U.S. DEPARTMENT OF LABOR

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ADVISORY BOARD ON TOXIC SUBSTANCES
AND WORKER HEALTH

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MEETING

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WEDNESDAY
NOVEMBER 20, 2019

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The Board met in River Room A at the Holiday Inn Paducah Riverfront, 600 N 4th Street, Paducah, Kentucky, at 9:00 a.m., Steven Markowitz, Chair, presiding.

MEMBERS

SCIENTIFIC COMMUNITY

JOHN M. DEMENT
GEORGE FRIEDMAN-JIMENEZ
MAREK MIKULSKI
KENNETH Z. SILVER

MEDICAL COMMUNITY

MANIJEH BERENJI
ROSE GOLDMAN
STEVEN MARKOWITZ
CARRIE A. REDLICH

CLAIMANT COMMUNITY

KIRK D. DOMINA
RON MAHS
DURONDA M. POPE
CALIN TEBAY*

DESIGNATED FEDERAL OFFICIAL

DOUG FITZGERALD

*Present via telephone

C-O-N-T-E-N-T-S

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

9:11 a.m.

MR. FITZGERALD: Good morning, everyone. My name is Douglas Fitzgerald and I'm the Designated Federal Officer for this Advisory Board, that's DFO. I'd like to welcome you to today's meeting at the Department of Labor's Advisory Board on Toxic Substances and Worker Health here in Paducah, Kentucky.

On behalf of the Department of Labor I'd like to express my appreciation for the hard work of our Board members in preparing for this public meeting and their forthcoming deliberations.

I also would like to thank my alternate DFO, Carrie Rhoads, as well as Kevin Bird and the contract staff for doing a lot of work to get this meeting off the ground, getting materials out to the public.

Just a couple of housekeeping items. First of all, in the unlikely event of an emergency the exits are fairly well marked out

here so I don't think there will be any problem.

The restrooms are to the left and across the restaurant past the elevators for your convenience.

As the DFO I serve as a liaison between the Board and the Department of Labor. I'm responsible for approving meeting agendas and for opening and adjourning meetings while ensuring all provisions of the Federal Advisory Committee Act or the FACA are met regarding operations of the Board.

I'm also responsible for making sure that the Board's deliberations fall within the parameters outlined in its enabling statute and charter.

Within that context I work closely with the Board's chair, Dr. Markowitz, and the Office of Workers' Compensation Programs to ensure that the Board as an advisory body to the Secretary is fulfilling its mandate to advise and is addressing those issues of highest priority and of greatest benefit to the Secretary of Labor

who is ultimately responsible for the administration of the Energy Employees Occupational Illness Compensation Program.

And finally, I also work with the appropriate agency officials to ensure that all relevant ethics regulations are satisfied.

We have a full agenda to cover over the next day and a half. Copies of all meeting materials and submitted public comments are or will be available on the Board's website under the heading Meetings.

The Board's website can best be found by entering "Advisory Board on Toxic Substances and Worker Health" in any internet search engine.

During Board deliberations I'd like to remind the members that when discussing specific cases to be mindful not to use personal identifying information or PII in those cases.

The FACA requires that the minutes of this meeting be prepared to include a description of all matters discussed today and any conclusions reached by the Board.

As the DFO I prepare the minutes and ensure they are certified by the Board's chair. The minutes of today's meeting will be available on the Board's website no later than 90 calendar days from today, but if they're available sooner they'll be posted sooner.

Although formal minutes will be prepared according to FACA regulations we also prepare verbatim transcripts and they will be available on the Board's website as soon as possible.

The Board's website has a page dedicated to this meeting. The page contains all materials submitted to us in advance of the meeting, and we will publish any materials that are provided by our presenters throughout the next day and a half.

There you can also find today's agenda as well as instructions for participating remotely in both the meeting and the public comment period later today.

If you are participating remotely I

want to point out that the telephone numbers and links for the WebEx sessions are different for each day so please make sure you read the instructions carefully.

If you're joining by WebEx please note that the session is for viewing only and will not be interactive.

The phones will be muted during the public comment period which opens at 4:30 this afternoon.

During Board deliberations and prior to the public comment period I would request that the people in the room remain as quiet as possible since we are recording the meeting to produce transcripts.

The Chair will also note that the public comment period isn't a question and answer session, but rather an opportunity for the public to provide comments about the topics being discussed and considered by the Board.

If for any reason the Board members require clarification on an issue that requires

participation from the public the Board may request such information through the Chair or myself.

I'm looking forward to working with all of you today at this hearing, and hearing your discussions over the next two days.

With that, Mr. Chairman, I convene this meeting of the Advisory Board on Toxic Substances and Worker Health.

CHAIR MARKOWITZ: Thank you. This is Steven Markowitz. I want to welcome back members of the Board. Welcome our new member of the Board, Dr. Rose Goldman, and the other members. We are happy to be here in Paducah. It's a beautiful day outside. Maybe we'll actually get outside, who knows.

I want to thank some people, Mr. Fitzgerald, Ms. Rhoads who are the designated federal officials who work with us.

I want to thank Mr. Vance actually for coming today and being both -- presenting but also being available for questions, comments and

interaction.

Of course we always thank SIDEM, Kevin Bird and his group for the support that they give this meeting.

Yesterday we had a great tour of the Paducah site, Gaseous Diffusion Plant. Arranged by Greg Lewis. Thank you, Greg. I know Greg's here. He's outside, but he's coming back. So thank you, Greg.

And thanks to the DOE officials, I didn't catch all their names yesterday, who arranged this tour and also led us through this tour. So it was very informative I thought.

And I want to thank members of the public, people from the USW Local here, from the Center to Protect Workers' Rights, from the Resource Center and others. You'll have the opportunity to introduce yourselves in a moment, but thank you for coming and listening to us and in the public comments sessions having an opportunity to speak about the program.

Let's do introductions and then I'll

go over the agenda and see if anybody has any corrections or suggestions.

I forgot to welcome Mr. Nelson, the Ombudsman, whom I couldn't see right off as well.

I'm Steven Markowitz. I'm an occupational medicine physician and epidemiologist from the City University of New York.

And I run the Former Worker Program for DOE at 14 different sites, 7 different states across the country.

MEMBER REDLICH: Carrie Redlich. I'm getting over a cold. Professor of medicine at Yale and director of the Yale Occupational Environmental Medicine. And I'm also a pulmonologist.

MEMBER GOLDMAN: Hi, Rose Goldman. I just joined the committee. I'm associate professor of medicine and also environmental health from Harvard Medical School.

And I'm a clinical occupational health physician and I practice at Cambridge Health

Alliance.

MEMBER FRIEDMAN-JIMENEZ: Good morning. I'm George Friedman-Jimenez. I'm an occupational medicine physician and an epidemiologist at Bellevue NYU Occupational Environmental Medicine Clinic.

MEMBER POPE: Good morning. My name is Duronda Pope. I'm a retired Rocky Flats worker and I currently work with the United Steelworkers Emergency Response Team.

MEMBER MIKULSKI: Good morning, Marek Mikulski. I'm an occupational epidemiologist at the University of Iowa.

I direct a Former Worker Program for the former DOE workers from two sites in the state of Iowa.

MEMBER MAHS: Morning, Ron Mahs. I'm a claimant representative. I spent my last 15 years working at the Oak Ridge plant and since I retired I just do safety training around the country for our international and CPWR.

MEMBER BERENJI: Mani Berenji,

assistant professor at BU School of Medicine, practicing occupational medicine physician.

MEMBER DEMENT: John Dement. I'm professor emeritus in the Division of Occupational and Environmental Medicine at Duke University and participated with the Building Trades Former Worker Program for the last 20 plus years.

MEMBER SILVER: Ken Silver, associate professor of environmental health in the College of Public Health at East Tennessee State University.

Twenty years ago last week I turned out Los Alamos workers and families for a private meeting with Dr. David Michaels working with Bill Richardson to create this program at the Cities of Gold Casino in Pojoaque, halfway between Los Alamos and Santa Fe.

And one thing led to another and a lot of the people who were at that meeting have passed on, but now in Tennessee each year one or two of my students have family members affected

by the program.

MEMBER DOMINA: I'm Kirk Domina. I'm from the claimant community representing the Hanford Atomic Metal Trades Council in Richland, Washington.

I'm a current Hanford worker, USW member. I've been there since 1983. I guess that's it.

CHAIR MARKOWITZ: If we could go around the side.

MS. RHOADS: Carrie Rhoads. I'm the alternate DFO with Department of Labor.

MR. BIRD: Kevin Bird with SIDEM.

STEFAN: Stefan with SIDEM.

MR. HARTMAN: Tim with SIDEM.

CHAIR MARKOWITZ: Yes, please.

MS. GILL: Good morning, I'm Alison Gill with the Paducah Resource Center.

MR. HARBISON: James Harbison with the Worker Health Protection Program.

MS. DISMORE: Hi, I'm Jill Dismore with Brightmore Home Care.

MS. SLAUGHTER: Hi, Jenny Slaughter with United Energy Workers.

MS. BROCK: Good morning, I'm Denise Brock, the NIOSH Ombudsman.

MS. JARISON: Deb Jerison, Energy Employees Claims Assistance Project.

MS. QUINN: Trish Quinn with the Center for Construction Research and Training, and with the Building Trades National Medical Screening Program.

MS. CHEN: Anna Chen. I'm with the Building Trades Medical Screening Program.

MR. M. NELSON: Good morning, I'm Malcolm Nelson, the Ombudsman for the Energy Employees Program.

MR. BALLARD: Good morning. I'm Chris Ballard, vice president with Critical Nurse Staffing and a home healthcare provider under the program.

CHAIR MARKOWITZ: Okay, thank you. And actually we're going to find a few minutes in the agenda for Mr. Nelson to make some comments.

So let's review the agenda. We're going to -- Mr. Fitzgerald is going to give us a brief update on the status of the pending recommendations within the Department of Labor.

Then Mr. Vance who's head of the Branch of Policy Regulation and Procedures is going to discuss various updates in the program including the Procedure Manual, the SEM, et cetera.

Then we're going to discuss some of the items from the last meeting or two that either we raised as issues that we wanted feedback on or items for ourselves to continue discussion.

And we're going to talk about claim status data. So these are data -- these are the accepted versus denied claims for the most common conditions seen in the program over the last three years.

And actually the Board members have a copy of that, paper copy of that in your folder. It's available on our website for those of you

who are on the phone or visiting by web.

And for the members of the audience here, we're going to show that on the screen so you'll be able to see what we're talking about.

Then we're going to discuss a little bit the reopened claims data. Those are claims that DOL reopened after the change in some of the procedures and policies pursuant to some of the recommendations we had made regarding presumption.

We discussed that briefly before. We're just going to touch base on that again.

And then we're going to discuss claims. The Board has been provided with I think approximately 70 claims and 4 conditions since July. Sarcoidosis, chronic beryllium disease, interstitial lung disease, and the fourth one is asthma, occupational asthma.

So we're going to be spending a fair amount of time discussing individual claims. We're going to protect personal information. We're not going to mention anything in the

individual claims that we discuss that would betray identity of that person.

That's going to take up much of the afternoon. Then we have a public comment period 4:30 to 6.

Ms. Rhoads, how many people do we have so far?

MS. RHOADS: Four so far.

CHAIR MARKOWITZ: Okay. So we encourage people here, people on the phone if you want to make a public comment that would be great.

And you should email Ms. Rhoads, is that how -- if you're present here just talk to her, but if you're online or on the phone just email Ms. Rhoads and indicate that you'd like to speak.

Tomorrow we're going to discuss Parkinson's-related disorders. The subgroup we have has been working on that.

And then we're going to discuss the public comments, both those that have been sent

in as well as those that are obtained later today.

And then pick up any issues that are left over from today, or any new issues.

And then finally, a review of the Board's working and whether any improvements are in order.

So are there any other issues that Board members would like to address? Okay. Well, if you come up with anything let me know during the day and we can find time for them.

So I turn it over to Mr. Fitzgerald now.

MR. FITZGERALD: Thank you, Steven. A brief update is a bit of an understatement.

There is not much to convey in terms of the recommendations that came out at the last Board meeting that are pending with the Secretary's office because they are pending with our new Secretary of Labor who has not had an opportunity to really review those recommendations and the other materials that the

program may have presented to the Secretary in terms of response to those recommendations.

If there was any question -- it's a matter of record what the recommendations were. However, we're just waiting for the Secretary's office to respond. And we will obviously publish those as soon as we have those cleared.

CHAIR MARKOWITZ: Thank you. Mr. Vance.

MR. VANCE: Good morning, everyone. My name is John Vance. As Dr. Markowitz mentioned I'm the policy branch chief for the Energy Compensation Program.

I was asked to provide some updates and some information about where the program is, where we're going.

And I also want to start by just saying thank you. You make my life very interesting. Don't think that the work that you are doing is in vain. We spend a lot of time looking at and considering the input of the Advisory Board.

I know that the director of our program Rachel Leiton is very interested in getting as much feedback and information as we can to improve the quality of our case outcomes, to find areas of our program that can be improved for not only claim processing but also for the outcomes for our claimants.

So it is a very serious process. It's something that we're very interested in hearing from you on. And the work that you are doing does have an effect. It is something that we spend a lot of time within the Department of Labor evaluating and considering and implementing change as a consequence of your input.

And as I go through some of the things I'll mention today I'll sort of highlight some of the things that we're working on that are a direct consequence of the input that you have provided. So again, thank you.

Let me just go through some things that I thought you might be interested in hearing about with regard to program updates.

The program continues to receive a fairly large number of cases on a weekly basis. From our Resource Centers we get a weekly tally of new claims being received.

I just did a pull of the cases that had been submitted from September 28 to October 25. We were looking at 626 new claims. So these would be claims being filed as new originating cases or add-ons to existing cases.

Our weekly tally runs from about 130 to a high of 184 during that time frame.

So our claim intake process is still running at a fairly active clip. So this is pretty consistent with what we have seen over the past year as far as our claim numbers.

So it's not a program where we're seeing a significant reduction in claims that are coming in. It's a pretty consistent number that we are seeing with our case intake process.

Some of our new initiatives that we're looking at for 2020 and actually are already engaged with expanding – we are centralizing our

medical benefit authorization process. So this would be for management of post adjudication case activities relating to claims with a living employee who is receiving medical benefits.

So we have a dedicated staff that is centralized out of Washington, DC but we have staff in all of our jurisdictional offices that are -- their singular focus is medical benefit adjudication.

So this would relate to activities relating to home healthcare. We're going to be transitioning that group to take over durable medical equipment and other types of ancillary medical services such as therapeutic care and oxygen therapeutic care and medical supplies and different kinds of things that we see associated with medical benefit authorizations including home modifications, auto modifications and that sort of thing.

That group as of right now has 19 staff. We are in the process of hiring 11 additional staff that will be dedicated solely to

medical benefit authorization.

We have a program integrity group that is now dedicated specifically to evaluating claims that we receive for waste, fraud and abuse.

They are an analytical group that is looking at instances of issues with how providers interact with the program, how different individuals interact with the program.

And they're doing a lot of data digging and data analysis to identify areas of potential fraud or abuse of our program.

We are also going to be expanding our quality assurance program. Right now the program engages in systemic quality assurance through our existing managerial oversight of the process, supervisory reviews, performance evaluations.

We also do annual accountability reviews which I'm sure you're all familiar with for quality assurance.

We also have a supervisory review process that's a systemic sampling of cases

looking for quality assurance on outgoing cases.

This is a consequence of actually a GAO recommendation from several years ago. So that is a quality assurance process.

But we are going to be engaged with the creation of a dedicated group of staff that will be evaluating quality assurance and their singular focus will be decision quality within the area of recommended decisions, final decisions by our final adjudication branch, and medical benefit authorization decisions. And that will be their singular focus.

I am the lead supervisor of this process. I have one person that has been hired and retained already. She comes from one of the other OWCP worker compensation programs and already has a great depth of experience in quality assurance so she is already in the process of designing our quality assurance plan. And we will be expanding that unit by three additional staff shortly.

Some other updates. We will be seeing

two new additions to the Special Exposure Cohort class.

The Y-12 class in Oak Ridge has been designated for the period of January 1, 1977 through July 31, 1979.

Y-12 already has an existing series of SEC classes so this is just an additional one.

We have done our preliminary assessment based on input that we received from statistical data from the National -- or NIOSH.

And we do our own internal evaluation to determine the number of cases that are potentially affected by this new class. For Y-12 it's approximately 280 claims.

And that will require the Department of Labor to evaluate those cases to determine whether or not there's any potential for that individual or the survivor to be qualified under the Special Exposure Cohort.

So we try to throw as broad of a net as possible for any case that is not currently compensated under Part B for the SEC to determine

whether or not this has an effect.

So we'd be looking for employees that have employment during that time frame, have one of the potential specified cancers. And then we actually commit to a manual review of each one of these cases.

The other site that's been added which is significantly smaller is the West Valley Demonstration Project in New York. The period of the SEC designation is January 1, 1969 through December 31, 1973.

That site is a very small site and there are only 20 potential claims that are impacted by that SEC designation.

The designation is effective November 24. We plan on publishing a circular notifying the public of that and then we will initiate case reviews.

We've already begun the preliminary assessment of cases, but we can't process any of those claims until the effective date of the SEC which is November 24.

Prepare yourselves. Dr. Markowitz asked for an update on the Site Exposure Matrices. So I have quite a list. So, settle in. Are you ready? All right.

And this is -- what I asked for was just some interesting information that you might find interesting about our Site Exposure Matrices.

So I've got several bullet points and I'll try to summarize and provide additional information as we go.

The public is making significant use of the Site Exposure Matrices. In a typical month we have approximately 1,300 different users based on unique IP addresses access the website and view over 20,000 pages of the Site Exposure Matrices.

We continue to receive public submissions with regard to facility information that is then evaluated by our SEM contractor for additions and updates to the Site Exposure Matrices.

A total of 129 DOE sites have SEM profiles including all of the major DOE sites. The current focus is updating and improving those profiles.

The Hanford site has the largest amount of information, Kirk, at 1 million cells of data.

At Paducah the spreadsheet is smaller with about 80,000 cells of data. Its size reflects the one mission focus of the GDPs.

Other sites like Idaho National Lab and Los Alamos National Lab have 220,000 to 275,000 cells of data. So we're starting the day early talking about cells of data, but I thought it would be interesting to just give you a size and scope of how much information is maintained in SEM.

The Site Exposure Matrices currently contains information for over 16,400 unique toxic materials used in DOE and RECA facilities covered under Part E.

We have added four new site profiles

in the past year including Weldon Spring Quarry and the Weldon Spring Raffinate Pits.

profiles have been developed for over 3,500 uranium mines and all covered uranium mill or transporters or buying stations.

These profiles identify the historical contractors and owners to the extent such information is available.

All of the DOE sites that were remediated by the DOE FUSRAP program which is the Formerly Utilized Site Remediation Action Program in the nineteen eighties and nineties have now been profiled in the Site Exposure Matrices except those few which don't have any documentation relating to their activities.

We have also done work in conjunction with DOE site closure profiles. These are profiles for facilities that have been shut down or were in a period of remediation.

Those are generally very unique profiles because the work activities are so distinct from the operational period. So those

are being profiled distinctly in the Site Exposure Matrices.

The ones that are undergoing that update is Rocky Flats, Mount, Feed Materials Production Center, and Area IV of the Santa Susana Field Laboratory.

And those actually will have their own profile within the Site Exposure Matrices that you would have to search for under closure profile.

The Site Exposure Matrices version 18 has been captured. For those of you that are not familiar we go through a process of evaluating -- the Department of Labor has its own internal variant of the Site Exposure Matrices that is updated on a realtime basis.

There is a periodic capture of that information and then it is sent through a process of security review by the Department of Energy. That review then allows us to then publish a version of the same Site Exposure Matrices that existed at that time of capture to the public.

So you're generally looking at a public version that's six months behind the version that's being updated realtime for Department of Labor employees.

So we are on version 18. And we are expecting that public release of that version by the end of the year or shortly thereafter.

Specific to Paducah the SEM team just completed the profile for the Paducah DUF6 facility. SEM profiles of the Paducah and Portsmouth depleted UF6 facilities have been posted in the internal Site Exposure Matrices within the last month.

These facilities convert the large inventories of depleted uranium hexafluoride at the sites which was a product of the enrichment process to a more stable uranium oxide for safer long-term storage.

As a result of this effort nearly 100 toxic substances were added to the Paducah profile along with approximately 120 labor categories and aliases.

The Paducah site's spreadsheet is now up to version 52.

So that's my SEM spiel right there. I hope that was not too much. But I thought that was all information that I thought you would find useful.

We are also working hard to make updates to our Procedure Manual. Now, the Procedure Manual is an internal guidance document for our staff, but it is public facing for folks to understand and see how our processes work for evaluation of claims.

We are currently in the process of publishing version 4.0. I was really keeping my fingers crossed that we would have had this done a week or so ago, but we had a last minute administrative issue that came up that required a little bit more vetting at a higher level of our Procedure Manual.

But we are good to go with version 4.0 which I'm hoping will be published today or tomorrow.

And let me give you some updates with regard to what's going to be happening.

Our versions of the Procedure Manual are generally going to be reflective of changes we've identified through interactions with our staff identifying process issues that they have questions about or need clarification on how to do certain activities.

We also make changes due to input that we receive from stakeholders such as the Advisory Board and also the public.

Many of these changes go through a very deliberate evaluation process. Any edit to our Procedure Manual must go through multiple tiers of clearance. It must also go through a legal vetting process. And then we actually have a process by which it has to go through a union process where it's basically federal employee unions get an opportunity to review that. And so it's a very laborious process, but it does go through a very rigorous process of review.

Some of the things that are going to

be happening in version 4.0. And these are just sort of the highlights.

There are always going to be a series of technical fixes and updates to the content. And there is the usual series of those edits and changes.

As a consequence of a regulatory change that occurred we have to require claimant signatures on claim forms now. So our process is changing to require that. We will no longer allow authorized representatives who are non-claimants to sign the claim forms so that we make sure that they're aware of their responsibilities for providing accurate information. So that process will be instituted with the publication of 4.0 of our Procedure Manual.

As a direct consequence of input from the Board we have actually added an instruction in our guidance that would allow our industrial hygienist staff to interact with claimants.

It's not going to mandate that contact, but it is going to allow a process to be

present that would allow IH and claimant interactions where it's deemed necessary.

We actually are right now looking at our first instance of this and we're sort of working through the logistics of it. And hopefully that will occur this week.

As a consequence of input from the Board we have modified our labor categories with regard to asbestos exposure.

So we have a presumption in the Procedure Manual that relates to asbestos exposure for particular labor categories.

We had messed around with this in the past and had changed it to rather than a presumption for an entire period of time we had separated it out and basically asked the industrial hygienist to evaluate each case on a case-by-case basis.

The Board had asked why and when we went back and looked at it we were of the opinion that we should be having our industrial hygienist look at more and more cases and give more

customized responses.

But there was a point by the Board that that may be having a detrimental effect with regard to how those presumptions for the exposure would be affecting causation presumptions.

So what we have done, we have expanded the standard for significant exposure to asbestos from the period of 1942 through 1995 rather than 1986.

The labor categories remain the same. We did add uranium millers and miners to the list of qualifying labor categories. So that addressed one piece of input from the Board.

And I don't believe that was a formal recommendation. I think that was just something that had come up in conversations and discussions with the Board.

We have always struggled with the issue of diagnosis versus symptoms. We receive a lot of claims for illnesses that are hard to define as either a true diagnosis or a symptom. So basically we provided some clarification as to

how the CE is to approach those type of situations.

And basically it boils down to asking the physician to provide a qualified opinion about whether or not the condition that's being addressed is a diagnosis or a symptom.

We've clarified guidance regarding SEM searches for pneumoconiosis, for pulmonary fibrosis and interstitial lung disease. Basically that those can be interchangeable.

All are searchable now under pneumoconiosis - other in the Site Exposure Matrices.

As a side note we also made a modification to the Site Exposure Matrices based on information that I heard during a conversation during some calls that we had with our staff where staff was providing the Advisory Board some recommendations with how to go about evaluating claims for pneumoconiosis - other and why asbestos, coal dust and silica was not listed in the toxins for pneumoconiosis, other.

They were being treated solely under health effects for asbestosis and chronic silicosis and black lung essentially.

We move those toxins under the pneumoconiosis - other. So that now reflects some input that I heard that I was like, I had asked that question why doesn't asbestosis, silica and coal dust appear under that pneumoconiosis - other category in the Site Exposure Matrices.

After evaluating it we now have those toxins under there. So that is a direct consequence of Dr. Redlich, I think you had identified that in a conversation and then that drew in a question that I had about how we would want to do that.

We've also provided updates with the role of our medical benefit examiners in evaluating claims for medical benefits.

So that group that I was talking about, the centralization of our medical authorization process, those case adjudication

activities are being conducted by medical benefit examiners.

Our Procedure Manual is being updated to reflect that new reality.

We have also clarified the requirements for obtaining medical benefits with regard to the submission of letters of medical necessity.

This is basically where a physician has provided some sort of written rationale or justification for a medical service such as home healthcare, oxygen equipment or supplies, home modifications or what have you. Any of the ancillary medical services that are covered in our Procedure Manual.

And it also updates some guidance that we have with regard to allowing home healthcare providers to provide transportation to and from medical appointments.

So, I moved along pretty quickly but those are the updates that I have for you.

Just some other quick things that I

thought you might be interested in. I and my IH team did commit to a series of trainings at all of our district offices in the first half of this calendar year.

We were talking about proper claim adjudication, assessment, making sure that folks were evaluating cases appropriately with regard to exposure analysis and applying that based on information in the case file, making sure that claim staff are carefully evaluating all of the information in a case file with regard to the DAR occupational history questionnaire and also the veracity of their Site Exposure Matrices searches.

We also had a very lengthy discussion in those sessions with regard to medical opinions supporting claims with specific focus on medical opinions that relate to aggravation and contribution which is an aspect of our standard for evaluating cases under Part E and the importance of claim staff to construct their exposure analysis around medical opinions that

are received from physicians that are relating to aggravation and contribution.

And the main theme there is that when a physician provides a medical opinion of aggravation and contribution the role of the claims examiner is to validate that the physician has an accurate understanding of the exposure history relating to the toxin that the doctor has identified.

So long as the doctor has identified an accurate understanding of those exposures and has some sort of medical health science basis to establish an aggravating or contributing circumstance to the disease in question that would be sufficient for acceptance under the program given our standard that exists is not merely causal, it's also aggravation and contribution.

All of our staff received that including our Final Adjudication Branch folks. It was a lot of travel. And our staff was very receptive to it. And we're hoping to continue

our efforts to engage the staff in improving the quality of their exposure analysis.

And that's all I've got on program updates.

CHAIR MARKOWITZ: Thank you. Questions from the Board? Dr. Dement.

MEMBER DEMENT: Thank you for that, John. I had a question. It goes back specifically to the other pneumoconiosis.

So where would -- just if a claimant has interstitial lung disease where would you put that person?

MR. VANCE: So what we've done is we've basically added that. There's three that we've basically said it's interstitial lung disease, pneumoconiosis and pulmonary fibrosis.

They would all be searched now under pneumoconiosis - other in identifying the toxins that the employee could have been potentially exposed to that are linked to those diseases.

CHAIR MARKOWITZ: Dr. Redlich.

MEMBER REDLICH: Just to re-ask that

because I'm one of those people who's logged in multiple times to the SEM and spent many, many hours putting in different terms and seeing what comes out.

So a clinician gives a diagnosis. And it's not going to be a pneumoconiosis. It's most likely going to be interstitial lung disease or pulmonary fibrosis.

Currently you're not able to enter that. Now, maybe this is a change that's coming. But you're not able to enter that as a condition.

So the clinician isn't going to enter in pneumoconiosis. Because that's not the diagnosis. Not necessarily the clinician, but the claims examiner, whoever, they're looking at the diagnoses that a physician has given this patient.

MR. VANCE: Correct. Depending on how it's presented if the doctor identifies one of these three the instruction will be that the pneumoconiosis - other search category is what is

applied for identifying the potential toxins that that employee had contact through either their labor, work process, incident, area, location and that sort of thing.

MEMBER REDLICH: Because just following up there are like 100 different diagnoses that as an occupational physician for 30 years I have never, ever diagnosed.

And yet the common -- most common diagnoses that are not in there. So I don't quite understand when we have all these rare conditions listed individually why we wouldn't list the term pulmonary fibrosis. Or interstitial lung disease.

MR. VANCE: The guidance that's going to exist is that in the Procedure Manual when this comes out, when it's published it's basically if a CE sees pulmonary fibrosis as a diagnosis, or interstitial lung disease, or asbestosis, or anything like that they are going to be able to search under that pneumoconiosis - other looking for the toxins that are associated

with that employee's work process, labor, or whatever linkage they can do to identify --

MEMBER REDLICH: Okay. And then asbestos is going to be in that category.

MR. VANCE: Correct.

CHAIR MARKOWITZ: Steve Markowitz. I have a question. Wouldn't it be less prone to error if you simply added the term pulmonary fibrosis, interstitial fibrosis of the lung, et cetera, into the SEM and when the claims examiner looks at that diagnosis directly from the medical records gets to the pneumoconiosis - other.

So that the claims examiner -- there's no room for the claims examiner to forget to translate pulmonary fibrosis to pneumoconiosis.

MR. VANCE: I'd have to look to see. Without looking at the Site Exposure Matrices right now I'm not certain if those don't already appear as aliases or not. And I'm not sure. I'd have to look and see.

Because when we have these conditions they actually identify aliases of those

particular conditions. And you're right, there is a history of lots of -- if it's happened in the history of medicine it's probably going to be something that we're going to have to deal with in this program.

But I would say I'd have to look and see how the Site Exposure Matrices currently presents whether or not if you're searching interstitial lung disease does that come up as an alias of pulmonary fibrosis. I'm just not familiar with that specificity without looking at it right now.

MEMBER REDLICH: You'll probably hear this come up again just because of the fixable items.

There are a number of examples of where what the SEM spits out is sort of beyond any common sense.

And I understand how someone who doesn't have the expertise to know what the most common cause -- occupational cause of pulmonary fibrosis is why when asbestos isn't there that

they would recognize that that's a problem.

So anything that then takes all the different claims examiners to get trained in doing properly if the system could be fixed.

And so at least currently in the most recent group of cases that we reviewed that was one of the most common easily fixable problems.

CHAIR MARKOWITZ: Dr. Dement.

MEMBER DEMENT: Yes, just as a follow-up because it's going to come up in a specific case that I reviewed and it has to do with a sheet metal worker at Rocky Flats who was there for many years, 30 years plus.

When the claims examiner looked at the SEM, came back with aluminum, carbon steel and synthetic vitreous fibers, but no asbestos.

I wondered how could that possibly be. So I went to the SEM and traced back through it. And if you just put in Rocky Flats, you put in sheet metal worker, sure enough asbestos is there.

When you put in other pneumoconiosis

it disappears. It made no sense. And so the claim actually went through the whole process of CMC and IH review without asbestos having been popped out from the SEM.

Somehow that filter is just not working right. And I'm looking at it right now and I think maybe it was updated since I last looked at it. It's not.

MR. VANCE: No, the change that I was talking about with regard to adding the asbestos silica and the coal dust to the pneumoconiosis - other will actually be reflected in the public update that occurs at the end of the year.

So I think in that particular situation that problem would be solved with this update because now what you're going to see is if you're searching for pneumoconiosis - other those toxins will now show up.

MEMBER DEMENT: So asbestos will show up under other.

MR. VANCE: Yes.

MEMBER DEMENT: It doesn't do it here.

MR. VANCE: It doesn't do it on the public version now. This is an update that's going to occur at the end of the year.

But it's occurred within the internal one that the claim staff is using to adjudicate cases now.

CHAIR MARKOWITZ: Dr. Friedman-Jimenez.

MEMBER FRIEDMAN-JIMENEZ: A number of claims that I've looked at have reflected what I think is an inadequacy of the treating physician understanding of the exposure.

And I think that the SEM could be a very valuable resource for treating physicians out in the community, but it's not entirely intuitive as our discussion is illustrating.

So I'm wondering if you could put together sort of a guide. I followed how the National Library of Medicine has developed their mesh subheadings over the last 30 years. This is not simple. Hierarchical classification can be very complicated.

But I think if we put together, say, the most common 50 or 100 diagnoses and how you find them in the SEM it could be fairly brief and make sure that it works.

That would go a long way toward straightening out the primary or the treating physician's access to this exposure information which is one of the weak links in the diagnostic process.

So I'm asking could there be a guide created either in the SEM or in the Procedure Manual that would be sort of a SEM for dummies, for people like me that don't do this every day, how you find the exposure information in the SEM reliably and don't run into the kind of paradoxes like Dr. Dement was describing.

CHAIR MARKOWITZ: This is Steve Markowitz. I have some questions, but if anybody wants to continue this line.

MEMBER REDLICH: Just one other quick thing while we're on the topic of SEMs and things that are hopefully quickly fixable.

And maybe this has been done already. But if someone has a sarcoidosis they put into the SEM sarcoid and then there are never any exposures that could cause sarcoid.

So it would seem that when that is the diagnosis one could put sarcoid in under the conditions, or one could make sure that one entered chronic beryllium disease into the SEM.

Because you're not creating the opportunity for that exposure to exist. So you'd get some -- just things again that don't -- sort of defy common sense where someone might have worked for 30 years around beryllium, but then they've been given the sarcoid diagnosis. And then they look to see if there was exposure at X site that caused sarcoid.

