UNITED STATES DEPARTMENT OF LABOR

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ADVISORY BOARD ON TOXIC SUBSTANCES
AND WORKER HEALTH

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SUBCOMMITTEE ON EVIDENTIARY REQUIREMENTS
FOR PART B LUNG CONDITIONS (AREA #3)

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WEDNESDAY, JUNE 29, 2016

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The Subcommittee met telephonically at 10:00 a.m. Eastern Time, Carrie Redlich, Chair, presiding.

MEMBERS

SCIENTIFIC COMMUNITY:

JOHN M. DEMENT

MEDICAL COMMUNITY:

CARRIE A. REDLICH, Chair
LAURA S. WELCH

CLAIMANT COMMUNITY:

KIRK D. DOMINA
JAMES H. TURNER

OTHER BOARD MEMBERS PRESENT

STEVEN MARKOWITZ, Board Chair
FAYE VLIEGER

DESIGNATED FEDERAL OFFICIAL:

CARRIE RHOADS

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

2 10:09 a.m.

3 MS. RHOADS: Good morning, everybody.

4 My name is Carrie Rhoads. I'd like to welcome

5 you to today's teleconference meeting, the

6 Department of Labor's Advisory Board on Toxic

7 Substances and Worker Health. This is a

8 Subcommittee on Evidentiary Requirements for Part

9 B Lung Conditions. I'm the Board's Designated

10 Federal Officer, or DFO, for today's meeting.

11 First, we appreciate the time and work

12 of our Board members in preparing for this

13 meeting and for their forthcoming deliberations.

14 Dr. Carrie Redlich is the Chair of the

15 Subcommittee, and the members are Dr. John

16 Dement, Mr. Kirk Domina, Dr. Laura Welch, and Mr.

17 James Turner. Dr. Markowitz, the Board's Chair,

18 is also on the line, as is Faye Vlieger, who is

19 another Board member. In the room with me are

20 Kevin Bird and Melissa Schroeder from SIDEM, and

21 we're scheduled to meet from 10 to 2 Eastern Time

22 today.

1 For timing, we're going to plan to
2 take about a 10-minute break at 11:30, depending
3 on where the discussions are, and a 10 to 20
4 minute break at 1:00, again depending on where
5 the discussions are. Copies of meeting materials
6 and any written public comments are or will be
7 available on the Board's website under the
8 heading Meetings and the listing there for this
9 Subcommittee meeting. The documents will also be
10 up on the WebEx screen, so everyone can follow
11 along with the discussion.
12 The Board's website is
13 dol.gov/owcp/energy/regs/compliance/advisoryboar
14 d.htm or you can just Google "Advisory Board on
15 Toxic Substances and Worker Health" and it will
16 probably be the first thing you see. If you
17 haven't already visited the website, I encourage
18 you to do so. And after clicking on today's
19 meeting date, you'll see a page that's entirely
20 dedicated to today's meeting. We'll publish all
21 the materials on that page. You can also find
22 instructions for participating remotely, and

1 today's agenda will be posted under that.
2 If you are participating remotely and
3 you're having a problem, please email us
4 energyadvisoryboard@dol.gov.
5 If you're joining by WebEx, please
6 note that this session is for viewing only and
7 will not be interactive. The phones will also be
8 muted for non-Advisory Board members.
9 Please note that we do not have a
10 scheduled public comment session today. The
11 call-in information has been posted on the
12 website. You can listen in but not participate
13 in the Board's discussion.
14 The Advisory Board voted at its April
15 26th through 28th meeting that the Subcommittee
16 meeting should be open to the public, and so a
17 transcript and minutes will be prepared from
18 today's meeting.
19 During the Board discussion today,
20 since we're on a teleconference line, please try
21 to speak clearly enough for the transcriber to
22 understand. The transcriber has also called in.

1 When you begin speaking especially at the start
2 of the meeting, please state your name so we can
3 get an accurate record of the discussion.
4 Also, for the transcriber, please let
5 us know if you're having an issue hearing or
6 understanding anybody or with the recording.
7 The minutes are prepared and then
8 certified by the Chair. The minutes of today's
9 meeting will be available on the Board's website
10 no later than 90 days from today, per the FACA
11 regulations. But if they're available sooner,
12 we'll publish them sooner.
13 Also, even though formal minutes will
14 be prepared, we'll also publish a verbatim
15 transcript, which will be more detailed in
16 nature. We are going to try to have the
17 transcripts posted within 30 days on the Board's
18 website.
19 I'd also like to remind the Advisory
20 Board members that there are some materials that
21 have been provided to you already in your
22 capacity as special government employees and

1 members of the Board which are not for public
2 disclosure and cannot be shared or discussed
3 publicly, including in this meeting. Please be
4 aware of this as we continue with the meeting
5 today.
6 And with that, I convene this meeting
7 of the Advisory Board of Toxic Substances and
8 Worker Health Subcommittee on Evidentiary
9 Requirements for Part B Lung Conditions, and I
10 turn it over to Dr. Redlich, who's the Chair.
11 Thank you.
12 CHAIR REDLICH: Welcome, everybody.
13 Let me just ask, did anyone else have trouble
14 getting into the WebEx website, or is that just
15 my internet?
16 MEMBER MARKOWITZ: Yes, I'm having
17 trouble, but I have all the attachments that were
18 sent.
19 CHAIR REDLICH: You have the
20 attachments.
21 MEMBER MARKOWITZ: Yes, I have the
22 attachments.

1 CHAIR REDLICH: Okay. So we put
2 together an outline, and, first of all, as I
3 wanted to say, for anybody who is listening but
4 cannot talk on this conference call, we are
5 interested in your input, thoughts, concerns, so
6 please communicate them afterwards through
7 whichever means you can communicate, and we will
8 receive that input.
9 We have, I think, a large agenda
10 today, and if anyone has anything to add to the
11 agenda, basically I wanted to give a simplified
12 overview since we've been away from this. I
13 think, Steve, the main thing we were trying to
14 understand was the issues and scope, number
15 three, and then what additional information we
16 needed to accomplish our task and some sort of
17 time line. I was thinking of a time line between
18 now and our next meeting, but there's also a
19 larger time frame, so we could discuss that.
20 Then I just want to make sure everyone has the
21 other documents that were provided.
22 Does anyone have any big-ticket items

1 for the agenda that does not fall under one of
2 these categories? Okay.
3 So I spent the weekend getting back up
4 to speed reading all the various documents that
5 we had received, and I thought, just so we were
6 on the same page, my simplified understanding in
7 about two minutes, and to see if others think
8 that this is our sort of goal, was that we have
9 the EEOICPA Act created by Congress that defined
10 very specific criteria for diagnosing beryllium
11 sensitization, chronic beryllium disease, which
12 is a complex and confusing area even for
13 knowledgeable pulmonologists. And so it seems
14 that this has been a challenging area to review
15 and adjudicate claims.
16 And then it's sort of complicated by
17 a number of factors. One is that there is a
18 substantial financial implication between having
19 just sensitization versus chronic beryllium
20 disease that can also push agendas and decision-
21 making. And then there's obviously a need for
22 consistency and fairness.

1 And also, having looked over some of
2 the data and the numbers, appreciation really of
3 the magnitude of the claims process. We're not
4 talking ten claims a year. And also thinking
5 about this, recognizing that there is overlap
6 between our task and that of some of the other
7 committees.
8 So I think we're going to -- that's
9 sort of the problem is how to make this claims
10 process specifically related to Part B lung
11 conditions, chronic beryllium disease, beryllium
12 sensitization. Silicosis, which is also in with
13 these diseases, seems to be less of an issue.
14 And so that is my overall sense, as a
15 very simplified view, of the sort of key
16 problems. If anyone has anything to add to that,
17 it would probably be good if anyone just gives
18 their name first before they talk.
19 Okay. And I will say the other thing
20 that I have done since our last meeting, I went
21 to the American Thoracic Society meeting and
22 spoke at length with my various colleagues at

1 National Jewish and other places that deal with
2 these claims and patients on a regular basis. I
3 realized over the weekend a lot of the feedback I
4 got from them related to issues about the actual
5 claims process. And so I think we sort of next
6 defined the issues and scope. I personally was
7 sort of feeling that we need to clarify what
8 we're covering to make sure we're not -- the
9 medical evidence group is also obviously dealing
10 with decision-making and processing of claims, I
11 think, overall.
12 Okay. So does anyone have any other
13 thoughts on the simplified statement of the
14 problem, number two? Okay. So number three,
15 defining the issues and scope of our agenda. And
16 I had thought maybe this will take an hour, maybe
17 it will take longer.
18 So we have, at the Department of
19 Labor, that is one of our handouts. We have this
20 in more than one form. So people aren't
21 confused, there is the actual document that we
22 received at the meeting, and then there is -- I

1 had just sort of taken the questions and claims
2 and organized them just in terms of the
3 categories that they addressed, so it's really
4 the same questions. These aren't additional
5 questions. And they're really quite technical
6 questions in terms of what's the best way to
7 figure out sensitization, and so I think our hope
8 is not to get too bogged down right now in
9 answering any one of these questions but
10 deciding, first of all, if these are the only
11 questions that we need to address or other issues
12 but also then what approach we need to take and
13 what additional information would be useful.
14 And so we have, for starters, the
15 questions raised by DOL. I put together a couple
16 of things in thinking about this that I also felt
17 we should discuss, potentially areas we wanted to
18 address, and so I wanted everyone's input on
19 this. That's number three under B that we want
20 to, I think, clarify our charge versus the other
21 subcommittees. You know, are we sticking to Part
22 B and not dealing with any of the Part E, sort of

1 COPD. I think the issue with sarcoid and
2 beryllium disease are closely linked. Add some
3 sarcoid questions. Sarcoid could also be under
4 E. And also if there's any overlap with the
5 other questions.
6 The other thing that had come up was
7 complications with Part B diseases and how to
8 address them, is that under our scope?
9 Why don't I stop here and get input
10 from others on the phone?
11 MEMBER DEMENT: Hi. This is John
12 Dement. As I went through our charge versus the
13 group that's looking at the Site Exposure Matrix,
14 there's a requirement, at least for 1993, and I
15 think the terms are an occupational or
16 environmental history. That's pretty vague. I'm
17 not so sure whether or not that overlaps with the
18 other committee or not or if it's something that
19 we should address directly in this committee,
20 because it relates more to beryllium directly
21 than it does sort of the general Site Exposure
22 Matrix.

1 CHAIR REDLICH: Okay. There was a
2 weird buzzing noise that seems to be gone. So
3 you're asking whether -- the issue of how we
4 assess exposure related to beryllium?
5 MEMBER DEMENT: Especially under the
6 pre-1993 criteria. There's a terminology in
7 there that states that what constitutes an
8 occupational or environmental history.
9 CHAIR REDLICH: Okay. And I think
10 that this whole issue of pre- and post-disease is
11 -- one thing that I also sort of, I think
12 everyone realizes, I just had to also be
13 reminded, is that we're dealing with the EEOICPA
14 is a statute from Congress, and that's actually
15 that one document that has a fancy number, 73841,
16 as far as definitions. So I think one can
17 clarify definitions, but we're probably going to
18 try and have to work within this framework.
19 And the other document that we had
20 sent out was, I think, a more detailed version of
21 the current way that these two paragraphs are
22 interpreted, so the people actually doing the

1 claims, and that's something we may want to go
2 through with more of a fine-toothed comb because
3 -- okay. So I think let's add, you're right, the
4 issue of the history, the occupational history.
5 MEMBER WELCH: Carrie, this is Laurie.
6 Yes, I agree with John, we should probably look
7 at -- well, John was raising the question, but my
8 thought is we should look at exposure assessment
9 for beryllium as it's defined in the statute
10 separately. This committee should look at that.
11 But I think that the other lung disease, like you
12 put in your agenda, Part E, COPD, this committee
13 should not address that, and that will be
14 addressed by probably all the other committees in
15 terms of how COPD is handled from the exposure
16 assessment through the claims process through the
17 consulting, industrial hygiene thing. You know,
18 that's going to come up because it's a big case,
19 but I think this committee should not deal with
20 Part E, other lung disease claims. That would
21 just be way too big.
22 CHAIR REDLICH: I agree, so I was

1 hoping others would be as Laura said. Okay. So
2 we can get into the -- my understanding also was
3 that there was also if you basically spent one
4 day at a beryllium facility, you were considered
5 having had exposure.
6 MEMBER VLIEGER: Dr. Redlich, this is
7 Faye Vlieger. That's correct. The exposure
8 basis for the beryllium is one day of presence.
9 CHAIR REDLICH: Okay. And that's in
10 the Act.
11 MEMBER VLIEGER: That's part of the
12 Act. There's a criteria for 250 days that pops
13 up a few different places but not for beryllium
14 disease.
15 MEMBER DOMINA: This is Kirk. That
16 one day falls under 10 CFR 850, is where you
17 apply the one day, which is a beryllium CFR.
18 MEMBER VLIEGER: That's a DOE CFR, by
19 the way.
20 MEMBER WELCH: And does that apply to
21 both the pre '93 and the post '93 cases?
22 MEMBER VLIEGER: Yes.

1 MEMBER WELCH: So this idea of having
2 some kind of occupational history seems like it's
3 not really relevant in a way.
4 MEMBER VLIEGER: True, but they apply
5 it nonetheless.
6 MEMBER WELCH: Oh, so then we need to
7 understand that at some point.
8 CHAIR REDLICH: Thank you. And
9 please, for those who are more familiar with the
10 details of all of this, don't hesitate to speak
11 up.
12 Okay. And I guess other thoughts --
13 thinking through it, part of it, when I spoke to
14 my colleagues, I think how the claims are
15 processed and what things are covered, to me,
16 that belongs through the other subcommittee, and
17 it's not our jurisdiction.
18 MEMBER WELCH: I would agree, too,
19 unless there's something specific, that's
20 beryllium-specific that doesn't apply to all the
21 other claims.
22 MEMBER VLIEGER: There is the issue,

1 I don't know that it's so much claims processing
2 as it's training, between the CMCs and the CEs,
3 the contract medical consultants and the claims
4 examiners, and the other people who adjudicate
5 the claims is that they're not trained to
6 standard definitions, and they are often -- this
7 comes under ruling medical evidence -- they often
8 discount something they don't understand for that
9 reason.
10 CHAIR REDLICH: Okay. So we
11 potentially have the situation where beryllium
12 disease is quite complicated in understanding,
13 sensitization disease, the pre, the post, that
14 what you're saying is that pretty much everyone
15 gets the standard training. There isn't sort of
16 a centralized core group that deals with only
17 beryllium or something or --
18 MEMBER VLIEGER: There may be some
19 sort of training, but it's certainly not
20 standardized.
21 CHAIR REDLICH: Okay.
22 MEMBER VLIEGER: And the claims

1 examiners, there's no group that deals with
2 beryllium claims. And the medical evidence they
3 get when sent to the contract medical
4 consultants, they don't follow the statute
5 because the Department of Labor is not required
6 to remind them of the statute requirements.
7 Therefore, the doctors use their judgment versus
8 the statute requirements, or they use the
9 beryllium case registry criteria, which is not
10 the statute.
11 CHAIR REDLICH: Okay.
12 MEMBER MARKOWITZ: Carrie, this is
13 Steve Markowitz. I just want to add to this. So
14 if the general is, should this committee look at
15 the application of the evidentiary requirements
16 in the claims process, I think what Faye is
17 raising is part of a more general issue. It's
18 not just the CMCs. What comes in from the
19 medical provider? How does the claims examiner
20 look at these issues? So I think we have to get,
21 to some extent, into the claims process to see
22 how the evidence is constructed, viewed, and

1 applied.

2 CHAIR REDLICH: Exactly. I agree.

3 Okay.

4 MEMBER WELCH: This is Laurie. One

5 more comment. Your number C, which was

6 complication of Part B, diseases for treatment, I

7 think that DOL had asked for specific help with

8 that: generally, what diseases can be a

9 complication of steroid treatment, for example,

10 which could apply to other lung diseases as well?

11 But I think if we can help define which diseases

12 should be accepted as complications of kind of

13 the central core -- it doesn't mean it would be

14 exclusive, but it would be presumptive -- I think

15 that would probably be helpful.

16 CHAIR REDLICH: That's right. And I

17 agree. Either fortunately or unfortunately, we

18 treat most pulmonary diseases with only a few

19 drugs, so I think we could cover this. If put

20 under beryllium, it would probably be similar to

21 the COPD group, too, if not exactly the same.

