UNITED STATES DEPARTMENT OF LABOR

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ADVISORY BOARD ON TOXIC SUBSTANCES AND WORKER HEALTH

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

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MEETING

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MONDAY,
DECEMBER 12, 2016

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

MEMBERS

SCIENTIFIC COMMUNITY:

LESLIE I. BODEN
KENNETH Z. SILVER

MEDICAL COMMUNITY:

VICTORIA A. CASSANO, Chair
STEVEN MARKOWITZ

CLAIMANT COMMUNITY:

DURONDA M. POPE

FAYE VLIEGER

OTHER ADVISORY BOARD MEMBERS PRESENT

CARRIE A. REDLICH

DESIGNATED FEDERAL OFFICIAL:

CARRIE RHOADS

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

1:06 p.m.

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

I'm the Board's Designated Federal Officer or DFO for today's meeting. First, we appreciate the time and the work of our Board members in preparing for this meeting. I'll introduce the Board members on the subcommittee and we'll do a quick roll call if that's okay.

(Roll call taken.)

MS. RHOADS: Great. We're scheduled to meet from 1:00 to 3:00 p.m. Eastern time today. If you would like we can take a break at 2:00, that'll be up to Dr. Cassano I think.

In the room with me is Melissa Schroeder from SIDEM, our contractor and John

Vance, Policy Branch Chief for DEEOIC.

At a, at a previous meeting the subcommittee requested that someone from the program be present.

Also here is Norm Spicer who is someone from OWCP who's on detail with us for a couple of months.

Copies of all the meeting materials and any written public comments are or will be available on the Board's website under the heading Meetings, and the listing after their subcommittee meetings.

Documents will also be up on the WebEx screen so you can follow along with the discussion.

The Board's website is dol.gov/owcp/energy/reg/compliance/advisoryboard.htm.

If you haven't already visited the Board's website, I encourage you to do so. There is a page entirely dedicated to today's meeting.

The web page contains publicly

available materials submitted to us in advance and we'll publish any materials that are provided after the meeting unless they contain PII.

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

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

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

The Advisory Board voted at its April meeting that the subcommittee meetings should be open to the public.

A transcript and minutes will be

prepared from today's meeting. During the Board discussion, as we're on a teleconference line, please speak clearly enough for the transcriber to understand.

At the beginning of the meeting, please state your name when you start talking so we can get an accurate record of the discussion.

I'd also like to ask the transcriber to let us know if they're having an issue with hearing.

As the DFO, I see that the minutes are prepared and ensure they're certified by the Chair. The minutes of today's meeting will be available on the website no later than 90 calendar days from today for FACA regulations. If they are ready earlier, we'll publish them earlier.

Also, although minutes will be prepared, we'll also publish the transcript which are obviously more detailed. So the transcript should be available on the Board's website within 30 days.

I'd like to remind the Advisory Board members that there are some materials that have been provided to you in your capacity as Special Government Employees and members of the Board which are not for public disclosure and cannot be shared or discussed publicly, including in this meeting. Please be aware of this as we continue with this meeting, especially since we have cases on the agenda.

These materials can be discussed in a general way, which does not include any PII, such as names, addresses, specific facilities that the cases will discuss or doctors' names.

And with that, I convene this meeting of the Advisory Board on Toxic Substances and Worker Health, Subcommittee on Medical Advice for Claims Examiners Regarding Weighing Medical Evidence, and I'm turning it over to Dr. Cassano now who's the Chair.

MEMBER CASSANO: Good afternoon or good morning everybody, depending on where you are. I'm Dr. Victoria Cassano. I am an

occupational and environmental physician with background in military medicine, radiation health, and some environmental health as well.

I just wanted to continue to go around the room for, very briefly, and get some introductions on the Board members. So Dr. Markowitz, and then we could just go from there.

MEMBER MARKOWITZ: Steven Markowitz, City University of New York, occupational medicine and epidemiology.

MEMBER CASSANO: Les?

MEMBER BODEN: Hi, I'm Les Boden. I'm a professor in the Department of Environmental Health at Boston University School of Public Health.

MEMBER CASSANO: Ken? Dr. Silver?

MEMBER SILVER: Oh. Ken Silver, Associate Professor of Environmental Health in the College of Public Health at East Tennessee State University.

MEMBER CASSANO: Ms. Pope?

MEMBER POPE: Duronda Pope, United

Steel Worker. With the emergency response team, but also a former worker of Rocky Flat.

MEMBER CASSANO: And Ms. Vlieger?

MEMBER VLIEGER: Hi. Faye Vlieger, worker advocate, former worker at Hanford.

MEMBER CASSANO: Hi. Okay. So the agenda has been posted and what I'm going to try to do is keep the initial discussion of the 14 Part E cases to end at about an hour, so if we can try to end that at 2:10, I am not going, I'm going to try not to take a break at 2:00. I know, because when I flushed out this agenda, I couldn't add properly.

So when we go through the training documents, I think I just want to do that very generally. We'll spend about 30 minutes on that, which will take us to about another 20 minutes to discuss how we're going to do this focus group with the CEs and a little bit about what kinds of questions we should ask, who should be present, who should not be present, and which of us is going to go because that's going to be a work, a

working group, not the whole subcommittee.

So if we can, we'll probably have about 10, 15 minutes on that. And then I think the closing would be primarily, where do we go from here?

We gleaned a lot of information, we've seen a lot of things that we like. We've seen a lot of, some things that we don't like. And then how do we move forward once we finish with the focus group?

So having said that, I would like to start with the Part E cases and we're just going to start at the top.

Please remember, everybody, when you're discussing these, we are discussing them from a de-identified template.

Please make sure that there is no personal information that we present on this call. I don't think there were any on the template, but just to be absolutely sure, we did not post the template.

So if we could start, I guess Dr.

Markowitz, you did the first three or two or --

MEMBER MARKOWITZ: Sure. Let me, why don't, why don't, let me suggest that I do one and then we move to a different person just to mix up the discussion a little bit.

MEMBER CASSANO: Okay.

MEMBER MARKOWITZ: And I'm not sure which is one.

MEMBER CASSANO: Oh, well, just start with any one of them. I don't, I don't really care.

MEMBER MARKOWITZ: Okay, fine. I'll do the, I'll do the hearing loss one. And it's labeled Hearing Loss if you want to look it up, if you're in front of a computer and actually want to look up this particular case.

This is a case that was accepted in May of 2011. So it's been on the books for a few years. Just a general impression, each, I did three cases.

Every case, the order of documents needs to be a little or a lot different, and so

in my template, I actually, the beginning of the template, wrote the page number of the more important documents just in part for myself so I could go back to them and part for anybody else looking at this, you could find it, zero in on exactly what, but this is a hearing loss solvents and noise case. And a single claim.

There weren't multiple entities for conditions claims here. Ultimately it was accepted.

The, to go through the -- it was clear from the EE1, from the claim form and from the CE form, whatever it's called, which acknowledges what the person's claiming, that the, this was about hearing loss.

And the entity was documented by an audiogram which showed sensorineural hearing loss. So clinical evidence was in place and was unquestioned and there was no need to seek out additional information about, from a health provider about the diagnosis.

The person submitting that audiogram,

the person who performed the audiogram or any other health provider never weighed in on the issue of causation.

So there was, there was nothing from the treating provider about that issue. Now, I should say that this person was a senior engineering associate for 24 years, from 1966 to 1990.

I don't think that's an extensive amount of specificity for this phone call. But my point is, it was that solvent-related hearing loss requires 10 years of exposure prior to 1990, 10 consecutive years, and this person had a single job title for 24 years prior to 1990.

So that was not an issue. That criteria was easily met for calendar time and consecutive years. And the, as I said, the person was a senior engineering associate.

If you know anything about the hearing loss criteria under EEOICPA, there are a certain number of solvents that are specified as being relevant.

Examples are Toluene, Styrene, Xylene, and a few others. And then there are about 20 specific job titles that are, that are provided, and a person has to meet one of those job titles.

The, so the issue here was, the industrial hygienist was asked to weigh in on the issue of solvents exposure and noise exposure, and the industrial hygienist produced a report in which he or she confirmed that there was exposure to solvents and noise for the requisite period of time, and ultimately the claim was then accepted.

It never went to a CMC, presumably because it wasn't necessary. There was a firm diagnosis. There was the industrial hygiene input.

And the only issue that I couldn't quite delineate was, I didn't really see, I saw the industrial hygiene report where they, he or she discussed solvents the person was exposed to, but in the occupational health questionnaire, I didn't see much of solvents.

So it wasn't clear to me where this

information the IH was using came from. There may be something in the file that I missed because, you know, these, reading these files is a, requires probably one or, one or more of those training courses.

But in any event, I didn't see where the information of the solvents came from. The other question I had was the job title.

My understanding on these, the solvent-related hearing loss issues is that person has to conform to one of the 20 job titles.

Although there may be some provision if you don't fall into one of those titles but you can otherwise prove solvents exposure. But I'm unaware of that provision.

