UNITED STATES DEPARTMENT OF LABOR

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ADVISORY BOARD ON TOXIC SUBSTANCES AND WORKER HEALTH

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SUBCOMMITTEE ON MEDICAL ADVICE FOR CEs REGARDING WEIGHING MEDICAL EVIDENCE (AREA #2)

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TUESDAY, SEPTEMBER 13, 2016

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

MEMBERS

SCIENTIFIC COMMUNITY:

KENNETH Z. SILVER
LESLIE I. BODEN

MEDICAL COMMUNITY:

STEVEN MARKOWITZ, Board Chair
VICTORIA A. CASSANO, Subcommittee Chair

CLAIMANT COMMUNITY:

DURONDA M. POPE
FAYE VLIEGER

DEPARTMENT STAFF:

CARRIE RHOADS, Designated Federal Official
JOHN VANCE, Policy Branch Chief, DEEOIC

A-G-E-N-D-A

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

1:00 p.m.

MS. RHOADS: Hi, everybody. Good afternoon or good morning depending on what time zone you're in.

My name is Carrie Rhoads and I'd like to welcome you to today's teleconference meeting of the Department of Labor's Advisory Board on Toxic Substances and Worker Health, the Subcommittee on Medical Advice for Claims Examiners Regarding Weighing Medical Evidence.

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

First, we appreciate the time and diligent work of our Board members in preparing for this meeting and for their forthcoming work.

I'll introduce the board members on the subcommittee and do a quick roll call. If everyone could just please respond when you hear your name.

Dr. Victoria Cassano is the chair of the Subcommittee.

CHAIR CASSANO: I'm here.

MS. RHOADS: And the members are Dr. Leslie Boden.

MEMBER BODEN: Hi.

MS. RHOADS: Ms. Faye Vlieger. I'm not hearing Ms. Vlieger. If you're on please let us know.

Ms. Duronda Pope.

MEMBER POPE: Here.

MS. RHOADS: Dr. Ken Silver.

MEMBER SILVER: Here.

MS. RHOADS: Dr. Steven Markowitz.

MEMBER MARKOWITZ: Here.

MS. RHOADS: And he's the Chair of the Board. And we're scheduled to meet from 1 o'clock till 3 o'clock Eastern Time today.

In the room with me is Melissa Schroeder from SIDEM, our contractor, and John Vance, Policy Branch Chief for DEEOIC.

At our previous meeting the Subcommittee had requested that someone from the Program be present at the Subcommittee meetings.

So, regarding the meeting today I don't think we are going to plan to take a break unless someone would like to. We'll just go the full two hours.

Copies of all meeting materials and any written public comments are or will be available on the Board's website under the heading Meetings and the listing there for this Subcommittee meeting.

The documents will also be up on the WebEx screen so everyone can follow along with the discussion.

The Board's website can be found at dol.gov/owcp/energy/regs/compliance/advisoryboard.htm. Or you can simply Google Advisory Board on Toxic Substances and Worker Health and it will probably be the first link you see.

If you haven't already visited the board's website I encourage you to do so. After clicking on today's meeting date you'll see a page dedicated entirely to today's meeting.

The page contains publicly available

materials that are submitted to us in advance of the meeting. And we will publish anything that's provided to the Subcommittee there.

You should also find today's agenda and instructions for participating remotely. If you are participating remotely and you're having a problem please email us at energyadvisoryboard@dol.gov.

If you're joining by WebEx please note that the session is for viewing only and will not be interactive. The phones will also be muted for non-Advisory Board members.

Please note that we do not have a scheduled public comment session today. The call-in information has been posted on the Advisory Board website so the public may listen in but not participate in the committee's discussion.

I've been asked about meeting minutes and transcripts also.

The Advisory Board voted at its April 26-28 meeting that the committee meeting should

be open to the public. The transcript and minutes will be prepared from today's meeting.

During the Board discussions today, as we're on a teleconference line, please speak clearly enough for the transcriber to understand.

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

Also, I'd like to let our transcriber know -- please let us know if you're having an issue with hearing anyone or with the recording.

As the DFO, I see that the minutes are prepared and ensure they're certified by the chair. The minutes of today's meeting will be available on the Board's website no later than 90 calendar days from today, per FACA regulations.

If the minutes are available sooner, we'll put them up sooner. Also, although formal minutes will be prepared, we'll also be publishing verbatim transcripts which are going to be more detailed in nature. Those transcripts

should be available on the Board's website within 30 days.

I would like to remind the Advisory Board members that there are some materials that have been provided to you in your capacity as special government employees and members of the Board which are not for public disclosure and cannot be shared or discussed publicly including in this meeting.

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

And with that, I convene this meeting of the Advisory Board on Toxic Substances and Worker Health Subcommittee on Medical Advice for Claims Examiners Regarding Weighing Medical Evidence.

And I'll turn it over to Dr. Cassano

who is the Chair of the Subcommittee.

CHAIR CASSANO: Thank you very much, Carrie. Good morning, good afternoon, everyone, including Board members and members of the public.

What I wanted to do first was to do a little bit of recap. This is our second -- just to go back to the agenda, this is our second Subcommittee meeting.

I wanted to first of all go through what we were asked to accomplish at the Subcommittee.

And we were asked specific questions by the Program, specific places where we could help.

Number one, clarifying and make recommendations regarding the assessment of medical opinions, especially about rationalization to support a particular conclusion and if there were any standardized triggers that we could come up with.

Second was our methodologies for

improving physician responsiveness.

Third was training resources for improving the quality of medical review of the medical evidence, and some type of guidance regarding assessing contribution or aggravation to a preexisting disease.

That was a pretty tall order. And in order to be able to accomplish that, we felt that we really needed a better understanding of the process that the CEs go through.

And in regard to that, we sent a list of action items to the Program and we got, about a month later, we got our responses. And then Dr. Markowitz and myself had a conversation with the Program, sometime late in August, so that we could do a little bit more clarification.

But other than seeing these results, the rest of the Board members have not had a chance yet to talk about their understanding and their appreciation of the responses that we got from the Program.

So I wanted to open this up, primarily

to the other Board members, for each of them to be able to talk about what their concerns, or whether they have additional questions, regarding the answers that we got.

And then myself and Dr. Markowitz can certainly chime in. We'll do a little bit of the summary of what we learned in our subsequent phone conversation.

And then we really need an open discussion about how to proceed from here. And to develop a real timetable for meeting with claims examiners, review of the claims process from the CEs' perspective.

And then you develop some type of report on our findings, concerns, issues, et cetera and then development of deliverables. So we have a lot to go through to develop this timetable.

And so I do really want to get started. Before I do that, Dr. Markowitz, do you have any opening comments?

MEMBER MARKOWITZ: No, I just -- the

next step is that we're going to walk through the responses from DOL and --

CHAIR CASSANO: Well, I'm not going to read them. But I think I'm going to talk about -- I'm going to ask that we go through each one of these answers. I'm not going to read through them. But to see if there are subsequent questions that the other board members have -- because I don't think they've had an opportunity to discuss that. Does that make sense to you?

MEMBER MARKOWITZ: Sure, sure.

CHAIR CASSANO: Okay. So the first question that we asked, or the first issue that we presented, was whose responsibility is it to gather information that would support a medical opinion?

In other words, information from IARC, information from any of the -- EPA, scientific research studies, et cetera. And the response we got was, that's really the claimant's responsibility.

And after further discussion with

them, we found out that they actually -- if there's a treating physician who is not expert in this area, they can actually their patient to someone who is knowledgeable.

