UNITED STATES DEPARTMENT OF LABOR

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ADVISORY BOARD ON TOXIC SUBSTANCES AND WORKER HEALTH

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SUBCOMMITTEE ON WEIGHING THE MEDICAL EVIDENCE (AREA #2)

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MEETING MINUTES

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MONDAY,

DECEMBER 12, 2016

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The Subcommittee met telephonically at 1:00 p.m. Eastern Time, Victoria A. Cassano, Chair, presiding.

MEMBERS

SCIENTIFIC COMMUNITY:

LESLIE I. BODEN

KENNETH Z. SILVER

MEDICAL COMMUNITY:

VICTORIA A. CASSANO, Chair

STEVEN MARKOWITZ

CLAIMANT COMMUNITY:

DURONDA M. POPE

FAYE VLIEGER

OTHER ADVISORY BOARD MEMBERS PRESENT:

CARRIE A. REDLICH

DESIGNATED FEDERAL OFFICIAL:

CARRIE RHOADS

Introduction and discussion of findings of 14 Part E cases

Ms. Rhoads called the meeting to order at 1:06 pm. The members took turns discussing their Part E cases in detail and gave their general impressions. Member Markowitz began with a hearing loss case. It was clear from the EE1, the claim form and the CE (claims examiner) form which acknowledges what the claim is, that the claim was about hearing loss. The industrial hygienist was asked to weigh in on the issue of solvents exposure and noise exposure, and the industrial hygienist produced a report in which he confirmed that there was exposure to solvents and noise for the requisite period of time, and ultimately the claim was then accepted. It never went to a CMC (contract medical consultant), presumably because it wasn't necessary. It wasn’t clear where the information for the solvents came from in the case file. The solvent-related hearing loss issue is that a person has to conform to one of the 20 job titles in order to have a claim be accepted. Member Markowitz said his only real question was how this particular job title ended up being compensated. It doesn't appear to conform with any of the listed job titles under the EEOICPA.

Member Vlieger’s first claim centered around breast cancer with metastatic sentinel lymph nodes with a subsequent claim made for hypothyroidism and a consequential condition of a hysterectomy and diabetes. They did not discuss an alternative diagnosis. The three diagnoses were accepted by the claims examiner. Member Vlieger considered that reasonable because no evidence was provided for the other two. Member Vlieger thought not all the exposures and causes of conditions were evaluated, because they didn't actually look at chemotherapy as the cause of the diabetes or that it contributed to the hypothyroidism. Member Vlieger thought that some of the claim was done properly and some of it could have been done better. There were some claimed medical conditions that did not make it to the CMC and no one knew why. In a lot of the documents the thinking wasn’t entirely clear.

Member Pope’s first case was congestive heart failure and rheumatoid arthritis. The case was denied. The stopping point in the case was the slim amount of information. It appears the department used the SEM to try to make the connection to the

health concerns which did not prove to be connected to the health concern and the claim stopped there. Chair Cassano said it’s troubling to see that the ball sometimes gets dropped and nobody knows why.

Chair Cassano’s first case was on ischemic heart disease and rheumatoid arthritis. The claim was remanded and then denied. The claimant did not initially provide medical documentation, so the department had to go back and ask for more medical documentation. The question is, were all exposures that might have caused the claimed condition evaluated? The claim was not sent to an industrial hygienist. It doesn’t seem like claims examiners are following the guidance because the guidance specifically says that the SEM is never to be used by itself to deny a claim. On cases that are uncertain, the claim should be reviewed by a CMC before denial. There could have been a little bit more involvement in the evaluation process in this case.

Member Silver’s first case was kidney cancer and TCE (trichloroethylene). The claimant did not have an opinion from a treating physician or any other outside expert. But when DOL received the claim, they got a hit in the SEM for this person's job title and a renal carcinogen, TCE, being in the matrix in that period of time at the site. The claim was referred to an industrial hygienist who concluded that the employee had significant exposure at low levels. The claim was paid exactly a year from the time it was filed. So this is a success story for the SEM supporting a cancer claim. This was essentially a trainee who was at a gaseous diffusion plant for three months, judged to have low level exposure to TCE, but causation was found and it was compensated. Member Silver noted that this is like the way NIOSH handles Part B radiation claims. NIOSH talks about efficiency processes where if they can get to a decision on the basis of some of the facts, they close the claim and pay it.