So if it exists, if anybody on the phone knows about that provision, that would be useful.

But just to close this out then, the question was how a senior engineering associate or whatever synonym that the IH came up with, if

there was an alternative job title that he or she equated it to, was considered to have significant exposure and to meet the criteria for noise-related hearing, or noise and solvent combined related hearing loss.

So that's pretty much it. The claim was accepted. It did go to, I did note here in my write-up that it went to Dr. Stokes internally at the National Office for an opinion, and that was presumably, that may have been in lieu of the CMC report, on what Dr. Stokes needed to weigh in here on. I'm just looking at it.

In any, in any event, my only real question was how this particular job title ended up being compensated.

It doesn't appear to conform with one of the listed job titles under the, in the policy of EEOICPA. End of my summary. Victoria?

MS. RHOADS: Dr. Cassano, are you still on the line?

MEMBER CASSANO: I'm on mute. That's why. Sorry. I'm on, I muted my phone so that

you didn't hear me typing and stuff like that as I take notes.

Faye, you had one on hypothyroidism. Do you want to go through that quickly?

MEMBER VLIEGER: Yes. It's a bit deceiving to say that one is hypothyroidism. I did go through it and, let me pull up my paper here.

So the claim was for initially something else, and the hypothyroidism was claimed as a consequential condition.

So the claims conditions were actually breast cancer with metastatic sentinel lymph nodes, and then a subsequent claim was made for the, for, it was actually a mild hypothyroidism and a consequential condition of a hysterectomy and diabetes.

So let me just go through a brief explanation of the claim and then I can answer the question.

So the actual first claim condition was the breast cancer with metastatic sentinel

lymph node, and that was in the process of being accepted when the claimant claimed a prophylactic hysterectomy so that they could continue her treatment without the possibility of ovarian or uterine cancer from the chemotherapy they were going to use.

When she claimed the prophylactic hysterectomy, she claimed the hypothyroidism and diabetes.

So the claim marched through with approval for the breast cancer and the sentinel lymph node, and then was later, during the process, accepted for the prophylactic hysterectomy.

However, the hypothyroidism and diabetes were never properly developed. No one related them to chemotherapy, there was no doctor's records saying that they believed that these were related to her chemotherapy.

So to go through the questionnaire, the original contention was actually for a Part B Special Exposure Cohort breast cancer, which was

accepted.

Then later on, the prophylactic hysterectomy was accepted, but the hypothyroidism and diabetes were not.

Breast cancer was considered a Special Exposure Cohort because she met that criteria, so there's no further development beyond providing biopsies.

So under B, are the contentions of the claimants addressed in a statement? Yes, they eventually, through a number of different succeeding decisions, addressed them all.

Is the occupational history questionnaire there? Yes. But she put unknown on everything because she had no idea what she'd been exposed to.

Is there a definitive diagnosis? Yes, for the breast cancer and the lymph node there was biopsy.

The hysterectomy, as a consequential condition, was proved by her doctor's records where they needed to do it in order to continue

her chemotherapy.

There was no development for the thyroidism and for the diabetes. The diagnosis, what was accepted did have objective medical evidence. The two that were denied did not.

Did they discuss alternative diagnosis? No. Were the three diagnoses accepted by the claims examiner? Yes. I considered that reasonable because no evidence was provided for the other two.

Were all the exposures, cause of conditions evaluated? In my opinion, no, they didn't because they didn't actually look at chemotherapy as the cause of the diabetes or that it contributed to the hypothyroidism.

But because the breast cancer was a Special Exposure Cohort cancer, they didn't have to do any further development.

I didn't see where the treating physician provided any causation on the two denied items of diabetes and hypothyroidism.

And then the claim was not referred to

an industrial hygienist. Because it was an SEC cancer, they didn't need to do that. Excuse me.

Number six, did it go to a contract medical consultant? Yes, but only for the impairment rating because there was a question about whether or not the claimant was actually at maximum medical improvement, and that's a requirement in order to do an impairment rating. Prior to that, there was no CMC report, at least not in the file.

Then on item eight, did the CMC provide a rational opinion regarding the nexus between exposures and disease? No, because he was only rating an impairment rating.

And nine, was the claim accepted or denied? Accepted for breast cancer, metastatic sentinel lymph node and prophylactic hysterectomy but hypothyroidism and diabetes were denied.

And again, the breast cancer was accepted because of the Special Exposure Cohort cancer.

Then item 10, the FAB followed the

determination of the CE in accepting the three items, but didn't really go into or look into the causation for the two items that were denied. That's the end of mine.

MEMBER CASSANO: Okay.

MEMBER VLIEGER: And I believe that's number seven.

MEMBER CASSANO: And so your feeling was that some of it was done properly, and some of it could've been done better. Correct?

MEMBER VLIEGER: Right. And I think, especially with chemotherapy and consequential conditions, I don't know how this actually falls into our toxic exposure stuff, but there's so many things that chemotherapy aggravates or causes that it's not that high, tall of a ladder to climb.

MEMBER CASSANO: Okay. Thanks.

MEMBER MARKOWITZ: This is --

MEMBER CASSANO: Go ahead.

MEMBER MARKOWITZ: This is Steven Markowitz. I just have a follow up question

here.

Not to prolong the discussion, but does this, here were some claimed medical conditions that, which there was not a treating physician rationale, and it didn't make it to the CMC for those particular questions and we don't know why. Is that --

MEMBER VLIEGER: That's right. At least it's not in the records I have.

MEMBER MARKOWITZ: Right. Right. I mean, I also have this challenge, a lot of documents that, some of the thinking wasn't entirely fair. Anyway, that's my question. We can move on.

MEMBER CASSANO: Duronda, you had one on heart failure, rheumatoid arthritis. I think that's the first one I've got listed from you if you want to go ahead, if you want to go through that one.

MEMBER POPE: Okay. Yes. The one I had was congestive heart failure and rheumatoid arthritis. This case was denied.

I think the DEEOIC had requested some more medical documentation. It doesn't look like there was any more medical documentation submitted.

There was also a --- I think the stopping point at this case was really slim in terms of the information that was in the case.

I think it stopped when there was conflicting information about the employment records.

Looks like the Department of Labor went to corporate and asked for the records and those records were conflicting with what the claimant had submitted.

The claimant had also submitted a statement from the union stating that he was a member in good standing on these particular dates.

At any rate, the, seems like they used the SEMs to try to make the connection to the health concern which did not prove to be connected to his health concern, and it pretty

much stopped there.

MEMBER CASSANO: Okay. Yes. It's a little bit troubling to see that there doesn't -- - some of these things sort of the ball seems to get dropped and we're not quite sure why.

I think if we write down some of the questions, these are the kinds of questions we need to ask, I'd say at the focus group as to why they go forward with some things and sort of let other things drop by the wayside. Because I think it's important for us to know.

I have one here on IHD and rheumatoid arthritis. And the original contention in this claim was heart disease initially noted as congestive heart failure, but was actually ischemic cardiomyopathy, which was the result of a myocardial infarction.

So basically, this is ischemic heart disease and rheumatoid arthritis. The congestive heart failure is subsequent to the ischemic heart disease.

So, and essentially this was, it, the,

to go through it briefly, it was remanded and again denied. Went all the way through, was denied, was remanded, and then denied again.

So the original contention was available for review. And all the contentions of the claimant were actually addressed. The occupational history questionnaire was utilized.

And then the ischemic heart disease, I was a little bit concerned that when they went through the SEM, they would've only gone through congestive heart failure, but they actually did go through and look at ischemic heart disease, and they looked at acute myocardial infarction as well.

They, the claimant did not initially provide a medical documentation, so they had to go back and ask for more medical documentation.

Now, the question is, were all exposures that might've caused the claim condition evaluated?

And I saw this as a recurrent issue when, in several that I looked at as well as the

ones you looked at, I'm sure only used the SEM and the claim is remanded by the FAB before the development, after they received documentation of the disease.

So again, and we'll get to this when we get to the training document, it seems like people are not necessarily following their, the guidance because the guidance specifically says the SEM is never to be used by itself to deny a claim.

So that's a little piece of interesting information. The claim, and again, the claim was not sent to an industrial hygienist because the SEM was not supported, and there was no medical evidence from treating, his provider.

I thought that was an appropriate decision because they didn't have anything in the background. However, the claim is also not referred to a CMC because there was no evidence, and no evidence of exposure.

And I think in these kinds of cases where you're really not quite sure what's going

on, that a CMC review is warranted before denial.

The claim was denied based on no medical evidence. I think it was a reasonable decision because there was no medical evidence provided, but I would think that they should've done a little bit more research on possible causations for, possible causations for myocardial infarction or at least severe atherosclerotic disease.

Things like carbon disulfide, methylene chloride. I don't know if dioxin-like compounds are in the mix at any of these sites, and diesel exhaust. And none of this was evaluated in any way. It just stopped at the SEM.

So I, my feeling was this could've been done a little bit better and a little bit more, excuse me, with a little bit more involvement, a little bit more involved evaluation.

