

U.S. DEPARTMENT OF LABOR

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ADVISORY BOARD ON TOXIC SUBSTANCES  
AND WORKER HEALTH

+ + + + +

MEETING

+ + + + +

WEDNESDAY  
APRIL 24, 2019

+ + + + +

The Board convened in the Lamar Ballroom at the Augusta Marriott at the Convention Center located at 2 Tenth Street, Augusta, Georgia, at 8:30 a.m. Eastern Daylight Time, Steven Markowitz, Chair, presiding.

MEMBERS

SCIENTIFIC COMMUNITY

JOHN DEMENT  
GEORGE FRIEDMAN-JIMENEZ  
MAREK MIKULSKI  
KENNETH SILVER

MEDICAL COMMUNITY

MANIJEH BERENJI  
STEVEN MARKOWITZ, Chair  
CARRIE REDLICH

CLAIMANT COMMUNITY

KIRK DOMINA  
RON MAHS  
DURONDA POPE  
CALIN TEBAY

DESIGNATED FEDERAL OFFICIAL

DOUG FITZGERALD

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

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

2 MR. FITZGERALD: Good morning  
3 everyone. My name is Douglas Fitzgerald and I  
4 would like to welcome you to today's meeting of  
5 the Department of Labor's Advisory Board on Toxic  
6 Substances and Worker Health. I'm the Board's  
7 Designated Federal Officer or DFO.

8 Before we begin, I'd like to go over  
9 some general housekeeping items so to make sure  
10 everyone's visit today is safe and comfortable for  
11 the next couple of days.

12 First, restrooms are located to your  
13 left down the hall. There's also a restroom  
14 downstairs in the lobby area. In case of emergency  
15 or if an alarm sounds, please follow the exits that  
16 are to your left, to your right, as well as to the  
17 back of the room and exit the building.

18 I'd like to express my appreciation for  
19 the work of the Board Members in preparing for this  
20 public meeting and for their forthcoming  
21 deliberations. I also wish to thank my colleagues  
22 at the Department of Labor for all their efforts

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1 in preparing for today's meeting, particularly  
2 Carrie Rhoads and our Committee staff; the  
3 Alternate DFO who makes this job so much easier  
4 for us, as well as our SIDEM contract staff who  
5 also do a fantastic job in arranging everyone's  
6 travel, preparing briefing books and running these  
7 meetings again.

8 As a DFO, I serve as the liaison between  
9 the Department and the Board. I'm responsible for  
10 approving meeting agendas and for opening and  
11 adjourning meetings while ensuring all conditions  
12 of the Federal Advisory Act are met regarding  
13 operations of the Board.

14 I'm also responsible for making the  
15 Board's deliberations fall within the parameters  
16 outlined in its enabling statute and its charter.  
17 Within that context, I work closely with the Board's  
18 Chair, Dr. Markowitz, and OWCP to ensure that the  
19 Board, as an advisory body to the Secretary, is  
20 fulfilling the mandate to advise and is addressing  
21 those issues of highest priority and appraisalment  
22 for the Secretary of Labor who is ultimately

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1 responsible for the administration of the Energy  
2 Employees Occupational Illness Compensation  
3 Program.

4 CHAIR MARKOWITZ: This might work a  
5 little better.

6 MR. FITZGERALD: Maybe, okay. All  
7 right, I just got the Chairman's microphone and  
8 maybe this will work a little better.

9 So within the context, I work with the  
10 Board's Chair, Dr. Markowitz, and OWCP to ensure  
11 that the Board, as an advisory body to the  
12 Secretary, is fulfilling that mandate to advise,  
13 and is addressing those issues of highest priority  
14 and of greatest benefit to the Secretary of Labor  
15 who is ultimately responsible for the  
16 administration of the Energy Employees  
17 Occupational Illness Compensation Program.

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

21 Regarding today's meeting, we have a  
22 full agenda for the next couple of days, and you

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1 should note that the agenda times are approximate.

2 So we'll try as best as we can to adhere to that  
3 timeframe, but we may not be able to actually meet  
4 exact times that the agenda lays out.

5 Copies of all meeting materials and  
6 public comments are or will be available on the  
7 Board's website under the heading Meetings. The  
8 Board's website, I think everyone can find that  
9 easily if you just go to the Department of Labor,  
10 dol.gov, and go to OWCP, you'll find the Advisory  
11 Board's website fairly easily.

12 There you can find a page that's  
13 dedicated to this week's meeting. It contains all  
14 materials submitted to us in advance, and you'll  
15 find the agenda for today's meeting as well as  
16 instructions for participating remotely in both  
17 the meeting and the public comment period later  
18 this afternoon.

19 Public comments will begin at 4:30 p.m.

20 And if you have not already scheduled to speak  
21 and would like to speak, please follow the Chair's  
22 directions prior to the public comment section

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1 later this afternoon if you're participating  
2 remotely.

3 If you are present and would like to  
4 speak, please inform Carrie Rhoads, the Alternate  
5 DFO, of your interest in speaking.

6 If you are participating remotely, I  
7 want to point out that the telephone numbers and  
8 the links to the WebEx sessions are different for  
9 today and tomorrow, so please make sure you read  
10 those instructions carefully.

11 If you're joining by WebEx, please note  
12 that sessions are for viewing only and will not  
13 be interactive. Phones will also be muted during  
14 public comment period. That begins at 4:30 this  
15 afternoon.

16 The Chair will also note that the public  
17 comment period is not a question-and-answer session  
18 but rather an opportunity for the public to provide  
19 comments about their own experiences and address  
20 any of the issues that the Board is discussing  
21 today.

22 During Board discussions and prior to

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1 the public comment period, I would request that  
2 the people in the room remain silent as possible,  
3 as quiet as possible since we're recording this  
4 meeting to produce transcripts.

5 If, for any reason, the Board Members  
6 require clarification on an issue that requires  
7 participation from the public, the Board may  
8 request such information through the chair or  
9 myself.

10 The Federal Advisory Committee Act  
11 requires that minutes of this meeting be prepared  
12 to include a description of the matters discussed  
13 during the next several days and any conclusions  
14 reached by the Board.

15 As the Designated Federal Officer, I  
16 prepare the minutes and ensure that they're  
17 certified by the Board's Chair. The minutes of  
18 today's meeting will be available on the Board's  
19 website no later than 90 calendar days from today  
20 per FACA regulations. But if they're available  
21 sooner, we'll post them sooner.

22 Although formal minutes are being

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1 prepared because they're required by the FACA  
2 regulations, we'll also be publishing verbatim  
3 transcripts which are obviously more detailed in  
4 nature, and these transcripts will be available  
5 on the Board's website as soon as possible.

6 I'm looking forward to working with all  
7 of you today and hearing your discussions. This  
8 week's meeting represents like the third full  
9 meeting of the Board since November, so I'd like  
10 to acknowledge the Agency's efforts to complete  
11 all the internal FACA procedures and public notice  
12 requirements to facilitate the Board's ambitious  
13 schedule.

14 I also would like to thank the Energy  
15 Program and Director Leiton who is here with us  
16 today for being here to lend her knowledge and  
17 expertise to the Board's discussions and for  
18 providing the case-specific data that will be the  
19 substance of much of that discussion.

20 And on that point, I just want to make  
21 sure that everyone is aware that the information  
22 that has been provided to the Board Members contains

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1 a lot of personally identifiable information, and  
2 please be cognizant of that when you are having  
3 discussions and talking about these cases so that  
4 you are aware that we have to be very careful about  
5 not disclosing information that is personal and  
6 proprietary.

7 And with that, Mr. Chairman, I convene  
8 this meeting of the Advisory Board of Toxic  
9 Substances Worker Health.

10 CHAIR MARKOWITZ: Thank you and  
11 welcome. Welcome to the Board Members for coming  
12 and attending the meeting, and welcome to the public  
13 as well, including the public that might be on the  
14 phone listening to us or watching through WebEx.

15 Can you hear me in back? Okay.

16 So I want to thank Doug Fitzgerald and  
17 Carrie Rhoads and Kevin Bird for all of the support  
18 for this meeting and for our efforts in general.

19 We were going to -- we went to Savannah  
20 River Site and I want to thank DOL and DOE Greg  
21 Lewis for arranging for that excellent tour  
22 yesterday.

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1           Anyway, when we were driving there and  
2 I was driving with Carrie Rhoads, and she was  
3 following Doug Fitzgerald in the car and I said  
4 to Carrie, I said, don't worry, Doug's not going  
5 to lose you because if he lost you, then Doug would  
6 have to do all the work that you do by himself.  
7 But thank you for -- (Laughter.)

8           And thank you for the Department of  
9 Labor personnel who are here today, Ms. Leiton,  
10 Malcolm Nelson, Amanda Fallon, and if there's  
11 anybody else.

12           I think Ms. Leiton will be here  
13 throughout the day, but she won't be here tomorrow.

14           So if there are questions that the Board Members  
15 have, clarification or whatnot, we should raise  
16 them today.

17           We may have access to John Vance  
18 tomorrow. Not quite sure whether we'll need that  
19 access, but in any case, just be aware of that  
20 because it's very good to have Department of Labor  
21 officials from the program in attendance and  
22 available by phone, certainly for clarification.

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1 I just want to say that the Board  
2 received materials in the last couple of weeks,  
3 and people have made efforts to review those  
4 materials as much as possible. I suspect we  
5 haven't had a complete opportunity to review all  
6 the materials, which is just fine.

7 I want to encourage Board Members to  
8 participate in the meeting even if there's some  
9 uncertainty about what you've read, or uncertainty  
10 about your understanding about what you've read.

11 Because what we want to do is get as much  
12 clarification as we can during the meeting, so don't  
13 be shy about raising issues, asking questions or  
14 the like.