So that would be another one where the issue of the diagnostic conditions that you can enter into the SEM.

Because if you simply added sarcoid in there then it would create the opportunity to consider that as a possibility.

MR. VANCE: Let me just comment on that because sarcoid, as soon as you have the word sarcoid you have to start going down sort of a dark path with regard to how the program adjudicates cases for sarcoidosis.

Because sarcoidosis and under our program is first evaluated potentially as a missed diagnosis of chronic beryllium disease.

So when we receive one of these claims for sarcoidosis the claims examiner is trained to say, okay, could this potentially be a missed diagnosis for chronic beryllium disease.

We would then go through the Part B test of evaluating that against the required legislative stipulations for acceptance of a chronic beryllium disease case.

So in other words, if you're presenting with a claim for sarcoidosis we would look at it and say, okay, could that potentially be a missed diagnosis of chronic beryllium disease because we then look at whether or not the establishment of the CBD criteria under the

law are met.

If the answer is yes to that then your case is going to be accepted for chronic beryllium disease.

If you don't go through that, if you do not meet that standard then what we would do is look at sarcoidosis as being under Part E as something that is affiliated with some other type of toxic substance other than beryllium.

MEMBER REDLICH: No, I do understand how that whole process works. But I can say that somewhere it appears that it gets cut off because sarcoid gets put into the SEM and there's no potential causative exposures.

Because -- and I've looked through a lot of sarcoid claims. So I do think that process needs to be looked at again.

It wouldn't stop that process, but one simple solution of prematurely having it come to a halt would be putting sarcoid into the SEM.

And even if you go through the entire process what the SEM spits out is frequently very

tightly related to the question that the claims examiner may ask the CMC.

So instead the claims examiner doesn't ask the CMC were there work exposures at X site that caused this person's disease. They will say, you know, and they'll list what the SEM spits out.

So it plays a huge role, maybe even too big a role in some of the decision-making. I just think it's an area you should look at because I do understand the process and it makes sense. It's just that for some reason it's getting cut short before that is being considered.

MR. VANCE: Okay.

CHAIR MARKOWITZ: This is Steven Markowitz. I have a few questions.

So, you mentioned that there's going to be some improvements in the quality assurance, expansion of personnel and the like.

Given our task 4 which is to look at the quality of the industrial hygiene medical

input into the process, right now are you envisioning or planning any changes in the quality assurance as it impacts the industrial hygiene and medical evaluations?

MR. VANCE: The focus of the quality assurance program that's being put in place, the planning that we're doing is going to be decision-specific. So in other words we would be looking at a sampling of decisions that are being issued across the board.

So in other words we would not be selecting a particular type of decision. Just these are the decisions that are being issued, and then an evaluation of that particular recommendation and the development and evidence that fed into that decision.

So that would encompass industrial hygiene reviews as part of Part E cases, but it would not be limited to that.

So it's basically all of the adjudication activities that could occur in a case could potentially be presented for review in

this quality assurance program.

And that would be at the district office level with the recommended decisions, the Final Adjudication Branch and their final decisions, and then our medical benefit adjudication activities.

CHAIR MARKOWITZ: So likewise, we're charged to provide advice on the use of medical evidence by the claims examiner. So that will be part of this newer enhanced review process.

MR. VANCE: That's correct. It will be any information that a CE or a FAB adjudicator or medical benefit adjudicator used or relied on to arrive at a determination of compensability.

So that would have to encompass both the employment and the medical evidence that's been presented in the case.

CHAIR MARKOWITZ: Yes. Dr. Berenji.

MEMBER BERENJI: Mani Berenji from Boston University School of Medicine.

So you did mention the update that you're planning to incorporate the industrial

hygienist who actually contact the claimant.

MR. VANCE: Yes.

MEMBER BERENJI: So I'm actually going through the Procedure Manual right now. So I believe, and correct me if I'm wrong, this is in section 15-11.

MR. VANCE: All right. So Procedure Manual version 3.1 is currently up on our website. Version 4.0 I'm hoping to have up -- I just had a zinger email today saying it really needs to be up as quickly as possible. I was hoping to have it up today.

So version 4.0, let me just walk you through what's going to be out there. This is going to be basically as of right now an optional process where there is an identified need to engage with the claimant to ask questions about some sort of difference of opinion or information that we think would be useful in talking with the claimant.

The first instance that we got, and I'm just going to talk in generalities. So we

have a physician who has offered an opinion of aggravation and contribution for an employee with prostate cancer.

The doctor is basically of the opinion that this employee's consistent exposure to TCE was a significant factor in contributing to the onset of prostate cancer.

Like I said before the role of the claims examiner is to determine that the physician has an accurate understanding of the exposure.

They did their role in evaluating the case based on the construct of exposure from the treating physician and sent it to an industrial hygienist.

The industrial hygienist looking at it is saying the person in this occupation, and I don't remember what the occupation was, they just could not understand where that employee would have had any reason to ever work with degreaser agents or whatever it is that would have had them in contact with TCE. And they wrote an opinion

to that effect, that there would likely have been based on their professional judgment insignificant exposure.

That contradicted what we were hearing from the treating physician.

In looking at the occupational history questionnaire and the nature of the information from the treating physician it was pretty clear that the claimant was saying that for whatever reason he did do a lot of work with this stuff.

So I flagged it as a case and said why don't we use this as our pilot to determine whether or not if we talk to the claimant they can shed any light on how exactly did you use this material, what was the nature of the work that you did with it, the frequency and that sort of thing.

So what is going to happen is that the claims examiner is responsible for the logistics of setting up a call.

The claims examiner will be on the call. We will arrange a call with the claimant.

The industrial hygienist will moderate the call. They'll basically go through and ask a series of questions.

Those are going to be probing questions. They're going to be asking describe what you did, what's the nature of the type of work that you did with this material.

All of these kinds of questions to try to elicit a better understanding of what the employee did with this material.

The CE and the industrial hygienist are going to basically construct a memo from that that describes the nature of the exchange.

That information thus far will be relayed to the claimant and said is this an accurate portrayal of the conversation that we had.

That information will then be fed back to the industrial hygienist for consideration as to whether or not the information is sufficient to convince them that their original characterization of exposure is accurate or must

be modified based on that input.

MEMBER BERENJI: Do you mind me asking a follow-up question to that?

MR. VANCE: All right.

MEMBER BERENJI: So when they actually have that deliberation between the industrial hygienist and the claims examiner if there's a need to do additional research like, say, in PubMed, for instance, or in some sort of current updated database to be able to look up a particular exposure depending on what the worker explains is there any process by which that would be further explored?

Because at least based on my previous reviews of these other IH reports it seems like they kind of go through the same verbiage in terms of these are the resources we reviewed.

But you actually can see that there's a repeated pattern by which they look at the same references time and time again.

Is there any -- at least in this current update will there be any anticipation of

looking into current literature on specific exposures based on what the worker describes to the industrial hygienist?

MR. VANCE: No. We're not envisioning that. The function of this interview will merely be to focus on the issue or toxin that is at question in the case.

So in this particular case it's TCE. The claimant could always provide additional information from whatever expert that they want, but as far as additional research along the lines that you're talking about the answer is no.

CHAIR MARKOWITZ: Dr. Dement.

MEMBER DEMENT: Excuse me. Just to continue the follow-up on the industrial hygiene updates.

And I think the language is somewhat consistent across them. But I'd like some definitions at least for my part to understand them.

And perhaps it even goes back to the legislation that established the program. They

often use the word "significant."

And by significant it could mean lots of things to lots of people. I assume that it passes sort of the first test. This is an exposure that's beyond de minimis and should be considered with regard to the outcome of the claimant. Is my interpretation correct?

MR. VANCE: I would say so. I mean, the Procedure Manual talks about this low, moderate, high, and significant range, and then insignificant.

I think the direction that we've been moving in is a bifurcation, either insignificant or significant, and then providing additional information that the doctor can evaluate and consider in his or her evaluation of causation.

I think that's open to debate as to the proper characterization of the level of exposure, especially in the absence of any specific monitoring information.

MEMBER DEMENT: Same question and it has to do with the changes in the manual perhaps.

I see a comment, the reference, very low, low, moderate, and high. Is there any tag to a reference level for any of that?

For example, low is only low if you have a reference level.

MR. VANCE: I think the best answer I can give you is it would depend on the subject matter expert who's looking at it and rendering an opinion in the absence of any definitive evidence.

So in other words looking at these cases you're often going to find that there is no industrial hygienist information, or industrial hygiene information at all in the case.

So we have to rely on the characterization of exposure based on the best judgment of the expert looking at it.

And this is the terminology that our industrial hygienist utilized. And so if you would be making a suggestion of defining or applying a specific definition, or changing the methodology that they employ now that's what we

would be looking for as far as input from the Board.

MEMBER DEMENT: Often when we have done exposure reconstructions for studies that I've done we use the same terms. I mean, it's not quantitative. It's clearly qualitative.

But to at least tag it to something, low relative to occupational exposure recommendation standards at the time.

So I do think it would be helpful if the hygienist says it's low or very low to at least say relative to what. What are you comparing it to? Is it 5 parts per million that was in effect in 1965, or is it 0.5 parts per million that's in effect now?

So I think some relative qualification of that would be very helpful. It would make the exposure assessments better.

The other thing, I don't know if the manual is going to change it. I consistently see this comment in the reports that I've reviewed that exposures beyond mid-nineteen nineties would

be within occupational exposure standards in the absence of data. There's no data so why make that statement?

Is that just a carryover from the memo that was rescinded? Is this something that's required that they put in there every time?

MR. VANCE: It's something that we utilize to basically say by 1995 our industrial hygienists feel pretty confident that they should be able to see something that would allow them to more reliably opine on the characterization of exposure.

And if they don't see that then they can't make a judgment that there would have been significant exposure.

Now, I think you and the Board has identified this as an issue and I know that it's been something that has been heavily debated as to how we could amplify or clarify that language, or provide more context to that language.

So the answer to your question is I would be really looking forward to something from

you guys that would help us with that.

It's a very, it's a challenge.

MEMBER DEMENT: Yes, it is. But I think we all recognize that things improved at the DOE sites as more industrial hygienists were employed in programs beyond radiation protection emphasis.

But I don't think it's fair to say in the absence of personal or area exposure monitoring then you assume.

I think it's just stated as it is. Stated appropriately.

MR. VANCE: Yes, and I think that's the nature of the conversations that I've been having with the industrial hygienists as to how we can improve that language, or improve the way that we communicate that.

But again, our view, and don't get me wrong. When we do have data after 1995 that would suggest that there was an exposure beyond some nominal level and a dangerous interaction in some way that would be something the IHs would

recognize and report on.

But I think that there is an acknowledgment that by the mid-nineteen nineties that the same type of dangers that existed would have been identified much more readily and would be in the case file.

And we tend to see a lot more occupational safety and data information in cases after 1995 that allows the IHs to basically say yes, absolutely. Look at it, it's right there.

But again, you're right. I think there are other instances where you're just never going to have that level of detail in every single case.

CHAIR MARKOWITZ: Steve Markowitz. The current language assumes that post '95 that DOE facilities somehow managed to assess across the board what the significance of potential exposures were for the portfolio of toxins within the complex which they couldn't possibly have done.

I'm sure they did it for certain

signal agents like beryllium, maybe asbestos, but certainly couldn't do it across the board.

So it's that assumption which is erroneous. But we accept the invitation to assist you in developing more appropriate language.

MR. VANCE: I do want to make it very clear that the Department of Labor is in no way suggesting that after 1995 everything was picture perfect and that there were absolutely no dangers that existed, or no incidents that existed at the site. That is not the case.

We readily recognize that there were instances of exposure that occurred after 1995. And I know that we have accepted claims based on solely post 1995 exposures that occurred.

It's just that our industrial hygienists feel that after that date that they would anticipate to see some reporting, some assessment, or something that they can rely upon in order to characterize that exposure.

And it may not be something

necessarily identifying a particular monitoring level or something like that, but at least something that would be indicative or convincing to them that an exposure occurred beyond a nominal level.

CHAIR MARKOWITZ: So, we're going to come back to this when we do claims review and we'll think through new language that might assist DOL. Dr. Berenji.

MEMBER BERENJI: So again, just kind of focusing on this industrial hygienist-claimant interaction.

To me this is phenomenal and I really appreciate the fact that you all have actually considered that because there's a lot of information that can be gathered by just talking to the claimant, by talking to the worker and getting an understanding. So to me that's great.

I'm a big fan of quality assurance and I'm really also happy to see that you guys are continuing to improve upon that.

I'm actually really trying to be of

use at least for you all to be able to provide language in terms of how this quality assurance can be done in a more optimized manner, especially when you have a complicated case with multiple exposures, multiple diagnoses, multiple symptoms.

In the medical world we always have what's called case conference. It depends on our specialty. But we actually do have a process by which we can convene.

So at least from a quality assurance enhancement perspective when it comes to deliberating a particular case where there's a lot of exposures, a lot of diagnoses would there be a consideration to incorporate some sort of case discussion, not only including the claims examiner, but also the industrial hygienist, the physician or medical director?

Has there been any thought as to how to incorporate the updated information from the worker and actually having a discussion about how to proceed?

MR. VANCE: Yes, we've had -- well, okay. So you covered a lot of ground.

I would say for our quality assurance program it would probably be absolutely the case that we're going to have findings from a much more in-depth evaluation of these cases around the construct of the decision under review which may be limited to a particular condition, issue, or what have you.

As far as our claimant interactions the challenge that we are facing, and I'll try to say this as delicately as possible.

And this has been something that we recognize that the Board is very interested in with regard to obtaining better quality decisional outcomes.

And let me choose my words because it's a debate that we have had and we've struggled with it.

In a worker compensation environment where there's a lot of money involved in the outcome people are going to provide information

in the presentation of the claim.

So a worker will provide lots of details. And now we are going to be in a position where we're going to be questioning the claimant about those.

We could be very well into a scenario where we're asking a claimant about something and it doesn't make sense.

The question would be how do you determine the accuracy of the information and how do you apply an adjudicatory process to that. That will be the challenge.

Because in looking at this particular case there have been questions about whether or not it's accurate that there would have been any reason for the type of employee that this employee was working with this material. But that's the question that we're going to be asking.

So the questions when we ask that are going to be probing. We're going to be saying describe it. What were you specifically doing.

How were you using it.

That information has to complement other information that we know about this employee.

So the question that the Board should be wrestling with because we are wrestling with it is how do you make these kinds of judgments because there are going to be instances where people are going to enhance information about the type of work that they did because this is a worker compensation program.

We generally will trust the information from the claimant if it is consistent, if it is detailed in describing work activities that are corroborated by other types of information.

But what do you do in the instance where that information doesn't align with any other information we have about that employee or other resources? How reliable is that information?

So claimant interviews are very

helpful in obtaining that type of information, but then how do you use it if it doesn't align with other information in the case file.

And that's the struggle in any kind of worker compensation program.

I personally think it's going to be great. We will be getting much more detailed information about it.

And I would say in the vast majority of cases that I've seen the information we get is actually very illuminating and very trustworthy.

But we have to be mindful in this type of an environment where there is large amounts of money on the line of misinformation.

And we just have to figure out how do we make sure that the claim outcome is an appropriate one based on the best possible information.

CHAIR MARKOWITZ: Steve Markowitz. I would just say that that's normal. In the occupational medicine encounter we probe. We try to get detail to verify the experience.

We compare that experience with what we know in general about that particular occupation or that work setting.

We look at how repeatable the information is within the interview. Say, compare the interview to the OHQ.

So that's normal. And that's all I can say. Dr. Goldman.

MEMBER GOLDMAN: Another point on it is somebody has -- just to follow up on what you said.

Somebody has a certain job title. And so the IH person does everything for that.

But frequently they're asked to substitute. Somebody is out of work and so that job, they get stretched to go fill in, or go clean up something. And that isn't their usual job title, but they're asked to do that.

So I'm wondering if there are ways -- so if you talk to the worker and they tell you that's what they did if there's a way to then follow back with other people, other workers

about that.

Because it wouldn't appear in the usual job record.

MR. VANCE: Absolutely. That is actually a very frequent occurrence in most DOE sites where you had workers doing a variety of things.

That's why I think these claimant interviews are so critically important because I think someone who was doing it, who was there and can explain it and provide a reasonable, compelling and convincing story about the nature of why it was they were engaged in this particular activity that would have been outside the routine for their labor category is very helpful.

And we know that. We know that in looking at some of these cases there were instances that people that were doing very administrative tasks could have potentially have gone in and done other types of work activities of a very production related type of activity.

It's the question of how do you judge and assess that accurately, and how do you make a judgment that that's a factual presentation of information that we can rely on in order to apply it in the adjudication process.

So we would use lots of different resources to try to corroborate that information and compare it to other information we know about that process.

CHAIR MARKOWITZ: Steve Markowitz. We're very happy to hear that DOL views these interviews that we recommended as being critically important.

Will the industrial hygienist get a chance to ask questions, or is it only -- you made it seem as if the claims examiner was taking the lead. Will the IH be able to speak?

MR. VANCE: Let me explain how it is that we're envisioning this working because we're actually in the middle of trying to figure out the logistics again.

So the IH or the claims examiner will

identify an issue that needs to be addressed. So the claims examiner says it would be very helpful, or a question arises from an industrial hygienist.

So it can be the claimant or the industrial hygienist that are raising a question that they think talking to the claimant may help resolve some issue.

That information then falls to the claims examiner to schedule basically a conference call with the claimant.

The industrial hygienist and the CE will be participating on that call.

The questions will be formulated -- the one that we are working on right now, the questions are being formulated by the industrial hygienist.

So our industrial hygienist is constructing a series of questions. And the CE will coordinate the call, be present, and sort of explain the nature of the call, but then it's going to be turned over to the industrial

hygienist to lead the claimant through a series of questions and then also seeking out other information as the claimant provides that data.

The CE and the industrial hygienist will maintain notes of the conversation. They will then prepare a memo that basically details the scope of the call, the nature of the communication.

They'll agree on a final version which will then be submitted to the claimant. The claimant will be asked to verify that it's an accurate portrayal of the conversation.

Once that has been done that information will be rerouted back to the industrial hygienist. And it could be a different industrial hygienist than the one actually reviewing the case, and asked for them to reevaluate the case based on whatever the nature of the issue is that sort of necessitated the phone call.

CHAIR MARKOWITZ: Quick question. Why wouldn't it be the same industrial hygienist?

They actually spoke to the claimant.

MR. VANCE: Contractor. We have contract industrial hygienists and they wouldn't be -- it's not part of their contracted responsibilities --

CHAIR MARKOWITZ: The federal IH is on the phone, but it's the contractor.

MR. VANCE: Correct.

CHAIR MARKOWITZ: The contractor IH report, will that come back to the federal IH who actually was on the phone call?

MR. VANCE: As of right now, no. What would happen would be -- and we are in the midst of working out the logistics.

The phone call is meant to collect information that is to address an issue. That information is assembled into this memo and then submitted back to more than likely an industrial hygienist that did not participate in the call.

That information in the phone call would have to be considered and weighed by another industrial hygienist that's probably

reviewed the case in the past to determine whether or not the original assessment of exposure needs to be altered based on this new information.

And that then would produce another industrial hygienist supplemental report that would go through our normal clearance process.

And that process involves generally having a federal industrial hygienist review that report and then release it for incorporation into the case file.

CHAIR MARKOWITZ: So my question is how many federal industrial hygienists are there?

MR. VANCE: We have two.

CHAIR MARKOWITZ: So of those two couldn't that supplemental report in the process go back to the one who was on the call?

MR. VANCE: Yes.

CHAIR MARKOWITZ: Okay, thank you. Dr. Redlich.

MEMBER REDLICH: Do these two federal industrial hygienists, do they review all of the

work that's been done by the contract?

MR. VANCE: Yes. A vast majority of the IH reports are individually screened by our team industrial hygienist lead.

Some of them go through -- some of the basic ones are not any longer. We have those go through the process and they are released with not -- I mean, each one is looked at, but not to the same degree -- there are certain types that aren't reviewed in-depth. But they're all screened basically by our team.

MEMBER REDLICH: So this sort of -- without the perspective of knowing what exposures actually caused the diseases that we see as occupational physician or occupational pulmonary physician, there becomes this, you know, thousands and thousands of exposures where when we actually talk with the patient knowing let's say the much narrower list of relevant exposures we can then hone in on those questions.

So as one suggestion it might be very helpful if the -- because the industrial

hygienist report and opinion carries a huge amount of weight.

Especially because most of your CMC physicians do not have our expertise, and they depend very heavily on the assessment from the IH person and the SEM.

Again, that also focuses as does the claims examiner. Because that really then focuses the questions that are asked.

And it might be helpful, I think many of us would be happy to sort of occupational medicine perspective that I think would just help facilitate the process.

It might also be very time- and cost-effective because one wouldn't be chasing exposures that really, you know, most of the exposures and most of the disease listed in 30 years I have never seen a case of.

MR. VANCE: Yes. As a policy branch chief that's worked for this program since 2001 I've seen it all. So everything that you have said I agree with.

I am always looking for ways to make this process more efficient, more of a resource.

MEMBER REDLICH: Because almost the SEM seems to sometimes make it less efficient because it now has just generated numerous irrelevant exposures that sometimes hide the basic. Like it was a dirty, dusty environment.

MR. VANCE: Yes. It's an ongoing process and the scope of the SEM has a huge amount of information. And any methods or logistical solutions that we can offer to evaluate 626 cases a month -- if you're talking about that's our intake you have to also understand the administrative reality of with that number of claims. Not all of these of course are going to be Part E cases.

But you're talking about a fairly robust volume of claims going through this process. And so anything that you -- I think this is to the entire Board.

Any efficiencies that you can find are going to be very helpful.

MEMBER REDLICH: We've seen one of the most common cases. You know, COPD, the pulmonary cases.

There's a very limited number of exposures that actually cause those diseases. So, if the IH people understood that they would then know what to focus on.

It's not that list of 7,000 chemicals and the like. It's a very, very small list. And that's really what's lacking here.

CHAIR MARKOWITZ: I have a few questions. So, can I go, Dr. Berenji? Short answer questions.

MR. VANCE: I love short answer.

CHAIR MARKOWITZ: The contractors. You've got Banda for industrial hygiene. You have QTC for the medicine. Any significant changes in the contracts or the contractor functions that we should be aware of?

MR. VANCE: The contracts are going to go through a re-bidding process in the next year. We have to have a new contract in place for the

industrial hygienists by April 30 of 2020.

And I don't know the exact dates for the QTC re-bid. But we have to exercise option years which add onto the contract and both of those are coming up for renewal.

CHAIR MARKOWITZ: Has there been any -- in terms of the federal industrial hygiene occupational medicine or toxicology expertise has there been any change in the people or resources that you have or use in that in the last 6 or 12 months that we should be aware of?

MR. VANCE: No.

CHAIR MARKOWITZ: Okay. How many public submissions to the SEM are there per month, per year, whatever? In recent times.

MR. VANCE: I'll have to get you that specific information. I'll probably get that today. I'll just go back the last six months and see what we have.

CHAIR MARKOWITZ: Is it possible to know how many of those are accepted by the contractor and DOL in terms of revising the SEM?

MR. VANCE: Absolutely. I can get a full summary of the last few months of public submissions and the work that has been done in conjunction with that.

I do know that some of the public submissions have resulted in pretty sizable alterations to some of the information in the Site Exposure Matrices. So I'll work to get that information to you.

CHAIR MARKOWITZ: Okay. So to the public, keep up the work. Good work.

The SEM, you talked about additions to particular agents, but what about the exposure disease links? That depended originally upon National Library of Medicine Haz-Map program.

In the past six months or year since we've last talked about this has that evolved at all? How is that updated? How do you make sure that whatever is new and established in occupational medicine is incorporated in the SEM? Not the agents, but the link in particular.

MR. VANCE: Well, I mean we continue

to work with the information that we receive from Haz-Map. We have our toxicologist onboard who's also evaluating updates to IARC.

And in fact, she's made two recommendations that we are going to likely move on with regard to new presumptions.

And I should have written it down, but it's one that involves lindane and another that involves -- I'll have to get you the update, but there are two presumptions and these are based on IARC data.

And we've already constructed out the presumption. And more than likely what we will be doing is issuing an interim update to our Procedure Manual to incorporate those into our procedure.

So these are going to be two new additional presumptions. I'm trying to remember. It's non-Hodgkin's lymphoma.

CHAIR MARKOWITZ: With lindane.

MR. VANCE: Lindane and penta --

CHAIR MARKOWITZ: Pentachlorophenol?

MR. VANCE: Pentachlorophenol, yes.

CHAIR MARKOWITZ: You mentioned that 100 new agents were added to the Paducah SEM. Just curious because you're 15 years into constructing the SEM. Paducah we learned started 1952.

How is it that 15 years into the SEM we discover that there are 100 additional agents that existed at the site?

I don't doubt it, I just want to know how it works.

MR. VANCE: Our -- Paragon is the team that does the research. They are constantly scouring the Earth for records.

And they have new treasure troves of data. And sometimes I, you know, just as an example, like I go through cases quite frequently and I'll find information that I think is kind of interesting that they've never seen before that I forward on. I'm like you guys should look at this. And that has the effect.

I mean, so records are found all over

the place.

The real story was a lot of our uranium mills and mine information came from one individual that had stored all of these records in his basement. And so somehow they got their hands on that.

So sources of information are out there. They are constantly being found and scoured. And one path leads to another and sometimes they will just uncover records.

And if they're looking at a particular process it could be that those records are stored in a different location.

So a lot of the closure site material that's introducing them to new information, sometimes in the closure information they may have processing data that goes back to some period in history that they didn't have access to. And that information then feeds into updates to the Site Exposure Matrices.

CHAIR MARKOWITZ: Does the industrial hygienist usually redo the SEM when they get the

referral from a CE? Or do they usually --

MR. VANCE: Yes. It's our process to go through and test the exposures and make sure that that information is accurate and correct at the time that they're reviewing the case.

CHAIR MARKOWITZ: My final question. You mentioned some revised asbestos language in the Procedure Manual which will be available perhaps tomorrow at noon after we end this meeting.

Is it possible that we could look at that language during this meeting just so we can actually have some conversation about that?

MR. VANCE: Yes, I can do that. The language isn't specific to asbestos. That was merely a change to the Site Exposure Matrices.

The language that changed is the addition of a statement with regard to interstitial lung disease, pulmonary fibrosis and pneumoconiosis.

CHAIR MARKOWITZ: No, I was referring to the language about significant exposure, '45

to '86, or '95.

MR. VANCE: Yes, I can get that for you.

CHAIR MARKOWITZ: Okay, great. Thank you. We're going to take a break soon but let's see if we can finish these questions. Ms. Pope.

MEMBER POPE: I was wondering if there's a process in place that asks -- that can assess the quality control of the resource centers, their effectiveness in helping the claimants.

MR. VANCE: Yes. I know that the resource centers are a contractor for the Department of Labor.

I know that they have their own internal quality control mechanisms. We have reporting with regard to their activities. So we can actually monitor the functionality of the resource centers.

And I do think that in the past they've gone through a quality assurance review by federal staff. So, I do know that there is

quality assurance oversight of our resource center activities.

And as far as my understanding, you know, the resource centers are amazingly well adept at responding to issues that the Department of Labor needs to engage with.

The resource centers have taken on a large onus in responding to phone calls and that sort of thing, and that's something that our Branch of Outreach and Technical Assistance has been monitoring and assisting with.

Our resource centers are also overseen by a federal manager. And I know her, she used to work with me, so I know what kind of person she is. She's a very detail-oriented and very motivated person.

So yes, I think the answer is yes, we do have a quality control evaluation process evaluating the work of the resource centers.

But I also know that the resource center contractor themselves are very, very keen on making sure that they are satisfying the

requirements of the contract.

And that means that they are being responsive to claimant interactions, they are being responsive to assisting with medical benefit and claim submissions, and providing good customer service with regard to any interactions.

As far as I'm concerned the resource centers have done a tremendous job in that regard. They're there, they're available, they're on the ground helping folks.

Issues that come up with regard to any kind of problems are quickly addressed. So if there are concerns we need to know about it and we take action with the resource centers to resolve those issues.

CHAIR MARKOWITZ: Other questions, comments?

MEMBER REDLICH: This is a very quick one.

CHAIR MARKOWITZ: Dr. Redlich.

MEMBER REDLICH: This is another very quick one. In terms of the total number of

claims let's say that go to a CMC in a given month about how many would that be?

MR. VANCE: I wouldn't even be able to --

MEMBER REDLICH: Just to get a sense of the volume.

MR. VANCE: I'd have to go back and get the statistical information on that or otherwise it would just be a complete guess. And it fluctuates month to month. It just depends on the sequencing of the cases, the population, or --

MEMBER REDLICH: Sure. Just like a range.

MR. VANCE: That would be another request by Steve for statistical data.

(Simultaneous speaking.)

CHAIR MARKOWITZ: Complete with rationale, yes. Other questions? Dr. Mikulski.

MEMBER MIKULSKI: This is Marek. There's a whole wealth of information data available through former worker programs.

It has been obtained following a rigorous methodology and research protocols.

I wonder to what extent it would be possible to tap into those resources and inform your industrial hygiene process.

I know in the past we had done some educational seminars for CEs and I thought that these were really helpful in terms of providing our input to help with the understanding, the environment of these sites.

Is there any way that we could maybe be of help to your adjudication process with this information?

MR. VANCE: Well, my response to that is I think that any information that the resource center or the Former Worker Screening Program can provide in case adjudication activities is always welcome.

We do get screening data. We do get information from the Former Worker Screening Programs that actually are incorporated into the official case file.

That information is oftentimes very critical because it usually involves an in-depth interview and screening process, an initial medical screening that provides diagnostic and other types of information, clinical data, that then feeds into the overall adjudication process.

And I think that the Former Worker Screening Program is also very helpful in communicating information to potential claimants and to the public.

So that's the big thing that I always encourage is that any outlets for information about our program and sources of evidence that can be used to assist the claims process is critical and that's where I think the Former Worker Screening Program is essential in giving us information that helps inform our claim process, and inform the public about the benefits that are available when you are screening individuals that are identified with potentially compensable diseases.

CHAIR MARKOWITZ: Steve Markowitz. A

follow-up question to the Haz-Map.

So, I don't follow Haz-Map and its evolution. Is that routinely updated? Is there an existing contract between NLM and the creator of Haz-Map?

I think the DOL's contract with the Haz-Map organizer was suspended or finished at some point.

The real question is is Haz-Map updated and are those updates incorporated into the SEM?

MR. VANCE: It is updated. Not all of the updates that occur are uploaded and reflected in the Site Exposure Matrices.

So it's Dr. Jay Brown who still is managing that process. He's in a status of trying to find someone else to host that platform and struggling with that.

That's something that the Department of Labor is aware of, but we don't really have responsibility for any kind of management of Haz-Map.

So Haz-Map still represents a significant source of data for the Site Exposure Matrices, but that doesn't necessarily mean that we are in complete -- that they are in complete agreement.

CHAIR MARKOWITZ: So as Haz-Map changes, adds or subtracts, who from DOL makes that decision whether that change in Haz-Map should be incorporated into the SEM?

MR. VANCE: That's a determination that's made under my branch with the medical health science unit.

It's usually a collaborative effort to evaluate the request or the change, whatever it is, and decide whether or not that is reflective of something that we believe is appropriate for the program.

CHAIR MARKOWITZ: Any other? Mr. Mahs.

MEMBER MAHS: Just to follow up on Dr. Goldman.

Something that the IH could check when

they have the -- some of the claims I've gone through, they disallow several of the toxins or chemicals because the SEM said it wouldn't be applied to this occupation.

Well, it depends on the occupation. Just like myself, if you're on construction I might be exposed to welding fumes, to cutting torch metal dust, epoxies, different cleaning chemicals every day because you mix crafts.

But if you look at the SEM in my occupation I wouldn't have exposure to those.

MR. VANCE: Right. Yes, and I agree -- the function of our claim process is to try and get as complete a picture of the exposures as possible. And the SEM is one resource that we use.

The Site Exposure Matrices is populated from information and primary source evidence. In other words there's something on a document that says we know that this material was there and that this laborer or person, whoever the labor category was that would have been there

would have engaged in that activity.

If it isn't on a piece of paper somewhere it's not going to be in the Site Exposure Matrices.

We would then turn to other sources of information such as the occupational history questionnaire, former worker screening material, clinical information from a physician, industrial hygiene records in the document acquisition request, or any other source of information in the file to try to build out a better understanding of the exposures.

So SEM is merely one resource that we use. And it is very true that you could have situations where employees are exposed to things that have nothing to do with their particular labor category and when you search in SEM you don't find anything like that under that labor category.

But hopefully in applying different kinds of filtering to your SEM search you can maybe identify and corroborate those exposures

through, say, a work process, or incident, or area, or location, or some combination of those things.

CHAIR MARKOWITZ: Okay. So, I guess the last question.

MEMBER DOMINA: When you have somebody whose work is highly classified and your claims examiners are privy to that walk me through how you would do that.

MR. VANCE: Generally if we have any understanding that there could potentially be a classified circumstance and engagement that would be something that we could address through a process.

I think that what we do is have -- Paragon has folks that are cleared to do that and engage with a discussion with the claimant I believe.

It has never been an issue where we have had to have a classified interview that I'm aware of that has caused us to sort of shut down the whole process.

I do know that there are things in the Site Exposure Matrices that are sensitive that require some level of effort to make sure that we're not publicly disseminating this type of information.

It's basically we handle those circumstances when they arise and they don't arise very often. And when we do we generally find it's not really a classification issue. It's not a security problem.