And that cleared up a lot for me as far as how, you know, medical research or epidemiological research is brought to the table in discussing a person's case. So I'd like other people to chime in on that one in particular, if they have any issues or questions.

MEMBER MARKOWITZ: This is Steven, let me just kick this off here. I don't confuse DOL's response that -- I'm not sure where this phrase came from, consensus documents from learned bodies, in this quote. I also don't remember where that came from.

The underlying issue is how the expertise that's needed on the causation side, and even frankly on the diagnosis side. How's that countered? How does that impact the process of claims review and determination?

And clearly it can come from the

claimant's position. It can come from the in-house industrial hygienist. It can come from the CMC. And the CE is kind of the focal point, the traffic person to assemble, and in some sense, make a decision based on this expert input.

CHAIR CASSANO: Anyone else with comments on this?

MEMBER BODEN: Yes, this is Les Boden. I sort of have a question about the Committee's thinking about these issues. So one of the things that I could imagine that the Committee might think about doing is trying to develop procedures that would synthesize and make the claims examiner's job easier and more transparent.

So I guess a question for the Committee down the road is whether, for specific covered illnesses, there should essentially be some kind of manual that describes what's in the, as we put it here, consensus documents from learned bodies.

It sounds like de novo each time a

case with a specific condition comes up, that there's going to be a presentation of received wisdom. And there's a question in my mind about whether that's the best way to do it.

CHAIR CASSANO: I think my understanding of this is that it has to be synthesized into an opinion by someone with the expertise. So it's not the CEs responsibility to read the IARC manual on QCE.

That would either be the treating physician or the -- whoever the treating physician refers to to get that medical opinion -- the industrial hygienist or toxicologist or the contracted medical consultant.

They would put all of the references together, and then synthesize those references and medical opinions. We might be able to develop some types of training documents for what we'll see later on their priority list, with some references, and a synthesis of those references with a generalized opinion about whether or not -- not on a specific case but in general, the

literature or does not support a causal relationship.

And that's sort of would be the first step towards quote unquote presumptions, if we were to go that far. Anybody else with comments or questions on this?

MEMBER MARKOWITZ: Yes, this is Steven again. So Les, could you just work through an example of what you're talking about? Because it seems like it's a way to streamline the consultation with the Haz-Map, which might make the CE's life easier and the decisions more transparent.

So could you just play out an example, for instance, of what you have in mind?

MEMBER BODEN: Well I might be able to start a discussion about it. I'm not sure I could play out a full example. But the idea would be, sort of, the CE is taking in information from various sources, whether it's the treating physician or another expert or a CMC, et cetera.

And the question is - wouldn't we want consistency over time, and over cases, in how various consensus documents are used? Understanding that each individual case is unique.

So let me give you an example from one of the sets of cases that we looked at, where a question was what was the degree of impairment of a particular individual?

And essentially the rule was that the doctor had to look to the AMA guides and describe something that was consistent with what the AMA guide said. So the AMA guides then, in this case it was specified in law I think, told the doctor sort of what they had to do to apply to a specific case.

You could imagine a similar kind of situation for deciding whether a particular illness was caused by or aggravated by work exposures, where you would pull together sort of consensus documents on the relationships between your occupational exposure and disease outcome.

Does that clarify at all?

MEMBER MARKOWITZ: Yes, well, sort of.

MEMBER BODEN: Yes.

MEMBER MARKOWITZ: It seems like, for commonly encountered conditions, an expedited form of what the Haz-Map does within the SEM. And it's conceivable, you know the devil's in the details, but it's conceivable it would make things more straightforward and probably consistent.

MEMBER BODEN: Yes.

MEMBER MARKOWITZ: But we'd have to play it out and see what one looks like and see if it makes sense.

MEMBER BODEN: Right. I'm not saying that this would necessarily be a one-day job, but that it might be something that would improve both the efficiency of assisting, and the consistency of how evidence is handled across cases.

MEMBER MARKOWITZ: Okay.

CHAIR CASSANO: Okay. Anyone else

with comments on this, and then we can move to the next?

MEMBER SILVER: Yes, Ken Silver here. If we do develop such a resource, I really hope it would not be bottled up in the realm of not publicly releasable documents, like many of the those that have been provided to us.

The reason is, if the claimants knew what target they were aiming at to persuade the claims examiner, they might work with their physician to submit a file that already contained some of that evidence.

CHAIR CASSANO: Okay. Can we -- now the next issue was an issue regarding the types of medical evidence, and the question was asked: does all of the medical evidence go to the CMC?

And the response we got was only medical evidence determined to be relevant. And I think that both Dr. Markowitz and I sort of had the question of, well how does someone without medical training determine what is relevant?

And I think our conjoined opinion, if

you would, was that the way we're going to be able to do that is to look at some of the cases and also, in talking with the CEs in the CE form, to determine, hey, why do you consider this relevant, but this not.

So that's something that we're going to have to find out down the road. Does anybody else have any comments about this that is different than what's been discussed?

(No audible response.)

CHAIR CASSANO: I hear none, so moving right along. And then the next question was about duty to assist. And really the answer there was, there is no regulatory duty to assist.

But they do help with phone calls and talking to treating physicians in trying to tease out the information that they need to answer the claim. So that one was relatively straightforward. The next one --- discussion --

MEMBER MARKOWITZ: It is Steven. Let me just ask a question before we move on. So I think, from our full meeting in April and then it

appeared again on this call, this question about duty to assist.

And DOL's response is there is none officially but we do it. So my question, really to the other members, is whether -- is there a problem here? Because, you know, apparently the routine procedure is that the claims examiners are assisting. And if the perception is that it's violated sometimes, or not infrequently, then maybe there's something that we should look at.

CHAIR CASSANO: Good point. And that would take the individual personality of the CE out of it, as well if there was some standardized regulation regarding, or at least policy maybe not regulation, regarding this is what the CEs must do to assist the claimant in developing the claim, and not just them flow around. Any other discussion on that --

MEMBER MARKOWITZ: This is Steven again. The procedure manual I'm sure addresses this, I haven't memorized it yet, but I'm sure

there's some direction given to the claims examiner about assisting.

Perhaps this is just one of those issues that, if we get around to looking at claims, we can look for evidence of this.

CHAIR CASSANO: Yes. Good point. The next one was sufficient evidence and historical wages. I think I still have an issue with trying to figure out how a doc is supposed to do that.

I think, in our phone conversation with the program, we were told that basically, if there's information about when the person was taken out of work, was the person put on light duty, that works if you've got a treating physician that's been around and the issue was relatively soon -- you know, relatively recent, but a lot of that information is not going to be available.

And so we do feel that this is still problematic and maybe not something that the clinician should really be responsible to do. It just seems more of an economic issue than a

clinical issue.

Steve, do you have any further comments? Or anybody else have any further comments?

MEMBER MARKOWITZ: No, I don't.

CHAIR CASSANO: Okay, anybody else? And the gentleman from the program that's on the call with us, if at any time you want to chime in and set us on a clearer path, please feel welcome to do so.

MR. VANCE: Thank you. This is John Vance. I appreciate that. I'll certainly identify anything I think that is important or noteworthy but, for the most part, I'm just going to sit and listen. And if I do hear something, I will definitely chime in. Thank you.

CHAIR CASSANO: Thank you. Thank you, very much. And the next is sort of a procedural thing about paper trails, telephone requests -- I don't think there's much discussion on that. It's all supposedly in the record.

