U.S. DEPARTMENT OF LABOR

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ADVISORY BOARD ON TOXIC SUBSTANCES
AND WORKER HEALTH

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MEETING

+ + + + +

TUESDAY
JANUARY 28, 2020

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The Board met telephonically at 1:00 p.m. Eastern Standard Time, Steven Markowitz, Chair, presiding.

MEMBERS PRESENT

STEVEN MARKOWITZ, Chair
MANIJEH BERENJI
JOHN M. DEMENT
KIRK D. DOMINA
GEORGE FRIEDMAN-JIMENEZ
ROSE GOLDMAN
RON MAHS
MAREK MIKULSKI
DURONDA M. POPE
CARRIE A. REDLICH
KENNETH Z. SILVER
CALIN TEBAY

ALSO PRESENT

MICHAEL CHANCE, Designated Federal Official
CARRIE RHOADS, Alternate Designated Federal Official
RACHEL LEITON, Director, DEEOIC
MELISSA SCHROEDER, SIDEM

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

2 1:04 p.m.

3 MR. CHANCE: Yes, good afternoon
4 everyone. My name is Michael Chance. I'd like
5 to first of all introduce myself. I'm the new
6 DFO, the federal officer, so I'll look forward to
7 working with you all on the board, and we look
8 forward to a productive meeting today.

9 First, we appreciate the time and
10 diligent work of our board members in preparing
11 for this meeting and the forthcoming
12 deliberations. We are scheduled to meet from 1:00
13 to 4:30 today, so please bear in mind the time.

14 In the room with me are Carrie Rhoads,
15 Rachel Leiton, Kevin Bird from SIDEM, our
16 contractor.

17 MS. RHOADS: He's on the phone.

18 MR. CHANCE: He is on the phone, yes.

19 MS. RHOADS: Yes.

20 MR. CHANCE: Yes, and I'm sorry, you
21 are?

22 MS. SCHROEDER: Melissa Schroeder.

1 MR. CHANCE: Melissa Schroeder, as
2 well. And, so we will go ahead and I will begin
3 discussing the remainder of the meeting.
4 We have agreed upon a break at 2:45 or
5 anytime that seems like a good time to stop. So,
6 that's our agreed upon time.
7 Copies of all meeting materials and
8 written public comments are or will be available
9 on the board's website under the heading
10 Meetings, and the list, and the listing there for
11 committee meetings.
12 The documents will also be up on the
13 Webex screen so everyone can follow along with
14 the discussion.
15 The board's website can be found at
16 dol.gov/owcp/energy/regs/compliance/advisoryboard
17 .htm. I think I got all that.
18 If you haven't already visited the
19 board's website, please do so. After clicking on
20 today's meeting date you'll see a page dedicated
21 entirely to today's meeting. The webpage
22 contains publicly available materials submitted

1 to us in advance of the meeting.

2 We will publish any materials that are
3 provided to the sub-committee. There you should
4 also find today's agenda, as well as instructions
5 for participating remotely.

6 If you are participating remotely and
7 you are having a problem, please email us at
8 energyadvisoryboard, that's all one word,
9 @dol.gov.

10 If you are joining by Webex, please
11 note that the session is for viewing only and
12 will not be interactive.

13 The session will also be muted for
14 non-advisory board members and please note that
15 we do not have a scheduled public comment session
16 today.

17 About the meeting minutes and
18 transcripts, a transcript and minutes will be
19 prepared from today's meeting. During board
20 discussions today as we are on the teleconference
21 line, please speak clearly enough for the
22 transcriber to understand.

1 When you begin speaking, and I hope
2 I'm doing that as well, when you begin speaking
3 especially at the start of the statement, please
4 state your name so that we can get an accurate
5 record for the discussion.
6 Also, I'd like to ask our transcriber
7 to please let us know if you're having any issue
8 with hearing anyone or can't spell a name, or
9 have any trouble with the recording.
10 As the DFO, I see that the minutes are
11 prepared and ensure they are certified by the
12 chair. The minutes of today's meeting will be
13 available on the board's website no later than 90
14 calendar days from today per FACA regulation.
15 But if available sooner, they will be published
16 before the 90th day.
17 Also, although formal minutes will be
18 prepared, we will be publishing verbatim
19 transcripts, which are obviously more detailed in
20 nature. Those transcripts should be available on
21 the board's website within 30 days.
22 I would also like to remind the

1 advisory board members that there are some
2 materials that have been provided to you in your
3 capacity as Special Government Employees and
4 members of the board, which you are not for
5 public disclosure, not to be shared or discussed
6 publicly, including this meeting.
7 Please be aware of this as we continue
8 with the meeting today.
9 These materials can be discussed in a
10 general way, which does not include us using any
11 personally identifying information such as names,
12 addresses, specific facilities, and if a case is
13 being discussed, or doctors' names.
14 So, thank you for your patience as I
15 went through that list and with no further ado, I
16 will turn it over to Dr. Markowitz.
17 CHAIR MARKOWITZ: Thank you.
18 This is Steven Markowitz and I want to
19 welcome everybody to the meeting of the board.
20 Welcome to Mr. Chance as the new DFO working with
21 us, that's great.
22 In a moment we'll do introductions but

1 I want to just welcome any members of the public
2 who are on the phone. Hopefully also able to get
3 online and look at some of the presentations
4 we'll be making.
5 I want to point out certain documents
6 on our website that we'll be referring to today
7 that are now available on our website under
8 today's meeting, and these include a letter with
9 new duties from the Deputy Secretary of DOL that
10 was sent December 30, 2019.
11 Secondly, responses from the
12 Department of Labor to our recommendations from
13 early in 2019 that was sent to us December 18,
14 2019. So, that's on our website.
15 And, then also on our website are the
16 board's data and case review requests that we
17 made at the end of December 2019.
18 So, otherwise other documents we'll be
19 discussing today, which should appear on the
20 website soon, there's, or not depending on
21 Department of Labor's policy, that we've been
22 provided with yesterday maybe for board members,

1 we were sent a copy, a draft of a new elements,
2 new chapters for the procedure manual, it's
3 called Bulletin 20-02, which we'll be discussing
4 today somewhat.
5 And, also today we received this
6 morning we received Department of Labor's
7 responses to our end of December board
8 information requests and claims review requests.
9 So, we will walk through those today as well.
10 This meeting is kind of an interim
11 meeting between our face-to-face meetings. I
12 don't know that we're going to make any
13 recommendations at this meeting. I kind of
14 review this, view this meeting as an opportunity
15 to catch up, to react to some of the
16 recommendations, or some of the responses we're
17 getting from DOL, and kind of brainstorm a little
18 bit about how to move forward on certain issues.
19 So, this may be a little bit more of a
20 free flowing discussion, I hope so, than at some
21 of the previous board meetings. But that's just
22 fine because that should move us ahead.

1 And speaking of ahead, so the board's
2 term, this term ends mid-July 2020. This
3 meeting, we’ll have another face-to-face meeting.
4 I think we'll discuss this again at the end of
5 the meeting but likely shoot for sometime in the
6 second two weeks of April, which would give us
7 enough time between now and then to do some work,
8 but also would give us time between that meeting
9 and the end of the term to close out or finish up
10 any board work at the end of June or beginning of
11 July.
12 So, that's, so in our discussion today
13 when we think about our work schedule and what we
14 hope to get done when, I think in April when we
15 meet face-to-face that's when we should shoot to
16 really have our recommendations that pertain to
17 some of the things we're discussing today ready
18 to go, which means probably work group meetings
19 between now and then.
20 So, with that, let me just then move
21 to introductions. Briefly the board members can
22 introduce themselves, mostly I guess for the

1 public, but I'm Steven Markowitz. I'm an
2 occupational medicine physician and
3 epidemiologist with the City University of New
4 York.
5 Dr. Silver?
6 MEMBER SILVER: Hi, this is Ken
7 Silver, Associate Professor of Environmental
8 Health at East Tennessee State University,
9 College of Public Health.
10 CHAIR MARKOWITZ: Dr. Mikulski?
11 MEMBER MIKULSKI: This is Marek
12 Mikulski, I'm an occupational epidemiologist with
13 the University of Iowa, Iowa City.
14 CHAIR MARKOWITZ: Dr. Friedman-
15 Jimenez?
16 MEMBER FRIEDMAN-JIMENEZ: Hi, I'm
17 George Friedman-Jimenez, I'm an occupational
18 medicine physician and epidemiologist at Bellevue
19 NYU Occupational Environmental Medicine.
20 CHAIR MARKOWITZ: Dr. Dement?
21 MEMBER DEMENT: John Dement, professor
22 emeritus at Duke University Medical Center,

1 Division of Occupational and Environmental
2 Medicine and Industrial Hygienists and
3 epidemiologist.
4 CHAIR MARKOWITZ: Mr. Domina?
5 MEMBER DOMINA: Kirk Domina, I'm the
6 Employee Health Advocate for the Hanford Atomic
7 Metal Trades Council in Richland, Washington. We
8 represent 14 affiliated unions and about 2,500
9 active members. I've been out here almost 37
10 years, I'm a USW member.
11 CHAIR MARKOWITZ: Mr. Mahs?
12 MEMBER MAHS: Yes, Ron Mahs, and I'm
13 representing the building trades.
14 CHAIR MARKOWITZ: Ms. Pope?
15 MEMBER POPE: Duronda Pope, United
16 Steel Workers, retired, Rocky Flats worker, 25
17 years.
18 CHAIR MARKOWITZ: Mr. Tebay?
19 MEMBER TEBAY: Calin Tebay, I'm a
20 sheet metal worker for the first 20 years, became
21 the Hanford Site Beryllium Health Advocate, and
22 now I am the Hanford Workforce Engagement Center

1 representative.
2 CHAIR MARKOWITZ: Dr. Goldman?
3 MEMBER GOLDMAN: This is Rose Goldman
4 on occupational and environmental medicine
5 physician, Cambridge Health Alliance, and
6 Associate Professor at Harvard Medical School and
7 Harvard School of Public Health.
8 CHAIR MARKOWITZ: Dr. Redlich?
9 MEMBER REDLICH: This is Carrie
10 Redlich, a pulmonologist and occupational
11 environmental medicine physician and a professor
12 of medicine at Yale School of Medicine, and also
13 director of the Yale Occupational Environmental
14 Medicine Program.
15 CHAIR MARKOWITZ: And, Dr. Berenji?
16 MEMBER BERENJI: This is Mani Berenji,
17 occupational and environmental medicine
18 physician, as well as an assistant professor of
19 medicine at Boston University School of Medicine.
20 CHAIR MARKOWITZ: Okay, thank you and
21 let me just say that Ms. Pope has told just that
22 she may not be able to attend the whole meeting

1 today because of a kind of urgent competing work
2 issues. So, we appreciate your attendance and
3 understand.
4 I want to spend a couple minutes
5 reviewing the agenda. We're going to discuss the
6 DOL's responses to our recommendations that was,
7 response that we received, it was dated December
8 18, 2019.
9 We have a PowerPoint, a couple of
10 presentations I think that we'll summarize their
11 response and also some of our thoughts.
12 And, then we're going to discuss the
13 new board duties that the Congress passed as part
14 of EEOICPA that we learned about December 30,
15 2019.
16 And, I've added next an acknowledgment
17 and brief discussion of the new draft Bulletin
18 20-02 from DOL, which we received yesterday.
19 We're going to spend a few minutes on
20 public comments. There was one public comment
21 that's been posted to our website for this
22 meeting. There were at least a couple comments

1 that came in after our last meeting in November.
2 And, then we're going to review the
3 action items that we developed in November, and
4 DOL's now given us a response to those action
5 items as of today. So, we can discuss their
6 responses and our reaction and the like.
7 I would like to get Item No. 7 to a
8 discussion about, beginning discussion about how
9 to improve or how to address the issue of the
10 quality of the industrial hygiene and medical
11 assessments as part of the claims process.
12 And, then we'll hear a brief update on
13 the Parkinson's disease issue, and then finally,
14 if there are any new items. And then we'll
15 discuss the next board meeting.
16 Are there any items that people would
17 like to add to what I've mentioned so far?
18 (No audible response.)
19 CHAIR MARKOWITZ: Okay, that's good.
20 So, Kevin I'm addressing you and I'm
21 addressing Melissa in terms of bringing --
22 MR. BIRD: Yes, that's actually going

1 to be Missy, so I'm actually participating
2 remotely like everyone else. But Missy is in the
3 room with Carrie.
4 CHAIR MARKOWITZ: Okay, so Missy, you
5 can hear me?
6 MS. SCHROEDER: Yes, I can hear you.
7 CHAIR MARKOWITZ: Okay, great.
8 Okay, so there was a document
9 PowerPoint that I sent recently called Asthma.
10 (Pause.)
11 MEMBER REDLICH: Are you going to be
12 showing that on the Webex or should we have that
13 --
14 CHAIR MARKOWITZ: No --
15 MEMBER REDLICH: -- as a separate?
16 CHAIR MARKOWITZ: -- it's on the
17 Webex. You haven't gotten these documents.
18 PowerPoints haven't been sent to individual board
19 members.
20 But this was a recent one, it's just a
21 few slides long. And Dr. Redlich, these are the
22 revised slides that you sent me, so worth waiting

1 a moment for.
2 (Pause.)
3 CHAIR MARKOWITZ: So, we're
4 discussing our reactions to the DOL responses,
5 and then for anybody who wants to look at
6 actually the full text of the DOL's responses to
7 us, again it's on our meeting website under
8 Briefing Book Materials, it's called the
9 Recommendation Responses from February, from the
10 board's February and April meeting. So.
11 So, Missy, are you able to locate, ah,
12 there you go. Okay, that's good. If you can go
13 to the next slide.
14 Okay, Dr. Redlich, you want to take
15 over here?
16 (Pause.)
17 MEMBER REDLICH: Sorry, I just had my
18 phone on mute. Oh, what happened to --
19 Sorry, my Webex just disconnected.
20 CHAIR MARKOWITZ: Okay, well if you
21 want --
22 MEMBER REDLICH: Yes, so I, okay, I'm

1 back.

2 Okay, so just as a quick review, the

3 advisory board had initially submitted four

4 recommendations regarding work-related asthma.

5 And the first three recommendations

6 related to either the definition of occupational

7 asthma, and so as to include both new onset work-

8 related asthma, and exacerbation of pre-existing

9 asthma.

10 And the other two recommendations

11 related to diagnosing asthma and defining an

12 asthma exacerbation, and I think there was

13 general agreement and the DOL incorporated those,

14 those recommendations.

15 So, currently the fourth

16 recommendation related to, and that's just to

17 fill in the history, the fourth recommendation

18 related to concerns that the advisory board had

19 as far as the criteria used to diagnose work-

20 related asthma and the specific wording that was

21 in the procedure manual.

22 And, so the, and since the concerns

1 that we had are highlighted in yellow as people
2 can see the PowerPoint, which was the two parts,
3 the just reading from what's highlighted in
4 yellow, but these are sort of the section that
5 was the criteria for deciding whether someone's
6 asthma was work related.
7 And, it stated the qualified physician
8 must provide a well-rationalized explanation with
9 specific information on the mechanism for cause
10 and contributing or aggravating the conditions.
11 The strongest justification for acceptance in
12 this type of claim is when the physician can
13 identify the asthmatic incident, or plural, that
14 occurred while the employee worked at the covered
15 site, and the most likely toxic substance
16 trigger.
17 So, and the Department of Labor on the
18 next slide if someone could switch to that,
19 responded. And I think at this point, we have
20 discussed the issue of a specific toxic substance
21 and that is wording that's in the original act.
22 And, the Department of Labor felt that they

1 should stick with their initial language.
2 And, I think we had probably discussed
3 this issue sufficiently. If anyone else wants to
4 chime in or voice an opinion, just briefly we've
5 considered for various reasons that most
6 exposures are mixed exposures, or even a
7 substance that is a single entity, like a sepsis
8 or lead. It actually it could be multiple
9 different exposures. But the DOL feels that the,
10 they should stick with the existing language.
11 So, if we go to the next slide, I
12 thought that a good ending of this discussion
13 would be that the advisory board and the DOL
14 respectfully differ in their interpretation of a
15 toxic substance.
16 So, I will just pause to see if anyone
17 else wants to comment further on that.
18 MEMBER GOLDMAN: Hi, this is Rose
19 Goldman, Carrie.
20 MEMBER REDLICH: Yes.
21 MEMBER GOLDMAN: A few questions
22 quickly. Would the, well particularly for

1 exacerbation of the asthma since it could be just
2 any irritant, would it be sufficient to label the
3 toxic substance as irritant? You know, rather
4 than having to actually name which particular
5 irritant, it could be a cleaning agent or
6 whatever in that particular instance?
7 MEMBER REDLICH: Yes. So, I know you
8 haven't been in on these prior conversations
9 regarding this topic. The issue is that the
10 original EEOICPA Act has the wording that is
11 quoted in the slide in terms of a specific toxic
12 substance.
13 I know people are not -- there's a lot
14 of background noise.
15 (Pause.)
16 MEMBER REDLICH: That's better.
17 CHAIR MARKOWITZ: Can I just, this is
18 Steven. Let me just make a, let me just offer a
19 friendly amendment. I don't think the Act says
20 specific toxic substance. I think it says toxic
21 substance.
22 MEMBER REDLICH: Yes, thank you.