And if it does we have resources to be able to address it. But as of right now I'm not aware of an instance where that's become an issue.

CHAIR MARKOWITZ: Go ahead, Dr. Redlich.

MEMBER REDLICH: Sorry to talk so much. One last SEM item that you might look at that has come up I think repeatedly is where an exposure such as asbestos might be widespread in multiple buildings at a site where someone has worked there for many years during a period of

time when we knew that was a widespread exposure.

But their very specific job category, you know, secretary, then results in it showing no exposure.

So, it seems that one should take into account how open the space is and the duration of employment and the likelihood that that person was only in that one job category that seems to -- that exclude what would seem to be a sort of obvious exposure.

I just mention that as one of the themes that's come up on a number of cases, particularly more with women than with men, not necessarily, but as a sort of more administrative job that is in a facility with a lot of exposure that may be open.

MR. VANCE: Yes, and I think that speaks to his concern which is that -- and this is a challenge that I think we're always welcome to receive input about how to handle these situations where you have folks that performed administrative functions, whether they were men

or women.

Under what context would they have been brought into contact. And contact means proximity, work activity, all these kinds of things that factor into an industrial hygiene assessment that brought them into contact with some of these very hazardous materials.

And that has been a challenge for a long time is what's your rationale, what's your justification for saying someone that worked in that type of capacity would have had reason to be exposed, or what would have been the extent or the interconnectivity of their work and their exposure to these materials. How did that occur. And that's been a challenge.

MEMBER REDLICH: I do think there's just some basic common sense that sometimes seems to be lacking.

Twenty years from 1950 to '70 is different than six months in 2001. And that sort of just overall magnitude.

You know, obviously if it's 20 years,

30 years, a number of years ago there is much greater likelihood.

CHAIR MARKOWITZ: This is the last comment. Dr. Goldman.

MEMBER GOLDMAN: This is just a very quick add-on to what Carrie said which is a job that's very typical for this kind of thing is a janitor.

So the janitor or the custodians where it wouldn't link to this, but they're all over the plant.

So I think that that would be a job title that could be highlighted as inviting a larger amount of potential exposures based upon the facility name.

CHAIR MARKOWITZ: You forgot to mention fire fighter.

Okay, we're going to take a break. We'll come back at 5 after 11:00. Thank you.

(Whereupon, the above-entitled matter went off the record at 10:51 a.m. and resumed at 11:11 a.m.)

MR. FITZGERALD: Okay, we're going to reconvene here.

Before we actually get back to business just wanted to let people know that are participating via WebEx that if they would like to take advantage of the public comment period please call the operator at *0.

And if you're in the room and would like to speak there's a sign-up sheet over here where the water is to my left.

Okay, call the operator after 4:30 when we change lines, *0. Thank you.

CHAIR MARKOWITZ: So, I would remind the Board members if you could speak directly into the microphone when you speak. Announce your name.

And also if you have a comment or a question if you could just put your name card upright that would help.

I think Mr. Calin Tebay is on the phone. And I think he's able to talk to us. If so I would welcome you. He's a Board member.

If you wouldn't mind just saying hi and introducing yourself briefly.

MEMBER TEBAY: Good morning. Calin Tebay. I'm a representative of the Hanford Workforce Engagement Center and also Hanford Site-wide Beryllium Health Advocate. Thanks for having me.

CHAIR MARKOWITZ: So, if you have comments or questions you're just going to have to interrupt us. It's fine, just jump in.

MEMBER TEBAY: Sounds good.

CHAIR MARKOWITZ: Okay, good. That was a nice test case. Good.

Okay, we're coming back to the agenda. I just want to briefly review a couple of action items that we haven't talked about so far. These are items from the last couple of meetings.

This actually, Mr. Vance, I don't think you need to come back to the table. But there was a couple of public comments last time, one from Ms. Vina Colley and one from Mr. Robert Roth about additions that should or needed to be

made to the SEM, one regarding neptunium and I can't remember what the other one was.

And we had simply asked to make sure that whatever information be provided, or at least they be informed about the procedure for adding, suggesting that information go into the SEM. So we're hoping that was done.

If you could later just get back to us about that.

And the second item was a certain number of claims were reopened as a result of the evolution in the Procedure Manual, in particular in relation to some of the presumptions that were partly accepted by the Department of Labor.

And the Department of Labor promised that they would provide us with updates on the number of claims that have been reopened and the outcome of those, the reopening of the claims.

So I don't think the Department of Labor necessarily has that today, but we would request that the Department of Labor provide that update in the foreseeable future so the Board can

take a look at that.

We're going to put up now the recommendations. So, this will be particularly helpful for Dr. Goldman, but I think helpful for the rest of us.

We're going to look at the cumulative recommendations made by the Board since 2016, since it was created.

And for the Board members I think there may be a paper copy of this in the folder. So if it's easier for you to follow along.

And I don't want to spend a lot of time on this. I don't want to re-discuss, re-litigate these recommendations. I just want to make sure that the current status of the recommendations, that we are agreed upon them.

Because I reviewed them. I wasn't sure with a few exactly where we were at.

So I will march through these, raise the questions and people can chime in.

So, first recommendation had to do with rescinding the Circular 15-16 which the DOL

agreed to do and did.

The second was adding Institute of Medicine to the SEM. Briefly, this had to do with a report that the IOM put out probably six years ago on the SEM to the Department of Labor.

And there's back and forth between us and the Department of Labor as to the sources that should be routinely looked at and incorporated into the SEM.

We had recommended that a subset of a table from the IOM report, that the Department of Labor make sure that they include those sources.

And the department agreed in a limited fashion to do that.

And so the question was, and I see here Dr. Cassano who's no longer on the Board and Dr. Berenji, the question was was there any follow-up that the Board wanted to do to look again at that list.

The particular issue, for instance, we recommended that EPA IRIS information, that the national -- the California program for evaluating

chemicals, those data be used, that the NIOSH reports be used, National Toxicology Program, in addition to the IARC, the International Agency for Research on Cancer.

And I think Department of Labor wanted some assistance from us in wading through some of those sources to figure out the extent to which they would be truly useful.

I think that's where we left off. And I take it from the comments this morning that I think IARC is probably the main source that's being used to update the Haz-Map which on the face of it would appear to be rather limited in terms of the sources.

The question is, and I don't want a long discussion on this, but should we further pursue this issue. Dr. Berenji.

MEMBER BERENJI: Yes, I'm happy to be a point person for the Department of Labor if they need additional resources.

I mean, I do feel that Haz-Map would be a good resource. The National Library, other

resources as indicated. So I'm happy to continue this effort.

CHAIR MARKOWITZ: The Haz-Map is the base program they use to create their exposure disease links within. But these other sources should take a second look, require a second look. Dr. Goldman.

MEMBER GOLDMAN: I think the National Toxicology Program monographs that have come out are important.

The other thing to consider, there are certain committees and review committees from the National Research Council and IOM. I would support using their reports that have come out because they're really very well researched and pull together a lot of information.

CHAIR MARKOWITZ: Does anybody want to work with Dr. Berenji on sort of re-looking at this issue in a limited way for additional sources that DOL might use to update the SEM in terms of the exposure-disease link?

Okay, so the volunteers include -- Ms.

Rhoads, the volunteers include Ms. Pope, Dr. Friedman-Jimenez, Dr. Goldman. That's in addition to Dr. Berenji. Okay, thank you.

The next item was that we recommended that former workers be involved at the resource centers in actually conducting the occupational health interviews. And the department agreed with that, to the extent that they were able to do that. They said that hiring DOL workers was of some priority. At the resource centers, though, it's a contractor that does that and the department has limited say in dictating who should be hired in that process.

We've discussed the next recommendation which was we had recommended that the industrial hygienist be able to interview the claimant. We've already -- we've received that update, so that's good.

We recommended the policy notes -- well, there were some policy calls that DOL makes periodically, national calls.

And the Board I guess voted in favor

of making the notes from those phone calls public. And the Department of Labor didn't agree with that.

The next recommendation that's F is case files should be made available to claimants through a public portal. And the Department of Labor agreed with that and says that it's working, both OWCP -- well, EEOICPA but more broadly within the Office of Workers Compensation Program in making available to claimants' electronic records.

Page 2, G, we recommended that the Department of Labor enhance its scientific and technical capabilities. The Department of Labor didn't agree with that.

H was we recommended that the entire case file go to the consulting medical physician, contract medical consultant, excuse me, or the industrial hygienist. And the department thought that was excessive and didn't agree with that.

Next is asbestos presumption. We had recommended several aspects of altering the

Procedure Manual to make sure that the presumptions around asbestos embedded what we know about -- medical science knows about asbestos. And I think those -- that recommendation was mostly accepted.

I do see here though that there was an issue of whether the job titles in the list that are a matter of the asbestos presumption, whether the job categories listed was complete.

And I see here that it says that Dr. Markowitz, Mr. Domina, Mr. Mahs, Dr. Mikulski and Dr. Dement will work on a response.

Does anybody recollect what our thinking was? Dr. Dement?

MEMBER DEMENT: I think we did work on updating the list a bit. But I honestly can't -- don't recall exactly where that stands. I don't think it was a formal Board recommendation.

CHAIR MARKOWITZ: Right, right. I'd be willing to take a new look at that list if anybody else wants to join me. Any volunteers? Dr. Dement and Mr. Domina and Mr. Mahs. Okay.

You got that? Okay.

Next is the asthma presumption. And Dr. Redlich, it says here -- you may have done this already I think. But we made recommendations around the language on modifying the Procedure Manual language around occupational asthma.

Much of that was accepted. And I know that all the language we had recommended was not accepted, but the question I guess, Dr. Redlich, is whether this is closed essentially.

We had recommended some language much of which was accepted, some wasn't, and end of story.

MEMBER REDLICH: Since there's a new manual coming out I'll review it when the new one is out.

CHAIR MARKOWITZ: Okay. So, Ms. Rhoads, occupational asthma. And Dr. Redlich will call upon others if she wants some assistance.

The COPD presumption. The Board had

revised -- submitted a recommendation, revised the recommendation a number of times. Ultimately the Department of Labor and the Board don't agree on a presumption for COPD.

Next page, L, the occupational health questionnaire revisions. So, Mr. Vance, if you could just bring us up to date.

So, we had made -- there had been discussion about the occupational health questionnaire. I know that the department had a draft of a new questionnaire. Where are we and how can we help?

MR. VANCE: Okay. So I do know that we have a completely re-drafted occupational history questionnaire that is going through scrutiny.

We actually had Paragon draft it up. And it was structured around much of the input that we got from one of your recommendations.

So, right now the document itself, we have got basically a spreadsheet and it's much more open-ended, and I think it incorporates a

lot of the recommendations about how you'd want to categorize information by work activity and various other types of things.

So it's right now going through an internal clearance review, and then I think we're going to probably be wanting to pilot it.

So it's still in a draft status. I'm not sure where it is with regard to the eventual piloting, but I do know that we do have a re-drafted occupational history questionnaire that's in development.

CHAIR MARKOWITZ: So the question I guess is if it's permitted that we take another look at this, when would be the most useful time for us to provide some input? Further input.

MR. VANCE: I don't have an answer for that. I recognize that it would be very important to have the Board look at our version once we get to a point where we think we're going to begin implementation and then getting any thoughts about that.

But I just can't give you an answer to

that question at this point.

CHAIR MARKOWITZ: So let me say that it's a Board request that perhaps after clearance so that you have a product that you believe you're going to use that we be provided with that and with some limited period in which we can provide input into that if that's all right.

MR. VANCE: All right.

CHAIR MARKOWITZ: Dr. Berenji?

MEMBER BERENJI: Yes, I just want to state that I'm happy to review any updated questionnaires. So if you need a point person to moderate that I'm happy to take the initiative on that.

CHAIR MARKOWITZ: Okay. Next is the -- thank you, Mr. Vance.

So next is our recommendation that two borderline beryllium lymphocyte proliferation tests be considered the same as one abnormal, and that was not accepted by the department.

And then finally, we had requested the sample of CMC reports, or really claims which we

could look at and -- which we've been provided with. So the department agreed with that.

We've also -- one of our recommendations which I think sits with the Secretary is that the Board be provided with resources to actually conduct a review of a larger set of claims. But I think that's still pending.

So if there are no questions about this we'll move on. Yes, Mr. Domina.

MEMBER DOMINA: I have a question for Mr. Vance. Under the asbestos presumption, on that mesothelioma, on why we dose those first before we accept them under E, why we're dosing them under B.

MR. VANCE: Well, under --

MEMBER DOMINA: Radiation dose under Part B. It's getting dosed before they'll accept it under E.

MR. VANCE: Well, if it -- so you've got to remember Part B has its own distinct adjudication process, and then under E.

If it meets the -- there is no presumption for mesothelioma that exists under Part B. So it's got to go through the dose reconstruction methodology.

If it is under Part E, mesothelioma we already have a presumption for under our causation standards for acceptance. So, you could have a case where we have a dose reconstruction ongoing on Part B, but we're able to accept it under Part E because of the presumption.

And I believe it's like -- it's a fairly straightforward presumption under Part E. I don't know the exact standard that exists.

MEMBER DOMINA: Yeah, but why does it have to go through B first when it takes six to eight months when you know it's going to get accepted under E?

MR. VANCE: They should be able to process the B, and as -- they don't have to wait for the Part B dose reconstruction. They should be able to issue a separate and distinct decision

under Part E accepting the claim if it meets the qualifications for approval.

They shouldn't have to wait necessarily for the dose reconstruction to allow that to occur, unless the presumption doesn't apply.

MEMBER DOMINA: Well, we can talk offline. That did not happen.

CHAIR MARKOWITZ: Steve Markowitz. The potential issue with mesothelioma, two aspects.

One is the life expectancy is a year or less so a prolonged evaluation under Part B is problematic because the person could easily pass away in the meantime.

And secondly, it's virtually unique in how it's caused by asbestos exposure. So the likelihood of being accepted under Part E is very high. So, it's --

MR. VANCE: Without knowing the specifics it's very hard to ever comment on a case. So we've got to sit down and talk about

it.

MEMBER DOMINA: I have the information with me.

MR. VANCE: And I'm also, just following up on your earlier comment, I am going to find out the process we go through for interacting with folks on classified information. So I'm following up on that right now.

MEMBER DOMINA: Thank you very much.

CHAIR MARKOWITZ: I'm sure there are relatively few mesotheliomas in the system and if they can be flagged when they come in so the E and B are simultaneous and so. Dr. Dement.

MEMBER DEMENT: I have a resource issue. Given our request for resources and obviously their limited ability to provide them, I have another request.

As we review these claims and as future Board members review these claims that we revisit how they're delivered to us.

A non-indexed with thousands of pages of material to review requires us to spend

probably 80 to maybe even 90 percent of the time we have to put on review trying to find information.

So even a crude index. And we saw such an index when we had the conference call with the claims examiner does exist. And request that future claims for review have such an index that we can actually get to the relevant information more quickly.

CHAIR MARKOWITZ: When we discuss claims, reviewing claims this afternoon or as soon as we get to it if we decide we want to look at additional claims then we should definitely make that part of the request.

Or if we decide that there are a certain number of the claims we've already received that we want to re-look at, or look further at we can make that request. So let's not formulate a recommendation at the moment, but just postpone it till a little bit later if we could.

Other comments? Okay. So, next we're

going to look at the claim status data the Department of Labor has given us which we may have briefly looked at in our September phone call.

And you, for the Board members, you have a paper copy, but for the public it will appear on the Board.

And if for some reason you can't see it up here because it's not big enough it's also on the back board. So if you turn around you'll be able to see it more clearly.

Actually, this -- okay, well. Yeah, let's skip this. We'll come back to this one. The report 1182 or something, or 1158. Let's do report 1158 -- it starts RPT1158. Second from the bottom. Okay.

So, speaking to the public here, can you all see this? Because if you can't see it behind me you can certainly make it out if you turn around. It should be the same thing, Board members, you have a paper copy of.

And for anybody on the phone, Mr.

Tebay, you have access? You're looking at this online?

MEMBER TEBAY: Yes, sir.

CHAIR MARKOWITZ: Okay, great. Okay, so let me just summarize what we're looking at.

The Board requested for common health conditions -- and by the way, I think we've made this available on our website. Is that right?

And so I think if you go to our website, today's meeting, you will see this. If not, then we will make this available.

In any case, so we requested for the most common conditions how many were accepted and how many were denied and the reasons for denial over the past three years.

This is not a longitudinal look. We're not looking at how, you know, 2010 to 2013 compares to the most recent period. This is a snapshot of what claims looked like over the past three years.

And this first thing we're looking at here is the most -- the top 20 health conditions.

And they're organized by ICD, International Classification of Diseases, ten codes.

And we're looking at the numbers of claims in that time period, three years. And the number that were approved, number denied, and the number of claims that are still pending.

And then the percent approved I calculated, I removed the claims pending and I just looked at of those that have been resolved what the percentage approved was.

And I highlighted in yellow the columns that were of most interest to make it easier to read.

And finally on the right you'll see the reasons for denial. Now, you'll notice there are only two reasons cited.

There are additional reasons and they are in this spreadsheet. They are hidden in this spreadsheet, which we can show them, but then the table would be so small we wouldn't be able to read it.

So they are the less common reasons

for denial and less relevant to our discussion. But if anybody wants to look at it they are there. And for that matter if you want to know the ICD codes they're there as well.

So you can see -- this is the top 20 health conditions. But we also have it broken down to the top ten -- we're not going to move to this, but we will in a moment, cancer, respiratory, neurologic and renal. Okay?

But right now it's the most common 20 conditions. You can see the total number of claims, that there are a handful of conditions which claims exceed 1,000 during the three-year period.

And by the time you get to the bottom of the list you're in the range of two to three hundred claims during the three-year period as opposed to 1,000 or more.

If you look at the percentage approved. So skin cancer, now this cannot be melanoma. This must be the more common skin cancers, basal cell, or squamous cell carcinoma

of the skin which are not metastatic and are resolved fairly quickly usually. Say 27 percent of those are approved.

The next is chronic obstructive pulmonary disease of which 52 percent are approved. A large number of claims, over 2,100 and somewhat over 50 percent are approved.

Now, I just want to point out that if you look at row number 16 you see emphysema.

Actually, yeah; thanks, Kevin.

You see emphysema, 310 claims. If we were to group these we would group emphysema with row number 2 of COPD.

Actually, emphysema you see 52 percent are approved. So it's the same whether it's called emphysema or called COPD.

Prostate cancer, 3 percent are approved. Hearing loss, almost 50 percent are approved. Over 1,000 claims.

We see skin again, skin cancer again appear, a similar percentage approved pretty much, 35 percent.

Asthma, a large number of claims, 832, 62 percent or almost two-thirds are approved.

Pneumoconiosis due to asbestos. This is asbestosis, 83 percent are approved.

Chronic kidney disease, one-third. Other interstitial pulmonary diseases. We had a discussion about that earlier, 53 percent which is not quite as high as asbestosis which is 83 percent.

Sleep disorders, 38 percent. Now let me say that some of these conditions are consequential conditions, right. So they're not primary conditions caused by toxins, but they were associated with a successfully claimed condition that leads to sleep disorder. My hunch.

Lung cancer, 41 percent approved, whereas GI cancer -- I'm sorry, this is metastatic disease, 12 percent.

So just so you know, people understand, these are cases in which the disease, the cancer has spread to another location. And I

think these are claims for where the metastatic cancer has appeared rather than what the primary cancer is.

Pleural plaques which are caused by asbestos, 83 percent. So that's very similar to asbestosis, was also 83 percent.

Fourteen is secondary malignant neoplasm. That's very similar to what I just mentioned under 12 which is metastatic cancer.

Parkinson's disease, 47 percent have been approved. Silicosis, 59 percent. Breast cancer, like prostate cancer almost none of them have been approved, two percent. And melanoma, 12 percent.

And then finally, polyneuropathy. You'll see when we get to the neuro conditions, neurologic conditions, there are all kinds of ways of discussing neuropathy. They're more or less grouped.

So you can see about 57 percent of those called polyneuropathy were approved. But we'll look a little bit more at that when we look

at them next.

So then finally, if you look on the right, why -- if you scroll back up, Kevin -- why were these denied, those that were denied.

And you can see that by and large it's negative causation, that the claims review process just didn't accept that this disease was caused by a toxin at Department of Energy.

And then the second most common reason was the medical information was insufficient. And you see that most commonly for the asbestosis and silicosis which is that the review process didn't have the medical information that they needed or deemed supportive to say that this person had asbestosis or silicosis. And that's less so, that's less true for other conditions.

So if there are no comments I would just march down. Go ahead, Dr. Friedman-Jimenez.

MEMBER FRIEDMAN-JIMENEZ: Question. The breast cancer finding is striking given that IARC classified rotating shift work as a 2A probable cause of breast cancer in humans.

The question is, under which part would this be approved? I know it's not ours, but is this included under section B? Is there any section under which rotating shift work could be identified as a cause of breast cancer?

CHAIR MARKOWITZ: Well, Steve Markowitz. Part E is about diseases caused by toxic substances. Part B is partly about that for silicosis and chronic beryllium disease, but it's mostly about radiation.

So rotating shift work, noise, all those other occupational exposures, very real, very important are not covered by the act.

You can correct me, Mr. Vance, if I'm wrong, but that's what I think. What we've heard before. So, somebody would have to go to Congress.

Yeah, Dr. Silver.

MEMBER SILVER: Question for the Board. We've been reviewing a lot of lung claims.

I notice that the top five conditions

denied on the basis of insufficient medical information are all respiratory; 46.8 percent for asbestosis down to 18 and a half percent for COPD.

But what's going on? Insufficient medical information in arguably occupational lung disease.

CHAIR MARKOWITZ: Well -- Steve Markowitz. We haven't looked at any asbestosis claims I don't think.

MEMBER SILVER: Well, they've kind of penetrated in our ILD and pneumoconiosis categories.

CHAIR MARKOWITZ: Okay. So to the extent that that's relevant when we discuss those claims that will be interesting. Dr. Redlich.

MEMBER REDLICH: Go ahead.

CHAIR MARKOWITZ: Dr. Goldman.

MEMBER GOLDMAN: Okay. We were just talking because it seems like bilateral pleural plaques would be pretty, you know, diagnostic for asbestos.

So it's sort of funny that it's negative causation. Unless it's something left from the pneumonia, but bilateral pleural plaques, that's about it.

And then the medical information being insufficient. I mean, you have an X-ray. So that seems like hard to understand.

CHAIR MARKOWITZ: Dr. Berenji, did you want to say something?

MEMBER BERENJI: Yes, thank you. So I just had a question or a clarification I guess regarding the claims pending column.

So, I've been doing some calculations. At least for the first two, approximately 25 percent of the cases are still in pending status.

Do we have an understanding as to how long they have been in pending status? Is this in order of months, years?

CHAIR MARKOWITZ: We weren't provided -- we didn't request that information, so.

MEMBER BERENJI: Can I make a request?

CHAIR MARKOWITZ: For these particular

claims? You think we should get that information for the same set of claims?

MEMBER BERENJI: Absolutely. I mean, a lot of these folks might be in limbo for years with no updates. So, I'm curious.

CHAIR MARKOWITZ: Okay. So Ms. Rhoads, if you could just add that. Thank you.

Any other comments? Dr. Redlich.

MEMBER REDLICH: Just to be fair, I would say that there are some claims that there just really is no medical information that's appropriate.

But I had a question, just a simple one as far as counting. Because I realize that -- and maybe someone could just explain how this works.

So let's say someone has a claim accepted for a condition like COPD. Then there may be a second claim filed for benefits or compensation once a diagnosis has been accepted.

Is that correct? So the claim is for -- not for the original condition, but for

benefits related to that condition. Does anyone understand what I'm asking, or?

No, no, no, let's say a case for COPD -- because the claims are not -- any given person can have multiple claims. So the number of people and the number of claims are not the same. There are more claims than there are people, at least that's my understanding.

So for something like one of the, you know, COPD or asbestosis, that may be accepted. And then there would be at a later point in time a new claim related to the benefits would seem reasonable and those seem usually to be accepted.

So I'm only asking that because the percent accepted, does that include these follow-up claims related to the benefits for the given condition?

CHAIR MARKOWITZ: That's a good question. Do you happen to know, Mr. Vance, offhand?

MR. VANCE: All right. I was struggling to understand totally. But I -- this

would represent each unique claim that's filed for a condition, whether that's COPD or asbestosis.

If you're talking about those medical benefits that are associated with the care of an accepted illness by a living employee, that's not reflected in this.

If you're talking about additional claims for like say, a consequential illness. So let's say if you have chronic beryllium disease and you have sleep apnea that's being aggravated by that, I don't know whether that would be reflected in this. I'm not sure if that answers.

MEMBER REDLICH: Well, it seems like some were maybe the claim was accepted, but then in terms of the extent of the impairment related to that claim, that that would be a second. Am I incorrect about this?

MR. VANCE: If you're asking about what would the benefit outlay from the acceptances of these cases, so in other words, how much money was paid as a consequence of these

accepted conditions for impairment, wage loss, or survivor benefit due to the acceptance of these conditions, we can get that information but that's not what we have here.

MEMBER REDLICH: So are these -- these are unique, because it -- it seems, someone could get, let's say, worse COPD, or --

MR. VANCE: Once we've accepted COPD, we've accepted COPD and any effects from that for the duration of the claim.

MEMBER REDLICH: Okay. I got it.

MR. VANCE: So in other words, if you have -- the best example is asthma. You have an asthma attack at work due to dust exposure you -- or exposure to cement dust or what have you.

And we accept that that exposure aggravated asthma, we're accepting that asthma forever. It's not a temporal approval, it is approval for work-related asthma for the duration of that person's life.

MEMBER REDLICH: Okay.

CHAIR MARKOWITZ: Okay, so let's, if

we could look at cancers. So this is a similar list because the most common -- many of these cancers make the top 20 list, although at the bottom you see bladder cancer which was not on the top 20, and you can see that 15 percent were accepted.

But overall, lung cancer is the most commonly accepted, 41 percent. Later I'm going to raise the idea of us looking at some lung cancer claims so we have better insight into the ones that are denied. But we'll get to that.

But the other ones we've seen on the previous page. I'm not sure we learn a whole lot new by looking at cancers separately.

Any cancers not here that in the occupational medicine world we might expect to be here? Mesothelioma wouldn't make this list because there aren't that many even though it's usually occupational in origin.

Okay, so let's go onto the next which is lung conditions. I mean, liver cancer wouldn't be here because it would be fewer in

number. It would be below the top ten.

Pulmonary conditions. Some of these you'd be tempted to combine. For instance, number ten, unspecified pneumoconiosis and number four, other interstitial pulmonary disease.

Turns out they have identical acceptance rates, so combining them would just increase the overall number of claims.

MEMBER GOLDMAN: So is other interstitial pulmonary disease, is that like beryllium disease? Like, it's not clear from the list what's chronic beryllium disease.

CHAIR MARKOWITZ: So, we have a, I think we have a separate -- Kevin, if you go to the CBD tab. So these are CBD, chronic beryllium disease listed under pneumoconiosis due to other inorganic dusts, 274 cases.

So these are not -- so this is the ICD code or codes that they carved out for us as representing CBD.

Now, if we go back to the respiratory conditions and now we're looking at number 4,

right? Other interstitial pulmonary disease.

We have the -- the ICD codes are provided in this table. I just hid them so we could read this. We can look at that, but you can see right off that there were 516 claims for other interstitial pulmonary disease and we just learned there are 274 for CBD. So I suspect these other interstitial pulmonary disease is not CBD.

It could represent a whole -- it could be asbestosis, silicosis. Could be mixed dust pneumoconiosis. Could be CBD. But that's the working diagnosis they're using.

And it is true if you look at this -- well, 83 percent of the asbestosis cases are accepted. Silicosis, it's roughly 60 percent. And then when you get to the less specific diagnoses, the interstitial pulmonary disease, pneumoconiosis, it goes down to 53 percent.

Okay. Any comments, questions? Otherwise let's move on to the next which is neurologic.

Sleep disorders, top ranked. I'm assuming most of this is secondary, consequential disease to some other primary usually pulmonary disorder.

But number two is Parkinson's. And we see 47 percent are accepted. And the main reason those that aren't accepted is negative causation. Eighty-four percent is negative causation.

We're going to talk about Parkinson's disease a little later today or tomorrow. DOL asked for help in identifying the toxins and the exposure conditions and so we are working on that.

And we also looked at some Parkinson's disease claims previously, if you recall. Even if you don't recall, we did.

And then you see neuropathies. And so neuropathies are listed in several different rows, right. It's row three, other and unspecified polyneuropathy. Row five, hereditary, motor, idiopathic neuropathy. I suspect six, autonomic nervous system, I suspect

there's some neuropathies in there.

Number eight, peripheral nervous system. Nine, inflammatory polyneuropathy. My guess is that these are all probably variations of the same thing. Maybe not entirely, but there are different ways of describing neuropathy.

And if you look at the percentage that are accepted it's around 45 or 50 percent for all of these categories unless I'm mistaken here, right.

Polyneuropathy, 57 percent. Hereditary motor, I don't know how you would call something hereditary and then say it's due to a toxic exposure, but regardless, 42 percent. Row eight is 46 percent and 52 percent. So about, close to 50 percent of neuropathies are approved.

We haven't looked at any neuropathy claims so we don't really have any insight into that.

And then lastly, there's some Alzheimer's, but relatively little Alzheimer's disease is approved, 11 percent.

If you look at number ten, toxic encephalopathy, very few cases, 33. Most are approved. And the few that have not been approved it was due to negative causation.

And I thought this was of some interest because solvents are common in the industrial world including the DOE complex.

Cognitive impairment is probably reasonably common. And the general -- I'm not speaking about the Department of Labor, but in general, occupational medicine doesn't do a good job of recognizing and attributing cognitive impairment to occupational exposures. And I think we see this here in the dearth of claims, frankly.

Dr. Goldman.

MEMBER GOLDMAN: There has actually been -- I reviewed this recently and there's actually a very good paper on this. It was from an international organization, I'm not sure if it was WHO, about how to grade chronic encephalopathy related to past solvent exposures

and giving a whole checklist of things that are very good predictors.

CHAIR MARKOWITZ: If you could send that around, yeah.

MEMBER GOLDMAN: I'd be happy to forward. It came up on a case that I saw, a veteran who had past exposures. But it was a very, very helpful way to be able to put forth some criteria for that. Do you want me to send you that paper?

CHAIR MARKOWITZ: Sure. Please do. I'm not saying the Department of Labor program is not recognizing important central nervous system disorders due to toxic exposures because you can see there are almost no claims for central nervous system disorders, encephalopathy. So the claims aren't even being submitted. So this is not -- I'm not commenting on the functioning of the DOL program.

I'm making more of a comment about occupational medicine in general that it's an under-recognized issue and that -- and this is in

a way confirmation that it's under-recognized because we have this comprehensive workers' compensation system which is getting claims for many different conditions and it's not getting claims submitted for cognitive issues.

Yes, Dr. Goldman.

MEMBER GOLDMAN: So one of the diagnoses -- I mean, you have Alzheimer's which is very specific, but there's another more general diagnostic ICD-10 which is cognitive impairment. And I'm surprised that that wouldn't be on the top ten because that's a very common disorder. And I'm wondering if you looked at that more general diagnostic code, cognitive impairment, so stated.

CHAIR MARKOWITZ: I can follow up with DOL and ask -- Steve Markowitz -- ask about that. But my sense is it would have appeared on this list if there were a significant number of claims. But we'll ask. We'll identify the relevant ICD codes. Ms. Rhoads, if you could just make a note of that. The relevant ICD codes

and we'll ask how many claims were submitted.

Okay, let's move on. Chronic kidney -- oh, Dr. Berenji.

MEMBER BERENJI: Thank you for recognizing me. I just had a question about the fact that there's a dearth of these claims for cognitive impairments.

It's probably most likely due to lack of education among the workers. So I'm not sure if there's been any efforts by DOL or the resource centers to at least have some sort of FAQ sheet just to kind of give folks an idea of what to be on the lookout for.

CHAIR MARKOWITZ: You know, Steve Markowitz. Let me say the former worker programs which have conducted 100,000 exams for the last 20 years of the complex, we don't address this issue, for a number of reasons.

One is it's not easy to address in a screening examination. It's easy enough to do a simple mental screening test, but then the follow-up becomes expensive and complicated and

prolonged.

So it's an issue that is, as I said before, I think general occupational medicine is just not -- hasn't received the attention it should receive.

And I'm not, again, I'm not saying the DOL program is in any way insufficient or inadequate in addressing the issue. I think it's a more general problem.

If we could go to the next is kidney disease. And most of these are variants of the same conditions, as far as I can tell.

Actually, almost all the claims are for chronic kidney disease. And several of the other categories should simply be added to that probably.

A third of those claims are compensated or approved. And those that aren't it's because of negative causation. We see that.

We don't know whether those are secondary or consequential conditions, right. If they're secondary to some other condition that a

person had or whether they are due to toxic exposure to the kidneys. But these are the results.

Next is chronic beryllium disease, 274 claims under Part E. Seventy-eight percent are accepted. And when it's not accepted it's not because of negative causation, but because of the medical information is insufficient. The documentation isn't there. That's the reason the DOL cites.

And finally, beryllium sensitivity, or almost finally, beryllium sensitivity is 327 claims, 93 percent were approved, and when it wasn't approved it was for lack of medical information.

And then finally, on chronic silicosis, 91 percent were approved. This is -- I'm sorry -- this, I should point out, is Part B claims. If it's accepted under Part B it's automatically accepted under Part E. Yeah.