Ten, let's see, where's ten? I have one here. Is this ten? Bladder, COPD and

bladder cancer. Who had that one?

MEMBER POPE: I had bladder cancer.

MEMBER CASSANO: And COPD?

MEMBER POPE: Right.

MEMBER CASSANO: Well let me, I'm trying to --

MEMBER POPE: COPD and bladder cancer. That was my --

MEMBER CASSANO: Okay. That's Duronda. Right. Okay. Ken, well this case, I have your cases here, but I'm not having --

MEMBER SILVER: I had kidney cancer and TCE.

MEMBER CASSANO: Okay. Why don't we go, that's right. You just had the kidney cancer and TCE one. Why don't you go through that?

MEMBER SILVER: The initial claim was for kidney and prostate cancer, prostate diagnosed maybe six years before the kidney cancer.

The employee had less than a year of on the job experience at a gaseous diffusion

plant. I won't say which one, but just to give you a feel.

He did not have an opinion from a treating physician or any other outside expert. But when DOL received the claim, they got a hit in the SEM for this person's job title and a renal carcinogen, trichloroethylene, being in the matrix in that period of time at the site.

So from there, it was referred to an industrial hygienist within DOL who concluded that the employee had significant exposure at low levels.

And I couldn't quite see through the crystal ball to appreciate how the industrial hygienist decided it was low level exposure.

The claim then went onto a contract medical consultant who did a very thorough job of accessing the peer-reviewed literature and honed right in on a particular epidemiologic study which found an increased risk of renal carcinoma for workers with less than one year of exposure to TCE.

And that seems to have clinched the case for her to arrive at even low level exposure for less than a year was sufficient to infer causation.

And the claim was paid less than, well exactly a year from the time it was filed. So, I guess this is a success story for the SEM supporting a cancer claim.

MEMBER CASSANO: Great. Somebody is talking in the background. If you're not speaking at the moment, if the speakers might mute their phones if they're going to have side conversations, I'd appreciate it. Let's see. Going back --

MEMBER MARKOWITZ: Victoria?

MEMBER CASSANO: Yes.

MEMBER MARKOWITZ: This is Steven. Can I just make a quick comment on that case?

MEMBER CASSANO: Yes.

MEMBER MARKOWITZ: So, and correct me if I'm wrong, but this was a, essentially a trainee who was at Paducah for -- or gaseous

diffusion plant for all of three months, judged to have low level exposure to TCE, but was nonetheless, causation was found and it was compensated.

So you know, I would regard this as a generous interpretation. Is that your impression?

MEMBER SILVER: Yes. And with a little bit of a wrinkle, some of the early documentation said that the claimant had worked there in an earlier time period, seven or eight years before, but as the claim progressed, that earlier employment history kind of fell out of the picture.

So, he was an apprentice and I think there might have been two time periods eight years apart, but in the end, for medical legal purposes, you're right. It was only the brief period later on.

MEMBER MARKOWITZ: Okay.

MEMBER CASSANO: So do you think they should've included that earlier period as part of

their evaluation? I mean, or --- because otherwise I would agree this is pretty generous.

MEMBER SILVER: Well, to make an analogy, they're having NIOSH handle Part B radiation claims.

NIOSH talks about efficiency processes where if they can get to a decision on the basis of some of the facts, they close the claim and pay it.

So I think rather than go down a rabbit hole of looking for documentation of his 1960s employment at the facility, they had enough to pay the claim based on his 1970s employment --

MEMBER CASSANO: Okay.

MEMBER SILVER: -- even if it was for a brief period of time.

MEMBER CASSANO: Okay. Got it. Faye, lymphoma and breast cancer.

MEMBER VLIEGER: Right. Let me pull up my document in front of me. And that was me talking in the background, sorry. I -- okay.

So the original contention for this

was numbered six in the emails, but that's not where I found it in the disc. There isn't --

MEMBER CASSANO: Yes. I --

MEMBER VLIEGER: Go ahead.

MEMBER CASSANO: I realized that afterwards that not all the discs had the tiles on, in the same order, and I tried to fix it, and I think the only overlaps, I think Dr. Markowitz and I overlapped on one. But anyway, go ahead. Sorry.

MEMBER VLIEGER: That's okay. I managed. It was okay. The original contention of the claimant was lymphoma and breast cancer, and that document was in the file.

The statement of accepted facts for the case addresses both conditions. The occupational history questionnaire was included in the file, however, she did not know what she'd been exposed to. And so everything was unknown, unknown, unknown.

And then this particular one is from a facility that I believe does not have a SEM,

and in the documents from the Department of Labor, they stated that they searched the SEM and could find no toxins that she could've been exposed to for the site. So I didn't quite understand that comment.

Because we even had discussed that the site, this was a rather new case, 2015, 2016. We had discussed that this site does not have a site exposure matrix.

So I wasn't quite sure where that statement came from, what SEM they could've looked at. So moving on.

The, there was a definitive diagnosis by biopsy of the lymph nodes. I could not find the biopsy for the breast cancer, but it was accepted in the statement of accepted facts that there was a biopsy and that she did have these diagnoses.

I don't believe under item three, all the exposures could've been, they're looked at for this because it was a cancer, it was evaluated under Part B and Part E.

So did the treating physician provide medical evidence regarding causation at employment? No. There was none of that.

This worker did not have, it says 250 days under Special Exposure Cohort. And so the site she worked at was under Special Exposure Cohort, but she only had six months at the site.

So item five, was the claim referred to an industrial hygienist? No. There was no evidence in the SEM of a toxin which causes breast cancer and lymphoma according to the claims examiner in the file.

And I don't believe that this was appropriate under item B because since there was nothing in the SEM, the CE didn't look any further than that.

It was not referred to an industrial hygienist because there was no evidence in the SEM that a toxin could've caused it. The claims examiner didn't go any further.

Number six, was the claim referred to a CMC? No, because there was not adequate

evidence to support sending it to the CMC.

There was nothing in contention because the claims examiner did not find any toxins that could've caused either breast cancer or lymphoma.

Moving down to item 9, it was denied for lack of evidence, and under Part B, the probability of causation was less than 50 percent that it was a radiogenic cancer because she had less than six months at a Special Exposure Cohort site.

They did a dose reconstruction that came in at 3.01 percent probability of causation, and it has to meet 50 percent to be qualified under a dose reconstruction.

So item nine, see the toxins that are known to cause lymphoma were not evaluated. So basically that is the end of my summary.

MEMBER CASSANO: Yes. So just make sure that, guys, that you somehow make note of the things that you thought were missing or where the appropriate chain was not followed.

This was an obvious one where the CE stopped at the SEM and went no further. So just, so that we have a record of what we're finding with these, so Duronda, oh, let's go back to Steve, Dr. Markowitz.

MEMBER BODEN: How about, wait, are you going to, have you forgotten about me?

MEMBER CASSANO: Les?

MEMBER BODEN: Yes.

MEMBER CASSANO: You didn't, you did one, didn't you?

MEMBER BODEN: No.

MEMBER CASSANO: No.

MEMBER BODEN: I haven't done any yet.

MEMBER CASSANO: Oh, you haven't done anything. I'm so sorry. I didn't mean to overlook you. Why don't you --

MEMBER BODEN: That's --

(Simultaneous speaking.)

MEMBER BODEN: The problem was that you did two in a row at the very end.

MEMBER CASSANO: Oh, okay. Why don't

you do your diabetes one.

MEMBER BODEN: Okay. I will do that. First of all, let me mention that it's actually not diabetes. And let me describe the case to you.

There may originally have been a claim for diabetes, but at some point, there were multiple diseases, presumably I think, all the diseases that the person may have had.

Colon cancer, lung cancer, cardiomyopathy, obstructive sleep apnea, hypertension, chronic beryllium disease, and then diabetes and dyslipidemia. So this was handed to our non-physician, so I will do the best I can.

This is a person who's had long experience at one of the sites from 1982 through 2003 as a chemical operator.

And there were, there were medical records that did support the diagnoses for all of the above-mentioned diseases.

There was certainly evidence to support the COPD, pulmonary function testing,

definitive diagnosis for the colon cancer, notes from the surgery thereby.

So the, all the diagnoses seemed very clear, and really the questions here -- sorry, almost all the diagnoses.

There was not a clear diagnosis for chronic beryllium disease, and that is not accepted by the claims examiner because only two of the CBD criteria were met.

So there were, there were no opinions, medical opinions regarding causation from any of the treating physicians involved.

There was also no evidence that the claim was referred to an industrial hygienist, although this, the COPD, for example, the question of causation for the COPD might well have used an industrial hygiene evaluation.

Let me talk for a minute specifically about the COPD. So this was originally denied along with everything else, but then it was, it was reevaluated when the claimant petitioned the, questioned that decision, it was sent to a CMC

and the CMC agreed that there were signs of obstructive lung airways disease, and that it was consistent with the possibility of it being work-related.