1 MEMBER GOLDMAN: So then if that's the
2 case, would it not be okay then to just have it
3 as a group label like irritants?
4 MEMBER REDLICH: I would be okay with
5 that. We have brought this up on several
6 occasions and have not convinced the DOL to
7 consider a broader interpretation of that word.
8 MEMBER GOLDMAN: But that would be for
9 --
10 MEMBER REDLICH: But I am open --
11 MEMBER GOLDMAN: -- exacerbation.
12 MEMBER REDLICH: But this is --
13 MEMBER GOLDMAN: For exacerbation.
14 MS. LEITON: Can I? This is Rachel
15 Leiton. I can address that in a little bit.
16 You know, we've gone back and forth
17 with our lawyers many times about using
18 something, you know, irritant is pretty much
19 going to be like generally toxic substance. We
20 would need a specific toxic substance. Specific
21 to the exposure that they might have had.
22 So, I don't think saying irritant's

1 going to really have that much of a difference in
2 terms of if you revise this and come back with
3 irritants. I think our lawyers are going to come
4 back with the same response as the one that we
5 provided to you already.
6 In terms of exacerbation and
7 aggravation, you know, our standard is a little
8 bit lower there but it goes on a case-by-case
9 basis. And, if a doctor comes in and says, you
10 know, this person was exposed to X, Y and Z
11 exposures or toxins, it can be more than one but
12 they have to be named, we have to be able to
13 verify them. That's what we're looking for.
14 Just for, from our perspective.
15 MEMBER REDLICH: But, I, you know,
16 also I think in practice a relatively high
17 percentage of the work-related asthma claims have
18 been accepted if I'm understanding the data
19 correctly.
20 MS. LEITON: That's correct. This is
21 Rachel Leiton.
22 MEMBER REDLICH: Yes, so I think that

1 there is some judgment that's being used in the
2 interpretation.
3 So, I think we felt that we had
4 probably discussed this issue sufficiently and
5 maybe we can move on to others. But I wanted to
6 just review the recommendations and the DOL's
7 response.
8 CHAIR MARKOWITZ: This is Steven
9 Markowitz. Can I just add something?
10 So, this, the slide we're looking at
11 says that we differ in our interpretations of a
12 toxic substance. I actually don't think it's a
13 different interpretation of toxic substance
14 because obviously we accept that the Act says
15 toxic substance. The issue is trigger. And the
16 issue is incident.
17 And it's, you know, it's because the
18 current language frames the events in the
19 workplace in terms of this specific actions that
20 happened, which is just unrealistic.
21 But regardless, we disagree and I
22 guess we agree to disagree and so we can move on.

1 MEMBER REDLICH: Okay, and so I did
2 want to just go back to the other yellow
3 highlighted sentence, which the DOL didn't
4 directly respond to, which was the qualified
5 physician must provide a well-rationalized
6 explanation with specific information on the
7 mechanism for causing, contributing to, or
8 aggravating the conditions.
9 And I think as we had previously
10 explained but maybe not provided the best
11 alternate wording, that the mechanisms by which
12 most agents cause asthma are actually, remain
13 poorly defined, and that most qualified
14 physicians would not be able to even provide that
15 information.
16 So, we were suggesting a simpler
17 alternate wording to that sentence, which would
18 be the qualified physician must provide a well-
19 rationalized explanation for his or her
20 conclusions, period.
21 Our prior, we don't need to go through
22 all the prior recommendations the life, we had

1 suggested prior alternate wording I think if it's
2 a simpler wording that I'm hoping would be
3 acceptable and that the DOL would reconsider for
4 that one sentence.
5 That's not something we've voted on as
6 a group but as I was reading over the DOL's
7 responses to our recommendations, I thought this
8 might be a simple improvement.
9 Does anyone have any comments?
10 CHAIR MARKOWITZ: Yes, this is Steven
11 Markowitz.
12 In our recommendation, previous
13 recommendation on that, we pointed out that the
14 mechanism of disease was a problem. And, we
15 recommended that the request of here quoting in
16 our recommendation, quote, thus the request that
17 the physician identify the mechanism of disease
18 is not feasible and should be deleted, end of
19 quote.
20 And, I think that's been rejected.
21 So, we can raise the issue again in the event
22 that, you know, perhaps the focus was on

1 something other than this word mechanism.
2 But, I think we can make a soft
3 recommendation on that and then move on.
4 MEMBER FRIEDMAN-JIMENEZ: This is
5 George Friedman-Jimenez.
6 The word mechanism is not defined here
7 and you can go as deep or as shallow as you like
8 in terms of how specific you get in the
9 mechanism. Mechanism could just mean
10 inflammation. Or it could mean allergic or
11 irritant mechanism, or it could mean an IgE-
12 mediated allergic mechanism with a specific
13 molecule identified.
14 And, in many, in most cases of
15 occupational asthma, the specific mechanism is
16 not understood at the specific molecular level
17 but it's understood that it's irritant-induced,
18 or it's irritant-aggravated, or it's sensitizer-
19 induced.
20 And, sometimes you can't even
21 distinguish sensitizer from irritant, and that's
22 agent specific.

1 So, I think that this would not be an
2 impediment for diagnosing occupational asthma
3 because you can just interpret mechanism to mean
4 what's known about the mechanism for that kind of
5 asthma.
6 CHAIR MARKOWITZ: So, can we agree on
7 Dr. Redlich's suggestion that the minutes reflect
8 that we advise reconsideration of the use of the
9 term mechanism, but that we not necessarily make
10 that into a formal recommendation since frankly,
11 you know, it's been the subject of a previous
12 recommendation.
13 Is that all right, Dr. Redlich?
14 MEMBER REDLICH: You know, the fire
15 alarm has gone off in my building, so I am going
16 to have to --
17 CHAIR MARKOWITZ: Okay.
18 MEMBER REDLICH: -- leave the
19 building.
20 CHAIR MARKOWITZ: Okay.
21 MEMBER REDLICH: I apologize.
22 CHAIR MARKOWITZ: Okay.

1 MEMBER REDLICH: I just have the phone
2 on mute so no one else has to hear it.
3 CHAIR MARKOWITZ: Okay. So, let us
4 know when you come back or whatever, but I'll
5 accept that as a yes.
6 (Laughter.)
7 CHAIR MARKOWITZ: Okay, any other
8 comments, Dr. Redlich if you're still on the line
9 about asthma?
10 (No audible response.)
11 CHAIR MARKOWITZ: Okay, so let's move
12 on.
13 MEMBER FRIEDMAN-JIMENEZ: George
14 Friedman-Jimenez again.
15 Maybe we could put in a sentence
16 saying that mechanism can be understood as
17 irritant, or allergen, or, you know, at that
18 level. We can work on the wording but just put
19 in a definition of mechanism that allows for our
20 current understanding of occupational asthma.
21 CHAIR MARKOWITZ: Yes, but, this is
22 Steven Markowitz.

1 But look at the sentence. It's quote,
2 the qualified physician must provide a well-
3 rationalized explanation with specific
4 information on the mechanism for causing, end of
5 quote, which means now that the personal
6 physician has to not only specify that there is a
7 mechanism, but actually name the mechanism,
8 right?
9 So, I, I don't think that addresses
10 the problem.
11 MEMBER FRIEDMAN-JIMENEZ: Well it has
12 to know the mechanism is inflammatory in most
13 cases and we can just say that that's the level
14 at which the mechanism needs to be stated.
15 CHAIR MARKOWITZ: I just, I think it's
16 a higher requirement of the personal physician
17 who frankly, is, may not be all that well versed
18 with any mechanism for asthma. It makes it
19 tougher.
20 MEMBER FRIEDMAN-JIMENEZ: Okay.
21 CHAIR MARKOWITZ: Okay, so any other
22 comments on this issue or can we move on?

1 MEMBER REDLICH: Yes, it's Carrie
2 again. I'm sorry, now I'm outside with the noise
3 outside but I think to be optimistic, I'm not
4 sure that the DOL necessarily rejected our prior
5 recommendation, but I think our alternate wording
6 sort of included both items, the toxic substance
7 and the mechanism.
8 So, I thought if we separated the two
9 it would be clearer. Because it seems to be a
10 relatively minor edit but the concern is if this,
11 I mean for no diagnosing physician generally need
12 to provide a mechanism.
13 And I think that just would sometimes
14 hinder a physician providing, making the
15 decision, the diagnosis.
16 I'm going to put my phone back on mute
17 because it's noisy.
18 (Pause.)
19 CHAIR MARKOWITZ: So, okay, Dr.
20 Redlich, are you still there?
21 MEMBER REDLICH: Yes, I am here.
22 CHAIR MARKOWITZ: Okay.

1 MEMBER REDLICH: I'm just keeping it
2 on mute.
3 CHAIR MARKOWITZ: Okay, fine.
4 So, maybe we should just formulate a
5 recommendation here and vote on it. That's
6 probably the best mechanism we have so to speak.
7 So, the proposal is that the procedure
8 manual be modified, so in the relevant section
9 regarding work-related asthma such that the
10 following sentence would represent the corrected
11 language. Quote, the qualified physician must
12 provide a well-rationalized explanation for his
13 or her conclusions, period. The strongest
14 justification dot, dot, dot, dot, end of quote.
15 That's what you have on the slide
16 there, Carrie, so would that suffice as the
17 wording for a recommendation?
18 MEMBER REDLICH: Yes, it would.
19 CHAIR MARKOWITZ: Okay. So, that's my
20 proposal and my motion as a recommendation. It
21 needs a second.
22 (No audible response.)

1 CHAIR MARKOWITZ: Would anybody like
2 to second?
3 MEMBER GOLDMAN: I second it.
4 CHAIR MARKOWITZ: Okay.
5 MEMBER GOLDMAN: I can second it,
6 Rose.
7 CHAIR MARKOWITZ: Okay, fine. So now
8 we're open for further discussion.
9 (No audible response.)
10 CHAIR MARKOWITZ: Okay, so the
11 question is whether anybody's capturing the exact
12 language of this. Kevin or Carrie Rhoads, can you
13 let me know whether?
14 MS. RHOADS: Yes, Missy's opening
15 document you might want to let her know what to
16 type, that's fine.
17 CHAIR MARKOWITZ: Okay. Okay, so the
18 recommendation, so shall I repeat it, Carrie
19 Rhoads?
20 MS. RHOADS: Yes, please repeat.
21 CHAIR MARKOWITZ: Okay. Okay, so the
22 recommendation is that in the procedure manual in

1 the applicable section with regard to work-
2 related asthma, that in Item 2 mid-paragraph, new
3 modified language conforming to the following be
4 used to replace existing language, colon, quote,
5 the qualified physician must provide a well-
6 rationalized explanation for his or her
7 conclusions, period. The strongest justification
8 dot, dot, dot, dot, end of quote.
9 Okay, so that's the proposal we're
10 going to vote on. Are there any, let me ask are
11 there any other comments on this?
12 (No audible response.)
13 CHAIR MARKOWITZ: Okay, so I think
14 Carrie Rhoads, we need to do a roll call because
15 otherwise it will be chaos.
16 (Pause.)
17 MS. RHOADS: We're getting ready to do
18 a roll call.
19 CHAIR MARKOWITZ: Okay.
20 MR. CHANCE: Are you ready, doctor?
21 CHAIR MARKOWITZ: We're ready.
22 MR. CHANCE: All right, bear with me

1 my first time through.

2 (Roll call vote.)

3 MR. CHANCE: Okay, that looks like a

4 unanimous vote.

5 CHAIR MARKOWITZ: Did you get Ms.

6 Pope?

7 MS. RHOADS: Yes.

8 MR. CHANCE: Yes, we did.

9 CHAIR MARKOWITZ: Okay, thank you.

10 Okay, great.

11 MR. CHANCE: That's all yes.

12 CHAIR MARKOWITZ: Okay, thank you.

13 So, if we could remove this PowerPoint

14 and we go to if you put up Markowitz PowerPoint,

15 we can continue on slide 5.

16 So, this is I'm going to discuss

17 asbestos now, and just to refresh your memory.

18 Most of our recommendation was accepted by the

19 Department of Labor on asbestos. The issue was,

20 the pending issue was this list of, hold on, let

21 me see if this is coming up here.

22 Okay, so we can, next slide we can go

1 through these. These are just excerpts from
2 which there was agreement. Next. And, next.
3 Basically industrial hygienist was given the task
4 of deciding on the significance of the exposure.
5 And, okay, so the pending issue is
6 whether there's a table that, a list that DOL has
7 in the procedure manual. You're on the next
8 slide I think it has the table.
9 So, these are the occupational titles,
10 the job categories, that are presumed to have
11 asbestos exposure. And, several of us, I think
12 it was Mr. Domina and Dr. Dement and I went
13 through five different DOE sites on the SEM and
14 looked for additional job titles that we thought
15 out to be included in this list, and so I provide
16 some examples in the lower left here.
17 And, so and we were asked by the
18 Department of Labor to, if we wanted to recommend
19 additional job titles that we do the research and
20 provide the published references supporting this,
21 which is fine.
22 If you go to the next slide.

1 So, we haven't succeeded in doing
2 that, we just haven't had the time to compile
3 that list and to more importantly actually, to
4 develop the scientific rationale, but we will and
5 this will be presented in April at our next
6 meeting.
7 But I want to point out just this is a
8 publication from a couple years ago, so this is
9 national mesothelioma mortality data from the
10 U.S. over a long time period, 1999 to 2015.
11 And mesothelioma is the signal tumor
12 related to asbestos, so it gives us an indication
13 of job categories that we can safely presume have
14 significant exposure to asbestos.
15 So, you'll see actually that many of
16 the non-highlighted job titles here are already
17 on the list. Let me point out that the middle
18 column with the numbers is the number of cases,
19 number of deaths in this database, and on the
20 right is the relative risk of the, of the given
21 job title.
22 There's some that are, titles that are

1 clearly irrelevant. Sailors, marine oilers is
2 one, and I think there's another one but I don't
3 quite see it.
4 But in any case, and then there are a
5 number that are highlighted that aren't on the
6 list, and these, this is just an example of the
7 kind of information studies that we'll be pulling
8 together to support modification of the list.
9 There are some titles here that we
10 would favor adding, excuse me, some titles that
11 have not made this list that we would favor
12 adding based on other studies. These studies are
13 never uniform in terms of identifying the V-set
14 of occupations or industries with an increased
15 risk for asbestos-related disease.
16 But this is the kind of information
17 we'll be putting together for specific, a limited
18 number of job titles in order to pursue this.
19 Are there any comments or questions?
20 We're not going to make any decisions about this
21 today, we just a commitment to do the work before
22 the next meeting.

1 MEMBER MAHS: This is Ron Mahs. I
2 think I'm up. I think I have six other
3 occupations to add to the list.
4 CHAIR MARKOWITZ: I'm sorry, you have
5 some more occupations to add to the list?
6 MEMBER MAHS: Yes, I believe I have
7 six more.
8 CHAIR MARKOWITZ: Oh, yes?
9 (Off-mic comment.)
10 CHAIR MARKOWITZ: So, if you could
11 send that to me.
12 MEMBER MAHS: I was going to before I
13 left but then it just came up so suddenly so I
14 had to wait till I go next week when I get off of
15 this class.
16 CHAIR MARKOWITZ: Okay, okay, so right
17 now the, Mr. Domina, Dr. Dement and I are the
18 ones who are working on this. We would welcome
19 additional people if you want, or if you have,
20 you don't want to join the effort but want to
21 send in information or ideas, just send it, send
22 it to us and we'll use it.

1 MEMBER MAHS: I was on that list.
2 CHAIR MARKOWITZ: Oh, is that right?
3 Okay, yes, Mr. Mahs' fourth, number 4. Thanks.
4 Okay, so let's continue. Dr. Dement,
5 we're going to discuss the Occupational Health
6 Questionnaire. Do you have a document or you
7 want, I have excerpts from in my PowerPoint from
8 there if that's helpful.
9 (Pause.)
10 MEMBER DEMENT: Let's use the Word
11 file that I sent to Kevin this morning if you can
12 pull that up, Kevin.
13 CHAIR MARKOWITZ: Okay.
14 MR. BIRD: Carrie, you guys have that
15 file, correct? I think you were on the email.
16 MS. RHOADS: Yes, we do. Would you be
17 able to provide me with the title?
18 MR. BIRD: It's just called, it's
19 called Occupation of History Questionnaire as
20 discussion. OHQ Discussion.
21 I see it as DOL ADTSWH Meeting January
22 27 OHQ Discussion.