MEMBER DEMENT: Most of these would actually be RECA claims. Right?

CHAIR MARKOWITZ: RECA? I don't know. You think so?

MEMBER DEMENT: I suspect a lot of them came from the uranium.

CHAIR MARKOWITZ: Unless they're Part B. Okay, so any comments on these tables?

I think it was helpful to the Board to see these data because it helped orient us both to the magnitude of claims, the salient conditions, the degrees of approval and the main reasons why some claims are not approved.

It's a few minutes after 12. I think we're going to break for lunch. And start up -- is 1 o'clock okay? Enough time? I think so.

Oh, I'm sorry, Dr. Silver, did you have a comment?

MEMBER SILVER: Another question to put out there to the occupational physicians who have dealt with solvent encephalopathy.

A Los Alamos worker Ben Ortiz made me his wingman specifically because he had chronic solvent encephalopathy. And it was extremely

difficult for him to keep track of paperwork, remember what happened at meetings, et cetera. And his daughter became his authorized representative. That's just my experience.

But I think it takes a lot of mental stamina to deal with the Department of Labor program. And these people essentially may be lost to follow-through. Just a thought.

CHAIR MARKOWITZ: Yes. If there are no other comments or questions we'll take a break for lunch. We'll start up again at 1 o'clock. Thank you.

(Whereupon, the above-entitled matter went off the record at 12:04 p.m. and resumed at 1:07 p.m.)

CHAIR MARKOWITZ: Okay, we're going to get started. Welcome back.

Mr. Tebay, are you on the phone? He is? Okay, good.

So we're going to spend most of this afternoon discussing individual claims which the department has provided for us.

I want to just first though review the department's own medical audit of its claims. And so the department has a process whereby the medical director reviews approximately 50 claims, completed claims, per quarter.

And we've looked at this before. I can't recall, probably a couple of meetings ago. I think it was this term of the Board. You may recall this.

But in any case, so I looked at the last five quarters. So all of 2018 and the first quarter of 2019.

So what happens is the medical director reviews the claims, divides them into various categories and then they're sent over to the policy branch, looks at -- looks and evaluates the medical director's audit and agrees or disagrees, and then recommends or prescribes an action that should be taken to correct any problem that the medical director found.

So, bear with me. I'm going to give you a few numbers. The director screens about 50

-- this is not available on a table, I'm just going to give you the numbers -- about 50 claims per quarter. So in five quarters about 250 claims total.

Two hundred fifty claims total, 2018-2019. About 40 percent of those were for -- I'm sorry. One hundred of those were for impairment. So he looked at the issue of impairment. How did the claim handle impairment, and found that 28 percent, roughly a fourth of the ones that addressed impairment needed improvement. That's the term used.

There were weaknesses and needed to be redressed, meaning the department had to go back and re-look at the claim, make some decision, determination about that. So one quarter of the impairment claims.

He looked at 83 claims for causation, how good was the causation analysis in the claim and found that one out of 83, or one percent needed improvement.

And then there were about 60 claims

looked at for other issues. I lumped them all together because they're less common and probably less pertinent to what the Board looks at. And of those others, again one quarter of them needed improvement.

So we have three categories. We have the causation evaluation, one percent needed improvement, we have the impairment, 28 percent needed improvement, and the other category, 23 percent needed improvement.

So what you see right away, two things. One is 28 percent of claims evaluated for impairment needing improvement is a lot. That's a lot of correction, a lot of -- that's a common, there seems to be a pattern of some. It's a minority, but it's 25 percent of claims.

But on the causation front, frankly, only one problematic claims evaluation was found.

So I'm just going to leave it at that because we're going to now discuss claims. We're going to mostly focus on causation and medical evidence, not on impairment.

But the question I think really is looking at the number of claims we're looking at, a limited number, but is our experience reflective of what the department's own internal audit is finding over the last five quarters. Make sense? Okay, good.

Okay. So we talk about individual claims. We do not mention anybody's name, we don't mention the number of their file.

We will cite in some cases the last four digits of their claim number or their file number for the purposes of keeping track who we're talking about.

And so it can be a little awkward because we're discussing the particulars of a case. We're not going to look at those particulars on the screen because that's private information.

And yet we're going to be making observations and trying to make sense. Hopefully it will be a coherent discussion.

So, people have volunteered to discuss

certain claims and the floor is open.

MEMBER DEMENT: It's a continuation of some of the discussion that we had this morning and it has to do with a claim that was filed for interstitial lung disease.

It's an older person born in 1939, worked at Rocky Flats from basically '67 to 1998. So he had a long-term employment there as a sheet metal worker.

Started out as a journeyman, then foreman, general foreman, then superintendent, worked himself up.

He filed a claim for interstitial lung disease, really was the classification based on a CT scan.

The initial review by the CE and the SEM didn't identify asbestos as one of the exposures. And we've discussed that this morning, sort of why that would occur based on what are perceived to be some changes that will be made in the SEM at the next release.

But be it as it will, the individual

didn't have an identified exposure to asbestos. He had some other materials that were sent to the IH for review.

So that was, to me, that was a flaw that tainted the rest of the review. And so that was fatal flaw number one.

Then it was sent to the IH who was also sent the -- with a statement of facts which just basically listed a lot of information, some aluminum synthetic vitreous fibers and I think diesel. Can't remember. I have it listed here. Anyway, the IH just reviewed those.

They were sent the OHQ and the OHQ does say that individual had a minimum of two years of asbestos exposure directly. But that wasn't considered in the IH review.

So the IH review basically came back with minimal exposures to these other materials. That was then sent to the CMC who also didn't identify asbestos exposure in sheet metal worker. So fatal flaw number one, fatal flaw number two, and fatal flaw number three.

And fortunately for the worker about the time the final decision to deny he had a former worker exam and the individual finally said -- the physician who issued that report -- this is asbestosis. Go file a claim.

So he filed. The claim was then awarded based on the asbestos presumption which easily was satisfied.

So I guess for me there was a number of issues here that I think could be made better. And I think the SEM, the update sounds like that might address it. Because I went through the SEM, I've tried to replicate why this would happen.

As I went through the SEM if you put Rocky Flats and you put sheet metal worker you have asbestos and a lot of other exposures.

If you then restricted it to pneumoconiosis other, then asbestos disappears. So that was the issue, I think the problem with this statement of facts based on the CE's review.

But it also didn't consider the

occupational history questionnaire, not just the listing of the asbestos specifically having worked with it, but if you go into the SEM and some of the buildings that the worker actually says that he was involved in it's specifically in those buildings as a sheet metal worker.

So I think you could have gotten the asbestos exposure through various routes.

I guess in terms of comments for improvement. Hopefully this interstitial lung disease, you know, a horse is a horse, of course, of course. You know, interstitial lung disease, if you have asbestos exposure, is that not still asbestosis. So the physicians can address those issues, but I think that needs to be addressed.

And I think it's a fairly consistent pattern. Unless the CMC sees the words asbestosis specifically, and I'm not sure that interstitial lung disease or being looked at from a perspective there. In fact, just a pneumoconiosis caused by asbestos and silica and other things.

The IH report contained the standard language about exposures post 1995. And I think that needs to be addressed.

I guess that's my basic comment about it.

CHAIR MARKOWITZ: Steve Markowitz. So how could an industrial hygienist in an occupational medicine position, how could it not occur to them that a sheet metal worker in that era had asbestos exposure?

MEMBER DEMENT: That to me sort of boggles my mind. It's a given exposure. If you don't want to use SEM, use Google.

CHAIR MARKOWITZ: Let me just make a comment. The Sheet Metal Workers Union is the only union, only trade that has had a continuous asbestos medical screening program since 1985. And with many, many publications that derive from that. So it is kind of a signal of the construction trades and what you will find if you look hard.

And people have looked for a long,

long time. So that's why I raise the question how could an industrial hygienist and physicians not understand that.

MEMBER DEMENT: The question was asked I think several times today. As a physician, industrial hygienist, you're given of course the statement of facts based on the CE's report, right?

But you know, in some ways don't you need to use your other professional judgment to say, you know, this is a worker who has an established known exposure certainly back in the time frame when this individual was there, certainly pre 1995.

CHAIR MARKOWITZ: Dr. Goldman.

MEMBER GOLDMAN: I have a question. Sheet metal workers usually have a pretty high exposure. And one of the questions I have, if you just did it by buildings.

So for asbestosis you need a significant amount of exposure. It's not a slight exposure. Somebody with mesothelioma, a

slight exposure, you could make that case.

So a question I have is if you were going to go to a broader, you know, okay, you're in the building, getting back to what Carrie said, you're a person who's not a sheet metal worker, but somebody who's just working there, could you get asbestosis?

You know, not like lung cancer, but asbestosis from sort of just slight but chronic long-term exposure which is different than the sheet metal worker, where, I mean, that is like a classic major exposure.

But if we were going to try to broaden it. I mean, how would we put in something that would deal with length and intensity of exposure for that?

MEMBER DEMENT: Yeah, I think as a hygienist just thinking about how I would approach those situations, I don't generally -- I take materials in buildings as being a potential for exposure. But unless you can go a little bit deeper and say how would that occur then I have a

hard time making that direct link.

Especially, I could probably do it for mesothelioma, but especially for asbestos. Probably not.

So I would go back. And this is one of those cases if that would occur and I had an individual who did -- I would go back and ask how, how were you exposed.

It wasn't uncommon for some of these buildings as we saw out in Paducah to be constructed of transite. And that could become damaged, repaired.

In fact, during the time period in the sixties, early seventies up into the eighties a lot of that work was done without a lot of control.

So the direct worker exposure plus the indirect worker exposure could occur. So that's the type of information I like to dig more into.

And you would, if you're taking this worker's history you would be doing exactly the same thing.

CHAIR MARKOWITZ: I mean, I think we'll get to this but there are a certain subset -- the minority, a certain subset of the CMC reports which are clearly inadequate. This sounds like one of them.

By the way, was that -- the last two digits of that case was 15? Anybody else have an ILD case they want to discuss while we're on interstitial lung disease?

I'll discuss a case while you guys are looking. This is a pulmonary fibrosis case that was denied.

I agreed with the decision. It was a person who worked as a decontamination worker for two years and then a draftsman designer for 26 years. And I thought the claims examiner's statement of accepted facts was well written.

The industrial hygienist -- so one of the problems with the industrial hygiene evaluation I see, and Dr. Berenji referred to this before, is that it's a standard set of references that are used almost independent of

the case.

My review is I never see reference to an occupational health questionnaire. The only thing particular to the case is a reference to the SEM. Otherwise it's a set of six other standard references, some of which are probably relevant.

But, and I can't tell whether the industrial hygienist actually looks at the occupational health questionnaire or not. The SOAF of the CE does seem to itemize which documents are sent to the industrial hygienist. To my knowledge, it seems that the claims examiner is sending the occupational health questionnaire to the industrial hygienist. But, you know, let's -- when we look at individual claims let's look at that. Let's try to address that.

Maybe the industrial hygienist looks at the OHQ and uses it, but I don't see it in their report. I see reference to the SEM and the standard references.

And so I don't know what to make of that. That's true for the EE-3 form as well. There's some occupational information there.

And then this was a decontamination worker for two years and the industrial hygienist says he may have been exposed to some of the relevant agents, but at low to very low level.

And I'm clueless as to how the industrial hygienist decided that, the low to very low. Or whatever synonym we might come up with because decontamination worker to me is a very generic kind of title.

The physician, very nice report. The CMC -- actually, the physician did refer to the occupational health questionnaire. So the physician looked at it. So that was good. It went beyond the IH report.

But ultimately relies on the industrial hygienist estimate of the dose of this low to very low. And can't come to the conclusion that there's any occupational relationship.

So given what I looked at in general yes, I would agree of this as a denial, but it's an instance in which I'd like to know in that two-year period of decontamination what did the person do and what were their exposures.

And that information is obtainable if you dig, if you do one of these interviews. That was my assessment of the case.

MEMBER DEMENT: What was the case number?

CHAIR MARKOWITZ: 1504.

Dr. Berenji, I think you may have reviewed -- I don't know whether you have the case -- a couple of the ILD cases. I can give you case numbers if that helps. And also Dr. Silver, if you have a -- okay, great, go ahead. And what's the last two digits if you could?

MEMBER SILVER: I'm going to do two at once, 1346 and 0411.

I admit I chose these because of my colorful interest in the history of the fuel cycle. They're both uranium mill with a little

bit of mine worker exposure.

And as we learned at our first meeting when the Part E amendments passed in 2004, miners and millers originally covered by RECA were written into Part E for an additional $50,000. RECA provides $100,000 and Part E provides an extra $50,000 so as to provide parity between EEOICPA claimants and uranium miners and millers.

So what happens is they initially file a claim with the Department of Justice. And that occurred in both cases. One is -- and they're both around 80 years old. One worked for eight years as an ore hauler when he was in his twenties. And the other worked as a personnel manager periodically going underground in his thirties and forties.

So the decades go by and one way or another they both wind up at National Jewish Hospital where based on X-ray evidence, pulmonary function tests and job histories they're diagnosed with pulmonary fibrosis.

The Department of Justice approved

their claims each for $100,000. And to DOL's credit, it didn't take more than six months for DOL to look over the claim record and issue the $50,000 supplement in each case.

So neither got sent to an industrial hygienist or CMC. So it may be helpful for the new Board member to know that this little side track exists on their party for people with interstitial lung disease from the mines and the mills.

And then one of them went on to get home healthcare benefits under Part E.

CHAIR MARKOWITZ: What was the diagnosis?

MEMBER SILVER: Pulmonary fibrosis.

CHAIR MARKOWITZ: Are there any other ILD claims that people looked at? We can come back to it if you find any.

Can we do sarcoidosis? Okay. How about asthma? The last two digits. What's the last two digits?

MEMBER MAHS: 67.

CHAIR MARKOWITZ: Okay, thanks.

MEMBER MAHS: Mine's COPD and occupational asthma. And denied claim was 2016 and then it was approved in 2019.

Had a statement of the case. And I couldn't read my own writing last time so I printed pages off this time.

August 25th, 2015 they filed a claim with worker's comp. Cited COPD. Submitted the form EE-3, occupational history and a representative of DOE verified he worked at Hanford site for various DOE contractors and subcontractors between '76 and 2005.

He did not submit any medical evidence with the claim. Seattle District Office obtained -- and this sort of leads to what John said this morning -- they obtained employment documentation from the DOE through a document acquisition request.

The DAR records were thoroughly examined for potential radiological dose records, incident accident reports, industrial hygiene

safety records, job descriptions, medical records.

They do not indicate a diagnosis of COPD or any other chronic respiratory condition.

The office on two different occasions, August 2015 and October requested medical information and had 30 days to find it. If he didn't send it in they recommended they deny the claim.

They denied from lack of medical information.

Then he got an authorized representative in 2018. They recommended on 6/28/2019 recommended acceptance of the claim, impairment under Part E of COPD and occupational asthma in the amount of $105,000.

He filed a claim -- it repeats in 2015 and 2018 seeking his benefits. They requested to have the medical doctor perform an impairment rating. The district office referred the case to a doctor and asked her to provide an impairment evaluation according with the American Medical

Association.

The district office received the impairment evaluation performed by the doctor. Had 42 percent impairment.

Stated in the employee's occupational illness compensation regulations the employee must be covered, a Department of Energy contractor or subcontractor to be eligible. And they were.

Table 5 on pages 104 to 107 are AMA's guide for evaluation on your COPD and occupational asthma concluded that the respiratory condition belonged to class 3 based upon results of pulmonary function tests and shortness of breath which limits your activities and daily living.

Again, this will repeat a lot of it. Their data supports that he worked as a material moving equipment operator at Hanford Plant as having been significantly exposed to ammonia.

Such exposures would have been associated with the gas storage activities as

well as the tank farm operations that support the activities at 200 east and west tank farms.

His exposures through the mid-nineties would have been occasional and would have been at very low levels.

However, there is no available evidence, personal and/or area industrial hygiene monitoring to support that after the mid-nineties as exposure would have exceeded existing regulatory standards.

And again that question comes up how did they estimate what he had at that time and where he worked because there was nothing there to substantiate it.

It bothers me on a lot of these. No matter how intelligent these guys are, the IH is and how much education he's got he can't tell from 1,000 miles away what the guy did 30 years ago.

If they've got the information they're confined -- to me if they were to ask for affidavits or if they've got witnesses that

worked in these areas that should be proof enough of one person's word. It would seem like.

This is a lot of repeat from the first part.

And highly likely that in his capacity as material moving equipment operator at Hanford was significantly exposed to multiple toxins. Please refer to the following table. And it names quite a few of them and they're all at occasional, low to moderate, or very low rates. Again.

My question, I had two questions on that. They waited almost four years after the first filing to be able to collect his money or get something done.

It seemed like if they had a standard questionnaire or answer sheet from the claims examiner to let him know up front we need this type of medical information, not a one-page letter from a doctor. That's what he sent the first time. I skipped that somehow.

Of what he actually needs, what kind

of proof they need, or what kind of medical history they have to submit.

And to round it out, I mentioned this morning it seemed like a lot of these cases after they get an authorized representative they win their suit or win their case because they have experienced people helping them.

Where do you find an authorized representative? Anybody? I'm just curious. And how would they go about finding somebody?

MR. VANDER BOEGH: Word of mouth. I was an employee out there and I just represent primarily a lot of PGDP people. I'm sorry, I didn't mean to --

MEMBER MAHS: No, no, that's fine.

MR. VANDER BOEGH: Really, that's what we're finding. We cannot get --

CHAIR MARKOWITZ: Very briefly. If could just-- Normally we don't engage back and forth, but very briefly.

MR. VANDER BOEGH: They know me as a whistleblower. They know that I stand up for all

the nuclear workers at the Paducah plant.

But they come to me and they won't go -- so really they prefer coming to somebody that's actually a sick nuclear worker and I am.

I've got the same experience that they've got. And I'm not real happy about it, by the way. I used to play basketball. So it's respiratory illnesses mainly that the plant sees from chronic beryllium disease.

We're just here to bring the facts. And we have a hard time -- we're not real big, but we're very effective because we work with John.

John and I met back in 2010. So it's hard for workers to get the word out. I'll advertise occasionally just to help people understand there's somebody there.

MR. FITZGERALD: You're signed up for the public comment period, correct?

MR. VANDER BOEGH: Yes.

MR. FITZGERALD: Okay. Take it up then. Appreciate that, thank you.

CHAIR MARKOWITZ: Thank you. You know, just the former worker programs which are at most DOE sites have -- most of them have staff in the community.

For our program we have mostly retired, some current workers who help former workers and will help them find an authorized representative. And that's true for the construction worker program and many of the programs.

I imagine some of the resource centers would also steer people in the right direction.

MEMBER MAHS: Well, that was just a thought I had up front if they were told where they could find one if they wanted one. It would help just like what needs they have for their medical history.

CHAIR MARKOWITZ: So what did the authorized representative do in this case that helped win the case? What was missing?

MEMBER MAHS: He found what medical records he needed and had a couple of affidavits

from people that he worked in different areas. If that was the same one I'm thinking, that's one or the other.

CHAIR MARKOWITZ: Any other -- anybody else have a case they want to discuss? Dr. Dement.

MEMBER DEMENT: We're on asthma, right?

CHAIR MARKOWITZ: Asthma, yes.

MEMBER DEMENT: This is 413. Number 413. This is a case of an individual who actually worked here in Paducah '91 to 2014, and then again for a year or so in '17-'18.

Lots of jobs. There's a very complex history. Janitor which we talked about. A window washer, a painter, a lubricator, and then a material handler. So they had lots of different jobs here at Paducah.

The claim is for asthma, acute bronchitis and COPD as the present claim.

The claim was denied for all three in March of this year.

For the most part I think the record of denial, is probably, I would probably agree with most of it.

Did not build the medical side of it at least in my opinion very strongly.

The individual had a chest X-ray in 2010 and the interpretation was some hyperinflation consistent with COPD.

PFTs have been normal pretty much throughout the years.

Some exposures -- and I think the CE actually worked pretty hard through the SEM with all these different job classifications to come up with some exposures for the IH to review.

The IH did review them, sort of -- this is a hard one for anybody to review, but came up with pretty low exposures for most of them.

And he reviewed -- the reviewed exposures were ammonia, diesel exhaust, oxides or nitrogen, actually silica.

CHAIR MARKOWITZ: So they were

treating this as a COPD case.

MEMBER DEMENT: Yes.

CHAIR MARKOWITZ: Asthma case --

MEMBER DEMENT: Asthma was sort of blended in with a review of the COPD. And so both of them actually went to the IH and the CMC as a group.

I pretty much agree with most of the review and assessment. Except I took strong exception to the comments in the CMC report.

I also note that in the DAR request there was a record that came back from the site. It was a request for use of respirators for this individual.

And the stated reason was acid gases UF6, oil mist, and gases undefined. So and clearly there were some exposure to this individual.

One comment and I think this is the one that I had. The CMC's review of the case, Pretty factual for the most part, but then I don't think ever considers the combination of all

these different exposures as opposed to each individual exposure as contributing overall to COPD.

The -- let me find the comment. This is the one where I think the individual made the comment that occupational exposure standards are specifically designed to keep risk below 1 in a million.

And that seems like a pretty uninformed comment by a CMC.

CHAIR MARKOWITZ: What was the relevance of that comment?

MEMBER DEMENT: Just trying to justify non-attribution to low exposure.

CHAIR MARKOWITZ: Dr. Goldman.

MEMBER GOLDMAN: I think I might have just looked over that case a little bit just to get oriented.

What I wondered about, it seemed to me that the person had a lot of, could have had exposure to solvents or irritants I should say, irritants as an exacerbating factor.

And when I just again briefly looked it over it looked like that was not addressed, that there was a lot of emphasis on latency, allergic type of asthma and not really wondering if there could have been maybe not the cause of the COPD, but exacerbations related to exposure to irritants.

So I don't know if I was missing something there, but I wondered about that.

MEMBER DEMENT: Yes, I did note in the comments about the latency issue which I thought was not appropriate.

And I agree, I think there were some exposures that were on the OHQ. Actually, the OHQ listed some of these that were on the list for respiratory use. I don't think they were considered.

The Board's gone around and around on this with COPD. With COPD is it not the combination of all of these vapors of gas, dust and fumes together that's the best predictor of risk?

And how we as a board can formulate a recommendation that's going to be acceptable is I think a challenge for us.

CHAIR MARKOWITZ: Okay, so asthma. Dr. Friedman-Jimenez, comments?

MEMBER FRIEDMAN-JIMENEZ: Are we done discussing those cases?

CHAIR MARKOWITZ: We're still on asthma. Do you have an asthma?

MEMBER FRIEDMAN-JIMENEZ: I looked at three asthma cases that no one else had picked and I discovered why.

I agreed with all three of them. I didn't have a problem with the final decision.

But in trying to get to know the SEM it turns out that when you put in asthma nothing comes up.

It doesn't list any of the causes of asthma in the SEM. And I tried occupational asthma, work-related asthma, work exacerbated asthma, work aggravated asthma. Nothing except coal miner's pneumoconiosis, miner's asthma,

which probably isn't even asthma at all.

So, my comment is not on these cases particular which are 5938, 0125, and 1066, but the general observation that the SEM does not seem to reflect, unless I'm missing something big, the causes of asthma.

I mean there are several hundred sensitizing agents that have been clearly identified as causing asthma and then even more irritants that aggravate asthma. The list is really, really long and I think that's a shortcoming of the SEM that maybe we've raised before, but I didn't remember that.

CHAIR MARKOWITZ: Steve Markowitz. So the Procedure Manual says that any exposure can aggravate a cause or contribute to asthma in the workplace.

But correct me if I'm wrong, Mr. Vance, or you can straighten us out on this. And therefore they don't send it to industrial hygiene review. It's supposed to go directly to the CMC.

But I think that's the reason why it's not--they don't link it to any of the 250 known causes because they acknowledge that the universe of agents that people were exposed to at DOE could do this. But if you could be more specific.

MR. VANCE: All right. So this is John Vance again.

So Dr. Markowitz is correct. So we used to try to inventory all of the things that were known to be associated with occupational asthma and we found the exact same thing. There's just anything can trigger an asthmatic attack or an asthmatic reaction.

So the standard has been vastly expanded. And I think that's reflected in the numbers.

When you look at the asthma claim approval rate it's because the standard that exists for asthma is so open.

And basically the threshold for an asthma claim to be approved is merely that there

has been a diagnosis of occupational asthma, and I think that we have taken some language that the Board has provided with regard to how to go about establishing that.

And then a physician reviewing the case needs to evaluate the history of the worker's exposure to toxins and hopefully identify some toxic material that was a triggering mechanism for an asthmatic exacerbation, or could be sort of looked at as the source cause for an occupational asthma.

So it's a very liberal interpretation and it's not predicated on necessarily a lot of effort on our part to evaluate the exposures that the employee encountered, but merely that the medical information from a physician would be indicative of a work-asthma relationship.

Whether that is through cause, aggravate, or contribute. It's a very simple and much more broad standard than exists in other types of scenarios for other kinds of conditions.

But really it relies on a physician

taking an interview with a claimant or survivor and just asking some questions about well, what was the nature of the work. What were the nature of the substances that they encountered and basically saying well, if this person was reacting to their work environment it was probably due to X, Y, or Z.

So long as the doctor is identifying that toxic substance triggering mechanism that case is more than likely going to be approved.

And I do know that we did make some revisions to the diagnostic and clinical evidence that we would need for work-related or occupational asthma that the Board had recommended. So it's a much more broader thing.

We generally will not evaluate the case for occupational asthma using an industrial hygienist.

Does that answer? Does that provide more background?

MEMBER FRIEDMAN-JIMENEZ: Yes. I do remember the discussion with Dr. Redlich and the

changes that were made in the Procedure Manual.

Two of these cases, the asthma diagnosis was denied, but it was called COPD and that was accepted which I think -- I mean the person did seem to have COPD.

But the question of why the asthma cases were denied based on lack of medical evidence, it seemed that maybe they hadn't really read the Procedure Manual in detail.

Although the CMC was quite good, Dr. Soo. So I don't think that's the issue.

CHAIR MARKOWITZ: I have a related question to this. The claims examiner sent out the statement of accepted facts and sends it to the CMC in an asthma case. And the CMC is supposed to accept these accepted facts.

MR. VANCE: Correct.

CHAIR MARKOWITZ: Correct. So the claims examiner says this person has asthma and I just need to know whether it's occupational asthma or not.

And the CMC looks at the available

records and says I don't see evidence this person has asthma.

Now, I can't blame the CMC. Okay, he or she wasn't asked that question, but they looked at the records and they don't see asthma so how can they answer the question of occupational asthma if they don't see asthma.

But clearly the CMC was answering a question that wasn't asked of him or her. So, what does the department do in that situation?

MR. VANCE: Well, my first comment is welcome to the world of worker compensation claim examining.

There's so many different issues that can come up. And I would say when we interact with our CMCs, when we interact with our claims examiners we're constantly stressing the fact that you have to make sure that you're asking the right question.

If you get an answer to a question that you shouldn't have asked in the first place it can create these kinds of diabolical problems

that are hard to escape from.

So if the question is when a person files a claim that starts us down the path of what it is that we need to look at.

If somebody files for occupational asthma that's what we're going to look at the case for.

If there's confusion as to whether or not it should be occupational asthma or a COPD claim that's something that we may ask the claimant to clarify. That might be something that bears out through the development of the case through the medical evidence.

Generally what I would say is when we are evaluating a case where a physician has been asked a question and either doesn't understand, or needs further clarification as to what it is that the CMC needs to be doing the doctor should not respond when they're unclear as to what's going on and should ask the CE to clarify.

Now, does that always happen? No. So then you end up in the scenario where the doctor

is asked a question and they're responding to that question but it's not producing a resolution to the issue that should actually be evaluated.

So the first step in any one of these cases is trying to make sure that the claims examiner has established the factual basis for accepting a diagnosis.

So if a doctor is saying this person has, say, an asthmatic condition, asthma is kind of interesting because you might have asthma, but the question that we need to then say or have someone answer is that okay, we know this person has asthma, or a reactive airway disease, or something.

But in order for us to sort of characterize it as occupational asthma we need a physician to look at it and say oh, there was some work-related exposure that can explain that condition.

Asthma is very challenging for that reason. Because you can have asthma, you can just have asthma and then it be classified as

asthma, but then when you're in a working environment you're exposed to something that makes it worse, or you've had a reaction or an exacerbation.

Does that--How do you characterize that, as occupational asthma or worsening of regular asthma?

What we'd be looking for is that physician's opinion that asthma has been either caused, aggravated, or worsened by something in the workplace. That's what the CMC should be focused on unless it's a question of whether or not -- do we even have the evidence to show that this person has asthma. And that's -- it's dependent on good claims examination.

CHAIR MARKOWITZ: Okay. Steve Markowitz. The problem there is that in this interaction the person with the greater expertise about disease is the doctor. Right?

So a claims examiner is doing the best he or she can. They looked at all the records. They looked at everything. They assembled

everything. And is assembling the best SOAF that they can.

But some of these -- not just asthma. COPD, some of these diagnoses are tricky. And so they pass along accepted facts that don't really correspond to reality.

A physician sees that and says I can't answer that question because there's a different kind of problem here.

And I understand the sense of making the claims examiner the traffic cop, in a sense the arbiter.

But here, but in this situation you've got this conflict in which the CMC, now part of the problem with the CMC is the CMC may not get every last medical record. Right? So they may not have all that information.

And so I understand that it's tricky, but it seems like a tension that somehow needs to be resolved in a more satisfactory -- because I looked at another -- it was the same. If I can just introduce another case.

It was an asthma case. It was an engineer at Savannah River for a couple of decades.

And the statement of accepted facts said the person had asthma. And the physician looked at it and said no -- looked at the records and said I don't see real evidence of asthma here so I can't make the judgment about occupational asthma because the person doesn't have asthma.

And I looked at the medical records. The personal physician had called it asthma several years before.

And it may have been in this kind of continuum between asthma and chronic obstructive pulmonary disease that older people get that can sometimes be a little confusing.

But regardless, the personal physician called it asthma. And what the physician, the CMC said. I don't see bronchodilator response. I don't see a methacholine challenge test. These are specialized tests that can prove to a high level of certainty that a person has asthma.

And so they questioned the SOAF, didn't confirm the asthma and said no, there's no evidence of occupational asthma. In fact, no evidence of asthma.

So I disagree with that CMC, both their reading of the underlying medical literature and their veto of what the CE had decided.

That seems to be an awkward kind of situation.

MEMBER POPE: I agree with you, Dr. Markowitz. I had somewhat the same situation in 3767 where they approved it for COPD but denied it with the asthma.

And there was supporting information from the attending physician to support that the asthma was definitely there. He had the work history to prove that he was exposed to the dust and the other asbestos, cadmium oxide, cement, crystalline silica.

But they had other supporting documents there to indicate that there was some

asthma -- the asthma was present with this individual.

But they denied it on the asthma and approved it on --

CHAIR MARKOWITZ: On COPD. Other asthma cases. Yes.

MEMBER MIKULSKI: I had a case that plays into what we've talked about here right now. The last three digits is 536.

And this was a Hanford worker who worked mostly in the office administrative positions in the seventies and the early eighties.

And has been diagnosed with asthma. Placed on the positive response to bronchodilator test in mid-2017.

The primary care physician which I think in this case was actually a pulmonologist opined that based on the review of their work history and specifically work in one particular building which according to SEM had exposures to diesel fumes it's more likely than not was the

case of occupational asthma and CMC agreed with that initially, but sort of overrode that opinion saying that in their review of medical records which were very, very scarce for this person they believed that these were seasonal attacks of asthma not related to any exposures.

To which the claimant presented another opinion from another primary care who consented with the first opinion.

And it kind of kept going in between the doctors and the case ultimately got denied.

CHAIR MARKOWITZ: What was the job title?

MEMBER MIKULSKI: So, this person worked as a senior secretary and stenographer, but they did have several months of exposure as a temporary expeditor in one of the buildings that according to SEM did have exposures to diesel exhaust. So I believe this was a plutonium recycled test facility building.

And I second what Dr. Friedman has said. I've looked for any links to asthma either

by building or aliases.

And the only thing I could actually find was that miners, asthma as the coal workers, pneumoconiosis.

So in other words there was really no specific links to asthma for any of the exposures from Hanford site.

CHAIR MARKOWITZ: Other cases of occupational asthma? Yes.

MEMBER SILVER: I have two from Oak Ridge. One spent 25 years between Y-12 and K-25 as an electrician. And the other was a janitor for four years around the time that the K-25 demolition was getting underway.

They have two elements in common. One is that they both wound up in the hands of a pulmonologist who sees a lot of Oak Ridge workers and knows the site pretty well.

And in both cases the claims examiner cited what Mr. Vance said which is that they don't try to find a specific agent. They rely heavily on the physician's opinion and the

medical evidence provided.

So the electrician had a history of pulmonary problems. I don't know how many times they requested the medical record, but when it was finally all in hand that pretty much made it a slam dunk.

In 1978 the documented bronchial trouble and 1993 acute bronchitis. In 1998, quote, "industrial related bronchospasm" while he was currently employed.

He didn't file until he was retired around age 70, but with that evidence in hand the pulmonologist seeing him had no trouble writing a succinct but very convincing letter of opinion that it was asthma.

Initially the claim for impairment was denied, but the claims examiner sent it back to the certified independent medical examiner, specialty plastic surgery, to take another look at the AMA tables.