15 We're going to start with introductions  
16 with the Board Members, and then with everybody  
17 else in the room actually briefly, and then we'll  
18 move onto review of the Agenda.

19 I'm Steven Markowitz. I'm an  
20 occupational medicine physician. I'm an  
21 epidemiologist and a professor at the City  
22 University of New York, and I run the largest Former

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1 Worker medical screening program with support from  
2 the Department of Energy. Mani.

3 MEMBER BERENJI: Good morning. I'm  
4 Mani Berenji, occupational medicine physician at  
5 Boston University School of Medicine and assistant  
6 professor. Pleasure to be here.

7 MEMBER DEMENT: I'm John Dement. I'm  
8 an industrial hygienist and epidemiologist. I'm  
9 at the Duke University Medical Center. I also have  
10 participated with the Building Trades Medical  
11 Screening Program since about 1998.

12 MEMBER DOMINA: I'm Kirk Domina. I'm  
13 the Employee Health Advocate for the Hanford Atomic  
14 Metal Trades Council in Richland, Washington. I'm  
15 also a U.S. DMBU (phonetic) member. I'm an active  
16 worker. I've been out there 36 years. I guess  
17 that's it.

18 MEMBER SILVER: Ken Silver, Faculty  
19 and Environmental Health at the College of Public  
20 Health at East Tennessee State University. It  
21 feels like a lifetime ago, but I was very closely  
22 involved with Los Alamos families in advocating

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1 for the law and making sure the people who spoke  
2 out early on got paid under this program.

3 MEMBER FRIEDMAN-JIMENEZ: I'm George  
4 Friedman-Jimenez. I'm an occupational medicine  
5 physician and an epidemiologist at New York  
6 University School of Medicine, and I run the  
7 Occupational Medicine Clinic at Bellevue Hospital  
8 in New York City.

9 MEMBER POPE: Duronda Pope, United  
10 Steelworkers Emergency Response Team, but also a  
11 former worker of Rocky Flats, 25 years.

12 MEMBER TEBAY: I'm Calin Tebay. I'm  
13 the Hanford Site beryllium health advocate and the  
14 Hanford Workforce Engagement Center  
15 representative.

16 MEMBER REDLICH: I'm Carrie Redlich.  
17 I'm an occupational medicine and pulmonary  
18 physician on the faculty at Yale of Professional  
19 Medicine, and at the Medical School, and I'm  
20 director of the Yale Occupational and Environmental  
21 Medicine Program.

22 MEMBER MAHS: Ron Mahs. Approximately

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1 20 years at all three plants at Oak Ridge, and that's  
2 about it.

3 MEMBER MIKULSKI: I'm Marek Mikulski.  
4 I'm an occupational epidemiologist with the  
5 University of Iowa. I direct the Former Worker  
6 program for the former nuclear weapons workers from  
7 the State of Iowa.

8 MS. LEITON: Hi. I'm Rachel Leiton.  
9 I'm the Director of the Energy Compensation  
10 Program at the Department of Labor.

11 MS. SPLETT: I'm Gail Splett. I'm  
12 with the Department of Energy at the Hanford Site.  
13 I'm the EEOICPA program manager there.

14 MS. WHITTEN: Diane Whitten with the  
15 Hanford Atomic Metal Trades Council.

16 MS. SLAUGHTER: I'm Jenny Slaughter  
17 with United Energy Workers.

18 MS. SHAVLIN: I'm Sarah Shavlin with  
19 United Energy Workers.

20 MS. JERISON: Deb Jerison, Energy  
21 Employees Claims Assistance Project.

22 MS. BARRIE: Terrie Barrie, ANWAG.

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1 MS. VLIENER: Faye Vliener, former  
2 member of the Advisory Board on Toxic Substances  
3 and Worker Health, charter member of Cold War  
4 Patriots, and a worker advocate.

5 MR. ARTZER: I'm Josh Artzer. I'm the  
6 current chairman of the Beryllium Awareness Group  
7 out at Hanford, and also the Hanford Workforce  
8 Engagement Center Representative.

9 MS. BUTLER: I'm Debra Butler, manager  
10 of the Savannah River Resource Center.

11 MR. BALLARD: I'm Chris Ballard and I'm  
12 with Critical Nurse Staffing, the Vice-President  
13 of Regulatory Affairs.

14 MR. NELSON: Good morning. I'm  
15 Malcolm Nelson. I'm the current ombudsman for the  
16 Energy Employees Occupational Illness Compensation  
17 Program.

18 MS. FALLON: Good morning. My name is  
19 Amanda Fallon. I'm a policy analyst in the Office  
20 of the Ombudsman.

21 CHAIR MARKOWITZ: Pretty exciting  
22 agenda, I think. We're going to review the agenda.

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1       Let's just take a look at the agenda. I think  
2 members of the public had access to a copy of the  
3 agenda from outside, right? Okay.

4               So we're going to hear from Ms. Leiton  
5 regarding relevant update for Board matters and  
6 other remarks that she might like to make.

7               And then Mr. Fitzgerald will go over  
8 a few items which are written out on the agenda.

9               Then Mr. Nelson will give us a summary  
10 of the Ombudsman report.

11              And then I will just briefly go over  
12 the items, the Board items, the action items,  
13 recommendations and whatnot from our first two  
14 meetings, and the DOL responses that we've received  
15 to date.

16              Just a brief update then on the  
17 presumption for COPD. And then after lunch -- by  
18 the way, times are quite approximate because I  
19 really don't know how long conversation will go  
20 on for.

21              So after lunch we will talk about the  
22 claims we've received for COPD, and then we will

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1 hear a report from the working group on  
2 Parkinson's-related disorders.

3 We will then discuss some claims in  
4 relation to Parkinson's-related disorders. And  
5 then we end the day with a public comment period  
6 from 4:30 to 6:00 p.m.

7 Tomorrow, after an introduction, we'll  
8 have just a brief discussion. It's 45 minutes for  
9 that time, Ken, and we won't need that much time  
10 just so you know. It's just going to be a review  
11 of the issue of the request from DOL to address,  
12 really provide assistance with how to look at  
13 non-cancer outcomes of various radiological  
14 materials.

15 We're going to discuss the public  
16 comments within the Board, and then we'll have an  
17 update on the presumption for solvent-induced  
18 hearing loss, have some time to review Board  
19 functioning, operation, structure, working groups,  
20 committees and the like with ideas to improve things  
21 if needed. And then we'll discuss any new issues  
22 that arise, and then make a plan for the next

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1 meeting.

2 So are there any suggestions about this  
3 agenda? Any additions? Any items people want to  
4 add that aren't covered by the topics? Okay.

5 So I would like to welcome Ms. Rachel  
6 Leiton who's director of EEOICP. I should say  
7 welcome back.

8 MS. LEITON: Can you hear me? All  
9 right. Thank you for having me and thank you all  
10 for being here. I know that you have put a lot  
11 of time and effort into reviewing our cases and  
12 reviewing the matters before you, and I know it  
13 takes a lot of time so I do appreciate all of your  
14 efforts on behalf of our program.

15 I have been asked to cover a few things,  
16 so I'm going to do my best to do that. There was  
17 a small list of items for me to cover. I'll be around  
18 all day if there are follow-up questions or  
19 whatever, and anything you want me to come up and  
20 help clarify.

21 The first thing that I was asked to do  
22 is review the changes from the latest procedure

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1 manual chapter which is 3.0. There is a  
2 transmittal, that's Transmittal 19-01 that goes  
3 through each and every change in quite some detail,  
4 so I'm probably not going to read them all.

5 A lot of them are changes from  
6 terminology. We used to have what you call a CE-2  
7 Unit. We now don't have that. It was a unit that  
8 was -- well, it was claims examiners in the district  
9 office that worked on matters that were, on cases  
10 that were in front of the FAB that weren't related  
11 to the FAB. It gets a little bit complicated, but  
12 so there were some references to that.

13 We've made some changes to our  
14 organizational structure, and I think I've  
15 mentioned whether it's here, but we did centralize  
16 some of our processes in terms of our medical bills,  
17 our home health care, all pre-authorizations, so  
18 we created a new Branch of Medical Benefits in  
19 National Office. We cover that in 3.0.

20 I also want to mention that we're  
21 probably soon going to have a 3.1, so a lot of that's  
22 going to be related to some of the changes that

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1 were made in our regulations.

2 But I will walk through -- I'm going  
3 to give you some of the highlights. This is a  
4 19-page document, so I'm sure you guys can read  
5 anything that I don't cover here.

6 As I said, some of it's just change of  
7 terminology, rewording of certain things. The  
8 Representative Conflict of Interest Guidance  
9 really didn't change, but again, we just kind of  
10 reworded it in terms of what we consider a conflict  
11 of interest. We have had this in the procedures  
12 for quite some time, so it's not really a change.

13 There is something new in chapter 15  
14 which we added, and that is we included language  
15 regarding the evaluation of an opinion of a treating  
16 physician. And it's basically in instances where  
17 a physician submits an opinion that a toxic  
18 substance exposure was a contributory or  
19 aggravating factor in the development of claimed  
20 illness specific to the individual.

21 His or her opinion must be determined  
22 to be well-rationalized, as that phrase is defined

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1 later in this chapter, before the Part E claim can  
2 be accepted. In particular, the physician must  
3 offer an interpretation of epidemiological or  
4 medical health science data that reasonably  
5 supports the opinion presented.

6 Moreover, the CE must corroborate the  
7 factual presentation of information used in the  
8 formulation of the opinion, e.g. medical history,  
9 verified periods of covered employment, and toxic  
10 substance exposure characterization with evidence  
11 available in the case file or obtained through the  
12 application of program resources such as the SEM  
13 or referral to a medical health science expert.

