

UNITED STATES DEPARTMENT OF LABOR

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ADVISORY BOARD ON TOXIC SUBSTANCES
AND WORKER HEALTH

+ + + + +

MEETING

+ + + + +

MONDAY,
JUNE 19, 2017

+ + + + +

The Advisory Board met telephonically
at 1:00 p.m. Eastern Time, 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
CARRIE A. REDLICH
VICTORIA A. CASSANO

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CLAIMANT COMMUNITY:

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

DESIGNATED FEDERAL OFFICIAL:

DOUG FITZGERALD

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

1:08 p.m.

MR. FITZGERALD: Thank you. Good afternoon, everyone. My name is Doug Fitzgerald. I'd like to welcome you to today's teleconference meeting of the Department of Labor's Advisory Board on Toxic Substances and Worker Health.

I'm the board's designated federal officer or DFO for today's meeting.

First, I want to take a moment just to say we appreciate the time and diligent work of our board members in preparing for this meeting and for their forthcoming deliberations.

I'll introduce the board members and at the same time take an official roll of those in attendance.

Let's begin with our board chair Dr. Steven Markowitz.

CHAIR MARKOWITZ: I'm here.

MR. FITZGERALD: Okay. Dr. John Dement.

MEMBER DEMENT: Yes, I'm here.

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1 MR. FITZGERALD: Mr. Mark Griffon.
2 MEMBER GRIFFON: Yes, I'm here.
3 MR. FITZGERALD: Dr. Ken Silver.
4 MEMBER SILVER: Here.
5 MR. FITZGERALD: Dr. Leslie Boden.
6 MEMBER BODEN: Here.
7 MR. FITZGERALD: Dr. Rosemary Sokas.
8 MEMBER SOKAS: Here.
9 MR. FITZGERALD: Dr. Carrie Redlich.
10 MEMBER REDLICH: Here.
11 MR. FITZGERALD: Dr. Victoria Cassano.
12 MEMBER CASSANO: Here.
13 MR. FITZGERALD: Mr. Kirk Domina.
14 MEMBER DOMINA: Here.
15 MR. FITZGERALD: Mr. Garry Whitley.
16 MEMBER WHITLEY: Here.
17 MR. FITZGERALD: Mr. James Turner.
18 MEMBER TURNER: Here.
19 MR. FITZGERALD: Ms. Faye Vlieger.
20 MEMBER VLIEGER: Here.
21 MR. FITZGERALD: And I believe we have
22 two members who may be joining us in a little bit,

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1 Dr. Laura Welch as well as Ms. Duronda Pope. If
2 they call in -- oh, and Dr. Friedman-Jimenez as
3 well.

4 All right, just a few words about folks
5 who are in the room today with me. I have Carrie
6 Rhoads who's the deputy DFO as well as Kevin Bird
7 from SIDEM, our contractor.

8 Just a few pieces of information to note
9 regarding meeting operations.

10 All copies of meeting materials and any
11 public comments are or will be available on the
12 board's website under the heading Meetings and a
13 listing there for this full board meeting.

14 Documents will also be up on the WebEx
15 screen so everyone can follow along with the
16 discussion.

17 The board's website can be found at
18 [dol.gov/owcp/energy/regs/compliance/advisoryboa](http://dol.gov/owcp/energy/regs/compliance/advisoryboard.htm)
19 [rd.htm](http://dol.gov/owcp/energy/regs/compliance/advisoryboard.htm) or you can use your browser and put in the
20 board's name and it will probably come up as one
21 of the first URLs.

22 If you haven't already visited the

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1 board's website I strongly encourage you to do so.
2 After clicking on today's meeting date you'll see
3 a page dedicated entirely to today's meeting.

4 The webpage contains publicly
5 available materials submitted to us in advance of
6 the meeting.

7 We will publish any materials that are
8 provided to the board where you should also find
9 today's agenda as well as instructions for
10 participating remotely.

11 If you are participating remotely and
12 you have a problem please email us at
13 energyadvisoryboard@dol.gov.

14 By WebEx, please note that the session
15 is for viewing only and will not be interactive.

16 Phones will also be muted for
17 non-advisory board members.

18 At this time I'd like to ask the
19 participants to put their phones on mute unless
20 they are speaking because we're getting a lot of
21 background noise.

22 Please note that we do not have a

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1 scheduled public comment session today. The
2 call-in information has been posted on the advisory
3 board website so that the public may listen in but
4 not participate in the board's discussion.

5 A transcript and minutes will be
6 prepared from today's meeting and during board
7 discussions today. As we are a teleconference
8 line please speak clearly enough for the
9 transcriber to understand.

10 When you begin speaking especially at
11 the start of the meeting please state your name so
12 we can get an accurate record of discussions.

13 And at each time when you speak during
14 the discussions please announce yourself so that
15 we will know who's actually speaking.

16 Also, I'd like to ask our transcriber
17 to please let us know if you are having any issue
18 with hearing anyone or with the recording.

19 As DFO I see that the minutes are
20 prepared and ensure they're certified by the chair.
21 The minutes of today's meeting will be available
22 on the board's website no later than 90 calendar

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1 days from today per FACA regulations.

2 But if it's available sooner they'll be
3 published before the 90th day.

4 Also, although formal minutes will be
5 prepared we will also be publishing verbatim
6 transcripts which are obviously more detailed in
7 nature.

8 Those transcripts should be available
9 on the board's website within 30 days.

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

16 Please be aware of this as we continue
17 with the meeting today. These materials can be
18 discussed in a general way which does not include
19 using any personally identifiable information such
20 as names, addresses, specific facilities, cases
21 being discussed, or doctors' names.

22 And with that I convene this meeting of

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1 the Advisory Board on Toxic Substances and Worker
2 Health and turn it over to Dr. Markowitz. Thank
3 you.

4 CHAIR MARKOWITZ: Thank you. So I
5 join in the welcome to this meeting. This is our
6 first meeting by telephone.

7 I hope it's a useful mechanism so that
8 we can address the issues and make recommendations
9 on a --

10 MEMBER SOKAS: Steve, can you speak up,
11 please?

12 CHAIR MARKOWITZ: Sure, is that any
13 better?

14 MEMBER SOKAS: Yes, much better.

15 CHAIR MARKOWITZ: That's much better?
16 Okay.

17 So, welcome. This is our first meeting
18 by telephone. I'm hoping it's a useful mechanism
19 so that we can use it in the future and not have
20 to wait six months between our face to face meetings
21 in order to have useful discussions and perhaps
22 make recommendations but we'll see.

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1 Because the telephone meeting is
2 relatively short we decided, meaning basically I
3 decided that we would skip the public comment
4 section. I apologize if anyone is offended by
5 that.

6 We do welcome public comments and we
7 have some written comments since our last meeting
8 and I welcome other written comments now or in the
9 future to allow a mechanism for people to provide
10 some comments between our meetings.

11 We will adjust our future in-face
12 meeting in October and November, the amount of time
13 of that meeting to ensure that we allow for adequate
14 public comments as we have in the past.

15 I think that we should do just -- we know
16 each other on the board but we should probably for
17 the benefit of any public participants who may be
18 new to board activities we should probably just go
19 around and introduce ourselves quickly.

20 I am Steven Markowitz and I'm an
21 occupational medicine physician and
22 epidemiologist at the City University of New York.

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1 Actually, maybe Kevin or Doug or
2 Carrie, if you could call people's names out that
3 would be the most orderly way of doing it.

4 MR. FITZGERALD: Okay, I will be happy
5 to do that. Dr. Dement.

6 MEMBER DEMENT: My name is John Dement.
7 I'm an industrial hygienist and epidemiologist at
8 Duke University Medical Center.

9 MR. FITZGERALD: Mr. Mark Griffon.

10 MEMBER GRIFFON: Mark Griffon. I'm a
11 consultant health physicist.

12 MR. FITZGERALD: Dr. Kenneth Silver.

13 MEMBER SILVER: Associate professor of
14 environmental health at East Tennessee State
15 University calling in from the great State of New
16 Mexico where I still keep up with some Los Alamos
17 families and former workers.

18 MR. FITZGERALD: Dr. Leslie Boden.

19 MEMBER BODEN: Hi, I'm a professor at
20 the Boston University School of Public Health.

21 MR. FITZGERALD: Dr. Rosemary Sokas.

22 MEMBER SOKAS: I'm an occupational

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1 physician and professor and chair of human science
2 at Georgetown University School of Nursing Health
3 Science.

4 MR. FITZGERALD: Dr. Carrie Redlich.

5 MEMBER REDLICH: I'm a pulmonary and
6 occupational environmental medicine physician, a
7 professor of medicine at Yale and director of the
8 Yale Occupational and Environmental Medicine
9 Program.

10 MR. FITZGERALD: Dr. Victoria Cassano.

11 MEMBER CASSANO: I'm Dr. Cassano. I'm
12 an occupational and environmental medicine
13 physician retired from both the Navy and the
14 Department of Veterans Affairs. And I now have my
15 own consulting practice.

16 MR. FITZGERALD: Thank you. Mr. Kirk
17 Domina.

18 MEMBER DOMINA: Kirk Domina. I'm the
19 employee health advocate for Hanford Atomic Metal
20 Trades Council in Richland, Washington. We
21 represent about 2,600 active workers.

22 MR. FITZGERALD: Mr. Garry Whitley.

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1 MEMBER WHITLEY: I'm a former worker of
2 40 years at the Y-12 National Security Complex in
3 Oak Ridge and work with the worker health
4 protection program at Oak Ridge.

5 MR. FITZGERALD: Mr. James Turner.

6 MEMBER TURNER: I worked at Rocky Flats
7 Nuclear Plant for 26 years. I was diagnosed with
8 chronic beryllium disease in 1993.

9 MR. FITZGERALD: Ms. Faye Vlieger.

10 MEMBER VLIEGER: Faye Vlieger, former
11 worker, Hanford Nuclear Plant and worker advocate.

12 MR. FITZGERALD: Okay, thank you very
13 much. Mr. Markowitz.

14 CHAIR MARKOWITZ: Sure. So,
15 something on the public comments I forgot to
16 mention. Some of the comments that have been
17 posted in the last couple of months, please make
18 sure, board members, that you read them.

19 They raise some new issues that we
20 haven't addressed in the past entirely. And in
21 particular I think the committee chairs take a look
22 and see whether these questions fall within the

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1 area of their particular committees that
2 correspond to the tasks of the charter for the
3 board.

4 So do take a look at those. We should
5 figure out whether (a) they're within the scope of
6 what we as a board should address, and (b) if so,
7 who should address them, how should we address
8 them. So please do take a look.

9 We only have two important topics at
10 today's meeting and then we'll get a little bit into
11 administrative issues.

12 So I think we can -- unless a board
13 member has something to add to the agenda, or a
14 comment at this point we can get into actually what
15 we're going to start with, item number 2 which is
16 the beryllium questions.

17 I should say that I got an email just
18 now from Duronda Pope who has had a family emergency
19 and won't be on the call. So she sends her regrets.

20 MEMBER FRIEDMAN-JIMENEZ: This is
21 George Friedman-Jimenez. I was just able to call
22 in so that I could speak. It was on listen-only

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1 mode. But I'm on the call. Thank you.

2 CHAIR MARKOWITZ: Okay, great.
3 Welcome, George.

4 So, let's start with Dr. Redlich's
5 draft recommendations, but more really responses
6 to the issues that DLL asked us to look at with
7 respect to beryllium.

8 MEMBER REDLICH: Okay. I had
9 circulated this to our subcommittee and to some
10 others to get their input.

11 I was planning to get the revised
12 version back to everyone before I have a two-week
13 block of inpatient attending. But I did not do
14 that so I apologize for you're not getting it - a
15 refresher because I think it can be hard for us to
16 keep track of what the other subcommittees are
17 doing and who has jurisdiction over which piece of
18 this activity.

19 So this is the refresher. The
20 committee was asked to address issues almost
21 entirely related to beryllium, chronic beryllium
22 disease, beryllium sensitization, and also a few

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1 issues related to chronic silicosis.

2 To date we have looked at some of the
3 data on these claims. We've reviewed about 80 Part
4 B cases, not the complete files, but the
5 recommended decisions.

6 And we have reviewed the various sort
7 of guidelines or training materials related to the
8 Part B cases.

9 And at our last meeting we had made just
10 one recommendation which we voted on which was the
11 recommendation regarding borderline BeLPTs.

12 So I believe that we don't need to
13 readdress that.

14 So at this meeting what I thought would
15 be helpful was we had come up with a couple of other
16 draft recommendations.

17 And also there was a pretty complete
18 response to the original questions that the DOL had
19 put forward to our committee.

20 Most of these questions overlap with
21 concerns that have been raised by either at our
22 meetings or had been submitted to our committee

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1 related predominantly to the activation of Part B
2 claims.

3 So, and I thought -- let me just stop
4 there if there are any questions.

5 If not, I thought we could discuss the
6 additional recommendations that we made. And I
7 will -- I think we'll go in order of the draft
8 document.

9 If everyone has that, it's on page 2.
10 I'm looking at the WebEx. Oh good, okay, so you
11 have it up.

12 And the highlighted was just the actual
13 recommendation.

14 So the second recommendation if anyone
15 cannot see it I will read it. The following
16 criteria are proposed to define a clinical course
17 consistent with a chronic respiratory disorder for
18 use in evaluating pre-1993 CBD claims.

19 And so the criteria are respiratory
20 symptoms that are chronic. And the asterisk
21 clarifies the word "chronic." Plus one of the
22 following four other conditions - abnormal

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1 pulmonary function test, abnormal chest imaging,
2 hypoxemia, or chronic use of respiratory
3 medications such as Adin or COPD inhalers.

4 And again, the asterisk explains both
5 chronic and also the tests.

6 I should just preface this that this was
7 one of the questions that we were asked to address,
8 and also one of the areas where the current training
9 manual and -- I forget the name of that procedure
10 manual had sort of multiple definitions for chronic
11 respiratory disorder that was not entirely
12 consistent in different places. So that was the
13 reason for addressing this question.

14 And I would say that the area that has
15 generated the most feedback in comments from other
16 members of the subcommittee and others was how one
17 defined chronic respiratory symptoms.

18 And so between being totally vague and
19 not defining it, or picking a specific number of
20 months.

21 So I tried to find a compromise and I
22 defined chronic as indicates symptoms or

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1 medication usage that are present for more than
2 several months to differentiate from symptoms or
3 medication usage wherever the term is being used
4 related to an acute infection or other problem that
5 resolves.

6 And also as far as the testing,
7 generally one does not perform pulmonary function
8 tests in the setting in acute illness, but one could
9 -- a chest X-ray.

10 So the point being that those studies
11 should be done not in the setting of an acute
12 transient illness such as pneumonia.

13 So I think it would be good to get
14 people's input, thoughts as far as this definition.

15 MEMBER SOKAS: Carrie, it's Rosie. I
16 like the definition.

17 My only suggestion might be to use three
18 months rather than several months. Present for
19 three months or more. Because that is what we used
20 for other things.

21 MEMBER REDLICH: Okay. The other
22 reason that -- I think that is reasonable.

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1 The concern I have in general with
2 greater specificity is -- I mean, I think all of
3 us have a sense of what chronic is. As with other
4 aspects of this task when one goes from a clinical
5 concept that we all understand to writing down the
6 specific criteria that a non-physician might then
7 use while looking through records, then there can
8 be some arbitrary decisions that may not make that
9 much sense.