And the report apparently, so the report was not in the records I received. There was a quote from the report saying, however most of his exposures were characterized as infrequent and incidental, and only exposures to chlorine and ammonia were characterized as, and I'm quoting from the CMC report, as intermittent, likely on a daily basis, and because of that and the fact that this, the claimant was a smoker, the CMC report said that the exposures were less likely than, to have less than 50 percent likely to have been a sufficient cause and to, or to significantly impact the COPD.

Now, what's a little puzzling about this is, in the, in the record there was, and I have to find this now for a second, there was a statement by the person representing the claimant in this case that the CMC had stated in his

report, which I could not see because it wasn't in the, in the, in the records that I received, that the worker had actually had substantial exposure to one of the nitrogen oxides, and that that might indeed have caused the COPD.

And, but that the CMC was not asked to look at that evidence reported by the CMC. So that was, that part of it was a little puzzling to me, and certainly raised questions for me, although I don't really know the medicine or the epidemiology behind this.

MEMBER CASSANO: And --

MEMBER BODEN: That, why this --

MEMBER CASSANO: Go ahead.

MEMBER BODEN: -- was disregarded.

MEMBER CASSANO: And, well, I think what we have to remember is that the CMC only sees what the CE sends to them.

They don't see the whole case. They see the statement of case and some of the, some of the industrial hygiene records, and some other stuff, at least according to training documents.

I do have a follow up question though. So the colon cancer was never developed at all?

MEMBER BODEN: The colon cancer was not really developed.

MEMBER CASSANO: Okay.

MEMBER BODEN: And, let me just get the, so this is from the hearing representative's document.

I have a quote here, now, it says, in reference to your claim for COPD, the District Office determined that, the District Office determined that your exposure to nitrogen dioxide was heavy and extended and according to the SEM, nitrogen dioxide is a substance linked to COPD.

But that exposure was not part of the charge to the CMC, and therefore wasn't considered.

MEMBER CASSANO: Okay. But even after all that, it was still denied.

MEMBER BODEN: It was still denied. That is correct.

MEMBER CASSANO: Wow. Okay. Okay.

And then, now let's go back up to I guess Dr. Markowitz. Do you want to do the Parkinson's or the prostate first?

MEMBER MARKOWITZ: Parkinson's is good.

MEMBER BODEN: Yes, I also did that case, so I'll have a couple comments at the end I think.

MEMBER MARKOWITZ: Okay.

MEMBER CASSANO: But anyway, go ahead.

MEMBER MARKOWITZ: Two claims, two claims here. Parkinson's disease and sleep apnea.

This is a nicely developed claim actually with a file of 550 pages long. And actually it's a recent decision too. It's from June of this year.

There's no question the person had Parkinson's disease and sleep apnea. That was documented by the treating physicians.

Both the conditions, actually the treating, they're different treaters, but they,

in both instances, the person provided a nice report linking the Parkinson's disease to manganese exposure and sleep apnea to a number of things, including the Parkinson's disease.

The claims examiner obtained a coworker affidavit, which is very useful because the job title didn't necessarily translate to manganese exposure, but that coworker affidavit was relied upon by the claims examiner to confirm the exposure.

And it was also reviewed, I think by the National Office of Industrial Hygienists within the National Office to address the issue of interpretation of this affidavit and the occupational history to confirm that there was manganese exposure. So that was nicely done.

They didn't send it to a CMC because they had rationalized reports, and also Dr. Stokes in the National Office reviewed it. The only -- and they accepted the claim for both Parkinson's and sleep apnea.

Frankly, the only question I had here

is not one of process, but the outcome, which is, I thought the sleep apnea was kind of a stretch to link it to either Parkinson's or the exposures.

But as a matter of process, they did have a treating physician's report that set out the argument, so, you know, all the necessary steps were followed as far as I could tell.

MEMBER CASSANO: I have a couple of questions. Well, I actually did this by mistake as well.

But I found it interesting that they had both an occupational physician and a neurologist that linked, not only to manganese, but also to TCE.

That actually the initial claim from the CE, and I know John Vance is on the phone, and he was involved in this and maybe he can give us some answers on this.

Because this is really, and two very good medical opinions, yet it was still, before it was denied at the, at the initial level, and

then I think remanded back and still sent to, the industrial hygienist confirmed the manganese exposure.

The toxicologist basically said that there was no epidemiological evidence of, that TCE causes Parkinson's disease, and that's not quite where the literature is at this point from my knowledge of the literature.

So what --- I'm trying to figure out why this wasn't just, why this wasn't just settled at the point of the CE having two very good well-rationalized medical opinions and still had, I can understand the industrial hygienist to document the level of exposure, but why did it have to go through so many loops?

The person had an advocate, and I think it was only after the advocate wrote to the National Office that this was actually accepted for manganese, which I find interesting because with manganese, you would see Parkinson-like syndromes during exposure, and it would eventually, they tend to get better post-

exposure.

With TCE, you see the long latent period, and then the development of Parkinson's disease, or Parkinsonian-like syndrome or Parkinson's disease.

So I think it was the right answer, but for the wrong reason. And I also think it was, it didn't need to go as far as it did. That's my only thoughts on that.

MEMBER MARKOWITZ: Well, I mean, understand one thing, Steve Markowitz, they did go down the TCE road for a while based on the SEM and based on the job title, but when it, when it became apparent that there was also manganese exposure, then I think they asked the TCE was confirmed by the toxicologist that it wasn't relevant, that then they went down the manganese, essentially down the manganese road, so --

MEMBER CASSANO: But it's still troubling that the TCE was discounted. But anyway, that's my only thoughts on that.

Who's next? Duronda, did you do both

of yours? Or who, Duronda or Faye, one of you didn't do one of yours.

MEMBER POPE: I didn't do the other one of mine. This is Duronda.

MEMBER CASSANO: Okay. Okay. And which one is that?

MEMBER POPE: That's the, it came out to initially like the bladder cancer, but it was initially COPD.

MEMBER CASSANO: Okay.

MEMBER POPE: And then the bladder cancer claim followed. So the original contention was COPD and they discovered a 38 percent impairment of whole body, 2009.

It wasn't discovered until 2015 of the bladder cancer. So they were all processed with the COPD repeated claim for most in the case, there was repeated claim for payment for rental equipment. A nebulizer, I believe.

And the refusal of that, I didn't quite understand that, but that was later figured out and accepted. Well, the claimant was able to

get that paid for.

And then that piece of it, the COPD, was awarded and that piece of it was accepted. And then he developed the, a tumor on his bladder, a cancerous tumor on the bladder, and I believe that it would not have, had he not been part of the SEC program, that he would've been denied of that piece of it as well.

But that was later, with the help of his advocates, that was later approved and it seemed like they had, he had tremendous support in terms of documentation, medical documentation.

They had a district medical consultant, which that particular individual, I hadn't seen in some of the cases that we had looked over before.

And that the DMC came with this decision to establish causation for the, for the case to be approved.

I just think that the more support that these claimants have, it seems like the better off they are. But that's a, pretty much

the summary of my, this case.

MEMBER CASSANO: Yes. I see a lot of that too, that if you present all the information up top, but you have somebody that is a known advocate or attorney or whatever that your case will go a lot better than, and maybe that's because it's better documented. Maybe, you know, there are all sorts of reasons for that.

So I will do one, and this was a colon cancer, breast cancer, skin cancer, both basal cell and squamous cell.

And the EE-1 is available, all the, all the contentions were addressed. But there were definitive diagnoses of all four, all four cancers.

The diagnoses were accepted by the claims examiner because it was a path report. The claimant, and I don't think I'm giving away too much here, was a computer analyst and security escort to nuclear areas.

So they only looked at radiation. They didn't look at anything else. She was not

considered a member of a Special Exposure Cohort, I presume because her job, her particular job category was not part of a Special Exposure Cohort.

So they used IREP and found 11 percent probability of causation, but they did each individual cancer, and then they did them from multiple cancers.

They did not look at any other exposures because the computer analyst job description is not listed in any SEM, and that was sort of the end of the case.

It was sent to, so it was sent to NIOSH for a dose reconstruction, then the evaluations at IREP.

There was no industrial hygiene search conducted by a mission support person who reviewed the particular site, industrial hygiene databases found no industrial hygiene report applicable to this particular individual.

Not considered a member of a Special Exposure, but they did note that both breast

cancer and colon cancer are specified FCC cancers.

And my, the decision not to send it to an industrial hygienist, I think, I said it was appropriate. I still probably believe that.

And it was not referred to a consulting, medical consultant, contracting medical consultant, and the reason for that was that it was considered to not have any exposure to the radiation.

I think there could've been a little bit more development on the industrial hygiene end to see if there were any synergistic effects from chemicals.

But again, I think that was a pretty reasonable decision. The claim was denied for everything. No, considered no exposure.

And when we looked at her personal, and I looked at her personal dosimetry records. For the most part they were all under 500 millirem. Total lifetime dose was not more than five rem, and therefore I think, at least as far

as the radiation goes, and I would presume also for the other hazardous substances, that there was really no, there was no significant exposure.

So let's see. Les, you have a meningioma one.