1 CHAIR MARKOWITZ: Correct.
2 MS. RHOADS: Oh, here we go. Thank
3 you.
4 MEMBER DEMENT: Thank you.
5 What I wanted to do in this discussion
6 is just go over a bit of the history behind the
7 occupational history recommendations that we're
8 currently discussing.
9 The original board had a sub-
10 committee, a working group, that looked
11 specifically at the SEM, as well as the OHQ, and
12 how these two were used on the claims
13 adjudication process.
14 And, based on the work of this sub-
15 group, the board adopted a number of
16 recommendations at the April 2017 meeting.
17 If you can scroll up, please. I think
18 I can do that. I have control.
19 And, among these were expansion of the
20 list of toxic substances to include among other
21 things, materials listed on the V-2 MediWorks
22 history that have been used for about 20 years

1 now.
2 Include frequency of exposure, and
3 that's just a rough from no exposure to having
4 been exposed daily, to allow some worker
5 generated free text to describe the circumstances
6 or tasks related to the exposure.
7 And, we've been looking, had been
8 looking closely at COPD and exposures causally
9 related to COPD. And, we suggested adding some
10 questions about vapors, gas, dust, and fumes,
11 which collectively, provide the strongest
12 relationship to COPD.
13 The original recommendations were
14 pretty much rejected by the DOL and I put in, you
15 know, on this slide, what the sort of a baseline
16 come back was is the OWCP recommended, welcomed
17 specific recommendations concerning modifications
18 of a draft with a draft revised OHQ, which was
19 apparently under development about the time the
20 recommendations were being made.
21 We did review that draft in great
22 detail and what we felt was that the new history

1 questionnaire is largely a pretext document
2 whereby workers can describe the work and work
3 circumstances, and exposures of the experience.
4 And, the board felt that recording
5 pretext was good but it needed more structure to
6 provide memory triggers to help claimants recall
7 specific tasks and exposures.
8 It's certainly been our experience in
9 the building trades program, that memory triggers
10 are helpful.
11 In some cases as we've discussed, the
12 board having co-workers discuss their exposures
13 with them, that is knowledgeable for on-site work
14 also was helpful.
15 So, the board went back to work. We
16 had a working group of this board established in
17 November of '18 and we went through the OHQ, the
18 draft OHQ in a great deal of detail and we made
19 specific recommendations with regard to changes
20 that might be made.
21 Is there a next page to this? Okay.
22 And I'm not going to through all of

1 the, there was a lot of recommendations made.
2 I'm not going to go through each one in great
3 detail. I guess as we heard at the last board
4 meeting, the DOL is developing another
5 Occupational History Questionnaire. They plan to
6 do pilot testing on it.
7 The board hasn't been provided with a
8 draft of it yet but we're hopeful that many of
9 our recommendations will be incorporated in the
10 responses that had suggest many, if not most, of
11 the recommendations that we made with this
12 November 2018 committee are going to be
13 incorporated.
14 There are some areas of disagreement
15 or where we don't know exactly where that's going
16 to go. We recommended actually that there be some
17 broad categories of toxic substances and a list
18 of specific substances provided in the current
19 Occupational History Questionnaire.
20 As I stated before, the draft
21 questionnaire that we looked at didn't have a lot
22 of information that would allow claimants to,

1 would stimulate claimants to at least recall
2 exposures, and we felt that that was not an
3 advancement of the Occupational History
4 Questionnaire.
5 We also suggested that, where there
6 are direct disease links in the OHQ, that these
7 substances really need to be added to the OH, to
8 the Occupational History Questionnaire. If
9 there's a direct disease link in the SEM, then
10 that needs to be added to the OHQ.
11 The DOE response was that they really
12 didn't want to add a whole list of specific
13 materials. That is that would require the
14 interviewer to read a long list of chemicals and
15 require the interviewee to pick chemical names.
16 I think, you know, I think we in
17 principle agree with a long list that read over a
18 telephone interview, or even an in-person
19 interview are not necessarily helpful.
20 But we do feel that the toxic
21 substances that have direct disease links that
22 have common exposures at the site, they are

1 commonly related to claims that we are having
2 reviewed, for example the COPD, the lung
3 diseases, those need to be specifically on the
4 OHQ to stimulate workers to recall those
5 exposures, if in fact, they had them.
6 So we'll have to wait and see what
7 that looks like. You know, it may not be an
8 issue but may be something for further
9 discussion.
10 The other area of some disagreement
11 was exposures related to COPD. The board, you
12 know, we've been trying to deal with the
13 relationship of exposures to COPD for, since the
14 board started.
15 The strongest associations are not
16 necessarily with any one toxic substance, but as
17 a group of toxic substances commonly called
18 vapors, gas, dust, and fumes.
19 In the literature, those exposures,
20 those complex mixture exposures, provide the
21 strongest relationship.
22 But, next page, please. But the DOE

1 response is that they didn't feel it was
2 appropriate. And, you can read it here to how
3 they, a linkage to a specific toxic substance and
4 a disease in the, in the OHQ.
5 We're not really asking for that. All
6 we're really asking for is that substances that
7 are known to be related to COPD be added in the
8 Occupational History Questionnaire.
9 These are common exposures, at least
10 the ones in the literature, individual toxic
11 substances in the literature that are related to
12 COPD. And, also many of the exposures are
13 related to other diseases such as pneumoconiosis.
14 So, I guess we'll have to wait and see
15 what the list entails, you know, the new OHQ.
16 I guess that's pretty much, you know,
17 what I have to say about it. You know, I guess
18 it's, you know, it's encouraging that we should
19 be seeing a new draft hopefully soon.
20 They are planning a pilot test of it.
21 It would have been my desire to see the draft
22 before it's pilot tested but I don't know that

1 that's going to happen.
2 Any other comments?
3 CHAIR MARKOWITZ: This is Steve
4 Markowitz, I have a comment.
5 You know, I understand some of the
6 point about not necessarily wanting to target one
7 condition like COPD for drawing attention to
8 particular exposures. But in fact, you know,
9 when we looked at the approved claims or excuse
10 me, the top 10 respiratory conditions under the
11 data given by DOL, there were really just three
12 or four dominant respiratory conditions which in
13 and of itself, is a dominant category.
14 And it really is COPD, asthma and a
15 couple in the pneumoconiosis, silicosis and
16 asbestosis with pleural plaques in there.
17 So, it is feasible actually to list,
18 to develop a finite list of target respiratory
19 toxins which would provide more information about
20 the dominant conditions that claimants submit
21 claims for, and would make, frankly, the life of
22 the claims examiner and the IH review, you know,

1 better informed and more straightforward.
2 MEMBER DEMENT: Well, I agree with
3 you, that statement, and I think, you know, I
4 think the list could be a rather succinct list.
5 It would cover a vast majority of the exposures
6 that we've seen related to these, these outcomes.
7 I guess the other issue with this, you
8 know, we've specifically asked for each of the
9 substances that the worker, you know, be provided
10 and queried about the conditions under which they
11 were exposed. Whether it's the task, the
12 buildings, whatever they want to provide in a
13 free text.
14 That can go a long way in terms of
15 assessing the potential for exposure, as well as
16 the possible exposure levels if that is paid some
17 attention to.
18 The other sort of operational issue is
19 here, I, and BTMed before the interview was
20 actually done, the exposure interview, the work
21 history interview, the worker is provided with a
22 paper copy of the Occupational History

1 Questionnaire that does in fact, list these
2 materials and tasks, and acts as a, more or less
3 a guide for them to try to recall exposures
4 before they come into the history interview.
5 I'm not sure operationally how that
6 could be incorporated in the DOL procedures or if
7 in fact, it already is. But it's a very helpful
8 process for us.
9 CHAIR MARKOWITZ: This is Steve
10 Markowitz. I have a question for Ms. Leiton.
11 So, what's the timetable for the draft
12 OHQ being ready for us to take a look at?
13 MS. LEITON: This is Rachel. Last
14 time I looked at it I thought it was pretty much
15 done, so I do expect that to be available in
16 draft form probably within at least the next few
17 weeks.
18 So, I am, I don't, I think we are
19 going to have the resource centers test it out,
20 pilot it. I don't want to speak for John Vance's
21 group to say exactly when they're going to start
22 that pilot or our research center contractor

1 folks, but I do expect it before your next board
2 meeting. I expect you to have the draft and at
3 least to be able to review what we've done.
4 I do think we've incorporated a lot of
5 what you're talking about here. With the latest
6 slide, we're trying to put it into a format that
7 will work well with our contractor's database so
8 they can just enter the information.
9 But, the draft as I said should be
10 available soon to you. Hopefully you'll be
11 pleased with some of the things that we've put in
12 there, while maybe not everything you guys have
13 asked for.
14 I think it will be a better product
15 and we'll see how it goes from there.
16 CHAIR MARKOWITZ: Will we see it
17 before it's piloted?
18 MS. LEITON: I have to actually see
19 what the exact plans are. I mean, I expect that
20 you will be able to see a draft shortly. Whether
21 or not we're not going to start the pilot before
22 your next board meeting I would doubt that, which

1 is when you'd be able to vote.
2 We'd at least like to see how what we
3 have is working out before we finalize it. So,
4 if we were to wait for you guys, that would be
5 April probably before we would, you know, see
6 your comments, your additional comments and then,
7 this can always be altered, you know, throughout
8 as we go.
9 I'd like to be able to start to use
10 something, see how it works, and then, you know,
11 if you guys have comments after we provide you
12 with the draft and you make recommendations based
13 on those comments, we'll take a look at those and
14 we can always revise it in the future.
15 But I would like to get it moving to
16 at least see how this pilot goes, see what
17 comments the resource centers have, what they
18 receive from the public.
19 We can take all of that with whatever
20 you guys come back with and revise it accordingly
21 after the pilot, if necessary. Or as
22 appropriate.

1 CHAIR MARKOWITZ: That's great, thank
2 you.
3 Dr. Dement, anything else on this?
4 MEMBER DEMENT: No. You know, and I'm
5 encouraged with the responses to our
6 recommendations from the Department. You know,
7 I, we'll see what it looks like but so far, I'm
8 pretty pleased with the responses back.
9 CHAIR MARKOWITZ: Any other comments
10 on the OHQ?
11 (No audible response.)
12 CHAIR MARKOWITZ: Okay, so we can move
13 on, thank you.
14 Just very quickly, let me just say
15 that this board and the previous board made a
16 recommendation that the board be provided with
17 some resources to assist in, in particular in
18 claims review.
19 And, the response from DOL in December
20 18 is that DOL will confer with the board's chair
21 to explore options for providing contractor
22 support.

1 So, that's great and I'm ready to
2 confer whenever DOL wants.
3 (Laughter.)
4 CHAIR MARKOWITZ: I look forward to
5 that discussion.
6 Any other comments or feedback with
7 regard to that?
8 (No audible response.)
9 CHAIR MARKOWITZ: Okay, so let's move
10 on to the next one, and I think we can turn you
11 back to Dr. Dement on the industrial hygiene
12 reports recommendation that we made.
13 So, is this, this is another
14 PowerPoint, another document, right, that --
15 MEMBER DEMENT: Yes.
16 CHAIR MARKOWITZ: -- this is the
17 companion document that you sent Missy. Carrie,
18 if you could locate it from the same email.
19 There you go.
20 MEMBER DEMENT: Okay. All right, I
21 sort of went through the same, the manner as I
22 did with the OHQ. And sort of going back and

1 looking back sort of the history of the board and
2 where it's been with regard to some of the
3 issues.
4 This specific recommendation was that
5 the (telephonic interference) reports not
6 consistently use the language that appear to,
7 appears to assume the exposures after 1995 were
8 within regulatory limits.
9 And, we, as we reviewed these claims I
10 know I've seen it many, many times and it's
11 nearly the exact same word phrasing, slightly
12 modified in some circumstances to make it
13 specific, but nonetheless, the same sort of fault
14 pattern and rationale.
15 So, I needed to go back and look at,
16 you know, where this came from. The first board
17 reviewed the procedure manual and the associated
18 circulars in a lot of detail, and one in
19 particular was Circular 15-06, and had to do with
20 post-1995 occupational toxic exposures
21 guidelines.
22 And, it was both a circular, as well

1 as a memo, attached memo, and it went through
2 sort of the rationale with regard to coming to
3 the decision that exposures post-1995 were within
4 regulatory guidelines.
5 And, I think the board recognizes,
6 accepts that, you know, industrial hygiene
7 programs at most of these sites certainly
8 improved substantially in the mid-1990s after a
9 lot of investigations and implementation of
10 different programs and policies.
11 But the board did not accept that that
12 was universally true of all exposures. At the
13 October of 2016 board meeting in Oak Ridge, we
14 recommended that this particular circular be
15 rescinded, and on this slide I've shown you what
16 our rationale was.
17 And, that is that there are a number
18 of issues with regards to the basis. First, it's
19 just sort of the data to support such a broad
20 conclusion that all exposures would be within
21 regulatory limits all the time, which is a pretty
22 bold statement.

1 And, so the DOL responded back
2 favorably. This is the DOL response. The
3 committee communicated to us that they had
4 rescinded the circular and I wanted to pick out
5 one sentence that I think is key, and it says,
6 this sentence sort of the third one from the
7 bottom, it says: the circular was rescinded to
8 avoid the appearance that any one cohort of
9 claimants was held to a higher burden of proof
10 than others.
11 And, so, you know, the board accepted
12 that and as we started to review these cases,
13 next page, please. As we began to review these
14 cases, we saw this language which almost mimicked
15 what was in this circular and in the associated
16 memo, appeared in the industrial hygiene reports.
17 That is, and I just pulled this as an
18 excerpt of one of the cases that I reviewed.
19 There is no evidence that this personal area and
20 industrial hygiene monitoring to support that
21 after the mid-1990s this would exceed existing
22 regulatory standards.

1 And, you know, while we accept that
2 exposures decreased substantially during this
3 time frame, it's hard to rationalize to come to
4 the conclusion that all exposures would have met
5 this standard.
6 And, so this statement appears and the
7 cases, the many that I reviewed despite the fact
8 that the document acquisition request produced no
9 IH monitoring personal or area, and that, in most
10 of the industrial hygiene reports that make the
11 statement, there's nothing in the report itself
12 providing data that supports a conclusion of
13 exposures within regulatory standards.
14 So, we made again, that a
15 recommendation that this not be included in the
16 industrial hygiene reports, it's just a matter of
17 just what appears to be just as a matter of
18 standard practice.
19 And, I didn't put on this slide the
20 detailed response. It said at least the
21 Department didn't agree with our recommendation
22 and there was about a four paragraph response and

1 I've summarized their major points.
2 And, they still maintain that in the
3 absence of definitive monitoring data, it's not
4 appropriate to assume a much higher toxic
5 exposure would occur by a contractor, or either a
6 contractor, or subcontracted employees.
7 It talks about exposures being
8 significantly reduced during time frame which we
9 certainly agree to. Next slide, please.
10 They also mention that, in addition to
11 regulatory standards, the sites adhere to other
12 recommendations such as the ACGH-TLVs, which
13 typically are lower than OSHA PELs.
14 They also said that the IH assessments
15 review all accompanying documentation, OHQ, the
16 claims form, work statement, affidavits, IH
17 records, et cetera, and will assign higher
18 exposures based on, and I put this in quotes,
19 employee descriptions of specific work activities
20 or work processes.
21 And, so this is sort of the final
22 statement in the, in their response back. Take a

1 position that unless there is definitive evidence
2 of significant exposures past the mid-1990s,
3 whether that's specific monitoring data or
4 relevant information, it's disingenuous to apply
5 industrial hygiene criticisms to make an
6 affirmative finding of significant exposure.
7 And, I guess the response to that is
8 that the board has never said that we want the
9 DOL to assign significant exposures post-1995.
10 So, I think that's a misinterpretation of the
11 board's recommendations.
12 We're not recommending a presumption
13 of exposures to toxic substance post-mid-1990,
14 however, we are recommending that the presumption
15 that all exposures were within regulatory limits
16 also not be made by the (telephonic interference)
17 in the IH assessments.
18 As I said in this one paragraph, that
19 in nearly all of the cases reviewed by the board
20 thus far, no industrial hygiene monitoring data
21 provided in the DAR or in the IH assessments to
22 support a definitive conclusion with regards to

1 exposures post-1995.
2 So, and I think this goes back and
3 this sentence, I think, you know, the board's
4 recommendation is I think consistent with the
5 DOE's response when you rescinded the circular.
6 You know, we see the possibility that it places
7 individuals whose exposures were either largely
8 or predominantly post-1995, it places those
9 individuals at a higher burden of proof.
10 It also places them at a higher burden
11 of proof to produce data, IH data, exposure data,
12 which the claimant not only is not aware of and
13 doesn't really have access to.
14 Next slide, please. That may be the
15 last one. I think it is the last slide.
16 MS. SCHROEDER: That's correct.
17 That's the last slide.
18 MEMBER DEMENT: So, the bottom line is
19 we are not suggesting a presumption of
20 significant exposures post-1995. We are
21 suggesting that this statement not be placed into
22 the reports without likewise supporting evidence

1 to make a negative exposure conclusion.

2 We are particularly concerned with
3 regard to individuals whose predominant exposure
4 was post-1995, and I for one, would like to, I
5 would like to review some claims that were denied
6 based on the lack of exposure post-1995 to see
7 specifically how the data available to the IH is
8 in fact, being used.

9 That's all I have to say about it. I
10 recommend reaffirming the board's position with
11 regard to this, specifically quoting the
12 rescinding of the prior circular and memo.

13 CHAIR MARKOWITZ: Thank you. Are
14 there comments?

15 (No audible response.)

16 CHAIR MARKOWITZ: This is Steve
17 Markowitz. I'll make a comment.

18 This has a couple of I think areas of
19 importance. Remember the CMC is probably keying
20 in on the industrial hygienist report as their
21 source, as their expert source of information on
22 exposure.

1 It's unclear that the CMC is really
2 going to go and look at the other sources of
3 information on exposure that might be available
4 even if the person, even if they're provided with
5 it.
6 So, and there's, in a way it's
7 understandable for the CMC to rely on the IH.
8 So, when they see blanket language post-1995,
9 that means they interpret there as being no, no
10 significant exposure post-1995.
11 So, it has some practical, some real
12 practical meaning.
13 Second comment I'd make is that if the
14 gold standard is industrial hygiene data and it
15 doesn't exist, then we don't have a gold
16 standard. Then you have to rely on whatever
17 additional information might exist, and the best
18 source of that information is going to be the
19 claimant.
20 And that's why we need an enhanced OHQ
21 and a better, more frequent industrial hygiene
22 interview.