Apparently, I'm not an expert, but according to the final decision the independent

medical examiner used the wrong tables in the fifth edition of AMA for evaluating asthma and in the end 10 percent impairment was awarded.

And then in the case of the janitor, it's interesting that there was no contemporaneous medical evidence when the person was employed.

The pulmonologist seems to have taken at face value that this never smoker denied symptoms prior to ever having been exposed at K-25. And some of the job tasks were packing up waste containing boxes and I'm not clear about the process, but grinding the boxes if they were over the weight limit. Leave it to your imagination.

Sweeping, dusting and cleaning excess oil from motors and bystander exposure to asbestos removal as K-25 was getting mothballed.

And the janitor had a strong response to a broncho challenge test and that pretty much won the case.

CHAIR MARKOWITZ: So did they get CMC

reports?

MEMBER SILVER: No. The claims examiners went pretty much by the book in relying heavily on the treating physician's medical opinion.

And in the first case sent the impairment evaluation back when they found an error. So, good job claims examiners.

CHAIR MARKOWITZ: Other cases of asthma?

MEMBER SILVER: Those numbers were 1633 and 0073.

CHAIR MARKOWITZ: How about chronic beryllium disease? Actually, I'll do a COPD case while you're sending it. This is a COPD case.

Machinist for 20 years. A carpenter for seven years. It was denied.

And I agree with the claims examiner's statement of accepted facts and agreed with -- for the most part with the industrial hygiene report.

Again, as I said before this

industrial hygiene report didn't actually cite the occupational health questionnaire so who knows whether it was actually reviewed or not.

But here the problem was the CMC report. The CMC denied it. And this was -- the logic of the CMC was there was no asbestosis and therefore I couldn't link asbestos to COPD which is contrary to Asbestos 101.

You wouldn't link the presence of interstitial lung disease or asbestosis to the presence of COPD in an asbestos exposed worker.

You wouldn't make one conditioned on the other. And the person had multiple other exposures that you could attribute to as a machinist and carpenter at a minimum on exacerbation or aggravation.

So, this was one of those really lousy CMC reports that unfortunately we've seen a few of.

But otherwise at the claims examiner level, at the industrial hygiene I didn't have any dispute with what they said. It was denied.

MEMBER DEMENT: Isn't that consistent with the earlier, maybe still existing presumption on COPD? I mean it ties it to asbestos exposure long-term.

The other report that you and I think Dr. Wilmer reviewed also said that 15 years post exposure when the COPD was diagnosed and the person didn't have pneumoconiosis, therefore it's not attributable.

CHAIR MARKOWITZ: Yes. Well, unfortunately asbestos is one of the few agents listed -- linked to COPD in the SEM.

But the finding of obstructive lung disease in the asbestos exposed shouldn't be dependent or conditioned upon the finding of interstitial fibrosis since they are somewhat different disease processes.

Okay. Kevin, do you have that slide that she wanted to show?

MEMBER REDLICH: Are the slides coming up? I just wanted to bring to everybody's attention the American Thoracic Society

periodically publishes sort of official documents that go through extensive review and are approved by the American Thoracic Society.

In this case it also went through extensive review and approval by the European Respiratory Society.

And this was looking at the burden -- sort of the idiopathic lung diseases, the ones that are not asbestosis, silicosis culprits, of course, pneumoconiosis, but the not garden variety, but the COPD, sarcoid, and asthma, and looking at what burden of those diseases are due to occupational exposures.

And what was novel -- this has been looked at before in terms of asthma and COPD and that's why we've I think recognized that a substantial contribution of asthma and COPD that may not be initially recognized as clearly occupational is.

And this document looked at most importantly interstitial lung disease and also sarcoid which had not previously been evaluated

and the occupational burden estimated in a systematic evidence-based fashion.

So, the next slide just gives the overall bottom line result of this extensive review of the literature and analysis that took a number of years.

I am the senior author on this. Maybe-- but it did go through extensive review.

So asthma, COPD, that prevalence is very consistent with prior -- multiple prior reviews and studies in terms about anywhere from 14 to 16 percent of those cases being attributable to occupational exposures.

Importantly we looked at IPF which is idiopathic pulmonary fibrosis, also termed pulmonary fibrosis or interstitial lung disease without a clear cause such as rheumatologic disease or something like silicosis.

And impressively over 25 percent of that was attributable to work exposures.

And this is in all people, not workers working only in industrial settings. So it

really shows a substantial burden of occupational fibrotic lung disease in some of the cases we've discussed.

And then also the sarcoid was a very high burden. Thirty percent. And this was attributable to work exposures.

And the other -- we haven't really dealt with hypersensitivity pneumonitis, but when that becomes chronic it looks like idiopathic pulmonary fibrosis.

So, I think the bottom line is that -- one thing is pulmonary fibrosis is a much less common condition than COPD or asthma, but I think the message is that when it does occur, especially in workers who have worked with asbestos and dust and fumes that those are substantial contributing source.

In terms of what exposures contribute to that similar to COPD the nature of the literature is that many of these workers have mixed exposures to asbestos dust, fumes.

And so the most common exposures that

contributed to that in addition to sort of a generic dust, fumes, particulates including asbestos were metal workers, metal working machinists.

And also there was a component of farmers too that's probably overlapping.

But the metal working and the asbestos and general dust and fumes. And so I think that's very relevant to this workforce.

I'd be happy to send the article around. But I think that --

CHAIR MARKOWITZ: Steve Markowitz. I have a question. So you must have done a big literature review because a lot of diagnoses, a lot of toxins.

Is the underlying scientific review that you did in support of these, did you broadly identify specific toxins such that that work might be usable within the SEM to improve the exposure-disease link?

MEMBER REDLICH: Yes, I think that -- it's similar to COPD in some regard in that those

studies have shown sort of the type of working exposures, dust and fumes.

And individual studies give some idea of starting to tease out what that exposure is.

But when you also consider it no one's exposed to just a single exposure. They may be working in a building that had a lot of asbestos, but there's also -- working as a machinist, or around other dusty, dirty environments.

And if you're thinking also typically many years of exposure. And in those workplaces.

So it's very hard to identify one causative agent.

But this involved extensive review of evidence-based literature search and review of available literature. There are numerous evidence tables in the document and an appendix with more information.

And it actually did -- I didn't include this table, but it did look at metal, wood, and silica individually and what those individual exposures contributed as also a

contributing.

So those were sort of the biggest contributing factors.

And it was felt that given the time period that many of these studies were done that asbestos invariably was another important contributing factor.

CHAIR MARKOWITZ: Another question I have is sarcoidosis. Was a lot of that misdiagnosed chronic beryllium disease?

MEMBER REDLICH: It included some.

CHAIR MARKOWITZ: Dr. Goldman.

MEMBER GOLDMAN: Carrie, how much did sort of what happened at 9/11 where all those workers had such a combination of dust, oils, whatever that mixture was.

And then now studies have gone farther, seen more people being diagnosed with real sarcoidosis, not necessarily chronic beryllium disease.

Does that help inform that there actually could be mixed dust oil exposures that

could lead to what we call sarcoidosis?

MEMBER REDLICH: It actually -- I don't believe any of the World Trade literature studies were included just because there were pretty strict criteria for inclusion in terms of the diagnosis.

CHAIR MARKOWITZ: Dr. Friedman-Jimenez.

MEMBER FRIEDMAN-JIMENEZ: Just a quick comment regarding the World Trade Center study.

It was not that thorough how well the chronic beryllium disease was excluded from those sarcoid cases. Not all of them were worked up.

And there is some U.S. Geologic Survey data that there was some beryllium in the World Trade Center dust.

So it's not 100 percent certain that they were not beryllium related. Some had negative lymphocyte proliferation tests, but some did not.

MEMBER REDLICH: And I didn't include the table that broke down individual exposures,

but beyond the sort of more general category that's also been used for the extensive COPD literature of vapors, gases, dust and fumes, metal dust was accounted really for 8 percent of all, which is a high percentage when you consider that many patients have actually worked in an office their entire life.

CHAIR MARKOWITZ: Steve Markowitz. When you call this occupational burden is this aggravate, contribute, or cause as a standard roughly you think?

MEMBER REDLICH: Who are you asking?

CHAIR MARKOWITZ: Oh, I'm sorry, I'm asking you actually. So in the underlying studies. I know there are many. There are probably hundreds of studies here that vary greatly.

But when you look at the percentages do you think they're looking sort of strictly at cause, or do you think they're including cases where COPD was aggravated or exacerbated by the occupational exposures?

MEMBER REDLICH: They-- for COPD there's actually a pretty good literature both in smokers and non-smokers.

In fact, the fraction that is contributed by these exposures in non-smokers is actually higher than that fraction.

So I think this is considering smoking. And actually in the non-smokers we didn't include it in that but it's an even higher fraction.

And smoking is less of a contributor to interstitial lung disease. It really is not a major risk factor the way it is for COPD.

CHAIR MARKOWITZ: Okay, thank you. Shall we move on-- shall we discuss sarcoidosis?

MEMBER REDLICH: I would just add one last thing about this. I think that it's important to recognize that most pulmonary physicians unfortunately, especially with a condition like interstitial lung disease, they do not think about the etiology of the cause because they're really concerned about the treatment.

And so I think lack of any recognition of it being work-related. These were all cases and many of these were from settings where there had been a thorough workup for other known causes of ILD.

So the asbestosis and the silicosis had been eliminated. So it's important to recognize that the lack of a treating physician recognizing any work-relatedness does not in any way rule out the possibility.

CHAIR MARKOWITZ: Dr. Friedman-Jimenez.

MEMBER FRIEDMAN-JIMENEZ: I'm just looking through the article now and I'm not clear on how much you took into account the prevalence of exposure.

In other words, if you have an attributable risk in an exposed group it can be a certain percent.

But then if only part of the population is exposed then that percent is lower in the entire population.

So my question is what attributable risk did you use?

MEMBER REDLICH: If anything this is probably an underestimate because of issues of duration of exposure.

I don't want to get into the technicalities of calculating the population -- most of these studies it was looking at the most common occupation that person had for a period of time.

And I think that is something that we take into account in terms of duration of exposure.

And so these were generally not the one month that someone's worked, but their most common occupation.

CHAIR MARKOWITZ: Dr. Berenji.

MEMBER BERENJI: I have a CBD case if we're still on CBD.

CHAIR MARKOWITZ: We're just starting CBD. That would be great.

MEMBER BERENJI: I'm right on time, I

love it. So, let's see. So the last three digits are 334.

So, I thought this was an interesting case first of all because out of all the cases I reviewed it was the shortest number of pages. But that kind of made me wonder that there might be some documentation missing.

And this is an additional comment that Dr. Dement made earlier about indexing these files.

At least in this case it was relatively easy to scroll through, but I did notice that there were a lot of items missing.

For instance, there was no statement of accepted facts. There was no--I didn't see an IH report. I did not see any CMC report.

So at least if there's some sort of face page stating what's actually in the file would actually make our job a lot easier. So just an FYI.

So at least in this case I thought the occupational health questionnaire was very

telling. I'm actually going through it right now again.

The second pass through actually reveals more information than I realized on the first review.

So this gentleman actually worked at the Savannah location, Savannah River I should say. And we actually had the pleasure of visiting that site back in the springtime. So it was actually interesting to actually read the case and actually use my previous experience visiting the site to kind of gain some more perspective. So this is the true benefit of being on this Advisory Board.

Nevertheless this gentleman worked as a laborer. If you actually look at what he describes in his work activity this is very telling because he actually worked underground in Building 400 and he also worked in the F and H units.

He describes working around a lot of dirt and he remembers actually packing up

contaminated dirt into bags.

So just based on my experience on this Advisory Board, kind of understanding the nuances of the decontamination process this individual was most likely exposed to a lot of different agents that unfortunately was not properly documented in the statement of accepted facts which unfortunately was not in my file.

But also in terms of doing a formal analysis it's hard to be able to do that if we're not actually picking up this qualitative information that's within the occupational health questionnaire.

So I'm actually really looking forward to reviewing your new draft from the Department of Labor so we can actually gain a better understanding of what we're missing especially when it requires us to really look into these text fields into what people actually say, and then being able to further investigate when the IH does their phone call with the worker.

So to me this is very important. I

think this is probably the most important part of this case.

But this gentleman was actually applying for CBD as well as hearing loss. And unfortunately there was limited medical documentation available in this case review.

But when I actually reviewed what medical history he had he actually did document that he had a history of sarcoidosis.

So this is where the plot thickens because unfortunately there's just not enough information to be able to decipher how he came about developing sarcoidosis, when was he diagnosed, who diagnosed this gentleman.

And unfortunately he did have some additional testing which was provided in this file.

He did have a lymphocyte proliferator, a proliferator testing done which was negative, but that was only one test date.

So, I feel like in this case the most important things to realize is that not having

the appropriate information and making a denial based on that to me would require at least in my humble opinion a reassessment of this case.

CHAIR MARKOWITZ: Do you remember was this a post 1993 case?

MEMBER BERENJI: This gentleman was working at Savannah River in the eighties. I can get you an exact date. Hold on.

So he was working at Savannah River in 1984 and he was kind of in and out of the location through the mid-eighties. And then he finished his position there in '91.

CHAIR MARKOWITZ: So this is a claim within the past three years, one of the recent claims.

MEMBER BERENJI: Yes. I believe this was denied in 2018.

CHAIR MARKOWITZ: Other CBD cases? Dr. Dement.

MEMBER DEMENT: Fairly brief case I think.

This is a case of an individual whose

employment history -- the employment history is one that -- the claim was for COPD, sarcoid and sleep apnea. He worked at Hanford for a period of time, 2009 to 2013, and INL for a couple of years.

The OHQ listed beryllium. There were four records from the DAR request testing for beryllium sensitivity that were all normal, and seven additional ones that were I guess after employment and they were all normal.

The PFT was mild fibrosis. Lots of different jobs. Production systems, utilities operator, nuclear facility operator and a staff specialist.

Any beryllium exposure is pretty well acknowledged. The issue for this individual is that there's no indication of beryllium sensitivity and so based on the criteria that is in place and operable it was denied based on lack of sensitivity.

And one issue I think is one of the physicians noted that this individual was on

steroids and it's possible it could be masked by the -- mask the sensitivity test.

So it's probably something that at least in my opinion might still be an open case.

There was a CT that actually the reviewing physician noted that suggested sarcoidosis of the lung. He had cutaneous sarcoid diagnosed in 2016.

So this individual has been on some steroids prior to at least some of the latter sensitivity tests.

It's sort of complicated by a whole series of early ones prior to the diagnosis that are all negative.

So I didn't disagree with the determination based on the criteria that we have at hand.

CHAIR MARKOWITZ: He had multiple negative beryllium LPTs at the time when he was ill with chronic lung disease.

MEMBER DEMENT: This preceded -- the negative beryllium sensitivity tests. This is

the question that I have. They seemed to have preceded the CT showing suggestive evidence of sarcoid.

But the individual had cutaneous sarcoid diagnosed much earlier. So, sort of a complicated --

CHAIR MARKOWITZ: Yes.

MEMBER DEMENT: -- of steroid use and non-steroid use I think.

CHAIR MARKOWITZ: But had some LPTs off steroids.

MEMBER DEMENT: I think so.

CHAIR MARKOWITZ: That is complicated.

MEMBER DEMENT: So there's no evidence of sensitivity. So all in all I think the criteria were applied appropriately.

CHAIR MARKOWITZ: Other CBD cases?

MEMBER REDLICH: I have -- it's in the sarcoid COPD category.

So this is a man who worked from 1970 to the present. So that's like 49 years at Savannah River Site, initially as a janitor, a

laborer, and moved up, operator and a procurement specialist.

And so the claims examiner notes that the diagnosis of CBD was made in 1981, pre-1993 after. And it was actually a pre-employment -- documentation pre-employment that the person did not have CBD because they have records going back to pre-employment evaluation.

And then in the statement of facts documents that throughout the course of its operations the potential for beryllium existed at Savannah River site.

And then he sort of cites the language as far as the diagnosis of sarcoidosis, as far as under which criteria to use.

And then the question that the CMC is asked is -- so I think one could say that one has potentially enough information at that point.

And this was a confirmed diagnosis. No one was questioning the diagnosis of pulmonary sarcoid.

The question was is it at least as

likely as not that the employee's exposure to beryllium at the DOE facility, I think everyone's familiar with the wording, was a significant factor in aggravating, contributing, or causing the diagnosis of sarcoidosis.

So the first CMC replies that thank you for referring this case. And this is an occupational medicine board-certified physician.

Thank you for referring and cites the language as far as the diagnosis of sarcoid and COPD from the Procedure Manual and states that this person he believes has chronic beryllium disease and not sarcoid.

So from the statutory viewpoint the answer to the question posted is that it's not at least as likely that the employee's exposure to beryllium was a significant factor in the diagnosis of sarcoid.

Instead, as per the June 16, 2017 guidance it's much more likely that this person has CBD.

And then he gives a rationale. He

says despite the presence of some differences between sarcoid and CBD there is still sufficient overlap.

And as -- explained his rationale for saying that this is CBD.

And so then after that though the CE sends an email that they don't think this physician understands sarcoidosis. And sarcoidosis is only accepted -- and then basically sends the case to another CMC.

And that CMC basically answers the question yes. So, the patient was eventually accepted as sarcoid, but I think if one followed the various guidance that this would have been appropriate to diagnose as chronic beryllium disease.

So there wasn't an IH assessment. It wasn't needed. We don't have the SEM involved here. We have documentation of pulmonary sarcoid that was new since employment.

CHAIR MARKOWITZ: So, I got a little lost. It's an accepted CBD case?

MEMBER REDLICH: No, it's accepted for sarcoid.

MEMBER GOLDMAN: Did he have a positive beryllium sensitivity test, or he didn't have it done?

MEMBER REDLICH: No. Because he was diagnosed years ago in 1981 with sarcoid. And there's documentation of that in the records. In fact, it was a little earlier than that, but it was after his employment.

There was actually a pre-employment chest X-ray which showed no sarcoid.

CHAIR MARKOWITZ: I'm sorry, this was an accepted case claim as an occupational sarcoidosis.

MEMBER REDLICH: Yes.

CHAIR MARKOWITZ: That is not considered CBD.

MEMBER REDLICH: Yes. I found it actually -- I was looking some of the accepted -- I know we tended to look at the denied claims.

I found looking at some of the

accepted claims helpful to -- and some of them were very correct.

It's just that I think this was accepted for the wrong condition.

And it's good it got accepted, it's just that I think someone else could have easily just answered -- I've seen other cases where answering the question would have just been no because beryllium doesn't cause sarcoid.

CHAIR MARKOWITZ: Questions? Comments? Mr. Mahs.

MEMBER MAHS: CBD case.

CHAIR MARKOWITZ: Ok.

MEMBER MAHS: CBD case.

MEMBER REDLICH: Can I just say one other thing about this? I think -- I think to me this illustrates that maybe there needs to be further training of the -- the question is everyone -- it is confusing and it took me a long time to figure this out.

But I think it shows that even when things are clearly delineated the implementation

of that down the sort of -- the train of steps can go wrong.

And I'm not sure that the current review process might have picked up that this was what I consider a misadjudicated case.

MEMBER GOLDMAN: You're saying it should have been beryllium.

MEMBER REDLICH: Yes. And I think that actually in terms of just optimizing uses of resources, time and the like that the claims examiner could have made that decision without it needing to go out for further review.

CHAIR MARKOWITZ: But the error was with the CMC?

MEMBER REDLICH: Well, the question, the CE noted the diagnosis of sarcoid. So that was not in the question. Or the year it was diagnosed which was pre 1993 and confirmed after 49 years of employment at Savannah River starting as a janitor and a laborer that this person had beryllium exposure.

Then wrote a somewhat complicated, you

know, you need to meet these criteria. It should have been clear that this person met the pre 1993 criteria. There's evidence of --

CHAIR MARKOWITZ: Chronic respiratory --

MEMBER REDLICH: Yes.

CHAIR MARKOWITZ: Other comments or questions about this case? Yes, Dr. Friedman-Jimenez.

MEMBER FRIEDMAN-JIMENEZ: I agree that training the CEs in this specific confusion would be useful.

And I don't remember exactly the language in the Procedure Manual, but maybe a note in the Procedure Manual that there is a high possibility of misdiagnosis of chronic beryllium disease as sarcoidosis, and that that should be addressed by the CMC.

Some way to get the CE to feel more comfortable with -- it sounded like the CMC had a very well reasoned and well stated opinion which was then questioned by the CE.

MEMBER REDLICH: This person actually cited some of our documents that we have submitted. So this was a more recent case.

And they cited from our quoting in summary in which situations in which a covered beryllium employee has been diagnosed that it would more likely be CBD than sarcoid.

So this person was really quite familiar with and appeared to be knowledgeable. So he wrote.

And the other concerning thing was that this wasn't someone who didn't give any thought to the letter that they wrote in response to the CE's question. They gave a detailed explanation for why this should be CBD and not sarcoid.

CHAIR MARKOWITZ: Well, yes, sure. To answer George's question there is language around sarcoidosis in the Procedure Manual, differentiate pre and post 1993.

But they do recognize the potential for confusion and a way how to deal with it. I'm

not sure it's adequate, but it's there. Dr. Goldman?

MEMBER GOLDMAN: So, having discovered that I'm a little concerned now that the person who really made a thoughtful response and then was sort of put down saying you don't understand sarcoid, what is that person going to do the next time they get a case?

So having discovered this is there a way to get back to this person who seems to have really done a good job and read this to say this has been re-looked at and your reasoning was logical and valid.

CHAIR MARKOWITZ: You're asking whether CMCs get feedback?

MEMBER GOLDMAN: Well, the first CMC, yes. Because that person who wrote this, what the committee now thinks is a more accurate note is told you don't understand sarcoid.

So what does that person feel now after they've gone to the trouble to do this. And if that person is going to be used again and

gets another case how are they going to respond.

It just seems like the person did get feedback from the CE, and that the person now is going to know they shouldn't give that answer and they were correct the first time.

They are getting feedback that's sort of an incorrect feedback. So it seems like if we feel that way there ought to be now a response back to that person that your thinking was reasonable.

CHAIR MARKOWITZ: Dr. Friedman-Jimenez.

MEMBER FRIEDMAN-JIMENEZ: I found the language in the Procedure Manual. It's very clear and explicit.

It says as such a diagnosis of pulmonary sarcoidosis is not medically appropriate under Part B if there is a documented history of beryllium exposure. That's very clear.

MEMBER REDLICH: And what's clear in this case, if it was a post 1993 it would be less

clear because of the issue of those criteria and meeting the BeLPT. And that would need to be addressed to meet the statute requirement.

So one would have to either see if there had been one, if it was a reason it was negative, or the like, or couldn't be done and address that.

But this was pre 1993. And acknowledged as pre 1993 by the CE.

MEMBER GOLDMAN: So it's feedback to the CE then.

MEMBER REDLICH: Yes, I would think. And whoever is performing oversight of the whole process.

CHAIR MARKOWITZ: Comments, questions on this case? Otherwise we'll move on. Ms. Pope.

MEMBER POPE: I just had a quick question for Mr. Vance. What is the frequency of I guess oversight over the CEs, that their training, re-training, re-certification?

MR. VANCE: Okay. So if you're asking

just like, are you talking about like performance assessment?

MEMBER POPE: Right.

MR. VANCE: Well, you know, every year employees have to go through a performance assessment just for the qualifications of the position.

That involves just like any other type of job a supervisory oversight of the work, the performance, the accuracy, quality, the timeliness and all those kinds of things.

These cases also, depending on the CE you could have their work being reviewed more frequently by a supervisor or senior.

Other CEs are given a little bit more leeway simply because they either have the experience or the knowledge to be able to apply their adjudicatory skills independently.

And like I mentioned before we do have internal quality control mechanisms evaluating the work that's being done by our staff through accountable review, by systemic review, by our

supervisory staff in addition to the regular performance assessments that are done by supervisory staff.

And I would just say the sarcoidosis cases are probably some of the more challenging ones.

The thing in the conversation that you have to keep in mind is that sarcoidosis as Dr. --

CHAIR MARKOWITZ: Friedman-Jimenez?

MR. VANCE: -- Jimenez mentioned, you know, if you're looking at it, yes. If you see a diagnosis of sarcoidosis you can treat it as a misdiagnosis of CBD.

However, the statute lays out the requirements that have to be satisfied in order for us to establish a viable CBD case.

So even though the word sarcoidosis is there, you still need to meet those statutory provisions that are in the law.

And that is pretty much solely reliant on a medical opinion saying oh, this is a chronic

respiratory disorder that's consistent with chronic or is consistent with a CBD condition. So we would still need that.

If that was absent from a case file you could very well end up with the CE saying okay, I don't have enough here to allow me to say that this sarcoidosis is a misdiagnosis of chronic beryllium disease.

They could then maybe look at it as this is just sarcoidosis. I'm looking at it as a condition in and of itself that could have been aggravated, or contributed to, or caused by another type of toxic substance exposure.

So this is a uniquely challenging problem that exists with regard to how we treat sarcoidosis. It can lead to a lot of confusion and a lot of interesting outcomes in the cases.

December 6, 2019

CHAIR MARKOWITZ: Dr. Goldman.

MEMBER GOLDMAN: So in this case though the first CMC person did do what you just said, made the linkage and that was rejected by

the CE.

Was that not sufficient when the CMC put it together that way, or did they need a treating physician or something else?

MR. VANCE: It's really hard for me to comment on something without looking at the actual specifics of it.

There can be any number of issues with regard to what the CE was evaluating, the weight of evidence that was being assigned to the quality of the input from the CMC.

It's just really hard to know without looking at it specifically and finding out what was the justification for the CE to say that there was a problem with this CMC versus someone else. It's very hard to comment on that.

CHAIR MARKOWITZ: Other questions, comments on this case? Mr. Mahs, you wanted to do a case?

MEMBER MAHS: Yes, Ron Mahs, case 3044.

The final decision was made on July

16, 2018. The reasons set forth below. Your claim for chronic beryllium disease is approved for payment of $150,000 under Part B of the act.

You're entitled to medical benefits for CBD and beryllium sensitivity retroactive to your filing date of October 17, 2016.

And some of these are six, seven hundred page claims so I may have missed it, but usually if it's that much time between the filing and the claim it's either been denied or reopened or something and the only item I found were they needed to identify buildings worked in.

In support of your claim you provided a report dated November 23, 2005 and signed by the doctor documenting positive blood beryllium lymphocyte proliferation test dated September 3, 2004 and October 6, 2004.

Test results established the diagnosis of beryllium sensitivity. Reviewed these test results as well as chest X-ray, CT scan, exercise test, pulmonary function test including your beryllium sensitivity have progressed to CBD.

This diagnosed November 23, 2005.

In addition, you completed employment history claiming employment at Coors Porcelain from June 27, 1981 to 2009 at the district office. Request to corporate verifier for Coors confirmed you were employed at Coors Porcelain in this time frame.

The corporate verifier noted that you participated in a beryllium screening program while employed at 600 Ninth Street location.

However, they had no information regarding the specific buildings you worked in.

And this was the only thing I saw where there could have been a delay.

You provided affidavits from work associates attesting that you worked in Building 16.

District office reviewed the evidence of record and issued the recommendation June 7, 2018 to accept your CBD under Part B of the act as you were a covered beryllium employee.

It was on a finding of facts and claim

for benefits based on beryllium sensitivity in 2016 you worked for Coors Porcelain as a beryllium vendor covered employee, January 1, '85 to December 31, '85. One year.

You were monitored for beryllium exposure presented -- during this employment. You were diagnosed with beryllium sensitivity in 2004 based on an abnormal LPT.

You were diagnosed with CBD in November 2005.

And the conclusion of law. A covered beryllium employee shall in absence of substantial evidence to the contrary be determined to have been exposed to beryllium in the performance of the duty for the purpose of compensation program if and only if covered beryllium employee was, one, employed at a DOE facility, present at a DOE facility, or a facility owned and operated by a beryllium vendor because employment by the United States a beryllium vendor or contractor of DOE during the period beryllium dust particles or vapors may

have been present at such facility.

It seems like they don't have to prove a longer time frame if they're working for the vendor.

A covered beryllium employee means the following. If and only if the employee is determined to have been exposed to beryllium in performance of duty in accordance with section 7384 of this title a current or former employee as that term is defined in section 8101 of Title 5.

You may have been exposed to beryllium at a DOE facility or facility owned, operated, or occupied by beryllium vendor.

A current or former employee, or any entity that contracted with DOE to provide management and operation management integration or environment remediation of a DOE facility or any contractor or subcontractor that provided services including construction, maintenance of such a facility.

Current or former employee of a

beryllium vendor or a contractor, subcontractor during a period when the vendor was engaged in activities related to the production.

Term covered beryllium illness means the following. Beryllium sensitivity as established by an abnormal beryllium lymphocyte proliferation test performed on either blood or lung cells, established chronic beryllium disease, any injury, illness, impairment or disability sustained as consequence of covered illness.

You're a former employee of a beryllium vendor and worked at Coors Porcelain during a period when the vendor was engaged in activities related to the production or processing of beryllium.

You were diagnosed with CBD. And be entitled to the compensation.

And what I understood from that she only was a covered employee for one year while she was exposed, so it wasn't a long time frame of being exposed if you're working for a

beryllium vendor.

CHAIR MARKOWITZ: Accepted CBD case.

MEMBER MAHS: She had the one-year time as being under the program.

CHAIR MARKOWITZ: Mr. Domina.

MEMBER DOMINA: Under 10 CFR 850 for the beryllium standard for DOE sites you only have to have one day to be accepted.

CHAIR MARKOWITZ: Dr. Dement?

MEMBER MIKULSKI: Is this another case?

CHAIR MARKOWITZ: Hold on. Any other comments on this case? Sure, Ms. Pope.

MEMBER POPE: I think what aided in her -- this claimant case getting approved was the fact that she had those two affidavits, those two coal workers that verified her presence in that one building that they were questioning that there was beryllium existed in that building before.

So I think that was supportive information that aided in her getting her claim

through.

CHAIR MARKOWITZ: Okay. Any other comments? Otherwise let's move on to another case. You had one, Dr. Mikulski?

MEMBER MIKULSKI: Yes. This is a sarcoidosis pre 1993 CBD case.

CHAIR MARKOWITZ: Was it accepted or denied?

MEMBER MIKULSKI: This is a denied case.

CHAIR MARKOWITZ: Okay.

MEMBER MIKULSKI: And I talked about this case before. The last three digits are 580.

And I have to say what prompted me to look in more depth at this case was an unusually fast turnover between the questions to the CMC and the eventual response. I believe it took the CMC one day altogether to issue an opinion, whereas the sheer volume of this case which is over 2,000 pages would have required a much more in-depth look and investigation of the records.

In any case, this is a former Y-12 K-

25 worker who worked in the various positions, various jobs for over 40 years, between 1970 and 2014.

Their job titles included chemical operator, janitor, utility special projects coordinator, and so on and so on.

This claimant was diagnosed with pulmonary sarcoidosis in 1978. And following a subsequent diagnosis of prostate cancer in 2016 filed both claims under Subtitle B and Subtitle E for cancer and for lung disease.

Both claims were eventually denied in 2018.

However, the CE did an excellent job in moving the claim from sarcoidosis to a pre 1993 and asked the CMC specifically for an opinion whether the medical evidence on record meets the guidelines to establish a pre 1993 diagnosis.

So CMC issued an opinion that kind of was based on a mix of the pre 1993 and post 1993 criteria where they took -- selected spirometry

results from 2016, married them with sarcoidosis diagnosis from pre 1993 and said that the claimant meets two out of the pre 1993 criteria without offering any further explanation.

So this was a huge file. There were hundreds of pages of historical medical documents.

I know the OCR wouldn't do much justice in trying to find specific medical records.

However, after looking at the individual medical test results it did appear that the claimant had evidence of clinical course consistent with pulmonary disorder.

As a matter of fact they were hospitalized for over 16 days by a pulmonary group where they did a series of tests which resulted in putting him on two years of steroid therapy.

The claimant did have radiographic evidence of diffuse reticulonodular patterns which were initially thought to be of the

infectious pathology.

However, the skin test PPD for tuberculosis which would have been most consistent with that pattern were negative.

And had a series of abnormal pulmonary function tests between 1976 and 1981 that did show a marked obstruction with FEV1 to FVC ratio as low as 67 percent without this being specifically evidenced in the record. So I actually had to make those calculations myself.

So this claimant was eventually denied in 2018. And this is basically the information I wanted to share about this claim.

CHAIR MARKOWITZ: Steve Markowitz. So they met the pre '93 abnormal radiology, abnormal pulmonary function. So which criteria didn't they meet?

MEMBER MIKULSKI: They met all the criteria.

CHAIR MARKOWITZ: Oh. And they got denied.

MEMBER MIKULSKI: Yes. So they had a

positive PFT, they had a positive chest X-ray, they had a positive clinical course consistent with the diagnosis of pre 1993.

On top of that they also had a positive -- I'm sorry, not a positive. A borderline LPT from 2016 which given the time from the last exposure might have explained that the response would have weaned off.

CHAIR MARKOWITZ: And the CMC did not believe it was CBD.

MEMBER MIKULSKI: No.

CHAIR MARKOWITZ: And what did the CMC miss?

MEMBER MIKULSKI: The CMC missed pretty much most of the pre 1993 criteria. So the only one that they have acknowledged was the pre 1993 diagnosis of sarcoidosis based on the clinical X-ray.

And they said, a bit confusing. In a statement where they mixed all those criteria a diagnosis of pre 1993 CBD needs to include three of the five criteria.