MEMBER BODEN: Yes, I had to hit the button. So, yes. So this is a person who was an explosives handler and machine operator from 1958 to 1966. And you'll see why I mention this. Then was a farmer for the next five decades actually.

So the contention of the claimant was that the claimant had a benign meningioma small vessel disease in his brain.

And there was separate contention that the claimant's skin cancer was related to his, who he's worked for, the Department of Energy.

The original contention was available for review and the contentions were addressed by the statement of the case. And there's actually an occupational history on the file.

The diagnoses for both the skin cancer

and the meningioma were supported by objective medical evidence.

But as in, I think all the other cases we're talking about today, there was no treating physician statement of relationship between the disease and occupational exposures.

There was some idea that a possible exposure to machining oils might have been related to skin cancer.

There were no specific exposures that were stated in the record that might've potentially been related to the benign meningioma.

Case was not referred to an industrial hygienist. It was no reason given, not surprisingly.

And it was referred to a CMC on the question of the skin cancer and the possibility that machining oils might have contributed.

The CMC gave what seemed to me, given the little that I know, at any rate, to be a reasonable report based on the questions that

were given to him.

He said that he did not think that there would've been enough exposure, nor that the, some of the, I guess, cellular changes that one might've expected, if it was, the skin cancer was related to machining oil exposure, was present, and given the fact that the person, after his employment at the Department of Energy, or at a contractor for the Department of Energy, had spent 50 years as a farmer, but it was unlikely that you could meet the more likely than not standard for the skin cancer.

MEMBER CASSANO: And then, but the meningioma was not developed, right?

MEMBER BODEN: The meningioma was not developed. There was no argument of that, a specific exposure that might've caused the meningioma.

They also, by the way, did a NIOSH dose reconstruction for this person, and, which I always find somewhat amusing.

A 4.18 percent risk of, that the skin

cancer was related to his exposures. Not 4 percent, not 4.1 percent, but 4.18.

MEMBER CASSANO: Yes. Not -- the IREP is a very interesting program for anybody that's ever used it. So your thoughts are that the skin cancer was handled properly, but --

MEMBER BODEN: Yes.

MEMBER CASSANO: Now, what are your thoughts about, and it was a benign meningioma, so ---

MEMBER BODEN: Yes.

MEMBER CASSANO: But again, we have no, we can't tell what reasons the meningioma was just dropped at the point of the CE and not, I think we have some answers in the training documents that help us with this, but from what we see in the case, we have no reason to know why the meningioma was dropped.

MEMBER BODEN: Yes. I, presumably, if he knew as much about the causes of meningioma as I do, he certainly would've asked for somebody else's opinion.

MEMBER CASSANO: Okay. So who are we now missing? Duronda, you did both, Faye you did both.

So just Dr. Markowitz and myself I think who are left. So Dr. Markowitz, do you want to do your prostate cancer one?

MEMBER MARKOWITZ: Sure. Yes, this is a, just a two minute one. Prostate cancer and coronary artery disease.

Prostate cancer was accepted under Part B. It met the threshold for probability of causation, so that was easy. Automatically accepted under Part E.

So then the only issue was heart disease and a long term chemical. And no question about the diagnosis. That was, the medical records were nicely assembled.

But I don't see that the whole issue of heart disease was developed at all. I don't see, there's nothing from the treating physician.

It wasn't sent to industrial hygiene or CMC, and so I don't, I don't know whether it's

sort of a blanket policy on heart disease or whether, you know, the SEM was explored.

There wasn't a result of the SEM in the, in the file. So the SEM was explored, and possibly they came up with nothing.

It's just okay to me. There wasn't sufficient documentation of the, of what was done. So that's all I have to say about that case.

MEMBER CASSANO: Okay. And I think the last one is, oh wait, no. That, I did the colon cancer, breast cancer, and carcinomas already, so I'm looking for my third case now which was multiple immune disorders. This is a very quick one, again.

The contention was, lupus, Sjogren's syndrome, and rheumatoid arthritis. I'm not sure how somebody gets three autoimmune disorders. I guess they're just lucky.

The person was a lab technician. There was no other, there was no other delineation of what kind of lab tech this person

was.

She did say in her exposure, in her occupational history questionnaire that she would take contaminated materials back and forth from the sites and contaminated laundry, she would also do, she would also, she would do testing on various liquids and stuff like that to see if there was contamination.

It was not real clear to me exactly what she was talking about. The only, oh, she, what's interested, I saw, she was also listed as anemia. She had, that was her other contention was anemia.

The only one that was evaluated was the anemia because the SEM was silent on all the others. So I don't know if she was working with some organic solvents.

There are some autoimmune disorders, noted the scleroderma, that are associated with some organic solvents epidemiologically. But they only looked at anemia.

And the claim is therefore not

referred to an industrial hygienist, but it was referred to a CMC only for the anemia.

However, it turns out that her anemia was an iron deficiency anemia, so the CMC opined that because it was an iron deficiency anemia, it could not have been due to a toxic exposure. I am, I think that's probably correct.

There are things that can compete with iron, compete with iron for heme, but I'm not, I'm not really well versed in all that. And basically the entire claim was denied for no evidence.

So that's where we're at on that, so again, I think some of the issues that we have when we look at all of these is that why are some contentions dropped without any explanation.

Why does, why do people start at the SEM instead of looking for other evidence or going to an industrial hygienist.

And I think, looking at this first, I think it's a good point to go look at the training materials because I think we will learn

something from that.

Does anybody have any further, excuse me, any further thoughts or comments on some of the general, the things we saw over and over again on the, in these cases?

MEMBER BODEN: I have a couple of comments. One is, I was surprised that, at the files that we thought were not, that for example, I had decisions referring to a CMC report that was not in the file.

And I don't know, you know, I don't know what else wasn't in the file. So there seems to be some slippage in documents getting into the file.

The other thing I want to say, and I think I wasn't clear on this, so there was this case that I had that had the COPD where there was not all the evidence.

Exposure was brought to the attention of the CMC. That was November 2013 when the decision was made, and the decision was essentially to reject everything else but to

remand the COPD.

But there's nothing else in the file. And that was, you know, three plus years ago. So I don't really understand that either.

There was supposed to be, they were supposed to look again at the decision. Perhaps send the question back to the CMC about the additional, and the file ended there as far as I can see. So that was one.

The other concern I have is the sense and those of you who are, who know much more about the system than I do might have some thoughts about this.

I got the feeling from these files that many of the people who were filing these claims aren't really in a very good position to advocate for themselves.

And that, you know, some people avail themselves of advocate that they want, I think they are not in a very good position to know if they've been given every opportunity to be successful in their claims.

MEMBER POPE: I agree with that, Duronda.

MEMBER CASSANO: Yes, I would, this is Dr. Cassano. I just, I would agree with that too.

It, I mean, we have trouble figuring out, gee is this the right decision or the wrong decision based on the information that we have.

So someone who is not well versed in any aspect of this whole process would probably not have a real good chance, unless they're a member of a, of an Exposure Cohort, Special Exposure Cohort, or you know, or they're, it's just a real obvious thing that's in the SEM where, you know, it's acute lymphocytic leukemia and, you know, benzene exposure or something like that. I think some people have, I think it would be very difficult.

Anyway, let's move to the training documents because I think, and I ask people for the people on the, on the line, I ask the Board, the subcommittee members to look at whether these

documents were complete, whether there was clarity, whether they were based on current scientific evidence and current policy, and also whether or not there were any gaps in the, in the, in the training documents as we saw them.

So, and then, also I didn't write it down, I noted some things that I thought were sort of glaring problems with the training. Not a lot of them, but anyway.

So what I want to do is just, the overview one, the DEEOIC claims process big picture.

And I just want people to speak up and talk about, this is just an overview of how the process goes.

I don't know what a red paying review is, so I was immediately lost at that point. I assume that's the CE's job. But I don't think there was much in this one in particular that had any issues.

But anybody else want to speak to the, to this original overview document?

MEMBER MARKOWITZ: This is Steven Markowitz. I just want to ask a more general question.

I thought that we had asked, perhaps at our first meeting, about how claims examiners were trained to do their jobs.

And I thought we were told that there weren't many training materials, that a lot of it was key specific training that was done in each region, each at the, at the resource center or, you know, not the resource center, at the regional office. And did I mishear that, because --

MEMBER CASSANO: No. I heard --

MEMBER MARKOWITZ: There's a list, there's a, to be just clear, a list, at this meeting we've got five or six to look at, but there's a list of 60 of them that were provided to us which were clearly very well developed and very informative, and had been developed over at least a decade. So did I mishear that or did we ask the wrong question or what?

MEMBER CASSANO: I'm not sure, but I heard that as well, that there, I must also add to your comment that I darn well wish I had seen these documents in April because I would've not flailed for six months of trying to understand how this process works.

But anyway, we've got them now and we can move forward. But maybe, I don't know if Carrie or John Vance can tell us --

(Simultaneous speaking)

MEMBER MARKOWITZ: We don't have to get into a back and forth on this.