On unavailable records, the biggest

question we had was -- how do you do this? Do you guys get a blanket release of medical records, so that the claims examiner can go and talk to whatever physician is on the list?

Or really more, again, a procedural question. And then the subsequent question is -- so if you can't get any medical records, how do you decide the case? Is it just an automatic denial?

That's my takeaway. I think Steve -- I don't know if Steve has some more takeaway from the conversation, but we do need other people's input here.

MEMBER MARKOWITZ: This is Steven. I'm rereading the DOL's response. I actually don't fully understand it. If no records exist, then I guess the CE goes to the treating physician to get whatever they can get about their knowledge.

But that means that records exist. So I'm not sure that I really get what happens when no records exist.

CHAIR CASSANO: Yes, I don't know how they would proceed. I mean, I would think that if it was something that was basically common knowledge, or at least well represented in the literature.

If you have a definitive diagnosis and you have a definitive exposure, then you can say the CE might be able to ask the CMC to make a decision, but if you don't even have a definitive -- I mean, you can send somebody, I guess, to another physician to get a diagnosis. And I guess the SEM would determine whether or not they were exposed.

So, in that case, I guess it could go to a CMC and there could be a decision made that's -- is that the process that's used in that case? Or do they just say, you know, sorry you don't have any medical evidence, you don't have any record. We can't approve your claim.

MR. VANCE: This is John Vance. I guess I'll use my permission to speak at this point.

(Laughter.)

MR. VANCE: Let me see if I can get some clarification. You have to keep in mind that these cases can identify sources of information that might not necessarily be medical from the onset.

So if we're talking about a survivor claim, somebody might indicate in that case -- well, you know, my father or my mother was treated at a hospital outside of Denver, and this is the hospital, this is the doctor.

We have some information about this facility, so that may be a lead that the CE may explore to try to contact the hospital to see if those records exist, but at the end of the day, Dr. Markowitz is correct. That if we have nothing, if there's no information, if we have nothing from the employee or nothing from the survivor, there's no avenues of development and we have no further medical documentation, then that case is not going to have a positive outcome.

In other situations where we have various types of medical documentation, but we don't really have a clear diagnostic opinion from a physician, those are instances where, if we're talking about an individual who passed away some time ago, we're looking at historical records.

Well, we would send that, probably, to a CMC, asking the doctor, you know, based upon this information, is there any basis to believe that this person had a condition that contributed to their death and was associated with the process of their exposure.

And, you know, if you can get that type of an affirmative response from a physician. And you are able to assemble some sort of medical documentation from the doctor to opine on, and so that's what we do.

But you have to keep in mind that these cases are extremely disparate. They have all kinds of assemblies of information and data that can lead a CE in different directions for development, but at the end of the day, if there

is absolutely no medical documentation in the file to support a diagnosed condition, then we're going to be without any avenue to get to a positive outcome.

CHAIR CASSANO: Okay, so you -- I mean, but you could recommend to the claimant that he's got to know that he now needs to go to a doctor and get a diagnosis, yes?

MR. VANCE: Yes, if you're talking about a living employee --

CHAIR CASSANO: Right.

MR. VANCE: -- but if you're talking about someone who's deceased, that's not going to be a possibility.

CHAIR CASSANO: Yes. Okay. Any other further discussion on that? I mean, that's what we thought would happen.

MEMBER MARKOWITZ: This is Steven. John, does that mean -- this issue of truly unavailable medical records is mostly an issue with the survivors claims?

MR. VANCE: Yes, I would say that's

generally the case. But, you know, when you're talking about individuals that were, you know, working at these places in the forties and the fifties and then passed away in the seventies.

Those are the toughest cases that we encounter for obtaining medical documentation. And the only thing we generally get in a lot of those cases is the death certificate. And that's why we utilize that in a lot of those types of cases to establish diagnosis.

MEMBER MARKOWITZ: Thank you.

CHAIR CASSANO: Any other comments/ questions on that? Okay. And the next issue was, again, this issue of weighing medical evidence, which is probably the stickiest wicket here.

We asked how are the CEs trained in weighing medical evidence. And the answer we got back was the CEs are trained to evaluate all evidence that's submitted in a case file, but we still don't have a really good answer on exactly how they're trained, what kind of training

materials, et cetera, to be able to tease out medical evidence.

The procedure manual talks about what methods to apply, but it doesn't have, I would call, an artificial intelligence to say, yes this diagnosis makes sense, this diagnosis doesn't.

Or, you know, the person smoked for 45 years and the smoking is more relevant than the exposure. So I think the answer, again to this as far as we know, is that we're going to have to talk to more CEs about this. And there are some training documents available. But, as I understand the process and what we were told on the phone, is that it's really the senior CEs that work with the newer people and get them up to speed and help them understand how to do this.

And that training materials may be available, but there's no standardized training manual, I guess, other than the procedure manual. Anybody else want to chime in?

MEMBER VLIEGER: Good morning, this is Faye. Can you hear me?

CHAIR CASSANO: Yes.

MEMBER VLIEGER: There was a problem with me calling in. I've been attempting for nearly 20 minutes to talk, and the moderator never came on. So here I am.

While it's all well and good that they say that their CEs are trained, and John you can chime in any time you'd like, the training depends on the background of the individual and it is not what I would call standard.

While there is standardized -- the CE's work is not standardized. And the recent report that came out, the 2015 audit, found that there was more than a 10 percent error going on in the way that claims were developed and processed by the CEs. So I think it would be well worth our time in looking at those training materials.

CHAIR CASSANO: Yes. We asked to see them, I believe. That was during that phone call, I believe we were told that they would get what they could to us. So that's on its way. We

do need to look at that.

MEMBER MARKOWITZ: Let me just chime in.

CHAIR CASSANO: Yes.

MEMBER MARKOWITZ: I think that I remember that the training materials are limited because much of the teaching is around specific examples, which are not volunteered to be standards or standardized across positions.

I'm sure we can get whatever training materials exist. But it'll leave the question whether we should be looking into, you know, a more standardized stereotypic type of training, but --

CHAIR CASSANO: Yes.

MEMBER MARKOWITZ: -- not that we need to answer that now, but I suspect that that's going to be on the table.

CHAIR CASSANO: Yes. And I think we all agree on that. Does anybody else have any input?

MEMBER SILVER: This is Ken Silver

again. Let me just cite one more time, a few years before the board was created, Sheldon Samuels was a major influence in Washington, D.C. in occupational health policy.

He floated an idea on Terrie Berrie's mailing list that a career ladder ought to be created for people doing this kind of work that involves continuing education and certification.

Mr. Howie seemed kind of interested in that idea when we met in April. There'd be some problems involving the collective bargaining unit but, you know, a journey of a thousand miles begins with a single step.

And I think we should keep our eye on the idea that we can't really get educated on this stuff by reading a procedures manual and going through a couple of internal education sessions.

A long-term solution really requires a curriculum with advancement and recognition for people who have acquired real expertise within the Office of Workers Comp.

CHAIR CASSANO: Any other comments? Great. Yes, we'll try to set up a focus group that's part of the agenda. We don't know what time or anything.

And then the question about the treating physician being compensated. The answer that we got on the phone call was, if the claim is accepted, then that -- it's somewhat compensated for the opinion.

If the claim is accepted, then yes there is compensation. If the claim is not accepted, there is no method to be able to compensate a consulting physician who was referred to develop a medical opinion, other than the contracted medical consultant.

I think this was a question you asked. So if you have any follow-up concerns with that, or questions about that, or anybody else for that matter.

MEMBER BODEN: No, not at the moment.