14 So that is a new section. Chapter  
15 15.13, we added some language regarding the CE's  
16 responsibility when a causation opinion of an  
17 employee's physician is found to be insufficient.  
18 And that's basically -- yes --

19 CHAIR MARKOWITZ: I'm sorry, before we  
20 move on, can I just ask you a question?

21 MS. LEITON: Absolutely.

22 CHAIR MARKOWITZ: So this new language

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1 about establishing toxic substance exposure and  
2 causation -- so if you could bring that up, Kevin.

3 MS. LEITON: In the transmittal or the  
4 chapter?

5 CHAIR MARKOWITZ: It's higher up. It  
6 precedes what we're looking at on the screen.  
7 Okay, that's it. So this language, this isn't  
8 entirely new?

9 MS. LEITON: No, it's just placed in  
10 this section. So we've got it in other places  
11 pretty much saying similar things, but this puts  
12 it in the section, makes it very clear they're  
13 supposed to be evaluating for it.

14 CHAIR MARKOWITZ: So is it new that the  
15 treating physician "must offer an interpretation  
16 of epidemiologic or medical health science data  
17 in support of their opinion." Is that new, because  
18 I don't remember seeing that.

19 MS. LEITON: The language itself might  
20 be new. In practice, it's something that we've  
21 asked for in training, and in addition, when we  
22 say must, we often go back and ask for whatever

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1 information we can get from the treating doctor.

2 One of the things that we're trying to  
3 refocus claims staff on is going back to the  
4 treating physician instead of immediately going  
5 to a CMC. And so I think this section was put in  
6 so that we could kind of drive that focus.

7 Obviously, we're not going to get  
8 perfect reports all the time, so we'll do as much  
9 development as we can around that.

10 CHAIR MARKOWITZ: You know, my concern  
11 is, we've discussed this before and I'm sure you're  
12 aware of it, which is that the practicing physician  
13 who wants to be supportive of the claimant is  
14 unlikely, actually, to be versed in epidemiologic  
15 or medical health science data in support of their  
16 opinion and would probably not have the time to  
17 do the research or to provide the reference list  
18 for that opinion.

19 And I understand what the intent is.

20 Maybe in the next version instead of using must,  
21 you could soften the language somewhat so that it's  
22 suggested that that would be, maybe not an optimal

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1 approach, but to the extent possible, the treating  
2 physician should provide that kind of information.

3 But to make it compulsory is probably  
4 overly ambitious, frankly, for what the  
5 practitioner can do.

6 The other question I have is, I was  
7 trying to understand what it means that it says,  
8 "The CE must corroborate the factual presentation  
9 of information used in the formulation of the  
10 opinion." So if the physician does an occupational  
11 history and gets information about details of their  
12 exposure, and that's not -- and the CE then looks  
13 at the various sources of exposure information and  
14 doesn't fully corroborate that because frankly you  
15 have a professional who's interviewing a patient  
16 and they're getting additional information.

17 That information that the physician  
18 collects and transmits shouldn't be discounted  
19 because the claims examiner can't exactly find a  
20 replication of that somewhere else. To me, it's  
21 an additional source of information rather than  
22 something that necessarily requires compulsory

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1           corroboration. Do you understand my point?

2                       MS. LEITON: Yes, I do. Again, in  
3 this language, we're trying to get the claims  
4 examiners to review the evidence in the case file.

5           So if we have a statement of accepted facts, we've  
6 got an exposure analysis against that report. And  
7 if they have questions or issues, to go back to  
8 that treating doctor instead of immediately going  
9 to a new doctor and saying, here's what we have.

10          You've laid out two years of exposure, we have  
11 10, or whatever it might be. So that's kind of  
12 the point of this.

13                       CHAIR MARKOWITZ: Sure.

14                       MEMBER DEMENT: I don't know if this  
15 thing is on. I think what Steven's talked about  
16 with regard to giving additional information, I  
17 think we'll hear that as we go through some of these  
18 cases. Because in some instances, in my view the  
19 case could have been better developed had either  
20 an industrial hygienist or physician really gone  
21 through and taken a more detailed history of what  
22 actually the individual did at a site.

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1           In some cases, it seems that the SEM  
2 sort of pre-empted what was actually in the  
3 occupational history itself, and maybe some other  
4 pieces of information. So I think it's important  
5 that it not be so tightly bound to verification  
6 on from site records which sometimes are quite  
7 incomplete.

8           MS. LEITON: Thanks. Okay, the next  
9 section that I was going to point out is chapter  
10 15.13(b). We've added some language regarding the  
11 CE's responsibility when a causation opinion of  
12 an employee's physician is found to be  
13 insufficient.

14           In these situations, the CE is to  
15 provide the physician with any employment or  
16 scientific evidence that DEEOIC has obtained to  
17 establish an accurate factual presentation of  
18 exposure.

19           That's what I was referring to earlier  
20 is we're trying to push it back to the treating  
21 as much as we can.

22           We deleted the section about exposure

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1 after 1986 through 1995 because we really want more  
2 of a case-by-case assessment of that evidence.  
3 I believe that in the prior section it probably  
4 talked -- I unfortunately don't have the chapter  
5 in front of me -- but it talked a little bit more  
6 about the likelihood of exposure during that period  
7 of time, and we prefer that they go to an IH for  
8 those assessments.

9 The next section we just edited for  
10 clarity. The hearing loss, we edited to clarify  
11 the process by which a finding can be made that  
12 the job is equivalent to the listed job, and to  
13 communicate ways in which an IH and SEM can be used  
14 to assist in the adjudication of claims.

15 The section that is relevant here, the  
16 newest section, is after the list of job categories.

17 We basically said employees often present evidence  
18 that they were in a labor category that is the  
19 equivalent of one of those listed here.

20 When a claimant makes a claim that a  
21 job the employee performed is synonymous to one  
22 of the qualifying labor categories listed above,

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1 and the CE conducted some labor category alias  
2 search that doesn't provide assistive information,  
3 the CE can seek assistance in evaluating the claim  
4 through a referral to a SEM mailbox. Our  
5 contractors can review the mailbox and provide the  
6 claims examiner with additional information, or  
7 submission to an IH referral, so we just clarified  
8 in the hearing loss presumptions or standards.

9 We also added a section after the list  
10 of toxins. The CE can also use the SEM to identify  
11 the employee's potential exposure to one or more  
12 of the listed toxic substances. They must  
13 carefully screen the evidence to apply appropriate  
14 SEM search filters.

15 This is something that we've been going  
16 around training on. Well, we've often trained on  
17 it. But using the SEM properly, filtering through  
18 the SEM properly to come up with the widest range  
19 of exposures that we can. And the claims examiner  
20 must look at each one individually to determine  
21 what a person might have been exposed to, each labor  
22 category in the SEM and then consult with an IH

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1 if there's a question.

2 CHAIR MARKOWITZ: This is Steve  
3 Markowitz. This strikes me as an important change,  
4 actually. We've heard repeatedly that if the job  
5 title -- with regard to hearing loss -- if the job  
6 title isn't on the specific list of 22 job titles,  
7 then you can't get compensated for solvent-induced  
8 hearing loss.

9 And this clearly opens the door to  
10 equivalent job titles. It actually may even relate  
11 to the recommendation of the Board, but I'd have  
12 to go back and look at that.

13 The SEM aliases are expansive but  
14 ultimately limited, so this weighing in by the  
15 industrial hygienist becomes very important,  
16 because the industrial hygienist really can help  
17 determine whether the person likely had solvents  
18 exposure. So this strikes me as an important  
19 change.

20 I'm still curious about 10 consecutive  
21 years of exposure prior to 1990, because the Board  
22 has made a recommendation about this. And it's

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1 the 10 consecutive years -- I mean I also wonder  
2 about the 1990, but it's the 10 consecutive years.

3 Because that's a foreign notion in occupational  
4 medicine that a person has to have continuous  
5 exposure.

6 I really can't think of a condition in  
7 which we look at continuous exposure. For a  
8 chronic occupational disease, we require  
9 continuous exposure over a period of time.  
10 Aggregate exposure, cumulative, right, total of  
11 10 years, but that might have occurred over a  
12 15-year period because the person changed jobs for  
13 a few years.

14 So I'm just curious about how  
15 intentional it was, the retention of the  
16 consecutive years of exposure rather than changing  
17 consecutive to another C-word, cumulative, which  
18 would better capture I think the occupational  
19 medicine knowledge.

20 MS. LEITON: When our toxicologists,  
21 our IH's reviewed this particular standard and  
22 through the research, they actually felt or

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1 determined that this was a pretty lax standard for  
2 solvents in hearing loss and that we were being  
3 generous.

4 So, I'm not going to debate that right  
5 here with you all, but that's the understanding  
6 that I was given. In terms of whether it was  
7 intentional, it was intentional to do it at  
8 consecutive.

9 And we allowed for the combination of  
10 noise and solvents, which was a matter of some  
11 debate legally. But we were able to establish the  
12 fact that there was some contribution of solvents  
13 and noise in the -- we could match that to the  
14 standard however in terms of whether or not that's  
15 not enough or that we should expand that.

16 That's something that I've been advised  
17 by our scientists isn't currently in the literature  
18 that we've reviewed however. Obviously, we will  
19 listen to whatever you all propose.

20 CHAIR MARKOWITZ: Okay. I mean, I  
21 don't want to continue this much work. The Board  
22 isn't -- I don't think it's our role to weigh in

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1 on generosity or not, but it is our role to weigh  
2 in on how compatible the program guidelines is with  
3 current occupational medicine thinking. So that's  
4 where we're coming from.

5 MS. LEITON: Sure. Okay, where was I?  
6 Okay. Chapter 18, Eligibility Criteria for  
7 Non-Cancerous Conditions. This may be a little  
8 bit confusing. What we did here, this chapter,  
9 this section 18.5(c) has to do with beryllium  
10 sensitivity.