MEMBER CASSANO: Yes.

MEMBER MARKOWITZ: But I just wanted to know whether anybody else had heard the same comment. That's all. We, you know, we can --

MEMBER CASSANO: No, it's actually in the minutes. It's actually in the minutes that, and then when we had the, when we asked the questions and we came, they came back with some answers for the questions, it was also reiterated in there. So I was surprised to find these.

MEMBER SILVER: Well, this is --

MEMBER CASSANO: Anybody --

MEMBER SILVER: Yes, this is Ken. I remember it putting a fine point on whether there was a career ladder and sort of internal certification program where people obtain objective credentials for expertise in a certain area, and the answer, paraphrasing, is that we've done training but it's more ad hoc as the district offices have needs that come up.

And Rachel said that she and John had done much of the training. So --

MEMBER CASSANO: Yes.

MEMBER SILVER: -- that would be Steve's recollection that we asked if there was something really rigorous and the answer generally was no.

MR. VANCE: Yes. This is, this is John Vance. Can I just comment really quickly and just say that, you know, I think Dr. Markowitz has a point that, you know, we do have basic framework training, and I think that this

training that we put up on our document library demonstrates the overall application of the process guidance, yet we do a huge volume of case specific kind of training because, you know, the training itself has to be applied.

And when you're applying it, you're going to have to work with a lot of cases. So whether we communicated that very clearly or not, the point I'd just like to make is that while we have this kind of training documentation, it needs to translate to actual case scenarios.

So there is a lot of hands on case specific kind of guidance that goes on with claims examiners and supervisory management staff.

MEMBER CASSANO: Oh, that makes a lot more sense.

MEMBER MARKOWITZ: The number, a number of these documents, this is Steve Markowitz, are PowerPoint slides and they're clearly used in training.

They're clearly used to properly to

enhance what people know and do. And I don't understand, frankly, why we weren't provided with this when we were, when we specifically asked how it is that you bring claims examiners up to speed.

Anyway, we don't have to, we, John, we don't have to get into that now. I just wanted to, we can move onto the quality and things, but --

MEMBER CASSANO: Yes.

MEMBER MARKOWITZ: -- wanted it out there.

MEMBER CASSANO: Okay. So does anybody have any additional comments on the initial overview document, which is the claims process document? If not, I will move to the next one.

Is that a, does somebody want to speak or not? Okay. So let's go into the next one.

MEMBER MARKOWITZ: I'd like to speak.

MEMBER CASSANO: That's --

MEMBER MARKOWITZ: This is Steve

Markowitz. I'd like to, this six pages summary is excellent.

It provides a very nicely structured outline of the places the CE might go to, how people like us might understand the program.

It's very clearly written. Obviously it's sort of an outline format, but I thought it was excellent.

MEMBER CASSANO: Yes. The only thing I wish it had was instead of using, I mean, I know what all these acronyms are except for red paying review, ESQ, red paying review, I would've wished that they had at least initially used, written out the acronyms and then reverted to acronyms afterwards so that we all know what was being talked about.

But these weren't written for us, and I presume the people they were written for understand what the acronyms are.

MEMBER MARKOWITZ: For --

MEMBER CASSANO: Anybody else?

MEMBER MARKOWITZ: This is Steven. I

was referring to document number two, not document number one. So, anyway.

MEMBER CASSANO: Oh, okay. Okay.

MEMBER BODEN: This is Les, but I just generally say that I, that not only did I think that the documents were carefully put together, but that also I appreciated the, they make it clear that when in doubt, one should be leaning toward the claimant. I thought that was pretty well done too.

MEMBER CASSANO: Any other comments on this particular one? Because I do have a couple of specific things that I, and I know I didn't ask you to do this, but as I went through it, I looked for specific things that I thought might be problematic in the process. And I don't know if anybody else did that.

But for instance, on slide 29, where it talked about the CMC review is not necessary. The first answer is when a treating physician provides a well rationalized opinion in response to a claim. That, I have no problem with. Or

when there's a presumption of a causation.

The last one I do, where it says circumstances of case development does not necessitate a medical opinion, such as there is no evidence of exposure to a toxic substance or plausible scientific associated between toxin and a diagnosed illness.

I'm not, I think that's beyond the scope of a CE. I, you know, the, and for all the reasons we've talked about, the SEM isn't complete, number one.

Number two, if you look at later on, there's a, they're not allowed to look at any literature unless it's been authorized by the National Office.

So they can't use anything but the SEM and the bulletins and the training documents to come up with that.

So my feeling is that that may be a problem, because I think that's why so many things stop too early.

And the next thing, a couple things,

where it talked about the statement of accepted facts. It talked about the employment history is relevant or toxic exposure that's relevant.

My feeling is, again, that I think the employment history and the possibility of certain toxic exposures are relevant, and I think we found that out when we looked at these cases.

Obviously somebody is dismissing some of the employment history and some of the potential exposures without asking for expert advice on that.

And then, this is, at page 35, it goes to where the recommendation that we made that we think the entire file should go to the CMC and the industrial hygienist because, again, I think if you narrow the focus of what the CMC is looking at, you may engender a false decision, or an inappropriate decision. Not a false decision, by the CMC.

And the only other, and this is a question I had on the second opinion, second opinion medical opinion, I saw a letter and this

is a question that doesn't have to be answered now, but I'd like to get an answer to it.

Does anybody specify what type of specialist they should go to? I saw in the thing that it says, well, you need to contact QTC. And QTC has all sorts of physicians all around the country.

Some of them are experts. Some of them are general practitioners, private care docs, PAs and nurse practitioners.

Well, I guess you wouldn't use a PA in a nurse practitioner, but a lot of them are primary care docs that might not necessarily have information on occupational causative exposure.

So those were my comments on this. Does anybody have, anybody else have any additional comments?

MEMBER VLIEGER: I, this is Faye. One of the frustrating things for claimants is when something is prescribed, the Department requires that it be prescribed by a doctor.

If a PA or a nurse practitioner does

something, for example, home health or a medical necessity piece of equipment, the Department defers back and requires that a doctor prescribe it.

Even though, you know, the states are allowing these to be prescribed by PAs and nurse practitioners. It's becoming a stumbling block when there's fewer and fewer practitioners for the people to go to.

So that's just my comment on that, what was your doctors versus practitioners and the NRPs.

MEMBER CASSANO: Yes. Now, I'm trying to remember the actual policy document that we, that we, that we worked on.

That defined the physician, and I think PA and nurse practitioner were excluded from that definition. Is that correct, Faye?

MEMBER VLIEGER: Yes.

MEMBER CASSANO: Okay. So maybe there's something that they can do, either you know, a physician or under, working under the

authority of a physician or whatever. But --

MR. VANCE: Yes, this is, this is John Vance. That's the way it would have to be because the statute itself requires a qualified physician's opinion.

MR. KEELER: Right.

MR. VANCE: But if we have a PA or a nurse practitioner that's working under the office of a physician who signs off on that person's assessment or what have you, that's fine. But the --

MEMBER CASSANO: Okay.

MR. VANCE: -- statute actually defines what a qualified physician is and that's an MD.

MEMBER CASSANO: Okay. That's what I thought. Okay. Any other comments on this one? Okay.

The next one was the development for causation. And does anybody have any comments or statements, other than me, about this one? No.

MEMBER MARKOWITZ: I did --

MEMBER CASSANO: Go ahead.

MEMBER MARKOWITZ: This is Steven. I was, didn't have a chance to go through all this, but there is another document in the list of 60 materials, excuse me, which is excellent on the issue of causation, addressing aggravation, contribution and causation.

I don't know if it's made its way into this training material or not, but there is another document. I don't remember the name of it, but it was excellent.

MEMBER CASSANO: Yes, because we can look at that online. I, anybody else have any questions or issues or comments on this one, because I also had a couple. Anybody else? Ken? Les? Duronda? No?

MEMBER POPE: No, I'm pretty much, this is Duronda, I'm pretty much in agreement to what you were saying on the prior documents.

I apologize for not speaking up earlier, but I think you're absolutely right in terms of the information that is initially

collected by the CE, all that information needs to go to the CMC and let them decide --

MEMBER CASSANO: Yes, we make, yes.

MEMBER POPE: -- what needs to be omitted or --

MEMBER CASSANO: I think there was a recommendation that was put forward at the last full meeting.

MEMBER POPE: Okay.

MEMBER CASSANO: So what I find troubling on this causation one is the note on Page 6 that says you cannot use studies or reports obtained from internet or other sources to justify case decision unless the DEEOIC National Office has specifically authorized its usage.

Where should you, and I agree in I understand why that's there, because you can go to the internet and you can find anybody that will make claims to anything, and unless its vetted in peer reviews, but my problem is that if you can't even look at those reports to say, you

know what? I'm not quite sure what's going on. I want to send this to an industrial hygienist or a CMC.

And then on Page 7 where it says, if the claimed condition is generally a condition that arises out of occupational exposure, you must pursue additional development whether possible.