CHAIR CASSANO: Okay. And I think that's how it works in a lot of other systems

too. But it's, you know, there are some safeguards that aren't in here. The next question ---

MEMBER MARKOWITZ: Sorry, this is Steven again. Causation reports can take a fair amount of time to create high quality reports. And I'm wondering whether there's actually a category of reimbursement for causation reports that recognizes something beyond the standard examination.

The issue really is, you know, if a physician is writing a simple, straightforward, skimpy, rationalized report, that's one thing. But if they're taking the time to actually document their statements and provide of references, et cetera.

I'm talking about the CMC, I'm talking about the physician that the claim goes to. That takes time. And I'm wondering if there's a recognition of that in the reimbursement system.

MR. VANCE: I don't want to offer an answer that I'm not 100 percent certain about.

All I can tell you is that what we would pay would be based on a coding structure in the billing for the services being provided by a physician.

So, in other words, if there's an ICD-10 classification for a reporting of that nature that can be billed to the government, that the government will reimburse that based on whatever fee schedule exists for the energy program.

Now I cannot specifically answer the question as to a fully-drafted comprehensive causation report. Is there a particular ICD-10 code for that? I don't think so.

But I'm just not familiar with billing coding enough to be able to answer that question with any degree of certainty.

MEMBER MARKOWITZ: Okay, thanks. Well, we can just put it on the list to find out. Thank you.

MEMBER BODEN: Yes, so this is Les Boden. Just to clarify, it sounds -- so there is, I gather, a specific list of payments for

procedures that may have procedures on it that may not be in the normal procedure coding because they're specific to things like writing a causation report? It was a question mark at the end of that sentence.

(Laughter.)

MEMBER BODEN: So is that correct, that there is a reimbursement available for activities that are not normal CPT procedures?

MR. VANCE: Yes, that's what I was saying before. I'm not certain that -- this is John Vance again. I'm not certain as to what would be an allowed billable service by the physician, based on that type of specific process or procedure.

We'd have to go back and take a look at what is our ICD-9 and ICD-10 coding for that type of service. And what are the potential different types of services that a physician could bill for? Because there are innumerable classifications and procedures that a physician can charge the government against for services

rendered.

I'm just not familiar, and certainly not going to be able to answer that with any degree of certainty. And, you know, that coding classification process is a very complicated one that has a lot of, you know, complicated service and procedure codes and other types of things that are going on. So that would be one that I would not be confident answering.

MEMBER BODEN: Right. So this might be something that we could try to get more information about because what physicians are doing for this program is different from what physicians typically do.

They typically provide diagnostic services and treatment services. They're not treating here, but also the diagnostic services they're providing are somewhat different from the ones that they normally provide. So I think if there's a way of giving us that information, as Dr. Markowitz suggested, I think that would be useful to the committee.

MEMBER SILVER: This is Ken Silver. I'm particularly interested in whether there are physicians out there essentially working on a contingency basis doing what Dr. Markowitz described, writing fully rationalized causation reports of someone who's not yet in the Part E program, the claim might be denied.

Will the physician see any payment for all of their library work and writing and re-writing?

MS. RHOADS: Why don't I pass these questions onto the program after the meeting is over and we'll see what we can find out?

MEMBER SILVER: Great.

MS. RHOADS: Dr. Cassano, did we lose you?

CHAIR CASSANO: -- and apparently, you guys can't hear me for some reason.

MS. RHOADS: Hi. We can hear you now. We heard you come on in the middle of your sentence.

CHAIR CASSANO: Okay, great. Okay,

I'm here. What I was asking -- I had a follow up question for Mr. Vance, in that -- and I guess Ken asked the same thing, was -- well he asked it in a slightly different way.

The physicians only get compensated if the claim is accepted. So a claimant could go out and spend $2,000-$2,500 for a what we would call a nexus opinion, and be out that $2,500, if the claim is not accepted, correct?

MR. VANCE: That is correct. And a sort of in response to Ken's question -- this is John Vance again. I am well aware that there are people being paid by claimants, and their attorneys or representatives, to provide input on these cases.

But the method and the methodology for payment for those services is not something that would be payable by the Department of Labor. That's sort of an external to the program.

So they're assembling cases by going to their own experts. And you have to think of it as not just the physician that they could seek

out input from. They could also be seeking out input from health scientists, toxicologists, industrial hygienists, and all of those are being paid through from fees being collected by an attorney, or however it's being arranged.

And those might not be payable or reimbursed by the Department of Labor, in any form, because we can only pay based on our authorized fee schedule under the method that we pay bills through the program.

CHAIR CASSANO: Okay, thank you. The next few -- I think the next one reviewed by CMC, again, goes back to how does the CE learn to weigh medical evidence, the CMC's report versus the training physician's report, et cetera?

And I think we sort of answered our own question, in that we really need to sit down with CEs and look at the training materials. So I'm not going to belabor this particular one, unless somebody else has -- or wants to address this separately from the other issue about weighing medical evidence in training materials.

Okay. Hearing none, I'm going to move on. Again, the next statement was assistance with rationalization, how complex, what do they want? And what we got back from the program was basically, well it's part of that whole gestalt of how the CE looks at things, whether there's enough, there isn't enough.

A doc saying, I'm an expert in this field and I say it's related versus a well-rationalized report. And there could be some standardization there, but I think it really is more mushy than we'd like it to be.

Steve, do you have any further comments about that? Or, again, I think this is something they need to learn about from speaking with the CEs. Anybody else have any discussion of this?

MEMBER MARKOWITZ: I do want to either put on the table -- this is Steven -- put on the or re-put on the table, I can't quite remember, that above and beyond speaking with claims examiners, looking at a number of claims

themselves. Individually, what the behavior is, what the CEs are doing in practice. And to have a real look at how medical evidence is interpreted and moved.

CHAIR CASSANO: Okay. Did we lose you? Hello? Okay.

MEMBER MARKOWITZ: I'm sorry. I just made a comment, could you hear me?

CHAIR CASSANO: I heard most of it, I think.

MEMBER MARKOWITZ: Oh, I'm just saying that we need to look at some claims to get a different picture. That's all.

CHAIR CASSANO: Okay. And the next question was the development letters, yes they will supply some of the development letters for us. And they state they're often lengthy. And physicians may not have the time or the inclination to respond, especially if they're not getting reimbursed for it.

Again, more about training resources, training materials. We're getting close to one

hour. And then I want to move on. I want to get this discussion done at the top of the hour.

And then again, looking for contribution or aggravation, this is something that they really need us to try to tease out for them. Again, it's hard to standardize that because it depends on quantity, length of time, dose and other contributing factors as to how much aggravation, how much contribution.

So that's the real question that's out there, and probably one that scientists have to answer. Quarterly reports, we will get. And we do have a list of priorities that I think answers this last -- what are the associated diseases that claimants are claiming most often? Any additional comments at this point?

MS. RHOADS: Hi Dr. Cassano, this is Carrie. Apparently when people were able to hear only some of the discussion, Ms. Vlieger got dropped off. Can we wait a few minutes for her to call back on?

CHAIR CASSANO: Sure.

MS. RHOADS: Thank you.

CHAIR CASSANO: Yes, we seem to be having some technical difficulties here.

MS. RHOADS: Yes, let me just check with the moderator and make sure she's calling back in, and then we'll join her back in.

CHAIR CASSANO: Okay. Thank you.

MEMBER MARKOWITZ: So this is Steven. Can I make a comment while we're waiting for Faye?