Member Vlieger had a case on lymphoma and breast cancer. This particular one is from a facility that does not have a SEM, and in the documents from the Department of Labor, they stated that they searched the SEM and could find no toxins that the claimant could have been exposed to for the site. There was a definitive diagnosis by biopsy of the lymph nodes. Member Vlieger could

not find the biopsy for the breast cancer, but it was accepted in the statement of accepted facts that there was a biopsy and that the claimant did have these diagnoses. There was nothing in contention because the claims examiner did not find any toxins that could have caused either breast cancer or lymphoma. This was an obvious case where the CE stopped at the SEM, went no further and the claim was denied.

Member Boden did one of his cases on diabetes, among numerous other conditions. This person claimed diabetes as well as multiple out conditions theclaimant contended they suffered: : colon cancer, lung cancer, cardiomyopathy, obstructive sleep apnea, hypertension, chronic beryllium disease and dyslipidemia. There were no medical opinions regarding causation from any of the treating physicians involved. There was also no evidence that the claim was referred to an industrial hygienist, although the question of causation for the COPD might well have used an industrial hygiene evaluation. The colon cancer was never developed for this case. In reference to the claim for COPD, the district office in this case determined that the claimant’s exposure to nitrogen dioxide was heavy and extended and according to the SEM, nitrogen dioxide is a substance linked to COPD. But that exposure was not part of the charge to the CMC, and therefore wasn't considered. The claim was denied.

Member Markowitz had two more claims, one for Parkinson’s disease and sleep apnea. There’s no question that the person had Parkinson’s disease and sleep apnea. The claims examiner obtained a coworker affidavit, which is very useful because the job title didn't necessarily translate to manganese exposure. The affidavit was relied upon by the claims examiner to confirm the exposure. The only question Member Markowitz had here was not one of process, but of outcome. He thought the sleep apnea was a stretch to link to either Parkinson's or the chemical exposures. However, the toxicologist said that there was no epidemiological evidence that TCE causes Parkinson's disease, though that's not quite where the literature is at this point.

Member Pope talked about a bladder cancer case. The case was approved with the support of medical documentation. The claimant used a district medical consultant. Member Pope also noted that

it seems the more support claimants have the better off they are.

Chair Cassano presented a colon cancer, breast cancer, and skin cancer (basal and squamous cell) claim. The claimant was a computer analyst and security escort to nuclear areas. The department only looked at radiation. She was not considered a member of a Special Exposure Cohort. The department used IREP and found 11 percent probability of causation, but they did each individual cancer, and then they did them from multiple cancers. They did not look at any other exposures because the computer analyst job description is not listed in any SEM, and that was the end of the case. It was sent to NIOSH for a dose reconstruction, then for evaluations at IREP. It was not referred to a contract medical consultant. The reason for that was that the claimant was considered not to have been exposed to radiation. Again, all possible exposures present at a work site need to be evaluated, regardless of whether SEM is silent. In many cases, collateral exposure is experienced when individuals, work in, around or are traversing an area with known exposures.

Member Boden also had a meningioma and skin cancer case. The person was an explosives handler and machine operator from 1958 to 1966. The diagnoses for both the skin cancer and the meningioma were supported by objective medical evidence. But as in all the other cases the committee talked about, there was no treating physician statement of relationship between the disease and occupational exposures. The CMC gave what seemed to be a reasonable report based on the questions that were given to him. He said that he did not think that there would've been enough exposure, and that some of the cellular changes that one might have expected were unrelated to machining oil exposure. Given the fact that the person had spent 50 years as a farmer it was unlikely that he could meet the more likely than not standard for the skin cancer. The meningioma was not developed. Why the meningioma was dropped at the point of the claims examiner is a mystery.