The claimant has only two positive criteria which include post 1993 CT scan criteria and the diagnosis of sarcoidosis.

CHAIR MARKOWITZ: We're not sure what medical records the CMC got. They're very voluminous.

MEMBER MIKULSKI: As I said this would have been a very laborious process of going over individual records. OCR does not really offer much help, optical character recognition.

Most of the pre 1993 records are of course handwritten. It wouldn't have been possible to pick up those records based on any sort of a search. And doing it manually may involve hours.

We really don't know from this how much access to the medical records the CMC had for this case.

CHAIR MARKOWITZ: Any comments or questions on this case? Because otherwise we're going to take a break and then come back and discuss more cases. Yes, Dr. Dement.

MEMBER DEMENT: Sounds like a case that needs to be re-reviewed.

CHAIR MARKOWITZ: Yes. Dr. Silver and Mr. Domina.

MEMBER SILVER: Can someone refresh my memory as to the payment schedule for CMC reviews? Are they paid by the case or by the hour?

CHAIR MARKOWITZ: By the hour, isn't it? By the case? A page per case ratio.

MEMBER SILVER: I know what our pay rate is, but that might have explanatory power.

CHAIR MARKOWITZ: Mr. Domina.

MEMBER DOMINA: What did the SOAF say in that one? Unless I missed it when you were talking.

MEMBER MIKULSKI: No, I don't have that information.

CHAIR MARKOWITZ: At break maybe you can look at the index. Okay, so we're going to take a 10-minute break or so. So let's come back here at a little bit after 3:15.

(Whereupon, the above-entitled matter went off the record at 3:06 p.m. and resumed at 3:23 p.m.)

CHAIR MARKOWITZ: Okay. So we're going to spend probably the next 20 minutes or so reviewing cases and then we're going to discuss what we've learned from the cases, the more generic issues.

And then we're going to stop at 25 after 4 but we'll probably start at 4:30 with the public comment session. We're just going to take a couple of minutes before 4:30 for a very short break.

And I think we're going to -- Mr. Nelson, if you could make some comments tomorrow morning that would be very helpful. Just to continue the flow for today.

If anybody in the audience here wants to make a public comment and you have not signed up there's a signup sheet right over here along the wall here.

And if anybody's on the phone or

online and wants to do the same they can tell the moderator. Oh, they have to email? Okay.

So later when you get on the other line if you press *0 then you'll be able to tell the moderator you want to make a public comment.

Okay, so let's do another claim. Dr. Berenji.

MEMBER BERENJI: Yes. I have a claim, last three digits are 048.

So this was a survivor claim. The interesting thing about this particular case was that her significant other had formerly filed a claim a few years back in 2014 for beryllium sensitivity.

And that claim was actually accepted in 2015 I believe it was.

And then unfortunately the initial worker, he actually had been working as a nuclear engineer over at the Idaho National Laboratory from the late seventies till about 2003 or so.

So he ended up passing away from a stroke in 2016. And then his significant other

applied for a survivor benefit in 2017.

So this is where terminology I think comes into play depending on what you're actually claiming.

So the worker himself had initially filed for beryllium sensitivity. And he actually got the claim approved because that's what he filed under.

And if you actually look at the Procedure Manual to be qualified for beryllium sensitivity you actually have to have one positive LPT test which he showed documentation for.

The survivor, the spouse actually filed for benefits claiming CBD. And unfortunately again terminology is key here.

The fact that the significant other had filed under CBD the claims examiner essentially stated that there wasn't enough medical documentation to satisfy the requirements for CBD.

So the claim unfortunately was denied

for the survivor based on the semantics of the case.

I thought that was interesting. I mean really in terms of should this have been accepted I'm not really sure.

The worker himself had been working at the Idaho National Laboratory since the late seventies.

And this is where the occupational health questionnaire really comes into play again.

You actually look at where he was working during those years. He actually had exposures to multiple different types of chemicals.

He also had exposure to uranium ore as well as different uranium byproducts during his work in the late seventies and early eighties.

So, he -- I'm not sure if he actually applied for additional benefits prior to his initial claim, but again in terms of the survivor when she was applying for survivor benefits she

was unfortunately denied because she had applied for CBD and her significant other had applied for beryllium sensitivity.

CHAIR MARKOWITZ: Just to clarify, the sensitivity claim was accepted.

MEMBER BERENJI: That is correct.

CHAIR MARKOWITZ: The survival CBD claim was not accepted.

MEMBER BERENJI: That is correct.

CHAIR MARKOWITZ: And was there medical evidence to support -- beyond the sensitivity to support CBD?

MEMBER BERENJI: There was not unfortunately, at least not with what the survivor had submitted.

So, that begs the question. I mean, could this case be reopened and if she could submit that documentation with pre and/or post '93 criteria I believe she'd actually have a case.

But since her significant other is now deceased due to what appears to be a stroke it

doesn't appear that he actually died of beryllium sensitivity and it was never clearly documented.

It would be interesting to go back to the initial worker's claim and actually review his claim to see if he actually had submitted any additional X-rays, CT scans, or any additional testing that could document he actually did have CBD.

It's just it's not clear based on what I have here because this is from what the survivor was filing for.

CHAIR MARKOWITZ: The survivor claim did not include the medical records?

MEMBER BERENJI: At least from what I have here. There's only 252 pages of records submitted.

I did see the occupational health questionnaire from her significant other, the worker, and there was one laboratory report showing the positive LPT.

I'm trying to see if there was any additional records in terms of medical

documentation, but I don't see it in what I have available here.

MEMBER GOLDMAN: What site was this?

CHAIR MARKOWITZ: Idaho.

MEMBER BERENJI: Idaho.

CHAIR MARKOWITZ: Comments or questions? Dr. Goldman.

MEMBER GOLDMAN: So if you apply for the sensitivity are you still -- I mean somebody who got the beryllium sensitivity test, I would assume they got the PFT and the chest X-ray as part of that, and that the only thing that was positive was the sensitivity.

CHAIR MARKOWITZ: I wouldn't assume that.

MEMBER GOLDMAN: No? Oh, okay. Because then if one did assume that then you would know that he didn't have CBD at least then.

But if he made the mistake on the -- if he did have it and he just made the mistake on sensitivity and she could get those old records then you would have CBD.

CHAIR MARKOWITZ: The former worker, if they get beryllium tests you get an X-ray and PFTs.

But current workers, certain subpopulations of current workers will get a BeLPT, but I don't know whether they are offered or whether they necessarily accept also having an X-ray and pulmonary function and spirometry.

MEMBER GOLDMAN: This is Rose Goldman again. They would be told they have a positive beryllium sensitivity test and then not get a chest X-ray and PFT?

CHAIR MARKOWITZ: I can't confirm what the site occupational medicine practices do onsite, but workers may select to get a BeLPT and may not get the other tests and then may be referred to their outside physician for further workup. So it's possible.

MEMBER REDLICH: I previously reviewed a number of the BeLPT claims and they seemed reasonable that the people who were sensitized had been evaluated and did not have any evidence

of lung disease at that time.

I can't say that for all of them. And the ones that were denied had a negative BeLPT and no evidence of any lung disease. So they seemed appropriate.

CHAIR MARKOWITZ: Other comments, questions? Otherwise another claim? Do we have another claim?

MEMBER REDLICH: I have one.

CHAIR MARKOWITZ: Dr. Redlich.

MEMBER REDLICH: I'll try to do this quickly because I know we're running short on time.

So this is an example of again the CBD sarcoid and the question of when a BeLPT is negative.

So this is a woman who had worked for three or several years as an electrician in the nineteen eighties at Savannah River Site and was diagnosed in the nineteen nineties with clear sarcoidosis at the time with pulmonary involvement and also conjunctival eye

involvement.

So the biopsy was done of her eye. But it was clear by chest CT scan and pulmonary function test that she had interstitial lung disease also and not simply the eye involvement.

Her disease was severe enough that she basically was started on 80 of prednisone and has been on pretty high dose prednisones since then.

So, now this did not go to a CMC. This was the CE's report.

So basically the statement of facts in this case -- in addition to that there is a letter stating from a physician.

She then more recently had a BeLPT that was negative. And there is a letter stating that after many years of steroids it could be falsely negative.

And then there was also -- she had been asked to request to submit evidence that she had CBD.

So this person did reach out to her treating pulmonologist who reviewed her records

back to 1997 and explained in an email that it wasn't appropriate to do a lung biopsy in the setting of having documented the disease.

And she did have a bronchoscopy later on because she actually had hemoptysis and at that time the bronch was done because of the hemoptysis and the infection that she had which was a consequence of high dose steroids for many years and it would definitely not be appropriate at that point in time to biopsy for -- to confirm the diagnosis.

So this information the claims examiner had.

And then their summary of the statement of the facts acknowledged the diagnosis.

It sort of referred to her one note that she didn't have evidence of active disease which I'm not sure what that was referring to given the years of high dose steroids.

And basically -- so it didn't go to a CMC or the like, but then the decision -- I think

there was -- the SEM was queried for sarcoidosis and there was found to be no exposure just by working at Savannah River in the nineteen eighties as an electrician. So her claim was denied.

And I would say that this is an example of a false negative BeLPT that was explained in a letter.

And yes, there was also a lack of a tissue diagnosis, but that was also explained by the pulmonologist that it would not be appropriate to get tissue.

And there was clear CT scan and pulmonary function testing and then the needing treatment.

So anyway, I guess this is also -- in terms of what would do to fix this problem.

So I think to fix this problem the CE number one would appreciate that there was beryllium exposure.

And actually the person in their notes that there was a reason for the BeLPT to be

falsely negative actually requested getting a second -- wanted the patient to get another BeLPT done.

In the setting of being on high dose steroids for years and actually having a fungal complication, infection, her immune system clearly is not functioning well.

So there would be absolutely no point in getting another BeLPT or to get tissue diagnosis.

So those requests being made of the claimant when there's documentation for a reason specifically addressing those concerns and part of the criteria.

So I think that again this is a CE who didn't really understand these issues.

CHAIR MARKOWITZ: Steve Markowitz. I have a question.

So this person met the post '93 criteria except for the positive BeLPT. That's part of the question.

And the other part of the question is

we learned previously that DOL acknowledges that someone on steroids might have a false negative and might invalidate the utility of the BeLPT and would accept a case even without that under those circumstances. I thought that's what we learned previously.

Does this case satisfy those criteria?

MEMBER REDLICH: Yes, except the other piece that is missing is that the tissue diagnosis was not from the lung. But there's clear pulmonary involvement and a pulmonologist documenting that based on the CT scan findings and the lung function.

I was just saying that in the past there's been some discussion of where the biopsy was taken.

And we have discussed before that there are medical reasons why you biopsy what is most accessible and least risky.

And there's even a letter from the pulmonologist indicating it would not be indicated to do an invasive procedure in the lung

when you could make the diagnosis.

So those issues that could be issues were addressed in the documentation that the CE had.

And the CE even put it in her letter mentioning that a BeLPT could be falsely negative, but still requesting a second BeLPT and -- request you submit a lung biopsy showing a process consistent with CBD.

And no evidence was submitted.

CHAIR MARKOWITZ: Comments? Questions? Any other cases? Yes, Dr. Silver.

MEMBER SILVER: Sorry to follow one downer with another.

This is a CBD claim at Los Alamos. When this program was adopted Richard Miller, the advocate from the union pointed out that it was the first entitlement program for workers in a quarter century.

And during that quarter century the rest of the social safety net was undergoing a big shredding.

I think this gentleman's experience with the EEOICPA program sort of illustrates a lot of human suffering that the program doesn't reach.

He had a 25-year career at Los Alamos starting at around age 40. Much earlier as a late teen and in his twenties worked a year at a uranium mill and spent two years on the construction services company Zia at Los Alamos.

His last 10 years were as a supervisor at a process at Los Alamos that is frankly notorious for chemically intensive work with plutonium.

So there would have been a lot of chemical exposures, neutron exposures, alpha radiation and job stress because of the national security imperative that surrounds that unit.

He'd been a construction supervisor earlier in his career and was detailed after the Tiger Team reports pretty much when he first started to enter a large number of buildings at Los Alamos that had some kind of violation of

regulatory standards to follow up on the Tiger Team recommendations.

So roll the clock forward. He's in his early sixties. He's experiencing shortness of breath.

He'd been enrolled in the beryllium worker surveillance program under the site occupational medicine program and all told between 2002 and 2011 he had four negative LPT tests, but one X-ray showed a nodule in the upper right lobe of his lung.

And then a subsequent X-ray showed nothing going on. Back when he had shortness of breath his pulmonary function decrements were on the order of 77 percent of normal.

And then his later pulmonary function tests were fully normal. So I've spent a little time in this community and it seemed to harken back to how medical test results would sometimes change in a company town atmosphere. I had hoped those days were over, but something in my gut bothered me.

While on the human side after having his CBD claim denied he developed prostate cancer and got a very small probability of causation from NIOSH.

The chemotherapy led to liver damage and he was diagnosed as well with cataracts and narrow angle glaucoma.

His dose to the eye was an order of magnitude less than what NIOSH says might be because of glaucoma and cataracts.

And his misery continued with a diagnosis of colon polyps, not yet cancer, hearing loss.

By that time he'd gotten an authorized representative. The audiogram never passed through the hands of a physician so he did not get compensation for hearing loss, plus he didn't have more than 10 years of chemical exposure before 1990.

So, just seems that -- I live in a part of the country now where people live in fear of being thrown out of the workforce in their

late fifties, early sixties.

And here's a man who has this cascade of health problems and a long history of going into multiple sites at Los Alamos.

So I was a little disappointed that the CE did not send it to an industrial hygienist to rake over some of those earlier work areas.

One of them were the high explosive sites, the firing sites and there was some hint in the literature that nitro organic compounds have some ocular toxicity.

I just felt that someone in this situation might have gotten a little more of a claimant friendly look from a claims examiner.

So there are a lot of people out there with complex chemical exposures. We haven't been to Rocky Flats yet, but when we do I'm sure we'll meet some plutonium workers who are in the thick of neutrons, alpha chemicals.

And Los Alamos is about to start producing even more plutonium pits. Hopefully the precautions of medical surveillance programs

will be more rigorous this time around.

Is that enough of a downer?

CHAIR MARKOWITZ: On that note any comments or questions?

MEMBER GOLDMAN: What about the lung nodule?

MEMBER SILVER: Well, the subsequent chest X-ray didn't see anything.

MEMBER GOLDMAN: Did he get a CT scan?

MEMBER SILVER: That never happened.

MEMBER GOLDMAN: You know what I'm thinking. That probably should happen for a nodule with that kind of exposure.

MEMBER SILVER: I agree. His authorized representative came in kind of at the last minute for an appeal hearing and wasn't really holding his hand through the whole process.

Nobody was. It's a non-union site. He wasn't yet a former worker so he was kind of on his own out there.

CHAIR MARKOWITZ: The former worker

program offers low dose CT scan for early detection of lung cancer to a subset of workers at risk.

But it's only offered by a couple of the larger former worker programs and not by the others. But it is on the national medical protocol.

MEMBER SILVER: You have to be a former worker.

CHAIR MARKOWITZ: Yes, former worker. If you're a current worker at Paducah, Portsmouth or K-25 then you also are eligible. Otherwise no other current worker is eligible.

Okay, so let's move on. What I thought we should do for the next 40 minutes is talk about more in general about the limitations, what we've seen today and previously in the industrial hygiene evaluation, the CMC evaluations.

This is under task 4 of the Board, evaluate the objectivity, consistency and quality of the industrial hygiene and medical input into

the claims evaluation process.

And then later we can get to -- perhaps today, perhaps tomorrow the claims examiner part of that under task 2 for the Board.

First, let's just discuss about the industrial hygiene. I don't think we need to come to conclusions.

I think that if we get the issues out and begin to develop some recommendation that in a telephone meeting with the Board in a couple of months we can formulate some recommendations which we could vote on.

So I don't think we should feel the pressure to do that today and tomorrow morning, but I think we should move in that direction if we see fit.

So let's discuss what we've seen so far about the objectivity, consistency and quality of the industrial hygiene evaluations.

Dr. Dement.

MEMBER DEMENT: I think we've discussed some of the issues before. I think

John Vance gave a report with regard to some of the upcoming changes which I think are positive with regard to the IH assessments and their ability to have some discussions with workers to fill in holes in the information particularly.

I think first of all it's important to realize that these assessments by the industrial hygienist are -- they're qualitative in nature.

They're largely at least as they're structured now predicated on their own experience with either the type of work being done or the site itself. And we know that's sometimes quite variable.

I think the assessments could be made better if a couple of things would happen.

One is that scope of knowledge with regard to the particular job and exposure be identified.

For example, if you're going to be assessing an exposure to asbestos or silica I think the hygienist, given the job category, the site and the exposure needs to state what he or

she is assessing.

What's the basis of that exposure. Was it simply having been in the facility, or is it something that he or she has knowledge of that the individual has, that's done a task, for example. A task -- the task and materials gives the particular of exposure. So I think they could be better.

And there are some reports that I've seen that happen and I found them very helpful where the hygienist said this person in this job category would have done these things. Therefore these are my opinions with regard to the exposure.

I think the other area where it could be at least made less objective at least is to require the hygienist to not just give low, medium, high, whatever their category is, but to tag that to what's the basis of that.

It's low, but it's low relative to what. Is it low relative to the exposure standards at the time, or is it low relative to

now.

Anyway, tag where that reference point is with regard to exposures.

I think the third area, maybe it's the fourth, I lost count, is to reword the assessment post 1995.

We all recognize that things got better. A more appropriate statement of what that state of knowledge is needs to be in the industrial hygiene report.

CHAIR MARKOWITZ: Steven Markowitz. I have a question about this low, medium, high because all these reports have the IH judgment about this job title in relation to this particular exposure taken from the SEM.

And it's very low to low, or occasionally it's moderate.

I agree with you that I don't know what those words mean, but the problem with pegging it to like a legal standard or regulatory standard at the time is those aren't necessarily protective.

And is it true that the IH could know how that exposure relates to the prevailing standard at the time. You know what I mean?

MEMBER DEMENT: Well, I think for a lot of tasks, and again it depends on hygienists.

If you tell me that you're using asbestos or silica and you're doing this task based on my own personal experience or even the literature, published literature, I can say that likely would have been excessive based on current standards certainly and probably even the standards in the past.

So you can make a qualitative assessment of that.

My comment is that just to state what's the basis of it. A lot of times in assessments that we've done using multiple hygienists to assess exposure into these broader categories of low, medium, high, you would tag it to some known exposure standard or guideline.

Say okay, this is where we are, this is the guideline. And then you would ask the

individual to assess where they would place this task or exposure in this paradigm.

Then the next question you would ask, what is your basis of it. Is it one, direct experience having measured it. Is it two, is it from the published literature, or is it specific to the site. So there's several categories.

And what you can do with that is if it's -- there's no basis except just published literature that's fine, but at least you know where it came from.

So anyway, I just think the hygienist exposure assessments could be -- there's always going to be guesswork, but at least state the basis for the guesswork.

CHAIR MARKOWITZ: Dr. Redlich.

MEMBER REDLICH: My other thing that I found that sort of is just a theme was -- because there's the concentration of exposure and then there's also the years of employment.

And you need to take that into consideration. So there's a difference between 1

year, 2 years, and 20 or 30 years.

And also then further back in time as a general guideline.

So I feel like that word of high, low, is then taken by -- and usually low by the CMC who doesn't have much training or experience and isn't thinking, okay, that's exposure for someone who spent 30 years in this environment where there was likely variable exposures over a number of years.

I think that's the type of guideline that could be given to the CEs that you really need to consider not just what they're estimating as an amount, but the duration.

CHAIR MARKOWITZ: Guideline to the CMC you mean.

MEMBER REDLICH: And also to the CEs in terms of the way they -- because the CEs take this information and then frame the questions.

And I think sometimes the question -- things can go wrong at several stages.

CHAIR MARKOWITZ: But the IH reports

I've seen, they do include duration. They have a table with the job title and the years that that person worked at that job title. And so that information is there.

Now, like you I don't know if it's used by anybody else but at least it's in the report.

MEMBER REDLICH: A lot of the ones I was thinking was the SEM, but didn't actually go into each person.

CHAIR MARKOWITZ: Dr. Berenji.

MEMBER BERENJI: Great insight by Dr. Dement and also by Dr. Redlich.

Just as additional comments at least as my experience doing independent medical evaluations I do get requests from insurance companies to opine on questions that they issue to me as an independent medical examiner.

But a lot of the times if I see something that's not quite adding up and I feel that there's additional insight that could be helpful in the case in terms of determining next

steps I do feel that the CMC or in my case as an independent medical examiner I have the obligation to provide those additional medical facts.

I mean, in my work as an independent medical examiner I've seen cases where someone comes to me for condition X and they have condition Y which is actually causing more of an issue.

Whether or not it's related to the initial exposure or question at hand to me that needs to be understood that there are other medical circumstances that are affecting this individual.

So I feel that the claims examiners, I understand they have a lot on their plate. They obviously have a lot they have to deal with.

But just issuing one or two questions to the CMC and just expecting the CMC to address those few questions without allowing the CMC to provide additional insight based on their medical opinion based on the medical review, I feel it's

a bit shortsighted.

So hopefully there can be some discussion about nuance. Every case is different. You can't necessarily put people into certain buckets and expect them to have the same outcome for every single case.

CHAIR MARKOWITZ: We have to accept at some level that the professional experience and expertise of the industrial hygiene will necessarily play a role. That's why we go to them.

But what is missing, and the Board's talked about this since 2016. What really needs to be a significant part of the process is the claimant, is the claimant's experience at the workplace, is what the claimant did, what the claimant was exposed to from their perception, what levels. Not quantitatively, obviously, but the way we normally talk to workers about their exposures.

And it's through a better improved occupational health questionnaire. It's through

a direct interview that that can take place.

I don't see any evidence in those IH reports frankly that anything the claimant says makes much of a difference.

Maybe it does, the IH doesn't cite it, but I don't see it in the reports. I don't see the IH cite the claimant, the claimant's experience and the OHQ or anything else as to -- they cite their expertise. They cite standard textbooks and the like.

And personally I think the IH would probably welcome frankly some real personal information from that worker about their experience because they can make a better judgment about the exposure.

MEMBER DEMENT: I agree with you totally. I know personally I have in the past had cases sent to me for review at the outset based on what the job category was. I would say they're not exposed.

But when you actually get to the point of discussing it with the individual you find

that this is not true.

And so put yourself in the place of the claimant. You've got this broad occupational history asking about zillions of exposures, but probably there may only be four or five that really are relevant to your case. But they're not developed well in the OHQ at least currently.

And that may be always the case even with one that's more task-based and asked more specific questions.

So I think you are left with at least in my opinion as it comes to the hygienist a not well developed description even from the worker themselves about what they've done.

Hopefully the new occupational history questionnaire can direct you better. I'm interested in if you tell me you were exposed to benzene, tell me how.

You can do it in two sentences and it will give me great insight. So that to me, the new occupational history questionnaire to at least pull these things out as it goes to the

hygienist.

And then the hygienist saying well, I know about these exposures. I have some experience with that either myself, published literature, or from the site.

I don't -- and I need to ask a few additional questions. And it may be only 10 minutes' worth of additional discussion with the claimant to get that better.

And as a hygienist I don't necessarily have to have experience with every material to give some qualitative level of exposure.

If you're telling me you were working with solvents and I know something about solvents, the vapor pressure and sort of what you were doing with it I can have an idea of where the magnitude of exposure would be just based on telling me what you did.

CHAIR MARKOWITZ: Dr. Redlich.

MEMBER REDLICH: I do feel like sometimes the piece that's missing is it's almost a shotgun approach at every potential exposure

without -- I would say if it's pulmonary fibrosis I don't really care about the solvents because I know that that doesn't cause it.

What I do care about is asbestos and dust and metals and that. And so then you target it to that exposure.

I've found looking at a lot of these that whatever sort of qualitative other information is on questionnaires where the person just describes, well, I was cleaning in all these different buildings around whatever that type of -- or it was frequently very dusty, that that qualitative information at least for the respiratory component is extremely helpful.

Because I think the SEM in attempting to be more precise is spinning a lot of wheels that aren't really relevant, or if anything can detract from what the relevant exposures might be.

At least for the more common respiratory conditions.

MEMBER DEMENT: I agree. I think a

lot of industrial hygiene time is being used to do assessments on exposures that are remotely relevant to the outcome.

You know, a long time ago the NCI developed for its own studies some case control an occupational history questionnaire that started and started with asking sort of the outcome first. Then it asked the job.

Then it goes down, it sort of branches and it goes and asks specific questions after you get into that one place.

What we don't have here -- we have this whole piece of occupational history. Most of it's not very relevant. It probably didn't go to the relevant part.

I don't know how to fix that except ask a lot of broad questions and have the ability to go back to it.

CHAIR MARKOWITZ: But that's why experts are included in the process. They're supposed to sift through that and do triage till they get to the point.

Other questions or comments? Dr. Berenji.

MEMBER BERENJI: So, I know Dr. Dement has mentioned this at previous Board meetings, but I'm just going to reiterate that for the record.

I mean, when it comes to the IH and really understanding the worker's occupational history I know gases, vapors, fumes, dusts, mists, this all comes into play.

And I know the Department of Labor has had some issues over the years with these particular terms.

But as we all know just getting a sense as to where a worker has been over their life course in their work depending on where they were working at what particular time we have to be able to utilize these terms.

And I know that at least for right now it seems like it's a closed case, but really if there's a way to at least get the industrial hygienist to understand that these terms really

do help us create a story of where the worker has been and what they've been exposed to I think it's worth reconsidering.

CHAIR MARKOWITZ: So, if there are no further comments on the industrial hygiene can we talk about the CMC, the medical evaluations?

MEMBER REDLICH: How about the claims examiner?

CHAIR MARKOWITZ: We'll get to them next.

MEMBER REDLICH: Okay.

CHAIR MARKOWITZ: Dr. Berenji.

MEMBER BERENJI: Again, I know that the Department of Labor had made a determination about providing the entire case file to the CMC.

And please correct me if I'm wrong, but at least according to this grid that we were provided today it does not want to proceed with providing the entire case file.

I guess from our end this is considered to be a closed case, but I highly encourage the DOL to at least reconsider because

to really make a full determination the CMC should have the entire case file. I mean that should be a given.

And it's just unfortunate that we have a disagreement in terms of how that should be. But I do disagree with that and I really think there should be reconsideration.

CHAIR MARKOWITZ: Dr. Friedman-Jimenez.

MEMBER FRIEDMAN-JIMENEZ: The main reason given is that it's too much for the CMC to go through.

And I think that can be addressed fairly simply by a good index to what's in the record.

We've all gone through these 2,000, 3,000 page records and it's incredibly time-consuming.

If there were a good index it would save -- as John said 80 or 90 percent of our time in doing review, and more importantly would save 80 or 90 percent of the CMC's time in doing the

review.

So, I think that issue can be addressed by indexing. It's some work. I mean someone's going to have to do that and so whether a CE does it, or you hire someone else to do it, to go through and pick out where's the SOAF, where's the final decision, where are the PFTs, what pages are these on.

Half a page index giving you a guide to where the important information is.

Then if you need more you can go searching through. And I've actually gone through several 3,000 page records and the only thing I've found was that the pulmonologist said he can't interpret this PFT because there's no height in the chart.

And so the guy had to wait six months for them to find out what his height was. But his height was in another PFT report that wasn't cited that I -- after 45 minutes I found.

I mean, it's really incredible how much time you can burn on this.

But I think the main objection that I've heard, and John, correct me if I'm wrong, the main objection has been that it's just too much information for the CMCs to go through. That can be addressed.

Are there any other objections to providing the full medical record?

MR. VANCE: You have seen these cases. You know what's involved. And it's just a question of keeping in mind when you're talking about a process, you're talking about the adjudication, the administration of over whatever number of cases are going through this process.

You've got to think of that logistical side of things. If you have the entire case file -- and I've seen case files. When you're talking about a case file you have to remember about the entire population of files.

We have cases that have tens of thousands of pages of documents. So you have to be mindful of a recommendation saying well, send the whole case file.

Some of these case files are huge. And so you also have to be aware of that kind of a scenario.

MEMBER REDLICH: To play devil's advocate. I mean I have been carefully through at least 50 or more of these cases.

And I can't actually think of a single one where that CMC having more information would have ended up with a more accurate decision.

I think the bigger issues in terms of different ones are what questions the CMC is asked, whether a CMC was even needed, where the treating physician had the correct answer.

So I think that -- I think the quality of the CMCs is such that most of them do not have training in occupational medicine in terms of thinking about causation.

They may be boarded in occupational medicine, or they may be a pulmonary physician who really doesn't think in terms of causation.

So I think that that's the least of the issues and probably the hardest to fix given

the more limited pool of high-quality physicians who could actually have the expertise to decide that.

So I think as often as possible the correct decision could have been made earlier in the stage before it went to a CMC.

Or if the CMC was asked the correct question. So I would just -- not to -- the process of how the CMCs are selected and what company.

I think the physicians unfortunately that work for a lot of these sort of disability type evaluation contractors really have extremely limited experience in cases like this.

CHAIR MARKOWITZ: Steve Markowitz. Mr. Vance, I have a question. I'll make a comment first.

So, some of the CMC evaluations are excellent. I'm a little surprised actually how good they are because this is not the most -- frankly reviewing claims as a medical doctor, it's not the most desirable type of work. I mean

let's be real about that.

So you have some really excellent CMCs and some excellent reports.

There's another group and I think it's the minority, the reports are not acceptable.

My question is what process is in place to identify the poor reports. I know that the medical director evaluates a certain number of claims every quarter.

Within the contractor, the QTC, is there a quality assessment process in place? If there is it's not working, but what is it at least?

MR. VANCE: There is a quality assurance process internal to QTC and their evaluation of CMC opinions. That's informed by our auditing process. That's informed by quarterly engagement we have with the contractor.

And we have had situations where we have identified physicians that have been problematic and we've gone through remedial training and more closer oversight of their work

by our medical director. So I mean that's the process.

And I think that we would be looking for any further engagement or input that the Board would have on how to better screen or identify reports that are problematic, or what the actions of the program should be.

But we basically contract out to QTC to have physicians evaluate these cases and provide medical opinions from qualified physicians.

Each one of our CMCs is a qualified physician. Now, whether or not the quality rises to the level that the Board would like to see, that's how do you best address that.

And the program does do that, but I think that additional information about the things that you see as defects in some of the opinions would be very helpful.

CHAIR MARKOWITZ: So, just if I could respond. So, my guess is most of the CMCs do have paper qualifications because it's an easy

enough thing for the contractor to look at and that there's some relevance between their qualifications and what they're asked to do although that is an aspect.

What I'm concerned about is that the medical director in the last five quarters has looked at 83 claims for the purposes of looking at causation in particular and only found one that needed improvement. And that's not in our experience.

Whereas on the impairment front when he looks at claims, it's 100 plus claims, 28 percent need improvement.

It's suggestive there's a systematic problem with impairment evaluation because 28 percent is too high.

But just sticking on causation for the moment, I think the review of causation competence in the CMC report is incomplete.

I think it's probably not the emphasis of the medical director.

We all have our strengths. You

wouldn't ask me to do impairment evaluations, believe me, but I'm okay on causation. So I think that's what's going on and we need to address that. Ms. Pope.

MEMBER POPE: I think a similar problem, a similar concern is also with the CE because the CEs are building the case.

And so they are framing the questions and they are earmarking so to speak the different documents that the CMC and the IH are looking at.

So, who evaluates those cases that the CEs -- because I'm sure there's bad players in that group of people that are building the cases, the CEs.

So who's evaluating those cases that they're developing? You can have similar problems in that category as well.

CHAIR MARKOWITZ: Mr. Domina.

MEMBER DOMINA: I'll agree with Duronda on that because some of the ones that I looked at, the sooner in the process there's a mistake, it gets bigger as the case goes.

Like one of mine I was going to wait till tomorrow where I did where it rolls in the SEM, the job title, the SOAF. The job title was presented wrong. Okay. And it happened to have been a Hanford worker who was a health physics technician at Hanford and both Idaho Falls.

Well, this one was mostly adjudicated in '18. And I know some of you may remember I've had heartburn with a health physics technician in the SEM because up until recently they weren't listed.

So when they did this last year, that showed what happened was -- this guy was a technician the whole 30 years.

But when it went to the CE, from the CE to the IH on the SOAF it listed him as a health physicist.

So now all of a sudden the job title -- when they pulled the SEM last year it showed like, I don't know, 16 or 18 substances for Idaho Falls and 160 for Hanford.

You go to Hanford today there's 2,099.

It was pulmonary fibrosis. It got weeded out because, you know, it's aluminum and some other benign things. Asbestos is never in there.

And I do know this came up on our September 4 conference call because Dr. Dement, Dr. Markowitz, I think somebody else was on it. John Vance was on it too.

And then the other part is the filters that the CEs have that we don't have access to denied this claim.

And then so when I'm looking at this, it was on a disk I believe we got this summer I had no idea if the guy is still alive or dead.

Well, unfortunately he passed away. I found the obituary in Idaho newspaper in like February and there's no survivor, you know?

But when you go from 100 and some chemicals or substances to 2,099 there needs to be a process that you go back and look at those claims.

Just like what John talked about earlier about reopening some of these claims.

It's a travesty to these people because it fell apart in the beginning and then it just -- and how an IH and a CMC who both reviewed it didn't notice that this person was listed as a technician all along and then it got to a health physicist somewhere along the line for a few years, you know, towards the end of the guy's career which he never was.