1 In order to get that additional
2 information in the case of industrial hygiene
3 monitoring data, it's not going to be additional
4 because most of that monitoring data probably
5 doesn't even exist. So, it's going to be any
6 data.
7 So, I'm just reinforcing what Dr.
8 Dement says and I think I want to hear if anybody
9 else has comments but frankly, I think we can
10 just -- based on what we're looking at this
11 document that we're looking at and just reviewed,
12 that we could compile a response that it doesn't
13 represent a new recommendation but it authorizes
14 a sub-set of people on the board just to write a
15 response to DOL summarizing these points.
16 Other comments?
17 MEMBER SILVER: This is Ken Silver.
18 Dr. Dement suggested that a review of claims
19 after 1995 might be illuminating. In particular,
20 I think looking at claims from clean-up workers
21 after 1997 might bring out the issues because a
22 lot of the work in the DOE complex in the

1 mid-1990s changed over to clean-up projects.
2 And, if anyone is going to have their
3 exposures measured, it would have been people
4 going into chaotic environments with a large
5 number of exposures, and working for contractors
6 who supposedly were selected because of their IH
7 and safety credentials.
8 So if we are going to review claims
9 with denial, let's make sure we get some from
10 clean-up workers.
11 MEMBER DEMENT: Yes, this is John
12 again.
13 I think to me as a hygienist, if I'm
14 asked to review a claim for an occupational
15 disease for which there's a known relationship to
16 an exposure, and the worker was there post-1995
17 and the OHQ clearly puts them in the category
18 that would, would have the exposure, then I think
19 this, this type of case really requires the
20 industrial hygienist to dive deeper including
21 perhaps a discussion with the, the worker
22 themselves and how that exposure occurred, and

1 under what circumstances it occurred.
2 So, I don't know how that was being
3 done before the new change to allow the hygienist
4 to speak with the worker, but I'd like to, I'd
5 like to see how that actually is, is implemented
6 based on the DOL response back in this, in this
7 letter.
8 MEMBER POPE: This is Duronda Pope.
9 I totally agree with Dr. Dement and
10 Dr. Markowitz, as well as Dr. Silver. Having
11 that IH interact with that worker is critical in
12 building the case. And, extrapolating all that
13 information that will help support that case
14 being developed.
15 I think, without that conversation
16 happening, you miss a lot of information which
17 we've seen with so many cases that we've
18 reviewed. But having that extra, having that
19 piece in there in that process is critical in
20 helping developing their case.
21 CHAIR MARKOWITZ: Other comments?
22 (No audible response.)

1 CHAIR MARKOWITZ: So, then the
2 question is, okay, so do we agree that Dr. Dement
3 can draft a response basically explaining what
4 he's explained to us that we'll submit to the
5 board without a formal recommendation, and we'll
6 authorize him and a small set of people to do
7 that?
8 Does anyone object to that way of
9 moving forward?
10 MEMBER GOLDMAN: No objection.
11 CHAIR MARKOWITZ: So, now to the
12 second issue that's raised is looking at
13 additional claims.
14 And the question is whether we, we
15 want to, whether we can come back to that a
16 little bit later in the call and maybe someone
17 while they're on the call can begin to formulate
18 some language around that claim, around that
19 request so that we're looking at language we can
20 actually either vote on or agree upon as opposed
21 to working it out right now.
22 What do you think, Dr. Dement, could

1 while we're dealing with other issues, do you
2 think you could put together a language of a
3 request for claims?
4 MEMBER DEMENT: Yes. I'll draft some
5 language we can discuss later.
6 CHAIR MARKOWITZ: You know, so far
7 we've seen they seem to key in on employment
8 dates so post-'95 claims and maybe that
9 translates into initial employment date post-'95.
10 But in any event, okay.
11 So, fine, if you could work on that
12 language then we can move on.
13 I don't know if any other comments on
14 this issue?
15 (No audible response.)
16 CHAIR MARKOWITZ: Okay, thanks. So on
17 the Webex you can take down that document.
18 So, next we're going to discuss the
19 new board duties. Actually, if you go back, go
20 to my, back to my PowerPoint because I've listed,
21 I've snipped these.
22 Okay, go to the next slide. Okay,

1 next. Next, these are just -- next. Next. Keep
2 going. Okay, next.
3 Okay, so here, so December 30, the
4 December 30 letter from the Deputy Secretary DOL
5 with language about the new duties acquired by
6 the board as a result of congressional amendments
7 to EEOICPA.
8 So, we need to discuss these. We need
9 to understand them to see where this leads us in
10 terms of what we discuss in the future.
11 So, the first is to provide advice
12 upon the, quote, the claims adjudication process
13 generally, including review with procedure manual
14 changes prior to the incorporation into the
15 manual and claims for medical benefits, end of
16 quote.
17 And, in the December 30 letter, OWCP's
18 plan is to submit changes to the board and
19 publish those changes within 10 days. The
20 board's recommendations are, quote, welcome at
21 any time, end of quote.
22 So, two aspects of this. One is we

1 have a new task. We've had four tasks in the
2 past. This seems to add a fifth task.
3 It's now on our website, to provide
4 advice upon the claims adjudication process
5 generally, which strikes me as a very broad,
6 potentially very broad set of activities or area
7 to, to look at.
8 Anybody have any thoughts about this?
9 MEMBER BERENJI: This is Mani Berenji.
10 I actually agree with you, Steven.
11 I actually went through that letter
12 and honestly, I think it's very vague. What does
13 advice entail? And, how would, you know, the DOL
14 reach out to us to seek that advice? I mean
15 what's the process behind that? It's a little
16 vague to me.
17 CHAIR MARKOWITZ: Yes. You know, the,
18 I think the language frankly that came over from
19 Congress is not, you know, very specific I think
20 is the underlying issue.
21 I mean, I don't personally feel like
22 we necessarily want to ask for further

1 specificity or definition at this point because
2 it's not clear how you get to that specificity
3 given the language we're looking at.
4 But I just want to set it out there as
5 a challenge.
6 MEMBER SILVER: This is Ken Silver. I
7 hope this isn't grandiose but what I take from
8 the congressional language is that they have
9 confidence in the work the board is doing, and
10 they're hoping to expand our scope to include,
11 well, what the language says, procedure manual
12 changes, and things that really involve claimant
13 interactions.
14 And, I don't know if it's an overreach
15 but maybe involving us at an earlier stage to the
16 process of changing the procedure manual would
17 fulfill the intent.
18 I'm a little bit troubled by the fact
19 that they'll publish changes within 10 days of
20 submitting them to us. That doesn't give us a
21 lot of opportunity for input particularly as, you
22 know, volunteers with other things going on in

1 our professional lives.
2 So, we could ask DOL to consult with
3 us earlier in the process of modifying the
4 procedure manual and adjudication process. I
5 think that will make our elected representatives
6 happy.
7 CHAIR MARKOWITZ: This is Steve
8 Markowitz.
9 So, you know, we, actually we had a
10 real live example because we were provided
11 yesterday with Bulletin 20-02, which is 69 pages
12 of language, some of it new, for the procedure
13 manual revising or maybe adding in relation to
14 three chapters in the procedure manual and it's
15 going to be published February 10. And, we were
16 provided with it yesterday.
17 So, on a practical basis, you know,
18 there's no way we can review it and make
19 recommendations as a board within that 10-day
20 period.
21 It's conceivable but not, by no means
22 likely that even if the board were not to vote on

1 recommendations, that we would be able within 10
2 days to simply review the document and provide
3 comments essentially as individual members of the
4 board.
5 I'm not sure that that's all that
6 useful to the Department frankly, and so I think
7 the 10-day period is at best, awkward and
8 realistically impossible for the board to make
9 consensus comments on.
10 Now, I think the Department
11 anticipated that because they further said that
12 our recommendations are welcome at any time.
13 So I, you know, I don't know what the
14 intent of Congress was when it said, quote,
15 review of procedure manual changes prior to
16 incorporation into the manual, end of quote.
17 To me it sounds like they wanted the
18 Department actually to hear us and for it to have
19 some impact on the changes before they were made.
20 So, the board only meets every three
21 months. You know, and that three, every three
22 months it's we alternate between face-to-face and

1 telephone meetings.

2 We could review a document in, within
3 that three-month period and make consensus
4 comments, recommendations about changes. But we
5 need certainly a much longer time frame than 10
6 days.

7 And so by way of example, this new
8 Bulletin 20-02, which we're not going to discuss
9 today because it was given to us yesterday and
10 it's 69 pages and so we can't have an informed
11 discussion.

12 I think we're going to have to put
13 into a committee to look at it and probably,
14 frankly it's best if we want to make some
15 consensus recommendations or comments, do that at
16 the end of April meeting. You know, well past
17 February 10. But I don't see what our choices
18 are here.

19 Comments?

20 MEMBER BERENJI: This is Mani Berenji.
21 I wasn't sure if there was any reference to any
22 additional resources. Didn't seem likely but I

1 thought it might be worth asking.
2 CHAIR MARKOWITZ: And resources for
3 what? What do you have in mind?
4 MEMBER BERENJI: Like, administrative
5 support or at least someone who could help with,
6 you know, doing some additional, you know,
7 research and helping us actually put together the
8 comments.
9 I mean, I usually in my practice, I
10 dictate to a staffer. So, if there was a way
11 where we could, you know, read the, you know,
12 recommended, you know, change to the procedure
13 manual, we could review it, we could have some
14 way to provide our input via Dictaphone or some
15 sort of transcription service.
16 I mean, would there be additional
17 resources to be able to meet that really tight
18 turnaround of 10 days?
19 CHAIR MARKOWITZ: Well, you know, I
20 can raise that. The Department's supposed to
21 confer with me about the issue of resources. So,
22 I can add that to the task that we're interested

1 in, sure.
2 MEMBER BERENJI: Thank you.
3 MEMBER GOLDMAN: This is Rose. I want
4 to go back to what you said, Steve. I think 10
5 days is not a reasonable time frame to review and
6 confer on something this important.
7 CHAIR MARKOWITZ: Yes. It's not going
8 to happen actually.
9 MEMBER GOLDMAN: Right, so I'm
10 wondering if the response is, well, we think this
11 is -- if we do think it's a good idea, we then we
12 need X amount of time and if for some people X
13 amount of resources or something. You know, but
14 something along that line?
15 CHAIR MARKOWITZ: This is Steve
16 Markowitz.
17 I agree, I think three months is
18 unrealistic. I mean, I think the Department
19 probably wants to move faster on procedure
20 manuals than that and they should, right?
21 So, maybe it's not 10 days but three
22 months is, and our limit is excessive, too.

1 So, that would require kind of a new,
2 a new way for the board to work, at least on this
3 specific issue. But it could be fashioned.
4 MEMBER REDLICH: This is Carrie
5 Redlich. I think also that on something like the
6 Bulletin or the new procedure manual, there may
7 be, it may be many pages long but the relevant
8 pages that we would want to review is probably a
9 small number of those pages.
10 So, I mean, obviously we need more
11 than a day or two, but I think something like a
12 week or 10 days would be reasonable. And the,
13 you know, and the way to give timely feedback.
14 It would be worthwhile that our
15 feedback with them (telephonic interference).
16 CHAIR MARKOWITZ: So, you're saying
17 that some members could review it within 10 days
18 and then provide comments. We certainly couldn't
19 get a board consensus around that. We could
20 maybe get a subcommittee consensus around that,
21 at best.
22 You know, we could use this new

1 Bulletin 20-02 as a test case. You know, the
2 clock started yesterday.
3 MEMBER REDLICH: Okay.
4 CHAIR MARKOWITZ: So, that said, by
5 the way, let me ask Ms. Leiton. Bulletin 20-02,
6 is there kind of a track-change version of it so
7 we can actually identify the text that's changed
8 in the procedure manual? Or, you know, the
9 equivalent?
10 MS. LEITON: I think that's a Bulletin
11 and Bulletins tell you in the whole content of it
12 what the changes are.
13 And, so a transmittal is where we're
14 actually making changes to the procedure manual
15 right now. We're saying we're going to replace
16 what the procedure manual says in this whole
17 chapter.
18 So, I don't remember if this is a
19 transmittal or a Bulletin.
20 So, in transmittals at the beginning
21 of the transmittal we'll outline here's what all
22 the changes are in the procedure manual that

1 we're making.
2 In a Bulletin, we're actually saying
3 these are changes what we're making right now.
4 They will be incorporated into the procedure
5 manual at a later date. We are working on an
6 update to the procedure manual for the spring,
7 probably, time frame that will incorporate a lot
8 of little changes that have occurred, or that
9 we've had to make over the course of time that
10 we, we see.
11 And, in that transmittal you'll see
12 oh, here's all the changes including this
13 Bulletin.
14 This Bulletin that you have right in
15 front of you has to do with a realignment of our
16 staff and centralization of preauthorizations for
17 medical benefits.
18 And it's really, it's really it's
19 outlining for them a process whereby instead of
20 just having, we've centralized all of our home
21 healthcare, now we're centralizing all of our
22 preauthorizations for anything that requires a CE

1 to review it before we can authorize a service.
2 That's just adding a little bit more
3 to the centralized unit. That unit has recently
4 increased significantly. This Bulletin is
5 critical in making that change so that they know
6 how claims examiners are going to get those
7 medical, those preauthorization requests to the
8 right person.
9 And, a lot of our procedures are that
10 kind of thing. We need to know what our process
11 is for getting this work done, or shifting this
12 work, or something like that. And, that's why
13 time is of essence. And, it's critical that we
14 can make these changes. Otherwise, our work
15 stops.
16 So, you know, just so you understand,
17 waiting months for the board to vote and be able
18 to provide us with comments, particularly when
19 it's something like this as an example, where
20 we've already made the change internally in terms
21 of our organization, now we need to give the work
22 to the people that are waiting to do it. And,

1 this Bulletin outlines that.
2 So, to answer your original question,
3 basically the Bulletins just say is telling you
4 everything that's happening right there in that
5 Bulletin. It's not necessarily change in the
6 proceeding manual, where it is right now.
7 CHAIR MARKOWITZ: Yes, I'm looking at
8 it actually. Steve Markowitz, and yes, it's
9 described as updated chapters, chapter 2, 28 and
10 29.
11 Okay, so is there, so are there
12 members of the board who would like to review
13 this document and provide some feedback comments
14 to the Department within the next 10 days?
15 MEMBER REDLICH: You're referring to
16 Bulletin --
17 CHAIR MARKOWITZ: 20-02.
18 MS. RHOADS: Dr. Markowitz?
19 CHAIR MARKOWITZ: Yes?
20 MS. RHOADS: Just so while you're
21 formulating this, I just wanted to remind the
22 board that under the FACA rules, anything that's

1 done by a subcommittee or a working group, or a
2 subset of the board, has to be presented to the
3 full board before it can be presented to the
4 program.
5 So, that doesn't necessarily have to
6 be a meeting. I don't know, I have to ask if
7 there's a way to do that other than by convening
8 the entire board at a meeting.
9 CHAIR MARKOWITZ: Okay, so to clarify.
10 So, if it's a committee of three and they agree
11 on certain comments, they're not really formal
12 recommendations but they're comments, then we
13 wouldn't be permitted to do that?
14 MS. RHOADS: You can't give something
15 directly from a subcommittee or a portion of the
16 board to the program. It has to go through the
17 full board first.
18 CHAIR MARKOWITZ: Okay. Okay, thank
19 you.
20 So, we don't, that's not going to
21 happen in 10 days. So, what we're going to do is
22 to have a committee that looks at 20-02 in a

1 longer time frame and since we're welcome to
2 provide comments at any point, we could develop
3 recommendations if needed, and submit those
4 comments at our meeting in April. And, that
5 looks like the best that we can do.
6 MEMBER REDLICH: Yes, and I think from
7 my review of this last night, it seemed that it's
8 more in terms of the procedures of how things
9 were working and not actually the contents or,
10 you know, any of the medical decision making or
11 that sort of issue. Just billing and other
12 issues.
13 CHAIR MARKOWITZ: Okay. Okay, so are
14 there, is there a subset of people on the board
15 who would like, over the next I guess three
16 months, to take a look at this document and, and
17 come back with some description or a comment on
18 any aspect that we might be helpful to the
19 Department on?
20 MEMBER REDLICH: Steve, this is Carrie
21 Redlich again. I just think our time may be
22 better spent if there are going to be, let's say,

1 changes made to the procedure manual, or, you
2 know, one thing we haven't seen since early on
3 was the training materials that are provided to
4 train people how to carry out what's in the
5 procedure manual.
6 So, it seems like those sorts of
7 documents would be our, you know, where we
8 should, could best put our efforts.
9 CHAIR MARKOWITZ: Okay, so we're going
10 to postpone then the formation of a sub-group to
11 look at this particular document so we can move
12 on and then we'll just, we'll figure it out.
13 That's the best we can do at the moment.
14 It's 2:45, so can we take a 10-minute
15 break and then resume at five of 3:00?
16 (Simultaneous speaking.)
17 CHAIR MARKOWITZ: Yes, don't hang up.
18 MS. RHOADS: Just put your phones on
19 mute so you don't have to reconnect.
20 MEMBER POPE: Dr. Markowitz, I need to
21 leave the meeting, Duronda Pope.
22 CHAIR MARKOWITZ: Okay, yes, okay.

1 MEMBER POPE: Okay.

2 CHAIR MARKOWITZ: Good luck.

3 MEMBER POPE: Thank you.

4 CHAIR MARKOWITZ: Okay.

5 MEMBER MAHS: Dr. Markowitz, it's Ron
6 Mahs. I have to go also now.

7 CHAIR MARKOWITZ: I'm sorry, who is
8 this?

9 MEMBER MAHS: Ron.

10 CHAIR MARKOWITZ: Okay.

11 MEMBER MAHS: Ron Mahs.

12 CHAIR MARKOWITZ: Okay, thank you.
13 Take care.

14 MEMBER MAHS: Thank you.

15 (Whereupon, the above-entitled matter
16 went off the record at 2:45 p.m. and resumed at
17 2:58 p.m.)

18 CHAIR MARKOWITZ: Let's see, we're
19 still looking that this PowerPoint on the Webex.
20 Let me just bring this up. Okay, could you go
21 to the next slide?

22 Okay, so the next one is about this is

1 a new authorization. When the slide appears, it
2 has to do with the board being able to
3 communicate with the program medical director.
4 Does everybody -- let's see? Can you
5 bring up that new slide or wrong thing here.
6 MR. BIRD: Dr. Markowitz, I think you
7 should be -- everyone should be able to advance
8 the PowerPoint to whatever slide.
9 CHAIR MARKOWITZ: Mine's not working.
10 Okay, here we are. Okay, fine, it's
11 up.
12 So, okay, so we make available to the
13 board the medical director of the program,
14 toxicologists and industrial hygienist, and
15 contractors when requested. And, the OWCP's plan
16 laid out in December 30 letter is that we will
17 submit questions and the specialist will respond
18 to the questions and then --
19 MEMBER GOLDMAN: But, Steve, this is
20 Rose. I'm not seeing that on the, on my version
21 of the webinar.
22 I'm still on the other slide.