Member Markowitz talked about a prostate cancer case. Prostate cancer was accepted under Part B. It met the threshold for probability of causation which means it was automatically

accepted under Part E. The only issue was heart disease and a long-term chemical exposure; there was no question about the diagnosis. The medical records were nicely assembled. The whole issue of heart disease was not developed at all. There was nothing from the treating physician. It wasn't sent to an industrial hygienist or a CMC. The SEM was explored and probably came up with nothing.

Chair Cassano reviewed a case on multiple immune disorders. The person was a lab technician. There was no other delineation of what kind of lab tech this person was. She did say in an occupational history questionnaire that she would take contaminated materials and laundry back and forth from the sites and do testing on various liquids to see if there was contamination. It was not clear exactly what process the claimant was talking about. Her other contention was anemia.

The only one that was evaluated was the anemia because the SEM was silent on all the others. It is unknown if she was working with organic solvents. Some autoimmune disorders, like scleroderma, are associated with some organic solvents, but they only looked at anemia. The claim was therefore not referred to an industrial hygienist, but it was referred to a CMC only for the anemia. It turns out that her anemia was an iron deficiency anemia, so the CMC opined that it could not have been due to a toxic exposure, which is probably correct. The entire claim was denied for no evidence.

Member Boden said there seems to be some slippage in documents getting into the claims files and that many of the people who are filing claims are not really in a very good position to advocate for themselves.

Discussion of training documents

Chair Cassano asked the committee to look at whether the training documents are complete, whether they have clarity, whether they are based on current scientific evidence and current policy, and also whether or not they have any gaps. The department does have basic framework training, and this training is put up on the document library. This training material demonstrates the overall application of the process guidance. The department does have a huge volume of case-specific training

because the training itself has to be applied. The committee thought that the claims process document was excellent. The documents were carefully put together and make it clear that when in doubt, one should lean toward the claimant. There is a document on the issue of causation that addresses aggravation, contribution and causation that should make its way into the training materials. The information that is initially collected by the claims examiner needs to go to the CMCs.

One of the frustrating things for claimants is when something is prescribed, the department requires that it be prescribed by a doctor. If a PA or a nurse practitioner does something, for example, home health or a medically necessary piece of equipment, the department defers back and requires that a doctor prescribe it. It was noted that the statute itself requires a qualified physician’s opinion.

Member Vlieger asked if there was a list of diseases that the claims examiners have or some sort of play book that they're using so that they question some diseases and don't question others. Where are they making these decisions from? The committee expressed its desire that the CMC see the broader set of records to ensure that that person can capably answer the questions that are being posed. It’s a safety net in case the claims examiner doesn’t provide everything that is needed.

Member Markowitz said the question, “If the SEM is no longer going to be updated or even looked at for new data from Haz-Map, where are they going to get their occupational disease list from if they don't allow them to go outside the department?” would be a good one for the SEM committee. He said that from the cases reviewed by the committee, there was a clear use of the occupational health questionnaire and consultation with the industrial hygienists – not just an exclusive reliance upon the SEM. For Part E cases, there is an occupational questionnaire for every single case.

Development of logistics and format for focus groups with Claims Examiners

The committee reiterated its desire to talk to people intimately involved in the claims examination process. It would be good to speak with actual claims examiners. Speaking to individual

claims examiners may be difficult because they are bargaining unit employees. The number of participants in the focus groups needs to be limited in order to be effective. Chair Cassano said that she would compile questions for the focus groups and put the questions in a formal request to the department. The committee asked that a skilled facilitator conduct the focus groups.

I hereby certify that, to the best of my knowledge, the foregoing minutes are on accurate summary of the meeting.

Submitted by:

Victoria A. Cassano, MD, MPHIL, MPH
FACPM, FACOEM
Chair, Subcommittee on Medical Advice for CEs re: Weighing Medical Evidence
Advisory Board on Toxic Substances and Worker Health
Date: __________