11 And what we did was we took out -- there  
12 was in the prior chapter, it said, "If exhaustive  
13 efforts produce little or no results, and the  
14 evidence of record contains the normal borderline  
15 LPT result along with a biopsy of the lung tissue  
16 showing the presence of granulomas, the CE may  
17 accept the claim."

18 In the new section, the new chapter,  
19 we basically took out that last section that says,  
20 "along with biopsy of the lung tissue showing the  
21 presence of granulomas, the CE may accept the  
22 claim." We're basically saying that if a doctor

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1 says that it's a false-negative and there's  
2 evidence of steroid use, we can accept beryllium  
3 sensitivity.

4 We still have the criteria for the  
5 biopsy in the next section down regarding  
6 established CBD before 1993. So the difference  
7 is that for beryllium sensitivity, the doctor can  
8 say it's a false-negative. You have steroids.  
9 Because beryllium sensitivity, we simply provide  
10 benefits for monitoring. CBD is a stricter  
11 standard, so we require that biopsy if there's a  
12 false-negative and evidence of steroid use.

13 MEMBER REDLICH: I appreciate the  
14 revisions in the language and including steroids  
15 as immunosuppressive therapy. There's a number  
16 of other agents that are used that are  
17 immunosuppressive in the treatment of chronic  
18 beryllium disease and other chronic fibrotic lung  
19 conditions such as sarcoid.

20 So in a future revision I think -- and  
21 especially with newer immunosuppressive agents,  
22 if the wording was simply steroids or other

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1 immunosuppressive medications, that would be more  
2 helpful to the physicians.

3 MS. LEITON: Okay.

4 MEMBER REDLICH: And I do appreciate  
5 because I think this is progress separate from,  
6 there are also -- it's acknowledged that the testing  
7 on lymphocytes that come from the lung from a lavage  
8 are more sensitive than peripheral blood  
9 lymphocytes. But that is rarely done now just for  
10 multiple reasons, including patient safety.

11 So the blood test using peripheral  
12 blood is not as sensitive as lavage lymphocytes.  
13 So you can still have false-negatives even without  
14 immunosuppressive therapy.

15 MS. LEITON: Okay. Thank you. The  
16 next section, Exhibit 21-4, this goes into some  
17 information about impairment ratings. Basically,  
18 we revised it to be a little more description of  
19 what we mean by activities of daily living.

20 We added a section where we basically  
21 say reported ADLs must be described in sufficient  
22 detail to allow a physician to apply the information

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1 to the assessment of whole person impairment in  
2 accordance with the AMA guides.

3 Basically, when we do impairment  
4 evaluations, not all physicians can do them, and  
5 so a claimant will go to their treating physician,  
6 request that they provide information to us, and  
7 we can then send it to a CMC.

8 So we wanted to make sure that the  
9 treating is describing those activities of daily  
10 living. That is a critical portion of impairment  
11 ratings.

12 The next section, Chapter 24 on  
13 Recommended Decisions, this is really just about  
14 formatting cover letters and what to include and  
15 what not to include in terms of it. We used to  
16 require that the amount of benefits being awarded  
17 be in the cover letter. It's not a requirement  
18 anymore because it's listed several other places  
19 in the recommended decision.

20 We also deleted the requirement for a  
21 wet signature for recommended decisions because  
22 a lot of these are being signed digitally. We do

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1 sign -- we physically have our hearing  
2 representative sign the final decision since that's  
3 the one that goes to court. But for recommended  
4 decisions and flexibility issues, we took out that  
5 signatory line.

6 We added here in Chapter 24.10(g), we  
7 included language that allows the use of letter  
8 decisions to accept additional claims for skin  
9 cancers of the same type under parties. So  
10 therefore, instead of going through a whole  
11 recommended decision process, we've already  
12 accepted skin cancer. We would just allow them  
13 to send a letter saying we're accepting more skin  
14 cancers.

15 The FAB decisions, this is what I was  
16 talking about earlier with regard to the term CE-2.

17 We no longer have these CE-2s. Since our claims  
18 have been digitalized, we have a different format  
19 for how claims examiners can review cases that are  
20 at the FAB when there are other issues at play.

21 Again, the format of the final decision  
22 was changed slightly with regard to what sections

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1 needed to be where in that final decision format.

2 And changes to the reference to CE-2s throughout  
3 a lot more of these.

4 There was a typographical error we  
5 changed in reopening. I'll skip to Chapter 29 on  
6 Ancillary Medical Services. We added a section  
7 on hearing aids just to clarify what's needed when  
8 they're billing for hearing aids.

9 And then in the Home Healthcare  
10 section, we deleted the whole Conflict of Interest  
11 section because we have it somewhere else, and we  
12 referenced the chapter that we talk about conflict  
13 of interest there.

14 Those are the highlights. If you have  
15 other questions about this Chapter 3.0, I'm happy  
16 to answer them.

17 CHAIR MARKOWITZ: I have a question.

18 By the way, do you need for the Board Members to  
19 identify themselves when we make comments?  
20 Whenever possible, okay. It's Steven Markowitz.

21 I just want to go back to Exhibit 15-4,  
22 Section 3(b), about asbestos exposure. And I've

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1 asked Kevin to find Procedure Manual 2.3 version,  
2 because that's where the language is, and it's being  
3 deleted. So we need to just look at what's being  
4 deleted.

5 So is this the transmittal document or  
6 is it -- okay. So if you could go online and look  
7 for the procedure manual 2.3.

8 MS. LEITON: It should be in archives  
9 of the procedure manual.

10 CHAIR MARKOWITZ: So let me -- I'll  
11 talk about it briefly while he's looking for it.  
12 So this section, if you remember asbestos, the way  
13 that the program approached presumption of exposure  
14 was that it looked at two periods of time, prior  
15 to 1986 and prior to 1996.

16 So you had this '86 and before, and I  
17 can't remember whether it's January 1st, 1986,  
18 December 31, 1986, and same for 1995-96. So I'm  
19 just going to use shorthand and say '86 and '95-'96.

20 But there was -- this section that's  
21 being deleted specifically refers to a presumption  
22 of asbestos exposure between 1986 through 1995.

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1           So what will be retained in 3.0, is  
2 being retained in 3.0, is the presumption that there  
3 is asbestos exposure for certain job categories  
4 prior to or through 1986.   Okay?   So the  
5 insulators, the painters, the pipefitters, the  
6 carpenters       and       the       like,       mostly  
7 construction-maintenance titles, will still be  
8 presumed to have significant asbestos exposure  
9 through 1986.

10           However, what's being deleted is any  
11 comment -- if I understand it correctly -- is any  
12 comment on what happened between 1986 and 1995.

13           And the old manual said between '86 and  
14 '95 that those same labor categories that I  
15 mentioned, you know the insulators, painters, et  
16 cetera, are presumed to have significant exposure  
17 from '86 to '95, but at low levels.

18           But I think the important thing is they  
19 were still presumed to have significant exposures  
20 through '95.   That their significant exposures  
21 continued beyond '86 through '95.

22           And that all other labor categories --

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1 I'm quoting here from the 2.3 manual, it's Exhibit  
2 15.4 -- actually, let me just hold off a moment  
3 because we're almost there. When you get there  
4 it's item 3, so you go down another page I think.

5 And you try to read through the superseded -- keep  
6 going. It's the next page. Okay, that's it.

7 So it's that Section B we're looking  
8 at which is being deleted. So it pertains to  
9 asbestos exposure between 1986 and 1995.

10 And you can see item B-1 is what I just  
11 mentioned, which is the labor categories cited  
12 above, have significant exposure but at low levels.

13 And then Item 2 is that all other labor categories  
14 are considered to have exposure to asbestos, but  
15 the extent of their exposure didn't surpass  
16 established occupational safety and health  
17 guidelines, and therefore the level of exposure  
18 is not considered significant.

19 So Item B makes partial sense because  
20 it removes the presumption that their exposure  
21 didn't surpass established occupational safety and  
22 health guidelines.

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1           However it does delete the aspect in  
2           which these other labor categories are presumed  
3           to have exposure to asbestos. That is to say the  
4           ones not on the list, but who worked at the  
5           facilities, were presumed to have exposure to  
6           asbestos.

7           I'm also concerned in Part 1 where  
8           between '86 and through '95 that the group including  
9           the painters, the millwrights, the insulators and  
10          the like are no longer presumed to have significant  
11          exposure to asbestos.

12          And this is important because when you  
13          get to the individual diseases, the asbestosis,  
14          mesothelioma and the like, and we can see for  
15          instance, we can just scroll down under asbestosis.

16          You see under Part 4(b) it says, Exposure. "The  
17          employee was employed in the job that would have  
18          brought the employee into contact with significant  
19          exposure to asbestos."

20          So I'm wondering what the thinking here  
21          is, and I'm wondering also what the practical  
22          significance or implication of removing this whole

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1 time period of presumed exposure to asbestos is?

2 MS. LEITON: I would like to get back  
3 to you. I think that there's probably rationale  
4 that maybe it's somewhere else or we have -- I need  
5 to find out, and I don't want to mis-speak on the  
6 record, so let me get back to you if you don't mind.

7 CHAIR MARKOWITZ: No, that's fine.  
8 Because what the CE is left with in terms of exposure  
9 presumption now entirely pertains just to 1986 and  
10 before. And so now the guidance, the document is  
11 silent on the period after '86, and I'm concerned  
12 that may have some important practical implications  
13 for evaluation of claims.

14 So, yes, that would be great if there's  
15 some clarification on that, and we may have further  
16 comments on that.