1 MEMBER BERENJI: I'm not seeing it
2 either. This is Mani Berenji. I'm not seeing it
3 either.
4 CHAIR MARKOWITZ: Okay, so now let me
5 just while that's happening or not happening, I
6 can just read it to you just so.
7 So, this issue has to do with new
8 authorization to us, to the board, that the
9 EEOICP medical director, toxicologists,
10 industrial hygienist and the contractors when
11 requested, will be made available to the board.
12 And, the plan as laid out by the
13 Department to comply with this is that the board
14 will submit written questions and the specialist
15 will respond to those questions, and how to
16 handle follow up questions will be determined
17 later.
18 So, one thing I'm curious about
19 actually, and Ms. Leiton if you're there, is all
20 this a written interaction? Is that what's
21 envisioned by the Department that we send in
22 written questions and we get back written

1 responses?
2 Or, the alternative is could there be
3 actually face-to-face communication at one of our
4 board meetings?
5 MS. LEITON: So, the way that the
6 Deputy Secretary wrote the letter was that yes,
7 the first step in this process would preferably
8 be, would be that there be a set of questions in
9 writing to be addressed by the specialist so that
10 they can be prepared to respond to what the
11 questions, or the set of questions are going to
12 be in advance.
13 They'd be able to prepare and they
14 could respond to those questions and then if the
15 board felt that there was still follow up
16 questions that required further interaction, we'd
17 work together to figure how that would, how that
18 would go.
19 CHAIR MARKOWITZ: So, if we for the
20 next board meeting, I don't know that this would
21 happen, but if we developed written, send in
22 written questions in ample time, might it be that

1 the medical director, industrial hygienist,
2 whomever, would actually be at the board meeting
3 and would give us verbal responses?
4 MS. LEITON: I believe the first step
5 that they would respond in writing with the
6 responses to those questions, and then if there
7 were follow up, follow up questions from there,
8 we'd determine whether it's appropriate for them
9 to be at a full board meeting or whether it'd be
10 appropriate for them to be a smaller group, or
11 how that interaction would occur.
12 CHAIR MARKOWITZ: Okay, so it would be
13 initially be back and forth would be in writing
14 and then with the possibility of face-to-face
15 communication later?
16 MS. LEITON: That's correct.
17 CHAIR MARKOWITZ: Okay, thank you.
18 So, I don't really see that we need to
19 discuss this much. I think that if we accumulate
20 questions for the named persons in this, in Item
21 No. 2 over the next period of time, that we can
22 collect those questions and submit them.

1 But we have a number of things we want
2 to get done today so I don't really see opening
3 up the floor to a general, to make a general list
4 of questions, if that's all right.
5 Comments?
6 (No audible response.)
7 CHAIR MARKOWITZ: Okay, next slide and
8 maybe I can do this. Okay here, so No. 3 can you
9 all see this No. 3 or not really?
10 PARTICIPANT: Yes.
11 PARTICIPANT: I can.
12 CHAIR MARKOWITZ: Okay, anybody --
13 MEMBER BERENJI: I can't see it.
14 CHAIR MARKOWITZ: Okay, you can?
15 MEMBER BERENJI: Cannot. This is Mani
16 Berenji.
17 CHAIR MARKOWITZ: Okay, fine.
18 So, the next one is that it simply
19 says that the Department of Labor will respond to
20 the board's recommendations in writing within 60
21 days of the date of submission, and that if the
22 recommendation is accepted, a time line of

1 implementation will be provided. If it's not
2 accepted, than a rationale and supportive medical
3 or scientific research will be provided.
4 So, that's, that's great. Any
5 comments on that?
6 (No audible response.)
7 CHAIR MARKOWITZ: Okay --
8 MEMBER BERENJI: This is Mani Berenji,
9 sorry, I had a question.
10 CHAIR MARKOWITZ: Yes.
11 MEMBER BERENJI: So, in terms of how
12 that actually will happen, does the DOL Secretary
13 directly respond to you, or does he have to go
14 through an intermediary?
15 CHAIR MARKOWITZ: I get, this is Steve
16 Markowitz, I get a letter from them and when I
17 get it, I ask Carrie Rhoads to send it to the
18 rest of the board. You know, more or less right
19 away. But that's the way it works.
20 MEMBER BERENJI: Got it, thank you.
21 CHAIR MARKOWITZ: Okay, next slide,
22 Item No. 4, which I'm having a hard -- oh, here

1 you go.

2 So, this is blanket language that the
3 board will advise the Department of Labor
4 Secretary in other matters that the Secretary
5 considers appropriate and that OWCP may provide
6 the board with directives in the future regarding
7 specific topics for its review and
8 recommendations. So, that's what it is.

9 Any comments on this?

10 MS. LEITON: Dr. Markowitz, this is
11 Rachel Leiton.

12 I do believe that there will likely be
13 forthcoming some additional topics that will come
14 from the Department for you guys to consider.

15 CHAIR MARKOWITZ: Okay, great. And
16 we're hoping to get you the answers in all the
17 previous topics.

18 (Laughter.)

19 CHAIR MARKOWITZ: Okay, so that's it
20 for this agenda item.

21 Next on the agenda is review of public
22 comments. I just have a couple of items that I

1 looked at that I wanted to raise quickly if
2 others have also have items.
3 We got one public comment this time,
4 it's on our website from Terrie Barrie, and
5 raising an issue that we're not going to discuss
6 now but it has something to do with the letter of
7 medical necessity. I think it's part, maybe part
8 of this new Bulletin 20-02.
9 So, when we get to look at that and if
10 we have a comment to make then, then fine. The
11 other issue that is raised in this public comment
12 actually is something that we've raised before.
13 There's a part of the procedure manual
14 called Exhibit 18-1. This is the matrix some of
15 you may recall, that was devised in 2006 by
16 Econometrica. Kind of a basis, I think, for some
17 of the decision making in the program early on.
18 And, we've looked at this, board
19 members have looked at this in the last few years
20 and it's increasingly discrepant with other
21 sections of the procedure manual.
22 So, for instance if you look at the

1 latency numbers that are latency periods that are
2 indicated in, in this Exhibit, it's different
3 from the new latency figures that were put in for
4 asbestos.
5 It says that the COPD consideration is
6 restricted to people who have never smoked, which
7 is obviously not the program policy.
8 So, I don't know that we need an
9 official recommendation of this, but it's a bit
10 of an embarrassment I think frankly, that this
11 Exhibit 18-1 is so out of sync with the rest of
12 the procedure manual that I think you should take
13 a serious look at it and either do away with it
14 because most of it's been integrated into the
15 rest of the procedure manual, or correct it.
16 I don't know if anybody else has any
17 comments about that.
18 MEMBER REDLICH: This is Carrie
19 Redlich. I agree there is just multiple
20 inaccurate pieces of information in the tables.
21 CHAIR MARKOWITZ: Another public
22 comment, it came in in December, it had to do

1 with the well-rationalized medical opinion from
2 the personal provider and seemed to indicate that
3 this was, it's a challenge for any number of
4 reasons, but the particular issue that's being
5 raised was, was whether there was an inordinate
6 delay in, and the receipt of those letters from
7 the personal physicians.
8 I don't know Ms. Leiton, if you all
9 track that. You know, the underlying problem is
10 that many of the physicians don't feel capable of
11 providing that kind of well-rationalized argument
12 because that's not what they do in life.
13 But regardless of the underlying
14 problems, what was pointed out was that the delay
15 ends up causing delays in the claims, in the
16 whole claims process.
17 So, I don't know if you have any
18 comment about that, Ms. Leiton.
19 MS. LEITON: I would have to look at
20 the letter in context. I'm not sure. You might
21 have it on. Is this the one from Terrie Barrie,
22 or are you referring to a separate one?

1 (Simultaneous speaking.)
2 CHAIR MARKOWITZ: No, this is from
3 Faye Vlieger back in December.
4 MS. LEITON: Okay, so I haven't looked
5 at that specifically but if I guess your question
6 is if the, are requests for letters of medical
7 necessity causing delays in the home healthcare
8 --
9 (Simultaneous speaking.)
10 CHAIR MARKOWITZ: No. No, no, it's
11 not letters of medical. No, this has nothing to
12 do with that.
13 MS. LEITON: All right.
14 CHAIR MARKOWITZ: It has to do with
15 the request to the personal physician for a
16 well-rationalized, you know, report.
17 MS. LEITON: But we, that's going to
18 always be our first place to go is to the
19 person's treating physician because we want to
20 make sure that we're giving the claimants the
21 opportunity to provide that from their own
22 doctor.

1 Oftentimes if we have some sort of
2 letter or an opinion from a doctor but it's not
3 fully well rationalized, that's often when we'll
4 go to a CMC to get further information.
5 But in terms of whether or not that's
6 putting a delay in the process, I think we're
7 pretty, our stats show that we're pretty timely
8 in our adjudication of our claims.
9 So, this is something we've always
10 asked for. It's something that again, it's an
11 opportunity for our claimants to go to their own
12 physicians instead of a lot of people sometimes
13 say that we'll go to our doctors instead of their
14 doctors and, and that's not a fair practice.
15 So, we always want to make sure that
16 when we're asking for additional information
17 that's medical in nature, that we'll go to them
18 first. And, some claimants actually do have
19 physicians that want to respond. We'll send
20 them specific letters asking for specific
21 information and we want to allow that time.
22 But again, we will go to a CMC, a

1 contract medical consultant to help us in those
2 situations. We have very tight deadlines for our
3 contractors to provide us with that information,
4 so they do it pretty quickly these days, and
5 again, I haven't seen, our statistics don't show
6 that there's demeaning delays as a result.
7 CHAIR MARKOWITZ: Okay, thank you.
8 So, let's we're going to move on. I
9 want to review the document that we got this
10 morning. These were the DOL's responses to our
11 information requests from our last meeting.
12 I don't have a PowerPoint on this but
13 we're going to just walk through this and I think
14 we can do it without any real difficulty,
15 although I see there is a document here.
16 Is this what you've brought up, is
17 this -- no, no, this is December 18. No, I'm
18 talking this is the one that we got this morning,
19 it's labeled DOL Response to ADTSWH December 23,
20 2019 Information Request.
21 So, if board members, if you got this
22 by way of email this morning, this is, yes, this

1 is an attachment actually. That is part of the
2 document that we're looking at on the Webex.
3 Okay, so the first item was that we
4 had requested 20 lung cancer claims from, that
5 has been denied under Part E from 2013 to the
6 present, and that we wanted certain, the claims
7 to meet certain requirements regarding the
8 latency and job title. And, the response back is
9 that, and we asked for it to be, the claims to be
10 indexed.
11 The response back from DOL was that
12 they couldn't do this. Their system doesn't
13 permit them to retrieve these cases because it's
14 very burdensome in terms of labor because it will
15 require manual review of cases.
16 But here's my question. So this
17 request grew out of a table that the Department
18 provided to us having to do with -- okay, so on
19 the Webex we're now looking at the request and
20 the response.
21 But here's the issue. We were
22 provided with a report 658 or it's listed in, I'm

1 sorry, 682 by the Department and the report 682,
2 which we can't show because it has personally
3 identifiable information, lists a large number of
4 lung cancer claims that were denied from 2013 to
5 2019.
6 It lists their job title, predominant
7 job title, and it lists their earliest date of
8 employment and some other employment relevant
9 date. So, and it lists them by name and by ID
10 number.
11 So, it was from that list that we were
12 requesting the 20, the 20 claims. So, what I
13 don't understand is why this would require manual
14 review to find these cases when the cases are
15 simply a subset of that table that we were
16 provided with.
17 And, I guess that's a long way of
18 asking Ms. Leiton a question. You may not be
19 familiar with the details so I get that, but of
20 those 500 claims in that report, we wanted just
21 20 of them that met the latency and job title
22 criteria, which are variables provided in that

1 report.

2 MS. LEITON: Are you sure that latency

3 is provided? I know the earliest date of

4 employment is provided. I don't know that

5 diagnosis date is provided. Again, as you said,

6 I don't have the report in front of me and other

7 staff members did a lot of work on this

8 particular request.

9 But my understanding is trying to get

10 the latency period of 15 years --

11 CHAIR MARKOWITZ: Okay, well, yes.

12 (Simultaneous speaking.)

13 CHAIR MARKOWITZ: I'm looking at the

14 report. It provides earliest verified employment

15 start date, which is good enough for us as a

16 latency date. And, we have final decision denied

17 date.

18 So, you know, the first case, case X

19 was denied November 2013, Hanford, earliest

20 employment date was April 1974 and the person was

21 an electrician. And, then there's diagnosis

22 date.

1 So, you could use earliest verified
2 employment date and diagnosis date frankly, for
3 the latency. And, the job, the position title is
4 in a separate variable.
5 So, I mean I'm happy that we can get
6 all, you know, at a subsequent time to speak to
7 whomever about the particulars here, but what we
8 were, we were trying to create a simple request
9 based on this table such that it wouldn't,
10 wouldn't require a lot of work on the part of the
11 Department.
12 So, you know, can I follow this up
13 with a conversation with you soon, or whomever?
14 John or whomever?
15 MS. LEITON: Yes.
16 CHAIR MARKOWITZ: Okay.
17 Okay, so back to the Webex. The next
18 question we had for them was does Department have
19 a guide for treating physicians on how to use the
20 SEM, and the answer is no but that there are
21 resources available on the SEM online that if the
22 physician wants, wants to go there.

1 Offhand I don't know how user friendly
2 they are for the physician, but that was the
3 response.
4 So, the next item we requested, the
5 next page --
6 MEMBER GOLDMAN: This is Rose, could I
7 ask you a question about that?
8 CHAIR MARKOWITZ: Yes.
9 MEMBER GOLDMAN: On the use of the
10 SEM, are you talking about it for the treating
11 physician or that consultant physician?
12 CHAIR MARKOWITZ: The treating.
13 MEMBER GOLDMAN: Consultant physician?
14 CHAIR MARKOWITZ: Yes, the treating
15 was the.
16 MEMBER GOLDMAN: The regular treating
17 physician I mean, is really going to go and try
18 to look through this SEM? I mean more likely the
19 treating physician's going to look at the
20 questionnaire, you know, about what the person
21 says they were exposed to, rather than try to use
22 the SEM.

1 I could see it as the consultant, you
2 know, being expected to use that but a treating
3 physician to just say what's wrong with their
4 patient? I think that's probably not likely, do
5 you, somebody in their office?
6 CHAIR MARKOWITZ: Yes, I would agree
7 with you. I think it's probably the uncommon
8 physician who's going to have the time and
9 interest to delve deep into the SEM --
10 MEMBER GOLDMAN: So --
11 CHAIR MARKOWITZ: -- but.
12 MEMBER GOLDMAN: -- I think that that
13 might be a question to ask with this new
14 questionnaire that you're, that's being
15 developed. If, that might be something easier for
16 a treating physician to look at, which is if
17 somebody that says they're an electrician.
18 Now if you add any of these possible
19 exposures, or for the request to the physician
20 who's writing a letter on behalf of their own
21 patient to say, you know, your patient has these
22 potential exposures.

1 But I just think this is unlikely. We
2 ought to figure out another mechanism that you
3 really want the treating physician to make that
4 kind of commentary.
5 Anyway, that's my two cents on that.
6 CHAIR MARKOWITZ: And, so Ms. Leiton,
7 is it possible for the treating physician to get
8 a copy of a completed Occupational Health
9 Questionnaire?
10 MS. LEITON: Well, that would have to
11 come through, it would likely normally come
12 through the claimant. The claimant can give him
13 a copy of that.
14 If they specifically ask us for it, I
15 believe that we have, I would have to look at all
16 the privacy act issues --
17 CHAIR MARKOWITZ: Right.
18 MS. LEITON: -- and stuff like that.
19 We usually give them our, well, we try
20 to give them our assessment that after we've gone
21 through the SEM and all the OHQ, and the
22 documentation that the electronic exposure from

1 the IH, all of that, will go, often go to a
2 doctor if we're asking a specific question about
3 causation. Or we'll say these are the, you know,
4 here's what we have determined they were exposed
5 to.
6 As for the OHQ, I don't think that
7 there's a bar against it but I don't know number
8 one, that it's been asked for, or number two,
9 whether there are other reasons why we wouldn't
10 give them the exact OHQ itself.
11 CHAIR MARKOWITZ: Right. Does the
12 claimant, this is Steve Markowitz, does the
13 claimant get a copy of the OHQ routinely?
14 MS. LEITON: A lot of times they'll
15 get it if they ask for a copy of their case file.
16 If they want a copy of it, we can provide it to
17 them at any time, they're welcome to it.
18 I don't know that we routinely send it
19 back out but often times at the resource centers,
20 especially if they walk in, they're sitting there
21 completing it with them. See what they're
22 completing.