10 And decisions that may be in part
11 limited by the available records.

12 And so these are cases, although the
13 request sort of referred to the term chronic
14 respiratory disorder for both pre and post 1993
15 claims, the original EEOICPA Act and there's really
16 only reference to this term chronic respiratory
17 disorder for pre-1993.

18 So those claims which someone would be
19 reviewing older records. And I actually went
20 through some older records just to see how this
21 definition might hold.

22 The problem that one gets into is that

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1 you may have more limited records, and they comment
2 on so-and-so's short of breath. It sort of might
3 be apparent to one of us that it's clearly a chronic
4 problem, but the physicians don't necessarily
5 comment.

6 The limitation is the notes that
7 physicians frequently write.

8 CHAIR MARKOWITZ: This is Steve
9 Markowitz. Also, looking back at old records it
10 also depends on how frequently the person saw the
11 doctor as to the documentation.

12 In the back and forth I had proposed six
13 months. But I think that Carrie has the right
14 approach of saying several months given this
15 particular purpose here which is for pre-'93 CBD
16 claims. So we're talking about really old
17 records.

18 This kind of ambiguity I think better
19 reflects kind of the quality of the information
20 that we're likely to have.

21 MEMBER CASSANO: This is Tori Cassano.

22 I understand not wanting to set six

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1 months. My concern with using several is the
2 variability between one claims examiner and
3 another.

4 One claims examiner may think several
5 means five. One claims examiner may think several
6 means three.

7 And so I think rather than setting a six
8 month limit, you want to set the lowest limit that
9 you can so that people don't arbitrarily say, well,
10 it was only four months, that's not several.

11 And I think that's where Rosie was
12 going.

13 MEMBER BODEN: This is Les Boden. I
14 have this same general concern about using several
15 which is whether that would end up being really
16 helpful for the claims examiner.

17 And perhaps a compromise -- and I don't
18 know what the right number is -- is to use a specific
19 number of months, but then add a sentence at the
20 end saying in many cases that level of specificity
21 isn't available, and a claims examiner will have
22 to use their best judgment about whether the claim

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1 fits.

2 Not those words, but that's the idea.

3 I think it's useful to indicate to the
4 claims examiner what the number is that if you had
5 it you could use, but give them flexibility if it's
6 indeterminate in the claim file.

7 MEMBER FRIEDMAN-JIMENEZ: This is
8 George Friedman-Jimenez.

9 This is difficult because it's
10 essentially a clinical decision. And I think
11 maybe saying something like for more than several
12 months, or can clearly be differentiated from
13 symptoms related to an acute infection.

14 Something that will trigger if it's
15 really ambiguous the case being referred to a
16 clinician to make a clinical judgment. Because I
17 don't know that the claims examiners are going to
18 be able to make a clinical judgment.

19 If someone is consistently improving
20 over six months or seven months they may have an
21 infection-related respiratory presentation. Or
22 it could be related to something else.

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1 It's subtle, and I think it is not
2 really something that a claims examiner would be
3 able to determine if it's outside the bounds of a
4 clear-cut case.

5 MEMBER REDLICH: I appreciate all
6 these comments which is why an earlier version
7 didn't have a period of time.

8 And I think this is one of the -- Les
9 and others clearly stated what the problem is, that
10 you want to give some idea of what -- that we're
11 referring to chronic versus just an acute transient
12 problem.

13 But one also wants to leave an out for
14 the scenario where I think it's clearly chronic but
15 because of limited records the record might not
16 have the specificity where it spells out exactly
17 how many months.

18 CHAIR MARKOWITZ: This is Steve
19 Markowitz. Let me make a suggestion.

20 If Les's approach makes sense which is
21 to add a number but then also add a clause or a
22 sentence saying that if an exact number isn't

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1 available the CE needs to figure it out.

2 If that approach makes sense then, Les,
3 if you want to propose either at this moment or in
4 the course of this discussion some language which
5 we can get down then we can send it to Carrie, put
6 it up, we can look at it and which will allow us
7 to vote on the recommendation.

8 So I don't know, Les, do you want to just
9 dictate that language now? I'm ready to type. Or
10 whether you want to do it yourself at your computer
11 and send it in.

12 MEMBER BODEN: I think it would
13 probably be better if I could think about the
14 wording.

15 The wording would be for the
16 alternative if records weren't -- obviously I'm not
17 in a position to judge what the number of months
18 should be if the records were good. So that should
19 be a position left to the occupational physicians
20 and the --

21 CHAIR MARKOWITZ: Well, yes, don't
22 worry about the number of months, just it's that

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1 sentence that we need added to this that gives the
2 CE leeway in case the records don't really.

3 If you could construct that sentence
4 then we could look at it.

5 MEMBER BODEN: I'll do that.

6 CHAIR MARKOWITZ: Okay, great, thanks.

7 And Carrie Rhoads, are you able to receive emails
8 so we can put it up and look at?

9 MS. RHOADS: Yes, I can I receive
10 emails. Also, you can read it and Kevin can type
11 it in live if you want to do it that way.

12 CHAIR MARKOWITZ: Okay. So let's
13 continue.

14 MEMBER REDLICH: Okay, thank you. I
15 think I would go with the three months and then the
16 wording that Les is going to come up with.

17 Then I think we should just see what
18 people feel about the double asterisk in terms of
19 not obtained during an acute illness.

20 An earlier version did not have that
21 caveat.

22 CHAIR MARKOWITZ: This is Steve

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1 Markowitz. It makes perfect sense to me. I'm not
2 sure whether the claims examiner will be able to
3 time things correctly, but this looks right to me.

4 MEMBER REDLICH: Yes. And so my
5 concern with this, and it is enforced by my past
6 two weeks attending on a very busy inpatient
7 pulmonary consult service, that patients can have
8 remarkably advanced disease before they come to
9 medical attention.

10 And then the one event that brings them
11 to medical attention, the infection that when
12 they're admitted is clearly on top of a chronic
13 process may also be their fatal event.

14 And so the only imaging, and I have
15 several patients that fell into this category in
16 the past two weeks despite living in a part of the
17 country that is well populated with physicians, is
18 that the only imaging available is imaging during
19 an acute setting.

20 And there was no prior pulmonary
21 function testing, and no prior imaging to sort of
22 -- and so someone might say, oh, but this is an acute

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1 illness because the initial diagnosis on the chart
2 is for pneumonia. But it's really chronic
3 interstitial lung disease, or COPD that was not
4 recognized. So that is the concern.

5 MEMBER CASSANO: Carrie, I think that
6 what you say --

7 CHAIR MARKOWITZ: Sorry, please
8 identify yourself.

9 MEMBER CASSANO: Hi, it's Dr. Cassano.

10 I agree with your last statement and I
11 think that in addition to what Les is doing instead
12 of having this here to add something that says in
13 cases of ambiguity when it is either records were
14 unavailable, or if the condition comes to light
15 during an acute illness it should be referred to
16 a CMC.

17 Because you're right, from our visit to
18 the Seattle office claims examiners are very
19 procedurally bound. And they don't usually -- if
20 they're given any wiggle room they usually don't
21 use it.

22 So if it's not written as it needs to

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1 be, or give them something like this they'll say
2 oh, they had pneumonia and deny the claim. Just
3 like calcified granuloma which with beryllium
4 disease because it's in the manual then, or the
5 policy, it just -- there's no thought process.

6 So I think we need to not make this
7 statement.

8 MEMBER SOKAS: I agree with Tori. I
9 think the double -- this is Rosie Sokas -- I think
10 the double asterisk part probably might not need
11 to be there.

12 MEMBER REDLICH: This is Carrie. I am
13 fine to remove it. It was not there originally,
14 but was suggested.

15 The other thing, I would just remind
16 people that this whole phrase is in context with
17 the period for pre-1993. And I included that on
18 the last page of this document because I found it
19 helpful.

20 I would say sort of not constrained, but
21 that is the context that this wording will be used.
22 So if someone could scroll on the WebEx to the final

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1 page.

2 But it does include the exact wording
3 from the EEOICPA statute. And it's the C part
4 there for diagnoses before the presence of. And
5 so it was number 4, clinical course consistent with
6 a chronic respiratory disorder.

7 I am, again, it's one of these
8 situations where a clinician might I think
9 understand the context of when the imaging was
10 done, but that a non-medical person, that might be
11 challenging to do.

12 So, does anyone object to removing the
13 double asterisk? Maybe we're going to come up with
14 a revised written text that we could look at.
15 Let's comment. If no one objects then we remove
16 the double asterisk.

17 MEMBER BODEN: So, this is Les. I've
18 been trying to do two things at once and sort of
19 draft a sentence.

20 And I just wanted to raise a question
21 which is so there are two possibilities if there
22 isn't adequate evidence on the record that three

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1 months or whatever the number of months is going
2 to be.

3 One is to have the claims examiner use
4 their best judgment. And the other is to refer to
5 a CMC.

6 So I'll read you what I have at the
7 moment and then ask the question about referral.
8 If that's okay? Is that okay?

9 CHAIR MARKOWITZ: Sure, yes.

10 MEMBER BODEN: Okay. So if there is
11 not sufficient information in available records
12 claims examiners should use their best judgment
13 based on those records about whether the condition
14 more likely than not was present for more than let's
15 say three months.

16 The alternative is to say that claims
17 examiners should defer. And of course I'm open to
18 changes in wordings. But the first question is do
19 we want this to be a matter of judgment for the
20 claims examiner. Because I've sort of heard two
21 different versions on that.

22 CHAIR MARKOWITZ: This is Steve

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1 Markowitz.

2 Given how many claims examiners there
3 are and the likely variation in a whole set of
4 factors relating to their performance I think we're
5 -- and given how important this is to the claimant
6 that they may rest on this interpretation of
7 chronic respiratory disorder that I think we're
8 probably better off with your second option which
9 is that it be referred to the CMC.

10 MEMBER BODEN: Okay, with that
11 specific question. Okay. I'll reword this and
12 get back to you once I've done that.

13 CHAIR MARKOWITZ: But let me ask --
14 this is Steve again. Are there other comments
15 besides mine on what Les just proposed?

16 MEMBER TURNER: This is James Turner.
17 I would think that some claims examiners probably
18 have become disgruntled. They might say well hey,
19 just pass it on rather than taking a look at the
20 claim.

21 CHAIR MARKOWITZ: Other comments?

22 MEMBER REDLICH: This is Carrie

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1 Redlich.

2 The only other possibility to this
3 which I think others haven't felt is specific
4 enough is to define chronic as symptoms that
5 persist, differentiate from symptoms related to an
6 acute infection that resolves without actually
7 defining.

8 And there was also a version that simply
9 had persistence at -- basically defining the issues
10 of chronic respiratory disorder you have to have
11 respiratory symptoms without defining the
12 chronicity because -- and the argument in favor of
13 not defining the chronicity is since the
14 respiratory symptoms alone you need some other item
15 that's on this list.

16 And if you've got abnormalities it's
17 likely.

18 The only thing that we would possibly
19 be over-calling would be a transient infection.

20 CHAIR MARKOWITZ: This is Steven. The
21 fact that the program has asked for help in defining
22 this term that they found to be ambiguous and

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1 certainly public commenters have focused on this
2 as well.

3 I think we're probably better off
4 erring on the side of being more specific rather
5 than less. In that sense I think the number of
6 months is probably better than reverting to
7 language like persistence or whatever.

8 MEMBER REDLICH: Yes, I think you're
9 probably right in that then somebody else will try
10 and define that more specifically if we don't. So
11 I agree with your point.

12 Okay, so I would prefer the three months
13 to the six months.

14 CHAIR MARKOWITZ: That's good.

15 MEMBER REDLICH: And then I think I
16 would defer to someone who knows more about the
17 process like Tori as far as whether all or a use
18 your judgment.

19 MEMBER CASSANO: I think if they cannot
20 make that determination based on the record they
21 need to refer.

22 Because what we're trying to do by

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1 standardizing is make it as close as we can the same
2 outcome for people with the same -- relatively the
3 same history.

4 And if you leave that kind of wiggle
5 room you're going to get some people, you know,
6 somebody maybe as you said the fibrosis was
7 discovered when the person became treated because
8 they had a pneumonia.

9 And they say oh, well they had a
10 pneumonia and it's only been four months since
11 their pneumonia, blah blah blah, I'm going to deny
12 this.

13 I think if it's not there with a low and
14 hard number and they can't make that decision then
15 they need to refer it to somebody with clinical
16 judgment or someone that can use clinical judgment.

17 MEMBER BODEN: Okay. Well, I just
18 rewrote it on that basis and I'll give you a read
19 and a question.

20 So the current rewritten version is if
21 there's not sufficient information in available
22 records to determine whether a condition is

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1 chronic, claims examiners should refer the case to
2 a CMC requesting an opinion about whether the
3 condition more likely than not was present for more
4 than three months.

5 Alternative more likely than not is
6 chronic because now you're talking to a CMC and
7 maybe you don't want to limit the CMC to three
8 months.

9 MEMBER REDLICH: Could we end it with
10 just refer to a CMC period?

11 MEMBER BODEN: I thought it would be
12 good to say why you're referring it. Because they
13 have to make specific requests to the CMC, right?

14 MEMBER CASSANO: I think you can do
15 both. I think you just need to switch it around,
16 Les, and say if the examiner cannot determine based
17 on the record whether the condition has been
18 present for at least three months then they should
19 refer to the CMC to determine if there is -- if this
20 represents a chronic respiratory condition.

21 And that way you are giving the CMC the
22 freedom to go beyond the three months. But you're

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1 not giving the CE the freedom to arbitrate
2 chronicity.

3 Does everybody understand that?

4 MEMBER BODEN: Just say it again, I'll
5 try.

6 MEMBER CASSANO: All right. If the
7 claims examiner cannot determine based on the
8 record if the respiratory symptoms were persistent
9 for three months or more then they should refer the
10 case to the CMC to determine if the condition is
11 a chronic respiratory -- is considered a chronic
12 respiratory condition.

13 So what you're doing is you're setting
14 the limit on the CE but not on the CMC.

15 MEMBER REDLICH: This is Carrie
16 Redlich. I agree because the question is not
17 whether the symptoms -- but the question goes back
18 whether the chronic respiratory disorder. That's
19 the bottom line question.

20 MEMBER CASSANO: Exactly.

21 MEMBER REDLICH: Yes or no, does this
22 represent a chronic respiratory disorder. And

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1 this was giving ways that one would -- so related
2 question.

3 How many cases approximately that there
4 was a question -- so this is only in the context
5 of the question does the person have CBD for pre
6 1993.

7 Do most of those get referred to a CMC
8 anyway?

9 MEMBER CASSANO: We didn't see that
10 many of them. Unless because we were looking
11 primarily at Part E.

12 The one that got denied that I know was
13 a beryllium case, and we talked about this already,
14 the only one that I saw that was denied for
15 beryllium that we thought was a CE problem was the
16 one with the calcified granuloma.

17 So, I can't really answer your
18 question.

19 MEMBER REDLICH: Okay. So let's see.
20 Should we reread the current wording?

21 MEMBER BODEN: If the claims examiner
22 cannot determine based on the record whether the

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1 condition was present for more than three months
2 then the case should be referred to a CMC to
3 determine if the condition was a chronic
4 respiratory illness.