17 MS. LEITON: Okay.

18 CHAIR MARKOWITZ: Does any Board  
19 Member have any comments, something you want to  
20 add on this? Okay.

21 MS. LEITON: I will try to get you  
22 something before I leave.

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1 CHAIR MARKOWITZ: Yes, okay.

2 MS. LEITON: So that's 3.0. Yes?

3 MEMBER REDLICH: This is Carrie  
4 Redlich. I appreciate the changes in 3.0. Just  
5 to point out, which I think we did last time, the  
6 tables have not yet been updated to reflect some  
7 of the changes in the text or the changes that we  
8 recommended. They still include things like  
9 specific inhalation challenge testing is a way to  
10 diagnose occupational asthma which is not available  
11 in the United States.

12 So I would just suggest that a future  
13 revision to look at the tables. There are also  
14 some other, you know, they're relatively minor  
15 suggestions we had made or pointed out. I think  
16 they're more than suggestions, but just, you know,  
17 factually correct. Such as whether granulomas can  
18 be calcified in a patient with sarcoid -- excuse  
19 me, with chronic beryllium disease. And they can  
20 be calcified.

21 The current text still says that a  
22 calcified granuloma is not characteristic of CBD.

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1 And I think it would just be more medically accurate  
2 to remove that sentence.

3 MS. LEITON: There are various  
4 opinions on that, so we have looked at them. We'll  
5 look at them again.

6 MEMBER REDLICH: It was just one  
7 example. I think it's definitely improving, but  
8 it could still use additional edits.

9 MS. LEITON: Okay, noted. Thank you.

10 MEMBER REDLICH: And one of them is  
11 just a question. Recognizing that some of our  
12 suggestions have been incorporated, I was wondering  
13 how has that been transmitted to -- I realize  
14 there's a whole education process -- to the CEs  
15 and the CMCs that there have been changes, the  
16 training materials. So how often are those  
17 revised?

18 MS. LEITON: We're in the process of  
19 revising all of our training materials to update  
20 them. We have a training lead who's going through  
21 them. We were missing one for a while because one  
22 of our training leads left, and so we had a gap.

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1           But we're back to revising all the  
2 materials, the basic CE materials, making sure  
3 they're in line with the current procedures. And  
4 so that's where we are right now with that with  
5 our modules; revising and updating them.

6           MEMBER REDLICH: And I realize that's  
7 challenging. We would be happy to review the  
8 relevant training materials such as related to Part  
9 B conditions.

10           MS. LEITON: Thank you. Okay, the  
11 next section, the next part that you wanted me to  
12 talk about was the status of the December 10, 2019  
13 data and claims request. This was the one with  
14 regard to COPD and Parkinson's. We did get you  
15 some information there.

16           For the other ones, we're going to talk  
17 about using a form and getting additional  
18 information for those requests. I think Doug's  
19 going to talk about that later. If the review of  
20 the --

21           CHAIR MARKOWITZ: We can -- after Doug  
22 introduces that form then we can come back to this.

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1           That's fine.

2                       MS. LEITON:   Yes.   Follow-up on the  
3   February    28,       2019       recommendation       of  
4   asbestos-related disease, asthma, and OHQ, we are  
5   still in the process of reviewing those. We got  
6   them in March. Our policy branch, our medical  
7   science unit have been working on those responses.

8                       We hope to have a draft within the next  
9   couple of weeks, but that has to go through  
10   clearance which means it has to go through the whole  
11   process of going through the Labor Department.  
12   So I can't guarantee you a time, but I have hope  
13   that it will be within the next month or so.

14                      Follow-up, let's see, review of the DOL  
15   responses to the 11/18 requests. So there was a  
16   request for information that we provided a response  
17   to in February, and you had highlighted some  
18   sections. I don't know if you have that up. Do  
19   you have that there?

20                      Okay. So the first section has to do  
21   with the Bulletin 19-03 which provides guidance  
22   to staff about reopening cases as a result of the

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1 presumptions that we changed for causation  
2 resulting from the Board's recommendations.

3 We do have a report on that. We've made  
4 it a priority for all of our claims staff to review  
5 these cases, and they're 98 percent finished  
6 screening and found -- so they looked at different  
7 groups. The first group was mesothelioma, ovarian  
8 cancer and pleural plaques. The second group was  
9 hearing loss, bladder cancer. And the third group  
10 was lung cancer.

11 They have reviewed, as I said 98 percent  
12 of all of those groups, and we found about 170 cases  
13 that have the potential to be reopened right now.

14 MEMBER BERENJI: I'm sorry. Can you  
15 clarify the denominator, 170 out of what number?

16 MS. LEITON: Yes. It's actually a  
17 pretty small percentage of cases that are going  
18 to probably be reopened. We've looked at all the  
19 factors. There were about 1900 cases that have  
20 been reviewed.

21 MEMBER BERENJI: And I'm sorry, can you  
22 clarify the 170, like what percentage were the

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1 mesothelioma cases?

2 MS. LEITON: It was pretty even. No,  
3 actually, I'm sorry, lung cancer was the highest.  
4 There were like 84 of those that were lung cancer;  
5 42 were for hearing loss and bladder cancer; and  
6 43 were for the mesothelioma, ovarian cancer, and  
7 pleural plaques in terms of what we have the  
8 potential to reopen right now.

9 MEMBER BERENJI: I'm sorry, that's not  
10 very clear. You seem to lump a lot of these various  
11 --

12 MS. LEITON: Yes, we didn't separate  
13 them out. We lumped them into three categories:  
14 mesothelioma, ovarian cancer, and pleural plaques  
15 was one category; hearing loss, bladder cancer was  
16 another category; and lung cancer was the third  
17 category.

18 MEMBER BERENJI: Okay. So can you  
19 clarify the lung cancer was 84?

20 MS. LEITON: 84.

21 MEMBER BERENJI: The hearing loss,  
22 bladder cancer was 42.

1 MS. LEITON: 42.

2 MEMBER BERENJI: And then the third  
3 category?

4 MS. LEITON: 43. That was the  
5 mesothelioma, ovarian cancer, and pleural plaques.

6 MEMBER BERENJI: Thank you.

7 MS. LEITON: The process moving  
8 forward obviously takes into consideration the new  
9 presumptions. The next --

10 MEMBER REDLICH: Carrie Redlich. On  
11 the subject of reopening cases, as you know, we've  
12 been given cases to review and had in the past,  
13 many of which we agreed with the final adjudication.

14 For ones that we have questions or  
15 disagree with that, have we established any process  
16 about whether it's possible for any of those claims  
17 to be reopened?

18 MS. LEITON: Obviously, we'll take  
19 whatever input you have and evaluate that. If it  
20 looks like a case needs to be reopened, then we'll  
21 reopen it.

22 MEMBER REDLICH: So from the ones that

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1 we had previously reviewed, it's not a large number,  
2 but if there are a few cases that we think should  
3 be reopened, could we give you --

4 MS. LEITON: We can look at the cases.

5 MEMBER REDLICH: Okay.

6 MEMBER BERENJI: Yes. That would have  
7 to be done in some sort of systematic fashion.  
8 I mean --

9 MEMBER REDLICH: Yes, I think that  
10 passes and I also think going forward with the cases  
11 we were just given. And actually, I think the prior  
12 ones since we got rid of them, I actually don't  
13 have the identifying information.

14 MS. LEITON: I don't know what to say  
15 to that.

16 MEMBER REDLICH: Yes, so I think the  
17 going forward with the ones that we have now --  
18 we haven't even started to discuss those cases yet.

19 MR. FITZGERALD: I would say as the  
20 DFO, I think when you discover things that are  
21 questionable and you bring it to the program's  
22 attention, they will give it the due consideration

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1 it should have.

2 It's just like when we do kind of  
3 accountability reviews and we do auditing of our  
4 own cases when we look at those things, if things  
5 are revealed in that audit process that look  
6 incorrect, the program will go back and revisit  
7 those things.

8 So in a sense, that's kind of what  
9 you're doing. It's not the primary role of the  
10 Board to do that, but to the extent that you find  
11 that sort of thing and share it with the program,  
12 they will consider the same. And the same when  
13 they would do any kind of audit and review of their  
14 work.

15 MEMBER REDLICH: Okay, given that we  
16 just got a number of cases to review, it seems like  
17 it would be helpful to clarify.

18 MS. LEITON: Yes, if you see something  
19 in a case after you've reviewed it, share it with  
20 Doug and he'll share it with us.

21 MEMBER REDLICH: Okay.

22 CHAIR MARKOWITZ: So I have a question.

1 Steve Markowitz. I'm just going to use  
2 approximate numbers. About 1900 claims fell  
3 within the areas of the revised causation standards  
4 and required review, and roughly 170 of them deemed  
5 to be relevant will require further review for  
6 possible change in the decision about those claims.

7 As a suggestion, and it's relevant to  
8 what we do, because we've been working on  
9 presumptions. And the impact of our  
10 recommendations on those presumptions are of  
11 interest.

12 So it would seem to be just as easy,  
13 when you look at those data, the 1900, to identify  
14 them by individual diagnosis, or the most important  
15 diagnosis, say mesothelioma or lung cancer or  
16 bladder cancer. The total number that have been  
17 reviewed, and then give the total number in which  
18 it's been deemed they need further review and  
19 reanalysis so they don't -- so the bladder cancer  
20 and hearing loss aren't lumped together. Because  
21 that -- that doesn't mean anything I don't think.

22 MS. LEITON: We can probably go back

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1 and do a report. This report came from our claims  
2 staff. We had asked them to look at them in stages.

3 So we had to group them so they could look at them  
4 in stages, and those are the groups we did that  
5 we analyzed them through.

6 This report just came to me last week.

7 So we can do some further revisions and look at  
8 what further reporting we can do.

9 CHAIR MARKOWITZ: That would be great.

10 By the principal diagnosis, that would be the most  
11 sensible. Thank you.

12 MS. LEITON: Okay. Number 3  
13 highlighted section where you indicated DEEOIC is  
14 developing a report that will identify the total  
15 number of Part E claims filed with a final decision  
16 to accept.