1 If it's over the phone, if they're on
2 the phone with them I don't, you know, I would
3 have to check and see how often the claims
4 examiner asks after that can you please send me a
5 copy of what we've recorded here. I'd have to
6 look into that a little further to see how much,
7 how often that happens.
8 CHAIR MARKOWITZ: Okay. Other
9 comments?
10 MEMBER SILVER: This is Ken Silver. I
11 think based on something Rose Goldman said, these
12 resources might be used if they were nested
13 within another educational resource aimed at
14 physicians who are writing letters for a resource
15 that provided guidance on what DOL is looking for
16 in those letters, and the factors to weigh.
17 And, the doctor who was presented with
18 that educational resource might take the deep
19 dive and poke around in the SEM and the procedure
20 manual.
21 I can't remember, is there a program
22 educational resource aimed at doctors who are

1 writing letters?
2 MS. LEITON: I'm not sure if that was,
3 this is Rachel, I'm not sure if that was for me
4 or not.
5 (No audible response.)
6 MS. LEITON: Go ahead.
7 (No audible response.)
8 MS. LEITON: Okay, well I think your
9 question had to do with whether or not there is
10 an educational program aimed at physicians.
11 What we do do a lot of outreach
12 towards the medical provider community around the
13 country. We will go out and talk about what our
14 procedures are, what our requirements are, we go
15 into pretty deep, deep dive on that.
16 We're doing one of them in fact, in
17 Santa Fe and in the end of February where we send
18 out letters to providers that we, that we have
19 lists of and they'll come to these events, and we
20 publicize these events, that sort of thing.
21 We also have an email blast that we
22 send out to subscribers who want to know more

1 about what's going on in terms of the medical
2 requirements aspects of the work. And those will
3 go out monthly. You can subscribe to those
4 online.
5 So, those are the kinds of educational
6 activities that we are involved with with regard
7 to the medical community.
8 CHAIR MARKOWITZ: Okay, thank you.
9 Other comments?
10 (No audible response.)
11 CHAIR MARKOWITZ: Okay, so next I
12 think we're looking at these Item No. 2, how
13 many, we asked how many public submissions were
14 there to the SEM in 2019 and what was the
15 outcome.
16 And, you can see them, there were 32
17 toxic substance inputs in 2019, and eight disease
18 inputs. And, you can see the fate of these
19 inputs in that some of them were of a toxic
20 substance says 32, eight of them were accepted,
21 five were already in the database.
22 And, others were either not verified

1 or classified as requests for information only.
2 And, of the eight disease inputs, none
3 of them were accepted. One was already in the
4 database and five were, couldn't be verified.
5 So, that's the answer to our question.
6 If there are no comments I'll move on
7 to No. 3, which is in the last two years what
8 change has been made to the SEM regarding
9 exposure disease links. And, if you could go to
10 the last page of this letter, there's a table
11 that gives you details. Keep going. Next, okay,
12 there you go.
13 So, I can summarize this for you in
14 that there are 32 items, actions taken. In 22
15 instances some disease exposure link was added,
16 and in 10 circumstances they were deleted.
17 And a lot of the additions were around
18 pneumonitis, and some of them, other ones related
19 to infection. Adding Lyme disease, adding
20 Hepatitis B and liver cancer, for instance.
21 And, then of the ones that were
22 removed, there were 10 and some of them were also

1 pneumonitis, and a couple of them were acute
2 toxic effects of solvents.
3 So, you get a sense of the level of
4 activity of the exposure of disease linkages.
5 But it just, while we're looking at
6 this for a second, Ms. Leiton, who actually is
7 the one that identifies these to add to the set?
8 Does this come out of Haz-Map and then
9 you all bring it up from Haz-Map into, into the
10 SEM, or is it done internally within your
11 department?
12 MS. LEITON: We have, our contractor
13 does a lot of the research that goes into this.
14 This is looks like these are the disease changes.
15 I'm not sure if this is just what was
16 added as a toxic substances or if these are all
17 effects from. Are these all effects or if these,
18 these might just be indications. Yes, these are
19 the links. So some of them would come from the
20 Haz-Map database.
21 CHAIR MARKOWITZ: And some would come
22 from Paragon, right?

1 MS. LEITON: Well, Paragon will do the
2 research for them, yes. A lot of times we get
3 this from various sources.
4 We can get it from NIOSH will uncover
5 some information that then will come to us and we
6 do additional research. They obviously don't do
7 the toxic links, they will do the actual toxic
8 substances that they might have found.
9 But the links will go through Haz-Map
10 normally and if not through Haz-Map, then it's
11 something that we've made a polity determination
12 on here.
13 But they all come through the national
14 office before they're added to the SEM through
15 the federal, through our federal staff.
16 CHAIR MARKOWITZ: Okay. Thank you.
17 If we could go back a couple of pages
18 to Item No. 4, we asked how many CMC reports were
19 issued each month in 2019. We just wanted a
20 sense of the volume.
21 So, it's you can see it's quite
22 numerous. I added it up, it's about 2,400 CMC

1 reports per year, or at least in the most recent
2 year.
3 And, I think John Vance told us
4 there's something in the order of 7,000, 8,000
5 new claims per year, or new cases or claims, I'm
6 not sure.
7 So, it gives you a sense of what
8 proportion gets CMC reports. A rough sense. But
9 that's a, there are a lot of CMC reports in the,
10 being developed.
11 Comments or questions?
12 (No audible response.)
13 CHAIR MARKOWITZ: Okay, the next Item
14 5 is an update on something we, this is just the
15 status of reopened cases from changes that the
16 program made in part as a result of board
17 recommendations.
18 And, if you look at the orange one on
19 the left, that's the total for all the district
20 offices and you can see that 50 were reopened out
21 of a total of, well, that's your lung cancer.
22 There's about 100 are reopened out of the total

1 of about 2,000. And, with the status on the
2 bottom left. We've seen this chart before.
3 Item 6 is the, we asked about pending
4 claims, which is an item found in the top 20
5 health conditions and we just wanted to know how
6 long they'd been pending.
7 And, turns out that's a very
8 complicated question, which the Department isn't
9 able to answer because there are any number of
10 sort of decision points, time, time periods.
11 And, so they wanted us to develop a more specific
12 question to answer that.
13 I'm not inclined to pursue that
14 although I'm open to doing that if there are
15 comments, or.
16 (No audible response.)
17 CHAIR MARKOWITZ: Okay, and the next
18 page, and this is we asked to have the quality
19 assessment evaluation conducted on this.
20 So, just to summarize here, so the,
21 there are federal industrial hygienists, a few in
22 the national office. Correct me, Ms. Leiton, if

1 I have this wrong.
2 There's an industrial hygiene
3 contractor named BGI. The IH contractor does the
4 IH evaluations which are reviewed internally by a
5 program manager and corrected for certain
6 requirements of the contract and consistency.
7 Those are sent to the national office
8 and then the national office federal industrial
9 hygienist then looks at it and checks it for
10 scientific technical accuracy and consistency.
11 And, so that's how quality assessment is done.
12 We're going to discuss this more in a
13 few minutes but go ahead.
14 MS. LEITON: That's correct.
15 CHAIR MARKOWITZ: Okay. Comments?
16 (No audible response.)
17 CHAIR MARKOWITZ: We're going to talk
18 about our own ideas for IH assessments so.
19 Before we get to that I just want to
20 go back to my PowerPoint. I just want to raise
21 one item that I thought was of interest. If you
22 could advance that. I can't do that here.

1 Keep going. Keep going. Okay, we
2 just reviewed that. Next. Okay.
3 Just, yes, we submitted this, oh, I'm
4 sorry, go back. Go back. Go back one.
5 Okay, just this is a recommendation
6 from our last board meeting just to remind you
7 that having to do with site wide job titles.
8 Okay, next slide.
9 So, this is for the we have a working
10 group that will, is continuing to work on
11 authoritative sources for use by the Department
12 in improving updating SEM.
13 And, this grew out of a review of the
14 SEM program by the IOM and Student Medicine in, I
15 think it was 2013.
16 And, we don't really have an update
17 but we will by April on which sources to use, but
18 here's a question I have for that group and for
19 the board as a whole. Next slide.
20 So, if you look at the language of the
21 Act, as least as likely as not that the exposure
22 to a toxic substance was a significant factor in

1 aggravating, contributing, or causing the
2 illness, my question is when you look at IARC
3 classification of carcinogens, next slide, we
4 have Group 1, which is definitely carcinogenic,
5 and we have Group 2A, which is probably
6 carcinogenic.
7 And, so the question is whether Group
8 2A carcinogens meet the standard from the Act, at
9 least as likely as not aggravate, contribute, or
10 cause. And, that's a question I would put to
11 the, to the working group.
12 The IOM review doesn't address this
13 head on. Can we go to the next slide, and just
14 give you the details from the IARC
15 classification, how it is they decide something's
16 a Group 1 vs. a Group 2. Set aside Group 1,
17 those we all agree. It's after definite human
18 carcinogens.
19 Group 2A, there are several ways you
20 can become a 2A carcinogen. One is to have
21 limited evidence in humans but sufficient
22 evidence in animals, and then you can read for

1 yourself the other combinations.
2 Regardless how you get there, the
3 conclusion of IARC is that this is a probable
4 human carcinogen.
5 So, if you go to the next slide, I
6 think it may be the last of the -- next one.
7 Sorry.
8 So, there aren't that many 2A
9 carcinogens around. We've got 80,000 chemicals
10 in use throughout the U.S., about 1,000 have been
11 evaluated by IARC, next slide. Of those 1,000
12 evaluated by IARC, half of them, the yellow, IARC
13 couldn't classify because there's not enough
14 during the studies. So, we set those aside.
15 Group 1 carcinogens, 120 are labeled
16 as definite human carcinogens. Another 83 is
17 Group 2A. And, so, these are on the next slide.
18 What's the practical significance of
19 this question? There's a Group 1 for lung cancer
20 and I looked at the SEM and as far as I can tell,
21 the SEM addresses most or all of these. I didn't
22 look through every last one but I looked through

1 the main ones and I didn't find any.
2 Group 2A, currently the SEM does not
3 to my knowledge, appear to address these as lung
4 carcinogens. Some of these agents here you might
5 be a little surprised to find.
6 Benzene is a probable human lung
7 carcinogen. Dioxin, which is 2, 3, 7,
8 8-Tetrachlorodibenzo-para-dioxin, the last one on
9 the list, is a probable human lung carcinogen.
10 And then there's some other which are
11 probably not relevant to DOE, a bunch of them
12 actually.
13 So, but my question really for the
14 working group on this is should 2A carcinogens be
15 included in the SEM as exposure disease links?
16 Any comments or thoughts about this?
17 MEMBER BERENJI: This is Mani Berenji.
18 So, I'm actually heading this work
19 group. I honestly feel that, you know, we need
20 to look at the IARC in more detail and then
21 compare to the other data sources that the DOL is
22 currently referencing, which I believe is

1 Haz-Map.

2 Rachel, feel free to correct me if I'm
3 wrong, but what is your main source, at least
4 according to the procedure manual when I last
5 checked, I believe it's still Haz-Map.

6 (Pause.)

7 MS. LEITON: I'm sorry, was this a
8 question for me? This is Rachel.

9 MEMBER BERENJI: Yes, this is Mani
10 Berenji. So, I just wanted to clarify what's in
11 the procedure manual in terms of what the SEM, at
12 least from my understanding of the procedure
13 manual, I'm trying to find the exact reference
14 but looks like most of the information that's in
15 the SEM is based on the data from Haz-Map? Is
16 that current? Okay.

17 MS. LEITON: So, it is but a lot of
18 that the Group 1 from IARC are all in Haz-Map, at
19 least that's my understanding. And, we use the
20 Group 1.

21 Group 2A is a very good, I would
22 suggest that that's a very good place to start

1 with regards to what more could be added, or how
2 exacerbation and contribution play into Group 2A.
3 But yes, the majority we do have
4 others that we've added in terms of that we've
5 made policy determinations on that we have
6 Bulletins and such for in terms of what, where
7 there's a connection and that, those sorts of
8 things are added into, to the SEM.
9 But SEM's always been a causation link
10 that we've said these are really more causation
11 that exacerbation. But thinking in terms of
12 exacerbation and aggravation is probably
13 beneficial.
14 MEMBER BERENJI: Thank you.
15 CHAIR MARKOWITZ: Other comments?
16 (No audible response.)
17 CHAIR MARKOWITZ: Okay, so let's move
18 on. If you could go forward with the PowerPoint
19 here.
20 The next issue has to do with
21 assessing the quality, objectivity, and
22 consistency of the industrial hygiene and the

1 physician input into the program. This comes
2 directly from our charter. Next slide.
3 Now let's talk about the M.D.
4 evaluation. Next slide. So, this is from the
5 minutes just to refresh your memory.
6 I had looked at, so the medical
7 director of EEOICP reviews a certain number of
8 claims every quarter and looks at them for
9 quality basically.
10 And, I've summarized here in the
11 highlighted that I looked at the most recent five
12 quarters, this is as of last November. I
13 evaluated about 250 claims, 100 of them for
14 impairment, and 28 of those were described as
15 needing improvement.
16 Eighty-three claims were for
17 causation, one needed improvement, and the
18 remainder of the 60 claims which were different
19 types, about a quarter needed improvement.
20 So, from the current quality check
21 that the program does, there are a couple of
22 things here. One is that the at least for that

1 time period, 28% of the impairment evaluations
2 requiring improvement is pretty high. Of the 60,
3 25% required improvement, that's also pretty
4 high.
5 On the causation front, only one
6 required improvement, that's clearly an outlier
7 compared to the others, and given our own review
8 of claims, my hunch is that the evaluation of the
9 causation argument in those claims is not, is not
10 complete is my hunch from our own look at claims.
11 But anyway, that's just describing
12 what the program does at present.
13 Any comments on that?
14 (No audible response.)
15 CHAIR MARKOWITZ: Okay.
16 MEMBER REDLICH: This is Carrie
17 Redlich. Can we have a better idea about what
18 aspect was considered needing improvement?
19 CHAIR MARKOWITZ: You mean on the
20 impairment?
21 MEMBER REDLICH: Yes.
22 CHAIR MARKOWITZ: Yes. I didn't track

1 that so I can't, and I did the work several
2 months ago so I can't tell you. I can't recall
3 offhand what, what the dominant problems were.
4 Okay, next slide.
5 So, I looked at the CMC contract, so
6 the name of the company is QTC, I think. Ms.
7 Leiton, is that right?
8 MS. LEITON: Yes, that's correct.
9 CHAIR MARKOWITZ: Okay. So, the
10 contract is QTC and they have a contract that
11 expires at the end of 2021, it's a five-year
12 contract. So, they're beginning the fourth year
13 of that contract.
14 And, let me just ask actually Ms.
15 Leiton. What's the time table for reissuing that
16 contract? I'm thinking in terms of if the board
17 wants to provide input into quality assessment
18 that may eventually impact what the RFP looks
19 like, what is the, how soon would the board need
20 to do that?
21 I mean, in other words, the contract
22 still has two years to go, so understood it's

1 there's some time.
2 MS. LEITON: Yes. I would probably not
3 be the best person to answer that question
4 because I'm not familiar with all of the
5 contractual rules.
6 That does take some time for us to
7 develop new proposals, language, RFP and there's
8 a timetable the Department has to go through, so
9 it's usually a good fair amount in advance but I
10 hesitate to give you an answer on that. We can
11 get back to you.
12 CHAIR MARKOWITZ: Okay. Okay, yes,
13 that would be useful because you know, it would
14 be nice to know that A is that our work while I'm
15 thinking about this might actually be used, but B
16 is what the time frame is because it takes a
17 little time to figure this, figure this out.
18 But so I've taken some excerpts from
19 this contract and there's training required for
20 the CMCs. I think we had some question about
21 that in the past. Next slide.
22 Either the Department of Labor or

1 QTCcan disapprove physicians in this program, and
2 I think that has been done to some extent in the
3 past. Next slide.
4 And, so here's what the contract
5 obligates QTC to do with reference to quality
6 control. So, this is separate from what I
7 described before as the program medical director.
8 And, you can read some of the language
9 there about conforming to the requirements of the
10 program. Doesn't really get into the nuts and
11 bolts but that the contract will be evaluated,
12 their performance, in accordance with certain
13 performance standards. Next slide.
14 So here I think is little bit more
15 informative. Performance requirement, summary of
16 performance objective on the left, and the
17 standard is that the report from the CMC has to
18 be complete, offer well-rationalized opinion,
19 unequivocal. That's rough. And, ensure the
20 proper forms are filled out and they use the AMA
21 Guide.
22 The performance threshold is that no

1 more than 5% of the medical evaluations will need
2 clarification, correction, completion, or
3 re-performance. And, that the contractor is
4 supposed to as a method surveillance, do periodic
5 evaluation of reports weekly, monthly, quarterly
6 reports and handle complaints from the program.
7 On the face of it, this no more than
8 5% requiring correction seems to be a lot lower
9 than the 25, 28% that the program medical
10 director found in the latest five quarters.
11 So, I would ask for the clarification
12 not on this call but in general from the program
13 about what, what this means.
14 Actually, we would like to see the
15 products of the method of surveillance, which is
16 the periodic evaluations that are obligated of
17 the contractor to understand better how that
18 jives with the performance evaluation that the,
19 that the Department's own medical director does.
20 If that's understandable.
21 Anyway, people have some comments
22 about this?