5 MEMBER REDLICH: Disorder. It's just
6 the wording.

7 MEMBER BODEN: You heard the question
8 in my voice.

9 And I have one little question about
10 that. Should it say whether the condition was
11 present for more than three months, or whether the
12 condition was likely to be -- no, I don't like that.
13 Never mind. I retract my question.

14 Okay, shall I just send this wording on
15 and somebody can go from there? Rather than --
16 would you like me to read it and have Kevin input
17 it?

18 CHAIR MARKOWITZ: Carrie, can Les send
19 it to you and you give it to Kevin?

20 MS. RHOADS: Yes, go ahead and send it
21 to my email at the energy inbox and we'll just cut
22 and paste it into the document that's on the screen.

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1 MEMBER BODEN: Okay. Will do.

2 MEMBER CASSANO: I have one more
3 comment about the definition.

4 Under chronic use of respiratory
5 medication such as asthma or COPD inhalers I'm
6 wondering if we should put the word "prescribed"
7 in there.

8 I don't know whether you can still get
9 Primatene Mist over the counter, but I'm sure there
10 are some naturopathic inhalers that are available
11 or some other un-FDA approved inhalers or remedies
12 or medications that could be used.

13 And I think we need to be a little bit
14 more specific.

15 MEMBER REDLICH: So you're referring
16 to let's say chronic use of --

17 MEMBER CASSANO: Medication.
18 Prescription medication. Prescribed medication.

19 MEMBER SILVER: Well, this is Ken
20 Silver.

21 Going back to Dr. Redlich's scenario a
22 little while ago in a part of the country heavily

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1 populated by physicians it seems to me there are
2 a lot of people who delay and delay and delay and
3 try naturopathic things and then come into the
4 clinic setting the bar at using prescribed
5 medications.

6 I mean, we don't want to open this to
7 sweat lodges in Santa Fe, but.

8 MEMBER REDLICH: This is all in the
9 setting of or and or. So it was trying to give
10 people multiple ways to qualify as a chronic
11 respiratory disorder rather than to eliminate
12 ways.

13 MEMBER CASSANO: Well, I'm wondering,
14 since we are defining out chronic symptoms, chronic
15 respiratory symptoms, do we need the use of the word
16 "chronic" to medications?

17 And then you can just say use of
18 prescribed medications.

19 Because they have to have the chronic
20 respiratory symptoms for over three months.

21 And then okay, they tried all this other
22 stuff. And boom, now they've gone to an urgent

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1 care center or whatever, or wherever they're
2 getting their healthcare, and they get prescribed
3 medication.

4 MEMBER REDLICH: I'm fine with taking
5 out the word chronic. Are others?

6 CHAIR MARKOWITZ: Yes, that's fine.

7 MEMBER REDLICH: So, Carrie, that
8 would be another edit to what's up on the screen
9 under D.

10 MS. RHOADS: I haven't gotten anything
11 in my email yet, so I'm not sure. Picking up from
12 chronic on part D?

13 MEMBER REDLICH: Yes.

14 MEMBER CASSANO: That's and
15 prescribed. Use of prescribed respiratory
16 medications.

17 MEMBER SILVER: Do you see the change?

18 MEMBER REDLICH: Yes. The word
19 "prescribed" you could -- well, prescription.
20 People borrow inhalers from people.

21 MEMBER SILVER: At one time Primatene
22 was available over the counter. These are pre-'93

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1 cases.

2 MEMBER REDLICH: I think that might
3 just confuse somebody.

4 MEMBER SILVER: The word prescribed.

5 MEMBER REDLICH: Yes, I think I would
6 just not have it.

7 CHAIR MARKOWITZ: So, what's the
8 suggestion, that simply say D would be use of
9 respiratory medication? Such as asthma or COPD
10 inhalers.

11 MEMBER SILVER: That would satisfy me.
12 Ken here.

13 MEMBER REDLICH: Any objection?

14 MEMBER CASSANO: No.

15 MEMBER BODEN: Are antihistamines
16 respiratory medications? And is that okay with
17 people?

18 MEMBER REDLICH: Sorry.

19 MEMBER BODEN: I'm just asking. I
20 don't know. I'm not making a suggestion.

21 MEMBER CASSANO: I would think like
22 Flonase, you know, guaifenesin, is that considered

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1 a respiratory medication. Then it would have been
2 Benylin that people took for cough.

3 MEMBER REDLICH: This is Carrie
4 Redlich. The fire alarm in my building has gone
5 off.

6 MEMBER BODEN: Oh great.

7 CHAIR MARKOWITZ: Okay, Carrie.

8 MEMBER REDLICH: Given the field that
9 we're in to not follow appropriate safety code we
10 are being instructed to leave.

11 CHAIR MARKOWITZ: Take care. Exhale
12 on your way out.

13 MEMBER REDLICH: We all have to leave.
14 I will call from my cell phone once I am out of the
15 building.

16 MEMBER BODEN: Carrie, did you get my
17 email? Les.

18 MS. RHOADS: I didn't see it yet. Let
19 me look again.

20 MEMBER VLIEGER: This is Faye Vlieger.
21 A number of times during the course of my treatment
22 I've been told to purchase over the counter

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1 medication.

2 And so I don't know about the trail of
3 those other than the doctor mentioning it to me many
4 times. They never appeared in the document notes
5 or the chart notes from the visit.

6 MS. RHOADS: Hey, Dr. Boden, I don't
7 have an email yet from you. Could you possibly
8 read it and we could type it right into the
9 document?

10 MEMBER BODEN: Sure. So, if the
11 claims examiner cannot determine comma based on the
12 record comma whether the condition was present for
13 more than three months comma -- and tell me to slow
14 down -- then the case should be referred to a CMC
15 to determine if the condition was a chronic
16 respiratory disorder.

17 MS. RHOADS: Does it look correct on
18 the screen? Can you see it?

19 MEMBER BODEN: I'm just going over it
20 now. Yes, that is what I said.

21 MS. RHOADS: Okay.

22 MEMBER BODEN: That should probably

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1 just follow -- be part of the paragraph with the
2 first asterisk.

3 Notice I said that's what I said. I
4 didn't say it was correct. So people should look
5 at it and see if it needs to be changed.

6 CHAIR MARKOWITZ: This is Steven. It
7 looks good. I think this is what we agreed on.

8 MEMBER CASSANO: But I think that do we
9 need then three months on the first line? Are we
10 going to leave several and then three?

11 CHAIR MARKOWITZ: No, no, the idea was
12 to change the several to three.

13 MEMBER CASSANO: Yes.

14 CHAIR MARKOWITZ: All right. Okay.
15 Were there any other comments on this section that
16 we're looking at right here? Just that one
17 paragraph that begins quote unquote chronic with
18 a single asterisk.

19 MEMBER CASSANO: I do have a general
20 question based on this discussion. I don't know
21 if it's possible, but is there any way that we could
22 have either a claims examiner or a supervisory

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1 claims examiner sort of standing by at these
2 meetings for us to be able -- for them to be able
3 to say yes, this would work, this is good for us.

4 Rather than having it go as a
5 recommendation and then not getting approved, or
6 adopted because it's too cumbersome, or whatever
7 for the claims examiners.

8 It would be nice to have some input from
9 the examiner to see if this kind of language
10 actually helps them.

11 CHAIR MARKOWITZ: Yes, this is Steven.
12 That's a good idea. You know, in the previous
13 meetings we've always had somebody from DOL who --
14 and not necessarily a supervisor claims examiner
15 or the like, but someone who obviously is
16 experienced and knowledgeable who's been able to
17 give us that kind of immediate feedback.

18 In this instance I think whatever
19 recommendation we make may not be accepted whole
20 cloth, and they may modify it slightly, hopefully
21 not too much.

22 But it's to conform with the realities

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1 of running the program. So for this instance I
2 wouldn't worry too much. But I think the point is
3 well taken.

4 So if there are no other comments on
5 this particular issue about three months I just
6 want to return and settle the issue of the 2d, the
7 issue of prescription medications because that
8 section in green is what we're looking at.

9 This is all about pre-1993 CBD claims
10 because the act only mentions chronic respiratory
11 disorder in relation to CBD in relation to the
12 pre-'93.

13 As a reminder, the pre '93 criteria
14 includes the claimant has to have a history of
15 beryllium exposure, but on the medical side they
16 have to have any three of chronic criteria. And
17 one of those criteria is chronic respiratory
18 disorder or clinical course.

19 But the other ones are actually if you
20 just go down to the end of this whole document the
21 other ones are abnormality on imaging, abnormality
22 on CT or chest X-ray, abnormality on PFT, pathology

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1 which frankly should be the whole story right
2 there, four is a chronic respiratory disorder, and
3 then five is skin patch test or beryllium blood
4 test.

5 And so the person in order to get a
6 successful claim will have had to interact with a
7 physician to get either 1 or 2 in addition to item
8 number 4.

9 Meaning that they've come to medical
10 attention and they haven't appeared to remain sort
11 of symptomatic and completely unattended for any
12 number of months or years until they become really
13 ill.

14 And so I think the fact that items
15 number 1 or 2 or 3 or 5 are required does raise the
16 standard in terms of the level of evidence that's
17 needed to have a chronic respiratory disorder.

18 In that sense I don't really think that
19 we necessarily need to say prescribed medication
20 because having a positive 1, 2, 3, or 5 means that
21 there is harder evidence of disease.

22 And so I think -- my own feeling is we

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1 can probably go without having to say it's a
2 prescribed medication, just that it was chronic or
3 usage. If we could scroll back up.

4 MEMBER CASSANO: Yes, can we scroll
5 back up? Because I can't see.

6 But it's only one of those. So it would
7 either be they don't ever -- I mean, respiratory
8 symptoms that are chronic.

9 But I guess you're looking at the
10 records so in order for it to be in the record they
11 would have to have seen a doctor. Okay. Because
12 it's any one of those.

13 So you could not have a PFT or a chest
14 X-ray or be determined to have hypoxemia. You
15 would be chronic respiratory symptoms plus use of
16 medication.

17 CHAIR MARKOWITZ: Right, right. So
18 item number 1, the symptoms, and item 2d,
19 medication use would get you according to our
20 suggestion a chronic respiratory disorder.

21 But you still, under the act you still
22 have to satisfy two out of the other four

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1 requirements.

2 MEMBER CASSANO: Okay, I see.

3 CHAIR MARKOWITZ: The bar is pretty
4 high in terms of objective documentation.

5 So I think that that then has sort of
6 colored my thinking about this. So Tori or those
7 who have spoken in favor of use of the word
8 prescribed here, or for that matter people who
9 think that we should not use prescribed, are there
10 other comments or general feeling about this?

11 MEMBER VLIEGER: This is Faye. I
12 don't know if you saw the note from Dr. Welch. For
13 some reason she can't speak anymore.

14 MEMBER WELCH: I think I'm on now. Can
15 you hear me?

16 MEMBER VLIEGER: I can hear you.

17 MEMBER WELCH: Okay, good. Carrie
18 sent me the instructions how to get on I think
19 because I logged on late the operator wasn't there
20 anymore. But I'm here.

21 CHAIR MARKOWITZ: Welcome. Do you
22 have a time constraint today?

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1 MEMBER WELCH: No.

2 CHAIR MARKOWITZ: I just want to make
3 sure. Okay.

4 MEMBER WELCH: And actually I've been
5 on the call for half an hour but I guess emails
6 aren't going through to Carrie. So I finally
7 emailed the whole group and a couple of you
8 responded to tell me what to do so thank you.

9 CHAIR MARKOWITZ: So anyway, are there
10 other comments on this issue of using the word
11 prescribed or not? Faye, I think maybe you were
12 -- or someone.

13 MEMBER VLIENER: Just that during the
14 course of coming up with a diagnosis for me I was
15 seeing the doctor and being told to purchase over
16 the counter medication.

17 Those recommendations I didn't ever see
18 any certainly.

19 CHAIR MARKOWITZ: All right. Okay,
20 any other comments on this issue about saying
21 prescribed or not prescribed?

22 Okay, so I think we'll just hold off on

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1 that for the moment. We'll come back to that issue
2 when we actually come closer to voting on this
3 recommendation. But I don't want to do that
4 without Carrie Redlich on the phone.

5 So I suggest if there are no other
6 comments on recommendation number two let's move
7 on and when Carrie Redlich rejoins us.

8 I can lead the discussion I think. So
9 draft recommendation three is recommending
10 substantial revision in the sections of the
11 procedure manual and related to appeals relevance
12 of Part B conditions, taking into account the
13 comments in this document and other feedback from
14 the advisory board.

15 So we're going to go through this
16 language. So unless you've already seen it you
17 won't know what we might be voting on. But so
18 that's what this recommendation is about.

19 And the rationale is that frankly
20 sections of the procedure manual and other
21 materials are inconsistent and confusing, and even
22 sometimes medically inaccurate. So they need

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1 correction.

2 And then the next piece is an
3 endorsement. We already discussed this issue at
4 length. And I can't remember whether it was at
5 length in the committee or at length at the full
6 board meeting or not.

7 So, I'm sorry, I'm getting an email from
8 Carrie Redlich. She's back online. Carrie, can
9 you hear us? Can you speak?

10 Okay. She can hear us but can't speak
11 apparently yet.

12 MS. RHOADS: Can you push *0 and get the
13 moderator's attention?

14 CHAIR MARKOWITZ: Okay, so while
15 that's happening just so you know. So we -- this
16 endorsement is our realization that in fact we
17 endorse the presumption of CBD in situations where
18 the diagnosis of sarcoidosis in an individual meets
19 the definition of a covered beryllium employee
20 under Part E or Part B. So that is the current
21 policy of DOL and we're simply endorsing it.

22 But in the rationale for our

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1 examination and endorsement the presumption
2 already exists and is stated in both circular and
3 in the procedure manual.

4 However, implementation of this
5 presumption has been problematic and revising the
6 relevant sections to the procedure manual and
7 training materials within the statutory
8 limitations of EEOICPA should help alleviate this
9 problem.

10 So, I think we get into discussing a
11 little bit of that language in subsequent pages.
12 But there's nothing to vote on because this is not
13 a new recommendation because this policy currently
14 exists for DOL. Let's go to page 3.

15 MEMBER REDLICH: This is Carrie. I
16 think I'm back on the phone now.

17 CHAIR MARKOWITZ: Okay, good. And
18 you're in front of a computer, Carrie, as well?

19 MEMBER REDLICH: Yes.

20 CHAIR MARKOWITZ: Okay, so take it
21 away.

22 MEMBER REDLICH: So, I think -- that's

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1 the last of the either recommendations for
2 different wording for this one.

3 Do we want to as a board vote on the
4 recommendations, Steve?

5 CHAIR MARKOWITZ: This is Steven.
6 Let's go through the comments and then come back
7 to the recommendations because there may be a
8 little bit of discussion in the comments.

9 The comments, we're not going to vote
10 on accepting or not accepting I think. I would
11 propose we simply endorse them with any possible
12 modifications that people have on the phone.

13 Because these are questions that DOL
14 asked us and not necessarily changes in the policy.
15 But this language we're going to look at in these
16 responses to comments do relate to the
17 recommendation number 3 I think which is that we
18 suggest they change some language.

