

UNITED STATES DEPARTMENT OF LABOR

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ADVISORY BOARD ON TOXIC SUBSTANCES AND WORKER

HEALTH

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

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MEETING MINUTES

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WEDNESDAY,

DECEMBER 21, 2016

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The Subcommittee met telephonically at 2:30 p.m.  
Eastern Time, Carrie A. Redlich, Chair, presiding.

MEMBERS

SCIENTIFIC COMMUNITY:

JOHN M. DEMENT

MEDICAL COMMUNITY:

CARRIE A. REDLICH, Chair

LAURA WELCH

CLAIMANT COMMUNITY:

KIRK D. DOMINA

OTHER ADVISORY BOARD MEMBERS PRESENT

STEVEN MARKOWITZ

FAYE VLIEGER

DESIGNATED FEDERAL OFFICIAL:

CARRIE RHOADS

**Introductions and Part B recommendation - sarcoid presumption and Part B case reviews**

Ms. Rhoads called the meeting to order at 2:35 pm. Chair Redlich suggested beginning with the case reviews. The cases addressed sarcoid and beryllium presumptions. The cases were reviewed in chronological order, with the beryllium sensitivity cases being the most straightforward. The question of determination on the beryllium cases will be left for later discussion. The cases as discussed:

- 1) The first case was an example of where the sarcoid presumption was somewhat used and illustrates some of the problems where a more clear-cut presumption would be helpful. This case was from Los Alamos, and the sarcoid diagnosis was made in 2010. The claimant applied for CBD and was denied because the BeLPT was negative with granulomas on the lung. In 2014 the claim was finally accepted. A number of similar cases ended up being denied because there were not enough knowledgeable pulmonologists to get those claims accepted. The director's letter in this case explained how the case was accepted.
- 2) This case was accepted for CBD and the person had a positive BeLPT. The key point to be drawn from this case was that if a claimant has a positive BeLPT and has evidence of interstitial lung disease, then the claimant has "pretty much" met the criteria. This person was not in a surveillance program. The claimant's pulmonary doctor obtained the claimant's history and personally sent off the BeLPT to the department.
- 3) This case involved acute berylliosis from 1946 with CBD diagnosed a year later. A successful claim was filed by the survivors in 2014.
- 4) This case was a sarcoid CBD; it was from Savannah River with a BeLPT that was negative. The sarcoid diagnosis was made years before the CBD was recognized. A pulmonologist wrote a strong

letter that the person had a diagnosis of CBD. It was accepted because there was pulmonary sarcoid.

5) There were several silicosis ILDs (interstitial lung disease) that the committee did not go through individually, but instead discussed the issue of exposure. Member Dement noted that in uranium mining and silicosis the SEM did not list silica exposure during uranium mining. But the SEM found aluminum exposure in two of the cases. Based on that, the CMC (contract medical consultant) opined that the claimants' conditions were not related to aluminum exposure even though chest x-ray information showed changes that would be consistent with pneumoconiosis. The SEM committee needs to look at why silica isn't associated with uranium mining and why a diagnosis of pneumoconiosis would not suffice for silicosis. Including silica in the SEM would make the process easier. In some of these cases, silica exposure was not properly identified in the exposure assessment as being relevant. Silicosis is covered under RECA. In many of these instances, one particular CMC came up with bad conclusions. A simple solution to this issue could be to have a presumption for certain job titles related to silicosis. Some of these cases will be passed on to the CMC committee. There needs to be a process to review the decision-making of the CMCs. If a claimant has a history of exposure and granulomas, should there be a presumption for that claimant?

### **Sarcoid cases**

Some of the reviewed cases revealed confusion around when the lung is involved in having a claim accepted. A lymph node biopsy is not a lung biopsy. The committee agreed that a lymph node biopsy should be accepted as the standard of proof, not just a lung biopsy. If there is a positive BeLPT wherever the biopsy is from, then it's CBD. A more common scenario is when there is extrapulmonary disease and the BeLPT is negative.

The committee thought about defining what it means to say "pulmonary involvement" or "pulmonary disease." Finding typical granulomas at other sites should be considered the same as finding them inside the lung. A CT scan that shows hilar adenopathy consistent with sarcoid could be a kind of presumption as well. The committee will pass these thoughts on presumptions to the department.

Another case had a diagnosis of sarcoid with a lung biopsy with no BeLPT. It was a clerical worker that worked in multiple buildings at Savannah River and the conclusion was that there was no beryllium exposure. Beryllium exposure is separate from the SEM. There was not a lot of beryllium used at Savannah River. To get a diagnosis of CBD under the legislation, there needs to be lung involvement. One criterion of the post-93 criteria is the need for a lung biopsy. Member Markowitz said that the department asked that the advisory committee help define phrases like "consistent with" and "characteristic of."

### **Recommendation for presumptions**

The committee's recommendations are in the current documents. The committee's understanding of presumptions is essentially beryllium exposure and a clear diagnosis of sarcoid involving the lung. The committee wants to present a presumption to the department based on beryllium exposure and a diagnosis of sarcoid and see how the department responds.

### **Borderline BeLPT**

There is modeling that suggests that three borderline BeLPTs are the equivalent of one abnormal and one borderline. The committee could recommend that either three borderlines or two borderlines are the equivalent of a single positive BeLPT.

### **Other items**

The committee decided that it would point out inconsistencies in the EEOICPA circular and PowerPoint description.

Member Markowitz said that a lot of the problems that DOL had in the past have stemmed from the language in the statute being translated into the procedure manual. Particular problems arise with phrases like "consistent with" or "characteristic of." There are a few areas where there could be clarification. Problems in the past have stemmed from CBD cases being denied. The issue was that the CBD claims did not meet the criteria. The most common denials among the cases examined by the committee were interstitial lung disease and sarcoid with negative BeLPT. All of the denied claims that physicians sent to Chair Redlich were in the setting of a negative BeLPT.

The committee did not want to review additional cases and instead wanted to spend time putting "things on paper." The department needs to clarify how it applies documented beryllium exposure. The committee has looked at ten denied CBD cases. Member Markowitz said it would be helpful to get a summary of the public comments on beryllium. If there is a finding of incompetence on behalf of the CMCs, it should be pointed out and corrected.

Member Vlieger said that the department is funneling CBD cases to one or two doctors and that the outcome from those doctors has been claim denial. There are good CMCs out there, but they may not have been given the guidance they need to "do good adjudication" under the program. Specific CMC reports that the committee has concerns about will be passed to the CMC committee.

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

Submitted by:



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Carrie Redlich, MD, MPH  
Chair, Subcommittee on Part B Lung Conditions  
Advisory Board on Toxic Substances and Worker Health  
Date: 3/21/2016