22 But I think it is something. Or interstitial

1 lung diseases, which would be under E. So we
2 probably, I mean, we could both give input. I
3 think it would be similar.
4 Are there any other just sort of
5 defining the issues and the scope of what we're
6 hoping to accomplish? Okay.
7 So in terms of what we need to
8 accomplish our jobs, I think, Steve, we had put
9 together -- I'll say first we put together a list
10 of data requests, which is one of the other
11 handouts -- I think everyone has seen the forms
12 before -- of the type of information just, I
13 think in part to understand the magnitude and the
14 process. And we got that. I don't think anyone
15 had a chance probably to look at it. There are
16 20,000, a large number of cases in the database.
17 I think some summary statistics on some of that,
18 of just number of X and percent accepted and the
19 number in the past couple of years.
20 I think I have played around a little
21 with this over the weekend and sorting by
22 different ways, and what I came back with was my

1 hope that there was some simple, simple solution
2 that almost there were very few cases that were
3 sensitization only, versus beryllium disease and
4 sensitization, that there would be some very
5 simple fix. I think it's not that simple in
6 terms of just the magnitude. So that piece was
7 helpful to me.
8 And I think we could learn more from
9 a closer examination of this data. So my thought
10 was one of the key -- I think if one actually
11 looked at the initial request that we had, I
12 think that the Department of Labor was quite good
13 in providing what they had that was, I think,
14 acceptable in their system. Other people will
15 know this better. I think some of the job
16 titles, worker site, gets way more complicated,
17 and so we had a wish list of things, I think.
18 But I think a lot of the basic just of us getting
19 a feel for the claims and what they are and what
20 percentage are accepted.
21 So what I was going to propose on the
22 data side is that if we all look around at that

1 Excel spreadsheet sometime over the next couple
2 of weeks and come up with what information,
3 summary sort of information we would like to gain
4 from that, and I am hoping that someone in the
5 Department of Labor could help us. Excel
6 spreadsheets are not my personal forte.
7 So that piece. And then when we look
8 at it, then I think after looking at that that we
9 might realize, I suspect we will realize that
10 there's additional data, some of which might be
11 on this original list, that we think would be
12 helpful, and we could then come up with an
13 additional list of data pieces that we would find
14 helpful and see what is available.
15 So that was a general frame of what I
16 was thinking in terms of the data related to
17 beryllium disease, beryllium sensitization, and
18 silicosis. Other thoughts on the data component?
19 MEMBER DEMENT: Hi, this is John
20 Dement. Spreadsheets don't lend themselves very
21 much to really doing much in terms of analyses.
22 I was able to take that spreadsheet and pull it

1 into SAS.

2 CHAIR REDLICH: Oh, you're ahead of --

3 oh, I'm impressed. Okay.

4 MEMBER DEMENT: I could at least run

5 tabulations and summaries on the data.

6 CHAIR REDLICH: Okay.

7 MEMBER DEMENT: I have a question.

8 CHAIR REDLICH: No, that's great. I

9 had asked someone to see if they could help me

10 with that, and it was too short time. But that -

11 - yes, go ahead.

12 MEMBER DEMENT: What's sort of

13 missing, to me, in the data are, for the denials,

14 the reasons for denial. I mean, we know that

15 they're denied, and we can tabulate the frequency

16 of filing versus accepted versus denied, but is

17 there -- are there other data fields that provide

18 the rationale for denial based on the criteria in

19 the statute?

20 CHAIR REDLICH: Yes, I agree totally.

21 And I think that was sort of, that's exactly one

22 of the questions I had. I also wasn't, there

1 were some other more technical questions I had,
2 whether this was like a final denial or an
3 initial. Where in the claims process -- and I
4 also wasn't sure, because someone -- so I had a
5 bunch of questions about the data.
6 Carrie, in terms of, I wanted to get
7 some clarification, Carrie Rhoads. In terms of -
8 - and, John, you're totally right, an Excel
9 spreadsheet, we need to do something with the
10 data. Are we at liberty to do that ourselves and
11 see what additional -- should we request
12 assistance as far as just the process of making
13 sense out of the data?
14 MS. RHOADS: We can go back to the
15 program and ask them for more explanation of what
16 they already gave you, if you'd like, or
17 additional fields they might have, whatever, we
18 can ask them for some additional help.
19 CHAIR REDLICH: Okay. John, my guess
20 is that, if we want to, as you said, sort of
21 analyze this, that you're probably as good as
22 anybody at doing this. And I agree. I think we

1 should come up with a list of additional fields
2 that we would like to see if we can.
3 MEMBER DEMENT: I know there must be
4 other fields in there that are used for managing
5 claims that I think will be helpful. I think
6 Steve pointed out that if we could get into the
7 claims process, how the statute is actually being
8 applied and look through that, I think this might
9 give us a first glimpse.
10 I guess, in my view, I think it's
11 going to be very difficult to really get down
12 into the meat of this without having some
13 specific case studies that we look at.
14 CHAIR REDLICH: Yes, I totally agree,
15 and that's why I put -- and I talked to Carrie
16 Rhoads before this call saying that I sort of
17 feel like it's so presumptuous to think that we
18 either understand it or to make recommendations
19 without actually sitting down and going through
20 some claims, seeing what the obstacles are, what
21 final decisions, and how it works.
22 So I guess my question is, what would

1 be the process for us to do this and to get the
2 information in terms of, could we request the
3 paperwork for 30 claims or whatever and --
4 MEMBER VLIEGER: Dr. Redlich, if I
5 could interject, this is Faye Vlieger. Among the
6 advocates, for many years, we have been
7 collecting a repository of claims paperwork,
8 recommended decisions, final decisions,
9 reconsiderations, remand orders from the claims
10 process, and the repository of the redacted
11 claims has been the EECAP website. And I had
12 sent information out previously about the
13 availability of these redacted files on EECAP, so
14 for expediency, if you wanted to go look at the
15 beryllium sensitization and the beryllium disease
16 files there just for your own leisure while we
17 wait for the Department of Labor to respond, but
18 there is a repository that's available to the
19 public right now.
20 CHAIR REDLICH: For a given claim --
21 I guess we all have our experience in other
22 systems, so I had reviewed quite a number of the

1 World Trade Center claims, and there was the
2 questionnaires and the forms, and then there was,
3 you could have everything from ten pages to a
4 thousand pages of medical documents. If there
5 were a thousand pages, there were usually ten
6 pages within the thousand pages. So the typical
7 documents you would have on a given claim, what's
8 the magnitude of it? I'm sure it's very
9 variable, but --
10 MEMBER VLIEGER: The size of the
11 reply, is that what you're looking for? It can
12 range from two pages to ten pages, and many times
13 the denial lies in the Department of Labor's
14 statement of accepted facts. And those facts are
15 the problem, is what they accept, pursuant to the
16 statute, in this particular -- in beryllium
17 disease, what the statute allows and what the
18 doctor that they referred it to decides, and like
19 I said, the further disparity between what the
20 statute allows and what the doctors actually are
21 approving, particularly the contract medical
22 consultants.

1 MEMBER WELCH: Carrie, this is Laurie.
2 The medical records reside somewhere, and I'm not
3 exactly sure whether the advocacy website has
4 that. But usually what I end up seeing when I
5 ask for claims, they have a long narrative from
6 usually the adjudication branch that says -- and
7 this is the same kind of information that they
8 send out to the consulting physician if they need
9 a physician opinion on causation. So they'll
10 say, you know, you worked at the Oak Ridge plant
11 from 1952 to 1982, and the SEM says you had these
12 exposures, and we got these medical records, and
13 they'll basically say they've approved, like,
14 say, for a COPD claim, which -- I haven't
15 actually reviewed beryllium claims -- but COPD
16 claims, they'd say, your diagnosis is accepted.
17 So then you don't necessarily, for that claim,
18 need to look at the medical records because
19 they've accepted the diagnosis, and usually the
20 discussion is about the years of employment for
21 construction workers that are accepted facts. It
22 may be a smaller subset of what they reported

1 they worked there. But then there's always a
2 pretty long narrative about the causation issues,
3 and one can get the consulting medical report,
4 which then is what the claim examiners rely on to
5 accept or deny a claim usually.
6 So do your files collect the actual
7 medical records, too, or is what you have is the
8 adjudication information?
9 MEMBER VLIEGER: Are you talking about
10 the EECAP files?
11 MEMBER WELCH: Yes.
12 MEMBER VLIEGER: Okay. I'm on their
13 web page right now, and the decisions are listed
14 by year, and it is the document from the
15 Department of Labor. In order to get the medical
16 evidence, you're going to have to have the
17 claimant's permission, or Department of Labor is
18 going to have to do a lot of redacting. And I
19 know that if they do that, it's going to take a
20 lot of time to get your file.
21 MEMBER WELCH: I actually think, not
22 having looked at files, I think we can make a lot

1 of progress without the actual medical records
2 because you can see the -- in the rationale,
3 they'll say, well, the pulmonary function test
4 showed obstructive lung disease, something like
5 that.
6 MEMBER VLIEGER: If they wanted to and
7 it's amenable to the Department of Labor, EECAP
8 would be willing -- I'm speaking for Deb Jerison.
9 She runs that non-profit. She would be willing
10 to compile her files and send it for CBD approval
11 and denial. I'm looking at the website right
12 now, and there are files through 2013 with CBD in
13 them, and she does these by year. She's also
14 done some spreadsheet analysis of CBD and other
15 lung diseases acceptance and denial for the
16 advocates. We've been at this for a number of
17 years, and she's provided the statistics and the
18 website for our data.
19 So that is something we can reach out
20 to her to do. She did participate or come to the
21 D.C. meetings and publicly speak, so she's out
22 there. She's willing to help.

1 MEMBER MARKOWITZ: Steve Markowitz.
2 I just want to say something. If we want to
3 understand the DOL process, we have to look at
4 data claims that are fully representative of the
5 DOL's process. Otherwise, we can be viewed as
6 looking at a selective population, which is not
7 representative and, therefore, doesn't speak to
8 the underlying issue. So I think we need to
9 define what we want to know, and if EECAP, in the
10 short term, is helpful in providing some
11 insights, but, ultimately, we want to get our
12 data from the DOL database so we have a
13 comprehensive understanding of how they do
14 things.
15 MEMBER VLIEGER: I agree with Dr.
16 Markowitz. This is Faye again. It's just I
17 think there's going to be a sizable delay in
18 getting what we're requesting from DOL. Yes, I
19 agree we need a full spectrum of what's going on.
20 MEMBER MARKOWITZ: Well, the problem
21 is, if we look at our smaller population, we're
22 vulnerable to the criticism that we didn't look

1 at a fuller population that would have given us a
2 more accurate picture, you know what I mean? In
3 which case, we haven't gotten off step one.
4 CHAIR REDLICH: Yes. So what I would
5 propose, I think, since -- what is available
6 right now, I think we can look at I think, what
7 would inform potentially what we simply ask or
8 the DOL or at least hone in on, one of the things
9 about beryllium is that there's a lot of -- and
10 the questions that we were asked were very
11 technical questions. What pathology counts and
12 the sensitization. And I suspect that to fully
13 understand this, we are not going to need not
14 only the summary of the rationale for the
15 decision-making but understanding the data that
16 that came from.
17 Now, the good side about pulmonary
18 disease is that there's a limited number of
19 diagnostic tests. There's PSTs, there's a CT
20 scan, and there's pathology and the beryllium
21 test. So we don't have like 50 different tests.
22 But I think I'm probably, at some

1 point, at least to understand this -- is going to
2 need to actually review some claims, what
3 happened, and what information the physician was
4 given and then what decision-making they made
5 based on what was in front of them.
6 MEMBER WELCH: Yes, I think that makes
7 a lot of sense.
8 CHAIR REDLICH: Because, I don't know,
9 I've just been doing IOB, for 25 years and 25
10 years of IOB conference, and two pathologists
11 look at a past biopsy, and one sees granulomas,
12 and the other doesn't. One sees a CT scan that
13 looks like classic this, and another one says,
14 no, it's that. Both highly qualified people. So
15 they're not sort of cut and dry.
16 I think a key -- I mean, I think we
17 would like -- and, for starters, reading some of
18 the summary reports, for those of us who haven't,
19 would probably be informative. My guess is that
20 the medical records -- I mean, I've never seen
21 anyone receive medical records with the
22 information exactly what we want and all the

1 extraneous information gone, which becomes one of
2 the problems, let alone the whole redacting names
3 issue. But I also feel that anybody
4 knowledgeable can sort of go through that stack
5 and, for these purposes, select out the critical
6 information because, from experience, when you
7 start to ask for medical records, the person
8 who's putting them together is not the sort of --
9 the person is nervous about not including
10 everything, and then it becomes sort of
11 overbearing because you get 500 pages of
12 documents and findings of five pages. But I do
13 think that's a solvable problem if we sort of
14 clarified what pieces of information from the
15 medical record we were interested in.
16 So even simple questions, like, okay,
17 in the chronic beryllium disease claims, what
18 percentage of them actually had a biopsy done?
19 What percentage of -- so I think, you know, some
20 of that -- and even a very basic question, which
21 I have asked a couple of people, and I suspect
22 some people have a better feel, which claims

1 currently coming in are the pre and the post
2 criteria?
3 MEMBER WELCH: You know, this is a
4 little bit getting into the weeds, but I was
5 looking at the spreadsheet that we got, and it
6 tells you the CBD diagnosis dates, but it doesn't
7 tell you the claim filing date or the application
8 date or anything like that. So it's hard to know
9 --
10 CHAIR REDLICH: That's right. But you
11 don't know which criteria were being used in
12 those cases, and that was actually one of the
13 questions we were asked is, the onset of disease
14 is important because the pre-1993 is a more
15 inclusive diagnosis.
16 MEMBER WELCH: Right. In the
17 spreadsheet, you can sort of guess at at whether
18 they had sensitivity, as well as CBD.
19 CHAIR REDLICH: And some of them, I
20 think from 1950 we know which -- I also think the
21 more recent claims where --
22 MEMBER WELCH: Yes, but you don't even

1 know it's a more recent claim. That's the
2 problem. We know when the diagnosis was. We
3 don't know when that claim was filed. So if a
4 diagnosis is 1980; in theory, the claim could
5 have been filed in 2015. We don't know. So it
6 would be --
7 CHAIR REDLICH: Yes. So that would be
8 actually one of the additional pieces of data
9 that we would like on the data that we have is --
10 MEMBER WELCH: Well, I was thinking
11 maybe one thing we could all do is whoever wants
12 to look at the spreadsheet and say, oh, I'd like
13 to know this about the claims, and then we can
14 accumulate a list of additional data fields we'd
15 like to see. Because I know, in the past, when
16 we've asked DOL to give us information, they
17 don't tend to have a data dictionary that will
18 give you all the fields that are available, and
19 we could pick and choose. We have to say, oh, do
20 you have this; do you have this? And for this,
21 maybe there aren't too many fields that we're
22 missing. So if we were all to put our heads

1 together and say, you give us a date. We could
2 let you know what we see that we want.
3 CHAIR REDLICH: Yes, I think that's
4 exactly a good suggestion. So we will sort of
5 look through the Excel spreadsheet, at least on
6 that one, come up with additional, in an ideal
7 world, columns that we would like and see what is
8 actually available.
9 MEMBER WELCH: That would be good.
10 MEMBER MARKOWITZ: This is Steven
11 Markowitz. Question on process. I'm thinking
12 about the next full meeting in October. So if in
13 the next whatever period of time, a few weeks,
14 whatever it is, we individually communicate with
15 Carrie Redlich about additional data needed, and
16 Carrie could assemble that and submit that to DOL
17 with the idea of getting some output when
18 available but preferably before the October
19 meeting, so that when we come into the October
20 meeting, we will have already understood what's
21 available and even, to some extent, looked at it,
22 with the idea that, in October, we might be able

1 to discuss the next level of data we're
2 interested in, which is actually examining claims
3 and a scheme for examining claims. It would be
4 nice to get to that point by the October meeting.
5 And the question then is, in order to
6 submit the next data request for existing data
7 from DOL in relation to this, do we need a
8 subcommittee meeting in September -- in which
9 case we've got to ask for the Federal Register
10 notice and all that business -- or can we do it
11 through individually sending the ideas to Carrie
12 Redlich, who assembles them and submits them to
13 DOL? So if you could just, for a moment, just
14 focus on that.
15 CHAIR REDLICH: Okay, yes. So what
16 about one possibility. John, since you've
17 already put this into SAS, would you be able to,
18 just for basic starters, generate some summary
19 numbers for us to look at? I personally would
20 like to put short time frames on things because I
21 feel like I get my head around everything, and
22 then, if we let it go for a couple of months, it

1 takes more time total every time we resurrect
2 things.
3 I would think that we could probably
4 come up with the additional sort of key things,
5 like the reason, if there is a reason, for
6 denial, or Laura's suggestion for clarification,
7 what dates. I mean, I would think in the next
8 week, we could come up with that list of things
9 and get that to the DOL sooner versus later.
10 MEMBER DEMENT: This is John. The
11 data in the spreadsheet are a little hard to deal
12 with from a summary perspective. For example,
13 many individuals have multiple conditions filed,
14 so there's a lot of parsing out, depending on
15 what kind of summaries you want. But I can send
16 tabulations now. It's just that it will need a
17 little work to pull out each one of these
18 categories for each individual.
19 CHAIR REDLICH: It's true. I was
20 trying to get the big picture first, because if
21 someone has beryllium, and then they have on the
22 E side additional claims. They could also have

1 asthma and COPD. I think the various overlaps
2 are important because when someone has beryllium
3 sensitization and some other condition, like
4 asthma or COPD, is that chronic beryllium
5 disease, or is it sensitization plus that? But I
6 was really thinking for just a very initial look
7 to speak to the B side of the spreadsheet because
8 --
9 MEMBER DEMENT: Yes. I could send
10 some summaries. I need some guidance --
11 CHAIR REDLICH: I actually, a biostats
12 person who works for us, I had come up with a
13 little list that I had given them to do. But I
14 think it makes more sense for us to do it
15 internally, so I gave them a list, and then I
16 thought let me wait and not have them to do this
17 until we have our call, because I think, and you
18 know what? I could send it to you. Sort of
19 really just percentage of, these claims accepted
20 -- I also wanted to get a sense of, in the past,
21 let's say three years, the numbers of various
22 claims, in terms of the current magnitude of the

1 volume because part of I feel like the decision-
2 making is the magnitude. I think -- yes.
3 Just a possibility, John, if you're
4 willing, what if we gave you our little wish list
5 and the things that can be done easily, you do,
6 and things that are more complicated -- and then
7 I think, with that, if we came up with the other
8 variables that we were interested in.
9 MEMBER DEMENT: Yes, that's fine. I
10 need some guidance. Administratively, what is
11 our requirement for sharing this, the summaries,
12 amongst ourselves versus putting it on the
13 website? What is our requirements, for
14 clarification?
15 MS. RHOADS: This is Carrie Rhoads.
16 The data set that was sent that you're all
17 talking about, that can't be shared on the
18 website or anything. Discussing it sort of
19 generally like we are now and trends is okay, but
20 the data itself can't be put on the website. You
21 can talk about it and share --
22 MEMBER DEMENT: Yes, tabulations.