19 Does that sound okay?

20 MEMBER REDLICH: Yes.

21 CHAIR MARKOWITZ: Okay, so let's just
22 start with item 1, beryllium sensitivity. And

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1 Carrie, are you?

2 MEMBER REDLICH: Sorry, when I moved
3 offices my computer's frozen so I'm just going to
4 need a minute.

5 CHAIR MARKOWITZ: Okay, that's fine.
6 Let me start with the first one because that's easy.
7 The first question has to do with consistency of
8 testing results among different diagnostic
9 facilities.

10 And the response is that National
11 Jewish Medical Center, ORAU and the Cleveland
12 Clinic are the only labs that we know of that
13 currently perform BeLPT on a regular basis.

14 These labs have extensive experience
15 with performing the tests, consistency among these
16 labs has improved, and does not appear to be an
17 ongoing issue.

18 Additional laboratories would likely
19 increase problems with accuracy and
20 reproducibility of performing BeLPT testing.

21 So anybody have any comment on that?
22 Okay. We'll go on to item number 2 here. And

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1 Carrie, just jump in when you're all set.

2 So, this question posed to us has to do
3 with the reinterpretation of quote unquote normal
4 test outcomes as abnormal by a consulting
5 physician.

6 Our response is that a patient's BeLPT
7 report from the lab performing the test should not
8 be reinterpreted by a consulting physician.

9 However, the quality of the
10 interpretation of standard clinical tests used to
11 evaluate patients with pulmonary disorders, chest
12 X-rays and CT scans, pulmonary function testing,
13 lung pathology can be quite variable and
14 significant inter-observer variability can occur.

15 These tests involve interpretation of
16 multiple images, patterns and/or data points, and
17 treating or consulting physicians routinely
18 re-review the studies themselves or with the
19 appropriate specialist such as a chest
20 radiologist, a pulmonary pathologist.

21 Proper interpretation also can require
22 comparison to prior testing results if available.

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1 So, this response is merely that if it
2 was BeLPT report you would take the report as is
3 from the laboratory, but for other clinical tests
4 that physicians routinely look at the data
5 themselves and can reinterpret their results.

6 MEMBER CASSANO: Steve, I have one
7 question.

8 CHAIR MARKOWITZ: Sure.

9 MEMBER CASSANO: When we're talking
10 about a consulting physician we're not talking
11 about their -- we're talking about a consulting
12 treating physician.

13 We're not talking about the consulting
14 medical -- contracted medical consultant, correct?

15 MEMBER REDLICH: This is Carrie. Yes.

16 MEMBER CASSANO: Okay.

17 MEMBER REDLICH: My guess is that the
18 question was asked in reference to the BeLPT. And
19 its answer could have ended after the one sentence
20 first paragraph.

21 I added the second one because some of
22 the cases that we reviewed it is not uncommon for

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1 the written report to not accurately reflect the
2 actual study.

3 And so to understand that it was okay
4 in various other settings to re-interpret the
5 written report.

6 MEMBER CASSANO: Okay, thanks.

7 CHAIR MARKOWITZ: Moving onto 3. So
8 Carrie Redlich, you have this in front of you now?

9 MEMBER REDLICH: Yes.

10 CHAIR MARKOWITZ: Okay. I don't think
11 we -- I think actually do you want to just
12 paraphrase some of these responses. That would
13 probably be sufficient.

14 MEMBER REDLICH: Okay. So I think
15 what's in 3 was are there new and better tools out
16 there and the answer is no.

17 And it was suggested that throughout
18 the procedure manual that's referenced to patch
19 testing was to -- could be confusing and that it
20 should be removed because it is no longer
21 recommended or done.

22 Anyone has questions or suggested

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1 alternate responses please speak up.

2 The next one is definition of beryllium
3 medical monitoring. The wording was taking the
4 italicized bolded was the wording of the comments
5 that we were given.

6 And so the question was what sort of
7 medical monitoring.

8 And the answer was we proposed using
9 what the American Thoracic Society recommends in
10 the recent evidence-based document that they
11 published which was every two or three years, or
12 sooner if there is a concern about progression of
13 disease.

14 And then it just mentions what that
15 should entail.

16 And I think what would be assistance in
17 examination of pulmonary function testing. And
18 then it left further testing such as bronchoscopy
19 or lung biopsy open for a case-by-case basis.

20 I don't think we want to prescribe more
21 on basis testing. That involves the judgment of
22 the physician.

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1 Are there any questions about any of
2 those? We could go on to number 2.

3 So the next couple of questions were
4 sort of just technically requesting clarification
5 of what characteristic imaging findings were.

6 They already have an existing list that
7 was reasonable. And I sort of tweaked it with a
8 few more suggested terms to use.

9 I don't think we need to go through that
10 in detail unless anyone has questions. But I said
11 that they were generally prescribed appropriately
12 in exactly what sections, and then suggested some
13 edits.

14 Number 2, the pulmonary function
15 testing. So does anyone have questions about the
16 imaging?

17 CHAIR MARKOWITZ: This is Steven. I
18 just want you to point out that one of your
19 suggested changes in CBD granulomas can become
20 calcified because I know there was a public comment
21 I think that addressed this. So I just wanted to
22 point out that that's a suggested edit.

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1 MEMBER REDLICH: That is. So the --
2 exactly. There was a whole discussion around
3 granulomas. And I suggest that getting into
4 whether it caseates and calcifies, removing that
5 text from the chest X-ray section and a calcified
6 granuloma is not characteristic of CBD was an
7 incorrect statement and should be removed.

8 Okay. And then number 2, the pulmonary
9 function testing.

10 So again, I think that your request was
11 to try and come up with a specific -- this is PFT
12 finding of is this CBD, no it's not.

13 And I think that the fact is that you
14 can have all different physiologic changes. It
15 can be restrictive, obstructive, or actually
16 involved in normal ranges.

17 So the wording they actually currently
18 have was adequate and it really cannot be specified
19 to a greater degree.

20 And I just mention also that it's
21 important to compare to prior testing. Because
22 someone can fall what looks like in the normal range

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1 but has actually had a substantial decline. They
2 may have started at 120 percent and gone down to
3 85 percent and that might still quote fall within
4 the normal range, but really would be an
5 abnormality.

6 A number of cases we have reviewed
7 included a situation such as that where if you only
8 looked at the last most recent breathing test it
9 would appear to be quote normal, but if you looked
10 over five different tests over a period of eight
11 years there was a clear decline. So that was added
12 as just a note.

13 And I think what some people would like
14 would be to say if it's this exact range or the like
15 it is or is not CBD and one cannot say that. So
16 that was the pulmonary function testing section.

17 Any questions? So the lung pathology.
18 So, they wanted guidance on the lung pathology
19 findings consistent with CBD.

20 And so the response basically, the
21 typical lung pathology of a non-CBD granuloma was
22 mentioned, but that there are other findings that

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1 can be consistent including just a lymphocytic
2 infiltrate.

3 And the other point that was made is
4 that in more advanced disease the process becomes
5 more diffuse and fibrotic, and you may not actually
6 have distinct granulomas.

7 And then I did make a note about there
8 were some inaccuracies stated in the section
9 related to pathology. And the main one related to
10 mediastinal lymph nodes.

11 So I think this is a situation where
12 there was additional detail that was added probably
13 to try and provide guidance but which actually
14 added I think inaccuracy and confusion.

15 So I think the simple thing is the
16 pathology can be in the lung or the lymph nodes that
17 drain the lung. And in fact when you take a biopsy
18 sometimes you preferentially biopsy nodes rather
19 than lung tissue because it can be a safer
20 procedure.

21 So there was wording in the manual that
22 if it was present in the node but not in lung tissue

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1 that was not the equivalent.

2 It's much simpler than that. If it's
3 in the chest -- well, that's the policy. You don't
4 need to discredit it because it's in the lymph node.

5 CHAIR MARKOWITZ: This is Steve
6 Markowitz.

7 Just looking at the language of the act,
8 both the pre- and post-1993, and it describes --
9 this is the post-'93 quote.

10 Lung pathology consistent with chronic
11 beryllium disease including, one, a lung biopsy
12 showing granulomas or a lymphocytic process
13 consistent with chronic beryllium disease, end of
14 quote.

15 And in the pre-'93 of the advanced
16 criteria quote lung pathology consistent with
17 chronic beryllium disease end of quote.

18 So that's I think probably why the
19 application of this language stuck literally to the
20 issue of lung pathology.

21 I'm not defending it, I'm just I think
22 pointing out the obstacle that we need to overcome

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1 in arguing that lymph nodes that drain the lungs
2 is equivalent to lung pathology.

3 I think you've done it actually.

4 MEMBER REDLICH: Thank you for
5 pointing that out and I will make sure that I in
6 the comments have a note about that the lymph nodes
7 drain the lung and are part of the lung. I will
8 make sure that that's clarified.

9 CHAIR MARKOWITZ: And I also think that
10 -- and maybe you state this, but if you can say that
11 a positive mediastinal lymph node biopsy or other
12 lymph node in the chest, if that in practice
13 translates to 95 plus percent of the cases having
14 actual lung pathology, that that would also be
15 persuasive.

16 MEMBER REDLICH: Okay. You're
17 correct, it does say pathology -- it does say the
18 actual lung.

19 So I will -- because the node was
20 considered part of the lung. Okay.

21 So the next set of questions that the
22 DOL case pertained to the post 1993 criteria.

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1 I felt in the order that they had
2 originally given us the comments and that's why
3 there may be some overlap in the responses.

4 So the issue 1 was again related to the
5 criteria used for post 1993 and defining the
6 wording characteristic of CBD. And that really
7 had been addressed in the earlier comments.

8 And then the issue 2 was addressing the
9 question of a chronic respiratory disorder.

10 The one question I had, they sort of put
11 this under the B part and referred to pre or post
12 1993 in terms of the issue they wanted raised.
13 Pre- or post-1993 as evidence of a chronic
14 respiratory disorder, issue 2, judging medical
15 evidence for pre or post.

16 I read over the manual and the original
17 act multiple times to see if there was reference
18 to chronic respiratory disorder in this section so
19 it really is only pre.

20 But I think that the comment part 3 or
21 post should just be pre.

22 This is one that we have discussed so

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1 I think we'll -- this section once we have a final
2 decision I would edit to be consistent.

3 What's in here is the same wording that
4 was in the recommendation that we started with.

5 And the other comment on here was just
6 pointing out some of the inconsistencies in the
7 wording that exist in the manual and also in the
8 guidelines for CMCs. That was basically page 6.

9 Then if anyone -- I think we discussed
10 the -- and this was just some of the existing
11 wording that had been in there for describing
12 chronic respiratory conditions.

13 So I think our recommendation would
14 simplify that.

15 Any questions? Issue number 3 was
16 necessitating lung lavages or lung biopsy on
17 critically ill or elderly patients.

18 And that is a risky procedure and it is
19 generally contraindicated in those situations. I
20 don't think there's much to discuss about that.

21 I think then someone has to make -- do
22 decision-making based on the available

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1 information. But it shouldn't be sort of a penalty
2 against someone that they didn't have the
3 procedure.

4 So, issue 4, this had to do with
5 specific diagnostic markers required for CBD. And
6 again there is no one single diagnostic test or
7 marker as that was stated previously.

8 And then issue 5 was guidance on the
9 relationship between sarcoid and CBD.

10 So, this response that goes on for two
11 pages basically gives the rationale for what had
12 already been in place, namely a presumption that
13 someone who has a pulmonary sarcoidosis and is a
14 quote covered beryllium worker, has beryllium
15 exposure, that CBD was the appropriate diagnosis
16 in the setting and not sarcoid.

17 And the reason -- this went on for two
18 pages and this is one sentence. I tried to address
19 the different issues that had come up in different
20 cases that had created confusion.

21 One of the most common was that we just
22 -- sarcoid, just for background, for people who are

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1 not familiar is a multi-organ disease and over 90
2 percent of the time it involves the chest and the
3 lungs.

4 However, it does involve other organs.
5 And sometimes the other organ may be where the
6 biopsy is taken because it's more accessible than
7 the lungs.

8 So that someone could have evidence,
9 let's say based on a CT scan with involvement of
10 their chest and what looked like sarcoid. But the
11 biopsy that documented granulomas was taken from
12 the skin.

13 So it clarifies why that would still be
14 pulmonary sarcoid even though the biopsy had been
15 taken from the skin.

16 And it also made the point that yes,
17 there are certain features that are more common,
18 let's say sarcoidosis in blacks and Caucasians, and
19 yet extra pulmonary involvement is more common
20 overall in sarcoid and CBD.

21 But both diseases occur in all racial
22 groups and people with CBD can have extra pulmonary

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1 involvement. So they shouldn't use those features
2 to start teasing apart which sarcoid and sarcoid
3 versus CBD.

4 So that is -- there was sarcoid that
5 involved the lung, and the person had beryllium
6 exposure, was a covered beryllium worker, but that
7 was -- basically CBD would be the appropriate
8 diagnosis in this setting.

9 And also if someone really does have
10 biopsy proven sarcoid that they don't also need a
11 BeLPT.

12 So, and also part of the section also
13 described why you could have a false negative BeLPT
14 test.

15 And this was already in the current
16 procedure manual noting that you could have a false
17 negative, and also that sometimes for various
18 reasons a BeLPT may not have been done.

19 So it was basically restating the
20 rationale and the argument for the presumption of
21 CBD when there is a diagnosis of sarcoid and a
22 history of beryllium exposure.

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1 Does anyone have any questions?
2 Because clearly this is an area that has created
3 confusion. And with the cases we reviewed I think
4 most of the ones that we would have considered not
5 properly adjudicated have to do with sarcoid that
6 was considered not beryllium.

7 Anyone? Hello?

8 CHAIR MARKOWITZ: We're here. I think
9 it looks good. If no one has a comment then maybe
10 we should move on.

11 MEMBER REDLICH: So, and someone had
12 asked why don't we just make a recommendation about
13 the presumption.

14 And I think the reason we didn't want
15 to make a new recommendation was that this wasn't
16 really something new. It had been previously
17 decided and there was good reason for that. And
18 it was really more understanding some of the issues
19 of the implementation that was the problem.

20 But I think the rationale for having the
21 presumption is very solid.

22 And so I tried to address any of the

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1 problems or the reasons that cases had been denied
2 in those that we reviewed and that others have told
3 me about.

4 Okay. Also, I will say -- to see where
5 this was -- that related to this is what qualifies
6 as a covered beryllium worker. And that may be
7 more the other group. But I just wanted to make
8 sure that that is clear.

9 Because there were some cases that we
10 reviewed that seemed like the person should have
11 been considered having had beryllium exposure.
12 But that was not.

13 MEMBER WELCH: Carrie, could you
14 clarify, was that a question that DOL asked us? Or
15 is that something --

16 MEMBER REDLICH: It was not asked
17 about. It just appeared that there were some
18 workers that to me seemed like they were covered
19 beryllium employees but the CMC or somebody did not
20 recognize beryllium.

21 MEMBER WELCH: This is Laurie Welch.
22 Are you finished with your list? Because that's

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1 probably something else we have to address later
2 if they didn't ask us the question.

3 MEMBER REDLICH: We just finished the
4 --

5 MEMBER WELCH: I think we should finish
6 the list and keep it on the to-do list.

7 MEMBER REDLICH: That's right.
8 Exactly. That's why I wanted to mention it.

9 And then the final -- so that would
10 actually be pages 6. We're almost done here.
11 Okay. And the next area they wanted comment on is
12 on the bottom of page 9, recommendations regarding
13 -- relating to conditions that are normal and
14 unusual consequential illness CBC.

