cover that  
6 concern in not using "e.g.". I think it would  
7 actually be more prescriptive in the list because  
8 at the end we have other information. With this  
9 change from "entity" to "other sources of  
10 information", I think we have covered that well.

11 CHAIR MARKOWITZ: Yes, personally, the  
12 "e.g." is "for example". That seems quite  
13 optional. It doesn't have the weight that  
14 actually naming/listing does. So, I would agree  
15 with that.

16 Other comments, suggestions?

17 Yes, Dr. Silver?

18 MEMBER SILVER: Maybe during the  
19 public comment period the folks who have worked  
20 as Authorized Representatives can tell us -- I  
21 don't know. I thought about when I started on  
22 this work and had some interactions, pro bono

1       only. I am sure I earned a reputation with  
2       people who work in the district offices as being  
3       a long list of adjectives, unreliable maybe being  
4       one of them. But I was supplying really good  
5       information from old DOE reports, from peer-  
6       reviewed journal articles, from the things that a  
7       document hound comes up with.

8               So, is it the provider of the  
9       information or is it the information itself? And  
10       I just want to make sure our formulation doesn't  
11       impair the ability of self-taught Authorized  
12       Representatives to deliver smoking-gun  
13       documentation.

14               CHAIR MARKOWITZ: Additional comments?

15               Yes, Dr. Boden?

16               MEMBER BODEN: Hopefully, just to  
17       respond to Ken's comment, maybe what we want to  
18       say is "any other information deemed by OWCP to  
19       be reliable" rather than to name the source of  
20       the information. I think that is a good point.  
21       What is a reliable source of information?

22               CHAIR MARKOWITZ: Okay. So, you are

1 going to need to propose some language that  
2 modifies what we are looking at to accommodate  
3 that.

4 Let me ask a question of Dr. Welch.  
5 You thought that it would be more effective if we  
6 actually provided the language of Item No. 4, the  
7 occupational history or affidavit from the  
8 claimant or coworker; No. 5, any other health  
9 provider.

10 Do you think that it is necessary or  
11 preferred that we provide that language as  
12 opposed to what we are looking at now in which we  
13 say that we recommend that these sources be  
14 included among the sources?

15 MEMBER WELCH: Well, I think if we put  
16 it in a paragraph the way we have it now, we have  
17 to be careful about the terms that we use when we  
18 describe it, such as "should be considered", "the  
19 occupational history or affidavit should be  
20 considered evidence of exposure". Do we need to  
21 say, "considered probative evidence of exposure"?  
22 And then, in the last sentence, it says, "should

1 be accepted", but "accepted" is not a term that  
2 is used in that paragraph.

3 So, I was thinking if we specifically  
4 said insert these as part of the list --

5 CHAIR MARKOWITZ: Right, right.

6 MEMBER WELCH: -- then we are using --  
7 we don't have to try to match the language where  
8 we are making some mistake that makes these sound  
9 less valuable, like just an add-on.

10 CHAIR MARKOWITZ: Okay. Okay.

11 MEMBER WELCH: And it wouldn't be  
12 four, five, six. The No. 3 would be the last  
13 one.

14 CHAIR MARKOWITZ: Right. I get that.  
15 I get that, yes. Yes

16 MEMBER WELCH: So, it would be we  
17 would move down the numbering.

18 CHAIR MARKOWITZ: Okay. So, yes, Dr.  
19 Friedman-Jimenez?

20 MEMBER FRIEDMAN-JIMENEZ: The language  
21 "should be considered evidence of exposure" might  
22 be misconstrued as saying, "should be considered

1 sufficient evidence of exposure", which it is  
2 really not. And that could cause them to say,  
3 "Let's just delete it." So, maybe we should say,  
4 "should be considered sources of probative  
5 evidence of exposure", or something like that.  
6 So that they are included among the sources --

7 CHAIR MARKOWITZ: Right.

8 MEMBER FRIEDMAN-JIMENEZ: -- but we're  
9 not saying that that is automatically proving  
10 exposure.

11 CHAIR MARKOWITZ: So, the  
12 recommendation is that we add, as an item number,  
13 a new Item No. 3, the occupational history  
14 obtained from the claimant or an affidavit of the  
15 claimant containing the same information. And  
16 then, add a new Item No. 4, which would be  
17 "information from occupational and other health  
18 provider who is not affiliated with the Former  
19 Worker Program". Those enter the list.

20 What precedes that is this language,  
21 George. "The following sources" -- quote -- "may  
22 be considered as probative factual evidence for

1 the purposes of establishing an employee's  
2 exposure to a toxic substance at a DOE facility".  
3 So, that is the language that would apply to  
4 these new items on the list. And I think that  
5 addresses your concern.

6 MEMBER FRIEDMAN-JIMENEZ: Yes.

7 CHAIR MARKOWITZ: Okay. Okay.

8 MEMBER CASSANO: Just a question. So,  
9 the recommendation is to add those two as Items 3  
10 and Items 4 and keep current Item No. 3 as Item  
11 5?

12 CHAIR MARKOWITZ: Correct.

13 MEMBER CASSANO: Okay. Then, I'm cool  
14 with that.

15 CHAIR MARKOWITZ: Okay.

16 MEMBER GRIFFON: Just one more  
17 clarification, Steve. When you say,  
18 "occupational history from the claimant", are you  
19 talking specifically about the occupational  
20 history questionnaire that they do through the  
21 Resource Center or any occupational -- because I  
22 think that might, well, in my opinion, that ought

1 to be listed, the occupational history  
2 questionnaire.

3 CHAIR MARKOWITZ: You want to list  
4 that specific --

5 MEMBER GRIFFON: Well, maybe not.

6 CHAIR MARKOWITZ: Right.

7 MEMBER GRIFFON: I'm asking, what did  
8 you mean by your language?

9 CHAIR MARKOWITZ: Right, right.

10 Well, here I'm a little lost because  
11 the answer really depends on how the program  
12 operates, because you have the occupational  
13 health questionnaire and, then, the history  
14 questionnaire and, then, you probably have some  
15 supplemental affidavits that are sometimes  
16 submitted --

17 MEMBER GRIFFON: Yes, right.

18 CHAIR MARKOWITZ: -- by either the  
19 claimant or coworkers, right? So, all that  
20 information should enter into the calculations.

21 I can come up with some language  
22 tonight that we can look at tomorrow. It will



1 say something like "occupational history  
2 information obtained from either the occupational  
3 history questionnaire or comparable affidavit",  
4 or something like that, something that is general  
5 enough to include all sources.

6 Yes, Dr. Boden?

7 MEMBER BODEN: So, I have some  
8 specific language to address Ken's concern.

9 CHAIR MARKOWITZ: Okay.

10 MEMBER BODEN: This is what is  
11 currently No. 3 and now is going to be No. 6 or  
12 7, or whatever it is. And it would state, "any  
13 other information deemed by OWCP to be reliable  
14 for purposes of establishing that the employee  
15 was exposed to a toxic substance at a DOE  
16 facility", et cetera. So, it removes "source",  
17 but keeps "information", essentially.

18 CHAIR MARKOWITZ: So, you're replacing  
19 the language --

20 MEMBER BODEN: Yes.

21 CHAIR MARKOWITZ: -- the existing  
22 language of three? Is that what you are saying?

1                   MEMBER BODEN: Right. I'm replacing  
2                   it. Essentially, it has to be somewhat  
3                   reformulated to give the idea that it is  
4                   information rather than source.

5                   CHAIR MARKOWITZ: Right, right. So,  
6                   you can get his language on the draft  
7                   recommendation.

8                   MEMBER BODEN: So, I will say it  
9                   slowly. It is "any other information" -- oh,  
10                  sorry.

11                  CHAIR MARKOWITZ: Dr. Welch?

12                  MEMBER WELCH: I mean, I actually  
13                  think it is okay to have "reliable sources"  
14                  because really what is above there are sources of  
15                  information. So, if something comes from the  
16                  Former Worker Program, this is saying it's a  
17                  source that can be used, and you don't  
18                  necessarily have to independently assess the  
19                  value of the information.

20                  Now what you are suggesting is that,  
21                  in addition to sources and information, some  
22                  information itself can be of probative factual

1 value. But I don't I necessarily want to take  
2 out the "other entity deemed to be a reliable  
3 source of information", because it is sort of  
4 like, you know, an affidavit from an industrial  
5 hygienist who used to work at the plant. Okay?  
6 So, they could deem that to be a reliable source  
7 of information. I guess that is what I am  
8 saying. It is like there is an advantage to  
9 saying "sources", and it seems like that is what  
10 this paragraph is about. It is how the  
11 information gets into the program.

12 I mean, I don't know that I'm saying  
13 I don't agree with your changes, but I don't  
14 think it is that simple. What do you think, Ken?

15 MEMBER SILVER: I think there are  
16 highly incentivized, increasingly sophisticated  
17 Authorized Representatives who aren't part of an  
18 entity who hit the stacks and know every document  
19 archived in the public arena, laid down by CDC  
20 over the years, whomever, and that is where they  
21 find reliable information.

22 And the District Office may have them,

1 you know, on sort of a black list, and they  
2 shouldn't be judged because of their past battles  
3 with the District Office; a four-square piece of  
4 paper should be judged.

5 CHAIR MARKOWITZ: But what if you just  
6 took the existing language that says, "any other  
7 entity deemed by OWCP to be reliable" and say,  
8 "any other entity or information source which  
9 provides information that is deemed to be  
10 reliable by OWCP"? Would that combine the two  
11 thoughts?

12 MEMBER CASSANO: Yes, I think it is  
13 almost too complicated at that point. I think  
14 just basically saying, "any other entity or  
15 source of information deemed reliable by OWCP",  
16 which is what we have originally --

17 MEMBER BODEN: But that is what Steve  
18 just said.

19 MEMBER CASSANO: Yes. Okay.

20 MEMBER SILVER: That's cool, yes.

21 MEMBER CASSANO: No, he added in a  
22 different source of information deemed reliable.

1 MEMBER BODEN: Oh, I see.

2 MEMBER CASSANO: Yes.

3 CHAIR MARKOWITZ: We have to see the  
4 change. If you could scroll up a little bit,  
5 just so we can see? Okay.

6 So, I think the language was "any  
7 other entity or source deemed by OWCP to provide  
8 information that is reliable". Okay. So, that  
9 switches it. What is reliable is the  
10 information, not the source. So, if you could,  
11 "any other entity or source that is deemed by  
12 OWCP to provide information that is reliable".

13 MEMBER WELCH: Or "to provide reliable  
14 information"?

15 CHAIR MARKOWITZ: Yes, "to provide  
16 reliable information". That's fine. And then,  
17 you can take out "necessary". Okay.