CHAIR CASSANO: Yes.

MEMBER MARKOWITZ: The issue of aggravation --- their response to that question is --

CHAIR CASSANO: Hello?

MEMBER VLIEGER: I am here. Can you hear me?

MEMBER MARKOWITZ: Yes.

CHAIR CASSANO: Yes, I can hear you. I can't hear anybody else now.

MEMBER MARKOWITZ: Are you sure you can't hear anybody else?

CHAIR CASSANO: Okay, now I can hear you. Okay.

MS. RHOADS: Is Ms. Vlieger back on now?

MEMBER VLIEGER: You can hear me again, right?

MS. RHOADS: Yes.

MEMBER MARKOWITZ: Oh yes.

MEMBER VLIEGER: All right, thank you.

MS. RHOADS: The moderator tells me that there are seven lines active, so that should be everybody. Sorry about that, go ahead.

CHAIR CASSANO: Faye, did you have a comment or do you need me to repeat what we said? I'm not quite sure where you fell off.

MEMBER VLIEGER: I fell off about five minutes ago. I was able to call in and hear you, but not be able to speak.

CHAIR CASSANO: Did you want to speak to something?

MEMBER VLIEGER: Just in general. I don't know how many times we're going to go back

and talk to the Department of Labor for information before we actually have an idea of how much we need to know.

It's becoming very stultifying to not be able to discuss anything with people in between meetings. And we need to rectify that.

CHAIR CASSANO: I think, yes, it does become difficult. I think maybe we should -- we need a little bit of clarification of the rules about how we can break up into subgroups and working groups and be able to share information and collaborate in that way.

Carrie, is that something that we can do in a couple of minutes, so that we can move on and get our game plan put together here?

MS. RHOADS: Sure, we were talking to another subcommittee about this as well. You can use email to communicate with the group, as long as you copy me and Tony, on the discussion. And you can break up into working groups as well.

CHAIR CASSANO: Okay.

MS. RHOADS: Maybe I can get some

guidance written on that as well for the next --

CHAIR CASSANO: Okay, thanks. And a working group can be up to three people, or doesn't it matter?

MS. RHOADS: It just can't be the entire Subcommittee.

CHAIR CASSANO: Okay. Who's there?

MEMBER MARKOWITZ: This is Steven.

CHAIR CASSANO: Steve? Were you about to say something?

MEMBER MARKOWITZ: Yes. Faye, does that address what you were raising?

MEMBER VLIEGER: You know, I'm not sure that you guys are getting to the heart of the issue. How many times do we have to ask for information before we just start making decisions?

CHAIR CASSANO: Well, I think we need to make sure we've got, just like the CE, all the relevant information. You know, I think we're pretty close, at this point. And that's why I want to move on now to the next step, which is

number five on the agenda - open discussion about how we should proceed.

We have a lot of information at this point. And there are -- we have been told that we can get training materials, we can meet with the CEs and we can get development letters and review those.

So, I think we're at the point where we can start to decide - Okay, what are we going to first? Who's going to do it? Do we break up into working groups to look at a variety of cases and report back? And that's the discussion we need to have now. So, without saying this is a free-for-all, I think we need everybody to give their input on this.

I could be partly directive about it, about what I think should be first and second and third, et cetera, but I want everybody to participate and especially you Faye, knowing how these things sort of work, to sort of make a sequence out of the next step.

MEMBER MARKOWITZ: This is Steven.

Maybe, before we get into that, Carrie could give us some insight into an approximate time table for the activities that Tori just listed - meetings for the claims examiner, whatever training materials you get, the development letters.

I know it's approximate, but do you have any sense of when we might have that?

MS. RHOADS: Well, for the training materials and the development letters, the Program is working on gathering them. They said a couple of weeks -- that they need to look up each one separately.

And the materials that you all have on your disks have cases that were provided to the Part B Lung Commission Subcommittee. And you all are welcome to go into those cases to look for examples, or to just review the process of what you can tell from those cases.

I will have to ask someone about a timeframe for speaking with CEs or the focus group that you're talking about, but I'll do that

and send out some information after the meeting. Does that cover all of your things?

CHAIR CASSANO: Just one question on the cases. You said they were all lung patients?

MS. RHOADS: They are. The first lung cases that they did were for the Part B Subcommittee, so they are listed under that Subcommittee folder.

But you all can go in there and look at those cases anytime.

MR. VANCE: Yes. This is John Vance. I was part of the group that did that work, so I'm very familiar with it. They accepted, in our cases, for beryllium disease, beryllium sensitivity and some other lung diseases like silicosis.

And what you have access to is medical records, copies of statements of accepted facts, any kind of CMC referral process that occurred. And some of those cases are relatively straightforward and other ones are more complicated.

But I do know that some of the cases, at least in the CBD examples with recommends to deny, you may find cases where there were conflicts in medical opinion and you'll see some examples of where you had lots of differing positions on particular situations.

CHAIR CASSANO: Yes, I think that would give us a lot of information. Beryllium disease is very finite. And I think we really do need to see cases from Part B because there are so many disparate types of information.

Beryllium is, compared to some of the other stuff we may be working with, relatively -- I don't mean to disparage anybody, but relatively simple. But when you're talking about organic solvent mixtures plus heavy metals plus something else, it gets very complicated.

So I think we need this in certain cases. What's the consensus out there?

MEMBER VLIEGER: This is Faye. We need to see Part B patients, not just Beryllium patients.

CHAIR CASSANO: Yes.

MEMBER BODEN: Right. This is Les. I thought, when I saw it and maybe I missed something, was three cases - they were by and large pulmonary cases, I think.

CHAIR CASSANO: Yes.

MEMBER BODEN: And my sense is, cursory at any rate with you, is that even though part of me wants not to have extra work, that three cases are not enough to tell the complete story of what's going on.

MS. RHOADS: Hi Dr. Boden, this is Carrie. Those three cases were in response to one of the -- someone had asked at the April meeting, that we see some examples with CMC referrals. So that's what those are.

MEMBER BODEN: Oh, right, okay.

CHAIR CASSANO: Anybody else on this issue, about getting Part B cases?

MEMBER MARKOWITZ: Sure. This is Steven. Yes. We have to, you know, make a more specific request. But my question is, you know,

just talking of the time table here, it's at five weeks before we meet in person.

DOL has had practice in turning around cases and settled some of the problems that they had initially. So the question is whether it's possible and people want to see some cases before our October meeting, so that we can have a better discussion.

Or whether we want to wait until the actual meeting, so that we can structure any of the questions of the Subcommittee. Personally, I would favor, if possible, looking at some claims before the October meeting, so that we can have a better discussion and get going.

But also that will help us formulate any more definitive requests.

CHAIR CASSANO: I would like to do that as well. I'm traveling extensively between now and then. But if we could -- Sorry, I could switch to it, but I'd like everybody to be looking at.

There are 14 priorities that are on

here. If we could get one or two cases of each of these, that would be 28 cases. We could then divide those up into working groups and have working groups review them and develop questions, at which point -- and I don't know if all -- this will probably not all get accomplished by October. We may be able to peruse them a little bit. But unless there's some time during the full Committee meeting, Steve, where we could break out and do this forum with the CEs, I don't see that happening the next full meeting.

MS. RHOADS: Hi, this is Carrie. Before you go on, I just want everybody to know -- another subcommittee has also asked for one of each of these cases. So they're already working on that. I'll definitely share that with both subcommittees when it's finished.

CHAIR CASSANO: Okay, great, thank you.