15 And there was a 2016 update that listed
16 these sort of secondary conditions. And I thought
17 that was an appropriate list. It included the
18 pulmonary hypertension, heart failure, bone
19 density, osteoporosis. And I thought that was a
20 reasonable list and did not have anything to add
21 to it.

22 And then number 7, input or suggestion

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1 regarding assessment of BeLPT either false
2 negative or borderline due to drug interference.

3 And this was addressed in the
4 borderline BeLPT that was the first recommendation
5 we voted on last time. And so we've discussed
6 number 7.

7 So moving onto 3, chronic silicosis,
8 there was really one comment or question and that
9 was clear guidance on the certification
10 requirements for the B readers and how that is
11 documented.

12 And there actually is on the internet
13 NIOSH provides a list of all certified B readers.

14 Also, my understanding is that a B
15 reading is not required by the act. So I just
16 mention that. I don't know if there was another
17 -- I sort of feel that maybe I didn't fully
18 understand the question that we were being asked,
19 but I think that this should not be a problem.

20 And then finally, other comments. I
21 basically just mentioned that the current
22 procedure manual has some areas that were confusing

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1 and inaccurate. Pretty much highlighted in my
2 comments.

3 And then also the final comment was that
4 concern just that the issue wasn't only the
5 procedure manual, but also the quality and the
6 oversight of the CMCs which is part of other
7 committees.

8 CHAIR MARKOWITZ: Okay, so thank you.
9 I think we should go back now and vote on the
10 recommendations.

11 If we could bring up. So,
12 recommendation 1 we already voted on. It's not
13 showing on the screen, but it's done. We voted on
14 it last time so we don't have to vote on that. Just
15 recommendation number 2.

16 And the only -- we have the new
17 language. The only outstanding issue is on 2d the
18 issue of whether we should add prescribed
19 medications as opposed to leaving it the way it is.

20 There's some variation of opinion. I
21 generally want to make a further comment before we
22 vote on various versions of this with or without

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1 the prescription.

2 MEMBER DEMENT: Weren't we going to
3 take off the double asterisk and the statement that
4 goes with the double asterisk?

5 MEMBER REDLICH: Correct.

6 MEMBER CASSANO: This was the old one.

7 MEMBER REDLICH: Yes, I don't think
8 this is --

9 MEMBER CASSANO: Oh, it is. Oh,
10 that's good now.

11 MEMBER REDLICH: The chronic I think is
12 the correct wording. I just wanted.

13 MEMBER CASSANO: Right.

14 CHAIR MARKOWITZ: Right.

15 MEMBER WELCH: This is Laurie Welch.
16 I had a comment about the prescribed.

17 I would leave it off because if people
18 are using over the counter medications it's hard
19 to document it anyway because it won't be
20 necessarily in the physician's record.

21 So I think it may be unnecessary and as
22 we talked about before some inhalers were over the

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1 counter so if the claimant can document they were
2 using Primatene Mist, that's fine.

3 I would leave it out.

4 MEMBER REDLICH: I agree.

5 CHAIR MARKOWITZ: Any other comments?

6 MEMBER REDLICH: We've agreed on that
7 the wording now if it's chronic, if the claims
8 examiner cannot determine if it's chronic then it
9 would be referred to a CMC to determine if the
10 condition was a chronic respiratory disorder.

11 CHAIR MARKOWITZ: I should just
12 facilitate things that we vote on just the issue
13 of this using the word prescribed and not
14 prescribed in item 2d.

15 And once we resolve that then we can
16 insert the approved line into the overall
17 recommendation and vote on that. Does that make
18 sense?

19 MEMBER CASSANO: Steve, since I was the
20 one that brought it up and I don't think there's
21 anybody else that agrees with me we can just forget
22 about it.

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1 CHAIR MARKOWITZ: Okay. Well, if
2 there's anyone else who -- maybe Rosie, I can't
3 remember.

4 Does anyone else feel strongly in favor
5 of using the word prescribed in D?

6 MEMBER CASSANO: No.

7 CHAIR MARKOWITZ: Okay. So let's just
8 go with the recommendation.

9 Anybody think we need to read this out
10 loud? Everybody's looking at it hopefully.

11 MEMBER REDLICH: Just to avoid
12 confusion I would get one of the following. I
13 would remove the double asterisk there.

14 CHAIR MARKOWITZ: Right.

15 MEMBER CASSANO: They're not there.
16 Oh, it's under one of the following.

17 MEMBER REDLICH: Yes, thank you.

18 CHAIR MARKOWITZ: Okay. Final
19 comments?

20 Okay. So draft recommendation number
21 2, all those -- well, we're going to have to do roll
22 call here. Carrie or Doug, if you want to just read

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1 people's names and they can vote in favor.

2 MR. FITZGERALD: Dr. Dement.

3 MEMBER DEMENT: Yes.

4 MR. FITZGERALD: Mr. Griffon.

5 MEMBER GRIFFON: Yes.

6 MR. FITZGERALD: Dr. Silver.

7 MEMBER SILVER: Yes.

8 MR. FITZGERALD: -- Jimenez.

9 MEMBER FRIEDMAN-JIMENEZ: Yes.

10 MR. FITZGERALD: Dr. Boden.

11 MEMBER BODEN: Yes.

12 MR. FITZGERALD: All right. Dr.

13 Welch.

14 MEMBER WELCH: Yes.

15 MR. FITZGERALD: Dr. Sokas.

16 MEMBER SOKAS: Yes.

17 MR. FITZGERALD: Dr. Redlich.

18 MEMBER REDLICH: Yes.

19 MR. FITZGERALD: Dr. Cassano. Dr.

20 Cassano?

21 MEMBER CASSANO: Get off mute. Yes.

22 MR. FITZGERALD: Okay. Mr. Domina.

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1 MEMBER DOMINA: Yes.

2 MR. FITZGERALD: Mr. Whitley.

3 MEMBER WHITLEY: Yes.

4 MR. FITZGERALD: Mr. Turner.

5 MEMBER TURNER: Yes.

6 MR. FITZGERALD: Ms. Vlieger.

7 MEMBER VLIEGER: Yes.

8 MR. FITZGERALD: And Chairman
9 Markowitz.

10 CHAIR MARKOWITZ: Yes.

11 MR. FITZGERALD: I believe that's
12 unanimous.

13 CHAIR MARKOWITZ: Okay, 14 in favor.

14 No no's and no abstentions. Okay, recommendation
15 number 3 if you could just scroll down there.

16 The advisory board recommends
17 substantial revision of sections of the procedure
18 manual and related materials related to Part B
19 conditions taking into account consideration of
20 comments in this document and other feedback from
21 the advisory board.

22 So this refers to the language we've

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1 just gone over. And I would propose particularly
2 for people who have maybe just seen this relatively
3 recently that if you have minor suggestions that
4 you send this to Dr. Redlich and those will be --
5 we'll figure those out even as we vote on this
6 recommendation now.

7 The issue is I think if you have a
8 significant difference with the language -- if we
9 vote in favor of this recommendation now we
10 probably can't amend a substantial difference. So
11 I think that's the way we should look at this.

12 Any comments on this recommendation?

13 MEMBER REDLICH: I would just say that
14 for those involved in some of the other
15 subcommittees if there are other parts that you
16 have come across such as the training materials
17 that you find inconsistent or have questions about
18 could you let me know.

19 So I have highlighted the substantial
20 areas in the document, but I'm not sure I had all
21 the training materials.

22 MEMBER CASSANO: Yes, I looked at the

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1 training materials. They're very confusing and
2 they are inconsistent.

3 CHAIR MARKOWITZ: Okay. So we're
4 going to think about. If you could do the roll
5 call.

6 MR. FITZGERALD: Okay. Dr. Dement.

7 MEMBER DEMENT: Yes.

8 MR. FITZGERALD: Mr. Griffon.

9 MEMBER GRIFFON: Yes.

10 MR. FITZGERALD: Dr. Silver.

11 MEMBER SILVER: Yes.

12 MR. FITZGERALD: Dr.
13 Friedman-Jimenez.

14 MEMBER MARKOWITZ: George, you're on
15 mute.

16 MEMBER FRIEDMAN-JIMENEZ: Yes. Can
17 you hear me?

18 MR. FITZGERALD: Yes, we got it. Dr.
19 Boden.

20 MEMBER BODEN: Yes.

21 MR. FITZGERALD: Dr. Welch.

22 MEMBER WELCH: Yes.

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1 MR. FITZGERALD: Dr. Sokas.
2 MEMBER SOKAS: Yes.
3 MR. FITZGERALD: Dr. Redlich.
4 MEMBER REDLICH: Yes.
5 MR. FITZGERALD: Dr. Cassano.
6 MEMBER CASSANO: Yes.
7 MR. FITZGERALD: Mr. Domina.
8 MEMBER DOMINA: Yes.
9 MR. FITZGERALD: Mr. Whitley.
10 MEMBER WHITLEY: Yes.
11 MR. FITZGERALD: Mr. Turner.
12 MEMBER TURNER: Yes.
13 MR. FITZGERALD: Ms. Vlieger.
14 MEMBER VLIEGER: Yes.
15 MR. FITZGERALD: And Chairman
16 Markowitz.
17 CHAIR MARKOWITZ: Yes.
18 MR. FITZGERALD: That's unanimous as
19 well, 14.
20 CHAIR MARKOWITZ: Okay, 14 yes, no
21 no's, and no abstentions.
22 We're going to take just a five-minute

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1 break and then come back. We've got a really
2 important discussion about solvents and hearing
3 loss.

4 So, I have 2:58 so let's reconvene in
5 five minutes. Thank you.

6 (Whereupon, the above-entitled matter
7 went off the record at 2:58 p.m. and resumed at 3:04
8 p.m.)

9 CHAIR MARKOWITZ: So we should get
10 started. If someone could do a roll call that
11 would be good.

12 MR. FITZGERALD: Certainly. Dr.
13 Dement.

14 MEMBER DEMENT: Yes.

15 MR. FITZGERALD: Mr. Griffon.

16 MEMBER GRIFFON: Yes, here.

17 MR. FITZGERALD: Dr. Silver. I think
18 Dr. Silver had some --

19 CHAIR MARKOWITZ: Yes, let's come back
20 to him.

21 MR. FITZGERALD: He was going to
22 disconnect because of his battery on his phone.

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1 Dr. Friedman-Jimenez.

2 MEMBER FRIEDMAN-JIMENEZ: Present.

3 MR. FITZGERALD: Dr. Boden.

4 MEMBER BODEN: Yes, I'm here.

5 MR. FITZGERALD: Dr. Welch.

6 MEMBER WELCH: I'm here.

7 MR. FITZGERALD: Dr. Sokas. All
8 right, not back yet. Dr. Redlich.

9 MEMBER REDLICH: I'm here.

10 MR. FITZGERALD: Dr. Cassano.

11 MEMBER CASSANO: Here.

12 MR. FITZGERALD: Mr. Domina.

13 MEMBER DOMINA: Here.

14 MR. FITZGERALD: Mr. Whitley.

15 MEMBER WHITLEY: Here.

16 MR. FITZGERALD: Mr. Turner.

17 MEMBER TURNER: Here.

18 MR. FITZGERALD: Ms. Vlieger.

19 MEMBER VLIEGER: Here.

20 MR. FITZGERALD: And Chairman
21 Markowitz.

22 CHAIR MARKOWITZ: Here. Okay. So we

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1 have 12 and the others will come back I'm sure.

2 So, Laurie, do you want to get started?

3 MEMBER WELCH: Yes, sure. So, at the
4 end of our meeting in April we had a really short
5 sort of an introduction to this concept of
6 developing a presumption for hearing loss caused
7 by solvents.

8 And we -- that showed then. And since
9 the supporting documentation, or Carrie loaded up
10 the supporting documentation on the
11 recommendations and if people have questions we can
12 go to those although I have to say I don't have every
13 page in my head.

14 So as you know the current -- there is
15 a presumption for hearing loss related to solvents.
16 And up on the screen in front of you now is the
17 current presumption.

18 So, someone has to have a diagnosis of
19 sensorineural hearing loss in both ears. And they
20 have to be exposed to one of the listed chemical
21 solvents which I have on subsequent slides, and
22 worked in one of the listed labor categories for

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1 a concurrent and unbroken 10-year period.

2 So this is the list of solvents. This
3 list is not unreasonable. This is based on the
4 ones that have been studied in animals and humans.

5 So these are ones that have definitely
6 been associated with solvent-related hearing loss
7 and for which you have -- because of animal experts
8 and biological basis that it's not complete.

9 And can we go to the next slide which
10 is the list of occupations.

11 And same with this. Well, this is
12 based on someone's understanding of occupations
13 that would have had however you define significant
14 solvent exposure or an opportunity for significant
15 solvent exposure.

16 But again it has some of the major ones.
17 If we sat down over a beer we'd probably come up
18 with these, but there are as you know hundreds of
19 job titles in the complex.

20 And so someone who worked as a chemical
21 operator might not have that job description as a
22 chemical operator. So that is a prescribed list

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1 that is so specific it is also too specific.

2 And I don't think anybody would agree
3 with me that these two lists are -- I mean they're
4 fine, and they'll be helpful, but they can't be the
5 final list. There has to be lots of people whose
6 job is not on this list who get compensated. Okay,
7 next slide.

8 So in terms of what data is out there
9 on solvents and hearing loss there are -- I think
10 that in the second bullet I mentioned the Nordic
11 Expert Group and the EU OSHA. Those are the two
12 documents that I sent to the group.

13 And they do a good review. I think one
14 of them is 2010 and the other is 2009 so they're
15 not really up to date but they're good.

16 And they have a pretty strong
17 conclusion that solvents cause hearing loss.

18 There's good data that it causes more
19 than the classic sensorineural hearing loss
20 because it probably affects acoustic threshold,
21 but those require quite sophisticated tests to
22 document something that's not present audiometry.

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1 So my recommendation is going to be
2 we're going to stick with the sensorineural hearing
3 loss because that's predominantly what people are
4 presenting with and we can build a presumption
5 around it.

6 So, to be really, really brief on what
7 the literature shows that the animal experiments
8 that are done with single chemicals and that list
9 that you looked at before is the list of chemicals
10 that have been tested in animals and show injury
11 to the auditory system.

12 Most workers are exposed to multiple
13 solvents and exposed to solvents that aren't on
14 that list. And there are some human studies that
15 suggest that a mixed solvent exposure or a mixed
16 organic solvent exposure with the exception of a
17 couple of ones that wouldn't be classified as
18 organic solvents causes hearing loss.

19 It's not something you find in animal
20 experiments because they generally aren't exposed
21 to mixtures in that way.

22 But again I think there's good data that

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1 mixed exposures will cause as well.

2 Where we come down to sort of a not
3 really great data that begs the presumption is dose
4 response. So how many years or what intensity of
5 exposure causes disease in humans.

6 There is some information in the Nordic
7 Expert Group and the EU OSHA summary of the
8 literature.

9 I would say looking at that the
10 literature suggests that you don't need to have a
11 very high exposure to cause hearing loss, or to be
12 a contributory cause in any case.