1 MEMBER BERENJI: Yes, this is Mani
2 Berenji, and I actually agree with you 100%
3 Steven. I really feel that there needs to be some
4 sort of, you know, process by which they have
5 some sort of automatic auditing every quarter, or
6 every six months. And, this 5% number is a
7 little disturbing, quite frankly.
8 And, then that begs the question, you
9 know, is there some sort of when, where, DOL can
10 actually, I'm sure they have something but how do
11 they systematically track contractors?
12 I mean, is there something already set
13 in terms of, you know, periodic evaluation, are
14 these folks meeting their metrics? I mean,
15 there's got to be some sort of internal process
16 that we just don't know about. I'm not sure.
17 MEMBER GOLDMAN: This is Rose. I
18 agree with that. Like, what are their internal
19 metrics and if they say 5% maybe they're not
20 really putting forth critical metrics, or that
21 they're reviewers don't have the same either
22 expertise let's say, that you brought to it when

1 you reviewed it and thought the 25% needed
2 improvement.
3 So, there's a whole lot that needs
4 further evaluation both the criteria and who is
5 the one actually doing the review of the cases,
6 and on what criteria?
7 CHAIR MARKOWITZ: Just so, this is
8 Steve Markowitz. Just unless I misheard, the 25%
9 was not mine. That was what the program medical
10 director found in the miscellaneous cases. And
11 28% were --
12 MEMBER GOLDMAN: Oh, well that's even
13 worse. Then their own person is finding 25% when
14 they're only supposed to have 5% is what you're
15 saying.
16 CHAIR MARKOWITZ: Yes, if we're
17 dealing with apples, comparing apples with
18 apples, yes. You know, I don't, I don't know.
19 MEMBER GOLDMAN: Oh. Well, we still
20 need to know what their criteria are but clearly
21 then what's the remediation if they're applying
22 their own criteria and find that 25% needed

1 improvement? Then what happens?
2 MEMBER DEMENT: Hey Steve, this is
3 John. One slide up, didn't it require that the
4 contractor develop a QC plan? Have we ever seen
5 that?
6 CHAIR MARKOWITZ: What kind of plan?
7 MEMBER DEMENT: Quality control plan.
8 CHAIR MARKOWITZ: We, I don't recall
9 seeing.
10 MEMBER DEMENT: Track quality. Yes,
11 have we ever seen anything in writing on what
12 that really is? I don't recall seeing anything.
13 CHAIR MARKOWITZ: Yes, I don't recall.
14 MEMBER REDLICH: This is Carrie
15 Redlich. I think we had seen some data in terms
16 of the timeliness of the reports but not an
17 evaluation of the, the content and the decision
18 making.
19 And, so I think the challenging
20 question is review of the decision making.
21 Because I think we, those of us that have been on
22 the advisory board now for several years have

1 reviewed enough of these cases that, you know,
2 while some were adjudicated properly, we feel
3 that, you know, that we've come across a number
4 that there's a problem.
5 And it's, you know, we've identified
6 several steps where the problem could be but we
7 have identified specific CMCs that we really
8 questioned their competency, and they seem to be
9 continuing to adjudicate cases. Or I mean, be
10 sent cases to --
11 CHAIR MARKOWITZ: Right.
12 MEMBER GOLDMAN: -- provide an opinion
13 on. And, so that is concerning.
14 MEMBER DEMENT: This is John again.
15 This quality control section 6.5 says that the
16 government has to approve of the contractor's QC
17 plan. I guess I'd just like to see the QC plan.
18 What is it?
19 MEMBER GOLDMAN: That's a very good
20 point, John.
21 MS. LEITON: This is Rachel. I
22 believe we responded to these, this line of

1 inquiry with regards to what we can give out from
2 the contract. There are certain proprietary
3 interests that we can't violate. There are
4 certain contractual obligations that we have
5 through the contractor.
6 And, so some of these things that, and
7 I believe you have asked for them before and
8 we've had to tell you that there are contractual
9 reasons that we're not allowed to give them out.
10 I'm just making that as a blanket
11 statement. I'm not saying individual inquiries
12 so like, you know, it might vary depending on
13 what you're asking for. But when you're asking
14 for contractual things that are proprietary to
15 the contract, there are issues.
16 CHAIR MARKOWITZ: All right, this is
17 Steve Markowitz and I recall that response.
18 (Laughter.)
19 CHAIR MARKOWITZ: But maybe there is
20 some information we could get. For instance,
21 these results of the method of surveillance, and
22 the like.

1 But here's my question. We've looked
2 at a number of claims and a lot of the CMCs are
3 fine, and there's some subset that, you know, we
4 don't agree with their evaluation.
5 We don't, I don't see any evidence
6 that the program's medical director is finding
7 much problem with the causation in the causation
8 front, which frankly, is the primary thing we
9 looked at, adequacy of medical evidence and
10 causation, not, not impairment.
11 So, if we had to design a quality
12 program, assessment program for the CMCs, how
13 would we do that and what would it look like?
14 (No audible response.)
15 CHAIR MARKOWITZ: And, I'm talking
16 about the content of the evaluation, not
17 timeliness or their credentials, or, you know,
18 other things that you're probably already pretty
19 well addressed.
20 MEMBER DEMENT: Steve, this is John. I
21 suspect it will be exactly what we're doing and
22 that's reviewing a, a sample of each CMC's

1 reports and recommendations. I don't know if
2 that helped.
3 CHAIR MARKOWITZ: Yes. So, the
4 program would identify some expert resource to
5 review a sample of claims and look specifically
6 at the issue of, of the content of how good the
7 CMC evaluation is.
8 MEMBER DEMENT: That would be the most
9 appropriate way to do it, and that will require
10 some resources to get that done.
11 CHAIR MARKOWITZ: Is it adequate to
12 have the, a single person who is the program
13 medical director do that, which is the way it's
14 set up now? Or is it, would it, should it be a
15 resource that has a little more distance from the
16 program, or maybe a different set of skills?
17 I don't have a predetermined answer to
18 that. I'm just trying to tease out elements
19 that, of, you know, potential advice.
20 (No audible response.)
21 CHAIR MARKOWITZ: I mean, should there
22 be a different contractor, a much smaller

1 contract, but different contractor that, that
2 looking specifically at the issue of, of the
3 quality and consistency of CMC reports?
4 MEMBER DEMENT: You know, I think
5 there should be some sort of peer review. And,
6 peer review should be outside individuals who
7 have the expertise and speciality to review the
8 cases.
9 I think, you know, I think some level
10 of peer review is needed.
11 MEMBER BERENJI: This is Mani Berenji.
12 I agree with John, there needs to be some sort of
13 independent entity that doesn't have any sort of,
14 I wouldn't call it biases but can maintain that
15 neutral stance.
16 CHAIR MARKOWITZ: But the, why can't,
17 again, I'm asking questions to try to tease out
18 the issues.
19 Why wouldn't if you had all that
20 expertise in-house, say in the medical director,
21 is there any built in conflict of interest? Is
22 there any built in problem with having that

1 person do it? Or what's the rationale for having
2 an independent entity do that?
3 MEMBER GOLDMAN: Well, this is Rose. I
4 think there is I mean, two situations. I mean,
5 if you look at a lot, most programs or even a
6 hospital, you have your internal quality control.
7 And, you do all of those things, right, in a
8 hospital?
9 And, then you do have at certain
10 points in time, an outside agency come, you know,
11 the, to now inspect and see that you're doing the
12 right thing.
13 So, that's a model that is out there
14 and also for educational programs the same thing
15 is true.
16 I don't know if that applies to this
17 type of work and assessment but it is certainly a
18 model that's out there in at least those two
19 realms.
20 MEMBER REDLICH: This is Carrie
21 Redlich. I agree that I think it would be in
22 everyone's interest to have an external group

1 review the quality.
2 You know, and I think we found that in
3 a number of case, we agree with the decision
4 making but I think it's, it just leaves the
5 Department of Labor up for criticism if it finds
6 that it, that they, you know, agree. It, you
7 know, provides more objectivity if it's an
8 external group.
9 MEMBER GOLDMAN: I think you need
10 both. And, I think we need to see the particular
11 criteria and since there was greater concerns
12 about problems with the causality approach, then
13 maybe that would be something more specific that
14 would be looked into in terms of what was the
15 process for determining causality or exacerbation
16 then.
17 And, if that was an area that was
18 particularly problematic, then maybe there would
19 be even greater focus on, on that. For the
20 external, if there was an external organization.
21 CHAIR MARKOWITZ: I do think, you
22 know, from an occupational medicine point of

1 view, Steve Markowitz, that to expect a single
2 individual to be, have a broad enough set of
3 knowledge to cover with all the areas encompassed
4 by the program, is stretching it.
5 That, you know, generally within
6 occupational medicine we occupy niches. And,
7 I'll be frank, I'm not very good at impairment.
8 And, so you wouldn't want me to be the person who
9 judged the quality of impairment ratings.
10 And, in that sense, given the limited
11 resources in-house at the Department, then one
12 advantage to an external entity is that they
13 could draw on different experts who could look at
14 specific issues. Say, beryllium. Say, cancer.
15 Say, impairment. You know, causation, et cetera.
16 MEMBER GOLDMAN: So, this is Rose
17 again. Is it only one person who does all the
18 quality control, and is that from the contractor
19 or from the Department of Labor?
20 CHAIR MARKOWITZ: Well, the, let me
21 give you, this is Steve Markowitz, a partial
22 answer and Ms. Leiton can correct me.

1 There are two levels. The contractor
2 does its own quality assessment and what we've
3 looked at on the PowerPoint is some of the
4 elements of the contract from Department of
5 Labor, the requirements of the contractor. We
6 don't know exactly what the contractor does or
7 what the performance level is. So, that's one
8 set.
9 The second is within the program,
10 there's a medical director who on a quarterly
11 basis, looks at a certain number of I think it's
12 50, 40 or 50 claims of different types, from
13 different locations, and then makes that
14 assessment.
15 And that was my summary earlier in the
16 call where I said that, you know, 25 percent of
17 the impairment evaluations he judged to be
18 needing correction. You know, 1 percent of the
19 causation evaluations and, you know, whatever.
20 So, it's those two separate
21 activities. The --
22 MS. LEITON: So, this is Rachel.

1 CHAIR MARKOWITZ: I'm sorry.
2 MS. LEITON: Is it okay if I jump in?
3 CHAIR MARKOWITZ: Sure.
4 MS. LEITON: So, we do have, so the QC
5 process for the contractors is they have to QC
6 just about everything. So, you're talking the
7 2,500 cases that go to CMC are being looked at.
8 That 5 percent's related to that, I believe.
9 The 50 cases that doctor, that our
10 medical director reviews every quarter are 50
11 cases and so, I mean, he gets different kinds of
12 cases in each set.
13 Impairment is always going to be
14 something that is a little bit more, well, it's
15 subjective but there's a lot of detail involved
16 in that. And, some of those affect the outcome
17 and some of those that he finds don't necessarily
18 affect the outcome but could have been done
19 slightly differently.
20 That being said, whenever a CMC report
21 goes to our claims examiners, they review it also
22 for thoroughness and for, to determine whether or

1 not it's answering the questions that we'd asked.
2 They'll go back for follow up. It won't pay a
3 bill if the report doesn't contain it needs to
4 contain.
5 Those are all done at the claims
6 examiner level. Now granted, they're not doctors
7 but they do know what they're looking for in
8 reports.
9 So, there is another layer in and of
10 itself right there to determine whether or not
11 the report is at least meeting the requirements
12 that we need it to meet for the Department to
13 move forward with a decision on the case.
14 So, those would be right now the
15 levels of review that it undergoes outside of
16 whatever internal processes they have in the
17 contract.
18 MEMBER MIKULSKI: This is Marek
19 Mikulski. Very briefly, do we actually know, and
20 I don't think I've heard an answer to that,
21 whether those 25 percent of the cases that
22 required improvement based on the medical

1 director's review are the same cases as the
2 contractor reviewed?
3 CHAIR MARKOWITZ: Well, you know --
4 MEMBER MIKULSKI: Is it the same pool
5 of cases rather?
6 CHAIR MARKOWITZ: Yes. I mean, this
7 is Steve Markowitz. I mean, it's a subset of the
8 CMC reports kicked out by the contractor, right?
9 So, they may kick out 2,500 a year and
10 what we're hearing is that, you know, roughly 200
11 per year are looked at by the medical director if
12 I have the numbers right.
13 MEMBER MIKULSKI: I think it's
14 extremely important to look at the criteria that
15 both are using in order to be able to recommend
16 or suggest anything else.
17 MEMBER REDLICH: Yes, and I think that
18 ones related to disability are quite different
19 than the causality.
20 And we've expressed before just the
21 concern that just the number of physicians who
22 have sort of expertise related to effective

1 causality is a relatively small, small subset of
2 the various specialists. Internists, med docs,
3 pulmonary docs.
4 CHAIR MARKOWITZ: Steve Markowitz.
5 You know, according to the contract, no more than
6 5 percent of the medical examinations should
7 result in need for clarification, correction,
8 completion, or re-performance.
9 And, yet when the medical directors
10 reviewed a large number of claims, of the
11 non-causation looks like 25 percent needed some
12 level of correction.
13 Now, maybe they're defining level of
14 correction differently. I don't know but that
15 those are highly discrepant percentages.
16 MEMBER FRIEDMAN-JIMENEZ: This is
17 George Friedman-Jimenez.
18 Assessing causation is quite different
19 from assessing impairment. There's a lot of
20 criteria and clinical practice guidelines for
21 impairment assessment. There are really no good
22 guidelines for causation assessment that make any

1 scientific sense.
2 It's something that requires a great
3 deal of interdisciplinary understanding of the
4 exposure assessment, epidemiology, biostatistics,
5 and it's not easy to assess whether it's right or
6 wrong.
7 And, so it seems to me that they're
8 apples and oranges in that 1 percent and the 25
9 percent can't really be compared.
10 But I think there is a cause for
11 concern about how do we assess the quality of the
12 causation evaluation. And that evaluation I
13 think maybe should be done by a group that
14 includes expertise in industrial hygiene, in
15 epidemiology, in clinical occupational medicine.
16 And, I don't know the medical
17 director. I don't know what his skill set is in
18 terms of those disciplines but I think this is
19 worth looking into more.
20 CHAIR MARKOWITZ: Other thoughts,
21 comments?
22 (No audible response.)

1 CHAIR MARKOWITZ: So, if we could just
2 spend, we've got 25 minutes so we've got to save
3 a couple, a few minutes for Dr. Dement's
4 recommendation, and a couple minutes on
5 discussing the next board meeting. And, Dr.
6 Mikulski, you need a couple minutes on
7 Parkinson's?
8 MEMBER MIKULSKI: Sure. I can give a
9 brief update.
10 CHAIR MARKOWITZ: Okay. So, then
11 let's spend just a few minutes then on industrial
12 hygiene evaluation because it's different, it's
13 different --
14 MEMBER REDLICH: This is Carrie
15 Redlich.
16 CHAIR MARKOWITZ: Yes.
17 MEMBER REDLICH: Can we just go back
18 to one second? I do think that with the
19 causation, I think we just have to remember that
20 this isn't perfect science. We're dealing with a
21 standard that is, you know, is it a contributing
22 cause? It's not, so I think there is some

1 judgment issues.
2 I think what we're looking to identify is if
3 there are really sort of major or gross issues.
4 Because I think there are some where they can be
5 a judgment call.
6 MEMBER FRIEDMAN-JIMENEZ: Absolutely,
7 I agree. But let me give you an example.
8 MEMBER REDLICH: And, also practical
9 issues of administering a compensation system
10 where --
11 MEMBER FRIEDMAN-JIMENEZ: Yes.
12 MEMBER REDLICH: -- you know, you end
13 up making decisions based on the available
14 information.
15 MEMBER FRIEDMAN-JIMENEZ: Right, I
16 understand.
17 So, let me give you an example of what
18 I'm talking about. When you have, some of the
19 cases that we've reviewed, there seem to be a
20 great deal of discrepancy in what the patient
21 thought they were exposed to, and what the CMC or
22 the treating physician said they were exposed to.

1 So, determination of exposure is one
2 area where, that we can look at the quality of
3 the, the decision making in the -- and that's
4 part of the causation.
5 The causation judgment, and I'll call
6 it a judgment, requires confirming the disease,
7 how well was the disease confirmed. It requires
8 confirming exposure, how well was the exposure
9 confirmed, or how close is it to reality do we
10 think.
11 And, then it requires the general
12 causation literature, how good is the evidence
13 that this particular exposure can cause the
14 disease? And, that's an epidemiologic exercise.
15 And, these are three different
16 processes that we may be able to assess one at a
17 time without really having to do the whole
18 causation judgment.
19 But I'm not saying that there should
20 be criteria. In fact, I'm more and more
21 believing that there can't be good criteria to
22 determine causation. That it is always a matter

1 of judgment and there seems to be some
2 consistency in the biostatistical literature and
3 the philosophy literature that that's true.
4 So, I'm not proposing that we try and
5 nail down an exact scientific causation but that
6 we look at how well the exposure of record
7 reflects the likely exposure, and how well the
8 disease diagnosis was made, and how well the
9 epidemiologic links were evaluated. Is it likely
10 to be a confounded association or a real
11 association based on the published epidemiology.
12 So, these are things that I think we
13 could assess, or that a committee could assess
14 but it may be difficult for one individual to, to
15 do all of those assessments on multiple cases.
16 So, maybe that's why the medical
17 director didn't call a large number of
18 questionable judgments.
19 CHAIR MARKOWITZ: So, clearly we're
20 going to have to do some work I think, some more
21 thinking out loud as a working group before the
22 next meeting. If perhaps we could come up with

1 an actual recommendation by the next meeting that
2 would be good.
3 But we also need to address industrial
4 hygiene. If you just go to the next slide. No,
5 actually we're on the, I'm looking at the agenda
6 on the WebEx. Could you go back to my PowerPoint
7 for a second?
8 So, the, and you go to the last slide.
9 Keep going.
10 Okay, so and this is a response from
11 the Department on quality assessment industrial
12 hygiene and I mentioned it before.
13 The contractor, the manager reviews
14 each report and then sends it up to the national
15 office who reviews it and approves it. So, it's
16 a different process than what we've been talking
17 about with the, with the MV.
18 And we don't, I don't have the
19 industrial hygiene. I don't think we were
20 provided with a contract to know, we would
21 request it though, to know about the comparable
22 kind of performance metrics that we see in the

1 QTC contract.
2 But is there any, because we need a
3 little bit more information on the industrial
4 hygiene side. But looking back on the claims
5 that we've looked at on industrial hygiene, would
6 we need to think about at least, what a, whether
7 their current process requires any change on the
8 quality assessment.
9 I should say the consistency doesn't
10 appear to be the problem with the industrial
11 hygiene reports.
12 (Laughter.)
13 MEMBER REDLICH: John has made some
14 suggestions.
15 CHAIR MARKOWITZ: Yes.
16 MEMBER DEMENT: Well, this is John.
17 You know, there are based on this
18 response there are certainly multiple levels of
19 review of the, the IH assessment.
20 You know, these assessments are in
21 many ways very similar to the CMC assessment, so
22 the causal link. It's highly dependent on the