If a condition is more than less likely caused by occupational exposure, how does the CE know this a priori without asking an industrial hygienist or a, and this is a question.

It's not a, it's not a derision of the, of the process. But if the medical evidence was not a likely scaling to an illness, and that it arises, but, I mean, most doctors don't know this. Most physicians don't know this.

So I'm not quite sure how a non, a CE would know this without asking. And that's the only comment I have on that.

MEMBER VLIEGER: The only question I

have along these lines is, are there some sort of list of diseases that would, that these claims examiners have?

Some sort of play books that they're using so that they question some diseases and don't question others? Because I am with you. Where are they making these decisions from?

MEMBER CASSANO: I agree. So that is a question and that's something that is a little troublesome.

Page 14, and this is something, a denial requires a closer look at the evidence and more development to be certain the DOE work related exposures during covered employment were not a significant factor.

And it seems like, and this is a good statement, but it seems like, and there are others that are, and Page 15 is the same thing.

The SEM is never to be used for a basis for denial. But we saw in claim over claim over claim in the 14 that we did, that if it wasn't in the SEM, it went nowhere.

So there seems to be a little bit of disconnect between what we're seeing in the cases and what CEs are supposed to do.

The other thing that, this came up at the main meeting, was talking about the former worker program documents.

A few other cases had former worker program documents in them, and it says very clearly on Page 19 that it is probative.

But I've never seen anything, I've never seen a case where it was actually discussed.

And then the next one is, developing for exposure, I think that basically is the same as the last one, other than it just has some place for people to take notes. So I think they actually had the same exact information in them.

So if we could stay on the fourth one, not the last one, which is the claims examiner training course, which just is a guide, but just go back to the earlier one please. Are we on that one?

MEMBER POPE: Yes.

MEMBER CASSANO: No, I'm sorry. Go back to developing for causation, not the other one. So, no. The second to last one. The one I was just on. That one. Thanks. Okay.

So does anybody else have any comments on this particular one? The last one is actually a duplicate of the fourth.

And they're not going to do the beryllium disease because I think Dr. Redlich, who's on the line, her group is looking at beryllium disease, and from what I looked at when I looked at that particular document, it looked more like that information was in her purview than ours.

I just wanted to go to Page 27 on this one because I found the development letter a little problematic.

In making the determination whether to specify, I can specifically identify exposures in the development letter, considered a purpose and likely outcome of providing this information.

That's a good statement.

I agree with the whole statement in general, but I think it may tend to make people not look at exposures that they don't already believe may be causative or probative for the development of a, of a medical outcome.

And then Page 31, we've done this already, entire file should go to CMC. And then a troubling phrase on Page 32, which I thought was very interesting, that the statement, a proper statement of accepted facts should preclude the physician from making their own findings of fact.

So this is where doing this, putting a, putting a SOAF in and then not sending the whole claims file leads to trouble on both the part of the industrial hygienist and the CMC because they are now limited, not only to just discussing the question that someone without the same level of expertise has and answering those questions, but also only looking at information that the CE deems relevant, and I think we've

identified that as a problem in general.

So I think, does anybody have, else have any comments on this developing for causation?

MEMBER MARKOWITZ: This is Steve Markowitz. So a couple comments. One is the desire to allow the CMC or any consultant to see a broader set of records is to ensure that that person can capably answer the questions that are being posed to him or her.

It's not to re-look at the question of the claims above and beyond those particular questions. Is that right?

MEMBER CASSANO: I believe that --

MEMBER MARKOWITZ: In other words, it's sort of a little bit of a safety net in case the CE doesn't, unknowingly doesn't provide everything that's needed.

They answer the questions and the physician or IH or whomever consultant can then see relevant documents that otherwise they may not have seen, but just to see inadvertently to

provide those to the consultant.

MEMBER CASSANO: Yes. I think that's one of the reasons, but also I'm a little bit concerned if the CE is actually asking the right questions, and I think we've seen this in some of the cases where we have contentions that are just dropped and we don't understand why.

On what basis are those dropped? And if they can't make a positive decision, then I would think rather than defaulting to the, I can't find anything therefore it's denied, it should default to, I can't find anything, let's see if one of our experts can.

MEMBER MARKOWITZ: Yes, well, that. Steve Markowitz. That's problematic because it's a much larger task, and it's really asking the consultant to essentially do or redo part of what the claims examiner's tasks are.

So, and that, if according to affect, is likely to be a little haphazard. So I'm not saying there's not a problem. I'm just not sure that what this --

MEMBER CASSANO: How to fix it.

MEMBER MARKOWITZ: Yes.

MEMBER CASSANO: Okay.

MEMBER VLIEGER: I have a, this is Faye. I have a general question along the same lines.

If the SEM is no longer going to be updated or even looked at for new data from Haz-Map, where are they going to get their occupational disease list from if they don't allow them to go outside?

And then, in looking at this training material, on Page 26 the claims examiner, at the bottom, is specifically told not to provide the claimant with copies of your SEM searches.

But the SEM that the claims examiner uses is not the same as the public SEM, and so they may be making a decision based on something that the claimant can't even defend against.

So this whole issue of the SEM and now they're, you know, with no contract with Dr. Jay Brown anymore, who's going to make the disease

links?

MEMBER MARKOWITZ: You know, this is Steve Markowitz. That would be a good question for the committee to take to make sure, the one on the, well, either the SEM committee or the one on the use of the industrial hygiene and physician consultants because it's made directly in line with, we'll try to make sure that question gets over to them, Faye.

MEMBER VLIEGER: Thank you.

MEMBER MARKOWITZ: I, for one, one other comment quickly. Just a friendly amendment to what, something that was said before, that our review of these 14 cases showed that the CEs typically did the SEM, stopped at the SEM, and didn't go beyond that.

I think the cases collectively showed a much broader experience than that. I saw, at least from the cases I looked at, a clear use of the occupational health questionnaire, a consultation with industrial hygienists, so I just, I just don't think it's true that, entirely

true that the 14 cases we looked at showed this, you know, exclusive reliance on the SEM without, you know, much movement beyond that.

MEMBER CASSANO: I don't mean all of them, but a lot of them did. There were at least, there were two, I mean, there were some contentions in a couple of mine and I think there were several, a couple of others where they, the reasons for it being denied was not supported by SEM, and that was the end of it.

But it's very clear in the training documents that that's not supposed to happen. So that, I mean, and I think again, it depends on whoever, who the CE is.

Some of them do, maybe the more experienced ones go into more advanced, more, dig a little bit more deeply than from others.

But I think that's something that, you don't, you, a claim should never be accepted or denied solely based on who happens to handle your claim. But I think that may happen more than we would like to see it. Okay.

We've got five minutes, ten minutes to talk about the focus group. So anybody, any thoughts? I guess some of the questions to the, to the program would be, is this something, my preference would be that we do this before the next full Board meeting, but I don't know if there is resources to be able to send three of us somewhere to meet with someone outside of a formal in person Board meeting. So if you guys could answer that question, I'd appreciate it.

MEMBER BODEN: For one second, there was one --

MEMBER CASSANO: Sure.

MEMBER BODEN: -- other comment that I wanted to make that was a concern to me in the documents, but it wasn't, we didn't get to that document. It was the one, exposure development for Part E cases. And you don't --

MEMBER CASSANO: I missed one? Oops.

MEMBER BODEN: So in the, in the document that was exposure development for the Part E cases, there's a line on Page 46 that

says, well, actually there were two things.

One is that there was a line on Page 46 which I just didn't understand about why exposure information obtained from FWP work histories are after October 2000 should be used only when corroborated with other evidence.

MEMBER CASSANO: Yes, I had that written down too.

MEMBER BODEN: And there was another place where they said basically that if you worked as a secretary, that you should be considered unexposed --

MEMBER CASSANO: Okay.

MEMBER BODEN: -- which I thought, that was on Page 46, if I remember correctly. Oh, no, that's Page 50. I don't, sorry, that was in another document.

MEMBER CASSANO: Yes.

MEMBER BODEN: But it seemed to me that this was in their causation development for Part E cases on Page 29, I saw it. No.

MEMBER CASSANO: I think, yes.

MEMBER BODEN: Sorry, I have the page here, but there was some place in there where basically it said, you know, if you worked as a, as a white collar worker that you weren't exposed, and that just seemed to me totally wrong from everything that I know.

MEMBER CASSANO: No, I agree. The other thing was that you don't always have to do, everything in the OHQ has to be corroborated, but if a DAR and the SEM allow a positive finding, you don't need to do an OHQ and I think the OHQ should be done regardless, because it may pick up other exposure disease relationships that haven't been considered by the, by the claimant.

MR. VANCE: This is, this is John Vance. They actually do occupational questionnaire for every single Part E case.

It's part of the normal initial development of a, of a case once it's created under Part E.

MEMBER CASSANO: Okay.

MR. VANCE: Yes.

MEMBER CASSANO: Then your training document is wrong. It does not, does not state that. It says that it doesn't have to be done if there's a positive --

MR. VANCE: I know that we put a lot of stuff online. Yes. I know, I know that we put a lot stuff online.