18 Does that now capture it? Okay. So,  
19 any other?

20 (No response.)

21 CHAIR MARKOWITZ: Again, on listing  
22 the occupational history and the other

1 occupational health provider, I will refashion  
2 the language into a list, so it mimics what is in  
3 the current proposed changes.

4 Any other changes?

5 (No response.)

6 CHAIR MARKOWITZ: Okay. So, is there  
7 a motion to table a vote on this proposal until  
8 tomorrow?

9 (Motion.)

10 CHAIR MARKOWITZ: And is there a  
11 second?

12 (Seconded.)

13 CHAIR MARKOWITZ: Okay. Any further  
14 discussion?

15 (No response.)

16 CHAIR MARKOWITZ: So, all those in  
17 favor of tabling the vote on this until tomorrow?

18 (Show of hands.)

19 CHAIR MARKOWITZ: All those opposed?  
20 And any abstentions? Thank you.

21 Okay. So, let me just say it is four  
22 o'clock. We are going to have a public comment

1 period at five o'clock. We are going to take a  
2 break. The question is, when do you want to take  
3 that break? Do you want to take it right before  
4 the public comment period or do you want to take  
5 it now?

6 Yes, okay. We are going to take a  
7 break now. Be back in 15 minutes. Thank you.

8 4:15.

9 (Whereupon, the above-entitled matter  
10 went off the record at 3:59 p.m. and resumed at  
11 4:17 p.m.)

12 CHAIR MARKOWITZ: We are now going to  
13 focus on the next proposed change which is  
14 Section -- it's on page 40, for those of you who  
15 have the written document. It is being brought  
16 up on the screens. And it's Section 30.232.

17 This falls within the scope of the  
18 Board's mandate because this issue addresses the  
19 question of causation, the connection between  
20 exposure and disease, and that clearly fits  
21 within at least (a) and (b) of our assigned  
22 tasks.

1           So, Section 20.232, and the title of  
2           the Section is "How does a claimant establish  
3           that the employee has been diagnosed with a  
4           covered illness or sustained an injury, illness,  
5           impairment, or disease as a consequence of a  
6           covered illness?"

7           So, Tori is going to read. Large  
8           sections of this are struck out. We are not  
9           going to read the sections that are struck out,  
10          just for the sake of time. You can see the  
11          section there, and if you scroll down on the next  
12          page, it continues and new language is what we  
13          will read.

14          MEMBER CASSANO: So, the new language  
15          reads, "To establish that the employee has been  
16          diagnosed with the covered illnesses required  
17          under Section 30.230(d), the employee or his or  
18          her survivors must provide the following:

19                 "(1) Written medical evidence  
20                 containing a physician's diagnosis of the  
21                 employee's covered illness (as that term is  
22                 defined in Section 30.5(s)) and the physician's



1 reasoning for his or her opinion regarding  
2 causation, and

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

8 CHAIR MARKOWITZ: So now, the reports  
9 from the various subcommittees.

10 Ken, do you want to go first this  
11 time?

12 MEMBER SILVER: Sure. Our  
13 subcommittee felt that the phrase "any other  
14 evidence OWCP may deem necessary" should be  
15 removed, feeling that it is overly-broad, not  
16 necessary, and could form the basis for  
17 adversarial interactions between OWCP and  
18 claimants.

19 Further suggestion to consider  
20 replacing the phrase "physician's reasoning" with  
21 "physician's rationale".

22 I'll leave it at that.

1 CHAIR MARKOWITZ: Okay. Mark?

2 MEMBER GRIFFON: We had a similar  
3 comment on that and said this is too vague,  
4 asking, also, is there where OWCP may ask for a  
5 second opinion?

6 And the second comment we had was  
7 asking for a written opinion, including the,  
8 quote, "the physician's reasoning for his or her  
9 opinion regarding causation", end quote, puts too  
10 great of an onus on the claimant at this stage of  
11 the claim's process, as many conditions will have  
12 been diagnosed by a general practitioner who may  
13 be incapable or unwilling to provide the report  
14 being required.

15 CHAIR MARKOWITZ: Thank you.

16 Laurie?

17 MEMBER WELCH: Yes, our group had a  
18 similar assessment to what Mark had just said.  
19 We were under the impression that this change was  
20 saying that all new claims or incoming claims now  
21 require a written physician opinion on causation  
22 from the person's treating physician, when the

1 practice has been that the claims examiners could  
2 award, could determine if it was a covered  
3 illness using other information without the  
4 treating physician's opinion on causation.

5 And so, again thinking that this is a  
6 burden on the claimant, and it also seems to be a  
7 really big change to the process, as the way the  
8 whole program has been running, the way our group  
9 understood the change.

10 CHAIR MARKOWITZ: Okay. Comments from  
11 other Board members?

12 (No response.)

13 CHAIR MARKOWITZ: So, if you could  
14 bring up the draft recommendation? Let me read  
15 this.

16 "The Board recommends that DOL remove  
17 the requirement that the claimant must produce  
18 written medical evidence where a physician  
19 describes the" -- quote -- "`reasoning for his  
20 her opinion regarding causation'" End of quote.

21 "The Board believes that sufficient expertise in  
22 the causation of occupational illness is unlikely

1 to be available in DOE communities, and the time  
2 commitment for physicians to produce such a  
3 documented report makes this requirement  
4 unrealistic and places too great a burden on the  
5 claimants.

6 "In addition, the Board is concerned  
7 that" -- quote -- "`any other evidence the OWCP  
8 may deem necessary'" -- end of quote -- "is  
9 overly-broad, unnecessary, and may form the basis  
10 for adversarial interactions between OWCP and  
11 claimants."

12 Comments?

13 (No response.)

14 CHAIR MARKOWITZ: It's late, but we've  
15 got to get there. We've got to get there.

16 (Laughter.)

17 CHAIR MARKOWITZ: Dr. Dement?

18 MEMBER DEMENT: So, what is our  
19 recommendation? I mean, are we recommending the  
20 language that has been proposed be removed and  
21 the existing language retained? I guess the  
22 concern at this point of the process of filing a

1 claim, a lot of times it is simply a diagnosis of  
2 a disease and may or may not have all this other  
3 written opinions, which will be developed as the  
4 claims process goes forward. Frankly, I don't  
5 see the reasoning for the changes.

6 CHAIR MARKOWITZ: Dr. Cassano?

7 MEMBER CASSANO: Yes. In looking at  
8 the old language, I mean, that seems incredibly  
9 onerous. I think the piece about -- I don't  
10 think requiring the written medical evidence with  
11 the rationale, as I look at this from writing a  
12 regulation, I don't think that basically says, if  
13 it is not there, the claim is going to be  
14 immediately denied. They are still going to  
15 develop it.

16 But I think if you remove that, then  
17 there is no basis for the treating physician to  
18 even try to give a rationale. And so, I have got  
19 mixed emotions on that first one. I fully agree  
20 with the fact that the second one is way too  
21 broad and could be horribly interpreted.

22 But I think we need to include -- and

1 maybe the answer is to say, "and where possible,  
2 the physician's reasoning or rationale" or "where  
3 applicable". Because they are going to have to  
4 develop a medical opinion. I mean, that is the  
5 whole point. You've still got to get to less  
6 than likely, at least as likely or not, or more  
7 than likely. And if we remove this, then there  
8 is no a priori need for the treating physician to  
9 even try to do it.

10 CHAIR MARKOWITZ: Dr. Welch?

11 MEMBER WELCH: Well, I think you can  
12 run a really adequate comp program and never get  
13 a causation opinion from the treating physician.  
14 So, I guess I disagree. I mean, if they can do  
15 it, fine. But most of them don't know how, and  
16 if they are going to do it, they are going write  
17 language that is not probative.

18 I mean, what was there before  
19 basically said the claimant provides information  
20 for the physician that could provide information  
21 on the diagnosis, and some other source brings in  
22 an occupational history. And then, OWCP asks for

1 other information.

2 But if what you get is all the right  
3 inputs, then the claims examiner with the  
4 consultant can make the causation decision. So,  
5 you don't have to have the treating physician.

6 And the way it is written now, it says  
7 the claimant must provide.

8 CHAIR MARKOWITZ: You are talking  
9 about the proposed language?

10 MEMBER WELCH: The proposed language  
11 is the claimant must provide. So, if they don't  
12 provide a physician's diagnosis and the  
13 physician's reasoning, you're done. That's the  
14 way this is written now.

15 CHAIR MARKOWITZ: I agree.

16 Other comments?

17 Dr. Boden?

18 MEMBER BODEN: I think there is  
19 another problem with this, in that the Act does  
20 not require, as we have talked about before,  
21 causation, right? It requires whatever the words  
22 are, aggravated, contributed to, et cetera, et

1 cetera. So, an opinion on causation is not  
2 required by the Act.

3 CHAIR MARKOWITZ: But that specific  
4 point can be addressed simply by replacing  
5 "causation" with "aggravation, contribution, and  
6 causation", if I get your point correct.

7 MEMBER BODEN: Right. I guess what I  
8 am saying is, however we decide to address this,  
9 we ought to in our reasoning include the fact  
10 that this is overly-restrictive because --

11 CHAIR MARKOWITZ: By discussing only  
12 causation?

13 MEMBER BODEN: By discussing only  
14 causation.

15 CHAIR MARKOWITZ: Dr. Redlich?

16 MEMBER REDLICH: Just in general, many  
17 of the points that we are bringing up relate to  
18 the tasks that we were asked to address on this.  
19 So, is there an urgency to change the rules now?  
20 It just seems like the order of this is sort of  
21 reversed.

22 (Laughter.)



1                   MEMBER REDLICH: I mean I am just  
2 confused.

3                   CHAIR MARKOWITZ: Okay. The timetable  
4 is not of our making. The question is whether we  
5 can contribute something really.

6                   MEMBER REDLICH: Okay, but can it be  
7 postponed --

8                   PARTICIPANT: No.

9                   MEMBER REDLICH: -- or just the wheels  
10 have to turn? Okay. Okay.

11                  CHAIR MARKOWITZ: Other comments?

12                  MEMBER CASSANO: Just one, and I don't  
13 know if it would be acceptable because this is  
14 not language that was changed. But, if you go to  
15 Part A, if you go to the subtitle under A,  
16 changing one word and making the changes about  
17 causation in there would make this acceptable.  
18 And instead of saying "must", you could put  
19 "should". And then, it would not be a dead-end  
20 and they would still continue to develop it.