17 I just got that report yesterday, so  
18 we do have a preliminary report on that. I can  
19 probably provide it to you. I'd like to do a little  
20 bit further QC, but generally we're looking at this  
21 by accepted-only cases under Part E, denied-only  
22 cases, and accepted and denied cases.

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1           So there are three different categories  
2           that we kind of have to look at it through the lens  
3           of. Overall, there were about 26 percent of cases  
4           referred to an industrial hygienist.

5           Now that's a little lower than I  
6           expected, so I want to double-check those numbers.

7           But you have to consider the fact that a lot of  
8           cases are either accepted or denied. They might  
9           be denied or accepted for other reasons, so that  
10          factors hugely into -- they won't go to an IH if  
11          there's no survivorship, for example. But I do  
12          have a report that we can probably share with you,  
13          once I've done a little bit more investigation on  
14          it.

15          The next section. You highlighted  
16          documentation submitted with requests to make  
17          changes in how its effects are provided to Dr. Jay  
18          Brown, Haz-Map for evaluation. I'm not sure what  
19          the question there is.

20                   CHAIR MARKOWITZ: What are we looking  
21                   at? Do you know which --

22                   MS. LEITON: It's right under --



1 CHAIR MARKOWITZ: Well, okay. Well,  
2 the question about Jay Brown I think is at some  
3 point we learned that the program doesn't have a  
4 contract with Dr. Brown to work on the SEM or to  
5 provide input into the exposure-disease links in  
6 the SEM.

7 But there's references at various  
8 points in which it would appear that the program  
9 continues to use Dr. Brown, so I just wanted some  
10 clarification about that.

11 MS. LEITON: Well, Dr. Brown still  
12 updates his Haz-Map, and we still utilize that  
13 information. So we still have the ability to  
14 provide him with information that he then uses in  
15 Haz-Map that we can correlate with the SEM.

16 CHAIR MARKOWITZ: I'm sorry, maybe I  
17 didn't quite hear everything.

18 MS. LEITON: So he's still --

19 CHAIR MARKOWITZ: Is he looking -- do  
20 you ask him specific questions about this agent  
21 disease links that he weighs in on and helps you  
22 and revise the SEM?

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1 MS. LEITON: My understanding is that  
2 we provide him with information that he can then  
3 use in the Haz-Map and add to his Haz-Map, which  
4 we can then add to the SEM.

5 Now we have other processes in place  
6 for adding things to the SEM or through policy  
7 changes that we can make of our own volition without  
8 the Haz-Map. But that's usually made through a  
9 policy determination first and then added to the  
10 SEM, so --

11 CHAIR MARKOWITZ: Okay. Thank you.

12 MS. LEITON: The second section was  
13 also about Dr. Brown, so I think that covers your  
14 highlights of this document which was the  
15 follow-up.

16 And the last thing you wanted me to  
17 cover was the updates to all prior Board  
18 recommendations, 2016 to present, on which new  
19 actions have been taken.

20 So I went through all of the  
21 recommendations you made, all of our responses,  
22 and one thing that I found was that you all had

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1 done in February of 2018, kind of gone back through  
2 all the ones prior to that date. So the '16  
3 recommendations, '17 recommendations, and we went  
4 through this back-and-forth.

5 So that document, the February 16th one  
6 really kind of covers the prior recommendations  
7 because you went back through them all. Rather  
8 than going through them again, I'd rather just cover  
9 that document. And then if you have questions  
10 about any other ones, I'm happy to answer them.  
11 But I just thought that might be the most efficient  
12 way to do this.

13 So in your February 2018 document you  
14 went through I think it was 10 different -- nine  
15 different recommendations, and kind of gave us  
16 responses that we then responded to.

17 MEMBER BERENJI: I'm sorry, I don't  
18 have that document so I'm not sure if that's going  
19 to be helpful for me.

20 MS. LEITON: It's on the website, your  
21 website.

22 CHAIR MARKOWITZ: Yes, maybe we can

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1 just wait a moment until Kevin can find it. It's  
2 under the --

3 MS. LEITON: It's under the  
4 recommendations. It's February 16, 2018 response.  
5 February 16, 2018. I'm sorry.

6 CHAIR MARKOWITZ: They're usually  
7 organized by meeting date.

8 MEMBER BERENJI: Right. I was under  
9 the assumption that we're going to go through the  
10 answers for the most recent meeting, and I'm still,  
11 have questions about these.

12 MS. LEITON: The most recent meeting,  
13 we're still evaluating those, so we don't have  
14 responses for those. Those need to be cleared.  
15 I will have responses once they've been cleared  
16 through the Department. So I don't -- I'm not able  
17 to respond to those right now.

18 The request to me was to go through all  
19 the previous recommendations, so I thought I'd  
20 start with the 2018 document if you still want me  
21 to do that.

22 CHAIR MARKOWITZ: Yes, that's fine.

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1 MS. LEITON: Did you find it? I've gone  
2 over my time, so do you want me to continue?

3 CHAIR MARKOWITZ: That's fine.

4 MS. LEITON: Okay.

5 MR. FITZGERALD: I'll yield my time to  
6 you.

7 MS. LEITON: Okay. That's August.  
8 August was our response to the February -- yes,  
9 yes, that's fine.

10 So walking through this document, so  
11 you provided us the February document that we then  
12 responded to in August. I was going to kind of  
13 just walk through those.

14 So the first one is the comments on  
15 recommendation incorporating Agency Health Effect  
16 Reviews recommended by IOM reporting to the SEM.  
17 The Advisory Board recommends that the program  
18 apply different data sources for expanding disease  
19 exposure links, including the following: IARC,  
20 Integrated Risk Information System, and the  
21 National Toxicology Program.

22 So we already used IARC Group 1. With

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1 regard to Causal Group 2(a), we will refer to those  
2 when we're talking about aggravation of  
3 contribution. We defer to a physician on that  
4 rather than incorporating it into the SEM.

5 With regard to the application of the  
6 IRIS and NTP databases, you've suggested a process  
7 for evaluating those. We asked for additional  
8 information in terms of how to exactly use those  
9 in our SEM.

10 Each database communicates voluminous  
11 and complex data on a range of toxic substances  
12 and health effect topics. We don't think that  
13 adding all of those in the absence of rigorous and  
14 comprehensive investigations would be prudent for  
15 us. So that was our response here.

16 I'm not sure how much you want me to  
17 read through our responses as go through and try  
18 tell you if they're action items, so I just kind  
19 of highlighted some sections in this.

20 CHAIR MARKOWITZ: That's fine. Just  
21 a summary of the responses would be good.

22 MS. LEITON: Okay. You also

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1 recommended that we identify a team that includes  
2 individuals with competence in toxicology,  
3 occupational medicine, and epidemiology to do a  
4 rigorous review.

5 While I would like to have the resources  
6 to do that, and I think we've talked about this  
7 before, it's kind of a catch-22 because our mandate  
8 is to evaluate claims on a case-by-case basis.  
9 We're not a research-centric organization. OWCP  
10 was not built to have that sort of a research arm,  
11 and so that's where we have -- we don't have the  
12 ability to have that rigorous scientific team as  
13 part of our organization. It's not the way it's  
14 set up.

15 While I understand and agree that, you  
16 know, having such a resource would be helpful, our  
17 mandate is and our funding is based on a workers  
18 compensation program where we pay for claims  
19 examiners and final adjudication branch.

20 We've been able to have our scientists  
21 that we do have, and the contractor to help us with  
22 individual case-by-cases. But, in terms of a

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1 research organization, this is not the way we're  
2 built.

3 CHAIR MARKOWITZ: Dr.  
4 Friedman-Jiminez?

5 MEMBER FRIEDMAN-JIMENEZ: Can you hear  
6 me? I would consider that part of the clinical  
7 practice of occupational medicine. If you get a  
8 case, for example, and you have to review 40  
9 articles on COPD and asbestos, that's part of the  
10 case. It's not research.

11 Research is finding new knowledge that  
12 hasn't been published, that hasn't been found  
13 before. So I would say that's part of the clinical  
14 practice of occupational medicine. And  
15 occupational physicians should be trained and  
16 prepared to do that kind of literature review  
17 because that's part of what we do.

18 It's not in the textbooks. It's not  
19 in, you know, a single document. Sometimes you  
20 have to do a broad and deep literature review for  
21 a single case as part of the clinical care of a  
22 patient.

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1 MS. LEITON: I agree.

2 MEMBER FRIEDMAN-JIMENEZ: Or the  
3 evaluation of a case.

4 MS. LEITON: I agree in terms of what  
5 a physician should be doing when they're evaluating  
6 the patient for a claim. Our claims examiners  
7 aren't in the business of occupational medicine.  
8 They're in the business of reviewing factual  
9 information that's presented on a claim, so that's  
10 what they're trained to do.

11 In terms of, you know, the  
12 case-by-case, yes. We try to obtain as much  
13 information as we can on a particular claim from  
14 a physician or an authorized rep, or whatever we  
15 can obtain from the claimants medically or  
16 scientifically. Then we have a contract medical  
17 consultant process where we can refer cases out  
18 if we can't get information from the treating.  
19 We also have our industrial hygienist on a  
20 case-by-case basis.

21 But in terms of generally having, as  
22 this suggests, a group of people we can go to, to

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1 provide us with the information that we're talking  
2 about here, which is an evaluation of all these  
3 different databases and resources that we could  
4 use to enter into our SEM, that's the kind of  
5 research I'm talking about in terms of doing that  
6 in-depth analysis for overall use in the program.