1 We're not going to put any data out there. It
2 would be simply tabulations. But how do we share
3 that among ourselves, Carrie?
4 MS. RHOADS: I can coordinate sharing
5 among the group through the DOL email.
6 CHAIR REDLICH: And the reason I
7 actually didn't -- because a person to just help
8 quickly summarize it, I wanted to clarify if it's
9 someone I work with regularly as a biostats
10 person, is that okay or not?
11 MS. RHOADS: I think if it's someone
12 that you work with regularly, it's okay. But let
13 me just, I'll check with our attorney.
14 CHAIR REDLICH: John is way more
15 qualified. John, it would be great if you -- I
16 don't think we need more than one person. But
17 that would be helpful to know because I just
18 don't want to violate any rules.
19 MS. RHOADS: Right. So the Energy
20 Advisory Board email is usually how we can
21 distribute things amongst the Board members.
22 CHAIR REDLICH: So, John, if we gave

1 you some ideas that we had on the simple side of
2 things, what timing do you think?
3 MEMBER DEMENT: Well, it depends on
4 how complicated your questions are. It's fairly
5 easy to write simple code to do tabulations in
6 this data. A week or so.
7 CHAIR REDLICH: Okay. So what if we
8 plan, and we'll come up with -- we'll give you
9 our suggestions in the next day or two, and then
10 in the next week or two, you would, with the
11 summary that you have --
12 MEMBER DEMENT: Yes.
13 CHAIR REDLICH: And I think if we
14 looked at that, while we're doing this, we would
15 come up with a list of the other variables that
16 we would be interested in.
17 MEMBER DEMENT: I think we ought to do
18 it simultaneously actually.
19 CHAIR REDLICH: Yes. Because when
20 you're looking, you realize you want more.
21 MEMBER DEMENT: I think this may
22 stimulate some questions. Tabulations that are

1 possible on this data are relatively simple.
2 MEMBER WELCH: You can completely
3 ignore the columns of medical conditions filed
4 and medical conditions approved. The ones that
5 have alphabetical data, like BDDS and stuff like
6 that, because in the end the data is embedded in
7 CBD approved or denied. So I think using the,
8 whether it's a survivor claim, a work site, the
9 diagnosis date, CBD approved, it's probably all
10 we need.
11 CHAIR REDLICH: Okay, okay. So I
12 think that is a general plan, and I would propose
13 we try and do it just so we can get to the DOL
14 the other variables we want sooner rather than
15 later because that will give them more time to
16 figure out what they can assemble for us.
17 MEMBER WELCH: This is Laurie. I have
18 a question for Carrie Rhoads. So if we want to
19 send information to John about data runs, should
20 we send those to you or can we send them directly
21 to him?
22 MS. RHOADS: I would say, for now,

1 send them to the Energy Advisory Board email. If
2 that proves to be too much of a burden, then we
3 can think about doing something else. But if
4 everything goes through there, it's better.
5 MEMBER WELCH: Okay, great.
6 CHAIR REDLICH: Okay. And then you'll
7 pass that on. Okay. So does that seem like a
8 plan as far as the data piece? And I think also
9 -- okay. So I think a little more complicated
10 is, I think, the desire that we all have to
11 better understand the claims process. And I
12 guess the issue is, what's going to be the best
13 way to do this and also in a way that it might be
14 a more than one-stage process in terms of an
15 initial review of maybe just decision letters
16 that could be done very quickly versus getting
17 medical records that would take more time?
18 So if anyone has thoughts on just the
19 process.
20 MEMBER WELCH: Well, what I was
21 thinking -- this is Laurie -- what I was thinking
22 about the spreadsheet and additional information.

1 If there are things like the date of the initial
2 decision, the date of the file adjudication, you
3 can kind of get a sense which cases went through
4 multiple levels of appeal because there probably
5 are dates for each of those things. Every time
6 they mail a letter to the applicant, there's a
7 date. And so, hopefully, those are captured in
8 some way. And then we could potentially then be
9 able to see claims that were decided fairly
10 easily without an appeal or ones that went
11 through -- you can end up going back to the
12 adjudication branch many times, and that would
13 probably give us the ability to pick out claims
14 that represented a spectrum of complexity, if
15 they have those dates. We could ask them for
16 that, too. We could say why don't you give us
17 ten claims that were decided in the beginning on
18 these criteria and these criteria and then ten
19 claims that had multiple appeals. But we may be
20 able to figure out how many there if we can get
21 more dates in the spreadsheet. Does that make
22 sense to anybody but me?

1 CHAIR REDLICH: I'm wondering whether
2 we should, to get more just of Labor, we could
3 just say, okay, maybe to the past, the 20 claims
4 that were most recently decided, recognizing they
5 may not be representative, but at least rather
6 than them hand -- and then we could sort of ask
7 if we have the 20 most recent, and do they think
8 those were representative. So you may also I
9 think have an idea, and looking over just the
10 decisions in that website -- I don't have strong
11 feelings. I think the sooner, if we look over
12 exactly some of those, I think -- but we'll have
13 to find out then, I mean -- so what do people
14 think? Should we just --
15 MEMBER VLIEGER: As far as the
16 documents on the website, they are representative
17 of what was submitted voluntarily by workers. So
18 I agree with Dr. Markowitz that we need a full
19 spectrum because we don't want to look like we're
20 slanted. However, I think when we go to the
21 Department of Labor, instead of saying, we want
22 this, do you have it, why don't we have them tell

1 us what they have, and then we can choose what
2 data we want to see? What are the columns? What
3 are they defined as, and what parameters do they
4 actually track.
5 What we've found when we've done FOIAs
6 of the system, a Freedom of Information Act
7 request, is many times they'll say, we don't
8 track that, or we don't track that in a way that
9 we can retrieve it. And so instead of a back-
10 and-forth, back-and-forth with DOL, why don't we
11 ask them what they do track, and then we can
12 decide what to get?
13 MEMBER WELCH: Good idea. We can see
14 what we get in response to that.
15 CHAIR REDLICH: Others may know
16 better. My sense is that a lot of the tracking
17 has to do more with things like the timeliness of
18 the claims process, rather than like some of the
19 questions we're asking in terms of the reasons
20 for denial or did the person have -- what
21 percentage of these cases that were denied had X
22 tissue diagnosis or something.

1 MEMBER WELCH: Carrie, this is Laurie.
2 I think that that stuff is not in the database.
3 CHAIR REDLICH: I guess we would -- it
4 would appear that the paperwork, as far as the
5 summary decision-making and rationale, should be
6 something that we could get sooner rather than
7 later.
8 MEMBER WELCH: Individual claims, you
9 mean.
10 CHAIR REDLICH: That's right.
11 MEMBER WELCH: Yes.
12 CHAIR REDLICH: So we could just say,
13 look, we have, for the past 50 claims, the most
14 recent 50, and see what we get. And then we'll
15 take a look through those, and it would give us a
16 flavor, and then we could, I mean, we could even
17 divide it among ourselves. My guess is that it
18 wouldn't take that long to flip through a
19 reasonable number.
20 MEMBER WELCH: Yes. I mean, I just
21 counted on the spreadsheet and it's a diagnosis
22 date, well, if the diagnosis date was 2013, for

1 example, then obviously the claim was after 2013.
2 So there were 35 accepted claims with a diagnosis
3 date of 2013, and there were 20 in 2014 and there
4 were 16 in 2015 with a diagnosis date. Now, I
5 think those are --
6 CHAIR REDLICH: CBD, correct?
7 MEMBER WELCH: Well, probably some
8 that were diagnosed in 2015 aren't adjudicated
9 yet, so we might want to, you know, look at the
10 35 that were adjudicated, that were diagnosed in
11 2013 that were accepted and then could probably
12 get another set if you want to look at ones that
13 were denied, too.
14 CHAIR REDLICH: And I think we want to
15 look both at CBD and beryllium sensitization.
16 Some are both, some are, you know, only
17 sensitization.
18 MEMBER MARKOWITZ: This is Steven.
19 But the goal of looking at this limited number is
20 not to draw large conclusions but simply to get a
21 better understanding of the kind of specific
22 information that is compiled and is used by

1 claims examiners to make decisions?
2 CHAIR REDLICH: I think so. My
3 thought was that this initial look could be done
4 in a week or two to get a feel for what we really
5 want of the claims process, in terms of the
6 medical records and the like, rather than
7 requesting all at once everything and it might
8 take months to get.
9 MEMBER WELCH: That makes sense. So
10 everybody gets an idea of what, as Steven just
11 said, what the --
12 CHAIR REDLICH: That's right. Because
13 I think, Lori, you have been reading these and
14 have an idea. But to me, we could just say,
15 look, could we have just the most recent 50
16 claims of CBD that have been processed and their
17 decisions, accepted or denied, and the last 50 of
18 sensitization and maybe a smaller number of
19 silicosis. You know, that piece of it -- and we
20 could take a look at that in a short period of
21 time, I think, and then say, okay -- and I
22 personally think it would be helpful to have a

1 phone call between now and the October meeting
2 because I would rather not, you know, to try and
3 do this, I think it would just be more time
4 efficient that way.
5 MEMBER WELCH: Yes.
6 MEMBER MARKOWITZ: So the goal would
7 be -- Steven. The goal would be to develop a
8 provisional understanding for recent claims the
9 claims process has operated to better understand,
10 secondly, to better understand the types of data
11 that enter the system and are used by the various
12 participants in the system, the claims examiner
13 and the like, to draw conclusions.
14 CHAIR REDLICH: Yes. And I guess I'm
15 partly -- the World Trade Center, there was, you
16 know, a vision of it. And then when you actually
17 looked at, and after looking at about 10 to 15
18 actual claims, the issues and the problems became
19 much clearer. And some of them seemed to have
20 quite simple solutions and others less simple.
21 And so -- exactly. I think this would, and I
22 think whatever number we got, if we got 50 of

1 each category, I think it would give us, we
2 recognize it's not representative of the whole
3 but at least initially where some of the issues
4 lie.
5 MEMBER MARKOWITZ: This is Steven
6 again. Just to --
7 CHAIR REDLICH: And I probably would
8 propose like almost a little cheat sheet of
9 accepted, you know, we could come up with a
10 little way to go over that and that we sort of
11 not graded it but had a sense of, you know, and
12 what was reason it was denied and does that seem,
13 you know, reasonable or not or what pieces were
14 missing and et cetera.
15 MEMBER MARKOWITZ: This is Steven.
16 But we're not -- this is a question. We're not
17 going to draw conclusions about the quality or
18 the consistency of the decision-making --
19 CHAIR REDLICH: No, no, this is just
20 hypothesis, you know, generating, I think, to
21 better hone in on what we do want.
22 MEMBER MARKOWITZ: Makes sense.

1 CHAIR REDLICH: Does that -- I mean,
2 just as one example, with the World Trade Center,
3 cancer, you think cancer, the diagnosis, the
4 requirement was you need a path report, so that
5 seems pretty straightforward. You know, you get
6 the path report. So there were a bunch of claims
7 that were denied when you looked at it because,
8 you know, there's the fancy oncologist who has
9 all the tumor markers and everything in their
10 notes, but the actual pathology report from the
11 pathologist is not there. Now, the person
12 clearly has a cancer. Any physician looking at
13 that would understand that. So that was like a
14 simple one where -- and there are multiple
15 reasons why the poor patient is unable to get
16 that path report which was done at a different
17 hospital and that hospital has been taken over by
18 this hospital and the records whatever.
19 So all you needed to say was a path
20 report or an oncologist diagnosis or something,
21 which seems like common sense, but I think when
22 you put these decision-making in a sort of

1 strict, you know, do this and then that, oh, you
2 don't have that so, you know -- so I think it was
3 at least on feel. I'm not saying that's what's
4 going on here, but I will say that the issues of
5 what was helpful from actually, the reason things
6 were denied. And it looks like, since that's not
7 going to be in the claim data -- and, Steve,
8 you're totally right, we don't want to make
9 preliminary conclusions based on this because we
10 recognize that this is not necessarily
11 representative.
12 In terms of the initial request, I
13 just put the number 50, but asking the DOL if
14 there are any other suggestions. Let's say 50,
15 you know, decided claims for beryllium disease
16 and 50 for sensitization and, I don't know, 20
17 for silicosis or something?
18 MEMBER WELCH: If you want to get a
19 sense of the claims process, I don't think you
20 need to look at a hundred claims. I would hate
21 to have to read a hundred of those.
22 CHAIR REDLICH: I was thinking maybe

1 we each did -- okay. We can go to a smaller
2 number. I was thinking why we're asking.
3 MEMBER VLIEGER: This is Faye Vlieger.
4 I agree. Once you read ten -- after you read
5 five you'll have an idea. After you read ten,
6 you'll be pretty sure what's going on.
7 CHAIR REDLICH: Okay. I say 20. I
8 would rather ask for more.
9 MEMBER TURNER: I was wondering if it
10 was possible, too, get to my case? My claim?
11 CHAIR REDLICH: Okay. Yes, from
12 talking to a number of people and physicians, I
13 do have some thoughts, but I don't have, but the
14 documentation to -- okay. So I would suggest
15 that we put a request in for, and recognizing
16 there's overlap, but I would like to see some
17 that are sensitization claim only and some that
18 the beryllium disease could be beryllium,
19 obviously, and sensitization.
20 MEMBER VLIEGER: That's fine.
21 CHAIR REDLICH: I think we should look
22 at some of the silicosis, too. So how about 10

1 of the silicosis, 20 of the beryllium -- so I
2 think -- Faye and Carrie, you can help us in
3 terms of what we're actually asking the DOL for.
4 We're asking for the summary as far as the, you
5 know, whether it was accepted or not and the
6 rationale and probably, if it's accepted, there's
7 less of a rationale.
8 But a given claim, and then would that
9 come with the history of the claim or is that
10 something we should --
11 MEMBER VLIEGER: If you're going to be
12 asking for the patient records, that's a
13 different ball of wax then asking for the
14 recommended decision and final decision in the
15 claim. Two different people write those
16 documents, and the recommended decision may
17 differ significantly from the final decision. In
18 each of the final decision and recommended
19 decision, there's something called the statement
20 of accepted facts, and that's what can vary
21 greatly. So that's the procedural process on how
22 they deny the claim.