13 But that the human studies in
14 populations that have been exposed for a working
15 lifetime, many of them.

16 So even though there may be an area of
17 signal effect that we might be able to see 5 years,
18 more at 7, more at 10. Most of the population have
19 more than 10 years of exposure, the human
20 population.

21 So we have a little bit of trouble
22 picking what that number of years of exposure would

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1 be. Can I have the next slide?

2 So a little bit more from those. And
3 this is kind of what I was talking about. But for
4 some of these solvents we see hearing loss at or
5 below the current OEL. And then either in humans
6 or in animal experiments.

7 And then people are looking at mixed
8 solvents among humans. The mixtures are often
9 MEK, MIBK, of which I think that most of those are
10 on that other list. Next slide, please.

11 And then the other interesting thing is
12 there is good data that noise exposure is
13 synergistic in causing hearing loss.

14 But we can't really assess noise
15 exposure in the population here because it's not
16 a habit that's considered unduly hurtful. So it
17 doesn't include any information.

18 I think that -- let me pause. Anybody
19 got any questions? Now because I'm going to go
20 into what I think are recommendations.

21 MEMBER FRIEDMAN-JIMENEZ: This is
22 George Friedman-Jimenez.

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1 To say that noise is not considered a
2 hazard under EEOICPA but hearing loss is an outcome
3 that we're considered about really doesn't make
4 sense.

5 So what is the process by which EEOICPA
6 can consider noise a hazard? Because we're
7 looking at only part of the picture and we know that
8 there's an interaction between solvents and noise.
9 And it's really confusing and misleading to only
10 look at one part of the picture.

11 So is there a way to rectify this
12 logical inconsistency?

13 MEMBER VLIEGER: This is Faye. Noise
14 is considered a mechanical injury like a broken
15 leg. It's not considered chemical. While it is
16 toxic it's not considered under Part E.

17 CHAIR MARKOWITZ: This is Steve
18 Markowitz. Yes, it's not in the act. Physical
19 hazards aren't in the act. So we couldn't consider
20 it.

21 But there is a way of thinking about
22 this which I'm sure, George, you're familiar with.

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1 So someone exposed to noise and to
2 solvents is going to have some impact on hearing.
3 And a piece of that is going to be had they only
4 been exposed to noise there would be hearing loss
5 from that. Had they only been exposed to solvents
6 there would be some from that.

7 But when you put the two together there
8 is an added loss due to the fact that they have --
9 and then added loss you can ascribe to the toxin,
10 to solvents. Because if it weren't for the
11 solvents they wouldn't have that added risk for
12 hearing loss.

13 So the solvents are responsible not
14 just for the noise, but they're in part
15 contributing to -- from the act to the added risk
16 that comes from simultaneous noise exposure, if
17 that makes sense.

18 MEMBER FRIEDMAN-JIMENEZ: It makes
19 sense, but what that implies is that the threshold
20 dose of solvents for a combined noise and solvent
21 induced hearing loss would have to be lower than
22 the single solvent induced dose.

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1 So we have to take that into account
2 when we're considering the threshold dose at which
3 we're going to call it solvent induced.

4 MEMBER WELCH: Right, and that's
5 actually what -- before I put these presumptions
6 out to the committee several members who are on the
7 phone looked at them and made that point.

8 I think for the occupations that are on
9 the list a great number of them we know they have
10 significant noise exposure.

11 So if you go to the next slide I think
12 I may have my recommendations.

13 Okay, so here's the recommendations,
14 what I would put forth. So people -- a claim that
15 meets the presumption for solvent related hearing
16 loss if there's a diagnosis of sensorineural
17 hearing loss.

18 And as I said before that could be
19 ignoring other impacts of solvent or noise, but the
20 presumption I think we want to say is diagnosis.

21 And significant solvent exposure
22 defined as worked for at least seven cumulative

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1 years in any of the job titles on the list in the
2 current presumption, or in any construction or
3 maintenance job.

4 Or, reported exposure to the specific
5 agents on the occupational health questionnaire or
6 evidence of exposure to organic solvents for at
7 least seven years.

8 Or, reported exposure to solvent
9 mixtures or evidence for those in the FEM for at
10 least seven years.

11 Or, exposure for seven years cumulative
12 established to work process.

13 And remember we talked about the last,
14 the DDWRP and COPD because there is a way that DOL
15 can develop more presumptions for tasks. They can
16 say someone who did this task has significant
17 solvent exposure. So it doesn't require -- the
18 problem getting into the SEM is that it -- specific
19 exposures. But one could set up a presumption for
20 a particular task that it represents the following
21 task, not a varying sort of task.

22 There aren't many of those, but the

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1 DDWLP says there's a way now that DOL is set up to
2 provide a little more help in the second tasks where
3 it's complex exposures.

4 So, I think that the literature clearly
5 supports a 10-year exposure period in human
6 populations.

7 And I thought, well, let's set it at
8 seven to take into account that many of the workers
9 who have solvent exposure are going to also have
10 significant noise exposure.

11 I don't think we can individually
12 assess noise exposure for the reasons we just
13 talked about. We don't have that information.

14 One could say well, if you have
15 sensorineural hearing loss they probably did have
16 solvent exposure already. We're getting noise
17 exposure already. So if they've got an abnormal
18 audiogram and they meet the definition of
19 sensorineural hearing loss they probably had noise
20 exposure. So that once they have that we can push
21 the level for presumption, the number of years for
22 presumption more than what we would need for

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1 solvents alone.

2 And if seven is the right number I think
3 that's the thing that we should make sure we agree
4 on.

5 And then there's one more slide, the
6 next one that says so then one more. This says the
7 claims examiner should not routinely deny claims
8 for solvents in hearing loss if the worker has had
9 fewer than six or seven years of exposure, does not
10 have a DDWL or is not in another category on the
11 list.

12 Claims that do not meet the
13 requirements set forth here but do have reported
14 exposure to solvents for at least five years should
15 be sent for review.

16 So that if you have seven you rate
17 automatically, if you have five you get NIH or CMC
18 review. The provision here is if you have fewer
19 than five your claim wouldn't be accepted.
20 Although that's not necessarily true. You could
21 still make a case.

22 So I think if people would weigh in if

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1 they think those numbers are reasonable. At seven
2 years of exposure your claim is accepted, between
3 five and seven you have to have a claim review, and
4 IH review.

5 MEMBER REDLICH: This is Carrie.
6 Laurie, before we get to just the number of years
7 your use of the word cumulative.

8 MEMBER WELCH: Yes.

9 MEMBER REDLICH: Maybe it's a stupid
10 question, but you clearly added that word. Could
11 you just clarify what you mean by it?

12 MEMBER WELCH: Well, the way that the
13 current presumption was to be continuous and
14 unbroken, and I wanted that to be in the correct
15 module. If someone had two years here and two
16 years there and were on different tasks it would
17 add up to seven.

18 MEMBER REDLICH: So just a total of
19 seven years.

20 MEMBER WELCH: Cumulative seven years.

21 MEMBER REDLICH: Yes.

22 MEMBER WELCH: So maybe it makes sense

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1 to take out the cumulative. I think that's a
2 reasonable edit.

3 MEMBER WHITLEY: Garry Whitley here.
4 I think the cumulative needs to be in there because
5 NIOSH say consecutive or continuous and they really
6 hold you to that.

7 Like if you had two or three jobs over
8 10 years, and then they were all listed in the list
9 they'll still say you have a break, or they weren't
10 consecutive in one job category and it's a fight.
11 So I think that needs to stay in there.

12 MEMBER REDLICH: That's fine. I just
13 wanted to -- that's what I assumed that you meant
14 and I just wanted to be clear about that. Maybe
15 a total of or something. But that's a minor point.

16 CHAIR MARKOWITZ: This is Steven. Can
17 you back up one slide? Laurie, I don't think this
18 was in the write-up that you sent around.

19 MEMBER WELCH: You're correct. And I
20 didn't have a rationale for that either.

21 CHAIR MARKOWITZ: Well, the rationale
22 you can get to later.

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1 MEMBER WELCH: Okay. So the idea
2 would be that caps with exposure to the list of
3 solvents in the range of occupational exposure
4 level, that DOL would develop one of the DDWL, or
5 direct, which would make it much easier for the
6 claims examiners to accept the claims.

7 MEMBER FRIEDMAN-JIMENEZ: Is OEL
8 observed effects level or occupational exposure
9 level?

10 MEMBER WELCH: Occupational exposure
11 level.

12 MEMBER FRIEDMAN-JIMENEZ: Okay.

13 MEMBER REDLICH: Is that setting too
14 high a bar?

15 MEMBER WELCH: I don't think that
16 that's what we were thinking. Those are the
17 solvent exposures that we want to be sure people
18 can get compensated for.

19 We don't want to make it too hard
20 because all the -- a lot of the jobs have stem
21 solvent exposures.

22 MEMBER BODEN: Could you just go up one

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1 more slide? I have a sort of trivial
2 non-substantive suggestion which is the last line
3 on that slide. It should say solvent exposure.

4 MEMBER WELCH: Oh, yes.

5 MEMBER BODEN: Like I said, not very
6 substantive.

7 MEMBER WELCH: No, that's important.
8 Yes. Because solvent exposure for seven years
9 cumulative.

10 MEMBER FRIEDMAN-JIMENEZ: Looking at
11 this language -- this is George -- I think replacing
12 cumulative by saying a total of at least seven
13 years, I think that would be clearer and I think
14 it addresses Garry's concern that they're still
15 enforcing the consecutive.

16 MEMBER WELCH: I like that.

17 MEMBER REDLICH: I know that the rest
18 of the word is different but cumulative and
19 consecutive both start with a C.

20 MEMBER WELCH: And people would say
21 what does cumulative mean and might interpret --

22 MEMBER REDLICH: Yes, I agree.

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1 MEMBER WELCH: That means everywhere
2 we have cumulative we would replace it with -- a
3 total of seven years. So that it has to be in the
4 other book do the same thing where it says
5 cumulative. It has to change too.

6 CHAIR MARKOWITZ: So, it's Steven.
7 While you are doing that apparently Rosie Sokas can
8 hear us but we can't hear her.

9 MEMBER SOKAS: Hi Steve, I'm back on.
10 It's Rosie.

11 I just wanted to agree with what you're
12 doing with the total. I think that's important.

13 CHAIR MARKOWITZ: What do you think?

14 MEMBER SOKAS: I think the cumulative
15 is really important because of the whole issue with
16 continuous in the past and then changing it to total
17 works well.

18 MEMBER WELCH: So on the very bottom
19 line can you add at least a total of.

20 CHAIR MARKOWITZ: So while they're
21 doing that -- Steve Markowitz -- I had a question.

22 In your rationale when you reviewed the

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1 long European agency report you listed a couple of
2 -- you listed N-hexane as showing an effect, good
3 evidence for an N-hexane effect.

4 But I don't see N-hexane in your list
5 of exposures here. On this slide.

6 MEMBER WELCH: Yes, we should add that.

7 CHAIR MARKOWITZ: And my other
8 question was in the current EEOICPA policy they
9 list a couple of solvents which I don't think you
10 have here. Methyl ethyl ketone and methyl
11 isobutyl ketone. So we probably should add those
12 as well.

13 MEMBER WELCH: We should add those too.
14 Those would go in the second line there. They can
15 go anywhere in there. MIBK and MIK.

16 CHAIR MARKOWITZ: MEK, yes.

17 MEMBER WELCH: MEK and MIBK.

18 MEMBER FRIEDMAN-JIMENEZ: Was there
19 any methyl butyl ketone exposure?

20 MEMBER WELCH: There may have been but
21 there isn't specific animal or human data on that
22 one. The ones that we're putting in here are

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1 specific exposures are the ones that are in the
2 evidence-based review.

3 And then the ones that aren't are in --
4 sort of covered by the next one down, solvent
5 mixtures.

6 MEMBER DEMENT: This is John. I have
7 a question about that specific point, Laura.

8 We say reported mixtures to solvents on
9 the occupational history questionnaire or evidence
10 of sustained solvent exposures.

11 When we say solvent exposures here we
12 are not restricting that to the list of specific
13 solvents above, is that correct?

14 MEMBER WELCH: That's correct. Yes.
15 So can we make that more clear?

16 MEMBER DEMENT: Well, the word "those"
17 in there confuses me. To those solvent mixtures.

18 I would just make it very general
19 because when I read it I'm almost forced to look
20 above and look at those particular lines.

21 I think my point is that these are very
22 mixed solvents and so they need to include them in

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1 here and make sure we don't restrict them in this
2 particular recommendation.

3 MEMBER BODEN: Maybe you should add the
4 word "any" to solvent exposures.

5 MEMBER DEMENT: Yes. Well, I think we
6 have to be careful to call them organic solvents
7 too.

8 MEMBER BODEN: Organic, right.
9 Because water is a solvent. Right.

10 MEMBER DEMENT: You have to say organic
11 solvents.

12 (Simultaneous speaking.)

13 MEMBER WELCH: Because the line that's
14 being highlighted, we should take out those which
15 you have highlighted right now.

16 (Simultaneous speaking.)

17 MEMBER WELCH: Exactly. And above
18 reported so we can do organic solvent mixtures on
19 OHQ. That should be in that same line.

20 MEMBER DEMENT: I guess my other
21 comment, I really like the expansion to
22 construction and maintenance jobs based on what

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1 we've seen in the DTMN data of reported solvent
2 exposures across category.

3 MEMBER WELCH: Yes, actually John did
4 a little sub-analysis of one of our studies and we
5 found a strong relationship between solvent
6 exposure and hearing loss.

7 However, it's not -- it was using the
8 data that we had which had not chosen to answer that
9 question. So we had some drawbacks but I think it
10 convinced most of us that there's a strong
11 relationship there.

12 So, can you go up? I don't know who's
13 doing the typing. Kevin. Could you go up and the
14 second bullet is reported. Add in there in
15 capitals MEK, MIBK, N-hexane comma. Yes, so we got
16 it.

17 CHAIR MARKOWITZ: And just an
18 editorial comment. For exposure to organic
19 solvents on the line below.

20 MEMBER WELCH: Okay, that's a big
21 improvement. Thank you all for reading the
22 document in so much detail. I think I've looked

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1 at this so many times that I kind of get glazed over.

2 CHAIR MARKOWITZ: Laurie, next to the
3 last bottom you use the word "sustained." And it
4 doesn't appear anywhere else. So I'm wondering if
5 there's any particular meaning.

6 MEMBER WELCH: And actually we need to
7 take that out because the SEM doesn't ever have
8 evidence of exposure. So we should take that out.

9 I think the claims examiner will be able
10 to use this. SEM only tells you that this job at
11 this location has this exposure and doesn't give
12 you any idea about intent of years.

13 So if the claims examiner is using the
14 SEM to identify that someone with seven years of
15 exposure, it's really combining the SEM with their
16 accepted employment.

17 But I think that would be pretty clear.
18 I don't know if Garry or Kirk or Carrie have any
19 thoughts on that particular thing.

20 You know, I think we can't use that
21 because SEM doesn't tell us about years. You think
22 that particular button is good enough for a claims

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1 examiner to say, okay, they worked as a pipe fitter
2 and that sort of job has solvent exposure and they
3 worked for seven years. That's what we're trying
4 to get at.