7 We do as much of that as we can in the  
8 creation of the SEM and the contracts that we do  
9 have. But again, our focus has to be on  
10 adjudicating claims on a case-by-case basis and  
11 gathering information on a case-by-case basis.  
12 That's what our focus is.

13 CHAIR MARKOWITZ: This is Steve  
14 Markowitz. You know, I think the Department  
15 doesn't fully appreciate how difficult your job  
16 is. Because, you know, various compensation  
17 programs within the Office of Workers Compensation  
18 Programs, EEOICP has to take on tens of thousands  
19 of different agents and the entire spectrum of  
20 occupational disease.

21 And I know I've said this before, you  
22 know, you have black lung which is really, you know,

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1 a very limited set of exposures, a limited industry,  
2 limited job titles. FECA I assume mostly deals  
3 with traumatic events rather than disease.  
4 Longshoremens again probably mostly traumatic  
5 events, so-called accidents.

6 But your job within EEOICP is really  
7 unique. And for that matter, I can't think of any  
8 other compensation program at the state or federal  
9 level that has the challenge that you have.

10 MS. LEITON: Yes, well thank you for  
11 that. I --

12 CHAIR MARKOWITZ: Well, you can say  
13 something, but I do want to make a point.

14 MS. LEITON: No, I mean I think you're  
15 right in that this is new territory for a  
16 compensation program. All of the different  
17 exposures, trying to come up with assessments, it's  
18 a lot. But go ahead and make your point.

19 CHAIR MARKOWITZ: Well, so for  
20 instance, we're happy to provide assistance with  
21 Parkinson-related disorders. But that's an  
22 example of an issue, you know, we're a Board that

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1 comes and goes, we provide advice and we're happy  
2 to do that with respect to that limited issue.  
3 But we don't have resources to do much above and  
4 beyond that.

5 And you need that internal capacity.

6 I wish the Haz-Map or some other resource out there  
7 was totally up-to-date, an agent disease link that  
8 you could rely upon. But such a resource really  
9 doesn't exist.

10 MS. LEITON: True.

11 CHAIR MARKOWITZ: And so our argument  
12 is only that you need a deeper capacity to be able  
13 to evaluate, not do research, but to evaluate  
14 existing knowledge to make sure the program  
15 accurately reflects that existing knowledge.

16 MS. LEITON: I understand. Okay. I  
17 do want to note there with regard to the first one  
18 that your latest set of recommendation is more  
19 specific, and I wanted to note that is something  
20 we're evaluating. With regard to the SEM, I think  
21 you've gone into more specifics there, so we will  
22 be evaluating that.

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1           The second set of recommendations is  
2           the hiring of former DOE workers to administer the  
3           OHQ.    The Board also requested specific data  
4           regarding the work performed by the former DOE  
5           workers.  I think we provided that data to you and  
6           indicated what we can and cannot do with regard  
7           to our contractor, and what we can hire for, what  
8           we can mandate versus what we can't mandate.

9           We can put in the contract that we  
10          prefer expertise and DOE former workers.  But in  
11          terms of getting a contract, we are not permitted  
12          to mandate that they all be former workers.

13          Number 3, comments on recommendations,  
14          claimant information sent to industrial hygiene  
15          and medical consultants.  The Advisory Board  
16          recommends that the program provide copies of  
17          entire case files to subject matter experts, such  
18          as industrial hygienists and medical consultants.

19          The Advisory Board further recommends  
20          that the claims examiner map be filed to indicate  
21          where relevant information is believed to be.

22          So I think we've gone back-and-forth

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1 on this over the years. You know, one of the things  
2 that we -- one thing that I do want to point out  
3 in this response from us is that we indicate that  
4 it's important that once a decision on one part  
5 of the case is made, it's not re-adjudicated and  
6 a referral to a specialist on another issue.

7 And that -- there's a tendency to do  
8 that when you're looking at everything, especially  
9 if we've already put in a statement of accepted  
10 facts that a case has been accepted for a condition.

11 We can't really go back and re-adjudicate that  
12 in a referral.

13 There's also different types of  
14 referrals that require different evidence in  
15 payment versus wage loss versus causation  
16 determinations. We do try to provide whatever --  
17 all the medical evidence to a physician whenever  
18 possible and when it's relevant.

19 When it's for an impairment evaluation,  
20 sometimes there's going to be less information  
21 because we're looking at a particular set of facts  
22 that need to be reviewed specifically for an

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1 impairment evaluation.

2 CHAIR MARKOWITZ: Can I just ask a  
3 question?

4 MS. LEITON: Yes.

5 CHAIR MARKOWITZ: Steve Markowitz.  
6 So having recently looked at claims, I don't know  
7 how the other Board Members' experience is with  
8 looking at claims, but it's not clear to me that  
9 the contract medical physician, the CMC, it's not  
10 clear to me what pieces of exposure information  
11 they get.

12 They get the IH report, but do they also  
13 get the Occupational Health Questionnaire? Or do  
14 they get any information that the claimant  
15 provides? Do they get an excerpt from the SEM?  
16 It's in the overall claims file but, you know, some  
17 of those files are 2,000 -- 5,000 pages. So do  
18 you know what the CMC gets with reference to the  
19 exposure, the various pieces of exposure  
20 information?

21 MS. LEITON: Well, they're supposed to  
22 -- usually there's supposed to be an assessment

1 of the IH, the exposure information that the claims  
2 examiner does in the statement of accepted facts  
3 that's referred to the physician.

4 Sometimes there's a separate  
5 assessment that is the exposure assessment. If  
6 it's a lengthy exposure assessment, the claims  
7 examiner will send, quoting the SEM, where these  
8 sources are from.

9 It really depends on the type of  
10 referral to the physician, whether it's a  
11 causation. If it's not a causation, that  
12 information won't necessarily be in there.

13 But I don't know that every time that  
14 we send something to a physician we're including  
15 the OHQ. A physician can ask for that in their  
16 assessment when they're looking at these cases.  
17 But we do try to include our factual assessment  
18 of exposure when we refer these to the CMC.

19 CHAIR MARKOWITZ: Dr. Dement?

20 MEMBER DEMENT: I guess, so along those  
21 lines, I think -- and we're just getting into  
22 reviewing these cases so it's pretty early. But

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1 certainly a trend that I see in the ones that I've  
2 reviewed, and maybe others have seen it as well,  
3 is the OHQ is looked at by CE, and many times it  
4 doesn't appear that some of the exposures that are  
5 actually listed in the OHQ are included in the  
6 statement of accepted facts that goes to the CMC.

7 I don't even think the industrial  
8 hygienist necessarily looks at some of that when  
9 they're assessing exposures. They're told by the  
10 CE to assess exposures largely drawn from the SEM.

11 In some cases, that's been helpful  
12 because the exposure on the OHQ were very vague.

13 I mean it goes both ways. But I guess one of my  
14 concerns is the exposure information is not  
15 developed.

16 And it goes back to some of the earlier  
17 recommendations is that we feel, and I think this  
18 Board feels, has felt, and maybe this Board will  
19 have a different feeling that the industrial  
20 hygienist particular needs to have access to the  
21 claimant to develop the case. And there's some  
22 in here which I reviewed that I think, as a

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1       hygienist, if I had a chance to talk to the  
2       individual, I could've figured it out whether or  
3       not there were actual exposures beyond what may  
4       have been in the SEM, or may be in the SEM, but  
5       not defined very well.

6                So see it goes back to, in my opinion,  
7       developing the case more broadly. And not all  
8       cases, not all claims are going to need that level  
9       of detail, but some will. It's sort of developing  
10      a triage process to make such a more detailed  
11      assessment work.

12               MS. LEITON: Yes, and we've also been  
13      back-and-forth on that particular issue as well.  
14      Our, you know, we believe that the claims examiner  
15      needs to be the one making the factual  
16      determinations. And if the industrial hygienist  
17      has questions, they can go back to the CE who can  
18      obtain that information.

19               There is kind of a legal basis for that  
20      chain of command or chain of custody of the case  
21      that needs to be with the claims examiner from the  
22      legal perspective, and that's kind of our struggle.

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1 But I understand what you're saying. We --

2 MEMBER DEMENT: I'm an industrial  
3 hygienist, not a lawyer.

4 MS. LEITON: I know. I'm aware. So  
5 back to our topic. Did you have something else?

6 CHAIR MARKOWITZ: Just a quick  
7 follow-up question. So as a matter of protocol,  
8 when the CE sends a statement of accepted facts  
9 and a request for industrial hygiene analysis, do  
10 they send the OHQ the EE-3, whatever the claimant  
11 affidavit, the results of the SEM, are all those  
12 pieces sent to the IH? Because the IH needs that  
13 in order to do their work.

14 MS. LEITON: Yes, I believe the OHQ is  
15 sent. You know, we do do an assessment, the claims  
16 examiners do do an assessment of those that are  
17 reported on the OHQ to see how it presents with  
18 the other information that we have in the SEM.  
19 The SEM is one of the sources that we rely on for  
20 that, but we will refer the OHQ to the IH as well.

21 CHAIR MARKOWITZ: So then the second  
22 part of that question then is, when a referral is

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1 made to the CMC, are those same pieces of the  
2 exposure data sent to the CMC?

3 MS. LEITON: Usually once it's  
4 reviewed by an industrial hygienist and we've  
5 confirmed certain exposure facts, that's what we'll  
6 send to the CMC versus the actual OHQ unless the  
7 physician wants to see the OHQ.

8 CHAIR MARKOWITZ: Okay, thank you. Is  
9 there a question?

10 MEMBER MAHS: Yes, Ron Mahs. I had a  
11 question when reviewing these cases, it kept coming  
12 back to me. Is the IH that's doing these claimants  
13 in a remote area, or is he at the site where the  
14 claimants are working?