1 If you're wanting to see the medical
2 records for each one, that's what's going to take
3 longer. So the initial ask, I would think, would
4 be for a specific claim to see the recommended
5 decision and the final decision, and then you'll
6 see how the process worked.
7 CHAIR REDLICH: And what about the
8 statement of accepted facts? Do we want to -- is
9 that --
10 MEMBER VLIEGER: Yes. If there's a
11 referral to a CMC, the statement of accepted
12 facts to the CMC may be significantly different
13 than what's actually memorialized in the
14 recommended decision or the final decision.
15 Sometimes, they're identical. Sometimes, they're
16 not. And so I would say, if we're going to ask
17 for a medical record for the claim in addition to
18 these, I would think that you would ask for the
19 CMC referral statement and the CMC report, as
20 well. Most of these go to a CMC.
21 CHAIR REDLICH: So right now I don't
22 think we're asking for the medical records

1 themselves because we want to get something
2 sooner rather than later. So just to be clear,
3 the specific request -- I'm just writing this
4 down -- would be the --
5 MEMBER VLIEGER: Recommended decision
6 to deny or accept.
7 CHAIR REDLICH: And then the final
8 decision.
9 MEMBER VLIEGER: Right. And that can
10 be to deny or accept or it can be a remand.
11 Those are the three options. And then something
12 that would be, in addition to that later on, you
13 know, we can discuss the contract medical
14 consultant referral and report, but that's going
15 to take more redacting.
16 CHAIR REDLICH: Okay. So the contract
17 -- okay, I understand. And then the statement of
18 accepted facts is what you're saying is really a
19 medical document?
20 MEMBER VLIEGER: No, the statement of
21 accepted facts is recited. It's memorialized in
22 the recommended decision and the final decision,

1 so it's in the record.
2 CHAIR REDLICH: Got it. It's
3 included. Okay. So it sounds like then that
4 would be the thing that we should be able to get
5 relatively quickly on each claim. And then when
6 we requested that, if five or ten years ago there
7 had been a previous decision, would that be
8 included? Would we get the history of the claim,
9 or would we only get that one decision-making?
10 MEMBER VLIEGER: Each person that
11 writes these has a different style, even though
12 there's a formula that they're supposed to
13 follow. And they may just briefly recite that
14 you applied and you were turned down. That may
15 be all they recite. Other times they could
16 recite the entire statement of accepted facts
17 from the previous ones. So if you're looking for
18 the chain on a claim that was attempted multiple
19 times, that's going to be a much more difficult
20 request, rather than saying, you know, for the
21 last 20, you know, you can hand us, it's a
22 different process, and each writer, each claims

1 examiner, each hearings representative has a
2 different style, even though they follow a
3 certain formula that's put to them in the
4 procedure manual.
5 CHAIR REDLICH: Okay. So at the
6 least, it would be apparent if it was a totally
7 new claim or one that had a prior decision of
8 denial?
9 MEMBER VLIEGER: Yes, they recite the
10 dates of claim in the statement of accepted
11 facts, so recite what evidence they received and
12 what evidence they accepted.
13 CHAIR REDLICH: Okay. Very good. So
14 I think I would propose, if everyone is in
15 agreement, that we put in a request for those
16 items for 20 cases of chronic beryllium disease.
17 You know, we say the most recent finalized ones.
18 Twenty of sensitization, or I think we probably
19 want more of the chronic beryllium disease than
20 the sensitization, and then also for ten of the
21 silicosis claims.
22 MEMBER WELCH: And, Carrie, it might

1 help to specify some proportion of accepted and
2 denied. You know, if we did the last 20 claims
3 and they were all accepted, then we wouldn't have
4 seen the -- I mean, it's probably unlikely. So
5 maybe you want to say the last --
6 CHAIR REDLICH: Why don't we say at
7 least ten that have been denied?
8 MEMBER WELCH: Okay.
9 CHAIR REDLICH: Is everyone okay with
10 that?
11 MEMBER MARKOWITZ: Yes, this is
12 Steven. I have a question, and maybe, Laura, you
13 can help here because you've looked at more of
14 these than many of the rest of us. If we're only
15 requesting either compilations or interpretations
16 of the underlying medical information and not at
17 this point requesting either the CMC report or
18 these medical records, how much are we going to
19 learn? In other words --
20 MEMBER WELCH: If a claim was denied,
21 you really don't understand it unless you have
22 the CMC report. So I think we should ask for the

1 CMC report with everything.
2 CHAIR REDLICH: To redact a CMC
3 report, that's maybe a several page report. We
4 just need to get rid of the name, you know,
5 right? Is that --
6 MEMBER WELCH: That's correct, yes.
7 It would probably have the, you know, if they did
8 a report correctly, your name would appear on
9 every page. And then sometimes within the text
10 of it, it will say Mr. Smith did this and Mr.
11 Smith did that. So someone has to go through it
12 and --
13 CHAIR REDLICH: Okay. But that's not
14 that --
15 MEMBER WELCH: The number of times the
16 guy's name is going to be mentioned might be a
17 dozen. Sometimes the report would be long but
18 it's blobbity, blobbity, blah about causation,
19 not about this case.
20 CHAIR REDLICH: Okay. So I agree. So
21 it seems like the CMC report, assuming it went to
22 a CMC which it sounds like a large number of them

1 do, would be a critical thing? So what if we add
2 that to our asks?
3 MEMBER WELCH: I think that's a good
4 idea.
5 CHAIR REDLICH: Carrie, I guess we
6 probably don't know, but this turnaround time for
7 an ask like this? Because, ideally, what I would
8 like to do is to get these, have us a chance to
9 look at them, probably come up with a summary of
10 our thoughts in terms of, you know, reasons for
11 denial before this October meeting.
12 MS. RHOADS: Okay. I will ask the
13 program about how long it would take them and
14 tell them, you know, why you need it and when you
15 need it by and see what --
16 CHAIR REDLICH: I mean, ideally,
17 because I think it would be very helpful. I
18 agree I do not think it would take any of us that
19 long to go through these, and it would, and I
20 would prefer, even ideally, to have a conference
21 call after we have done that because I think it
22 would help us to focus our decision-making, and I

1 think the critical thing being then also our next
2 request because, having looked at that, how much
3 we felt, you know, we needed more than a CMC
4 report. So that's going to be, I think, in terms
5 of understanding the process --
6 MS. RHOADS: Right. I'll ask them how
7 quickly they can get this together.
8 MEMBER WELCH: When I've asked, you
9 know, sometimes our workers ask me to look at
10 their case file, and then I always want to see
11 the CMC report, so the worker actually calls
12 their claims examiner and asks for it, and
13 usually I get it back in a couple of weeks. And
14 that's one individual person, but it's not that
15 long for someone -- so I think when we're keeping
16 our asks down to 50 files, I just don't think it
17 should, it's not that -- it's a copying thing,
18 you know. So I think we should be able to
19 schedule a conference call in September and
20 definitely have time to --
21 CHAIR REDLICH: Yes. And if there is
22 a piece of the ask that is problematic and the

1 other pieces are not, that would be helpful to
2 know. Okay. So is that -- I think now we've
3 basically come up with a plan for data in the
4 next really week or two. We've come up with a
5 plan for initially reviewing this information
6 that I think we're talking about over the next,
7 you know, month or two, before September. I
8 would hope that in September we could talk again
9 for the piece in terms of understanding this
10 aspect of the claims.
11 You know, I think understanding our
12 mission would really be focusing on, you know,
13 the reasons that these are being denied related
14 to really use the criteria and the pre, you know,
15 or post 19 -- you know, versus the issues of
16 what's the, you know, who's the quality or the
17 person doing the review because my understanding
18 is that those aspects of the process would go to
19 the other subcommittees. Is that -- is everyone
20 in agreement?
21 Okay. So what if we do this? What if
22 we take a ten-minute break and come back? And I

1 think, looking at our initial agenda, we have
2 gotten up to four. We've addressed A, and we've
3 addressed B, in terms of at least the initial
4 information about that. And we've partially come
5 up with a time line. But I did also want to just
6 raise, you know, potentially other information
7 and also we haven't, information also, you know,
8 our approach to sarcoid question.
9 So what does everyone think about a
10 ten-minute break? It is, let's call it 11:30.
11 Or 15 minutes? Any votes here?
12 MEMBER WELCH: Should we all hang up
13 and call back in? Is that the plan?
14 MS. RHOADS: We can just have the
15 moderator put the call on hold or mute for ten
16 minutes and then come back on.
17 CHAIR REDLICH: Okay. So we will be
18 back on at 11:40. And please, everyone, in the
19 meantime, we are actually making very good time,
20 but if there are other items or thoughts, do not
21 be shy. Okay.
22 (Whereupon, the above-entitled matter

1 went off the record at 11:29 a.m. and resumed at
2 11:43 a.m.)
3 CHAIR REDLICH: I think we are making
4 a lot of progress. We are still in the define
5 other data and information needs.
6 MS. RHOADS: Has the moderator added
7 back in the public line?
8 OPERATOR: Yes. Everyone can hear you
9 at this point.
10 MS. RHOADS: Okay, great. Thank you.
11 CHAIR REDLICH: I think we have
12 everyone back on. So I had a couple of thoughts,
13 but I wanted other people's thoughts in terms of
14 -- and I think, at this point, we're thinking
15 about additional pieces of data information that
16 will help us.
17 So I will repeat that whoever is
18 listening on the line to not speak. We welcome
19 your comments, suggestions, particularly focused
20 on pieces of information that would be useful in
21 terms of decision-making.
22 Are there other sort of constituents,

1 constituencies that we might want to hear from?
2 And I'm thinking of something, let's say,
3 physicians who are involved in the decision-
4 making, some of the, you know, people who are
5 struggling with doing the CMC reports or the
6 group within the DOL that makes a final decision?
7 And I was thinking more of really the specific
8 issues related to beryllium, not the process. So
9 I wanted other people's thoughts.
10 MEMBER VLIEGER: The physicians that
11 I deal with on these claims struggle to write
12 documents that meet the criteria that the
13 Department of Labor will accept, and I think
14 you've already touched on that in the defining of
15 the criteria. There are physicians who, you
16 know, from this area, pulmonologists, well-
17 respected pulmonologists that are ignored because
18 they're not meeting some tick box that the
19 Department of Labor requires. And I think the
20 vagueness of those requirements, even though the
21 statute is quite clear, and then presenting it to
22 the physicians in a way that they understand what

1 the requirements are is one of the hurdles for
2 the claimant.
3 CHAIR REDLICH: Okay. And so I guess
4 do we think that there would be another group
5 that would be helpful, in a more formal way, you
6 know, either canvas which are sort of the
7 particular areas. You know, I assume that there
8 are probably certain pieces that are more
9 challenging than others. I have sort of done
10 this informally with colleagues of mine, and I
11 did find what they told me useful. Some of the
12 things they told me I think related to other
13 parts of the process, but they were also a sort
14 of narrow group of people who know a lot about
15 this and I don't think were representative of the
16 actual clinicians who were --
17 MEMBER MARKOWITZ: This is Steven.
18 You know, an interesting idea, I think, Carrie
19 Rhoads, have we definitely decided to meet in Oak
20 Ridge next time in October?
21 MS. RHOADS: Yes, we're looking for
22 places in Oak Ridge.

1 MEMBER MARKOWITZ: So, you know, Oak
2 Ridge has a limited pulmonary community, and we
3 could reach out to them, at least put them on
4 notice that we're meeting them, and they might
5 participate in a public comment process about
6 their experience. And that way, we could get
7 some feedback. The only other organized group
8 would be the CMCs, but we expect to get, you
9 know, some of their issues through looking at
10 claims. I don't really know how else one could
11 look at the practitioner's experience.
12 CHAIR REDLICH: Just so I understand,
13 the total number of CMCs in the system is about
14 how many?
15 MEMBER MARKOWITZ: I think the range
16 is -- this is Steven. I think the range is 50 to
17 100, but I'm not sure.
18 CHAIR REDLICH: And these are
19 physically scattered in different parts of the
20 country?
21 MEMBER WELCH: Yes.
22 CHAIR REDLICH: Yes.

1 MEMBER VLIEGER: I mean, in theory,
2 the claims should go to a specialist who's in
3 that area, so you would have an oncologist and
4 you'd have, you know, for the whole range of
5 people, not just for beryllium disease. You'd be
6 sending it to, you know, there could be thousands
7 of consultants.
8 CHAIR REDLICH: But would it be in
9 certain sort of hotter spots of the country that
10 there might be, I don't know, five to ten CMCs
11 that would be useful to --
12 MEMBER VLIEGER: The QTC contract
13 vetting process is not understood by anyone, and
14 QTC is the one that collect the doctors -- QTC is
15 the name of the contractor. So the list of
16 vetted doctors in pulmonary occupational medicine
17 specialties is something we probably could
18 request. But I see them from all over the
19 country. They aren't necessarily doctors in the
20 region where the claim is originating.
21 CHAIR REDLICH: Okay. Because one
22 thought I have thought about, you know, just is

1 would it make sense, since this is a very
2 complicated area and for consistency and the
3 like, once you have records, you don't have to be
4 geographically for these claims to be sent to a
5 smaller group of people, you know, concentrated
6 in a smaller number, rather than sort of one
7 person has two and another has three all over the
8 place. And I don't know if that's happening now
9 or not, how it's decided. Are there CMCs that
10 only do beryllium disease? Are there others that
11 only do cancer? Because I wasn't totally clear
12 when they say a specialist what they meant by a
13 specialist.
14 MEMBER WELCH: We'd have to ask the
15 Department of Labor about that.
16 MEMBER VLIEGER: I was going to say
17 Laura could speak to that because she's seen more
18 of the reports probably than I have, but the
19 vetting process that QTC does, the doctors are
20 then supposedly reviewed by their application,
21 but I personally can attest to the fact that QTC
22 does not always vet the doctors appropriately for

1 specialty. The doctor may say that they're
2 qualified, but in claims that we review their
3 qualifications at a hearing, we find that the
4 doctor is not qualified to be opining in that
5 specialty.
6 CHAIR REDLICH: Okay. And I guess
7 some of these issues are ones that, Steve, I
8 assume the other subcommittee is addressing.
9 Knowing, and I think Laura and I probably are two
10 people from the medical side that know as much
11 about beryllium, as there are really a very small
12 handful of doctors. So just off the bat, and I
13 don't mean to sort of say negative things about
14 my pulmonary colleagues or my occupational
15 medicine colleagues, but, you know, world-
16 renowned interstitial lung disease specialists
17 who deal with sarcoid and all these other
18 diseases are clueless about beryllium.
19 MEMBER MARKOWITZ: And they're
20 probably not CMCs either.
21 CHAIR REDLICH: That's true. And the
22 occupational medicine ones, but if someone was

1 saying were they qualified to be a CMC, they
2 would look awesome qualifications on paper, board
3 certified and this and that and the like. So --
4 MEMBER MARKOWITZ: This is Steven.
5 Isn't the underlying problem that, and this is
6 what DOL actually raised in their list of issues
7 and if you look at the statutes, the underlying
8 problem is there's some very vague phrases that
9 it's not clear how you apply them. And so
10 whatever group, whether expert or not, until you
11 get in the room to examine records and apply
12 these vague phrases is coming up with
13 inconsistent results.
14 CHAIR REDLICH: For beryllium is
15 pretty specific.
16 MEMBER WELCH: Well, not really. You
17 know, you need radiography consistent with the
18 disease.
19 CHAIR REDLICH: But then there is the
20 other more extensive handbook that gives more
21 information.
22 MEMBER MARKOWITZ: You're talking

1 about the procedures manual?
2 CHAIR REDLICH: Yes, it's pretty
3 detailed. I mean, my thought is that it sounds
4 like what's happening is you've got a list of
5 pretty specific things you need to meet and you
6 don't meet them, and that's why it gets denied,
7 not that it's vague and it would fit under it.
8 MEMBER MARKOWITZ: Well, you know, but
9 I have to say, if you look at the issues that DOL
10 looks, as part of their PowerPoint, one of the
11 handouts that we received, they want help with
12 this issue of, you know, "characteristic of CBD."
13 They want help with a consistent uniform standard
14 for what is a chronic respiratory disorder. So
15 whatever details they've elaborated in their
16 procedures manual, they appear to still be
17 struggling with this probably for the same
18 reasons why some claimants are unhappy with how
19 they apply it, which is that these are, they
20 haven't been specified enough or some variation
21 of that.
22 MEMBER WELCH: Or if the procedural

1 manual was developed by the claims examiners and
2 one internal physician that's changed or, you
3 know, they asked some external person many years
4 ago, they might want a broader input. You know,
5 maybe, you know, if we look at what they've been
6 using and say that's good, that would be helpful
7 to them because, otherwise, you get people
8 arguing about what the statute says. The
9 procedure manual --
10 CHAIR REDLICH: So I guess I sort of
11 feel that one of the problems is is that, as you
12 try and define that in more detail exactly what
13 is meant, it then becomes harder to ever accept a
14 claim. And when you go to ILD conference and,
15 literally, a biopsy is read three different ways
16 by three different pathologists, it's almost, and
17 I think it's why people get towards some
18 presumption things because -- so, honestly, if
19 you look at the ATS document on beryllium and the
20 like, yes, you could tweak the manual that they
21 have, but it's pretty detailed.
22 MEMBER WELCH: Yes, but I think the

1 question is whether -- so when we look at the
2 denials, we'll get an idea.
3 CHAIR REDLICH: That's right.
4 MEMBER WELCH: Because you're coming
5 into it with the idea that there's probably
6 people that have CBD who are having their claims
7 denied because there's evidence required they
8 just can't get, even though they, you know, an
9 expert would say they have CBD, or more likely
10 than not anyway. And I think wait until we see
11 some, and then we'll get a better idea.
12 CHAIR REDLICH: And I suspect and it
13 sounds like there are also cases, and I think
14 consistency is important, of whether the, you
15 know, person has a positive, you know,
16 sensitization and doesn't have COPD but has some
17 other pulmonary condition, like asthma or COPD
18 and someone sort of decides -- I actually don't
19 think the question is do they definitely have the
20 disease because this is a compensation system,
21 so, I mean, I think that is a question, but then
22 I think it's also what makes sense in the setting