21                   I mean, this is from somebody that  
22 writes this stuff, wrote this stuff. I have real

1 problems taking that whole requirement out  
2 because I really think, No. 1, it will never go  
3 through and, No. 2, basically, then all you need  
4 is a diagnosis from an EHR or a medical record.  
5 And there is nothing that says that a physician  
6 has to at least address the concept of the effect  
7 of the exposure on the medical condition. And I  
8 think that weakens things a lot.

9 And I am trying not to be hard-hearted  
10 here. I am trying to look at this from a  
11 practical perspective of somebody who is going to  
12 be looking at this regulation and making a  
13 decision.

14 CHAIR MARKOWITZ: Dr. Welch?

15 MEMBER WELCH: One thing I think would  
16 be useful for our Board to do, or to make  
17 recommendations for, is to help OWCP develop  
18 presumptions for some of the common illnesses.  
19 So, if there were a presumption of how you are  
20 diagnosed with asbestos-related disease, you  
21 wouldn't need the treating physician's opinion.  
22 So, we don't want to end up requiring that in all

1 the cases anyway.

2 Like I said, I mean, there's a lot to  
3 -- I'm familiar with the trust funds that  
4 administer asbestos claims, for example, and they  
5 don't require physicians' opinions. They require  
6 these 10 pieces of information that, then, lead  
7 to presumption in 90 percent of the cases that  
8 come in. But we already discussed that  
9 particular point. But I think we should be  
10 careful about requiring an opinion from the  
11 treating physician.

12 CHAIR MARKOWITZ: So, Dr. Whitley?

13 MEMBER WHITLEY: Why couldn't you just  
14 stop it after 30.5(s)? Written evidence, you  
15 know, containing physician's diagnosis of  
16 employee's covered illness as divined by 30.5(s).  
17 Why do you need that other part in there?

18 MEMBER FRIEDMAN-JIMENEZ: It's  
19 implied.

20 MEMBER WHITLEY: That he has to give  
21 the opinion?

22 MEMBER BODEN: I have a proposal.

1 CHAIR MARKOWITZ: Okay. Yes, Dr.  
2 Boden.

3 MEMBER BODEN: Yes. My proposal is  
4 that we have a preamble that I think includes the  
5 stuff that is up there and, also, includes some  
6 language about the causation of illness being too  
7 limiting, and then, says that something to the  
8 effect that we don't think the changes should be  
9 made.

10 That is, I don't know if people object  
11 to anything in the original language. It would  
12 seem to be much less restrictive. But, then,  
13 that's fine. Then, we should talk about that.

14 Go ahead.

15 MEMBER POPE: As Garry was stating, I  
16 don't see what is wrong with stopping right there  
17 after the 30.5(s).

18 CHAIR MARKOWITZ: So, I understand  
19 that suggestion. Do you mean to suggest that the  
20 physician should be addressing the issue of  
21 aggravation, contribution, or causation? Or are  
22 you simply saying that the physician should

1 simply provide evidence for the medical  
2 diagnosis, what the disease is? It is the latter  
3 one, right? The "covered" part is misleading in  
4 that sense, though.

5 Yes, Dr. Friedman-Jimenez.

6 MEMBER FRIEDMAN-JIMENEZ: The original  
7 language, in the first paragraph, paragraph 1,  
8 the last sentence, it says, "and to the extent  
9 practicable, a copy of the diagnosis and summary  
10 of the information upon which the diagnosis is  
11 based". That phrase "and to the extent  
12 practicable" I think gives the leeway that, if  
13 they can't find a physician that is willing to  
14 comment or state their opinion on causality, then  
15 it is not going to throw out the case. It will  
16 just have to go to the contracted medical -- the  
17 CMC.

18 But, if we just stop it after 30.5(s),  
19 then that still will require them to give an  
20 opinion because it says, "covered illness". And  
21 covered illness is defined as an illness that is  
22 caused by the toxic exposure. So, that would

1        imply that the physician would still have to give  
2        his opinion or her opinion on why it was a  
3        covered illness.

4                    So, I think adding that phrase "to the  
5        extent practicable" gives that degree of  
6        flexibility, and maybe we should suggest that  
7        they do that.

8                    CHAIR MARKOWITZ: If you could remove  
9        the word "covered", that would address that  
10       concern.

11                   MEMBER FRIEDMAN-JIMENEZ: Remove the  
12       word "covered"?

13                   CHAIR MARKOWITZ: Yes. I am just  
14       saying if we remove the word "covered" in  
15       30.5(s), it is clear that the interest is in the  
16       diagnosis, not the causation aspect.

17                   MEMBER REDLICH: But, then, the next  
18       part of the sentence it goes on and says it  
19       again. In No. (2)(b), it is restated. It is  
20       sort of repetitive. Or is that something  
21       different?

22                   CHAIR MARKOWITZ: That's a

1 consequential -- yes, it is a different category  
2 than this issue.

3 MEMBER WELCH: So, Carrie, it says,  
4 "an injury, illness, impairment, or disease  
5 sustains the consequence of a covered illness".

6 MEMBER REDLICH: Oh, I'm sorry.

7 MEMBER WELCH: Yes.

8 MEMBER REDLICH: I'm sorry.

9 MEMBER CASSANO: Okay. Take the word  
10 "covered" out and strike the end of it on "the  
11 physician's reasoning" or put "to the extent  
12 practicable, the physician's reasoning".

13 MEMBER BODEN: I don't think you can  
14 take the word "covered" out because that just  
15 says that the physician has diagnosed you with  
16 some illness. I mean, it could be the flu that  
17 you had last week, right? I mean, it sort of  
18 doesn't make any sense in this context.

19 MEMBER CASSANO: But Part E is any  
20 illness anyway. So, under Part E, any illness is  
21 covered. So, I would just take out --

22 MEMBER BODEN: Is that right?

1 CHAIR MARKOWITZ: So, Dr. Welch?

2 MEMBER WELCH: I think if you leave  
3 the word "covered illness", that means a specific  
4 condition that has been established to be caused  
5 by toxic exposures. So, I think we might want to  
6 try as best we can within this language to  
7 separate the medical diagnosis, the diagnosis of  
8 a specific medical condition, from the  
9 determination of work-relatedness or toxic-  
10 relatedness. "Covered illness" puts them both in  
11 one phrase.

12 So, if what we want the physician to  
13 provide is documentation that supports the  
14 specific diagnosis, the specific medical  
15 diagnosis, you could make that, you know,  
16 "written medical evidence containing a  
17 physician's medical diagnosis for the illness  
18 that is claimed", or however. Or just leave it  
19 that way. But, in a way, that is what the old  
20 language did.

21 MEMBER CASSANO: Yes, but it just went  
22 on and on and on. The old language is "and",



1 "and", "and". So, they had to provide all of  
2 that. It wasn't "or".

3 MEMBER WELCH: But it is not providing  
4 very much, in my opinion. I mean, that is  
5 something that the advocates could weigh-in on  
6 because they have dealt with that. But it is  
7 providing the name and address of the physician  
8 who can provide the diagnosis, a medical release  
9 for other records, an occupational history, and  
10 other things OWCP asks for.

11 CHAIR MARKOWITZ: Mr. Giblyn?

12 MR. GIBLIN: Yes. Just to clarify,  
13 and you can see this in the preamble, this used  
14 to be for Part D, which is no longer in  
15 existence. And that is why we had all the  
16 language that was in there. So, that is why it  
17 is being replaced. This is now for establishing  
18 a covered illness for Part E. So, I just wanted  
19 you to understand what prompted this change.

20 CHAIR MARKOWITZ: Ms. Vlieger?

21 MEMBER VLIEGER: If we go back to the  
22 definition -- and that's on page 15 -- "covered

1 illness means, under Part E of the Act relating  
2 to exposures, at a DOE facility or a RECA Section  
3 5 facility, an illness or death resulting from  
4 exposures to a toxic substance."

5 So, it has got a slightly different  
6 definitive term under these rules than commonly  
7 what you would think. "Covered" means you are  
8 covered by insurance. This means an illness that  
9 will be considered. Now that is my opinion of  
10 what it means.

11 CHAIR MARKOWITZ: So, let me summarize  
12 where I think we are at and see if we can direct  
13 things. It seems that there is some agreement  
14 that the absolute requirement that the claimant  
15 produce a physician's report that contains a  
16 rationale around causation, aggravation, and  
17 attribution, the requirement meaning must produce  
18 is excessive, right?

19 We also seem to agree that, if the  
20 treating physician or examining physician can  
21 produce such a rationalized report, that that  
22 would be useful to the process. And so,

1           therefore, it should be permitted, perhaps even  
2           encouraged, right?

3                       So, we are in agreement about those  
4           points, right? Now we just have to come up with  
5           language.

6                       (Laughter.)

7                       CHAIR MARKOWITZ: Dr. Friedman-  
8           Jimenez?

9                       MEMBER FRIEDMAN-JIMENEZ: Carrie had  
10          her hand up first.

11                      CHAIR MARKOWITZ: Yes, Carrie?

12                      MEMBER REDLICH: I guess while we are  
13          on this sort of wording, every time it refers to  
14          cause or resulting from the toxic exposure,  
15          previously, we have been told that that could be  
16          a contributing factor and not simply caused by.  
17          And so, is that just implied in all the wording  
18          every time it is used? All it needs to be is  
19          stated once, that that is the implication.

20                      CHAIR MARKOWITZ: Yes. No, I think we  
21          should point it out whenever we see it, actually.  
22          It would probably be helpful. But I agree with

1 you.

2 Okay. So, other comments? I need  
3 some specific suggestions now on what we are  
4 going to propose around the language, either the  
5 new language or the old language, that consensus  
6 that I described just now.

7 MEMBER WHITLEY: I think since it is  
8 part of the definition, that you leave the  
9 "covered" in there and just say, "written medical  
10 evidence containing physician's diagnosis of the  
11 employee's covered illness as 30.5", just like it  
12 is, and stop.

13 CHAIR MARKOWITZ: Well, that to me  
14 implies that the claimant has to produce a report  
15 from a physician that not only gives a diagnosis,  
16 but the reason why it is a covered illness. So,  
17 it is a backdoor into the issue of causation.  
18 And so, that is why. But, if you take out  
19 "covered", all you are left with is the doctor  
20 just has to produce a diagnosis, period.

21 MEMBER WHITLEY: That will work.

22 (Laughter.)

1 CHAIR MARKOWITZ: George?

2 MEMBER FRIEDMAN-JIMENEZ: It seems to  
3 me that the fundamental problem is that, as I  
4 understand it, the process is either a treating  
5 physician provides the rationale for causation,  
6 and causation meaning cause including  
7 exacerbation, aggravation, or contribution, or  
8 the CMC provides it. Is that correct? Or am I  
9 wrong on that?