I don't know that that's the, when this, when this training was effective because we have, you know --

MEMBER CASSANO: Okay.

MR. VANCE: -- more than 10 years of --

MEMBER CASSANO: Excuse me. I have a pesky dog in the background. Okay. Thanks. So how we, could you, John, while you're, while you're talking, is it possible that we could meet with these CEs between, sometime between now and the next full Board meeting so that we can start to synthesize everything that we've learned?

MR. VANCE: Well, I talked to Rachel about this just a little bit ago. This is John

Vance again.

You know, I think that we're certainly amendable to having you all interact with folks with the staff.

The problem that we are going to have is with bargain level employees being asked to provide input on case adjudication activities.

So we have bargaining level, which basically means these are unionized employees. And that presents a lot of personnel issues for the Department of Labor with regard to how we would allow the Advisory Board to interact with those folks.

I'm not suggesting that the answer is definitively no, but I want you to be aware that that is a concern that will raise issues with how and when we would maybe potentially allow that to occur.

So the director has been clear that she will make folks available, but it'll probably be at a managerial or policy level.

Much more doable than regular bargain

level employees because as you can imagine, there's all kinds of union issues that could be associated with that type of activity.

MEMBER CASSANO: Yes. I hear you. So I mean, if it was somebody that was in a supervisory capacity, what I'm trying, what I would, what I would hope to get is people that are still fully involved in the process every day, whether that's a supervisor, a person that's in a supervisory capacity, and therefore not part of the bargaining unit.

But somebody that still has their hands on the day to day processes of what's going on rather than, you know, somebody that's so far up in the, in the, in the, in the hierarchy that they, and this happens with any bureaucracy.

They tend to lose touch with what's really happening on the ground floor, if you follow what I'm saying.

MR. VANCE: Oh, I absolutely understand and I think Rachel is really willing to be as flexible as possible.

So I would certainly encourage you to lay out exactly what you are proposing with the understanding that bargain level employees is probably going to be a tough sell, but we definitely, and I think Rachel is definitely very flexible in allowing access to managerial or policy level staff to address whatever questions you might have.

MEMBER BODEN: So, this is Les Boden. I'm, I think it would really not be as good for us not to be able to talk to people who are, you know, at the claims examiner level.

We need to understand what they're experiences and their jobs and we need to understand it in a way that, I'm not totally sure that managerial level people would be able to provide us with.

So I think we should try to explore what the labor relations issues are there and see if there's a way that we can resolve them reasonably.

You know, it's not obvious to me what

those would have to be. But that's certainly something that I'm willing to talk about.

MEMBER CASSANO: Well, I agree with Les.

MEMBER BODEN: Really talking to people who are, who are, you know, claims examiners.

MEMBER BODEN: Well, just from an academic study, we'd start off offering participants anonymity and we could probably do that here, right?

MEMBER BODEN: We have to figure, I mean, there are obviously things that we'd have to figure out, but it just, I think it's worth further discussion to try to understand what the issues are before we give up on it.

MEMBER CASSANO: I mean, I agree. I would prefer to have, I was just trying to find a compromise.

You know, there's a, there are people that are managerial, that are supervisory and not part of the bargaining unit that are still

involved in the process. But I agree that having the people that are actually doing the work every day is better.

So John, if we could pursue both of those options, I would appreciate it. And so, and then if the answer is no on the bargaining unit, we'd need, if we can email back and just move through Steven and myself or whatever on what the issues are and how we might be able to mitigate those issues, probably the best option.

Any, and Steve, you have any thoughts or comments? Anybody else have any thoughts or comments?

MEMBER POPE: I, this is Duronda here. I absolutely agree that we need to hear from the people that's on the ground floor.

A lot of times the information as far as what the problems really are don't really reach the top, and I think we've already heard from the Department heads at our initial meeting in April.

If we get further down the chain, the

people that are actually doing the work that always, you always get more information as to what's really going on. It's been proven time and time again.

MS. RHOADS: Okay. This is Carrie. I have a suggestion. If you all could write down exactly what you're wanting from the people that you would want to be in the focus group, then it would be easier to evaluate who exactly could do that, from a union perspective and from just a practical perspective as well.

MEMBER CASSANO: Okay, great. So how we'll handle that, if people could send their thoughts on what they want to ask to me, I will compile them, send them back out to the group, and then send them to Carrie, just so we don't have a lot of duplication, and Carrie isn't getting emails from everybody. I would appreciate that.

And then just, I know we're running out of time, our comment is, the whole subcommittee cannot meet with these folks because

then it would be a subcommittee meeting, so we have to decide on a working group to do that.

At the minimum, it would be one claimant representative or one industrial hygienist and one physician, which I guess would be myself.

But certainly I think we could have more as long as we don't have the whole subcommittee. So we could get three volunteers and we get one person to volunteer not to go.

MEMBER MARKOWITZ: Yes, well, this is Steve Markowitz.

MEMBER CASSANO: Yes.

MEMBER MARKOWITZ: This is the reason, another reason to keep the number limited, which is that, you know, for an effective focus group, you, the number, the number of people we're learning from need to vastly outnumber the observers for the --

MEMBER CASSANO: Okay.

MEMBER MARKOWITZ: -- questions just for, to make it effective. That's all.

MEMBER CASSANO: So why don't we just leave it with three people. One physician, one industrial hygienist, and one claimant advocate and you guys can decide amongst yourselves which one of you are going, who, which one of you will go, and I guess some of it will depend on timing as well.

So the last two questions, the two questions to the program are, number one, please see if we can get three actual CEs and not managerial people, and number two, what kind of timing could we, could we manage to accomplish this in. And number four is where would we do this?

MEMBER MARKOWITZ: So Victoria, it's Steve Markowitz. I think they're going to want to see the written request just --

MEMBER CASSANO: Okay.

MEMBER MARKOWITZ: -- to speculate, before they answer any of those questions.

MEMBER CASSANO: Okay. So I will, guys get your, get your thoughts to me on what

kinds of questions you want to ask, and also some of the issues you want to discuss.

I will compile them, get them back out, and then I will put in a formal request. But before I do that, I'll have it vetted by the group. Okay?

MEMBER BODEN: Sure. Just a quick question. Is sending things to you and not to the whole group a, or to the, to be distributed in the whole group sort of a violation of our sunshine principles or --

MEMBER CASSANO: Well, we did that with the cases. Carrie --

MEMBER BODEN: Or --

MEMBER CASSANO: -- if I'm going to --

MS. RHOADS: The group is allowed to email each other if you just copy the designated inbox as well.

MEMBER BODEN: Okay.

MEMBER CASSANO: Okay.

MEMBER BODEN: So, but I'm thinking also that, so you're just going to compile the

suggestions and then send it out to the whole group? Is that what you're --

MEMBER CASSANO: Yes. That's what I'm going to do so that Carrie doesn't have to sit there and go, well, three people wanted this question answered and one person wanted this.

I'll just put them all together and compile it. I'm not going to edit it. I may wordsmith a little bit, but then I'll send it back out to the group, and Carrie's going to see it as it develops anyway, but, or the DOL thing will see it as we develop it.

But that way, there's a final, at least a final document with the request on it going to the programs and not five people sending a variety of requests directly to the program without them being sort of, because some of the questions may be worded differently but mean the same thing, and I think that that's a need, we have to, that's our responsibility to make it clear and concise rather than have the program try to compile it and figure out what it is we

want.

MEMBER BODEN: Okay. Just a final question. Has, I mean, during a focus group is actually something that people are trained to do that there are methods and ways of doing them.

Is there somebody in our group who has, you know, training in doing focus groups? And if not, should we consider getting some advice on that?

MEMBER VLIEGER: Dr. Silver, what's your experience?

MEMBER SILVER: I relied on the skilled facilitator for my beryllium studies.

MEMBER CASSANO: Yes.

MEMBER BODEN: Right.

(Simultaneous speaking)

MEMBER CASSANO: Now, and I was, that was one of my next questions. Is it possible, given what we're trying to do, and this is a question for the program, to have a skilled facilitator?

MS. RHOADS: I can, I can pass that

along and see what they think.

MEMBER BODEN: Okay.

MEMBER MARKOWITZ: That then should also be in our written request.

MEMBER CASSANO: Okay. Okay. Okay. Any, we're over time. Any final questions or comments? Everybody know what next steps for us? Yes?

MEMBER BODEN: Yes.

MEMBER CASSANO: Okay, great. Thank you all.

MEMBER MARKOWITZ: Thank you.

MEMBER CASSANO: Thanks for the participants and talk to you all soon. Bye.

MEMBER POPE: Bye.

MEMBER VLIEGER: Thank you. Bye bye.

(Whereupon, the above-entitled matter went off the record at 3:07 p.m.)

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C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Subcommittee on Advice for CEs RE: Weighing Medical Evidence (Area #2)

Before: Toxic Substances and Worker Health Ad. Bd.

Date: 12-12-16

Place: teleconference

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

Neal R. Gross

Court Reporter