MEMBER MARKOWITZ: Carrie, what's the timetable, roughly, for that?

MS. RHOADS: I think in a couple of

weeks. I'm not sure. I'll check with Doug and make sure.

MEMBER MARKOWITZ: Okay, but that means a couple of weeks before the October meeting. That's good.

MS. RHOADS: Hopefully, yes. I think the beginning of October was what they talked about, but I need to check before saying for sure.

CHAIR CASSANO: And, Carrie, we're going to be getting these by disk, correct?

MS. RHOADS: Yes, because there'll be cases that'll have PII on them.

CHAIR CASSANO: Okay. So if we get these by the first of October, we can divvy them up. I can divvy them up and maybe -- I don't know, we're now two weeks before the 16th.

And maybe right before the meeting on the 16th, we can have a little bit of a discussion about what we found, generally, in these cases. And that would move that bit along.

I think once we see these -- I think

it's important to see these cases before -- and to look at the training materials and the development letters before we have our focus group with the CEs. Other thoughts about that?

MEMBER BODEN: Just a question. Is there a specific time, maybe I missed this, that we plan to have these focus groups?

CHAIR CASSANO: Not yet. We need to figure that out.

MEMBER BODEN: Okay.

CHAIR CASSANO: But I don't see it happening before the next full meeting.

MEMBER BODEN: No.

CHAIR CASSANO: Because I think it would have to be an open meeting, correct Carrie?

MS. RHOADS: Yes. If you want to have another Subcommittee meeting, we have to publish that in the Federal Register and everything. Yes, but you can discuss it by email or some other method.

CHAIR CASSANO: Okay, so we can do that. So if we get these by October 1st, I will

make sure I'll divide them among the group, somewhat equitably.

And maybe by the 10th, I have to look at my calendar, let me go back in my calendar -- let's see, so if we get these by the 1st, which is a Thursday, the Subcommittee meeting is -- I'm in September, wait a second. October.

No. There we go. So, the first is a Saturday. So if we get them sometime around there, probably the week of the 11th, 12th and 13th, we can have some -- obviously, if we're going to be talking via email, we have to talk in generalizations, so we'll have to code Case 1, and just put diagnosis, no PII, no nothing.

And then the working group that's working on that will submit questions, issues, concerns they have about how the case worked, so that we can may be able to finish that work by the time of the full meeting.

And then maybe at the full meeting, after the full meeting, we can discuss the training materials and the development letters.

And then, obviously, we would need a six weeks lead team before we could have a focus group?

And I'm not sure how we would work that. Would we travel to meet? I don't think on the phone would work very well. Any suggestions on that?

MEMBER VLIEGER: I don't know why we couldn't do write ups and then compare the write ups, or at least be able to have small work groups discussions.

CHAIR CASSANO: Yes.

MEMBER VLIEGER: I don't see a problem doing small work group discussions over the phone.

CHAIR CASSANO: Yes, you can do that. But I think that the focus group --

MEMBER BODEN: Those are separate issues, actually.

CHAIR CASSANO: Okay.

MEMBER BODEN: One would deal with claims and work groups --

CHAIR CASSANO: Yes, you can do that.

We can discuss those over the phone that week, right before the full meeting. And then, probably within two weeks of that full meeting, have discussions about the training materials and development letters.

Maybe put some type of a report together. And then set up a focus group meeting.

MEMBER BODEN: Can I ask a question? This is a, really, and Advisory Committee rules question. I have a concern about CEs feeling comfortable having full and open discussions about issues in their jobs in a public setting. But I don't know if anything else is consistent with Advisory Committee rules.

MEMBER MARKOWITZ: This is Steven. It hadn't occurred to me that the focus group would be open public access.

CHAIR CASSANO: Yes, I was hoping it would be.

MEMBER BODEN: That's what I was hoping also. But I just wanted to be sure that we could do that.

MEMBER MARKOWITZ: It could be a subset of a subcommittee.

CHAIR CASSANO: Yes. I mean, as long as one person on the subcommittee didn't go, it's not a full subcommittee meeting. And, therefore, we can do it in private, right? Carrie?

MS. RHOADS: I think so. But I have to ask about focus groups, specifically. I'll make sure I don't forget.

CHAIR CASSANO: And the other reason for doing that is because we wouldn't want to inadvertently publicly blab PPI as we're talking about a particular case. I think it's scary to do it that way.

MS. RHOADS: Absolutely.

CHAIR CASSANO: So I'm not sure if you can suspend the rules for that. If different people on the Subcommittee worked with a couple of CEs, and then another group worked with another couple of CEs, then -- I'm not trying to be not be transparent here, but there is some legitimate concerns with PPI, et cetera.

And people talking about whether or not they feel they have the information they need to do their job. That's something -- we want people to be honest with us about this. So I would prefer not to have it public if we can.

MEMBER MARKOWITZ: This is Steven. Not to mention that it wouldn't work for Subcommittee members to be present at a focus group. It would inhibit the discussion.

CHAIR CASSANO: Right.

MEMBER MARKOWITZ: So, inevitably, it's going to be a relatively small subset of the Subcommittee that would be present. And again, I agree that it's not a question of subverting the rules, it's a question of effectively getting information.

CHAIR CASSANO: Yes. So going back now to the agenda, we should have had a vague timetable of how we're going to advance. We're going to get cases, we're going to look at cases, we're going to have our big meeting, we're going to then look at training materials and

development letters. And then we're going to meet the CEs.

MEMBER MARKOWITZ: This is Steven. Let me ask you a question about that. Talking about the Subcommittee agenda for the October meeting. We should be in the position of sharing with the larger Committee, our review of development letters.

We should be in the position of reviewing the training materials and reporting back to the committee on that. And it sounds like we'll have some claims to look at. And we can have the beginning of a discussion about what we found the claims at the full board meeting.

CHAIR CASSANO: Yes.

MEMBER MARKOWITZ: Is that realistic? Is that right?

CHAIR CASSANO: Steven, I don't think it is that realistic at this point. I know you want some kind of report, but I think a report on getting to this point and what we are looking at and how we're going to move forward and

discussing the claims at the next meeting, is probably as much as -- I only have one week where I'm not traveling between now and the Subcommittee meeting. So I'm freaking out a little bit.

MEMBER MARKOWITZ: No, I wasn't saying that a report should be produced. I was saying that the discussion at this Subcommittee has with the full Committee would include having looked at some of the development letters, having looked at whatever training materials have been given to us.

And then having an open discussion about that. Not having settled on any sort of position or even the next steps about that. But bring that discussion to the full Committee.

CHAIR CASSANO: I mean, we could. What does everybody else think? I mean, I think we have to have somewhat of a discussion about our evaluation of the procedure manuals and some of the other stuff.

You know, we've been in on this

subcommittee and they understand how we got here from where we were. But the full Committee isn't going to understand that.

So I think we have a lot to present up to that point. We can certainly try to look briefly at some of the development letters and see the low hanging fruit that may be there, as well as the training materials.

But I don't think we can do a deep dive into any of it before that meeting. Other comments? I mean, you know, I don't see us being able to do a very comprehensive evaluation.

MEMBER MARKOWITZ: Right, yes, okay. You know, we've got time.

CHAIR CASSANO: We'll talk about that.

MEMBER MARKOWITZ: We'll see where we're at. Yes. We'll see how far we get. Obviously, my job is to move the process along. But not faster than we can.

So we'll revisit the agenda of this Subcommittee in the larger full Committee meeting in a few weeks.