10 CHAIR MARKOWITZ: Yes, the --

11 MEMBER FRIEDMAN-JIMENEZ: If the  
12 treating physician doesn't provide it, who does?  
13 The CMC?

14 CHAIR MARKOWITZ: Or whatever, right.  
15 You know, there are various routes.

16 MEMBER WELCH: It is my understanding  
17 there are certain circumstances that the claims  
18 examiner can accept a claim without sending it to  
19 the CMC, if there is strong evidence and there is  
20 a presumption or a procedure that allows that.  
21 So, not everything has to have a written  
22 physician opinion that summarizes it.

1 Toxicologists might. The industrial hygienists  
2 might.

3 MEMBER FRIEDMAN-JIMENEZ: Because this  
4 paragraph is entitled, "How does a claimant  
5 establish that the employee has been diagnosed  
6 with a covered illness?" And so, that has to be  
7 established somehow. Now you are saying there  
8 are three ways, the treating physician or the CMC  
9 or the claims examiner, is that right? So, those  
10 are the only three ways that it can get  
11 established?

12 CHAIR MARKOWITZ: Well, there may be  
13 other ways. But go ahead. Continue making your  
14 point.

15 MEMBER FRIEDMAN-JIMENEZ: So, the best  
16 that I can see, using a combination of the  
17 previous language and the current proposed  
18 language, is to just add in the phrase "to the  
19 extent practicable", which they had in the  
20 previous language, and use that to sort of soften  
21 the requirement. And then, if they can't find a  
22 physician that they can produce or is willing to

1 state that they think that it was a causation,  
2 then the CMC or the claims examiner will do it.

3 But we can't just take it all out, and  
4 then, it won't be recommending any way for the  
5 claimant to prove that it was caused.

6 CHAIR MARKOWITZ: So, to say that the  
7 claimant must provide to the extent practicable  
8 leans on the side of the claimant is expected to  
9 produce such a report. I mean, that is the way I  
10 would interpret that.

11 So, I don't think that is the sense of  
12 what we are discussing here. I think the sense  
13 is that, when it is possible, the claimant may  
14 produce -- it will help his case, right? -- may  
15 produce such a reasoned report, right, but must  
16 produce evidence of the diagnosis? So, the  
17 "must" applies to the underlying diagnosis, and  
18 the "may" applies to the rationale of the  
19 physician that this is occupationally-related,  
20 right?

21 MEMBER CASSANO: So, it might be  
22 appropriate, instead of saying, "to the extent

1 practicable", to say, "and, if possible, a  
2 physician's rationale relating the medical  
3 condition to a toxic exposure", whatever the  
4 language is about substantially affect and  
5 causative and aggravated, and all that sort of  
6 stuff. And I can work on language, if you like,  
7 tonight, with Laurie's permission.

8 CHAIR MARKOWITZ: But my question is  
9 whether we should or are advocating striking the  
10 old language as is proposed and, then, tweaking  
11 the current language to soften it, so that it is  
12 not an absolute requirement, or are we talking  
13 about maybe deleting, suggesting deleting the new  
14 language and going back to the old language?  
15 Because that is like a big dividing line.

16 MEMBER CASSANO: No.

17 CHAIR MARKOWITZ: I'm sorry, I said,  
18 "A or B?", and you said no.

19 (Laughter.)

20 MEMBER WELCH: Do not go back to the  
21 old one.

22 CHAIR MARKOWITZ: You do not want the



1 old? So, agree with striking the old language.  
2 So, the sense is we should tweak the proposed  
3 language to soften it, essentially. Let's not do  
4 that right now. Vickie, you could do that. And  
5 we will, then, appear tomorrow morning with  
6 language that reflects that sentiment.

7 We don't have a proposal to vote on.  
8 We don't have the language. So, there is no  
9 motion to, there is no proposal to vote on, if  
10 I've even got that right.

11 Okay. We only have a few more  
12 minutes, but we have an easy one coming up. So,  
13 let's deal with it.

14 (Laughter.)

15 CHAIR MARKOWITZ: No, I knew the other  
16 ones were hard. So, this is page 39. Let me say  
17 this is Section -- it is 39 at the bottom -- it  
18 is Section 30.230(d)(2)(3).

19 And this, by the way, this is not a  
20 change, a proposed change by DOL. This is us  
21 noticing that there is a phrase which says,  
22 quote, "caused or aggravated", end of quote, but

1 it is missing "contributed". So, this gets back  
2 to the point that Dr. Redlich was raising.

3 MEMBER REDLICH: Consistency.

4 CHAIR MARKOWITZ: Yes. Okay. So, the  
5 proposal is -- now this is not a proposed change  
6 by DOL. So, this is us adding our two cents to  
7 the process, and I don't know where that fits  
8 into the NPRM, but here it is.

9 (Laughter.)

10 CHAIR MARKOWITZ: By the way, I should  
11 say that this is relevant to the Board's scope  
12 because it addresses A and B, which relates to  
13 really causation and aggravation and contribution  
14 to a work-related illness.

15 So, I'm reading. "The Board notes the  
16 phrase 'an opinion of a qualified physician's  
17 expertise in treating, diagnosing, and  
18 researching the illness claimed to be caused or  
19 aggravated by the alleged exposure' and differs  
20 from a phrase, actually, about 10 lines, which  
21 was, quote, "was a significant factor in  
22 aggravating, contributing to, or causing the

1 illness". End of quote. And it should be made  
2 consistent with that language.

3 So, we don't have to go through the  
4 subcommittees here because we all agreed on this  
5 one. But any comments on this?

6 (No response.)

7 CHAIR MARKOWITZ: Okay. So, do I have  
8 a motion?

9 MEMBER VLIEGER: So moved.

10 CHAIR MARKOWITZ: Okay. Second?

11 (Seconded.)

12 CHAIR MARKOWITZ: Okay. Any  
13 discussion?

14 (No response.)

15 CHAIR MARKOWITZ: Okay. All those in  
16 favor of this raise your hand.

17 (Show of hands.)

18 CHAIR MARKOWITZ: All those opposed?  
19 And any abstentions?

20 Okay. So, we need to break at five of  
21 5:00. I recommend that, just for a few minutes  
22 before the public comment period, I do think we

1 should, however, start the next one because we  
2 are short of time tomorrow.

3 So, let me point this out. This is on  
4 page 54. It has to do with the requirements  
5 about changing physicians. Okay, I'm sorry, it  
6 is page 55. It is Section 30.405, Item (b) and  
7 (c).

8 If you could bring that up? And,  
9 Tori, if you could read this?

10 MEMBER CASSANO: Oh, I'm sorry, I  
11 forgot my job. So, both sections at the same  
12 time, (b) and (c)?

13 CHAIR MARKOWITZ: Yes.

14 MEMBER CASSANO: Okay. "After  
15 selecting a treating physician, may an employee  
16 choose to be treated by another physician  
17 instead?"

18 Item (b) says, "OWCP will approve the  
19 request if it determines that the reasons  
20 submitted are" -- cross out "sufficient"; add  
21 "credible" -- "and supported by probative factual  
22 and/or medical evidence, as appropriate.

1 Requests that are often approved include those  
2 for transfer of care from a general practitioner  
3 to a physician who specializes in treating the  
4 occupational illness or covered illness, covered  
5 by EEOICPA, or the need for a new physician when  
6 an employee has moved."

7 And (c), strike out "If a claimant  
8 disagrees with the decision of...," and "then  
9 OWCP" -- this is not going to make any sense --  
10 strike out that -- "insufficient reasons for...."  
11 Basically, it says OWCP may deny the requested  
12 change of physician if it determines that the  
13 reasons submitted are not both credible and  
14 supported by probative evidence.

15 "If a claimant disagrees with such an  
16 informal denial, he or she may utilize the  
17 adjudicatory process described in Subpart (d) of  
18 this part."

19 CHAIR MARKOWITZ: And that last  
20 paragraph that she read was the new proposed  
21 language, to make it clear.

22 MEMBER CASSANO: Right.

1 CHAIR MARKOWITZ: Can we hear from the  
2 subcommittees first?

3 Mark, do you want to go first?

4 MEMBER GRIFFON: Sure. Subpart (b),  
5 we basically said that the new language we didn't  
6 think clarified or further added anything to the  
7 original phrase. This notion of medical evidence  
8 seemed like an implausible requirement.

9 And for Section (c), we said it seemed  
10 okay. The change, the proposed changes seemed  
11 okay.

12 CHAIR MARKOWITZ: Laurie?

13 MEMBER WELCH: We pretty much agreed  
14 with what Mark said. We couldn't understand what  
15 would be medical evidence, factual medical  
16 evidence that would support the change of a  
17 physician. And all the physicians couldn't  
18 figure out what that was talking about.

19 (Laughter.)

20 MEMBER WELCH: So, it really doesn't  
21 make any sense. We would go back to the old  
22 language in (b) and, also, take out that

1 "credible and supported by probative evidence" in  
2 (c).

3 (c) sort of repeats (b), except that  
4 it says the claimant has the right to appeal the  
5 decision or disagree with the decision using the  
6 adjudicatory process. So, I don't think it is  
7 necessary to insert that new language. I would  
8 go back to the old (c), just to be able to get  
9 rid of the probative evidence.

10 We think that the claimants should be  
11 able to change physicians if they don't like the  
12 physician they are being treated with, and that  
13 is not probative evidence. They just might want  
14 to see somebody else. I think it is within  
15 OWCP's authority probably to limit the number of  
16 times that happens without having to write it  
17 into the statute.

18 MEMBER SILVER: Our group did not like  
19 the phrase "credible and supported by probative"  
20 in (c), vague and unnecessary. Overall, too much  
21 emphasis on medical necessity while lacking  
22 specificity.

1 Further suggestion that there should  
2 be a specified period of time within which OWCP  
3 approves or denies the request, say two weeks  
4 from receipt. Otherwise, it is considered  
5 approved.

6 And special concern about changing  
7 oncologists. Imagine that.

8 CHAIR MARKOWITZ: So, let me just  
9 address a point that I forgot to address, which  
10 was how is this issue relevant to our mandate.  
11 The past (b) and (c) for us relate to the  
12 collection and use of medical evidence in either  
13 establishing claims or related to Subpart B or  
14 Subpart E.

15 And the issue of which physician that  
16 the claimant uses has to do with who they go to  
17 for evidence of either consequential illness or  
18 issues of impairment. And so, there is some  
19 relation, I think, to the scope of what we have  
20 been asked to do.

21 Okay. Let me lead and, then, we are  
22 going to stop for a break and continue tomorrow.



1 But let me read draft language that reflects the  
2 sentiment of the various subcommittees.

3 "The Board notes that the added  
4 language does not clarify what the claimants need  
5 to produce and finds it implausible that  
6 claimants can provide medical or factual evidence  
7 in support of a request to change physicians.  
8 The Board recommends that claimants be permitted  
9 to change physicians without requesting  
10 permission from OWCP."