5 MEMBER VLIEGER: This is Faye. That
6 will work. We have gotten claims approved under
7 the ten-year rule where we proved that they had in
8 excess of a normal work day that is overtime.

9 And our documentation proved that they
10 had the equivalent of ten years exposure.

11 So I just want to make sure that if we
12 could put something in there or equivalent to seven
13 years.

14 Because, for example, a painter can
15 work double shifts, weekends, evenings, and when
16 we showed that overtime then they actually met the
17 ten-year requirement.

18 MEMBER WELCH: Oh, good point. One
19 way to do that would be to put an "or" and an hour
20 which if we assume people work 2,000 hours a year
21 to say 7 years or 14,000 hours.

22 MEMBER BODEN: Or you could say

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1 full-time equivalent which is common.

2 MEMBER WELCH: Okay. Does full-time
3 equivalent make sense to the people who know the
4 claims better? If we say seven full-time
5 equivalent years would that work?

6 MEMBER VLIEGER: This is Faye. An
7 eight-hour day is considered the norm. And so they
8 call it just a workday.

9 MEMBER CASSANO: So actually a year's
10 worth of an eight-hour workday for usually
11 computing salaries is 1,280 hours makes up a work
12 year. And so you just multiply 7 by 1,280.

13 MEMBER BODEN: Sorry but that actually
14 sounds way too low.

15 MEMBER VLIEGER: Yes. I'd say 2,000
16 hours.

17 MEMBER BODEN: Two thousand, yes.

18 MEMBER REDLICH: One could add an
19 asterisk here and then basically explain what's
20 meant by the seven years.

21 MEMBER WELCH: Maybe it's 2,080.

22 CHAIR MARKOWITZ: Kirk, did you have

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1 something to say?

2 MEMBER DOMINA: Yes. I don't know if
3 I like putting hours in there because
4 non-bargaining people a lot of times don't have
5 their hours listed because they're salaried, not
6 hourly. So I think you've got to be careful or
7 you're going to cut some people out that have --
8 that should be in there.

9 MEMBER VLIENER: I think if we use
10 equivalent seven years or equivalent work days that
11 that would work. And the eight hours presumed are
12 already in the program.

13 MEMBER WELCH: I'm sorry, I did
14 miscalculate. It's 2,080, not 1,280. I don't
15 know what I was thinking.

16 CHAIR MARKOWITZ: Can't we just say
17 seven years or its equivalent?

18 MEMBER REDLICH: Yes, and then you
19 could have -- Carrie -- you could have just an
20 asterisk that explains what that meant.

21 MEMBER WELCH: I don't even know if
22 you'd need the asterisk if you said seven years or

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1 its equivalent. Because the only way to get an
2 equivalent of seven years is adding up things. So
3 let's just use equivalent.

4 MEMBER VLIENER: And the way they get
5 around the continuous wording on your SECs is they
6 use the word aggregate.

7 MEMBER WELCH: Aggregate. That's
8 sort of funny.

9 MEMBER REDLICH: I think total.

10 MEMBER WELCH: So two places and not
11 the other two. I don't know if that was -- serious
12 grammatical decisions.

13 CHAIR MARKOWITZ: Any more comments on
14 this slide? Otherwise if we can go to the next
15 slide for a moment.

16 MEMBER CASSANO: I do have one comment
17 and it's just a question. And that's in the bullet
18 about reported exposure to the list of when we talk
19 about cumulative or total exposure.

20 Is it painfully obvious that we mean
21 over the years any combination of those. And it's
22 not we're just saying that it's seven years for

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1 styrene, or seven years for toluene, but reported
2 exposure to any of the following.

3 I mean, I think it's obvious but some
4 people may not. You know, at year 1 you're exposed
5 to styrene and you're not exposed for two years,
6 and then two years later you're exposed to toluene
7 is somebody going to say well that's not seven years
8 total exposure to one particular solvent.

9 I mean, I'm trying to think on the
10 lowest level of comprehension that you can get.

11 CHAIR MARKOWITZ: Well, before carbon
12 disulfide you'd put "or." I think that might
13 address that.

14 MEMBER CASSANO: Okay.

15 MEMBER WELCH: Yes, I think so, because
16 the next bullet is really combined exposures.

17 MEMBER CASSANO: Right, but I'm
18 talking about sequential exposures to different
19 solvents.

20 CHAIR MARKOWITZ: Right, and the next
21 bullet is mixtures actually.

22 MEMBER WELCH: Right. So I think the

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1 mixtures would cover sequential exposures.

2 Really, if someone was denied it
3 because -- the intent is pretty clear.

4 MEMBER CASSANO: I just work with
5 claims examiner stuff all the time, not these
6 claims examiners but others. And I'm amazed at how
7 concrete people can be.

8 You know, what actually we could do.
9 Reported exposure -- I don't know. Never mind.

10 It is what it is. I'm not wedded to any
11 changes. I just saw it as a possible problem.

12 MEMBER BODEN: Well, if you really were
13 worried about it you could say reported exposure
14 to any combination of and then list.

15 MEMBER FRIEDMAN-JIMENEZ: For one or
16 more.

17 MEMBER BODEN: One or more.

18 MEMBER FRIEDMAN-JIMENEZ: I think that
19 would solve it.

20 MEMBER REDLICH: There's a word
21 missing I think in the next part as it is for
22 exposure organic solvents.

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1 MEMBER WELCH: Two organic solvents.

2 MEMBER REDLICH: Okay.

3 CHAIR MARKOWITZ: Yes.

4 MEMBER BODEN: So one or more of the
5 following I think is what you need to say.

6 MEMBER FRIEDMAN-JIMENEZ: One or more
7 organic solvents in the SEM. I think that's the
8 exposure that we were talking about.

9 MEMBER WELCH: Well, we were talking
10 about a combination of say two or three of those
11 other ones.

12 CHAIR MARKOWITZ: It's not an SEM but
13 it could be in the OHQ.

14 MEMBER BODEN: Yes, that's the next
15 one.

16 CHAIR MARKOWITZ: Can we go to the next
17 slide for a moment? I just want to understand as
18 part of the recommendation.

19 So the OEL --

20 (Simultaneous speaking.)

21 MEMBER WELCH: We could if we want to.

22 We could say PEL. And maybe that's what we're

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1 talking about. Do we want it to be the OSHA PEL,
2 do we want it to be the ACGIH. I mean, those are
3 all the OEL.

4 It could be the DOE stats. But if it
5 --

6 CHAIR MARKOWITZ: Well, part of the
7 problem is DOE, there weren't a lot of exposure
8 measurements done at DOE.

9 So if they go to apply this, if they
10 accept it and look at these directives, these work
11 links, they're not going to be able to decide which
12 tasks actually were associated with any
13 occupational exposure, whether it's ACGIH or OSHA
14 or what have you.

15 MEMBER WELCH: And if the idea were to
16 use other sources. Like for example, you know the
17 exposed OEL. For tasks with likely exposure,
18 where exposure was likely to have been about --

19 MEMBER REDLICH: I'm a little confused
20 about this.

21 MEMBER WELCH: We could leave it out
22 too. I mean, we could just leave it out.

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1 MEMBER REDLICH: The individual
2 solvent OELs are quite high. So is this
3 restricting? Because I could imagine lots of
4 scenarios where you look at -- I mean, many
5 workplaces we actually look at the solvent measured
6 data and it's usually quite low even though it's
7 a lot of solvent. Because it's on each individual.

8 MEMBER WELCH: Well, what I was
9 thinking really was that setup has directed this
10 work process which would allow the claims examiner
11 to accept a claim for exposure to solvents if
12 they've done this task, whatever the task is.

13 So DOL decides in advance that this task
14 has enough exposure.

15 But then the claims examiner doesn't
16 have to figure out if there were solvents in the
17 SEM. Because there's going to be jobs where all
18 of us would say of course they're solvent exposed.
19 But there's nothing in the SEM that says it's
20 solvent exposed. So this is another way to assure
21 that tasks that are clearly associated with a
22 solvent, degreasing for example, that that's a task

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1 where they certainly did that in industrial
2 settings.

3 How you develop it and how you agree
4 that that's a solvent exposure task really can't
5 rely on the DOE internal industrial hygiene data
6 because that would be insufficient. It would
7 really have to be this IH data, epi data on the
8 tasks. So it's not a small job to develop one of
9 these things.

10 CHAIR MARKOWITZ: The other thing is
11 that if they accept an expanded list of jobs,
12 particularly if they include maintenance
13 instruction, most of these tasks that are obviously
14 exposed to solvents are going to be included in
15 those jobs.

16 So this would become most relevant to
17 jobs where we don't quite know whether they were
18 exposed or not. And I don't think there's going
19 to be the either specific or general knowledge to
20 permit this exercise. So I'm not sure.

21 MEMBER REDLICH: There may be data that
22 would show the levels were below, like past the OEL

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1 or something, and that would then sort of be
2 counterproductive potentially.

3 MEMBER WELCH: Let's just take this
4 line out because it's really -- if we can get
5 Department of Labor to accept the rest of it that
6 would be very valuable and if it's going to be
7 confusing and difficult we don't want to do that.
8 I want to make it part of a presumption. Is that
9 okay with everyone?

10 CHAIR MARKOWITZ: Yes.

11 MEMBER REDLICH: Well, I think it's
12 more internally consistent also because the
13 previous ones mentioned that there's not a good
14 dose response.

15 MEMBER WELCH: Yes. Okay. Good. On
16 the very last slide, Kevin if you're editing I can
17 turn.

18 CHAIR MARKOWITZ: Okay, so we have now
19 two slides which represent the recommendation.
20 And I feel like we're getting pretty close to a vote
21 here. We're also getting pretty close to 4 p.m.

22 So, are there additional comments?

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1 MEMBER WHITLEY: Garry Whitley here.
2 I want to make sure we all understand that prior
3 to 1990 is not in this. It was in the old one.
4 It's gone.

5 MEMBER WELCH: Absolutely it's not.
6 And in the rationale I do say that the exposure
7 should be counted up to the last day they worked
8 because we're looking at health effects that occur
9 below their exposure.

10 MEMBER WHITLEY: I agree. I just
11 wanted to make sure we got that on the record.

12 MEMBER TURNER: This is James. I was
13 wondering, has a study been done on these chemical
14 solvents causing a sense of smell, taste, feel, and
15 sight? Your eyesight.

16 MEMBER WELCH: There is some data, some
17 studies, I think the last time I looked at it about
18 a sense of smell. And they are neurotoxins
19 generally so they can cause problems with memory
20 and concentration.

21 There's been quite a bit of research on
22 that topic which is usable. I don't think it

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1 matters here though.

2 CHAIR MARKOWITZ: Maybe we can discuss
3 that more fully either in the subcommittee or
4 future, the larger range of solvents effects beyond
5 hearing.

6 MEMBER WELCH: Yes.

7 MEMBER FRIEDMAN-JIMENEZ: This is
8 George. I have a question about the seven year
9 choice.

10 I'm looking at the Nordic Expert Group
11 on page 76 and they quote a study of petrochemical
12 workers where 26 percent of the workers in a
13 department with solvent exposure and low noise
14 exposure had significant worsened hearing
15 thresholds in a five-year period.

16 So I'm wondering how much uncertainty
17 is there around that seven years. And maybe it
18 should be five years.

19 I haven't reviewed the data in detail
20 but seven years sounds kind of long to me to have
21 a significant hearing loss.

22 Is there enough evidence you think to

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1 make it seven rather than five as the cutoff that
2 we put in our document?

3 MEMBER WELCH: This is Laurie. I
4 don't think there's a lot of evidence one way or
5 another.

6 I mean, there may be one or two studies,
7 probably human studies, 15 or 20. Many of them
8 don't even tell you when you go and read the study
9 how many years of exposure the workers had.

10 Most of them didn't look at a dose
11 response related to years of work. Most of them
12 don't have useful information.

13 And so it's partly just the way I
14 approach a presumption. So I'm putting in my --
15 prejudice is not the right word, but you know.

16 So seven is really solid. I mean you
17 couldn't argue that seven years is not long enough.
18 And I think people could argue about five. So I
19 wanted to pick one that was like the literature
20 makes it incontrovertible.

21 And then if people have had solvent
22 exposure but don't quite make that seven years,

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1 well then they get an IH review.

2 MEMBER BODEN: Laura, I think that's a
3 completely justifiable way of doing it.

4 Might we want to add a sentence that
5 says there is evidence that less than five years
6 of exposure can induce hearing loss? So it is
7 important not to take seven years as the cutoff.
8 To make it a little stronger.

9 MEMBER CASSANO: Well, I think then we
10 need to change the at least five years to IH or CMC
11 because we could make that a lower number. Make
12 the seven years what the presumption is, then use
13 a lower number down here for five. So, whatever
14 you think would be appropriate.

15 MEMBER WELCH: I think that's fine.
16 In the rationale for the presumption I do have at
17 least one study of human exposure to toluene with
18 hearing loss at levels of 50 for seven years with
19 one other study showing effects after five years
20 of exposure. So it's in there.

21 MEMBER BODEN: Right, but I would start
22 to kind of put it in the body of the presumption

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1 as a way of making sure that people don't miss it.
2 To say something about either less than seven years
3 or five years.

4 CHAIR MARKOWITZ: This is Steven. I
5 don't understand the suggestion. Les, you want to
6 cite the basis for the numbers in the
7 recommendation?

8 MEMBER BODEN: No. What I thought --
9 so I think we have something in the recommendation,
10 I don't have that particular part in front of me
11 that says that --

12 CHAIR MARKOWITZ: Right, that's in the
13 rationale.

14 MEMBER BODEN: Either the rationale or
15 the recommendation. So, what if somebody has six
16 years of exposure. Is there anything there that
17 says, well, if it's less than seven but more than
18 some other number then it should be referred?

19 MEMBER WELCH: Yes. It says at least
20 five years. The very last slide.

21 MEMBER BODEN: Okay, so it is in there.
22 Yes, okay, that's what I wanted. I just couldn't

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1 remember if that was.

2 MEMBER SOKAS: And I think -- this is
3 Rosie -- I think Tori's suggestion was to lower that
4 a little. Because the study showed that at five
5 years 26 percent had some evidence of hearing loss.
6 You might want to go a little bit below that to
7 encourage people to send it to an IH or CMC.

8 CHAIR MARKOWITZ: Well, to play maybe
9 the devil's advocate here the CMC and the IH aren't
10 going to be able to perform a whole lot of magic
11 on the number of years. And they don't necessarily
12 have good access to intensity data. So I'm not
13 sure what they're going to do.

14 I think one of the strong suits of our
15 recommendations in general is we really try to make
16 it as much science-based as we can and not depart
17 too much from the studies which I think is a real
18 gain for DOL. I think it's a real contribution of
19 the board.

20 So, what I've heard and what I see in
21 Laurie's rationale is citing one study about five
22 years. There's not much of a data base for these

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1 lower numbers.

2 I personally would prefer to leave it
3 at five just because of the argument that this is
4 based on the best science.

5 I do understand the alternative.

6 MEMBER SOKAS: So just to mention, I
7 mean there are a couple of case reports of people
8 who were bathed in solvents and wound up with
9 temporary hearing loss based on an acute exposure.

10 MEMBER WELCH: This is Laurie. I
11 guess what I was hoping would happen with claims
12 that were sent to the IH is that the IH would say
13 well, we've set seven years as kind of the average
14 solvent kind of job, but this is pretty intense so
15 we should award at a lower number of years.