CHAIR MARKOWITZ: Dr. Redlich.

MEMBER REDLICH: I agree with all of the comments that were just made. And I didn't mean to damn all of these CMCs because a number of them are excellent.

I think that as a solution to one of these issues is that if these physicians do have expertise in determining causality which is the main question they are asked, typically they're asking did A exposure cause this -- did X specific exposure cause this disease.

And I think the real question is did employment at whatever, you know, sites over this period of time cause this patient's condition.

And then let them see what information, exposure information has been collected.

But they should have the expertise to look at that, and more expertise in a certain way because the question has been narrowed down by a CE and an IH that don't have the perspective of what can cause this condition.

And I think -- because a number of the ones that I had questions with the final conclusion, the issue was this physician wasn't asked the right question.

And if they had been asked a broader question instead of, you know, did aluminum cause your COPD, or did your work exposures as a welder or whatever cause it, or instead of asking -- and the similar thing with the sarcoid being asked, does beryllium cause sarcoid.

So I think it's sometimes the question.

CHAIR MARKOWITZ: Just to play devil's advocate. You're not going to get physicians to

work as CEs.

The CE has a limited set of knowledge and formulates the questions, and sometimes they're not going to be right.

And then there ought to be a corrective process when they refer it to the IH or the CMC which allows that SOAF to be corrected over time, right? With additional input from the IH and the CMC.

I don't see how else you could do it. I don't see -- I mean, there may be some CEs that are just not doing the right thing, but necessarily their knowledge is limited and they're necessarily going to miss the mark sometimes.

I mean, it needs to be corrected, I'm not saying it doesn't, but it's kind of the nature of the beast I think. But Dr. Goldman.

MEMBER GOLDMAN: So, I'll just say I'm coming to this committee new. This is my first time.

But as an observer --

CHAIR MARKOWITZ: Welcome, welcome.

MEMBER GOLDMAN: I'm going to throw something out that's maybe totally naive, but whatever. But what I'm hearing is it's an imperfect process just by all of these factors.

So what I'm wondering as a sort of systematic way to deal with this because we're sort of randomly looking at things.

What if there was a system where for all the cases that were rejected, that were declined, and I know there's tons of them, that there was a random sample of the declined that had some systematic way that it went to either another CE or another level of review sort of like what we're doing but in a systematic way and would cut it down to only those that are declined so that there might be yet another way to be looking at these things and picking up some of these things.

Because it just seems -- and that there might also be for the more complicated things that you know ahead of time, the beryllium

and the sarcoid seems really complicated, that for all of those that get declined there is this second level of sort of an automatic review that doesn't have to have the person applying for it.

Now, maybe that's not possible, but just a thought.

CHAIR MARKOWITZ: Dr. Dement. And we have a couple of more minutes and then we're going to take a short break before public comment.

MEMBER DEMENT: I would agree with Dr. Markowitz. The CE plays a key role and without them, without their work, this thing would just grind to a halt because there has to be some sifting through this information and ferreting out what's important and what's not.

And for the most part I don't think they do that bad a job based on what I've seen. Sometimes they miss it, sometimes they don't.

But I do agree that it's the responsibility I think and it should be of the hygienist and CMC to look at what they've given

in terms of these accepted facts, to also look at the OHQ and some other information just to make sure -- that what's there is correct.

The other thing is I like the idea of a stratified random sample based on even causation as a reason for rejection.

CHAIR MARKOWITZ: You want a variant of accepted facts to be corrected facts.

MEMBER DEMENT: Yes.

CHAIR MARKOWITZ: Okay.

MEMBER REDLICH: It's true. I mean, a lot of the statement of facts are very accurately put together. For --- How many total CEs are there? Are we talking 100, 200?

MR. VANCE: Claims examiners, I think we're in the neighborhood of 240 to 250. I can get the exact numbers.

MEMBER REDLICH: And do they all do all types of cases? Is it geographically based, or do you have a group that let's say have more expertise in a certain area?

MR. VANCE: They're trained to

evaluate and apply the criteria that are under the statute for adjudicated cases. So they handle whatever cases come across.

The only distinction that we have right now is the medical benefit group that's handling the -- post adjudication medical benefit authorization process.

MEMBER REDLICH: I mean, personally for something like the beryllium sarcoid I really think those are very challenging for a non-medical person to appreciate some of the issues that have come up repeatedly such as it can be pulmonary sarcoid even though the biopsy was taken here.

Or when it's legit that there is a negative BeLPT, understanding immunosuppression.

I mean, as just a potential solution, and we do this more and more in medicine. We have nurse practitioners and PAs that are doing very specialized areas that are only in interstitial lung disease clinic, or only in the asthma clinic. And they're very good. They don't

know all of pulmonary, but they know ILD really well.

And you could consider a group that have more experience. Because any one of these things if you see it intermittently it's very challenging.

And being able to sift through 1,000 pages and pick out -- I mean, two cases that we didn't get to are two that were basically it was not recognized that it was pulmonary sarcoid because I mean -- I'm just finding a tiny one page in the middle of 1,000 that is relevant.

But they did have evidence of like a biopsy on the bronch that was pulmonary sarcoid that hadn't been recognized because the major diagnosis was let's say neurosarcoid.

But I think things like that are something that would be hard to train all of the CEs, but you might consider it.

CHAIR MARKOWITZ: And on that note we will take a five-minute break and resume at 4:30 for the public comment session. Thank you.

(Whereupon, the above-entitled matter went off the record at 10:00 a.m. and resumed at 10:10 a.m.)

CHAIR MARKOWITZ: Okay -- this is Steven Markowitz. We're going to begin the public comment session. Mr. Fitzgerald, are there any comments you need to make for this session or are we good?

MR. FITZGERALD: I think we're good to go.

CHAIR MARKOWITZ: Okay, if there's anyone on the phone and you want to make a public comment you're welcome to. Just press star zero and wait for the operator and tell the operator that you'd like to speak and then you'll be added to the list. So thank you.

I'm going to ask people to limit their remarks to about seven minutes or so, roughly seven minutes.

And I will give you some indication when your seven minutes is up so we request cooperation.

Our first is going to be a phone caller, Terrie Barrie. Ms. Barrie?

MS. BARRIE: Hello.

CHAIR MARKOWITZ: Terrie, you there?

MS. BARRIE: Yes I am, Doctor.

CHAIR MARKOWITZ: Okay. We welcome your remarks.

MS. BARRIE: Okay, well thank you. Good afternoon, Dr. Markowitz and members of the Board. This is Terrie Barrie, founding member of the Alliance of Nuclear Worker Advocacy Groups.

I appreciate you allowing me the opportunity to provide comments.

The U.S. Ombudsman released his 2018 report to Congress a couple of weeks ago. The report includes recommendations to DEEOIC which will improve the program.

I'd like to call to your attention a concern detailed on page 31 of the report about the first responders.

And I quote, Over the years individuals who worked or had worked as first

responders approached us to complain that the SEM database did not list all of the buildings, all of the incidents, and/or all of the toxic substances they encountered in the course of performing their job, end quote.

I searched the SEM for 25 of the major sites and I provided the spreadsheet which is listed on your website to see how many toxic substances are reported for fire fighters.

I found it astounding that with the exception of the Hanford site the average number of toxic substances listed which a fire fighter could have been exposed to is 22, only 22, where the average number of total toxic substances at the sites other than Hanford is 1,770.

According to the Ombudsman's report the first responders suggested that, quote, It is time for the program to re-think its approach to compiling information in the SEM database about their exposure, end quote.

ANWAG supports the first responders' request and encourages the Board to look into

this issue.

I was happy to hear that Department of Labor is instituting a quality assurance program to review claims, although I do have some concerns whether this will interfere with the Board's statutory responsibilities.

I'm hoping that this is the result of a federal court decision handed down last December, Adams v. DOL.

The court remanded the case back to DEEOIC. The case involved a claim adjudication which the Board also has identified as problem areas.

For instance, the claimant was previously approved for beryllium sensitivity, but despite the fact that the claimant's assertion that the beryllium exposure caused, contributed to, or aggravated her COPD claim the claims examiner failed to list beryllium in the statement of accepted facts to the industrial hygienist.

The court also found that DEEOIC

relied too heavily on information in the SEM.

But what I found most interesting and intriguing is the court's statement on risk factor.

From page 339 I believe of the decision, and I quote, DOL's final decision fails to have a rational connection between the facts and the ultimate choice made when it cherry-picked evidence supporting its decision and neglects to substantially confront the relationship between the elevation of risk and aggravation of the disease.

I remember the Board discussing how the DEEOIC determines whether an exposure aggravated disease or condition.

In light of the court's decision perhaps the Board may be able to provide guidance to DEEOIC on whether increased risk factor is related to the aggravation standard in the statute.

I'm not asking this for this individual claimant, but as an overall program

policy.

I will provide the link to the court decision in my written comments.

I am disappointed that the latest version of the Procedure Manual was not provided to the Board before the meeting despite Ms. Leiton's statement during the Board's teleconference in September that it would be released the end of that month.

I have two concerns I'd like to bring to the Board's attention about -- the new Procedure Manual.

How long has the claims examiner been using this new version? And according to John Vance today the personal physicians will now need to validate their understanding of the exposure.

The reason these two questions, these two concerns is that an AR came to me a couple of weeks ago that she was told by the claims examiner would feel better accepting the rationalized report from the treating physician after the claims examiner had a toxicologist

review that letter.

It's important to note that the personal physician provided peer reviewed scientific studies supporting his decision.

I ask the Board to carefully review the changes to the Procedure Manual when it is finally released and weigh in on whether it is a reasonable request by DOL.

And I would also like to point out for future references if you ever discuss lung cancer claims that the SEM links beryllium exposure to lung cancer. So I just found that out and I thought that would be interesting for you.

Thank you again for the opportunity and for your work to improve the program. Thank you.

CHAIR MARKOWITZ: Thank you very much. Next is Ms. Vina Colley who is on the phone I think.

MS. COLLEY: Yes. I'm Vina Colley with National Nuclear Workers for Justice and we want to thank you for allowing us to speak and

thank you for holding these important meetings.

The National Nuclear Workers for Justice has long asked for a meeting in Paducah and for Portsmouth and we're very honored that you are at Paducah, and hopefully at your next meeting that you will be at Portsmouth.

We are also hoping that they re-look at the SEM database to find out what happened to -- our union put together a very specific data on the buildings, what was in the buildings, what the workers could be exposed to and so far I don't know what happened to that data, but it needs to be put back into the SEM and the Board needs to look at that procedure that the union put in.

And we also would like for the Board to get the Moody report with the radiological chemical report by Kenton J. Moody dated January 5, 1995, and it was done by Lawrence Livermore National Laboratory to be added to the list of the exposures for the Portsmouth Gaseous Diffusion Plant, the Paducah, Kentucky plant, and

the Metropolis plant.

These three sites handled reactor fuel from Russia and many other sites like Hanford, Savannah River and the reactor fuel was being reprocessed without the workers' knowledge and we were being exposed to transuranics like plutonium, americium, neptunium, technetium-99, cesium-137, et cetera.

Not to mention the fluorides and the other chemicals that we were exposed to such as tricoethylene and stuff.

And now that americium has been found in the air monitors offsite and has shut down one school in Piketon we are now looking at testing many more schools.

The ASA report has found americium offsite 14 miles from the Piketon plant now. And we can see we have a critical situation going on here with the workers and the community, which the Board I know doesn't address the community.

I met with some workers last week and a contractor with a cancer told me he has two

affidavits of proof that he worked at the plant, that -- it isn't good enough now for his cancer even though it is an SEC cancer.

So he went to the local union hall and he requested the records. And he was only told that the DOL has picked up these records.

My question is how do these workers and families get proof of employment if the DOL is going around and picking up these workers' records and what are they doing with them? Are they keeping them? Are they destroying more records? If so we need to know.

I also was told that Social Security now is charging for records, for workers to get their records. It seems everyone is bloodsucking money from the workers.

The SEC at the Piketon and Paducah and Oak Ridge was the first SEC site mandated by Congress.

Now at Portsmouth they are making workers and families petition for an SEC to prove that their families either worked there, or had

the cancer.

So if we're an SEC site why are they making these families do this? It's just mind-boggling why this is happening.

The resource centers is misleading to workers and families that these centers are helping them file claims.

The center doesn't help them put together what is needed in their files. The resource center employees are not certified advocates. They need help putting claims together.

When the workers come in there with their claims and the families, they need to have this 800-page manual sitting there beside the worker's claim and look at the records to see what they need before they send these records off, because once they send these records off to DOL they're going to be guaranteed to be turned down and once you get a denial it's hard to overturn these records.

So these resource centers need help

putting these records and claims together.

Again, I want to thank you for allowing me to speak and I'm really concerned about the program.

Some of the CMCs, just like myself and my records were sent to someone, a CMC which I have their name.

And they were told that I worked at Paducah, I smoked a pack of cigarettes every day my whole life. And I don't understand -- and I never worked at Paducah. I'm a Portsmouth gas diffusion worker.

So I'm just wondering how many of our claims are getting so confused and mixed up and our diagnoses are being confused and mixed up to where these denials need to be overturned because they don't have our records.

So, there's a lot of things I'm concerned in the program, but I am thankful that the Board is listening. I heard some very good comments from some of the people there on the Board today.

And I'd also like to know if you have public comments today for the workers there at Paducah or is that tomorrow?

CHAIR MARKOWITZ: Public comment session is today.

MS. COLLEY: Okay. I never heard anyone there. Did anyone give public comments today?

CHAIR MARKOWITZ: We received a couple of written comments in the last couple of days if that's what you mean.

MS. COLLEY: Okay. Because some workers told me today, they understood that they were supposed to give comments tomorrow so there's some type of confusion there for them I think.

CHAIR MARKOWITZ: Yes, so we welcome written comments today, tomorrow, you know, whenever actually. But the public comment period is for today.

Yes sure. And Ms. Colley, there are some people here who are going to make some

comments so maybe they are included.

MS. COLLEY: Okay, thank you. And again I'd like to offer you to come to Portsmouth. And I'll be glad to get us a tour for the group.

And we have asked many, many times for Portsmouth and Paducah so you know, now it's Portsmouth's time. Thank you.

CHAIR MARKOWITZ: The next is Mr. Stephen McFadden. Sure, right up there where the microphone is.

MR. MCFADDEN: I basically wrote and printed my comments.

So I'm a child of the Manhattan Project. Dad worked at Hanford. High school science student, two scientific degrees and worked by the summer internships and student employeeships at the DOE and ERDA labs.

So I wanted to raise occupational health issues relating to students, interns and summer workers.

So these folks are working with

potential exposure to exotic toxics often in classified areas, in legacy facilities with little information about what's being done, with no access to photos of the workplace, little documentation of the work that's being done or what work they did.

And if they get uncommon disease not often diagnosed with long latencies, difficult to attribute, little epidemiological statistical power.

If you don't know the agent and there's not a signature biomarker you're probably not going to be able to prove causation. And research involves unknowns by definition, and therefore unknown risks. And occupational health is a lagging science.

On statutory issues SEC exposure cohorts require 250 days of work. Students may work less.

EEOICPA has monetary limits which coordinate with other benefits. So with a long disability you may end with zero benefit by the

end.

Students have little baseline for income. The definition of child is basically dependent as opposed to based on SSA -- based on right to inherit.

And the EEOICPA was passed in 2000 which is six decades into the nuclear weapons program. And there may be Social Security and other workman's comp decisions that were made prior without information.

So my view is that EEOICPA was done on the cheap presuming that other benefits were accessible.

So I want to whip through three examples.

At Lawrence Livermore this was an SEC cohort, U Cal Davis Department of Applied Science a.k.a. Teller Tech had students that were student employees out at Lawrence Livermore.

It's an SEC cohort. For instance, in the biomed computer center there were 20 solvents used in that building. So if you got hit with

the solvent the question is which 1 of the 20.

But more importantly DAS students were given a letter which said that their stipend was not taxable.

Now, if they filed for no withholding on a W-2 no Social Security benefits were taken out. That means they're not covered by Social Security disability whereas if they had withholding taken out and filed for a refund at the end of the year then they were covered for Social Security disability for those years.

So DOE at Livermore had grad students with Top Secret security clearances working in an SEC cohort who was not covered for Social Security disability, child, old age, or survivor benefits and therefore bear risks.

Example two, high performance fuels laboratory. You're probably familiar with FFTF at Hanford. It's a liquid metal, i.e., sodium fast breeder reactor.

It was fueled by NUMEC if you've read the Seymour Hersh, the Samson Option, and Kerr-

McGee Cimarron which is the Silkwood case.

So page 19, I watched them for a few days stuffing fuel pins. It's basically the Silkwood process by hand. So they want to automate that.

So the high performance fuels lab was developing a device to walk the pellets up, have them tip over and laser scan them in a device that would be in a plutonium clean room which could be remotely serviced. So this is an engineering feat.

They had the device fabricated offsite. They took delivery at Pasco Airport so they could have their engineers work on it outside of union rules.

Then they had it moved to the basement of the 309 building which is the plutonium recycled test facility.

So they had me spray paint four cans of spray paint in the basement of the plutonium recycled test complex. This is not a bright idea.

So a third example is -- the key point about the third -- and Hanford's SEC cohort.

The key point about the third example is I was in an administrative building but 30 yards away down the hall was the 3706 building which had been the first radiochemistry lab in the Hanford 300 site.

And so there are reports which say there were multiple grams of plutonium in the vacuum system. And we're talking about 1945 filter technology.

So, just stepping foot on the site there are unknown hazards.

Let me cover SSA's definition of disability. First they require disability to be severe. And there's a tendency for non-combination if you have multiple disabilities.

They require a medically determinable impairment. And that means you have to have the diagnosis, and if you don't have a diagnosis you lose.

Then you have to show objective

medical evidence. That means, well, they sort of define what that is.

You need a medically determinable impairment. But they always talk about objective evidence and it's whatever they say it is more or less.

So, you have problems with severe and getting a formal medical diagnosis, and then supporting with objective evidence.

Social Security is run by -- the claims are made by disability examiners who have maybe 6 to 10 weeks of experience.

They go to a state agency medical consultant in Texas for instance. Some of the SAMC's are running 20,000 cases a year. That means maybe the average case gets six minutes of review which is about enough to say insufficient evidence through DLI, date last insured.

You must prove that you got disabled before the date last insured.

Now, if somebody is working in stocks they need 20 out of the last 40 quarters. That

means no more than five years later can they file a claim.

The claimant is denied after the five years. That will be res judicata against them. They can never apply again.

So within five to nine years your cases are all dead.

The effect of a denial is a lot of people who are denied never work again. The lifetime average income is severely impacted because it's a 35-year inflation adjusted income average.

You may have little old age benefits. You need 40 quarters to be able to be eligible for old age benefits.

Res judicata applies against reopening cases on grounds of new evidence or new issues.

And unless in the first application you beat res judicata the case will go through and four years later it will come out a denial with no black letter right to appeal because the first thing you have to do in reopening an old

case is beat res judicata.

Now, in the HALLEX and POMS there are lists for -- SSA listing has like 14 categories and there are lists of exceptions to res judicata and dates.

Like for instance, they did not have immune disorder category before 1993. So if you were denied before '93 and then they added immune disorder you may be able to get another bite at the apple. SSI --

CHAIR MARKOWITZ: I'm sorry, you're sort of wrapping up?

MR. MCFADDEN: SSI has major issues economically. So you have nuclear fuels and weapons workers have unknown number -- undisclosed hazards working at targets for both nuclear annihilation and Cold War espionage. EEOICPA was done on cheap.

You really shouldn't have -- former nuclear workers destitute. DOE had students with Top Secret security clearances working at SEC cohorts who did not even have SSDI coverage.

And SSA's a severe and objective medical evidence and formal diagnosis requirements are problematic.

And statutory changes may be needed and maybe your designated federal official could talk to the congressional committees to see if there's anything they could do to change statute if you feel that is necessary. Thank you a lot.

CHAIR MARKOWITZ: Thank you. There may be members of the audience ought to talk to those congressional committees.

But in any event, before we go on to the next is there anybody, have we got anybody from the phone who wants to speak? -- Okay, so one? Okay.

I also would encourage anybody who has come in since the beginning of the public comment period, or anybody who's changed their mind and would like to make a public comment, we would welcome your comments.

Okay, let's move on to Evelyn Jeffords.

MS. JEFFORDS: Well, I've had a claim in for many years. My husband worked at the plant. Gary Vander Boegh is my representative. He's my spokesman also if it's all right.

Can you speak for me?

MR. VANDER BOEGH: Oh, now?

MS. JEFFORDS: Now.

MR. VANDER BOEGH: I can if you want to just let me summarize it real quick.

CHAIR MARKOWITZ: Well -- what's the claim for and what's happening with the claim. Can you just tell us in your own words?

MS. JEFFORDS: My husband worked at the plant.

MR. VANDER BOEGH: And your husband's name was --

MS. JEFFORDS: Robert Jeffords, yes.

CHAIR MARKOWITZ: What's happening with the claim?

MR. VANDER BOEGH: Her claim was denied for three of the five statutory requirements for beryllium disease. The claim's

examiners in this area do not approve claims for the statutory requirements. They denied the claim based on procedures.

Now, she's one of about -- well, several. There will be several people that can share this. But, to keep this moving, and I don't want to take more than seven minutes for the whole thing I would say, but Ms. Jeffords has fought this claim. She heard about me.

Somebody asked this morning how did they find out about authorized representatives. I'm the only authorized representative that came forward and requested Rachel Leiton to set a number or a program of tracking where they could help people at Hanford.

We've got people calling us all over the nation. I'm C-001 as an authorized representative for Ms. Jeffords. She's one of at least a dozen that had their claims, that were forced to go to federal court even though the statutory requirement would have approved her claim where everybody else in the nation was

getting their approval. She's now close to 90. She just turned 89, or getting close.

MS. JEFFORDS: I'll be 90 in November.

MR. VANDER BOEGH: Okay, now with that said, her claim is absolutely in front of the judge and we will be looking at reopening those claims because of the landmark decision that we're so proud of for federal judge, and some of you heard me talk about it, a precedent-setting decision that overturned the CBD claim for Charles Stone.

Once you overturn a claim that was illegally denied, Judge Russell issued the only arbitrary and capricious decision against DOL. Then we are able to go back and we're going to ask for -- Mr. John Vance, or whoever he is, to reopen all the claims that were statutory compliant.

Everybody else got paid across the nation but since we had four whistleblowers from Paducah that triggered this sick worker program; Ron Fawlor, Chuck Deuschle, Bud Jenkins -- I

represented Bud and he passed away before he could get compensated -- And John Tillson.

We're the group in Paducah, Paducah Gas. We've got several of my co-workers back here and have got several people that never worked in the plant except Jean Gross who we worked together. She was a subcontractor and I was Lockheed Martin.

Evelyn is just here because she wanted you all to hear her story. I can give it to you and it will be a claim that will be reopened in federal court before Judge Thomas B. Russell hopefully.

CHAIR MARKOWITZ: If you want to briefly tell her story, that would be great.

MR. VANDER BOEGH: Excuse me?

CHAIR MARKOWITZ: I said if you want to briefly tell her story.

MR. VANDER BOEGH: Oh, yes, yes. Her husband was actually a guard under my dad, Don Vander Boegh. My mother and dad both worked at the plant. They also worked at -- my mother

worked at Oakridge. She built the bombs. My grandfather was in the Manhattan Project. So I'm one of the products of the plant.

I'm not the first born because her first born in our family died after my mother -- Jean helped me with the claim, my mother's claim -- and she was exposed to radiation and vapors coming out of the K-25 plant.

When Evelyn came to me, she pulled out the documents that she had and, lo and behold, it said there was a guy by the name of Don Vander Boegh that he worked with. We as an authorized representative developed her claim and we enhanced it, go after all the records, and now we're finding that the records are disappearing.

They fired the lady in Oak Ridge that was giving us the records, Amy Rothrock. These are all things that Jean Gross is aware of. Then they became -- they put somebody else in and now we're suspecting that they are destroying the records when we file claims. Her records -- we've got partial records. Her husband was a

guard with three of the five criteria and nobody would believe us when we originally -- nothing changed -- I've got another claimant right back in the back, Minnie Donald. She'll verify every time we submitted the records to DOL, and I met John -- almost 10 years ago. We just needed to get the right people to understand the evidence. Fair enough?

When we have to do this, we now go in federal court and we're going to try to reopen her claim and reverse the denial. She's been waiting how many years? Nine years for me to overturn this denial.

CHAIR MARKOWITZ: So what was the reason for the denial?

MR. VANDER BOEGH: She didn't meet the 305 criteria because they decided that COPD wasn't indicative of chronic beryllium disease. You and I have talked about some of this. Judge Russell just -- we just had an approval.

They went out and got a CMC. With Evelyn's permission -- the CMC is not for you but

it's for Charles Stone, but that CMC report clearly indicates that for five years Charles Stone was being abused and she's got the same -- her husband had the same thing as eight more that we filed and got denied in federal court until Judge Thomas B. Russell got a hold of this claim.

Now we can go back and they've got to follow this consistent pattern and that's what we'll do. There is nothing else. Evelyn just wanted to come down. She was nervous. She has a little bit of a problem speaking for people but she did a great job in front of the mayor of Paducah, Bill Paxton.

He told her he wasn't going to talk to her that night. We got that on video. Go look at the city meeting on August 28, 2012, and there she is trying to tell the mayor and he wasn't going to listen to her. We document a lot. I'm Lockheed Martin and that's where I get my expertise. There's not a CD that's 10,000 pages I can't go through in probably a day -- and we catch it all.

CHAIR MARKOWITZ: On the list is David Jeffords. Does David Jeffords also want to speak? Okay --

MR. VANDER BOEGH: No, that's her son and that's who I'm really working to help also.

CHAIR MARKOWITZ: Okay.

MR. VANDER BOEGH: Is that it?

MS. JEFFORDS: Yes.

MR. VANDER BOEGH: All right. Let's go back to the back.

CHAIR MARKOWITZ: Okay. So thank you very much.

Our next speaker is Gary Vander Boegh.

MR. VANDER BOEGH: Well, you told me a while ago --

CHAIR MARKOWITZ: Reset the clock for seven minutes.

MR. VANDER BOEGH: You teased me. He said I was going to have to wait to last.

CHAIR MARKOWITZ: No, you're not the last actually. We have more. Go ahead.

MR. VANDER BOEGH: Really everything I

want to do here today is I want to thank John because first time I ever met John the first thing he did was say, Why don't you come up. We took David Nowlin, Ronald Reagan's ethics attorney.

I done this because I'm a decorated Lockheed Martin employee. Jean Gross knows all about it so everybody can snicker in the back row but we don't care about snickers. You brought up something about the CMCs. When I was assisting Department of Energy under Don Seaborg, I was a whistleblower. He asked me to be one because something was wrong at Paducah.

We found out what it is. You're going to hear from some people. We found the plutonium, and I brought this up to Rachel Leiton at our June meeting and I asked her, Why are you not considering the exposure evidence of the plutonium? We've got a thousand cylinders of plutonium out there.

And by the way, you know plutonium can't be a big bunch of heavy -- you can have

plutonium as big as that in a cylinder, right? We could see it from here. It's inside the cylinders and we've already captured that. What we do is I'm not only an environmental engineer and an authorized representative, but I'm a witness for the Department of Energy, Department of Justice, and the FBI.

Now, I filed my whistleblower complaint at the request of Don Seaborg -- Jean knows him well -- and they ran Don out of the plant, and then came after me. We're going to get there because this is honesty and integrity and you're going to find out that Paducah claimants because of Ron Fowler, Chuck Deuschle, Bud Jenkins, and he was my claimant. And his wife died and they wouldn't pay him.

We're getting so many claims and I did make some notes but I'm not going to get through them. I'll get you all your own personal documents. We found plutonium and there's not a worker in here -- Mike Driver is sitting right back there.

We all found the plutonium when we were there so you don't have plutonium in your technical basis document or your authorization basis for Paducah. So the SEM is a bogus SEM. So if you can't evaluate worker's claims, and I think you all would agree, if you conceal the chemicals we were being exposed to.

I'm a sick nuclear worker. I don't like it. I worked in the 720 building and what you brought up today, what we found is a pattern of the workers being diagnosed wrongly because in the 720 building Jean and by the way, right there is Harbison -- you know him -- and Fred Buckley. They all knew, and we interviewed and worked together, that plutonium is all over the plant. You won't find it in the technical basis documents.

We're also going to hear from somebody that also pointed out that it's not just here. It's at Portsmouth. We sent it to Portsmouth. And Kirk can back me up because it's his own USW membership that also got exposed. We had Hanford

early on.

Then we brought in the Russian uranium, Uranium One, go to Tucker Carlson on November 2, 2017 and buckle your seatbelt. That's my information that Sean Hannity and Tucker Carlson are talking about, Uranium One in Paducah, Kentucky.

We were processing uranium nuclear reactor returns. Depleted uranium -- I'm a civil engineer so I just learned all this from Dr. Chris Busby and everybody else, at Portsmouth by the way. They've been here. I brought them in.

We're telling the truth and we just want everybody in the back that works for Cold War Patriots and Denise Brock and all of them that don't work for us, we want all of them to keep snickering and making a joke out of it but, by God, I'm watching my worker die.

Vina Colley that just got off the phone, there will be another speaker, we're the Nuclear Whistleblowers Alliance and, unfortunately, I've got to be the chairman

because everybody else is too busy.

I'll get it done because I'm a Lockheed Martin decorated two-time president award winner and I don't care if anybody likes that or not. We're just getting at the truth and Kirk knows me well, I'm going to get the workers the money that they deserve without any political leader saying they don't deserve it.

I reported all of this to Donald Trump, uploaded to Make American Great Again, January 2017. So I've built my background. I've given it to DOJ Christopher Wray. If you want me to call -- well, I ran out of battery. There's Bill Campbell right there who will tell you what I was doing for you.

So I'm the nuclear whistleblower and I will be in the headlines. I put myself there. Oh, yeah, I know what they did to Karen Silkwood. In fact, I've been warned and so have my cohorts; Vina Colley, Jeff Walburn, Chick Lawson out of Portsmouth.

We're going to bring it all together

for you. It's all about honesty, truth, and all of this subjective -- we just had a decision by Judge Russell that was then cited in the Adams versus DOL decision. You can't cheat nuclear workers by hiding their facts and John knows this. John can't change anything but we're going to help him. We're going to help him change this whole thing. Concealing factual evidence and some of it is crossing the line into the criminal area. We want Jean Gross to be able to honestly say there's plutonium out there.

We're going to let her read Mitch McConnell's own document. How's that? Fair enough? Really that's all I've got. You all did a great job. I want to thank you all. You brought up the very things, and at least I got here.

But every time, and John knows, I had a 10:00 hearing and when I had the 10:00 hearing -- yeah, 10:00 -- I had Anthony Zona on the phone. That never goes well because he never understands what happens at Paducah, he's in

Cleveland.

John and I are going to work through these things. I can honestly say John Vance and Jim Bibeault are some of the best people I've ever had to work for -- work with and I'll try not to work for. No, I don't think John would want me working for him.

By the way, I built the landfill at the plant. I designed the landfill. I save $60 million in the first 60,000 ton. I got a t-shirt and then I got terminated because I wouldn't put radioactive plutonium from the C30 -- 1 building into the landfill.

I want to tell you, I'm sure I wasn't with you today and I wasn't going to tell you what building not to go into, but I'll tell you after I get done. You all will get your own email. If you went into the plant and you breathed, remember what you said earlier? Look, everything around that plant is loaded with beryllium.

I was exposed in the 720 building. I

complained right after I started working. It was raining down from the ventilators. Jim Key stepped up and told Congress the ventilating systems are all the same in the machine shop.

They didn't separate them so what did we do? We went in there and we started working. I started in '92. Next thing I find out I'm breathing plutonium, neptunium, everything. So we're going to give you the documentation.

Thank you Dr. Markowitz.

CHAIR MARKOWITZ: Thank you very much. Good luck, John.

Our next is Donna Hand on the telephone. Ms. Hand.

MS. HAND: Yes, thank you.

CHAIR MARKOWITZ: I want to thank you for your long detailed written public comment -- written comment that you sent in.

MS. HAND: Correct and then I won't dwell on -- when I use it because I think one of you should have it. The first thing is the site exposure matrices. I would like to look at the

definition of the site exposure -- this is actually in the statute and this came directly from the public law that was passed.

And it says in there, The term site profile means an exposure assessment of a facility that identifies toxic substances or processes that were commonly used in each building or process of the facility and the time frame during which potential for exposure to toxic substances existed.

You know, why did Congress use the word potential? Then in the definition of toxic substances, toxic substances again has had the potential because of its radiological nature, chemical nature, and biological nature. So it doesn't have to definitively cause it, but does it have the potential to do that.

This is a legal definition. I know there's a difference between the medical causation and the legal causation. And just like with black lung, if you meet the legal causation or criteria, then it's accepted underneath these

programs.

The other issue is that back in 2005 OWCP determined at that time that these are the references that the District medical consultants, which are now contract medical consultants, will use, as well as what will be in each district office.

One was the National Library of Medicine, specifically PubMed. A lot of the FAB decisions was based on PubMed but, yet, now they are ignoring this. The Agency for Toxic Substance Disease Registry, the toxicological profile is supposed to be used. Again, they are not. They are saying anything from the internet you can accept.

Back in 2010 when the advocates met in Washington, D.C. with John Vance and Jeff Kotsch, they said that we would start using the hazardous substance database. You know, that you can use that. But -- again, we used that as references for our physicians, our treating physicians, and they are ignored because they said it's not well

rationalized.