11 So, that is a clear statement, and  
12 then, whether people divulge from that or from  
13 that statement, we can discuss tomorrow. Okay?

14 So, let me call for a break now. And  
15 then, we will reconvene just a minute before 5:00  
16 because, then, we have got to start the public  
17 comment period. Thank you.

18 (Whereupon, the above-entitled matter  
19 went off the record at 4:56 p.m. and resumed at  
20 5:02 p.m.)

21 CHAIR MARKOWITZ: Thank you. We will  
22 now begin the public comment section. We have

1 eight speakers, all of whom are here in person.  
2 So, there are none on the phone who will be  
3 speaking.

4 Almost all of our time has been  
5 requested, actually. So, I don't think we are  
6 going to have any extra time to accommodate  
7 additional speakers.

8 Apparently, I have to turn it over to  
9 the moderator now. So, can Terrie Barrie come  
10 forward?

11 MS. BARRIE: Thank you. Thank you  
12 again for giving me time to make a few comments  
13 tonight to the Board. I have to commend you.  
14 Your work so far is astounding, and I thank you  
15 for this.

16 One thing I would like to remind you,  
17 especially for the people who aren't very  
18 familiar with this program, Congress enacted this  
19 program to take the burden of proof off the  
20 claimants. Okay? The records aren't there.  
21 There needs to be some kind of assumption that  
22 they were exposed to the toxic soup I mentioned

1 yesterday.

2 I have four more remarks here. This  
3 is just kind of bringing up things I noticed  
4 between yesterday and today.

5 Probative evidence -- nope, I'm sorry.  
6 There was a discussion about the development of  
7 claims by the claims examiners and that the  
8 claims examiners, if the claimant doesn't provide  
9 medical evidence, that the claims examiner will  
10 help the claimant develop the medical evidence or  
11 whatever is needed to support the claim.

12 In the regulations today, it does say  
13 that each and every criteria must be met by the  
14 claimant and be provided by the claimant for the  
15 claim to be processed, basically. So, I am not  
16 sure how that fits with what was said today. I  
17 have never heard -- and you could probably poll  
18 the Authorized Reps who are here today -- of  
19 claims examiners actually calling the claimant  
20 and saying, "We need this piece of paper" or "We  
21 need that." They might say, "You don't have  
22 sufficient evidence," but I don't think they are

1 very specific on, "Well, you need to get me this  
2 test for your heart disease or you PFT." But,  
3 like I said, check with the other ones.

4 We heard a lot yesterday and today  
5 about the weight given to the personal  
6 physicians' reports. I think yesterday it was  
7 said that the wage loss claims, the Department of  
8 Labor actually relies on the personal physician  
9 since they know how much they can work and, you  
10 know, they actually do the physical evaluation.

11 I know of two instances of wage loss  
12 claims where the personal physician's letter,  
13 whether it was well-rationalized or not, one was  
14 actually rejected outright. And the other one  
15 was completely ignored. It was never given any  
16 weight whatsoever. And, you know, both of those  
17 claims have been denied.

18 So, maybe what you heard is what the  
19 ideal is, but when it translates down to the  
20 individual CEs, that is not always what is  
21 happening. So, I am hopeful that when the Board  
22 gets a chance to take a review of some of these

1 claims, they can audit that or check it out to  
2 see if it is prevalent, if it is common, or if  
3 these two claims were unique.

4 This also applies when it comes to  
5 personal physicians. I was really happy when  
6 somebody talked about having a template for the  
7 personal physicians to follow, because they are  
8 not familiar with the program. It saves a lot of  
9 time for them if they know what the Department of  
10 Labor requires.

11 Well, this has been tried by -- and  
12 please don't think that I am a front for the home  
13 healthcare people -- but this was tried by home  
14 healthcare agencies. They knew what the  
15 Department of Labor requires to approve home  
16 healthcare, and they developed a letter. It has  
17 been circulated for other physicians to use.

18 I didn't see that as a bad thing. I  
19 mean, as long as the information provided by the  
20 physician is true and accurate, there is nothing  
21 wrong with that. But the Department of Labor,  
22 there was a big fuss about that during our Denver

1 meeting. So, they didn't seem to be very  
2 appreciative of having the same type of letter  
3 submitted from different doctors from across the  
4 country.

5 But that doesn't mean that those  
6 letters are fraudulent. Okay? It is just an  
7 easy way to get the necessary care to these  
8 workers.

9 And when it comes to home healthcare,  
10 like I said, I am not a front. I don't get paid  
11 by them. I work with every person who tries to  
12 help the workers.

13 The reason you need home healthcare,  
14 I am going to read you just a short email I got  
15 from a spouse. It says, "Sorry, I did not get  
16 you the facts last night. It was a downhill day.  
17 I had to bathe, shave, and dress my husband. He  
18 fell on me. He pinned me between the floor,  
19 sofa, and coffee table."

20 Now, if this worker had home  
21 healthcare because of a covered disease -- and,  
22 apparently, he did not -- there would have been

1 someone there to help the spouse. Okay.

2 All medical things that the worker  
3 needs is covered by this program and needs to be  
4 given to the workers who are covered.

5 And I think that is all I have for  
6 tonight. Again, I thank you very much.

7 CHAIR MARKOWITZ: Thank you.

8 Next will be Deb Jerison who has  
9 requested 10 minutes.

10 As we are approaching the time limit,  
11 I may -- I haven't done this so far -- but I may  
12 just give you a little bit of notice.

13 MS. JERISON: Please do.

14 I had two things I wanted to speak to  
15 today. I'm really glad that you are taking a  
16 look at Final Circular 1505. I'm not going to  
17 get into it in a lot of detail, but I did have  
18 some information I had come up with that I  
19 thought could be useful. I will leave the full  
20 report.

21 But the average compensation paid to  
22 each worker before Final Circular 1505 came out,

1 I think it was December of 2014, the average  
2 compensation was \$157,861. Now there was only  
3 eight months of data I had after that document  
4 was released or the Circular came out, but the  
5 average compensation that was paid to each worker  
6 after the Circular came out was \$17,743.

7 Seventy-two percent of the cases were approved  
8 before Final Circular 1505 was released. Sixty-  
9 five percent were approved after the release of  
10 it.

11 Final Circular 1505 only has 57 jobs  
12 that are covered in that Circular. Before that,  
13 there were 123 jobs with approved claims before  
14 that. Those jobs were self-reported, so there  
15 could be some discrepancies there.

16 But I also wanted to speak a little  
17 bit about the rules and some of the changes, if I  
18 can get to the right version. I was really happy  
19 that you're getting a chance to review the rules  
20 and you are doing a great job. The discussion  
21 was really interesting to listen to.

22 I think there may be more time that is



1 needed than doing it before early May. A lot of  
2 the implications of these changes aren't  
3 immediately obvious, and it will take a lot of  
4 work to truly understand how the changes will  
5 impact the sick workers. I encourage you to talk  
6 to advocates, if you need any on-the-ground kind  
7 of information.

8 EECAP has already made several  
9 detailed public comments on the rules changes,  
10 but here is some additional information on  
11 several sections.

12 Section 30.5(x) restricts the  
13 definition of who is eligible for EEOICPA by  
14 removing workers who provided delivery and  
15 removal of goods from the premises of a DOE  
16 facility. A look at previous claims shows that  
17 around 1,080 claims filed for people delivering  
18 or removing goods have been adjudicated, with 347  
19 of those claims being approved and 589 being  
20 denied. These previously-approved claims have  
21 paid \$77,739,510 in compensation and \$14,058,821  
22 in medical benefits to these sick workers. It

1 seems arbitrary and capricious to restrict  
2 eligibilities for workers transporting goods so  
3 late in the program's history.

4 Then, 30.205 and 30.206 redefine who  
5 is covered for beryllium claims by removing the  
6 phase "or a facility owned, operated, or occupied  
7 by a beryllium vendor", unquote, and changing it  
8 to "a facility owned and operated by a beryllium  
9 vendor".

10 A review of the current beryllium  
11 vendors shows this wording would remove 80  
12 percent of them from EEOICPA. Of the current 75  
13 beryllium vendor sites, only 15 of them are a  
14 facility owned and operated by a beryllium  
15 vendor.

16 30.230 and 30.5(w) offer different  
17 dates, August 13th and January 1st, 1942, to be  
18 used as the earliest any claimant can claim  
19 coverage under EEOICPA. The Einstein-Szilard  
20 letter to President Roosevelt recommending the  
21 U.S. begin the nuclear program was dated August  
22 2nd, 1939. According to DOE's Manhattan District

1 history, Book 1, Volume 1, a memo dated February  
2 20th, 1940, discussed the first transfer of funds  
3 for the Manhattan Project. I suggest either of  
4 these dates would be better than DOL's suggested  
5 dates if it is appropriate to dictate a start  
6 date to eligibility.

7 In reviewing the data, there have been  
8 251 claims filed with Employment between January  
9 1939 and August 1942. Of those claims, 124 were  
10 approved and 96 were denied. Setting a 1942  
11 employment start date is inequitable for the  
12 claimants with work in the early years who  
13 haven't filed claims yet.

14 Just a mention on Section 30.231. I  
15 would just like to note that I provided district  
16 offices specific DOE document proving exposure  
17 for claims, and these have always been considered  
18 irrelevant and non-probative by the CEs.

19 30.232(b) requires a fully-  
20 rationalized medical report. We got into this  
21 quite a bit. Doctors who have written these  
22 reports say that such a report takes between six

1 and ten hours to write. Sometimes that is with  
2 grad students. However, most doctors don't have  
3 the experience, let alone the time, to provide a  
4 report that meets the EEOIC's requirements. This  
5 means many valid claims are denied. This is a  
6 major stumbling block for most claimants, and the  
7 CMC reports just don't always stack up, either.

8 EECAP investigated Parkinson's disease  
9 claims from June 27th, 2006 through February  
10 2014, and found that no personal physicians'  
11 reports led to any claims approval. In October  
12 2014, DEEOIC finally approved one Parkinson's  
13 claim based on a non-DOL physician's letter, and  
14 that is the one that took grad students. This  
15 claim is especially interesting because DEEOIC  
16 had previously denied it numerous times based on  
17 CMC reports. It took 10 years.