CHAIR CASSANO: Okay. Yes, it also depends on how soon we get the material. You know, if it takes until October 1st to get the material, we can do a very cursory evaluation of it, and present that.

But we can talk offline or email back and forth about that. Any other comments about how much we should look at before the full Committee meeting?

MEMBER VLIEGER: I would hope that we would have at least a plan, going forward, of how we're going to attack things for the timeline when we're at the October meeting.

CHAIR CASSANO: Yes. And I was going to try to pin some of that down today. And that's what we were doing, as far as looking at the cases and then getting the training materials and looking at that.

And then, I was hoping we could develop some kind of a report, maybe not an official report, but sort of consolidate some of our findings on the procedure manual and the

training materials. And maybe some cursory recommendations for process improvement. And then we'll talk about the development of deliverables. This is all on the agenda.

But the first thing is to get all of the relevant information. And then go on from there. I can send out a timetable after this meeting, based on when we're going to get all of the additional information, and send that out to everybody.

MEMBER VLIEGER: Couldn't we at least start on the documents that we have that are for the perspective of the Subcommittee? And at least start working on those in some Subcommittee groups?

CHAIR CASSANO: Which documents are you talking about? Well, we already have cases that we can look at for how they weighed medical evidence in our hands. So I don't know why we couldn't do some subcommittee work with what we already have, and then just add the additional cases as they come.

MEMBER VLIEGER: How many cases are on that disk? They're just the three pulmonary cases?

MS. RHOADS: There are three pulmonary cases from the April meeting and then there's about 50 cases on there.

CHAIR CASSANO: Oh there are? But they're all pulmonary, correct? They're all beryllium cases?

MS. RHOADS: They're all lung cases, right?

MR. VANCE: They are all Part B lung --

CHAIR CASSANO: Okay.

MEMBER VLIEGER: Well there's also the cases from the Cleveland office. There's three cases from the Cleveland office with referrals to CMC.

CHAIR CASSANO: Those are still Part B cases?

MEMBER VLIEGER: Yes, but it goes to referring to the weighing of medical evidence.

CHAIR CASSANO: We can certainly do that but, again, we're going to be re-doing work because we're going to have to look at the Part E plans as well.

But certainly we can look at them and have discussions and I can divide people up into subgroups. And we can get some of that done.

MEMBER VLIEGER: My point is of starting on some of this is, I don't think we're going to see a big difference in what we already have in our hands versus any new -- only the difference in the disease and how it's handled. So that's why I'd at least like to start on what we have.

CHAIR CASSANO: We certainly can do that. What's the consensus on this? Should we wait a couple of weeks to get the other cases, or should we have discussions on the beryllium cases that we have?

MR. VANCE: This is John Vance. Let me interject really quick. The 50 cases that Carrie Rhoads just mentioned. When we did that

pool, that would be -- it was focused primarily on Part B lung diseases.

CHAIR CASSANO: Right.

MR. VANCE: A vast majority of those cases will also have a Part E component to it, just to let you guys know.

CHAIR CASSANO: Okay.

MR. VANCE: Like I said before, some of those cases, as Faye mentioned, will have CMC referrals. I know a couple of cases that I specifically pulled for that actually did have conflicts of medical opinion in there. And so that would relate to both the Part B and E case.

CHAIR CASSANO: Okay. So what we'll do is we'll take a look at those cases, and I will have to take a look at them. And what I'll do is I'll pull the ones that seem to be -- that have Part E components to them -- and we can have some discussions on them. And then I'll divvy them up. Does that make sense to everybody?

MEMBER SILVER: Sure.

MEMBER VLIEGER: Yes.

CHAIR CASSANO: And then we'll get the additional 28 cases, or whatever we're going to get from the others. So, after this meeting, I will send out a timeline for how that will be accomplished, and how we're going to synthesize a discussion of that.

Does everybody want to write a synopsis of the case? We're going to have to number the cases and just do it Case No 1, contention and views, et cetera, and then we're going to have to put down your concerns or the issues or the questions that you have.

MEMBER BODEN: This is Les. I don't know exactly how to do this, but I think it would be advisable to have a sort of common, straight, general template --

CHAIR CASSANO: Okay.

MEMBER BODEN: So that we're all discussing the same things.

CHAIR CASSANO: Okay, I can get that done.

MEMBER BODEN: That would be great.

That would be great.

CHAIR CASSANO: Okay. So we're going to look at the preliminary cases and the, probably over the next two weeks, before we get the other ones, and we'll set up some way of -- some standardized template to look at them and add specific questions and then move on from there to the new cases that you're getting.

And if we get the training materials and the development letters, we'll certainly take a look at those. And, also, people will document their issues or concerns on that. And we can bring that to the full committee.

MEMBER POPE: This is Duronda Pope.

CHAIR CASSANO: Yes.

MEMBER POPE: So just to be clear. We're going to be looking at those cases as a full committee, not as focused committees?

CHAIR CASSANO: No, we cannot -- I will divvy those cases. I will look at the cases. And so that people aren't just picking one case or two cases that seem interesting to

them, I will pick the cases that I think we get the most bang for the buck out of.

MEMBER POPE: Okay.

CHAIR CASSANO: And then I will put that list out, and what suggestions on who should look at them or what working group would look at them - probably an industrial hygienist, either you or Faye, and either me or Dr. Markowitz, if I can impress him, so that we have a civilian, an industrial hygienist and a physician on each of these.

MEMBER POPE: Okay.

CHAIR CASSANO: Does that make sense?

MEMBER POPE: Yes.

CHAIR CASSANO: Okay. So I'll put that together and we can go from there. And I'll send out a little bit of a timetable of how we're going to get that done.

MEMBER POPE: Okay.

CHAIR CASSANO: Now I also think, even though we have some of this documented, we need to put out some type of synthesized document on

what we found regarding the procedure manual and the training materials. What do other people think about that?

So that a year from now, when we're going back to try to work on process improvement, we understand what our concerns were at the beginning. And especially if new people come on, or people leave the committee, we need to have some documentation other than the minutes and the summaries of the meeting. Comments?

MEMBER VLIEGER: I have a question.

CHAIR CASSANO: Yes.

MEMBER VLIEGER: This is Faye. The question I have is - How are we going to provide the summaries, other than to ourselves and the Department of Labor? Are any of these summaries going to be uploaded?

CHAIR CASSANO: I think once they are finalized, yes, but I think they can be used as a work product. If we can communicate by email, then we can put a document in that email that's a working document or a draft or something,

correct?

MS. RHOADS: You can. If you are summarizing cases, just make sure that there's no PII in your summary.

CHAIR CASSANO: Right.

MS. RHOADS: Just be able to do that without putting identifiers in there.

CHAIR CASSANO: Right. And that's what I'm going to do with these cases, is I may actually -- I will code them or number them. I don't know if it's acceptable -- I haven't opened the disk to see if I can blank out PPI in it or not, which would make it a little bit easier.

But I don't want to be sending cases back and forth, that's for sure. It's just going to have to be Case No. 1, TCE, Parkinson's Disease.

MS. RHOADS: Right, you shouldn't be sending anything from the disk or changing anything on the disk.

CHAIR CASSANO: Okay.

MS. RHOADS: If you want to make

summaries, just make sure you don't transfer any PII into your summary.

CHAIR CASSANO: Okay, okay. And that's why we need to number them and code them and move from there. But then the report would obviously have -- the synopsis would not have any of that.

It would just say -- you would try to synthesize it, I think. In our discussion and our evaluation of these cases, these are the general problems that we've had, while we're talking about specifics.