1 of the current compensation. Because, I mean,
2 with any of these, whether it's Agent Orange in
3 Vietnam or the World Trade Center, it's not, you
4 know, it's sort of defining parameters that you
5 hope in the end that you compensate people that
6 deserve it and the like, recognizing any of these
7 systems, even when we use more probable than not,
8 that means that we're 51-percent sure so half the
9 people maybe it wasn't related.
10 MEMBER MARKOWITZ: Yes, but WTC and
11 Agent Orange don't give diagnostic criteria,
12 unlike this statute. They don't tell you what
13 criteria you need to meet in order to be
14 recognized as having this disease or that
15 disease.
16 CHAIR REDLICH: WTC has its criteria,
17 you know, X amount of exposure, you need this to
18 document the diagnosis.
19 MEMBER MARKOWITZ: But not the level
20 of detail that's in this statute.
21 CHAIR REDLICH: That's right, that's
22 right. So part of my feeling is the level of

1 detail, partly the level of detail that we are --
2 because it all does go back to, we go back to the
3 statute, the statute is pretty specific for, you
4 know -- that's right. And then there is some
5 further discussion of what a CT consistent with
6 beryllium disease.
7 I think the point is that, everyone is
8 right, that when we review some claims, we'll get
9 some idea of the areas that are being denied and
10 maybe the areas that are being approved, you
11 know. Both ways, we're sort of wondering why.
12 MEMBER VLIEGER: Well, one of the
13 problems with that adjudication of these claims
14 is the statute is written in a manner that is a
15 little bit of a loop. So pre-CBD claim process
16 is first in the statute, and then, when they
17 transported that with the post-CBD criteria into
18 the procedure manual, instead of saying for pre-
19 1993 diagnoses, this is what's required, under
20 the post-1993, instead of saying in addition to
21 this you need this, they looped it. And to read
22 the procedure manual, it's quite confusing, and

1 that's why the doctors can't quite understand it.
2 Many times, I will write a letter and
3 specifically state out the criteria. And even if
4 you compare the U.S. Department of Labor's
5 brochures and pamphlets on the disease, it does
6 not match the wording that the claims examiners
7 are held to in the procedure manual.
8 So I think one of the things that
9 needs to be addressed is the clarity in the
10 procedure manual, and the way it was written is
11 very convoluted.
12 CHAIR REDLICH: Okay. And that is the
13 document, just so we're all talking about the
14 same thing, I believe that is the document that
15 Carrie sort of sent to everybody this morning in
16 one of the attachments.
17 MEMBER WELCH: Yes, it is.
18 CHAIR REDLICH: Okay. It's about a
19 20-page thing?
20 MEMBER WELCH: Yes. What you're
21 really looking at is about three paragraphs under
22 CBD, and you'll see that it's very convoluted.

1 Sorry. The pre-1993 criteria is stated, and
2 then, when you go to the post-1993 criteria, you
3 have to infer from the previous criteria what's
4 in there. And I think that's part of the
5 problem.
6 CHAIR REDLICH: Okay. And then I
7 think two things related to that, in terms of
8 pieces of data that I think would be helpful, is
9 what percentage of these beryllium claims are
10 under the pre- and post-1993 is one question
11 because, obviously, being pre-1993 gives more
12 wiggle room in terms of not needing to
13 demonstrate the sensitization. And then also how
14 that's being decided because my understanding it
15 seems that that's one of the questions would be
16 onset of disease and how that's being defined in
17 terms of onset of symptoms or documentation that
18 you saw, and I don't know if anyone on the call
19 knows the answer to that. But it sounds like
20 that's an area of confusion.
21 MEMBER WELCH: Once the worker
22 receives one positive beryllium sensitivity test,

1 that qualifies them for a medical benefits card,
2 and then they are eligible to use that card for
3 their ongoing monitoring. That leads into when
4 they would apply for a CBD claim if they meet the
5 criteria, so then we run into the criteria
6 confusion problem.
7 CHAIR REDLICH: Okay. But does anyone
8 have any sense now of, let's say, claims filed,
9 or reviewed from those when they originally
10 filed, recently, how many of them would be using
11 the pre- or the post-1993 criteria? I mean, when
12 this CMC person, is that part of their decision-
13 making, which criteria am I going to use, or is
14 someone else saying we've determined that this
15 person was pre- or post-1993?
16 MEMBER WELCH: This is Lori. I'd ask
17 John to answer about what I said to him in the
18 meeting. I said it seems like this should be
19 easier because all your claims should now be post
20 '93, and he said, no, a lot of claimants are
21 asking to have the pre '93 criteria applied
22 because they want to demonstrate that their

1 symptoms, that their chronic lung condition began
2 before 1993. And so I don't know what proportion
3 it is, but it's something that apparently the DOL
4 is struggling with, whether, you know, what kind
5 of documentation to accept that the chronic lung
6 disease began before '93.
7 CHAIR REDLICH: That's right. And
8 they asked us that question. Okay. And in the
9 CMC report and the rationale, I would assume that
10 when you read that over, it should be clear what
11 criteria are being used, or is that a potentially
12 wrong assumption?
13 MEMBER WELCH: No, it's clear.
14 CHAIR REDLICH: Okay. So that's also
15 something, when we look at the most recent 20
16 claims or so, we should have a sense of?
17 MEMBER WELCH: Yes.
18 CHAIR REDLICH: Okay. I just wanted
19 to make note because I think that is, this is
20 obviously an important area, and it is one of the
21 questions on the list of the specific questions,
22 the pre- and the post-1993, and one could --

1 okay. And also if we could ask, it's probably
2 not in the database, but we could still ask
3 because then it keeps it as something to remember
4 as a variable that we would be interested in.
5 MEMBER WELCH: Right, yes. I mean, if
6 we get the --
7 CHAIR REDLICH: Someone could say,
8 yes, I saw the doctor now, but my disease started
9 ten years ago, you know.
10 MEMBER WELCH: But the date of
11 diagnosis should tell us that. So if there is a
12 case with a date of diagnosis of 1990 and then
13 the case is being adjudicated in 2012, we would
14 be able to see that that's a pattern. But since
15 all we have is a date of diagnosis and not the
16 adjudication date, we don't know if there are
17 many with a long gap, you know, many where
18 there's a 20-year delay between the diagnosis.
19 Those would probably the accepted claims.
20 Just for everybody's information, I
21 just kind of counted out of that spreadsheet, and
22 there are 24,000 applications for either CBD or

1 BES, and there were around 2500 approved and 2500
2 denied for CBD. And I didn't count how many were
3 beryllium sensitization. There's some for which
4 there's no information at all on the claim,
5 whether it was approved or denied, and I don't
6 know what that means, but that was one of our
7 data requests.
8 Just to give you an idea of what kind
9 of numbers we're talking about, there's been, you
10 know, 2500 accepted ever. In the last three
11 years, it's around 50.
12 CHAIR REDLICH: That's right. It
13 wasn't a huge number for those. Okay. So I
14 think --
15 MEMBER MARKOWITZ: Carrie, can I --
16 this is Steven. I'm reading the minutes from the
17 full Board meeting in April, and John Vance said
18 that DOL is currently seeing more pre '93 cases
19 than post '93 cases. So it's a --
20 CHAIR REDLICH: Okay. We're going to
21 have to deal with that issue. And, again, I
22 think we can clarify what, you know, the wording

1 on this statute, but I think we're sort of stuck
2 with the statute.
3 So I guess, potentially, I would be
4 interested, if we -- okay. Maybe this is
5 information we could get. For the past 100
6 beryllium claims, how many different CMCs were
7 adjudicating? You know, is there any
8 concentration, or it is just --
9 MEMBER WELCH: There's definitely not
10 concentration. There's no system to send it to a
11 smaller number of people.
12 CHAIR REDLICH: But at least it would
13 be going, I think what would be helpful would be
14 some idea of, I mean, what have they considered?
15 Because they pick someone, quote, with the
16 relevant specialty, so are these cases -- I think
17 it would be helpful to know -- and the CMC report
18 is, correct me if I'm wrong, that's a critical
19 step in this stage, right? Where things could
20 either --
21 MEMBER WELCH: Yes, absolutely. I
22 mean, for all these claims.

1 CHAIR REDLICH: Okay. So I just would
2 like to know for the claims for beryllium, who
3 they send them to. Are they pulmonologists, occ
4 med doctors? We said, okay, these hundred claims
5 were reviewed by these 30 physicians. Who are
6 those 30 people? That's something the DOL should
7 let us know, right?
8 MEMBER WELCH: Well, when you look at
9 the report, you know, for the claims that we look
10 at, we're going to get the CMC report and it has
11 their, you know, their qualifications, to some
12 degree. I mean, there was a case I looked at
13 recently where he was occupational medicine-
14 boarded, but his initial training was in
15 orthopedics.
16 CHAIR REDLICH: So that's the case
17 with probably the great majority of occupational
18 medicine.
19 MEMBER WELCH: But that person was
20 considered qualified to opine on an occupational
21 lung disease case.
22 CHAIR REDLICH: So maybe the, I think

1 the Department of Labor must have some little
2 guidance that they use, okay, we have this claim,
3 we need to decide who to give it to. So we could
4 ask them what they're using.
5 MEMBER VLIEGER: They base their
6 choice of doctors off of who QTC vetted, and the
7 vetting process that QTC uses has not been
8 disclosed.
9 CHAIR REDLICH: Let's see what we
10 get, right?
11 MEMBER VLIEGER: No, and we also can't
12 get the CMC training manual, so that might be
13 something you want to ask for, too.
14 CHAIR REDLICH: We would get the sense
15 of these ten, but the question is -- exactly. I
16 think, frankly, most occupational medicine
17 physicians, you know, I think are people who do,
18 you know, injury management.
19 MEMBER WELCH: I mean, I think there's
20 two things there. There's trying to find
21 consultant physicians who understand the disease,
22 or they're trying to help with the adjudication

1 process so it's not so complicated that you need
2 to have everyone being reviewed by, you know, a
3 subset of three doctors in the country.
4 CHAIR REDLICH: But you know what?
5 The number of total beryllium, those were
6 accepted claims, and that's why I think that
7 recent numbers, but I don't know. Let's say you
8 had 300 claims a year or something will have that
9 information related to beryllium. When you do
10 something regularly and familiar with it and you
11 understand it, it potentially would make sense to
12 concentrate that in a smaller number of people.
13 When we did the World Trade Center, we had, like,
14 five of us who all sort of reviewed them and
15 actually had some conference calls to discuss,
16 you know, so I do think -- why don't we just do
17 this? Say we'd like to know who they consider
18 qualified, you know, which types of physicians.
19 I assume that they have, you know, board
20 certified in occ med or pulmonary, if that's what
21 they're using. But why don't we just find out?
22 Okay. So you said the thing that you

1 haven't been able to get is the training, the
2 criteria used?
3 MEMBER VLIEGER: We don't know the
4 vetting criteria, and we also don't have the CMC
5 training manual.
6 CHAIR REDLICH: Okay. So there's
7 probably a vetting criteria for just, in general,
8 being on their panel. And then once you're on
9 the panel, depending on what your disease is,
10 would you go to like a neurologist or a -- you
11 know what I mean? Do we know?
12 MEMBER VLIEGER: Like Dr. Welch said,
13 it's they don't look any further than the
14 certifications. They also don't look if they
15 meet the criteria where they're supposed to be
16 actually practicing still, where they're supposed
17 to not get more than 25 percent of their income
18 from doing CMC work, you know. That's the type
19 of thing that nobody ever seems to want to answer
20 --
21 CHAIR REDLICH: But I'm just asking is
22 there a separate criteria depending on what the

1 condition is?

2 MEMBER VLIEGER: Well --

3 CHAIR REDLICH: Criteria for any case.

4 MEMBER VLIEGER: Well, criteria for

5 using a particular CMC, the claims examiners and

6 their supervisors are supposed to choose who is

7 well qualified.

8 CHAIR REDLICH: Okay. So I think,

9 personally, it would be helpful to know, and I

10 don't want to overlap with the clinical

11 subcommittee, but just simply for cases that have

12 to do with Part B, are there specific criteria

13 that they use to decide which CMCs they use? And

14 could they let us know for the past, you know, I

15 don't know, 20 or 30 CMCs. Maybe it will become

16 apparent from the reports, but I think that this

17 is an issue it can't hurt to ask. We would like

18 to know for the last, I don't know, 30 cases

19 reviewed that were under Part B who the, you

20 know, what the credentials were: how many were

21 board certified in what -- or even it seems to me

22 there's a pool of people that then review any of

1 them? I just don't understand quite the process,
2 unless someone else --
3 MEMBER MARKOWITZ: You know, who the
4 CMC is ought to be in the database.
5 CHAIR REDLICH: That's what I'm
6 saying. They should have --
7 MEMBER MARKOWITZ: And we want a
8 larger, I don't know, number per year I can't
9 remember, but we want a larger representative
10 pool. So if we ask for the last couple years --
11 CHAIR REDLICH: And I think the other
12 committee may be looking at this across the whole
13 system, and maybe it is the same across the
14 system. But I think specifically related to
15 beryllium where they, you know, having different,
16 you know, who they're picking. So could we put
17 that in as a request? Carrie, do you understand
18 what we're asking?
19 MS. RHOADS: Yes, I'll write it down
20 and send it to you after just to make sure.
21 CHAIR REDLICH: So we're trying to
22 understand who is actually writing these reports,

1 and we'll get some idea from the claims that
2 we're looking at. We would just like a little
3 bigger look at that question. And then we also
4 would like, if we can see the criteria that are
5 used to pick people, if they have criteria, in
6 addition to who actually got picked. And we also
7 are interested whatever information about the
8 training that these people get. Have we covered
9 those pieces?
10 And then just also related, you have
11 the CMC report, and then how critical is the next
12 stage in terms of the person in, like, the
13 Department of Labor, the person who makes the
14 final decision?
15 MEMBER WELCH: Well, if the CMC report
16 come back and say it's not CBD and the claims
17 examiner recommends a denial and it goes to the
18 adjudication branch and they look through the
19 whole file and make sure it was handled properly
20 and then they send the letter denying the claim.
21 CHAIR REDLICH: Okay. So the claims
22 person pretty much goes along with the CMC

1 report; is that what you're telling me?
2 MEMBER WELCH: Yes, they send it to
3 the CMC because they need a causation opinion to
4 adjudicate the claim.
5 CHAIR REDLICH: Okay. So that carries
6 a lot of weight.
7 MEMBER WELCH: There might be some
8 cases that where the claims examiner can award it
9 based totally on the evidence in the record. But
10 probably most are going to a consulting physician
11 to get a causation opinion, like this is CBD
12 opinion.
13 CHAIR REDLICH: Okay. So I think, in
14 terms of that's something that we should be able
15 to get relatively quickly and have some idea of
16 who's reviewing the CMCs, what their
17 qualifications, at least on paper, are. We
18 recognize that that may not reflect reality, but
19 it's a start. And whatever information we can
20 get as far as their training specific to this,
21 and we'll also get a feel for some of this by the
22 claims that we review. Does that seem like --

1 okay. And then I think, from there, we could
2 decide whether we thought that any more
3 physician-level input would be useful.
4 So, now, Carrie, the list of questions
5 that the DOL came up with, you know, which are
6 all very specific, good questions about what to
7 do about -- they have felt that, after years of
8 looking over these claims -- so I'm just curious
9 who in the Department of Labor came up with those
10 questions.
11 MS. RHOADS: I think it was probably
12 the policy branch, but I can ask who they had
13 working on it, if you want to know specifically.
14 CHAIR REDLICH: I just think that
15 we're trying to sort of -- yes, I think that
16 would just be helpful. People directly involved
17 with the claims --
18 MS. RHOADS: Okay. I can ask them how
19 they put that list together.
20 CHAIR REDLICH: And I don't know, in
21 terms of the claims person, again, that reviews
22 beryllium, is it decided on a geographic basis or

1 the beryllium are funneled to their beryllium
2 specialist claim people? How does that work?
3 MS. RHOADS: Okay.
4 CHAIR REDLICH: Because this is just
5 a small number of all the claims. So it seems to
6 me it might make sense to have your beryllium
7 specialist who are very familiar with those
8 issues, but I don't know. How many different
9 claims people are reviewing these CMC reports
10 just for beryllium?
11 MS. RHOADS: Okay.
12 CHAIR REDLICH: If we're thinking
13 that, at some point, there needs to be further
14 education of people involved in the process, I'm
15 just trying to get a sense of the number of who
16 we're talking about.
17 MS. RHOADS: You mean the number of
18 different claims examiners?
19 CHAIR REDLICH: Well, that are dealing
20 with beryllium.
21 MS. RHOADS: Okay.
22 CHAIR REDLICH: Because I think if