There's a list of questions there that I've got; A, B, C, D, E, F, and G, that I would like for the Board to look at and respond. Specifically, Number F. When the NIOSH chemical guide in OSHA both informed the public about target organs affected by a toxic substance, can a claimant use that target organ of the toxic substance to provide a scientifically-known leak of exposure and claimed illness.

For example, I have a client that had optic neuropathy. When we went to NIOSH chemical guide, plutonium and nitric acid will cause optic neuropathy; target organs, eyes. He was exposed to plutonium nitric acid. In his testimony before the final adjudication grant he informed them that he was at a higher level than what the IH has stated. We requested to have a communication or conference with the IH. That was denied.

In the final decision, the FAB hearing officers then said level has nothing to do with it. He still denied it even though we informed

him of the level that was higher by testimony. Your other job is the work of an industrial hygienist.

In OWCP, back in the very beginning, has interpreted at least as likely as not to be more than a suspicion and less in the preponderance of the evidence. OWCP has defined significant factors to mean any factor. OWCP has determined that aggregating and contributing to is defined to be the same as in a workman compensation principles.

There is nowhere in the act or the regulations that says significant level of exposure is required. Nowhere. Just that, you know, did the person come in contact with it and did that toxic substance have the potential because of its nature to aggregate, contribute, or cause that illness.

The regulations do state that OWCP will consider the nature, frequency, and duration of the exposure to the toxic substance. So the industrial hygienists can only address the

nature, which is the route of exposure, inhalation, ingestion, and skin absorption. That's left out all the time. They don't even address skin absorption.

Is it soluble or insoluble, and the frequency, direct or indirect, chronic or acute, et cetera. Duration; daily, weekly, monthly, for how many years. Again, why does the IH determine significant levels when the act doesn't require it?

In fact, if you look at question number C, the FECA has now developed in their occupational disease checklist, the list that addresses nature of exposure, they've got primary, secondary, intermittent, and environmental. The degree of exposure; heavy, medium, light, and ambient. Frequency; hours per day, and how many years.

Can something like this be made? Back whenever Rachel Leiton just became the director, she was head of policy. So was John Vance, but in 2008 when the unified procedure manual was

created, she stated that in the Statement of Effects must be based on actual facts. Once interpretation might include levels of exposure, and that is might so it doesn't have to.

However, terms such as light, heavy, undue, severe, and abnormal should be avoided since they are subject to great differences of interpretation. That was determined by her back in 2008 when she did the unified procedure manual.

The other issues that you can read is like I told you the definition of covered illness means the illness or death resulting from exposure, and is it work related. Several court cases have already determined work related. U.S. Supreme Court cases have said is it work related which can be, you know, is it their job duty? Is it in their building area? Building area is never discussed, just labor category.

As you know, labor category does not define what actually the job or the task of the worker. There was a secretary. She was a

secretary of the polymer lab. She wrote in that she was a secretary.

But as a secretary in the polymer lab, the only thing that separated her from the lab tech was a file cabinet and they were only about three feet high. Whenever they opened up things, she was exposed to it, too.

In the Pinellas Plant in the environmental report, in the outside air was tritium. In the outside air was krypton. In the outside air was cobalt. If you don't address all the issues and all the exposures in their work duties, you've missed some of the point. Whenever we tried to explain this and inform the IHs of the unusual exposures, it's completely ignored.

I will not go on because I know that it's time consuming but the main thing we'd like for you to do is determine what is well-rationalized report. Well-rationalized report, according to the regulations, are only needed for consequential illnesses. However, this program

now requires every doctor, treating physician to do a well-rationalized report.

I've had several doctors get a copy of the work history of my claimant and then show them where the site exposure matrix says that they were exposed to this toxic chemical and it has this health effect and they are still denied because it wasn't well rationalized.

The regulations only require medical evidence. What is entitled to a well-rationalized report? Is there a form? You know, you've got to have this, A, B, C, D. That would be guidance then that would be consistent not only for the CMCs but then for the treating physician.

Shouldn't the treating physicians be given the statement of accepted facts as well as the criteria for Part E that, at least as likely as not, was a significant factor and what that means. And does it just have to be causal that it includes aggravating and contributing to?

Because whenever the case examiners

asked for the causal information from the treating physician, they're saying, I can't say that it caused it. This is a big problem that's been here since 2008. I've been working in this program since 2002 and then in 2008 I started representing claimants.

Chronic beryllium disease. Chronic beryllium disease symptoms are just similar to asthma symptoms. Chronic beryllium disease also has an upper respiratory infection. A lot of the workers will have upper respiratory infections before 1993 in their work history.

We also have workers that show up, chronic cough for three months straight. Yet, this isn't a chronic respiratory disorder that the Department of Labor will use for the pre-1993 criteria. Pre-1993 criteria since 2008 has been treated for, tested for, or diagnosed with. That has not changed.

Then all the evidence; the chest x-ray, the pulmonary function test, or diffusion capacity test in the clinical course can be after

1993. So if you have COPD in 1982, you can still have a chest x-ray in 2004 or later on. These are final adjudication branch decisions that have been put into their significant decision list.

The only issues that -- I have a client that has been diagnosed with chronic beryllium disease but now her treating pulmonary physician doesn't know anything about chronic beryllium disease so he says she has asthma.

Well, again, asthma like symptoms is what chronic beryllium disease is. That's why it's so hard to distinguish. Even several experts do not realize about chronic beryllium disease so there's an education that has to be going on.

A medical narrative should address who, what, when, where, why, and how. If the treating physician doesn't have all that information, how can they do a well-rationalized report? If the CMC doesn't have all the information, how can they do a well-rationalized report?

CHAIR MARKOWITZ: Ms. Hand --

MS. HAND: -- So again, I thank you very much. I would appreciate that, if you would finish reading all seven pages. And I was informed that this will be put onto the website in addressing issues that I have brought forth in these. Because it is very disgusting whenever you go and do what the Department of Labor, the EEOC says. You get the references. You have a talk with the treating physician.

You give them the work history and they say, Okay, yes, I can write that it has potential, yes. I can do that. And then to say that's not sufficient enough but they don't tell you what is insufficient. And then you get denied whenever you've addressed everything they told you to address.

I really appreciate all of your time and your enthusiasm and work on this because I know it has taken hours and hours of your own personal time and your work time to discuss these, so I really appreciate the Board very

much. Thank you so much.

CHAIR MARKOWITZ: Thank you. Thank you for your written comments which amplify the comments you just gave us.

That ends our public comment period. I'm sorry, Deb Jarison. Of course. I'm so sorry.

MS. JARISON: Thank you, Dr. Markowitz, and members of the Board for allowing me to speak. My name is Deb Jarison. I'm the Director of the Energy Employees Claims Assistance Project.

I've heard from a couple people on a couple issues I thought might be something you'd be interested in and perhaps you can help DOL with them. One thing I've heard is that DOL has changed the way they are approving terminal claims.

It used to be that a doctor's letter stating that a worker's/claimant's illness was terminal was enough to move the claim quickly. DOL is now requesting that the letter must state

that death is imminent.

I don't know whether this is a change in policy or a lack of claims examiner training but several reasons occurred to me why this could be a bad idea. I'm not sure imminent death is a way that most doctors are used to writing letters.

People in hospice can have different outcomes depending on the individual. Terminally ill patients and their families may face extreme emotional responses to hearing that they or their loved ones face imminent death. They've got enough stress to deal with.

Under the old guidelines it was possible to get a payment to a terminal claimant quickly. I've seen it happen in one case with Mr. Vance's intervention. Payment reached the claimant within the last day of her life. She wanted the money to provide for her disabled daughter and I was really grateful to DOL for making this happen.

I've also been hearing complaints

about medical billing issues. It's a really thorny problem and it's tough. The National Office of Medical Benefits Examiners have helped with this for people who are savvy enough to find them, but most claimants can't do that and I don't think there's a phone number published anywhere for the department. I found these claimants to be very compassionate and helpful

Claimants and doctors need more help and resources to handle the problems with medical bills. Claimants often can't find the resources to deal with problems with medical bills. The CE's can tell them to go to the resource centers but not how to address the problem specifically.

They don't understand what to say to the resource center to get the problem fixed. Sometimes claimants can't even tell which bill is the problem. Sometimes claimants don't know there's a problem until they receive a collection notice which adds a lot of stress.

Claimants often don't get the information on why a bill was denied. Many don't

understand what the resource centers can and cannot do. It seems like some education with both claimants and doctors on this might be beneficial.

Claimants often don't have the language to explain the problem to their doctor or the resource center, especially when it comes to coding issues. It would be really helpful, I think, to claimants and physicians if DOL could develop clear, concise, step-by-step directions written for a lay person to explain how to deal with medical billing issues.

These instructions could be provided in paper to claimants when they receive their white card to make sure that people without access to the internet have that information.

It would be helpful if claimants would also be given information on what each of the different players in the medical billing department do like the roles of the claims examiner, the resource center, the medical benefit examiners, and the billing contractor.

Thank you very much. I really appreciate this Board and enjoy listening to your discussion.

CHAIR MARKOWITZ: Thank you. Mr. Vance, I got just a question after this comment, is it true that the claimant has to produce a letter that says, from a physician saying that death is imminent?

MR. VANCE: Okay.

CHAIR MARKOWITZ: Because that's tough.

MR. VANCE: All right. So, there's this -- nothing actually changed. What we have is a process for identifying claims for terminal status.

And the problem that we were running into was the fact that this created an incentive for lots of folks to come forward asking for their case to be categorized as terminal, with the expectation that that would create some expedited processing of their case.

So, basically, what we did was, we met with our staff and we just simply reiterated the

fact that when you're evaluating a case for a terminal status claimant, we need to have the appropriate documentation to support that that's factually accurate.

So, nothing's changed in our procedure, what we basically stipulated to our staff is that you need to have pretty good confident material or information that would substantiate that.

The reason why this is important is because in order to expedite cases, in order to create this system for moving cases through the process quickly, takes a lot of effort and a lot of resources.

So, we want to make sure that we're dedicating staff to that process in cases where we have a pretty good confidence level that that person is actually in an end stage, imminently terminal, however you want to characterize it.

Which is eminently difficult to do, because of the reasons that were discussed tonight, which is that it's very hard for a

physician to document that this person has days, weeks, or what have you, to live.

So, the Department of Labor does have a mechanism for moving cases along quickly. We will dedicate staff, we will dedicate resources and efforts to move claims through the process, and I think we have a very good track record of doing that.

But the reality is, there are a lot of folks that are using that process in a way that I think is disingenuous. And it's also a reality that we are faced with very challenging situations, trying to figure out, okay, you're terminal, what does that mean?

We don't really have a definition of that, we are just basically looking at it and saying, is there reasonable evidence to suggest that this person, given their medical or physical or psychiatric status, that they are at death's doorstep? And it is a challenge.

CHAIR MARKOWITZ: Well, this is a question for the physicians in the room. So, the

criteria for getting into hospice is --

MEMBER GOLDMAN: It's six months.

CHAIR MARKOWITZ: -- six months? Six months, so --

MEMBER GOLDMAN: So, yes. So, six -- hospice usually categorize terminal as about six months. If you're saying imminent, and many of us have been, tell families it's imminent and then, somebody's living on and on and it's -- you can't play God, actually.

But usually, imminent implies within days. You're at the bedside, you've called the family to be there. But terminal would be about roughly six months. And even that is not precise.

CHAIR MARKOWITZ: Well, my question is, terminal could be construed as being a year. I mean, you've got an illness, you know --

MEMBER GOLDMAN: Yes.

CHAIR MARKOWITZ: -- mesothelioma is terminal. But doctors are comfortable with the six-month hospice time frame. Would that help,

to use that time frame, because doctors are used to that?

MR. VANCE: This -- we treat it as a matter of days and weeks, because we're talking about a situation where we want to try to get the money into the hands of the individual that qualifies for it while they are alive.

So, we struggled with trying to define what terminal means and, yes, a lot of people commonly look at six months, but there are lots of different things that you have to consider when doing that.

So, my basic thought in this is that, whenever we can get convincing information that we're dealing with someone that does not have an extended period of time of life left, that the program will designate that case properly as terminal and try to move through this process, from start to finish, in as quickly a time as possible.

Especially when we're talking about imminently terminal people, where you are talking

about days of life, hours in some instances, where we're trying to move from a situation where we've got to issue a recommended decision, get a final decision in place, get payment documentation back and forth, oftentimes in very emotional fraught situations, where a employee or a survival is unable to actually sign documentation, where we are trying to then get a power of attorney involved, so that they can sign off on these documentation, and then, doing an expedited federal payment through the Department of Treasury.

That takes, it's like launching nuclear weapons, you've got to have --

CHAIR MARKOWITZ: Wait, wait, wait --

MR. VANCE: -- a certified, all this kind of stuff --

CHAIR MARKOWITZ: -- we don't use that analogy that here.

MR. VANCE: Well, it's like launching missiles, you have to have all these different people involved in the process. And so, it's a

very resource intensive process.

And I always point out, when you're talking all of these resources off our normal process, that means other cases are not being adjudicated. So, I mean, it's a challenge. And I know it involves some very difficult scenarios.

CHAIR MARKOWITZ: Okay. Thank you. Thank you very much. This ends our public comment period. We will resume tomorrow at 8:00. I'm sorry, what time? 8:30, 8:30, I'm sorry, 8:30. I'm sorry, there's another person?

MR. NELSON: Oh, yes, there's two, these two right here.

CHAIR MARKOWITZ: Who want to speak?

MR. NELSON: Yes.

CHAIR MARKOWITZ: Oh, yes, come on up and give us your name.

MR. NELSON: I won't take much of your time, I know you're tired. My name is David Nelson and I worked out there in the '80s, and I've had two claims --

CHAIR MARKOWITZ: I'm sorry, speak a

little bit into the microphone.

MR. NELSON: I've had two claims, one was cancer and one was asthma, I guess it's asthma, after hearing about the beryllium today, I don't know it's not beryllium. But they were both denied.

And I worked for two years out there on the roofs. And the thing about it is, they let us go up there without any kind of protection. We didn't have any kind of PPE or anything. And they knew that that roof was hot. We found out later that the roof was actually 100 times hotter than the legal limits.

So, I feel like that they need to reopen my claim and that people need to know the truth about how hot the roof is. A lot of people don't even realize that, they think, well, they were just working on the roof, they weren't around any of the contamination, but we were.

And they actually allowed me to bring it home. We wore our clothes up, just like I have on right now, we wore it home. My wife got

sick, she came down with thyroid cancer. My son actually got sick and died of Hodgkin's lymphoma.

And so, I feel like they need to reopen that and look at it again. And again, thank you for your time, I know you're tired and --

CHAIR MARKOWITZ: No, that's -- but Mr. Vance or maybe the Resource Center here can apprise you on how to proceed.

MR. NELSON: Okay.

CHAIR MARKOWITZ: Okay? Thank you.

MR. NELSON: All right. Thank you.

CHAIR MARKOWITZ: Next?

MR. NELSON: My name is Howard Cook. I worked for Allied Signal, Allied Chemical, Honeywell, and Metropolis. I retired in 2007.

I have a claim, it was denied. But that's not the reason why I'm speaking today. The reason why I want to speak to you today is that Honeywell seems to be the ugly stepchild of the sick worker program.

Any time we go for any kind of

treatment, I know over in Paducah that they have the scan, where they do a scan, to be sure that you don't have cancer.

Well, the ones in Metropolis are not eligible for that. And that's a big problem, because that's how you stay alive, is if you get treated early. But because we're the stepchild of the program, we're not entitled to it. All we're entitled to is Part B, under the cohort status.

Now people that worked before 1976, Allied done work for DOE, so they're entitled to Part B without any dose reconstruction. So, but after '76, you have to have the dose reconstruction.

Well, like I told you, I had a claim, I worked out there almost 26 years, and my percent was three and a half. Now, I didn't work in a bubble, which you'd almost think that you would have to work in a bubble, being around that type of radiation for almost 26 years and they say, oh, only three and a half percent.

And you have to have 50 percent to qualify for the settlement. And I'm not aware of anybody, and we've had a bunch of people that have come down with cancers and died that hired in after '76, but I'm not aware of anybody that has got their settlement.

And I think it all falls back to the dose reconstruction. Now, I know we're not supposed to argue that, but the dose reconstruction, when you see something that's not right, you have to say something.

Now, with our plant, the only thing they use for dose reconstruction is a urinalysis. They don't use any samples, air samples, any other data that they collected out in the plant. Only thing they use is the urine samples.

Well, the urine samples, if you work Monday through Friday, you have to sample twice a month. And so, you'll be off Saturday and Sunday, you come back in Monday morning and that's when you leave your sample.

Well, we all know that the radiation

goes through your kidneys pretty quick. So, anybody that showed up positive or hot on Monday had to really be glowing on Friday. And that's not to say Monday, Tuesday, and Wednesday what they was exposed to, by Monday, it was all gone.

That would be like if a cop pulled me over and said, you been drinking? And I said, well, maybe a little bit. And he said, well, you go in next Monday and we'll check you and see if you're over the limit. Well, it don't happen that way.

CHAIR MARKOWITZ: You'd be a lucky guy.

MR. NELSON: Yes. Well, unless I was an alcoholic, then I probably wouldn't pass it.

And then, if you worked the shift work, you would have what we call long break. You'd get off Friday morning and then, you wouldn't leave a sample again until Wednesday afternoon.

Now, does that tell you why the urinalysis is not showing up any samples that's high enough to warrant a settlement?

And then, we found out later that, from in the mid-'90s, we got some material from Fernald, the weapons plant in Ohio. And it was contaminated with plutonium and other daughter products.

And we was processing that and we was never sampled for plutonium exposure. So, we don't know what effect that's had on the workers out there, because we was never sampled, you don't know if you was exposed to it or not, but probably were. If you worked out there, you was exposed to it.

And then, I think also in late '90s, we started getting the uranium from Russia, to convert over to UF6. Well, we was just told that it was natural uranium. But come to find out, it's uranium-1 and it's weapon grades material and it's contaminated with all these daughter products that we're not licensed to handle in Metropolis.

And I know to get Part B, you have to say that you're doing work for DOE, but when

you're part of that treaty that they signed, I think in '89, where they was taking missiles to convert it over to electric use, they told Russia -- because Russia could not make the UF6 pure enough to sell on the open market.

That was a flaw that they had. And to get around that, our government told them, we have a plant in Metropolis that will process your uranium and make your UF6 pure enough that you can sell on the open market.

Now, if that's not working for DOE, I don't know what is. We were part of that treaty with the Russians, in order to get them to tear down their weapons and convert it over into UF6.

So, I just wish somebody would take another look at Honeywell and see why we're the, and I apologize, but we're the bastard child of the program. And we need to be treated better.

And I had a friend call me the other day, and he has cancer, and he said, I'm tired of it, I'm not -- they wanted to take his lymph nodes out and he said, no, I'm not going to do

it. I hear that all the time.

And it's frustrating when they call you and say, what can I do? And I say, all you can do is file a claim. And he says, I've already done that, I've been denied. And I said, well, you have to file another claim. And most of them have already filed two or three. So, it's already dead in the water.

But if we could take another look at the Honeywell plant and conditions that the people were working over there, and especially that dose reconstruction, that's --

CHAIR MARKOWITZ: Okay.

MR. NELSON: -- I think --

MR. VANDER BOEGH: DOE contract --

MR. NELSON: -- we got --

MR. VANDER BOEGH: DOE contract deposition.

CHAIR MARKOWITZ: Okay, thank you.

MR. NELSON: Okay. Thank you for your time.

CHAIR MARKOWITZ: Thank you. I'm

sorry, there's another speaker? Sure, come on up. There are two more? Okay. Five minutes each, because --

MS. DONALD: My name is Minnie Donald. And well, I have a lot of questions, but I'm not going to have time to bring them all, but I will -- somebody told me that I broke the record.

I have 14 illnesses approved and they have -- ever since Congress put this program together in 2001, I applied for all my illnesses and I got denied. But done through the years, they approved one here and one there.

And I put in for chronic beryllium disease. I had Gary to represent me and they denied me. They said I had nothing proving that I had that. So, we dropped it.

So, I got Donna Hand, the one you just got through talking to, she took over representing me. And I got approved for chronic beryllium disease in July of this year.

The same thing that I had when Gary represented me, but they denied me. That was, he

represented me in 2012 and they denied me. And the same identical x-ray that went by them, they approved it in July. So, what do you say about that?

MR. VANDER BOEGH: Oh, he's not -- who, me?

MS. DONALD: No, I'm talking to you.

(Laughter.)

MR. VANDER BOEGH: Oh, well, actually --

CHAIR MARKOWITZ: Don't yield too much of your time to him, that's my advice.

MR. VANDER BOEGH: I can't, I'm not going to -- I'm going to answer her question. I think it sucks, because we carried her claim with every -- by the way, this is -- oh, I'm sorry. I'm probably talking loud enough to probably get it over there.

We actually -- Minnie came to me and that's probably one of the first time, and it's not just her, we had claimants with three out of the five criteria, that they were then told by --

well, John just left, because he already confirmed you're relentless, by the way. So, I think I'll use her as an AR next.

But what we just found was, the three out of the five criteria were being overridden because somebody said you could have a -- they just kept saying, before '93, when we had all of her x-rays, they didn't show any kind of chronic beryllium disease connection.

But it was COPD and we just won that with Charles Stone, and he's 90 years old, and Minnie got her claim turned around, and we never changed a thing, she never changed a thing.

So, she waited, since 2004, I came in, and I said, what is this? She meets three of the five criteria, automatically they were after me, I think, because I was helping workers. And Denise Brock just got up and left, and there's Jean going.

So, we all know they were not playing our claimants at Commonwealth Environmental Services. Minnie is an example. We then got

Donna Hand to go back, right, Minnie?

MS. DONALD: Right.

MR. VANDER BOEGH: And when Donna came in, all of a sudden, our claims are not being approved. Minnie gets a reopening by Rachel Leiton. And Rachel then says, well, all she needs is an x-ray. Well, guess what? It's the same x-ray that I had in 2012 when she got denied. Right, Minnie?

MS. DONALD: Right.

MR. VANDER BOEGH: So, what we're looking at is disparate treatment. Because in Paducah, we found the plutonium secret and in Paducah, we've linked it to an email and some -- well, it's actually a document from USEC, where Mitch McConnell is on it, in 1999.

And so, we just can't say -- we just don't need Mitch McConnell's help anymore, okay? He's given us enough help. Eighteen thousand claimants are just like her, I'm seeing them every day. Thank you, Dr. Markowitz.

CHAIR MARKOWITZ: Okay, thank you. All

right. Ms. Donald, anything else you'd like to say?

MS. DONALD: I have one more, if I have time. Do I --

CHAIR MARKOWITZ: Sure, go ahead, briefly, because there's one more person that wants to speak. But go ahead.

MS. DONALD: Okay. All right.

CHAIR MARKOWITZ: Oh, I'm sorry, did you -- are you finished?

MS. DONALD: Well, I mean, one more person --

CHAIR MARKOWITZ: Oh, yes, yes, there's one more person.

MS. DONALD: Oh, one more after me?

CHAIR MARKOWITZ: No, no, yes, sure --

MS. DONALD: Oh, I'm sorry.

CHAIR MARKOWITZ: -- if you have some final comments.

MS. DONALD: Okay. There is a limit on the impairment rating and there's a limit on the wage loss. But they got those two combined.

Okay. They owed me 18 years of wage loss and they paid me for 12 and it topped me out. Now, I can't get any more impairment ratings and they still owe me six years' worth of wage loss, because those two are combined and they should not be combined.

And I had talked to Malcolm about it before and it came out in his book, the first of the year, saying that. But nobody never done anything about it.

Those two should not be combined, it's not fair and it's not right, because both of them have their own limit, but they got those two combined. You cannot get paid for both. So, who can straighten that out? They say, you need to go to Congress, but who? How? Who's going to Congress?

CHAIR MARKOWITZ: Well, no, no, I mean, that's actually --

MS. DONALD: I mean, well, anyway, I can't --

CHAIR MARKOWITZ: That's not what this

Board was asked to address to by DOL, so we can't address that. We cannot address that.

MS. DONALD: Well, okay, that is a problem --

CHAIR MARKOWITZ: But we hear you.

MS. DONALD: -- that need to be straightened out --

CHAIR MARKOWITZ: Yes, we hear you.

MS. DONALD: -- because they owe me six years --

CHAIR MARKOWITZ: Okay, thank you.

MS. DONALD: -- that I got promised and can't get back.

CHAIR MARKOWITZ: Thank you. Gentleman in the back?

MR. DRIVER: Dr. Markowitz, I actually called you a few years ago and had a very good discussion with you and I really appreciate, sir, all that you've done to try to help us. I'm very much aware of that. The rest of you, I don't know you.

My name is Mike Driver, I go by, or my

given name is Charles Michael Driver. I worked at the Paducah Gaseous Diffusion Plant for 14 years. If I tried to give the information, all the information that I have to you, we'd need about a month, not five minutes. It is absolutely incredible.

I share just bits and pieces of information sometimes with people and they say, you're kidding? Can't believe this, this reads like some horror novel or something that's been written by somebody, it's just all been dreamed up.

So, I'm going to try to give you the high spots. Number one, everything, especially this guy right here, he's nuts, he's absolutely nuts, but he's right. He's right. I've never been able to find anything wrong --

MR. VANDER BOEGH: You are kidding, right?

MR. DRIVER: -- with what he has claimed. No, you know it, I've told you before. I've never found anything wrong, he's got it

right. Listen to him. Please.

And the rest of them, all of them back here, I've been sitting here, what, for an hour or so, listening to each one of them, they're telling you the truth.

I went to the plant because that was the best job and the best benefits that I could get. Nobody ever told me how dangerous it would be.

They said, yeah, you're working with uranium, but unless there was a full-blown release somewhere, you're not going to get hurt. There's nothing out here that will hurt you, boy, just go on out there and do your job. I heard that a thousand times if I heard it once. So, I did.

Now, after I served for three and a half years in security, in which case, we went all over the rooftops of every building there, laying on our bellies, shooting blanks at each other and practicing war games and things that you do when you're on a SWAT team.

And then, I crawled around in the ditches, that we done found out later, they were all roped off with the yellow ribbons and everything, and all nice exposure for that right there. Goes on and on.

After working, I went over to working in one of the process buildings as a plant operator, Class A operator. Went through my training, passed with flying colors, excelled in every area.

My health was perfect, absolutely perfect, you couldn't ask to be any more healthy than what I was at that time. But that swing shift was about to kill me, I'm just not a nocturnal person. I like to get eight to ten hours of sleep at night, especially since I'm retired now.

But that swing shift, man, it hurt, it just hurt me. So, somebody walked in one day and said they're cranking up the powder crew again, they need people that wants to work on the powder crew. Everybody just sit there.

I didn't know what the powder crew was, and I said, well, tell me about that. They said, we'll be doing straight days, for as long as they continue to overpack these barrels. Straight days? I'll take it.

So, I worked for the next five years as a crew leader, actually. Bud Jenkins trained me, which he's been mentioned two or three times here already. He trained me to be the crew chief, because he only wanted to be on there for a while and he got a chance to go to another day job.

So, I actually was the lead beagle, that's a Kentucky term. I was the lead beagle for the powder crew for five years, until we packed up all of the drums of UF4 uranium, which we found out later were contaminated with plutonium. Also contaminated with arsenic, lead, silver, nickel, and mercury.

Now, if you got time and you want to talk to me again, I'll be glad to come in and sit down and tell you where every one of those things

are found in the plant, because it was denied by Industrial Hygiene. It was denied that any of those elements were in the plant at all, and they were, in abundance.

And that's where I got exposed. That, plus then, when we finished that job, Curley Ware, who's dead now, he and I volunteered to work another year on a cleanup crew. That was the RARP group.

And basically, what we did is we went into all the buildings and where stuff was dusty and laying there for years and years and years, we went and we cleaned it all up. Operated forklift, I helped, Curley was ground man, sometimes he'd operate the forklift.

We'd pick all this nasty stuff up, it was all contaminated from 30, 40, 50 years been sitting there, nobody ever touched it. And we put it in these big cargo boxes, about as big as this opening right here, huge boxes.

Packed all that stuff up, sealed it up. Industrial Hygiene, let's see, no, Health

Physics. Health Physics would come by, they'd take their swipes, check it out, look. Everything's below background.

That's another misnomer. What is background? Right here, background should be pretty, pretty low. But background, when you take a reading in one of those process buildings, that's all that's already there, that we get exposed to, plus whatever we stir up. That's going to make it sound simple, okay? That's as easy as I can do it.

So, I was poisoned with arsenic, lead, silver, nickel, and mercury, which was aggravated by my exposures to uranium, radioactive materials.

Well, the Department of Labor just threw that out the door, they said, no. And like I said, for years, well, from 2001 until 2007, they said there's no arsenic in the plant.

Arsenic is in the plant, it was injected into the system to kill any biological items that were in that plant, because when they

did the PIM program, back in the, what was it?, '80s or 90's, I can't remember exactly when that was, they discovered that there was actually stuff growing inside those old pieces of equipment. And so, they started then injecting arsenic into the system.

They lied about it for six years. This is the United States Department of Labor, whom you are challenging, whom you are supposed to be investigating right now. Same people --

CHAIR MARKOWITZ: Energy.

MR. DRIVER: Excuse me, my choice of words is my choice of words. You think for six years, they would lie repeatedly? While I fought and fought and fought to try to get my disability and try to get my healthcare, any kind of coverage, anything?

I may have been the first whistleblower, no offense to anybody else around here, because when I got sick -- well, out in the buildings, there's cells panels about as big as that screen right there, there's two or three

hundred gauges on there, and then, there's dozens and dozens and dozens of other areas of equipment and things sitting around. I know I'm getting past my five minutes, but you might find this interesting.

The night before I turned my badge in the next morning and left the plant, just walked out cold turkey, quit, the night before, I had an alarm come in one of my panels.

Now, you've got to remember, I aced every test I ever took, I knew that plant inside and out. I even went down in the tunnels between the buildings and checked them out when I was in the guard department, and nobody else did that.

But that night, I went out and I looked at that panel, and I could not remember what those gauges represented. I couldn't remember which one represented pressure or flow or temperatures. I couldn't. I couldn't identify any of them.

So, the next morning, when I walked out past the guard shack, I handed my badge to

the guard and I said, you turn that in this morning, right now. Tell them I'll give them a call, but I've got to find out what's going on. Because my memory was so bad.

Guess what? That was 21 years ago. My memory is still that bad. I have a really hard time remembering things. That's called toxic encephalopathy.

Also, walking from the parking lot in here, by the time I got in here and sat down, my legs were just doing this. That's called toxic neuropathy.

And just as the young lady back here said a little while ago, she was talking about not getting her lost wages. Guess what percentage of my lost wages have been offered to me? Applied for three times, by Donna Hand, and every time, they turn it down and say, no, you don't qualify.

Guys, we need your help really bad. People are being taken advantage to no end whatsoever. And it's not new. I know -- I used

to go to church with about half to three-fourths of the people who worked out at the Resource Center when it first started. That's another little story, and I will quit after I tell you that one.

Because people kept telling me, go to the Resource Center and tell them what buildings you worked in, they can tell what chemicals you were exposed to. So, I did that.

Very sweet young lady took me into her office. My wife was with me, she helped me to recall all the different buildings. Of course, it was every building out there, because I was in the guard department and I was a Class A operator. So, we took care of all of that. She was very polite.

We walked out to the counter, and I'm standing there at the counter, and she's getting one last paper, I think, I had to sign or something like that, and my wife's standing right there.

And there's another woman sitting at

the counter right there. Right there. And I heard her saying, yes sir, Mr. So-and-so, yes sir, yes sir, if you need anything at all, you call us, that's what we're here for, is to help you, we want to help you in any way possible. We'll fill out all your paperwork, we'll research this, we'll do that, do all this other stuff.

And as soon as she stopped talking, this other lady finally finished what she was doing, she turned to us, she goes, Mr. Driver, there's one thing I have to tell you. I said, okay, what's that?

She said, don't ask this office for anything else or any more help, because you're not going to get it. And she turned around and she walked off. Because I was a whistleblower.

Now, I've fought these people for 21 years. They're long overdue. Long overdue. Now, I don't know if you can jerk a knot in their tail, I understand, I understand you all stand for what you stand for.

But people need to know this, from the

President's office all the way down. You got people that have whined and cried and fussed and carried on, I mean, we done everything we can. And they just turn a deaf ear to us, they don't care. So, thank you --

CHAIR MARKOWITZ: Thank you.

MR. DRIVER: -- for your time. I appreciate everything you've done and are trying to do. Just, good luck with it. And you want to hear more --

CHAIR MARKOWITZ: Okay.

MR. DRIVER: -- I'm easy to find.

CHAIR MARKOWITZ: Thank you very much.

MR. DRIVER: Thank you.

CHAIR MARKOWITZ: All right. Dr. Redlich wants to just, is not going to be here tomorrow, so she just wants to make one comment before we break. Then, we'll resume at 8:30.

MEMBER REDLICH: I appreciate everyone's input and I do want to say that I think we tend to focus on the claims that are problematic and we do appreciate the magnitude of

this effort and that there -- we obviously haven't brought up the claims that were appropriately adjudicated, which many were. So, I don't want to totally misrepresent. And we appreciate everyone's efforts.

CHAIR MARKOWITZ: Okay, thank you. So, thank you to people who spoke today, people on the phone, and we look forward to tomorrow at 8:30. Thank you.

(Whereupon, the above-entitled matter went off the record at 6:08 p.m.)