1 experience and knowledge base of the industrial
2 hygienist doing it.
3 And, you know, I think some level of
4 peer review of that you know, is, should be
5 designed into the program as well. I'm not sure
6 this just passing it up the line through the
7 chain of command is, is that necessarily that
8 type of peer review.
9 MEMBER SILVER: This is Ken Silver.
10 I've been struck by the remarkable consistency of
11 the cited sources. I have not seen a lot of
12 specific gray literature, NIOSH HHEs, to reason
13 by analogy or focus research studies from
14 industrial hygiene journals cited. It seems to
15 be the same handful of textbooks that come up
16 again and again.
17 So, while consistency is one of DOL's
18 criteria, it may be compromising the quality of
19 this work.
20 MEMBER DEMENT: I agree. I don't
21 think there's a lot of necessarily original
22 review of the older or contemporary literature in

1 the process of putting together many of these IH
2 reports.
3 And, I have to say and I have reviewed
4 a few of them that I thought were done very well.
5 They did in fact, like, go to the literature and
6 look for information on exposure that was in,
7 that was at least published.
8 So, I, you know, I think early on I
9 was a big advocate for more IH review of cases,
10 and I still am.
11 Unfortunately, I think the, you know,
12 I'm feeling as I'm going through these more in
13 detail that it, in some cases I'm not sure it's
14 really helping. It's actually hurting as opposed
15 to helping the case.
16 CHAIR MARKOWITZ: This is Steve
17 Markowitz.
18 You know, one aspect of this is
19 looking at it prospectively. If the OHQ is
20 modified and provides more useful information,
21 and if a sufficient number of industrial hygiene
22 interviews are done and provides information,

1 then it's possible for the industrial hygiene
2 evaluation to have well, first of all they'd have
3 different kinds of, and probably better
4 information to depend upon, and then we would see
5 less consistency in those reports, and more kind
6 of well, thought really, go into, you know, the
7 level, the likely level of exposure to the
8 various agents.
9 Which it's hard for them to do now
10 because frankly, the individual information they
11 give is so limited. So, it may be that looking
12 ahead that quality assessment program could,
13 could look at those new tools or new and improved
14 tools and how useful they are.
15 MEMBER REDLICH: This is Carrie
16 Redlich. I mean, this is speaking only
17 concerning the occupational pulmonary cases, but
18 those are a good number of them.
19 I feel that this attempt to provide
20 greater and greater precision is, is not
21 necessarily improving the overall accuracy.
22 And, your point earlier that to sort

1 of, the number of exposures that actually cause
2 occupational lung diseases is relatively small.
3 The number of diseases is relatively small.
4 And, so they're, you know, some of
5 these go on and on about relatively esoteric
6 exposures that, you know, where what's needed is
7 to focus on the few biggies, you know, asbestos
8 and silica and metal dust.
9 So, I think that narrowing it to, and
10 I understand that for other diseases and I don't
11 mean to overly narrow things, but especially
12 depending on what the condition is, it seems that
13 this desire for greater precision is where some
14 of the conclusions that sort of defy common
15 sense, where that ended up. And, it was I think
16 putting both the exposure and the potential
17 diseases together.
18 And it's just sort of the SEM that has
19 all these, I mean, I see more occupational cases
20 then probably very few other physicians in the
21 United States. And, so much of what's in the SEM
22 is not anything that's on either the exposure or

1 the disease side. Or so rare and unusual and is
2 so limited literature on.
3 So, I feel that sometimes, and I don't
4 know how to stop that from happening but that to
5 me what was most helpful in almost every single
6 case was the questionnaire. Not to, you know,
7 devalue the SEM and the like. But the
8 descriptive information on the questionnaire, and
9 I think that point's been made before.
10 MEMBER DEMENT: This is John. I feel
11 like --
12 MEMBER REDLICH: And, looking at this,
13 and I think we should give some more thought in
14 terms of, and I think we do have and maybe if we
15 just tally it up from the cases we've reviewed,
16 what would be the, a way to fix the issue we
17 found.
18 MEMBER DEMENT: I agree. This is
19 John. I agree.
20 In some ways, I think the industrial
21 hygienists have been constrained by one, just
22 having what's available in the file itself, which

1 in some cases is an occupation history that
2 certainly have proved, could probably actually
3 have been administered in a way that enhanced
4 information on exposure.
5 So, you know, it seems like the IH
6 assessments have I don't know, they've, in some
7 ways they've just become pretty rote and routine.
8 And, you know, if it's '87 to '95, pre-1985, '87
9 is high, then medium, then none, incidental.
10 So I'm not sure that, I'm not sure
11 it's really helping in most cases. And, actually
12 I saw in some cases where this statement about
13 low exposures and no exposure post-1995, was used
14 by the CMCs to ignore the possibility of causal
15 exposures in that time frame.
16 So, it's in some ways it's not
17 helping. It's not helping to inform this disease
18 or in adjudicating the case.
19 They need their proof. And, hopefully
20 the access to workers and access to a better OHQ
21 will improve the process.
22 CHAIR MARKOWITZ: Okay, so we, this is

1 Steve Markowitz. We need to close this
2 discussion. Very useful, and then move on to the
3 recommendation that Dr. Dement was drafting.
4 (Pause.)
5 MEMBER DEMENT: Hi Kevin, did you get
6 a, get that email in the draft? Can you bring
7 that up?
8 MR. BIRD: Yes, Carrie and Missy, you
9 have that right, I forwarded it to you.
10 (Pause.)
11 MEMBER DEMENT: This is John. I,
12 after our discussion drafted this for
13 consideration of the board for, this for a
14 request for information that is judicial claims
15 to evaluate the process that was elaborated on,
16 and the response to our recommendation concerning
17 post-1995 exposures.
18 And, basically the essence of it is we
19 would like to look at, and I'm saying 10 claims
20 that's to me a lot, that having first employment
21 at a DOE covered site after 1995.
22 I'd like to list certain diseases that

1 we know was a common exposure and a common
2 outcome at the DOE sites. And, so I've suggested
3 the four that you see here.
4 And, the claim was denied because of
5 lack of a causal connection as submission
6 information. So, limited exposures to the
7 outcome.
8 And, I also again this request that we
9 have at least some rudimentary index in these
10 claims that are sent to us on a PDF, that will
11 allow us to go to documents, the key documents
12 such as we saw in our review of some claims with
13 the claims examiners on a telecon.
14 There clearly is an index. We'd like
15 to see it included in the file.
16 (Pause.)
17 CHAIR MARKOWITZ: So, Steve Markowitz.
18 So, Item No. 3, these are negative causation
19 claims, right?
20 MEMBER DEMENT: Yes.
21 CHAIR MARKOWITZ: I think the DOL, you
22 know, has their categories of reasons for denial

1 and I think negative causation is --
2 (Simultaneous speaking.)
3 MEMBER DEMENT: Yes, maybe that --
4 CHAIR MARKOWITZ: -- addressed there.
5 (Simultaneous speaking.)
6 MEMBER DEMENT: -- needs to be stuck
7 in there.
8 CHAIR MARKOWITZ: Well, no, I think
9 it's, no, I think it's _ well, yes, it does
10 because another category is insufficient medical
11 information. So, medical evidence. So that
12 could be confused with that. So, we should
13 probably just modify it to use the negative
14 causation.
15 MEMBER DEMENT: Now, why don't we just
16 put it in there the claim was denied because of
17 negative causation?
18 CHAIR MARKOWITZ: Yes, yes. I don't
19 think there are going to be many claims for, good
20 claims for asbestosis with first exposure after
21 1995.
22 MEMBER DEMENT: Not likely.

1 CHAIR MARKOWITZ: So that it would be
2 good to know, it would be good that there aren't
3 too many asbestosis cases.
4 (Laughter.)
5 MEMBER DEMENT: Well, you know, we
6 could target something else if it's appropriate.
7 I thought COPD will probably be a likely one to
8 look at, maybe even asthma.
9 But if there is at least say a leak
10 with a likely lower level of exposure in
11 asbestosis or silicosis.
12 (Pause.)
13 CHAIR MARKOWITZ: Yes. Other
14 comments?
15 (No audible response.)
16 CHAIR MARKOWITZ: Okay, so then the,
17 this is a recommendation or a request. I think
18 we should probably vote on it.
19 I second this proposal. Are there,
20 the floor is open for discussion. Any comments?
21 Friendly amendments?
22 (No audible response.)

1 CHAIR MARKOWITZ: Okay, so we're
2 looking the proposal that's been modified, Item
3 No. 3 at the end conditions claimed, and what was
4 the phrase, John, that we, you added?
5 MEMBER DEMENT: Had their claim denied
6 due to negative causation.
7 CHAIR MARKOWITZ: Right, okay. Okay,
8 so any comments?
9 (No audible response.)
10 CHAIR MARKOWITZ: Okay, so I think we
11 need to do a vote.
12 MR. CHANCE: Okay, you ready?
13 CHAIR MARKOWITZ: We are.
14 MR. CHANCE: All right.
15 MR. CHANCE: Dr. Berenji?
16 MEMBER BERENJI: Yes.
17 MR. CHANCE: Dr. Dement?
18 MEMBER DEMENT: Yes.
19 MR. CHANCE: Mr. Domina?
20 MEMBER DOMINA: Yes.
21 MR. CHANCE: Dr. Jimenez?
22 MEMBER FRIEDMAN-JIMENEZ

1 GEORGE: Yes.
2 MR. CHANCE: Dr. Goldman?
3 MEMBER GOLDMAN: Yes.
4 MR. CHANCE: Mr. Mahs? I think he's
5 gone. Dr. Markowitz?
6 CHAIR MARKOWITZ: Yes.
7 MR. CHANCE: Dr. Mikulski?
8 MEMBER MIKULSKI: Yes.
9 MR. CHANCE: Dr. Redlich?
10 MEMBER REDLICH: Yes
11 MR. CHANCE: Dr. Silver?
12 MEMBER SILVER: Yes, my phone was on
13 mute.
14 MR. CHANCE: And Mr. Tebay?
15 MEMBER TEBAY: Yes.
16 MR. CHANCE: All right.
17 CHAIR MARKOWITZ: Okay, thank you.
18 MR. CHANCE: All right.
19 CHAIR MARKOWITZ: Dr. Mikulski, you
20 want to give us a very brief update on
21 Parkinson's?
22 MEMBER MIKULSKI: Yes, absolutely, I

1 thank you so very much. I don't have a
2 PowerPoint this time but maybe this is good in
3 the interest of time.
4 Just very briefly. So we've had a
5 chance to provide the board members with a, with
6 a short write up at our last in-person meeting.
7 This write up covers topics and
8 provides answers to at least some of the
9 questions that the DOL has requested of the board
10 in terms of definitions: clinical,
11 symptomatology, as well as disease classification
12 coding for Parkinsonism and Parkinson's.
13 We've also touched upon the main risk
14 factors associated with the increased risk for
15 both Parkinsonism and Parkinson's, and I feel
16 fairly confident that we have done a fairly
17 complete review of the literature research
18 studies on the topic.
19 As we are moving ahead in this process
20 of formulating the final recommendations for the
21 Department of Labor, we've also reviewed a
22 handful of Parkinson's accepted and denied

1 claims, which has provided some very interesting
2 information in terms of things that are in
3 common, as well as discrepancies in a way that,
4 that this disease exposure based claims are being
5 reviewed.
6 I don't want to go into any details
7 but it seems as at least in terms of the accepted
8 cases, what really provides the basis for a
9 decision in favor of the claimant is a very
10 well-rationalized review, medical review of both
11 the disease and the disease exposure links
12 existing in the SEM.
13 In other words, for those with
14 accepted claims, the SEM provides with the
15 disease exposure link for their particular jobs
16 held during the DOE employment.
17 On the contrary, with the denied
18 cases, most of these denied cases lack that
19 information or, or the primary care physician or
20 a neurologist out of the house was not able to
21 provide a fully detailed review of work history,
22 as well as provide a well-rationalized argument

1 in favor of accepting the claim.
2 One might argue whether a mechanic is
3 more likely to be exposed to manganese than a
4 janitor and again, the devil is in the details.
5 But I think what this provided is, what this
6 review provided will also be helpful in making
7 the final recommendations.
8 On behalf of the working group I'm
9 hoping that we will be able, I'm planning on the,
10 on being able to present the final
11 recommendations at our next in-person meetings.
12 If there is any opportunity, or if any
13 board members would feel like the document that
14 we provided previously needs any edits, please
15 contact us. You have our email information,
16 address information.
17 And, let me stop it here.
18 CHAIR MARKOWITZ: Great. Any
19 comments?
20 (No audible response.)
21 CHAIR MARKOWITZ: Okay --
22 MEMBER REDLICH: Did you send that out

1 again? Is that possible to circulate it again?
2 I think I've got a paper copy of it, I'm not sure
3 I had an electronic version of it.
4 MEMBER MIKULSKI: Should I send it --
5 MS. RHOADS: It's actually posted
6 online. It's posted online at the last meeting,
7 I think.
8 MEMBER REDLICH: Oh, okay.
9 CHAIR MARKOWITZ: Why don't you send
10 it to Carrie Rhoads and then she can send it
11 around?
12 MEMBER MIKULSKI: Sure. I will send
13 the most recent version.
14 CHAIR MARKOWITZ: Okay, thank you.
15 I think the end of the board's term in
16 the mid-summer provides a useful deadline for us
17 closing out some of the issues that we, this
18 board has dealt with, so that's a helpful
19 timetable.
20 So, this is the last item. We're a
21 minute late now but, which is the next meeting.
22 So, I'm going to ask Ms. Rhoads to

1 send out some dates. I think we're going to look
2 at the last two weeks of April in particular.
3 And part of the timing of that because
4 we always have trouble with scheduling, but is
5 that in the event that we need a telephone
6 meeting to close out certain issues of the board
7 prior to mid-July, that still gives us the
8 necessary six weeks lead time to publish in the
9 Federal Register the notice of a telephone
10 meeting.
11 So, would be reluctant to go much into
12 May, so that's why we'll be looking that last two
13 weeks of April in particular.
14 As far as locations, so we've been
15 going in order, rank order by the most number of
16 cases and claims, and Ms. Rhoads has provided the
17 data for that, and the next place to go I'm sorry
18 to say, is Las Vegas because that's where the
19 Nevada Test Site is. It's got 20 percent more
20 cases and claims than the next highest, which is
21 Portsmouth.
22 So, although I'm told the Nevada Test

1 Site would, which we'll get a tour of, is very
2 interesting so that's nice. So, that's sort of
3 the target location.
4 Any questions about this?
5 MEMBER DOMINA: Hey, this is Kirk
6 Domina. Hey, you know, if we could have this
7 meeting the third full week of April, April 22
8 and 23, the Advisory Board on Radiation and
9 Worker Health is going to meet in Hanford. And,
10 so that's a little bit of a conflict for us, and
11 so, you know, if we could stay away from that, it
12 would be greatly appreciated.
13 CHAIR MARKOWITZ: That's the 22nd and
14 23rd?
15 MEMBER DOMINA: That is correct.
16 CHAIR MARKOWITZ: Okay, okay. Well,
17 good, that's good to know.
18 Okay, so that's it pretty much for our
19 business. Any closing comments or questions?
20 I'm going to be sending around --
21 MEMBER REDLICH: This is Carrie
22 Redlich. I know it's super late. Can I just set

1 up one quick thing?
2 It's just about fixing small things
3 with the SEM. I forget what that is but I bring
4 it up because we last time meeting, we identified
5 two issues. One that fibrosis is not linked with
6 asbestos or pulmonary fibrosis. I mean, there
7 were two common things that accounted for a large
8 number of the decision making that's just sort of
9 defied reason.
10 And, the other was that sarcoid is not
11 linked with beryllium, so multiple times someone
12 was asked, you know, the question of an exposure
13 link with sarcoid, which is not possible.
14 And, I did play yesterday and the day
15 before with the SEM again to see if this had been
16 changed whether, you know, pulmonary fibrosis was
17 in there, was it linked to asbestos. And, it
18 currently is only to silica because of coal
19 workers and mass of fibrosis.
20 So, this seems like a easy, fixable
21 thing that someone could do. And I was just
22 raising what is the process and I don't, maybe

1 this could just get passed on?
2 CHAIR MARKOWITZ: Ms. Leiton, what do
3 you think? What's your advice on this?
4 MEMBER REDLICH: Just so we know what,
5 how to enable this to happen.
6 MS. RHOADS: Rachel had to leave so
7 why don't you send me an email about it and then
8 I will ask her.
9 MEMBER REDLICH: Because I think I'm
10 happy to send an email, just be nice if we could
11 do whatever steps are needed to fix it.
12 MS. RHOADS: Sure.
13 MEMBER REDLICH: I was sort of hoping
14 it would have happened, but it hasn't.
15 MS. RHOADS: Yes.
16 CHAIR MARKOWITZ: Yes.
17 MS. RHOADS: I'll pass it on to her.
18 MEMBER REDLICH: Okay. Thank you.
19 CHAIR MARKOWITZ: Okay, thanks.
20 So, I'll be in touch about the working
21 groups that we need, the work that needs to get
22 done, and we're going to have form a new one

1 around this quality assessment but we've started
2 with a really good conversation and I think we
3 need to make some requests for information from
4 DOL, and but also then continue to talk through
5 improvements in the quality assessment.
6 Any closing comments?
7 (No audible response.)
8 CHAIR MARKOWITZ: So I don't know
9 whether Mr. Chance, you have anything? I mean,
10 just thank everybody for your attention, for your
11 preparatory work, for the willingness to
12 entertain some documents that were sent around
13 more or less at the last minute, and look forward
14 to getting some more work done.
15 Mr. Chance, any closing, anything else
16 you need to say?
17 MS. RHOADS: No. He had to step out
18 as well. We don't have anything else.
19 (Laughter.)
20 MS. RHOADS: You're good.
21 CHAIR MARKOWITZ: Okay. Bye now.
22 MS. RHOADS: Meeting is adjourned.

1 Bye-bye, everybody.
2 (Whereupon, the above-entitled matter
3 went off the record at 4:36 p.m.)
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