1 we're trying to fix something then it sort of
2 figuring out just the stages that it might need
3 some fixing at. Okay. So are there data and
4 pieces of information that we would like? I also
5 felt what we needed to talk about was sarcoid.
6 MEMBER WELCH: I was actually just
7 looking at how many beryllium sensitivity cases
8 there were, but I can tell you how many sarcoid
9 cases there are in the database. That might
10 help. Let me just do that.
11 CHAIR REDLICH: Yes, but I looked.
12 There were not nearly, there weren't, they're
13 more on the east side. And I guess for anybody
14 who's not directly familiar, sarcoid looks like
15 beryllium disease, and so I do know from seeing
16 some of the data from Hanford and talking to some
17 of the physicians involved that the feeling is --
18 and, actually, I pulled off the internet some of
19 the data they had from Hanford, and the feeling
20 was there was an excess number of sarcoid cases.
21 So rather than getting in the details of one side
22 of things, you know, there are, it can be

1 confusing. If someone has sarcoid and worked
2 with beryllium and, for whatever reason, didn't
3 have a BeLPT done or it was done and was
4 negative, assuming that they had exposure and how
5 common would that be, you could argue for some
6 sort of presumptions in certain circumstances.
7 So I do think that is something that we should
8 consider, and then, right now, the issue would be
9 what other data would be useful to help in that
10 decision-making?
11 MEMBER WELCH: The other thing that
12 can also happen with those cases is that they
13 could go to, become a Part E.
14 CHAIR REDLICH: And the database, most
15 of them are on the E side.
16 MEMBER WELCH: Right. But there's a
17 lot of denials on the E side, too.
18 CHAIR REDLICH: Exactly. So I think
19 I was sort of thinking that -- okay. So to
20 address that --
21 MEMBER WELCH: I guess the question is
22 if there's some data you want at this point, when

1 we go back to our data request, that would help
2 you. Do you want to look at some of those cases
3 specifically?
4 CHAIR REDLICH: Yes. So that's what
5 I was thinking, that the sarcoid cases would be
6 helpful to look at.
7 MEMBER WELCH: Why don't you ask for
8 ten that were approved and ten that were denied?
9 CHAIR REDLICH: Sounds good. So that
10 is going off into the E category, but that's the
11 one pulmonary disease in the E category, unless
12 other people objected, that I thought we should
13 take a look at.
14 MEMBER WELCH: Well, how about cases
15 that were denied -- I mean, there were some that
16 were approved under B, and it would be
17 interesting to know about those. But, I mean, we
18 could ask John to give us a list of, an idea,
19 like, of all the people who were approved for
20 sarcoid under B also were beryllium sensitive,
21 for example. That would make it like that's not
22 a question. But it might be interesting to look

1 at ones that were specifically denied under B and
2 then approved under E to see what additional
3 information was, you know, because E allows a
4 much more open interpretation of the medical
5 results.
6 MEMBER VLIEGER: The other disease
7 that they tend to get shunted to is
8 pneumoconiosis, and that's also an E disease.
9 And just a point of clarification, beryllium
10 sensitivity is an E coverage, Part E like echo.
11 MEMBER WELCH: Oh, because it's
12 medical card only.
13 MEMBER VLIEGER: Right.
14 MEMBER WELCH: Okay.
15 CHAIR REDLICH: I thought beryllium
16 sensitization was B and E. Am I wrong about
17 that?
18 MEMBER VLIEGER: There are not Part B
19 benefits under beryllium sensitization.
20 CHAIR REDLICH: So you don't get
21 benefits, but you file under both; is that it?
22 MEMBER VLIEGER: Yes, that's right.

1 CHAIR REDLICH: Okay. So you could
2 be, in other words, what you're saying is -- is
3 it possible that, let's say, beryllium
4 sensitization, it could be denied, could it be
5 denied in B and accepted in E, or once it's
6 accepted it's accepted in both, but then the
7 benefits you get would potentially be in E and
8 not in B; is that it?
9 MEMBER VLIEGER: Right. The E would
10 follow with one beryllium sensitization, and you
11 would not get Part B, like boy, unless you were
12 approved for CBD, sarcoidosis, or for silicosis.
13 CHAIR REDLICH: Okay. So if you are,
14 if you're approved for being sensitized, then it
15 should be in both B and E; is that correct?
16 MEMBER VLIEGER: Right. Now, you
17 would only get the Part B if you were first
18 approved for beryllium sensitivity or pre-1993
19 CBD.
20 CHAIR REDLICH: Okay. I think I
21 understand. So you raise a good point, though.
22 I think when we are looking at this -- it is true

1 that you could have interstitial lung disease,
2 pneumoconiosis, one of those diagnoses, and --
3 yes, we're getting into the potential category.
4 And that category with sensitization, a category
5 for even without it, but, basically, because a
6 lot of people with interstitial lung disease do
7 not end up getting a tissue diagnosis, but they
8 have a diagnosis of pneumoconiosis or ILD.
9 I eyeballed the data, and it didn't
10 look like there was huge, huge numbers, but I
11 think it would be helpful, John, in terms of
12 we'll add this to the list of the basic data
13 things, at least I think it would be helpful to
14 get a sense of just the numbers. So in addition
15 to sarcoid, at least to get some idea of what's
16 in the pneumoconiosis/ILD category?
17 MEMBER DEMENT: Yes, a lot of the
18 workers list multiple conditions. And if you
19 look across the table, you can see the ones that
20 are approved and not approved. Most of the
21 sarcoid under B, and there are relatively few,
22 have other conditions, as well. Most of the

1 sarcoid looks like it's under E.
2 CHAIR REDLICH: That's right. The
3 sarcoid -- that's exactly -- yes. Sarcoid is
4 under E, that's right, and they tend to be
5 multiple things. So I think it would, because
6 there is the potential that the diagnosis of CBD
7 was called something else, and the things that
8 would most likely be called, if that were the
9 case, would be sarcoid or this
10 pneumoconiosis/ILD.
11 MEMBER MARKOWITZ: This is Steven. B
12 doesn't recognize sarcoidosis as compensable, so
13 sarcoidosis couldn't appear under B.
14 CHAIR REDLICH: That's right, yes.
15 All I'm saying is if we're addressing the problem
16 related to CBD, we're sort of not doing justice
17 if we -- the question is, are there some CBD
18 claims that are in the E category that really
19 belong in B because the person was -- I guess
20 they should be -- ideally, if someone thought
21 that that's what they had, they would file under
22 B, get denied, and maybe they would be accepted

1 under E. I think, Laura, that's what you were
2 getting at.
3 MEMBER WELCH: Yes, and you don't have
4 to worry about cases being under E that weren't
5 reviewed under B. B is worth more to everybody,
6 and the claims examiners look at that. And I
7 don't think that gets overlooked.
8 CHAIR REDLICH: Okay. So I'll tell
9 you what. As a data point that I think would
10 just help to see how big this pool is, would be -
11 - I would propose, as far as the data side, that
12 we look at the overlap of people that have filed
13 a B -- I mean, my guess is if you file for
14 silicosis it's under E, but it's conceivable you
15 also filed under B.
16 But I would simply say for how many
17 total silicosis claims and then how many of those
18 were, as Laura suggested, filed under both B and
19 E.
20 MEMBER WELCH: Well, do you remember
21 that under B you had to work at a lot of test
22 sites for silicosis? I thought you said another

1 site.

2 CHAIR REDLICH: I'm sorry. Excuse me.

3 I meant sarcoid. I apologize.

4 MEMBER WELCH: Oh, okay.

5 CHAIR REDLICH: I apologize. So, for

6 sarcoid. For sarcoid, just because that is so

7 sort of specific in the beryllium issues, let's

8 just look at sarcoid. It does look like -- my

9 look at this, it looks like a lot of the sarcoids

10 were an E. And to me, it seems like that same

11 person would have -- what we're talking about,

12 would have filed under B because there would be

13 more benefit there and might have been denied but

14 awarded under E.

15 But whichever way it is, if we simply

16 got a sense of diagnosis sarcoid, how many are

17 filed under B, how many under E, how many under

18 both, how many are denied, we'll have a feel for

19 what this sarcoid tie is.

20 MEMBER WELCH: Well, the thing is when

21 you look at the spreadsheet a little more, you'll

22 see that there are people who are just -- it

1 seems that sarcoid is not compensable under D.
2 They have to get CBD. But they could have a
3 sarcoid diagnosis and be accepted as CBD, and
4 you'd see that in the -- you'd see, for some
5 reason, they're listed denial for sarcoid under
6 B. And they should all be denied, and there's
7 some that for which there's a yes.
8 CHAIR REDLICH: I know, I know. I
9 spent many hours looking and sorting this data
10 set over the weekend.
11 MEMBER WELCH: If you look at the CBD
12 column alongside, the ones that were accepted for
13 sarcoid were also accepted for CBD and some that
14 were turned down were accepted for CBD.
15 So I think that the sarcoid column
16 under B is going to be extremely confusing
17 because, as Steve said, there's not supposed to
18 be any. They're all supposed to be nos. It's
19 really only there -- the way it would help us is
20 not the yes or no on those but the fact that they
21 came in with a diagnosis of sarcoid and were
22 applying for CBD under B, so --

1 CHAIR REDLICH: Yes, and we may not --
2 from this initial look, because if we don't have
3 the chronology, in terms of just looking at what
4 the piles look like, we could just -- and then if
5 we see what the numbers look like, what if we
6 simply said what number of sarcoid cases are
7 there under, you know, E, and what percentage
8 have been accepted, and what number are under B,
9 and which are under both, something like that,
10 and just see what they, recognizing --
11 MEMBER WELCH: Yes, maybe. And I --
12 CHAIR REDLICH: And there should be --
13 if sarcoid has been accepted under B, there
14 should also be a diagnosis of beryllium disease.
15 MEMBER WELCH: Yes, that's right.
16 I'll --
17 CHAIR REDLICH: So I think if we just
18 see what these piles look like, and I think then
19 we could, you know, we'll look at it and we'll
20 obviously have some additional questions because
21 clear potential cases that would seem not to make
22 sense to me would be if someone had sarcoid and

1 then, you know -- the other one is if they have
2 sarcoid and they are sensitized to beryllium, to
3 me, that should be chronic beryllium disease. So
4 --
5 MEMBER DEMENT: There are no -- 135 is
6 sarcoid, right?
7 CHAIR REDLICH: Yes. Or I'd have to
8 check.
9 MEMBER DEMENT: There are no medical
10 conditions approved under B that have sarcoid in
11 any way. I mean, even in a multiple diagnosis.
12 MEMBER WELCH: Yes, so that makes
13 sense.
14 CHAIR REDLICH: Okay so then they are
15 all under E, so that's -- okay. So that's where
16 I thought they were mostly.
17 Okay. So let's just look at sarcoid.
18 They could have been denied under B. Is that
19 right? But they shouldn't even --
20 MEMBER DEMENT: Yes, they could have
21 been denied under B.
22 CHAIR REDLICH: Okay. So what if we

1 propose this? Let's look at whatever sarcoid is
2 under B, and it appears whatever number that is
3 should have -- are all been denied. But let's
4 just see what number are in that B category.
5 MEMBER DEMENT: In the B category,
6 there are four that are purely sarcoid, and there
7 are four that are sarcoid plus something else:
8 one beryllium disease, one sensitivity, and one
9 just a lung disease.
10 CHAIR REDLICH: Okay.
11 MEMBER WELCH: Yes. Can I just add
12 something? I think the data actually has the
13 date of approval and denial.
14 MEMBER DEMENT: In that calendar year.
15 MEMBER WELCH: Yes.
16 MEMBER DEMENT: We have your approval
17 or denial, so we can look at that.
18 MEMBER WELCH: Right. I just don't
19 know what the initials underneath it stand -- you
20 know, ICY and CY. I couldn't figure that out.
21 So you actually can see what a lot of
22 claims that have a diagnosis date in the '70s and

1 '80s were adjudicated in the 2000s. How
2 interesting.
3 CHAIR REDLICH: Yes, I know. It's a
4 huge lag between the diagnosis on some of them.
5 MEMBER WELCH: Well, that's because
6 people are trying to get before that '93 date, I
7 think.
8 CHAIR REDLICH: So you don't know when
9 it was filed. Okay. So let's do this then.
10 For under -- there's only a handful,
11 so you already could have answered that under the
12 B. So let's now just go to sarcoid under E, and
13 if we could just look at, from the data, the
14 total number of sarcoid cases, how many are
15 accepted, how many are denied, and I guess among
16 those, under E, I think it would be helpful to
17 know if there's sarcoid with beryllium
18 sensitization. If there's sarcoid with beryllium
19 disease, it should be over in B.
20 MEMBER DEMENT: Well, possibly. It
21 could have been filed but denied in B.
22 CHAIR REDLICH: Maybe -- yes. I think

1 you're right. I think we know what we're talking
2 about. We just want to see what's in this
3 sarcoid category that is maybe, you know, been
4 accepted, denied, and what's going on there. And
5 I would propose also then, could we, in the
6 request, when we ask for some CMC reports, if we
7 could request the last ten sarcoid claims? Is
8 that okay with everybody?
9 MEMBER MARKOWITZ: Do you want to
10 differentiate between approved and denied or --
11 CHAIR REDLICH: Why don't we say of
12 the last --
13 MEMBER DEMENT: Well, most of them are
14 denied.
15 CHAIR REDLICH: A bunch of them are
16 denied. That's right. So we need -- why don't
17 we just take the last 15 sarcoid claims and at
18 least ten of them denied.
19 MEMBER DEMENT: Most of the claims are
20 denied, unless they also have beryllium disease.
21 The rest of them are pretty much --
22 CHAIR REDLICH: Yes and what I didn't

1 look is I think the issue is, to me, if they have
2 sarcoid and beryllium sensitization, that's sort
3 of the key thing that -- but also I think -- so
4 let's do the both from the data and requests from
5 review of claims with sarcoid.
6 MEMBER WELCH: I don't think you need
7 to bother. I just looked at it, and under Part E
8 it says if they have a sarcoid approved, they
9 have a CBD approved. All of them, every single
10 one.
11 MEMBER DEMENT: They do. They're --
12 pretty much.
13 MEMBER WELCH: There's a couple that
14 are blank.
15 MEMBER DEMENT: Yes, there are a couple
16 blanks in there but most of the sarcoid have
17 something else.
18 CHAIR REDLICH: So I still would like
19 to look at, I don't know, five or ten denied
20 sarcoid claims.
21 MEMBER DEMENT: Actually, Laura, there
22 are six approved that just are sarcoid.

1 MEMBER WELCH: They don't have
2 anything under CBD one way or another.
3 MEMBER DEMENT: No, they have nothing.
4 If you look at the medical conditions --
5 MEMBER WELCH: You look at the medical
6 conditions, too, over there.
7 MEMBMER DEMENT: The medical conditions
8 that are approved over there --
9 MEMBER WELCH: Yes, you're right.
10 That's 135, you're right.
11 CHAIR REDLICH: I think, you know,
12 sarcoid is something that is pretty specific when
13 someone has sarcoid.
14 MEMBER WELCH: Right. But if they're
15 denied -- yes, you can look at them, but it's
16 like --
17 CHAIR REDLICH: Because it's a whole
18 literature on machining and, you know, there are
19 all kinds of other exposures, but the type of
20 work, and there is an excess of sarcoid in
21 Hanford from this study. I had pulled one I
22 found on the internet including a PowerPoint of

1 data presentation on Hanford.
2 MEMBER MARKOWITZ: This is Steven. So
3 the goal in looking at the denied sarcoid is to
4 look at the level of evidence, whether or not
5 they have any beryllium sensitivity or disease,
6 and then also to look at what affirmative
7 evidence exists that they actually had sarcoid.
8 Is that right?
9 CHAIR REDLICH: Yes, I think the
10 question is if it's true sarcoid and they worked
11 in a place with beryllium, because some people
12 would argue just in terms of probabilities that
13 on a more probable than not basis, that is more
14 likely beryllium disease than sarcoid.
15 MEMBER MARKOWITZ: But the point of
16 looking at the claims is actually to examine what
17 the claim record shows in terms of beryllium
18 exposure and what it shows in terms of --
19 CHAIR REDLICH: Right, exactly. So
20 the question is, is it really truly sarcoid, and
21 if it is sarcoid, is it beryllium disease that's
22 being miscalled sarcoid?