18 The first report came from a Dr. Hunt  
19 in 2008. Two reports, then, came from a Dr.  
20 Orgel. One in 2013 came from a Dr. Gresh.  
21 Between the letters from Dr. Orgel and Dr. Gresh,  
22 an independent physician that the claimant had to

1 pay to do the letter provided a report  
2 recommending the claim be approved, which DEEOIC  
3 found not probative enough, partly because of  
4 spelling and cut-and-paste errors. Unlike the  
5 letter from Dr. Orgel, the claims examiner did  
6 not ask this doctor for a clarification. In many  
7 ways, this letter was more detailed than the CMC  
8 reports.

9 DOL's document recommendation proposed  
10 changes not within the scope of the Advisory  
11 Board discusses changes in Section 30.70 to  
12 30.726. And OWCP states that these changes are  
13 being made to conform to the existing FECA  
14 regulatory schemes.

15 EEOICPA and FECA are very different  
16 programs. EEOICPA is a remedial statute and must  
17 be interpreted more liberally than FECA, which is  
18 not remedial. While I know it is a pain for OWCP  
19 to have to administer these two programs  
20 differently, it is improper to cut claimants'  
21 benefits and increase the claimants' burden of  
22 proof for their administrative convenience.

1                   Also, Section 30.805 increases the  
2 sick worker's burden of proof for wage loss and  
3 adds a threat of discontinuing the claim when a  
4 person cannot meet any step. As of July 2015,  
5 only 1,210 wage loss claims have been paid. So,  
6 I even wonder why this change would be necessary.

7                   CHAIR MARKOWITZ: I'm sorry, one more  
8 minute, if you would.

9                   MS. JERISON: I'm sorry?

10                  CHAIR MARKOWITZ: One more minute, if  
11 you would.

12                  MS. JERISON: Okay. For additional  
13 comments on EECAP's proposed rules changes, you  
14 can check the Radioactive Daughter Blog.

15                  Thank you.

16                  CHAIR MARKOWITZ: Thank you.

17                  Next we will hear from Ms. Stephanie  
18 Carroll, who has requested 10 minutes.

19                  MS. CARROLL: Thank you.

20                  It was hard to prepare for this  
21 because I had so many different things I wanted  
22 to make comments on today.

1           But what I would like to say is this  
2 program was intended to be fair and equitable,  
3 and the claims should have a uniform application  
4 of the law.

5           CHAIR MARKOWITZ: Hand it to her.

6           MS. CARROLL: Okay. Hello. Okay.

7           Anyway, it was intended to have a  
8 uniform application of the law.

9           I also believe, because I am a  
10 specialist in chronic beryllium disease, that  
11 Congress intended for the program to establish  
12 chronic beryllium disease, to establish beryllium  
13 sensitivity. Beryllium sensitization is  
14 established by one abnormal beryllium blood test  
15 or a lavage showing a positive response. That is  
16 not the current medical diagnostic criteria. You  
17 could not get a doctor to say that someone has a  
18 diagnosis of beryllium sensitization with one  
19 beryllium blood test.

20           Beryllium sensitization is a beryllium  
21 illness under the program, along with chronic  
22 beryllium disease and any other illnesses that

1 are consequential to those first two illnesses.  
2 So, they should be looked at the same. They are  
3 kind of put together in the Act.

4 So, what is happening now is a huge  
5 change in the program when it comes to chronic  
6 beryllium disease. Now it looks like, page 32 of  
7 the new rules, they are asking for -- well, let  
8 me just tell you what is happening, once I look  
9 at my notes. I can't even think.

10 Anyway, as it used to be and what I  
11 thought that Congress demanded was, yes, medical  
12 evidence is needed to establish CBD, medical  
13 evidence being a pulmonary function test showing  
14 obstruction and, yes, I agree, a physician should  
15 weigh-in on if there is obstruction found on a  
16 pulmonary function test. But I don't think any  
17 physician can write a well-rationalized medical  
18 report describing how they came to the conclusion  
19 that this person meets the current diagnostic  
20 criteria, medical diagnostic criteria, for  
21 chronic beryllium disease. And that is what is  
22 being asked.



1           A physician cannot write that if they  
2           are going by current medical diagnostic criteria.  
3           The only way you can establish chronic beryllium  
4           disease is to see if they meet the medical  
5           requirements. You know, they have got specific  
6           findings on CT. That's okay to have a doctor  
7           review the CT exam and see if there are  
8           granulomas found, honeycombing, ground glass, any  
9           other number of other things that are listed in  
10          the Procedure Manual.

11           If a physician finds those, well, has  
12          findings of those criteria, of course, it would  
13          be on the report. So, there is your weighing-in  
14          of the medical professionals.

15           But it is up to the claims examiners,  
16          and they have it in the Procedure Manual, the  
17          list of criteria that they have to meet to  
18          establish chronic beryllium disease. And this  
19          isn't happening right now.

20           I literally am one of the only people  
21          that gets chronic beryllium disease approved in  
22          this program. Now, if you want data, this is

1 what you ask for. You ask for the V81.4  
2 Diagnostic Code. That is beryllium  
3 sensitization, and that starts our poor beryllium  
4 workers on this journey of being monitored for  
5 beryllium sensitization and getting an enormous  
6 amount of invasive diagnostic tests that never  
7 actually meet the current medical diagnostic  
8 requirements to establish CBD.

9 So, people are not getting diagnosed  
10 with CBD anymore, since about 2006. So, lots of  
11 beryllium sensitization, so the stats will look  
12 like you have got a lot of people being approved  
13 under Part B for beryllium. No, not for chronic  
14 beryllium disease.

15 Now, when it looks like people aren't  
16 being diagnosed with CBD, people onsite may  
17 assume, oh, some of these safety measures might  
18 be working now because nobody is getting  
19 diagnosed anymore. There's 300 people sensitized  
20 at Rocky Flats. There has probably been 80  
21 people approved under the program. And when you  
22 are sensitized, Lee Newman said in 1992,

1 sensitization is preclinical chronic beryllium  
2 disease. You have the illness when you are  
3 sensitized.

4 So, my workers are going through this  
5 monitoring, and they are getting yearly or every-  
6 other-year CT scans, PFTs, chest x-rays, exercise  
7 tests, no matter how sick they are, and they  
8 always qualify for a lavage biopsy, always. It  
9 doesn't matter what the tests say or what their  
10 health issues are. And they continue to not get  
11 diagnosed.

12 Now I'm so worried about the fact that  
13 even I may not be able to get people diagnosed  
14 anymore, because what is going to happen is they  
15 are now asking for, even if a doctor says the CT  
16 scan is consistent with CBD, I was just told they  
17 are not going to accept that, even though it is  
18 mandated; it is in the law that they should  
19 accept that statement. Now they are going to  
20 want a well-rationalized letter to explain how  
21 this doctor came up with that statement. And  
22 that is outrageous, and I'm telling you, nobody

1 else is getting people approved for this illness.

2 This Act came about, first and  
3 foremost, for chronic beryllium disease. This is  
4 what drove this Act, and it is being ignored and  
5 nobody is getting diagnosed. And it is very sad.  
6 People beryllium sensitized, never smoked, have  
7 pulmonary fibrosis, positive B-reads, findings on  
8 CT scans that are consistent with CBD,  
9 obstruction. They are on oxygen 24 hours a day,  
10 and they are not getting even a statement that  
11 says that their clinical findings are consistent  
12 with CBD.

13 But they are contributing a lot of  
14 their specimens to research. So, that is, I  
15 guess, one of the good things to come out of  
16 this, if you can call it that.

17 So, I really want to stress that the  
18 beryllium disease issue needs to be covered. And  
19 the rule on page 32 actually says -- it has  
20 always been if you were treated, tested, or  
21 diagnosed with a chronic respiratory disorder,  
22 you would fit into the pre-1993 CBD.

1           Arbitrarily, about a year-and-a-half  
2 ago, the program decided to get rid of -- not  
3 test it anymore. You got treated or diagnosed  
4 with a chronic respiratory disorder. And then,  
5 they decided you had to be diagnosed and have  
6 long-term treatment for a chronic respiratory  
7 disorder prior to 1993.

8           These arbitrary new policies really  
9 affect people's ability to get approved and get  
10 recognition for an occupational illness they are  
11 suffering from. Now it looks like you are going  
12 to have a chronic respiratory disorder, No. 2 on  
13 page 32, "If the earliest dated medical evidence  
14 shows that the employee was either treated for or  
15 diagnosed" -- we got "tested" out of there --  
16 with a chronic respiratory disorder on or after  
17 1993, "the criteria set forth of this section  
18 must be used." So now, you have to have a  
19 chronic respiratory disorder before you can even  
20 use post-1993 CBD criteria? I don't know where  
21 that came from.

22           So, well, I wish you all had more

1 time. I think it is absolutely outrageous and  
2 un-American to not allow this Board to have more  
3 time to look at these rules. I think it is just  
4 outrageous.

5 CHAIR MARKOWITZ: I'm sorry, one more  
6 minute.

7 MS. CARROLL: Yes. I am just so  
8 pleased that you are here, and you give me hope.  
9 So, thank you very much.

10 CHAIR MARKOWITZ: Thank you.

11 So, I would like to welcome Jeanne  
12 Cisco. Ms. Cisco has requested 10 minutes.

13 Welcome, Jeanne.

14 MS. CISCO: Thank you. Hi.

15 Is it on?

16 I'm Jeanne Cisco from Portsmouth.

17 I've worked at a gaseous diffusion plant for over  
18 41 years, and I am here to talk to you about the  
19 SEM and some of the things collectively that the  
20 Worker Health Protection Program Coordinators  
21 came up with that we would like to have you look  
22 up.

1           We think that the Department of Labor  
2 needs to have transparency when chemicals and  
3 other items are added or removed from the SEM, as  
4 well as an auditing process of the addition and  
5 deletion to the SEM, with the rationale and  
6 documentation used to justify the action.

7           At Portsmouth, I submitted probably --  
8 I don't know -- thousands of chemicals in 2011.  
9 Many claims were processed up to that point, but  
10 very few chemicals were on the SEM there. We got  
11 the list of MSDS sheets from the current  
12 contractor in 2011 and submitted those.

13           The Department of Labor came back.  
14 They said they needed to know where they were at,  
15 what buildings and departments, in order to put  
16 them in. To make a long story short, I worked  
17 with the Department of Labor for over a year  
18 trying to get those chemicals added to the SEM,  
19 and I got a statement from the contractor to  
20 prove that those chemicals -- it is difficult for  
21 the Department of Labor to put into that SEM the  
22 chemicals in what building and what department

1 because the processes are not identified -- okay?  
2 -- well enough. And I heard today they don't  
3 have those resources. I heard the Department of  
4 Labor say that.