16 So they wouldn't be looking at the
17 nature of the work they did based on their OHQ. Now
18 that's asking, you know, we've asked for a big
19 change in procedure by revamping the OHQ and then
20 making sure that the industrial hygienist has it
21 and the hygienist can go back and interview the
22 worker.

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1 So if they do all that.

2 MEMBER REDLICH: This is Carrie. What
3 is something we said for consistency. And this
4 opens the door for a lot of individual judgment.

5 MEMBER BODEN: That's true. On the
6 other hand we don't want to create a situation in
7 which we take the best scientific evidence and say
8 we can really support seven years and have people
9 assume that if somebody is 6.9 years that they don't
10 qualify.

11 MEMBER REDLICH: I like having some
12 other, like it's not an absolute. But if we're
13 going to then we should maybe get some idea of what
14 we are expecting the IH or the CMC review to do.

15 It doesn't have to be in this slide, but
16 if we're saying we have a lower threshold set for
17 IH or CMC review does it do something.

18 MEMBER CASSANO: Well, to determine if
19 there was an event, or there is either an event or
20 another reason that hearing loss would be
21 manifested with less exposure. With less
22 cumulative exposure would be how you would say it.

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1 What this thing says here to the claims
2 examiner is if they have anything less than five
3 years of exposure the claim is denied. That's what
4 this says.

5 If you're a claims examiner reading
6 this seven years I can approve it. Five years, I
7 have to send it to the IH or CMC. If it's less than
8 five years I will deny it. That's how a claims
9 examiner thinks.

10 CHAIR MARKOWITZ: This is Steven.
11 I've got a procedural question actually for Doug
12 or Carrie. Can we go past 4 p.m.?

13 MR. FITZGERALD: Yes.

14 CHAIR MARKOWITZ: Okay. Keep going.

15 MEMBER CASSANO: So, a claims examiner
16 is going to use that term of at least five years
17 to say well, it's 4 years and 11 months, I'm going
18 to deny the claim.

19 So, if we're -- I'm not saying it should
20 be anything different, but if everybody is okay
21 with that, that's fine.

22 But if you're not okay with that then

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1 we should say claims that do not meet the
2 requirements set forth here but do have exposure
3 to organic solvents and have a profound hearing
4 loss should be sent to the IH.

5 I'd hate to send everything, but I don't
6 know how to allow the claims examiner to defer
7 without a hard number like this what should be sent
8 and what shouldn't.

9 So basically anything that's been
10 exposed less than five years will be denied.

11 CHAIR MARKOWITZ: This is Steven. I
12 have an idea. We could use the word several.

13 MEMBER REDLICH: I would defer to
14 Laurie. How strong is the literature for less than
15 five years? Because hearing loss is very common.
16 And on the other side this could potentially
17 increase the number of claims substantially.

18 MEMBER WELCH: This is Laurie. I
19 guess that's kind of what I was trying to do. I
20 was thinking about that.

21 Because we don't have -- you can have
22 different ways that you assure that it was people

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1 who had kind of industrial strength solvent
2 exposure because that's what the studies are about.
3 They were people who were in jobs where there's
4 ongoing daily exposure to solvents.

5 Or you could have even -- it doesn't
6 really matter so much what your particular job and
7 tasks were. We're setting a limit on the number
8 of years.

9 But if you have a kind of end job that
10 reported exposure to solvents needs a review that's
11 going to be just about everybody who working in the
12 complex.

13 Well, I mean there probably are some
14 people who didn't, but most people did a lot of
15 solvent use. The people working in labs, organic
16 solvents used to clean up.

17 So it's really a question of balance.
18 And it --

19 (Simultaneous speaking.)

20 MEMBER WELCH: -- that number of five,
21 making it three.

22 MEMBER BODEN: I completely agree with

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1 Laura. I think that really five. We are going to
2 miss some people who maybe should have been
3 compensated, but I think that this proposal will
4 both streamline the process in general and get more
5 people compensated than were before.

6 And the issue was the fact that older
7 people often have sensory hearing loss. I think
8 five is fine.

9 MEMBER WELCH: I can add more to the
10 rationale about what the IH or CMC should do with
11 this to basically say you want to look at the claim
12 and see if they have the equivalent of either they
13 were in a high exposure task or the high exposure
14 labor category that you could end up with fewer than
15 seven years. I can add that to the rationale.

16 I think I need to do that because I
17 looked back at the rationale and there's nothing
18 there that says what the IH or CMC would do with
19 the case. So I can put that in the rationale.

20 Hello? I think everybody's still
21 here.

22 CHAIR MARKOWITZ: We're here.

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1 MEMBER BODEN: We're not in
2 disagreement so we haven't said anything.

3 MEMBER DEMENT: This is John. I think
4 in reality, I think five years is a reasonable
5 threshold.

6 Sending to IH, all they're going to be
7 able to do is try to discern whether or not there
8 was some really abnormal solvent use.

9 For example, we have workers who report
10 cleaning various facilities and structures using
11 solvents from a bucket and rag. So as an IH if you
12 see that then that's something to be concerned
13 about. And certainly I think five years is a
14 reasonable threshold.

15 And if that occurs between five and
16 seven you'd probably recommend compensation.

17 MEMBER BODEN: Is there somebody who's
18 not okay with that?

19 MEMBER CASSANO: I am sort of agnostic.
20 I just wanted everybody to understand what that
21 number meant to a claims examiner. And if
22 everybody's okay with that then that's fine.

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1 I think it's a reasonable number.

2 CHAIR MARKOWITZ: No, I think that was
3 a good reminder actually of how this will actually
4 operate if adopted so that was useful.

5 So if we can then -- I think we're
6 getting close to being able to vote here. Any
7 other comments on this slide? And actually for at
8 least five years cumulative, I guess we have to
9 change the language there for at least a total of
10 five years.

11 MEMBER REDLICH: And I'm about to lose
12 my phone.

13 CHAIR MARKOWITZ: Okay, then we should
14 definitely take a vote. Any other comments on
15 this? Okay, can we go back to the previous slide.

16 Any comments here? Okay. So if there
17 are no comments then I think we can take a vote.

18 Is there any need to read this out loud?
19 I don't think so. I think we've gone through this.
20 So if we could do a roll call.

21 MR. FITZGERALD: Certainly. Dr.
22 Dement.

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1 MEMBER DEMENT: Yes.

2 MR. FITZGERALD: Mr. Griffon.

3 MEMBER GRIFFON: Yes.

4 MR. FITZGERALD: Dr. Silver.

5 CHAIR MARKOWITZ: Let's come back to
6 him.

7 MR. FITZGERALD: Okay. Dr.
8 Friedman-Jimenez.

9 MEMBER FRIEDMAN-JIMENEZ: Yes.

10 MR. FITZGERALD: Dr. Boden.

11 MEMBER BODEN: Yes.

12 MR. FITZGERALD: Dr. Welch.

13 MEMBER WELCH: Yes.

14 MR. FITZGERALD: Dr. Sokas.

15 MEMBER SOKAS: Yes.

16 MR. FITZGERALD: Dr. Redlich.

17 MEMBER REDLICH: Yes.

18 MR. FITZGERALD: Dr. Cassano.

19 MEMBER CASSANO: Yes.

20 MR. FITZGERALD: Mr. Domina.

21 MEMBER DOMINA: Yes.

22 MR. FITZGERALD: Mr. Whitley.

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1 MEMBER WHITLEY: Yes.

2 MR. FITZGERALD: Mr. Turner.

3 MEMBER TURNER: Yes.

4 MR. FITZGERALD: Ms. Vlieger.

5 MEMBER VLIEGER: Yes.

6 MR. FITZGERALD: Okay. Dr. Silver?

7 CHAIR MARKOWITZ: Steve Markowitz
8 votes yes too.

9 MR. FITZGERALD: Okay.

10 CHAIR MARKOWITZ: Ken? That's
11 thirteen yeses I think.

12 MR. FITZGERALD: Yes.

13 CHAIR MARKOWITZ: Thirteen yeses, no
14 no's and no abstentions. So that passed.

15 And I just want to thank Laurie for a
16 lot of hard work on this particular issue, and a
17 lot of clear thinking too so thanks.

18 MEMBER WELCH: Well, thanks. I
19 appreciate that.

20 CHAIR MARKOWITZ: Okay, so just to --
21 I forgot to do this at the beginning of the meeting
22 so let me just turn it over to Doug for a couple

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1 of minutes just to get a short report on the status
2 of our previous recommendations.

3 MR. FITZGERALD: It won't take a couple
4 of minutes, but before the meeting I did have an
5 opportunity to go check in with Gary Steinberg,
6 deputy director of OWCP to find out what the status
7 of the recommendations were.

8 And there's two sets and they're kind
9 of at different stages in the process. But he's
10 had some discussions with the second floor and
11 things are moving through the clearance process on
12 the first set of recommendations and that's about
13 the only thing he could really offer at this point
14 in time.

15 The Secretary is starting his seventh
16 week here and he's still getting his leadership
17 team in place.

18 So we're hopeful things are moving
19 forward. And on a hopeful note most of you are
20 aware that the charter renewal was signed by the
21 Secretary so that's in place. And there will be
22 a Federal Register notice hopefully published this

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1 week. We hope to get it over to the Federal
2 Register this week and then it may be published next
3 week. But in any event that will be out.

4 And on the second set of
5 recommendations as you know there was a lot of
6 complexity with those recommendations and they're
7 sitting with the department being reviewed and
8 they're developing their responses to those
9 questions.

10 CHAIR MARKOWITZ: Thank you, Doug.
11 We're happy to provide some leadership on these
12 issues and we hope that the program will be improved
13 as a result.

14 I forgot to actually thank Carrie
15 Redlich for all the work she did on the beryllium
16 issue which was difficult in part because the
17 language that's been worked on so far in the program
18 has been complicated and sometimes a little
19 convoluted frankly.

20 I think Carrie, you presented a lot of
21 clarity on these issues so thank you very much.

22 MEMBER REDLICH: This is Carrie. I

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1 had one quick question. It sounded like there
2 might be a new procedure manual that was in the
3 works. Did I understand that?

4 CHAIR MARKOWITZ: If you go on the
5 website there is a reconfigured procedure manual
6 if that's what you're talking about.

7 There's a little preamble and it states
8 that the content hasn't been changed, but it's --
9 we don't have a way to make it much more readable
10 which I think it is.

11 If you're referring to some draft
12 changes they were thinking about making prior to
13 our April meeting I don't know the status of that.
14 But those are substantive issues.

15 MEMBER REDLICH: Okay.

16 CHAIR MARKOWITZ: And so we've voted on
17 the recommendations. When we submit them we
18 submit the rationales. And so if you have some
19 minor comments on the rationales please send them
20 to Carrie and Laurie directly.

21 And what's a reasonable time frame, by
22 this Friday while it's still fresh? And then next

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1 week we'll be able to submit the recommendations
2 if that works for Carrie and Laurie.

3 MEMBER WELCH: Yes, that's great. And
4 I have a request that whoever was editing the
5 PowerPoint could you send it to me because I want
6 to then paste that back into the Word document.

7 MR. BIRD: We can do that.

8 MEMBER REDLICH: And could you also do
9 the same for the Part B recommendations? Thank
10 you.

11 MR. BIRD: Absolutely.

12 CHAIR MARKOWITZ: Okay. The next
13 meeting, face to face meeting will be in the fall.

14 And Carrie Rhoads is going to circulate
15 some time windows. It has to be after October 1
16 because that's the new fiscal year. And it can't
17 be soon after October 1 because who knows what
18 happens, if they'll actually get the budget done
19 on time, October 1.

20 So, we're going to look at the weeks of
21 October 16, November 6 and November 13. Some of
22 us have a conflict towards the end of October so

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1 we're avoiding those dates, but trying to get it
2 in before Thanksgiving.

3 So Carrie will circulate these three
4 one-week windows. If you give all possible good
5 times then we'll try to resolve this as quickly as
6 possible.

7 And then finally as to location. So
8 this is my thinking. I revisited the DEEOICP
9 website and looked at by state the number of claims
10 and the number of cases for the nine most common
11 states. You know all those states.

12 And we've been to Washington State,
13 we've been to Tennessee. Those are really the
14 leading in terms of the number of claims and the
15 number of cases.

16 But by a lot the next location is New
17 Mexico. Almost 14,000 claims from New Mexico and
18 the next highest after Tennessee and Kentucky is
19 Ohio with about 10,000 claims.

20 And if you look at the number of cases,
21 the number of people the discrepancy is also that.

22 So if we're going to continue with the

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1 spirit of going to places where people are and where
2 there's some open facilities so that we can learn
3 more about the complex then that argues for us to
4 go to New Mexico.

5 But the floor is open for comments.
6 James Turner, because I know James you would like
7 us to go to Colorado, but in any case let me just
8 open it up for comments.

9 MEMBER WELCH: Well, this is Laurie.
10 I was just on vacation in New Mexico and I visited
11 Los Alamos. And it was so interesting and I
12 learned a ton without having a special board tour.
13 So I think it's a great place for us to meet just
14 for the continuing education of the board. Just
15 my two cents.

16 MEMBER DOMINA: This is Kirk. If
17 we're going to go to New Mexico, and I think I talked
18 to Dr. Markowitz about it, about having time to both
19 go to Los Alamos and Sandia because they are, I
20 don't know, 90 minutes apart or something.

21 But I think it would be best if we're
22 going to one state to hit both of those locations.

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1 Plus there is a bunch of uranium miners
2 there also.

3 CHAIR MARKOWITZ: Kirk, just for
4 clarity, do you mean having the opportunity to meet
5 in one place, right, but to have the opportunity
6 if DOE can arrange it for us to tour both sites.

7 MEMBER DOMINA: That's correct.
8 Because I know logistically it might be tougher for
9 some people. But if we're going to travel that far
10 I believe the people deserve and the workers
11 deserve for us to visit both of those sites.
12 Because I don't want to leave anybody out.

13 And then like I said the third part is
14 all the uranium miners. So that's my two cents.

15 CHAIR MARKOWITZ: We can arrange a
16 couple of days of tours, but all tours are optional
17 anyway. But people could attend one or the other
18 if they lack the time to do both.

19 Other comments.

20 MEMBER REDLICH: I agree that sounds
21 like a good idea. I would just take for down the
22 road in the future a lot of the beryllium claims

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1 that were denied that seemed concerning were from
2 the Savannah River Site. So I would just put that
3 down the list for the future.

4 CHAIR MARKOWITZ: And South Carolina
5 is high up actually in number of claims and cases.

6 MEMBER REDLICH: I agree with New
7 Mexico.

8 CHAIR MARKOWITZ: Okay. So, any other
9 -- before we close the meeting any final comments?
10 We have a couple of subcommittee meetings, one this
11 week on presumptions, one next week combined IH and
12 CMC subcommittee with the weighing medical
13 evidence subcommittee.

14 Chairs should give some thought as to
15 whether they want to meet by phone prior to the next
16 full board meeting.

17 We do have to come up with an agenda for
18 the next full board meeting since we've covered an
19 awful lot already. So give some thought to that
20 as well.

21 Comments? Okay. So thank you all and
22 we'll be in touch.

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1 (Whereupon, the above-entitled matter
2 went off the record at 4:14 p.m.)
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