1 And I think, by a look at -- we would
2 have a feel for that because I feel like, after
3 the end of the day, we don't want to then feel
4 like, gosh, we actually missed a group of people
5 that -- and concern has been raised.
6 My understanding is that Hanford also,
7 if you have sarcoid, and I can check because I
8 was reading this last night, and in the Navy, I -
9 - we have the Groton Sub Base here, that they
10 consider sarcoid an occupational disease, in the
11 sub. So I just -- I think we should see what the
12 sarcoid is. They're not a huge number. And
13 then, is it truly sarcoid, and do they have
14 beryllium exposure, as you said.
15 MEMBER WELCH: So there were -- so you
16 kind of figure -- well, there's two categories
17 with sarcoid. There's sarcoid that is beryllium
18 disease accept it as that under the Part E, for
19 whatever reason. And then there's sarcoid that
20 they decided wasn't CBD and of those, there were
21 130 cases in the database, people who applied
22 with a diagnosis of sarcoid primarily and were

1 denied.
2 CHAIR REDLICH: Okay. So what if we
3 took a look at -- requested 15 of those?
4 MEMBER WELCH: That's fine.
5 MEMBER MARKOWITZ: It's Steven.
6 Again, the 15 is just going to get -- it's fine.
7 It's going to give us some hints about what's
8 going on. Knowing that to actually get a more
9 thorough look at possible misdiagnosis or
10 misrepresentation of the validity of the claim
11 that we would need a considerably larger number,
12 right?
13 CHAIR REDLICH: Yes. I was thinking
14 just in this very short run to even get a feel
15 for what other questions we might want about that
16 group and what's in it.
17 MEMBER MARKOWITZ: Because if we look
18 at a limited number and don't find a problem,
19 we're not necessarily going to conclude that
20 there's not a problem, right?
21 CHAIR REDLICH: That's true. But we
22 will also, by looking at the data, we'll at least

1 have some idea of the total number of sarcoid
2 claims in there, which is not huge huge. But
3 that is correct. I guess I would call it
4 exploratory, and maybe we should look at a little
5 bit larger number. They wouldn't take very long
6 to look at, I don't think.
7 MEMBER MARKOWITZ: Well, I mean, for
8 exploratory purposes, you know, we only need a
9 limited number. To get a real handle on it,
10 we're going to need a significantly larger
11 number. So that's fine. I just wanted clarity
12 about --
13 CHAIR REDLICH: That's right, I would
14 consider this -- that's right. It's exploratory.
15 MEMBER MARKOWITZ: Okay.
16 CHAIR REDLICH: That is correct. And
17 I was thinking also if then we do want more
18 information at least it would give us some idea
19 of what information to request.
20 MEMBER MARKOWITZ: Right, right.
21 CHAIR REDLICH: That's what I was
22 thinking.

1 And then, not to prolong this until
2 whenever, but I think once we are looking at
3 sarcoid and because of the point that was made, I
4 feel like we should do the same with the
5 ILD/pneumoconiosis. And you know what, I don't
6 have the data set open now because I didn't want
7 to start cooking on columns and sorting, but I
8 think it would be helpful to know the number of
9 ILD/pneumoconiosis claims, again, accepted and
10 denied, you know, similar questions to that that
11 we're asking about sarcoid.
12 And if -- because if you had a
13 pneumoconiosis and you had a sensitization, a lot
14 of people would say that sounds like chronic
15 beryllium disease. Laura is probably looking at
16 that right now, but I am refraining myself and I
17 am not opening the data. So if we could just add
18 that to the data piece.
19 MEMBER WELCH: I mean, the thing is if
20 you have -- you'll be looking at the interstitial
21 lung disease under Part E includes a lot
22 asbestosis but you don't -- I mean it's a very

1 non-specific diagnosis. Maybe we should leave
2 that for later because there are -- well let's
3 see, there are --
4 CHAIR REDLICH: It didn't seem like
5 that large a number, but I --
6 MEMBER WELCH: Two hundred approved
7 under interstitial lung disease and a lot more
8 denied, like --
9 CHAIR REDLICH: Okay. Since I don't
10 have it open, the other aisle, is pneumoconiosis
11 separate from ILD or is it in the same --
12 MEMBER WELCH: In this spreadsheet,
13 all we got was ILD. So there's, you know, 900
14 altogether, 200 approved and 700 denied.
15 CHAIR REDLICH: Okay. But that's over
16 all these years.
17 MEMBER WELCH: Yes.
18 CHAIR REDLICH: Out of 20,000 claims.
19 MEMBER WELCH: So asbestosis is
20 clearly a different category because there are
21 thousands and thousands of those.
22 CHAIR REDLICH: Okay. So I would

1 propose that we, in the same exploratory way, I
2 think we would want to first look if there are
3 any with pneumoconiosis, or ILD, excuse me, and
4 beryllium sensitization from the data piece.
5 That's really the piece that could be a --
6 potentially an inappropriately denied claim.
7 Does that make sense?
8 MEMBER WELCH: Yes, there are some.
9 CHAIR REDLICH: So I would propose
10 that we also request -- I'll look at the overlap
11 with sensitization. I would think, you know, if
12 they have CBD also then they're in the B
13 category, so we're talking about the people that
14 don't have CBD but have pneumoconiosis,
15 sensitization, and are denied.
16 MEMBER WELCH: There are, you know, a
17 very small handful. There's like six that are
18 sensitized and have a diagnosis date under ILD.
19 CHAIR REDLICH: Okay. So I think --
20 MEMBER WELCH: And they were all
21 adjudicated more than a decade ago.
22 CHAIR REDLICH: Okay. So --

1 MEMBER WELCH: And I don't know that
2 that -- I'm not so sure we'll get much out of
3 that.
4 CHAIR REDLICH: Okay. So should we --
5 then the other pneumoconioses are -- do not have
6 sensitization?
7 MEMBER WELCH: Right.
8 CHAIR REDLICH: Okay. So since that
9 is a grab bag, I would still personally just like
10 to -- because a lot of things get thrown into
11 that grab bag, as just an exploratory thing, I
12 don't -- if we could maybe look at ten of those
13 claims to see what's going into that category?
14 MEMBER WELCH: There's a handful that
15 have -- that were approved that had both
16 beryllium sensitization and ILD, and they're
17 under Part E, and there's a handful that have
18 beryllium sensitivity and were denied for ILD.
19 So you could look at, you know, you could look at
20 five of each of those that are beryllium
21 sensitive and approved and beryllium sensitive
22 and denied.

1 CHAIR REDLICH: Okay.
2 MEMBER WELCH: You won't get more than
3 that many for each one because there's only about
4 that many. There's a few more that were
5 beryllium sensitive approved and ILD, and John is
6 quicker than I to look at the diagnoses. They
7 had multiple lung disease diagnoses.
8 CHAIR REDLICH: Okay.
9 MEMBER WELCH: Accepted as beryllium
10 disease and beryllium sensitivity, and then they
11 have this ILD diagnosis, too, so they may --
12 CHAIR REDLICH: So I guess -- you know
13 what? I think the issue that comes up is and
14 another way to look at it is -- and from talking
15 to some of the physicians involved, it seems like
16 there's many more people have beryllium
17 sensitization than have beryllium disease. When
18 you have beryllium sensitization with another
19 pulmonary condition, that starts to get confusing
20 in terms of, do you have two separate entities or
21 do those two combined and now you have chronic
22 beryllium disease?

1 Since that seems to be an intersection
2 that generates a lot of issues, it might just be
3 good to have a sense of how big that tie is,
4 which really would say, if people have beryllium
5 sensitization, how many of them have some other
6 pulmonary diagnosis?
7 MEMBER WELCH: So in some ways the
8 other thing that comes up with that is that
9 beryllium sensitization, and they have some
10 chronic lung disease that is an interstitial
11 disease, not just COPD, why wasn't their claim
12 already accepted as CBD?
13 CHAIR REDLICH: That's what I'm
14 saying.
15 MEMBER WELCH: Well you won't find --
16 well, you might find those by looking at these
17 ILD diagnosis dates. But I think the problem is
18 then piecing that out of the spreadsheets could
19 be hard.
20 CHAIR REDLICH: Yes. So I would just
21 say why don't we, at least to have an idea of the
22 numbers because basically, a lot of people, once

1 they have a chronic pulmonary condition and they
2 ever smoked one cigarette in their life, that
3 condition is COPD. So I've had lots of patients
4 that are called COPD and they're not COPD. They
5 got ILD and, you know --
6 MEMBER WELCH: Right. Well take a
7 look at whatever number you want, and then we'll
8 go from there because otherwise we're kind of, I
9 think, spinning a little bit.
10 CHAIR REDLICH: Yes. So let's just
11 say why don't we just look at -- because this is
12 an initial look and we'll have some idea of
13 positive BeLPT with another diagnosis in the
14 pulmonary realm and what those are, and then
15 we'll have an idea. You know, because the main
16 pulmonary diagnoses are COPD, asthma, and then
17 this, you know, ILD thing.
18 MEMBER WELCH: Okay.
19 CHAIR REDLICH: And the question is
20 was their diagnoses that they gave us, were those
21 all the pulmonary -- you know, we basically want
22 to see that overlap because that's just a

1 potential pile of things that could be getting
2 denied, then re-evaluated, and -- so just to
3 summarize then, the other categories we wanted to
4 look at was the sarcoid, if we are -- people are
5 getting misdiagnosed as sarcoid, and also if they
6 are sensitized and have a pulmonary condition
7 that's getting not called CBD, what is that?
8 MEMBER WELCH: Okay.
9 CHAIR REDLICH: And then we would have
10 some idea of at least as an exploratory --
11 MEMBER WELCH: Can you make a request
12 that DOL be able to understand, like, you know,
13 it's called this and that, you know, like ones
14 that have a positive, whether B has approved and
15 interstitial lung disease approved, those are the
16 ones you want to look at, that weren't accepted
17 for CBD, is that the group?
18 CHAIR REDLICH: Well, I mean I guess
19 to do this, the first thing we need to make sure
20 is that in the Excel spreadsheet we were given,
21 that that captures the pulmonary conditions.
22 MEMBER WELCH: Well, I guess the ones

1 we asked for. It captures COPD, asthma, and
2 interstitial lung disease.
3 CHAIR REDLICH: Okay.
4 MEMBER WELCH: But it's not everybody
5 with a COPD diagnosis. It's people that have
6 something related to beryllium in some way.
7 CHAIR REDLICH: Well, what we
8 requested was -- no because there are people
9 under there that are in Part E that are not in B.
10 MEMBER WELCH: Right because we didn't
11 get every single COPD E case. We got ones where
12 they had filed for something related to
13 beryllium.
14 CHAIR REDLICH: I think we'll have to
15 clarify that.
16 MEMBER WELCH: You don't want all the
17 COPD cases. There are 10,000 of those.
18 CHAIR REDLICH: I know, but --
19 MEMBER WELCH: We definitely don't
20 want them. I mean we only want the ones where
21 people were asking to be adjudicated for
22 beryllium disease in some way or another, not a

1 COPD case.
2 CHAIR REDLICH: I'm just saying the
3 initial request didn't clarify that, so I think
4 we should check.
5 MEMBER WELCH: And I think what you
6 can see, and this is a visual thing, but you can
7 see what conditions people filed for.
8 CHAIR REDLICH: Yes and I don't have
9 it open now, but when I looked it looked like
10 there were people, you know, if you sorted under
11 COPD, that filed only under E.
12 MEMBER WELCH: I don't know.
13 CHAIR REDLICH: Okay. Well, we'll
14 have to check that in terms of what data we have.
15 MEMBER WELCH: Yes, because I think
16 these are all people who had a Part B claim to
17 start with. I mean, everybody's got something
18 over on the Part B side. So they originally had
19 applied in some way or another for a beryllium --
20 CHAIR REDLICH: Okay, so that's what
21 we want.
22 MEMBER WELCH: Yes, and then they end

1 up on the E side with other diagnoses.
2 CHAIR REDLICH: Okay, that's right.
3 And what we're trying to get a feel for is really
4 do we have people that are on the E side that may
5 be misdiagnosed or denied chronic beryllium
6 disease who have it?
7 MEMBER WELCH: All right. So if you
8 look at people with an ILD diagnosis who are
9 beryllium sensitive and those who are not, just a
10 handful of those, to get some sense of what's
11 going on.
12 CHAIR REDLICH: Exactly. That's
13 right.
14 Okay, and so we're going to look at
15 that on just the numbers data that are not a huge
16 number, and we're just going to do that to get a
17 feel for the overlap with other pulmonary
18 conditions, recognizing that things like COPD and
19 ILD can get misdiagnosed.
20 MEMBER DEMENT: Yes, this is John.
21 It's not clear to me what data we really have.
22 There are people, and a lot of them in this

1 database, in fact most of them, who have nothing
2 in terms of medical conditions filed under Part B
3 but under Part E.
4 MEMBER WELCH: Oh, really? Okay.
5 CHAIR REDLICH: And that's -- I didn't
6 want to open it now on the call, but when I
7 looked at it over the weekend that was my take.
8 MEMBER DEMENT: Yes, and actually the
9 majority of them --
10 CHAIR REDLICH: And the request was,
11 not knowing what the numbers were like, the
12 request was COPD, too. But we can, it's clear,
13 if someone hasn't filed under B, then we would
14 just not look at those for the question we're
15 asking now, right?
16 Because really the question we're
17 asking now is if someone got beryllium
18 sensitized, they think they have a beryllium
19 condition, and it's being called sensitized, but
20 there's possible CBD because those are also the
21 people, a number of the questions that we were
22 asked relate to that cohort, and then what is

1 being done then to evaluate if they have CBD and
2 how frequently and all these other things. So I
3 think at least getting a sense of what that group
4 is.
5 Okay. So I think we at least have the
6 request in terms of the data piece, and then, in
7 terms of the CMC reports that we want to review
8 related to all of this, I think, basically, we're
9 interested in people that have, there aren't that
10 many, you know, with pneumoconiosis and a BeLPT
11 that have been accepted or denied. And I think
12 also, at this point, we're not interested in
13 ancient history. So another way to look at this,
14 since there's not a ton of those claims is, you
15 know, the last ten pneumoconiosis claims and
16 making sure that we include the few that have a
17 positive BeLPT. Is that -- in terms of the
18 actual claims that we're looking at. And I
19 think, in terms of looking at further, it would
20 just be helpful to see what the numbers are with
21 this overlap, you know, how many overlap with
22 COPD and things like that. Is that okay with

1 everybody?
2 MEMBER WELCH: Are you talking about
3 that latter part of the spreadsheet analysis
4 request or something from DOL?
5 CHAIR REDLICH: I think the piece from
6 DOL, I would like to see the grab bag of the
7 pneumoconioses diagnoses.
8 MEMBER WELCH: Okay.
9 CHAIR REDLICH: And I think the other
10 stuff, let's just wait and see how big this pie
11 is.
12 MEMBER WELCH: Okay.
13 CHAIR REDLICH: I think it is an
14 important pie, a piece of it, because those are
15 people that, you know, have a lung condition, are
16 sensitized, and then are being, you know, re-
17 evaluated and the like.
18 MEMBER DEMENT: Are you talking about
19 the silicosis?
20 CHAIR REDLICH: No, all I was simply
21 saying was the people that are sensitized that
22 have some other pulmonary condition.

1 MEMBER DEMENT: Okay.
2 CHAIR REDLICH: Okay. And then I
3 think we decided that -- so for silicosis, I
4 think we would just want the same number of
5 claims. I think silicosis is not as complicated,
6 the number of claims, the number denied and
7 number accepted, and I think we decided we wanted
8 to review, we picked a number of silicosis cases.
9 MEMBER DEMENT: Just on a quick look
10 under Part B, it looks like about half the
11 silicosis cases or slightly less than half were
12 approved.
13 CHAIR REDLICH: Yes, okay. I think,
14 in terms of other data, and we've expanded the
15 data section, we've expanded a little bit some
16 cases we want to review, and with that expansion
17 has included some sarcoid and some
18 pneumoconiosis. And we have talked about also
19 other information related to who is the people
20 reviewing the beryllium claims that we would
21 like.
22 We can get input from whoever is on

1 this call, but is there other pieces of data we
2 think or information that we, at this point --
3 obviously, I think, once we look at things, we
4 will decide we want more, but, at this point, do
5 we have any other asks? Going once, going twice.
6 Any other people we want to talk to? Oh, and I
7 guess, Carrie, we also asked just who came up
8 with the list of questions for us.
9 MS. RHOADS: Right.
10 CHAIR REDLICH: And where they got
11 their -- I mean, I think it's a good list of
12 questions, I just, in terms of their sources
13 because those are issues. Okay. So I think
14 that's a very pretty thorough and good list of
15 data information needs.
16 So in terms of the timeline for this
17 data. So, John, you had volunteered the sort of
18 basic stuff in a week or two?
19 MEMBER DEMENT: Yes, if you can get me
20 the questions, I can, first of all, evaluate the
21 data here to respond to it and get back, and I
22 should be able to turn it around in about a week.