MS. RHOADS: And just to be clear, no one should have to redact anything on the disks either.

CHAIR CASSANO: Okay.

MS. RHOADS: I don't think you'd be able to do it, but just don't even try.

CHAIR CASSANO: Don't even try. Yes, ma'am.

MS. RHOADS: Right.

CHAIR CASSANO: Thank you. I heard

you loud and clear. And then, farther on down, once we have a great handle on how this was done and what our issues and question and problems are, we can start to develop our recommendations, which is Number D under the timetable.

And then we can have a discussion on whether we're going to develop training materials and/or try to work on developing presumptives. But I think the presumptive issue is more for the full committee than for us. Other comments?

MEMBER SILVER: Tori, this is Ken. I splashed a little bit around in some of the case files. When the template is developed and sent out, it would be helpful if it emphasized the key issues we should hone in on.

The files are so voluminous, it seems like our success will be largely determined by what we decide not to look at.

CHAIR CASSANO: Right. And I know that from winding my way through 6,000 page case files myself, that you learn very quickly what's important and what isn't important.

MEMBER SILVER: Yes, so if you could steer us towards these three, four or five main issues, that would be most helpful.

CHAIR CASSANO: Okay. I will do my best. I may need Steve's input on this as well, but I will do my best.

MEMBER MARKOWITZ: We are sure you will. So there is an issue that we need to make sure stays on our agenda here, which is something that DOL asked us about, however difficult the issue is, which is how to really operationalize the legal requirements under the statute, the aggravation, contributions, disease be incorporated into the claims process.

CHAIR CASSANO: Yes.

MEMBER MARKOWITZ: Have those words defined, et cetera. So I'm not saying that I have an answer to that, but we need to figure out a way how to further that discussion.

CHAIR CASSANO: That's on my down more on the bottom of my deliverables. I don't think we understand this. I mean, I'm getting a better

understanding. But I don't think I understand it enough yet, until I look through a bunch of cases to see how they're put together, to see how we incorporate that.

I think that's one of the last things, you know, we can get to. I've actually gotten through this agenda. I can't believe it. I would like some other comments from individuals on anything that seems to have been missed, anything that we glossed over, anything that you think needs a little bit more solid discussion.

MEMBER VLIEGER: I think we need to review the Department of Labor's responses to our questions, in light of how we find the evidence in the files.

I don't find that all of the district offices actually do the claims processes the same way. They have different checklists for doing things. They have different form letters.

And it think that, in order to make this program as uniform as possible, we need to examine what DOL thinks is going on versus what

we find in those files.

CHAIR CASSANO: Yes. I mean, I think that's obvious that we need to do that. But in a non --

MEMBER VLIEGER: I was strictly doing it for information because when I deal with different district offices, and they say well we always do it this way, and I haven't seen it with other district offices, then I actually question whether the training materials are actually uniform.

CHAIR CASSANO: They're not. Well they've already told us they're not.

MEMBER VLIEGER: Yes, they told us that there's basic materials that are uniform, but that the individual training is not. But I think some of the basic materials are not uniform either.

CHAIR CASSANO: I think we'll find that out when we get the training materials. I want to -- our discussion is to enlighten or to help DOL move this process forward.

It's not to say, you know, you think this is what's happening, but this is what's really happening. I think we just report on what we see is happening.

And I think DOL can make its own conclusions in some way to be able to say, gee we didn't realize it was happening this way. In order to make sure that -- you know, we're an advisory committee, we're not the Inspector General, we're not the auditors. I think we need to do that.

MEMBER MARKOWITZ: This is Steven. I just want to remind you. Our charter is to make recommendations to the Secretary of the Department of Labor regarding four areas and, specifically, how to make improvements in those areas.

So that's our chartered mission and that's what we're aiming for.

CHAIR CASSANO: Right. Thank you, Steve. You said it --

MEMBER VLIEGER: I don't have anything

different in mind, it's just that I want to make sure that we don't necessarily take what we get and not review.

CHAIR CASSANO: I don't think that's anybody's intention.

MEMBER VLIEGER: Okay.

MEMBER MARKOWITZ: Yes. I mean there is, in a way, a more difficult issue beyond the training materials, which is, chances are the regional or district offices have developed some limited variation in how they do things, that is probably not captured or reflected in the training materials. And the only way we could really look at that is by systematically looking at things across different offices.

CHAIR CASSANO: Yes.

MEMBER MARKOWITZ: And we may get there, but right now that's in the back of our --

CHAIR CASSANO: Yes.

MEMBER MARKOWITZ: We need to keep that on the radar.

CHAIR CASSANO: Yes. Any other

comments, suggestions, questions? If not -- if we're done for right now, can we close the meeting, Carrie?

MS. RHOADS: Sure, if there's nothing else to be done, we can definitely do that.

CHAIR CASSANO: Okay, because I think it's going to take a little bit of clarification on my part to put together the timetable to get through the cases that we have, and do the templates.

My job -- I will reiterate what I've been asked to do. I've been asked to take an initial look at these cases, pull ten or fifteen that probably are most relevant to Part E, including some with referrals, some without referrals, et cetera, divide those up into two or three -- probably three subcommittees -- two working groups, excuse me.

And then develop a template for what we should look for in those cases. Is that correct? Did I miss anything?

MEMBER MARKOWITZ: No. And this is

Steven. So, Carrie, are you the one who assembles the to-do list from this meeting?

MS. RHOADS: Yes, I usually right up a list and then I send it to Dr. Cassano, and she adds her input.

MEMBER MARKOWITZ: And then you distribute it to the Subcommittee?

MS. RHOADS: Right.

MEMBER MARKOWITZ: Okay.

CHAIR CASSANO: So I will try to have that done, let's say -- today is Tuesday -- I'll try to have that stuff out to you by Friday. And we can go from there. And Dr. Markowitz, am I allowed to entice you into service on one of the working groups as a physician representative?

MEMBER MARKOWITZ: Sure.

CHAIR CASSANO: Thank you. Any closing comments from anybody? Mr. Vance?

MR. VANCE: Well, Carrie, when you actually use -- or Steven -- When you assemble the action list, if you know by then when you have a target date for the developing letters or

the training materials or whatever, if you could add that to that, that would be great.

MS. RHOADS: Yes, I will. Thank you.

MR. VANCE: And this is John Vance. I don't really have anything else to add, other than just thanking you for allowing me the opportunity to participate.

CHAIR CASSANO: Oh, we appreciate -- you're going to be participating a lot more, I think.

MR. VANCE: I have been participating behind the scenes, collecting information for you guys, so I already am helping.

CHAIR CASSANO: Okay, great. And, if there's stuff that you want to put together, to send to us that might enlighten us a little bit, please do.

I guess Carrie -- you guys will figure out how that gets done, within the rules, et cetera.

MS. RHOADS: Sure.

CHAIR CASSANO: Thanks.

MS. RHOADS: Okay then, if there's nothing else, do you want to go ahead and close the meeting?

CHAIR CASSANO: I would -- if there are no objections, I will close the meeting. Thank you all for participating. I appreciate it. Those members of the public that listened, thank you as well.

I want to thank the Program, I want to thank Mr. Vance and Carrie, the transcriber and all of the members of the Subcommittee.

(Whereupon, the above-entitled matter went off the record at 2:44 p.m.)

C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Medical Advice for CEs Regarding Weighing of Medical Evidence

Before: Toxic Substances and Worker Health Adv. Bd.

Date: 09-13-16

Place: teleconference

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

Neal R. Gross

Court Reporter