5 That is essential for someone who is  
6 filing a claim to get the right -- well, for one,  
7 we were never monitored for chemical exposures at  
8 Portsmouth ever. Okay? So, how could they tell  
9 the frequency, duration, all those things on  
10 exposures, and then, the Department of Labor has  
11 to use the SEM that does not describe the work  
12 processes and the many classifications that go  
13 into these chemicals. That's impossible for  
14 anyone to do that with what they are doing today.

15 I just think that I was involved in  
16 the beginning, when this program started, when  
17 they came to Portsmouth and they asked on the  
18 different processes. And I can remember looking  
19 at the retirees answering the questions on  
20 radiation, and I'm thinking chemicals. But, you  
21 know, they never told us the chemicals. We did  
22 not have a need to know.



1           We now at Portsmouth at a list of MSDS  
2 sheets. Not all of those were added. Some have  
3 been removed. They are not assigned to the  
4 proper classifications. I have a letter from the  
5 plant that I submitted and did not get a response  
6 on, and it basically states what I'm telling you.  
7 All classifications worked in buildings together  
8 around those chemicals, and my guess is it's that  
9 way throughout the industry.

10           One thing that concerned me today that  
11 I heard is that you're thinking about presumption  
12 and you're going to use scientific research on  
13 the chemicals. And to try to help this process  
14 along, I want you to understand that in the  
15 nuclear industry you can't use typical other  
16 scientific facts. You need to know what we did  
17 and the specific chemicals and things that we had  
18 to use.

19           Now DOE does not release everything;  
20 they can't for national security, but there are  
21 ways to find out those things. You can get on  
22 the Manhattan Project website. They release

1 important things daily or often. They just  
2 released on nickel dust that is not in our SEM.  
3 It should be in there. It wouldn't be hard to  
4 win a COPD claim if that was in our SEM, and  
5 probably throughout the industry.

6 So, the Coordinators felt that, when  
7 you add something or delete something, we should  
8 know what it is and why. And when we propose to  
9 add something to it like our independent  
10 investigations by NIOSH -- Ken spoke today on  
11 some language that you're starting to write there  
12 or suggest. The Department of Labor should  
13 accept those types of reports. They are done by  
14 NIOSH. They are done by OSHA. They are done by  
15 credible agencies that describe the processes in  
16 these plants.

17 We have Site Profiles. Okay? That  
18 was come up with to help for Subtitle B. And  
19 they could use those. There's a lot of  
20 information in those on the processes and the  
21 chemicals.

22 Okay. Several of the reviews that I

1 have read have suggested that the Department of  
2 Labor incorporate other databases. All of that  
3 should be done, in my opinion.

4 Like I said, the processes, my  
5 coworker will cover that a little better.

6 Once you even submit into the SEM the  
7 chemicals, they never get to the classification  
8 because there is the break. You've got the  
9 processes and the classifications, and many  
10 worked in this, and the SEM doesn't capture that.  
11 So, you have got your work cut out for you.

12 I think that the Department of Labor  
13 would welcome any and all information that they  
14 could get. DOE has a Computerized Accident  
15 Injury Reporting System, CAIRS I think, that was  
16 mentioned today.

17 You have many people at these sites  
18 that would help in any way we can to help make  
19 this better for the sick people. Something that  
20 bothered me is that they did not go back prior to  
21 2011 and review the people whose claims went  
22 through. If there's any changes, I think that

1 that needs to be looked at and made retroactive  
2 back to any improvements to the program.

3 I think another area was medical  
4 guidance for the claims examiners.

5 CHAIR MARKOWITZ: One second. One  
6 more minute. Okay?

7 MS. CISCO: One minute?

8 CHAIR MARKOWITZ: Yes.

9 MS. CISCO: Okay. Medical guidance  
10 for the claims examiners; health physics people,  
11 they only had two across all of the DOE  
12 complexes. So, how many claims went there? They  
13 didn't.

14 I can't do this under pressure. I'll  
15 submit more later.

16 CHAIR MARKOWITZ: Okay.

17 MS. CISCO: The health physicists I  
18 don't think were used, District Medical  
19 Consultants. Usually, the Former Worker Program  
20 medical reports and a personal physician's report  
21 that uses the proper language of cause,  
22 contributed to, or aggravated, that was spelled

1 out. That's ignored and it is sent to the CMC,  
2 and then, they make a ruling.

3 CHAIR MARKOWITZ: So, thank you.

4 I might add that there is another  
5 public comment period tomorrow, and there may be  
6 time on the schedule if you want to cover  
7 additional points, just so you know.

8 Thank you.

9 Next is Paige Gibson who has requested  
10 five minutes.

11 MS. GIBSON: As he stated, my name is  
12 Paige Gibson. I worked at the Mound Miamisburg  
13 Plant for 13 years. My father worked there for  
14 23 years.

15 While I was at Mound, I was a decon B  
16 worker. I was the Health and Safety Rep for the  
17 Union, and I taught HAZWOPER. I am currently a  
18 nurse and a Coordinator for the WHPP program,  
19 and, proudly, a worker advocate.

20 As Jeanne stated, I am going to cover  
21 some other points that the Coordinators were  
22 concerned about and that we're facing every day

1 out there.

2 First of all, there should be user-  
3 friendly published guidelines on what happens  
4 during the claim process. From my understanding  
5 today and from other issues, the claims examiners  
6 are gods in the process of a person's claim.  
7 This person who has a high school education and  
8 two months of in-house training is making medical  
9 decisions and denying or agreeing with a  
10 claimant.

11 When they say that we have to have or  
12 we should have a doctor's diagnosis on a covered  
13 condition, it is you have to. The claims  
14 examiner will tell you, "You have to supply me  
15 with more likely than not." The explanation is a  
16 bonus, if you can get a doctor to do that. But  
17 sending a template with my workers to the doctors  
18 that says, "Please have your doctor say that you  
19 are more likely than not got this disease because  
20 you were exposed to toxins at Mound," or at GE,  
21 or one of the subcontractors in my area, the  
22 doctors don't have a clue what is at Mound. We,

1 as workers, didn't have a clue until recently.

2 Mound is closed, and they have access  
3 to me or to a reading room that gives them access  
4 to the exposures, because the majority of them  
5 don't use the computer. They haven't, unless you  
6 walk them step by step, they don't use computers.  
7 So, you have to provide that for them.

8 When you talk to them to get your  
9 claim going in your regional office -- Portsmouth  
10 would be ours -- the job classification, I don't  
11 exist according to DOL. There is no such thing  
12 as a decontamination worker B. And then, I  
13 became a demolition technician. I didn't exist  
14 at Mound. So, I don't have a record.

15 And I love the fact that DOE is  
16 working with DOL now to get our records. There  
17 is a problem with that, though. Our incident  
18 records aren't there. They for Mound were  
19 buried. For others, they just were destroyed and  
20 never made it into our files. Our exposures  
21 aren't there.

22 So, if they don't exist and DOL is not

1 recognizing my affidavit or other workers'  
2 affidavits, how are they going to know? And that  
3 is the crux of those affidavits. All along, up  
4 until yesterday, I thought they were great. I  
5 knew that on the worker's occupational history  
6 that was taken that you could put down dead  
7 people because they didn't call them. The claims  
8 examiners never called them to get any more  
9 information.

10 So, I submitted affidavits, thinking  
11 that these would hold value, and they don't.  
12 They are ignored because they aren't proven by  
13 DOE records which don't exist. It's a quandary  
14 that every worker advocate faces out there.

15 Job classifications don't exist. We  
16 don't have doctors who are willing to get  
17 involved or have the experience or knowledge of  
18 these sites.

19 I tell my workers, when they go to get  
20 their letter, there's three things. It is not  
21 tell your doctor. It is not workman's comp.  
22 It's not a lawsuit. And nobody will call them.



1 Just sign the letter. And we get letters. And  
2 it is a shame that you have to tell a doctor  
3 that, but I understand the process of lawsuits  
4 and whatnot.

5 Another big concern across the nation,  
6 not just at Mound, unless there is an SEC in  
7 place, is that somehow DOE decided that January  
8 1st, 1980, all sites became safe. I process  
9 hundreds of claims, either as an Authorized Rep  
10 or as just helping or as a witness, and 1980 is  
11 the cutoff date. I can't figure out why. It is  
12 through Circular 1506 that it is mentioned.  
13 There is mention of 1995 and the Tiger Teams  
14 coming into place.

15 A real quick story about Tiger Teams.  
16 The first six months I was at Mound, they said,  
17 "Tiger Team is coming. Overtime." Great. So,  
18 our bosses would take us around to buildings and  
19 labs and say, "Everything in there in the  
20 dumpster." It was a brand-new camera still in  
21 the box. "Hey, if you're throwing this away, can  
22 I have it?" "No, no, throw it away. Throw it

1 away."

2 Chemicals that were stacked high,  
3 throw them away. One jug, that's it. Throw them  
4 away. And I could never understand why, until  
5 later, that we don't want the Tiger Team to have  
6 find you, and then, the contractor has to pay.  
7 It wasn't a surprise like OSHA shows up. Tiger  
8 Team let the company know, "We're coming." So,  
9 all these things disappeared.

10 CHAIR MARKOWITZ: Excuse me. One more  
11 minute.

12 MS. GIBSON: Okay. Just to state that  
13 the 1980 date is very important. In the 1980s is  
14 when Reagan took over; Star Wars was big, and  
15 there was a boon in hiring in the DOE complex.  
16 The effect on thousands and thousands of people  
17 not being process through the claims because they  
18 started after that date has got to be changed.

19 Exposures happened after that date,  
20 accidents, and people are sick. And those dates  
21 and the job classifications have to be changed.

22 I thank you. I think you guys are

1 doing a wonderful job. You've jumped off running  
2 at this Board, and I appreciate your work. Thank  
3 you.

4 CHAIR MARKOWITZ: Thank you.

5 Next we'll hear from Donna Hand, who  
6 has requested five minutes.

7 MS. HAND: Okay. In the very  
8 beginning, we were talking about weighing medical  
9 evidence and the physicians had to have a  
10 definitive everything. Again, I remember we go  
11 back to the statute and the regulations, and it  
12 says it is not that high of a standard.  
13 Congressional intent and findings have stated  
14 you're not going that high of a standard; there's  
15 not medical certainty.

16 So, that "maybe", "probability", you  
17 know "plausible", those wordings can be used by  
18 the physicians and should still be accepted  
19 underneath this program, because that still fits  
20 that standard that Congress in the statute and in  
21 the regulations, at the Secretary's discretion in  
22 2006, used. So, that part there.

1           Also, the case examiners, they write  
2 what they call a Statement of Accepted Facts.

3           The Statement of Accepted Facts is, then, being  
4 sent to the contract medical consultants, along  
5 with the specific questions, not general  
6 questions, specific questions.