1 CHAIR REDLICH: Okay. And my guess
2 is, when we look at that, we will have other --
3 and I think also what we were going to do in that
4 time and while we're doing that is any other
5 variables that we are hoping we can get for the
6 data piece, correct? And then, in the meantime,
7 we are hoping in the next, like, month or so,
8 that the Department of Labor, just speaking in
9 terms of timeline, would come up with the
10 examples of the recommended, you know, the
11 decisions, the final decision, the statement of
12 facts, and the CMC reports. And, Carrie, you're
13 going to find out what's feasible there.
14 MS. RHOADS: Yes, I'll ask the
15 program.
16 CHAIR REDLICH: Okay. And, ideally,
17 we'd love to get those sooner, rather than later,
18 because we'd like to review them before our next
19 in-person meeting. And I would propose that we
20 pick a time for a call, you know, after we have
21 at least had a chance to look at the basic data,
22 and, hopefully, depending on how long it takes to

1 get the reports --

2 MEMBER WELCH: Well, we have to do the

3 Federal Register notice, so I think we have to

4 pick, we have to give six weeks. So we don't

5 have to pick a date now and then see where we get

6 that in because we have what? Let's see. July,

7 August, September. We have three months, July,

8 August, and September, before we're getting close

9 to our meeting.

10 MEMBER MARKOWITZ: If we pick a date,

11 you know, mid-September, that's probably the best

12 we can do.

13 MEMBER WELCH: Yes, that's what I was

14 thinking, too.

15 CHAIR REDLICH: Okay. So, and

16 actually, six weeks would be in the beginning of

17 August.

18 MEMBER WELCH: Right. So we could

19 wait a little bit and then pick a date, or we

20 could just -- I mean, I suggest why don't we

21 start working on a date in September, and then

22 we'll deal with what we have by then.

1 CHAIR REDLICH: I agree. So Labor Day
2 this year is on September 5th. It's a little bit
3 late. How about if we pick the week after that?
4 MEMBER WELCH: Do you want to do it
5 over the phone or -- I guess we could.
6 CHAIR REDLICH: Yes. So why don't we
7 do this? Carrie, can we have someone send out
8 like either a, you know, invites or, you know,
9 one of those calendar things, whatever, and we'll
10 find a time for a call the week of -- or do
11 people want to do it that week of Labor Day?
12 Right now, does anyone have a strong preference?
13 MEMBER WELCH: I mean, doing it the
14 week of the 12th just gives us that much more
15 time to get --
16 CHAIR REDLICH: Yes, exactly. I think
17 that is better. And Labor Day week is always a
18 dangerous week.
19 MEMBER MARKOWITZ: Why don't you poll
20 people for the week of the 12th and the week of
21 the 19th just to be safe?
22 CHAIR REDLICH: Okay. That sounds

1 good. So our goal is to set up our next call the
2 week of either the 12th or the 19th and, at that
3 point, we will hopefully have reviewed data, have
4 some idea. I mean, in the meantime, we can
5 request -- we don't need to wait until then. I
6 think very shortly we could request additional
7 variables that we would like and go ahead and
8 we'll, you know, however people want to do that,
9 either feed it to me and I feed it to Carrie or
10 if someone else wants to be the person. And then
11 we will, hopefully, by the October call, have
12 reviewed data, even if there's any additional
13 data, and, ideally, some of the reports.
14 So my thought, if we get, in an ideal
15 world, if we get the reports in time to review, I
16 was thinking it would be helpful to make up a
17 little criteria for rejection or whatever thing
18 so that we could then come up with some summary
19 of the reports, and I think it would probably
20 become apparent, once we reviewed some of them,
21 what we would want. So, ideally, we'd be able to
22 sort of say we've reviewed the 50 reports and I

1 think, at that point, have a better feel for some
2 of the issues.
3 And then I guess also, Carrie, by that
4 call, whatever information the additional things
5 that we had requested, in terms of just
6 information about the physicians doing the CMC
7 reports because I think that's probably something
8 either -- they should be able to give that to us.
9 And I think someone had also mentioned also
10 whatever that people that had trouble getting
11 before but at least what criteria there are from
12 the selection and training.
13 MS. RHOADS: Okay. I will pass those
14 on to the program.
15 CHAIR REDLICH: And I guess, you know,
16 if it's something that we can get and it will
17 take extra time or if, for some reason, we can't,
18 then that's probably, you'll probably get an
19 answer relatively quickly.
20 MS. RHOADS: Probably.
21 CHAIR REDLICH: Okay. Are there any
22 other items?

1 MEMBER MARKOWITZ: This is Steven.
2 There are a couple of issues. One is the
3 silicosis is within the domain of the committee.
4 It's a lot more straightforward for a number of
5 reasons.
6 And then, secondly, on the attachments
7 that Carrie sent around, which was from our April
8 meeting where the DOL lists issues that they want
9 help on, there are a number of scientific issues
10 related to CBD that we haven't discussed --and
11 sensitivity -- that we haven't discussed, and we
12 probably don't need to discuss them here now.
13 But we should develop a plan for it.
14 For instance, they've asked for our
15 input into, quote, consistency of testing results
16 among different diagnostic facilities. We're
17 probably not going to get that from the claims.
18 That's probably --
19 CHAIR REDLICH: You know what? Thank
20 you because that was another question I had.
21 And, actually, Laura knows a lot about the
22 literature on consistency. But my understanding

1 now is that there are two facilities doing the
2 testing. Is that correct, or it is more than two
3 currently?
4 MEMBER WELCH: I don't know what
5 happens if you're, you know, if you call up Quest
6 and they tell you what that was. I don't know
7 where it goes. You know, then we send them out,
8 from our program, we send them out to National
9 Jewish or ORISE.
10 CHAIR REDLICH: Yes. So I guess the
11 first question I had related to, those are the
12 only two that I am familiar with. So an
13 important question is are there any other labs
14 that are doing the testing? And that's something
15 that whoever is getting these records would know
16 from reviewing them.
17 MEMBER WELCH: For the Department of
18 Labor's question, are they questioning a
19 particular lab?
20 MEMBER MARKOWITZ: My guess is -- it's
21 Steven. My guess is they see discrepant results
22 between the two labs.

1 CHAIR REDLICH: You know, the American
2 Thoracic Society came out about a year or two ago
3 with one of their official documents that sort of
4 reviewed this. My understanding is that I think
5 there is much more consistency, and you can
6 correct me, Laura, that I think this is more of a
7 history issue, but I think there is --
8 MEMBER WELCH: Yes. I mean, I think
9 that there's a -- DOL did a cross-comparison of
10 labs, but it was probably ten years ago, between
11 what was done in the three reference labs because
12 Specialty in California was doing it. I don't
13 think there's been so much cross-reference
14 between the two, but, you know, you can get, if
15 you take the same guy and test him every year for
16 ten years, you will not come up with the same
17 results. I mean, the data from Wellman or
18 whatever their new name, shows that in their
19 surveillance program. And sometimes it's people
20 who have a very low sensitivity index, and then
21 the next time it's negative, the next time it's
22 borderline, then it's positive. So they're not

1 really, it's not a lab variation as much as it's
2 the biological variation of the test.
3 CHAIR REDLICH: That's right. And --
4 MEMBER WELCH: I'm happy to take a
5 look at what's new on that and just kind of put
6 together a summary.
7 CHAIR REDLICH: I have recently done
8 this, and, honestly, there wasn't, as far as I
9 was aware, of anything really new on this since
10 the ATS document. And I sort of, you know, the
11 newer, more relevant science on diagnostic tools,
12 I just don't think there is a newer or better
13 tool out there now. But it is true that we need
14 to address, I guess, at this point, the question
15 is a plan for how to address this.
16 MEMBER WELCH: You know, if what
17 they're getting, is they're getting reports from
18 physicians that are saying, well, we don't have
19 an LPT, but we've done this something or other
20 and it shows sensitivity. Then they may need
21 help knowing whether to accept that or not. So I
22 think maybe some more clarification, and then we

1 can do that at the next meeting on what the --
2 you know, we don't see there's an issue on moot
3 or variability, but can they be more specific?
4 CHAIR REDLICH: Okay. And maybe, in
5 terms of an approach, I don't really want to
6 propose a whole evidence-based review. I mean, I
7 think there's a recent official document that --
8 but, you know, there are, and I think it's beyond
9 our scope, there's issues of, you know, one test,
10 two tests, and the like, but that's sort of been
11 decided, and that one positive is positive. But
12 I do think there was one or two other questions
13 that I actually wasn't totally clear what the
14 question was, and I would propose, if anyone has
15 -- like, one of them I think I put a question
16 mark on it. I just have to find it. But I think
17 if we have questions that we're not quite sure
18 they're asking, we could go ahead before the
19 meeting and, since Carrie is going to get back to
20 who actually came up with these questions, we
21 could ask for clarification, as far as that goes.
22 And then I think -- but, Steve, you do

1 raise a question. I have an opinion on some of
2 these, and I think it's reasonable, but, like,
3 something like input of false negative and false
4 positive and contribute to that. What I would
5 not like to propose is that we do some evidence-
6 based review on the subject. That's over and
7 beyond. But I think that there are -- and I
8 think we could cite, you know, recent, like ATS
9 document, address a number of these questions.
10 MEMBER MARKOWITZ: This is Steven.
11 Look, I don't think we have the resources or
12 ability, nor are they asking for any sort of
13 systematic review.
14 CHAIR REDLICH: Yes, but I think
15 guidance and I --
16 MEMBER MARKOWITZ: They're trying to
17 take advantage of the fact that, you know, their
18 expertise in the past has not been necessarily
19 all that great, so they're trying to take
20 advantage of the fact that they have some people
21 that will do some work. And I think if a subset
22 of people put together their own consensus

1 opinions that are reference that that would
2 suffice.
3 CHAIR REDLICH: I agree. And I think,
4 at this point, that many of us would be able to
5 do that. Now, I mean, don't you agree, Laura,
6 that I think -- and John -- you know, just in
7 terms of if you've been seeing these people that
8 -- okay. I guess, you know, I was feeling a
9 little bit -- but, like, looking at some of the
10 actual claims reports might add some
11 clarification to some of the questions, and so
12 that's why I didn't want to get too bogged down.
13 And a couple of them are, like, you know, one was
14 on critically ill patients. Yes, you don't do
15 that. And that's one of the reasons why you
16 might not have a tissue diagnosis.
17 MEMBER MARKOWITZ: So maybe in the
18 September call, we can revisit these questions
19 when we know more and kind of identify what our
20 product is and also what our time table is.
21 CHAIR REDLICH: That sounds good. And
22 I think what we could also do by then is, you

1 know, sort of maybe identify those that require a
2 little more time than others. Okay.
3 And then the other issue that you
4 mentioned was silicosis. So I think we had
5 included that in the data requests and also the
6 review of charts request. I occasionally mince
7 my words between silicosis and sarcoid, so we
8 were going to look at the number of cases in the
9 data accepted and then also look at, given a
10 number of silicosis cases and at least, you know,
11 the number that have been denied.
12 Okay. So I think that is the
13 silicosis piece. Do we have other items or
14 issues?
15 MEMBER VLIEGER: I'd like to point out
16 that, along with the review of records that we're
17 requesting, please review the procedure manual
18 for these conditions, particularly CBD and
19 sarcoidosis, as the procedure manual is very
20 convoluted for both the claims examiner and the
21 claimants. And if we could, you know, look at
22 that and maybe clean that up a bit with the way

1 that we look at the wording of it. A lot of why
2 these claims go to a CMC with a really circuitous
3 list of evidence is based on the way the
4 procedure manual has the claims examiner do the
5 work.
6 CHAIR REDLICH: Okay. So now just so
7 we're clear, are you talking about the document
8 that got emailed?
9 MEMBER VLIEGER: No, there's
10 additional evidence. You only sent part of the
11 procedure manual. It's actually a few paragraphs
12 below CBD is where sarcoidosis is. So you need
13 to look at the procedure manual starting under --
14 MEMBER MARKOWITZ: 12C. 12 is
15 sarcoidosis.
16 MEMBER VLIEGER: Yes, but there's more
17 to the procedure manual than what you were sent.
18 It's actually quite lengthy.
19 MEMBER WELCH: At one point, we got
20 sent, in response to a question, a link to the
21 procedure manual, and I can send that or Carrie
22 can.

1 CHAIR REDLICH: Yes. What I had done
2 is I thought I had taken the relevant chapter
3 from it, but what you are saying is that there
4 are other relevant chapters in there that I
5 missed. Is that --
6 MEMBER MARKOWITZ: Actually, it's in
7 the same chapter, but, regardless, you know, the
8 procedure manual is available on the EEOICP
9 website. It's available through the Advisory
10 Board, our first meeting with the references.
11 CHAIR REDLICH: Okay. And I had just
12 resent it. So I agree. And that's something I
13 think -- you had mentioned that it conflicts with
14 some other either pamphlets or information. I
15 think if there is any other sort of documents
16 where there are some conflicts, that would be
17 really helpful to get them.
18 MEMBER VLIEGER: Those are DOL
19 publications.
20 CHAIR REDLICH: Okay. Was there a lot
21 of -- Carrie, is there someone who could take a
22 look and see what other relevant information

1 there is?

2 MS. RHOADS: Well, which ones are

3 people thinking conflict with each other?

4 Because I can look up whichever ones you think

5 conflict.

6 MEMBER VLIEGER: I think, Carrie, if

7 you provide the current pamphlets on CBD and Part

8 B lung conditions, they show a simplified method

9 for what's really required, but then, when you

10 provide that information, it doesn't meet the

11 criteria in the procedure manual.

12 MS. RHOADS: Are you talking about,

13 like, brochures or something?

14 MEMBER VLIEGER: Yes, the pamphlets

15 and the handouts, the one-pagers that are at the

16 resource center and then the handouts that DOL

17 gives out at town hall meetings. There's like

18 five pamphlets.

19 MS. RHOADS: Those should be on the

20 website, as well. I'll take a look and see

21 what's on there.

22 MEMBER VLIEGER: Yes. There's

1 different versions of them, too, and I'm not sure
2 which versions are still active. So it will be
3 important to see if there's more than one version
4 of those.
5 MS. RHOADS: Okay.
6 CHAIR REDLICH: So this is just a
7 general question, and I suspect it will come up
8 under the medical advice subcommittee, but, as
9 institutions have switched to electronic medical
10 records, any medical history has sort of
11 disappeared from some institutions and it's
12 become sometimes even more challenging to get
13 records, at least at our institution. And I
14 don't know if that is a more general problem or
15 not. In this case, I guess we will find when we
16 review some cases because there can be an issue
17 of lack of documentation and then there can be an
18 issue of lack of actually having the record that
19 would have the documentation. And the World
20 Trade Center, that was only, you know, 10 or 15
21 years old, that was a big issue where just not
22 really even being able to get the medical

1 records. So I think we will get some insights
2 into that when we review things. I don't know if
3 anyone has a thought or opinion on that. Laura
4 or --
5 MEMBER WELCH: No. I mean, I think we
6 should, maybe partly because I'm running out of
7 steam a little bit, I feel like we have a lot of
8 stuff that's going to be coming in and we have
9 another call and I can process it all better the
10 next time around.
11 CHAIR REDLICH: Maybe just because --
12 I think let's leave that for now. Okay. I think
13 we have gotten a ton done today. Any other
14 thoughts? Steve, anything else that you think we
15 should be covering?
16 MEMBER MARKOWITZ: No, no, that's it.
17 CHAIR REDLICH: You know what? I do
18 think the overlap between the others, you know,
19 maybe when we have our call in September, it
20 might be good to get a little feedback on the
21 other two.
22 MEMBER MARKOWITZ: Right, yes. I

1 wouldn't worry, you know, I wouldn't worry about
2 overlap at this point.
3 CHAIR REDLICH: Okay. Well, thank you
4 all very much. I appreciate everybody's time.
5 Carrie, do you have anything else?
6 MS. RHOADS: No, nothing else. Just
7 thanks, everybody, for your time.
8 CHAIR REDLICH: Okay. And --
9 MS. RHOADS: And all the work that
10 you're going to do.
11 CHAIR REDLICH: I guess you'll
12 circulate maybe the current understanding of our
13 endless requests, and then we will review it and
14 see if we have it on paper correctly.
15 MS. RHOADS: I can send you a list of
16 what we think the action items are, and also I'll
17 send something around about picking a date for
18 the next call.
19 CHAIR REDLICH: Right. And then we'll
20 also get with John in terms of the data requests.
21 Very good. Okay. I think we are ready to
22 adjourn.

1 And then, in terms of getting feedback
2 from anybody who is on the phone, how does that
3 work?
4 MS. RHOADS: Well, anybody who has a
5 comment, in the Federal Register the comments
6 were to be sent to the Energy Advisory Board
7 email. That can be used for anything, as well,
8 after the meeting.
9 CHAIR REDLICH: Okay. So someone
10 would submit comments or suggestions to that, and
11 then you would pass them on to us?
12 MS. RHOADS: I would, yes.
13 CHAIR REDLICH: Okay, very good.
14 Thank you all. Happy July 4th.
15 (Whereupon, the above-referred to
16 matter went off the record at 1:24 p.m.)
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C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Subcommittee on Evidentiary Reqs. for Part B Lung Conditions (Area 3)

Before: Toxic Substances and Worker Health Adv. Bd.

Date: 06-29-16

Place: teleconference

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

Court Reporter