7           With that Statement of Accepted Facts,  
8 they said, "We have accepted their employment.  
9 We have accepted the exposure here. We have  
10 accepted the medical evidence."

11           Why can't these Statements of Accepted  
12 Facts also be sent to the treating physician?  
13 Also, why can't that standard of aggravating,  
14 contributing, causing also be sent, along with  
15 the definitions that are used to the treating  
16 physician? That would help explain a little bit  
17 more of, oh, yes, I can say that. I can't say  
18 with medical certainty because that is really  
19 what causation is. I can't say. I don't know  
20 what specific chemical it was.

21           But if all I have to say, was it  
22 plausible, yes, I can do that. You have already

1 determined he was exposed to this chemical, this  
2 chemical, and this chemical. And I know that  
3 that chemical does it. Yes, I can say that then.

4 But that is not what is done. In  
5 other words, the treating physician sees the  
6 medical part, the diagnostic, you know, the  
7 pulmonary function test, the lab work. You know,  
8 they see that.

9 The contract medical consultants just  
10 see what the Department of Labor has sent to  
11 them, which is we have accepted this medical  
12 condition. How much of it, you know, they don't  
13 know. So, was it a progressive disease? Was it  
14 slowly? Was it mild at first and, then, severe  
15 now? They didn't see any of that.

16 So, why can't that Statement of  
17 Accepted Facts, which whether the CMC agrees with  
18 or not, they still have to accept it, everything,  
19 be sent to both the treating physician, instead  
20 of a verbal phone call and say, "Hey, we don't  
21 understand. This is our issue. But this is what  
22 we have accepted. This is the criteria of our

1 program. Can you give us an opinion now?"

2 Again, the statute did state that the  
3 Secretary can use physicians to help determine  
4 Part E. However, those physicians are to be  
5 experts in treating or researching in that  
6 particular issue. So, it is just pulmonology, or  
7 whatever. So, if you are not treating it, you  
8 are not researching it, you are not writing it,  
9 you're really not considered an expert to the  
10 Secretary. Really, it wobbles down to the final  
11 decision, no matter what, is the Secretary's  
12 decision, which is, again, the DEEOIC.

13 Again, experts can only issue opinions  
14 within their own field. So, if you are an IH,  
15 you can only address, you know, whatever IH can  
16 address. They cannot address the medical. They  
17 can't address the legal. A medical can't address  
18 the legal. So, you can do it as a personal  
19 opinion, but you can't do it as an expert  
20 opinion.

21 Interpretative questions, you know,  
22 and administrative questions and legal questions,

1 it all comes down to specifically Part B, chronic  
2 beryllium disease. It is established.

3 And in the very beginning of the  
4 program, since 2004, they have said that the pre-  
5 1993, you can use that if it was treated for,  
6 tested for, or diagnosed with a chronic  
7 respiratory condition before 1993. Then, you use  
8 that criteria.

9 However, the chest x-rays, the  
10 pulmonary function tests can all be after that.  
11 And they have issued decisions of that. So, you  
12 can have a pulmonary function test from work  
13 showing a mild obstruction. Okay, that meets the  
14 pre-1993 criteria. Then, you can have the chest  
15 x-ray in 2000. You can the rest of it, the other  
16 two criteria. So, you can have all the three  
17 criterias later on. It doesn't have to.

18 And there have been several, several  
19 decisions from 2004 on doing that. Then, all of  
20 a sudden, in September of 2015, they changed  
21 their policy.

22 And the skin patch test, I agree we

1 need to have more non-invasive tests to do  
2 chronic beryllium disease. The skin patch test  
3 is being done for people that have exposure to  
4 hip replacements. The Mayo Clinic, Johns  
5 Hopkins, and several of them, have done the metal  
6 testing for the hip replacements, and they did it  
7 with a skin patch test. And it is more accurate  
8 than the allergic patch test where you do the  
9 prick on the back, everything. So, why isn't  
10 there something like that for beryllium?

11           Again, the main thing is the reports.  
12 Like I've used chronic -- the Collaborative on  
13 Health and the Environment.

14           CHAIR MARKOWITZ: One more minute.

15           MS. HAND: Okay. And in that report,  
16 you know, it says the causes for COPD, and it has  
17 strong and it has good and it has limited. This  
18 evidence has been turned down. I've established  
19 that, well, this is proof that there has been  
20 peer-reviewed studies, but they won't accept it.

21           There are other languages, you know,  
22 and the World Health Organization has defined



1 chronic respiratory diseases and lists allergic  
2 rhinitis as a chronic respiratory disease. They  
3 won't accept that.

4 I've listed -- in the DMC Handbook,  
5 OWCP has a list of reference materials that they  
6 approved for their contract medical consultants  
7 to use. I've used those same reference  
8 materials. They said, "No. Won't use them.  
9 Won't accept them."

10 So, again, thank you so much, and  
11 discuss more tomorrow.

12 CHAIR MARKOWITZ: Okay. Thank you  
13 very much.

14 Tim Larew, who has requested three  
15 minutes.

16 MR. LAREW: Thank you, Dr. Markowitz.

17 My name is Tim Larew. I serve as  
18 Chairperson for Cold War Patriots, a national  
19 association of more than 36,000 former and  
20 current nuclear complex workers and their  
21 families, as well as miners, millers, and  
22 transporters. Our mission at Cold War Patriots

1 is to connect the men and women of our nuclear  
2 complex and their families to the information and  
3 resources they may need if they suffered a work-  
4 related illness, and honor them for their  
5 sacrifice and their service.

6 The enactment of this Advisory Board  
7 has been a long-time legislative goal of our  
8 organization, and we are encouraged by your  
9 efforts on behalf of the worker community that  
10 you have begun here in our nation's capital this  
11 week.

12 Over the past several years, I have  
13 had the privilege of meeting the several thousand  
14 former nuclear complex workers and hundreds of  
15 EEOICPA claimants that have been approved and  
16 hundreds more that have been denied.

17 The message I convey to you on their  
18 behalf today is this: any nuclear complex worker  
19 would gladly forego the compensation and medical  
20 benefits provided by EEOICPA if they could simply  
21 be restored to good health. Since this is not  
22 possible, these sick former workers do ask that

1 the intent of the law to provide compassionate  
2 compensation and medical benefits in a timely  
3 manner be respected and honored by all those  
4 entrusted with faithful administration of the  
5 Act.

6 You on this Board will now play a very  
7 significant role as you apply your individual  
8 skills and experiences in fulfilling the promise  
9 of EEOICPA. Cold War Patriots welcomes the good  
10 work you are now undertaking, and we will support  
11 you fully in your important mission.

12 Thank you.

13 CHAIR MARKOWITZ: Thank you.

14 Next, actually, our last speaker is  
15 going to be Mr. Hugh Stephens, who has requested  
16 five minutes.

17 MR. STEPHENS: Thank you, Dr.  
18 Markowitz.

19 I just wanted to say a few words about  
20 causation. We have been talking about causation  
21 in the program. One thing I want to say is,  
22 first of all, the normal causation standard,

1 preponderance of the evidence, is applicable in  
2 the program for most things; if you need to  
3 supply a birth certificate to show that you are a  
4 survivor, for example.

5 So, the preponderance of the evidence  
6 is the typical standard and it is at work within  
7 the program. I think, under Part B and E, the  
8 idea is that we need a reduced standard, the  
9 50/50 standard, the tie-goes-to-the-runner  
10 standard, because of the lack of evidence and the  
11 difficulty that you run into determining whether  
12 radiation caused your cancer or whether your  
13 exposure to occupational hazardous substances in  
14 your occupation caused your illness.

15 And so, when you look at causation  
16 under Part B, we have the 50/50 standard. And  
17 so, under Part B, if the dose reconstruction  
18 shows that radiation is at least as likely as not  
19 to have caused your cancer, then you are paid.

20 The causation standard under Part E  
21 that we have talked a lot about includes  
22 contribution and aggravation, and so, is a

1 further reduced standard. And it is a more  
2 typical standard that you run into in the  
3 workers' compensation context, the idea being  
4 that workers should be compensated more liberally  
5 probably than in the civil litigation system.  
6 And so, I think we can all agree that Part E is a  
7 reduced standard.

8 But, when it comes to radiation and  
9 whether it is considered under Part E as a  
10 potential hazardous substance causing,  
11 contributing to, or aggravating a cancer or  
12 another illness -- and I think there is  
13 increasing evidence that radiation can cause, can  
14 be a contributing cause of both malignancies and  
15 other types of illnesses or conditions. And we  
16 have been able to have at least one claim  
17 approved where radiation was identified, in  
18 addition to asbestos, as potentially contributing  
19 to a claim for cancer.

20 And so, I think this is becoming more  
21 important. And what I would like to throw out  
22 there as just the idea is, when they determine

1 that radiation is at least as likely as not, and  
2 that is defined as causing your cancer or enough  
3 to consider it to have caused your cancer, the  
4 problem is they are also in this program treating  
5 that same evidence, the fact that you did not  
6 reach the 50-percent threshold in the dose  
7 reconstruction, as meaning that radiation did not  
8 contribute to or aggravate, primarily contribute  
9 to.

10 And I think there is within the  
11 program this conflation of the idea of  
12 contribution into causation, because I think  
13 there is a sense that, if it doesn't cause it,  
14 how can it contribute to it?

15 But we know that there are  
16 contributory portions of the process. I think we  
17 are understanding the process of how cancer comes  
18 about better and how radiation might play a role  
19 in the many steps leading up to cancer.

20 And so, one thing we can consider is  
21 maybe for my clients I would prefer that the  
22 threshold be 1 percent. If you have 1 percent

1 probability of causation, you ought to get paid  
2 under Part E, even though you fail under Part B.

3 For the Department of Labor, who knows  
4 what it is? But somewhere between 1 percent and  
5 49.9 percent, we might have -- there is a reduced  
6 standard. And so, under Part E, we should  
7 consider at what point with significant  
8 radioactive radiation exposure acknowledged in  
9 the dose reconstruction, when could it be  
10 considered to have contributed?

11 With that, I will let everybody go  
12 home. Thank you very much. I appreciate all  
13 your work.

14 CHAIR MARKOWITZ: Thank you.

15 And this concludes our public comment  
16 session. It also concludes day two. We will  
17 meet tomorrow morning at 8:30. Thank you.

18 (Whereupon, the above-entitled matter  
19 went off the record at 6:01 p.m.)  
20  
21  
22

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This is to certify that the foregoing transcript

In the matter of: Meeting of the Advisory Board on  
Toxic Substances and Worker Health

Before: US DOL

Date: 04-27-16

Place: Washington, DC

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Court Reporter

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