15 MS. LEITON: We have a contract with  
16 the industrial hygienist that we refer these to,  
17 and so they have a variety of different experiences  
18 in terms of their history and resumes and that.  
19 So they're not on site with the DOE facility.

20 MEMBER MAHS: It seems odd how they get  
21 an exposure level without actually seeing the site  
22 and knowing what's going on.

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1 MS. LEITON: Well, they're industrial  
2 hygienists. They have expertise in this area.  
3 That's why they do this for us.

4 MEMBER REDLICH: I had one related  
5 question, just more for the process. And I would  
6 second that reviewing some of these claims, that  
7 makes me appreciate the challenge of your job.  
8 They're really --

9 MS. LEITON: They're long. Some of  
10 them are very --

11 MEMBER REDLICH: No, and it's just  
12 multiple diseases definitely, and physicians are  
13 not always helpful in this process, but I think  
14 this is a simple question. There were one or two  
15 where there had been a hearing and a taped --

16 MS. LEITON: Transcript.

17 CHAIR MARKOWITZ: Transcript.

18 MEMBER REDLICH: -- transcript. How  
19 often does that happen, or what stage of the  
20 process? Because in just following up on what Dr.  
21 Dement said that the worker's description of what  
22 they did in that transcript was sometimes helpful.

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1       And I wasn't clear, you know, when and how that  
2       happened.

3                   MS. LEITON:   So we issue a recommended  
4       decision at the district office level, and that  
5       is conducted by our claims examiner to develop the  
6       case and they do all of the initial development  
7       referrals to the IH; to the CMC oftentimes.  Once  
8       they issue that recommended decision, the claimant  
9       has the right to appeal it.

10                   All cases go to our Final Adjudication  
11       Branch who issue the final decision on every case,  
12       whether it's accepted, denied, whatever.  They  
13       issue that final decision, which becomes the  
14       decision of record.

15                   Before that final decision is issued,  
16       a claimant can ask for a hearing with hearing  
17       representative.  And that's where you'll see the  
18       transcripts.  They'll meet with them either on the  
19       phone or in person and present their arguments.

20                   They can also, claimants can request  
21       a review of the written record where they submit  
22       additional information in writing.  That can be

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1 additional medical reports. It can be whatever.  
2 Or they can waive their right to object, and they'll  
3 usually do that if they haven't accepted so we can  
4 issue a decision quickly.

5 At that stage, after the hearing, the  
6 Final Adjudication Branch hearing representative  
7 will review all the evidence and issue a  
8 determination. Sometimes that determination is  
9 to affirm the recommended decision.

10 Sometimes if they get additional  
11 information that they feel requires more  
12 development, they can remand the case back to the  
13 district office and say, conduct additional  
14 development before we do a final decision. And  
15 they'll issue a new recommended decision after  
16 that, which will then go back to the FAB.

17 They can reverse. If there is enough  
18 information to accept, then they'll reverse a case.  
19 So those are the process stages.

20 MEMBER REDLICH: Thank you. That was  
21 very helpful. I guess there's nothing simple about  
22 this process. And just a related question, some

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1 people have had attorneys involved and others have  
2 not. How common is that? And the attorneys seemed  
3 to be involved in the process of the hearing.

4 MS. LEITON: Any claimant has the right  
5 to an authorized representative. It doesn't have  
6 to be a lawyer. It can be somebody that can  
7 represent for them. That could be a daughter or  
8 something like that. They just have to put it in  
9 writing and say this is the person I want  
10 representing me.

11 Some of them will hire attorneys. They  
12 don't need to. We'll hold a hearing with the  
13 claimants. We try to assist them through the  
14 process by talking to them. The claims examiners  
15 will talk to them. They can go to the resource  
16 center.

17 So there are a lot of other ways that  
18 they can do this alone, but sometimes they do it.  
19 I don't have an exact percentage. I think it's  
20 probably less than half to have authorized reps,  
21 but don't quote me on that because I'm not sure.

22 MEMBER REDLICH: Thank you. That was

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1 helpful.

2 MEMBER MIKULSKI: This is Marek  
3 Mikulski and this is a question along the lines  
4 of the procedures. In looking at the claims that  
5 we have received, I've noticed a lack of consistency  
6 in referrals to the CMCs and IH. I was wondering  
7 if you could comment on at what level the decision  
8 is made for referral of the case to CMC and IH?

9 MS. LEITON: So a claimant --- claims  
10 examiner will first develop the case with the  
11 claimant and say we need medical information, or  
12 we need exposure information. The employment  
13 information we go directly to Department of Energy  
14 first, and they will provide us with employment  
15 information if they have it.

16 But then we'll go to the claimant, ask  
17 them for information. If the claimant comes in  
18 and doesn't have a diagnosis for example, that's  
19 kind of a nonstarter. We won't really go to a CMC  
20 at that point because we don't have a diagnosis  
21 on which to base anything.

22 But if we get a diagnosis, if we get

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1 some indication from the doctor, even if it's, I  
2 believe this is related to his work, we'll develop  
3 it further to either hopefully go back to the  
4 treating doctor, say this is what we know, you've  
5 indicated some sort of causal relationship. And  
6 if they can't always provide us with information,  
7 but we know that there was exposure because we've  
8 done exposure assessment, we'll send it to a CMC  
9 because their physician couldn't provide us the  
10 information.

11 But there's various stages that we have  
12 to go through. First, we determine if there's a  
13 diagnosis. We determine if there was covered  
14 employment. Then we determine whether there was  
15 any exposure, if we have any evidence of exposure.

16 And then it goes to a CMC. So it really depends  
17 on at what stage, you know, what the facts of the  
18 case are to determine whether it's going to go to  
19 a CMC.

20 It's not a requirement. Sometimes we  
21 can get the information from the treating doctor  
22 without doing that. But it really depends on the

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1 case.

2 CHAIR MARKOWITZ: I'm sorry, Ms. Pope.

3 MEMBER POPE: Duronda Pope. It just  
4 seemed like there was some inconsistency in some  
5 of the cases that I was reviewing in terms of  
6 information from the treating physician was given  
7 to the CMC and the IH.

8 And they looked at this information but  
9 it just seemed like there was so much information  
10 supporting the fact that there was exposure. The  
11 illness was verified and confirmed. But at the  
12 final adjudication, it just seemed like it wasn't  
13 enough. I just didn't understand, you know, the  
14 weight.

15 MS. LEITON: I would have to see the  
16 case. There's so many varieties and variations.  
17 If I saw the case to talk through, I could, but,  
18 you know. The determination is based on the  
19 evidence that's in the case file and the  
20 determination by the claims examiner based on the  
21 procedures that they follow.

22 So, you know, in terms of

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1 inconsistencies, once you guys have reviewed these  
2 cases and have questions, I can be in a better  
3 position to answer those sorts of questions. It's  
4 10:15, you want me to continue?

5 CHAIR MARKOWITZ: What's the sense?  
6 Do we want her to finish this or should we -- why  
7 don't we take a break for a few minutes. We will  
8 reconvene at 10:30.

9 (Whereupon, the above-entitled matter  
10 went off the record at 10:15 p.m. and resumed at  
11 10:36 a.m.)

12 CHAIR MARKOWITZ: Okay. We're going  
13 to get started again. I think Ms. Leiton was  
14 reminding us of our requests and DOL responses --  
15 or our recommendations and DOL responses, so you  
16 can continue.

17 MS. LEITON: Okay. Is it on? How  
18 about that?

19 Okay. So, I was on No. 3. I think we  
20 talked about the referrals to the industrial  
21 hygienist. I think we've beat that one to death  
22 already, unless you have further questions.

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1                   Yeah.

2                   MEMBER TEBAY: I'm Calin Tebay.

3                   I -- in reviewing the claims -- and,  
4                   so you know, just these claims -- working at the  
5                   HWECC -- for you folks that don't know what the HWECC  
6                   is, it's the Hanford Workforce Engagement Center  
7                   -- in a year's time -- and I'll -- this will be  
8                   relevant here shortly, but in a year's time we've  
9                   seen 4,000 individuals.

10                  Some of those people are repeat at our  
11                  facility, and a majority of those are EEOICPA  
12                  claimants.

13                  And with the new presumption law for  
14                  the State of Washington, we're starting to see,  
15                  obviously, more and more go in that direction as  
16                  well.

17                  So, we review claims on a daily basis  
18                  and we're getting a lot of folks coming in with  
19                  denied claims or people that are starting claims.

20                  But when we talk about the CMCs and the IHs,  
21                  what's concerning for me --- and I think I'm  
22                  piggybacking onto several earlier comments, but

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1 there seems to be all too consistent reviews by  
2 IHs and CMCs almost like the reviews are based on  
3 assumption because the information is not in the  
4 file.

5 Often we see the review from the IH say  
6 that there is significant exposure. The claims  
7 examiner says there's significant exposure.

8 Yet the IH's response at the end of that  
9 review says, there's no exposure at or above an  
10 OEL or a PEL; therefore, maybe the condition or  
11 disease is not verifiable, it's not confirmed,  
12 whatever that term may be.

13 So, my question is, is that -- we see  
14 that often. So; one, I don't believe -- and maybe  
15 this is a question solely on the Board -- that just  
16 because you're not exposed at or above a PEL, does  
17 that eliminate you from having a condition or  
18 disease? I don't think so.

19 Or the fact that just because you were  
20 exposed at or above a PEL, that doesn't also confirm  
21 that you're going to get a disease or a condition.

22 So -- but the information I'm more

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1 interested in, is how did the IH come to that review  
2 or that piece of information?

3 Is there something in the file that says  
4 that individual was not exposed at or above a PEL  
5 or an OEL?

6 And if it's not in there, then the  
7 summary or the remarks, they're based on assumption  
8 because we all know that the records, those  
9 exposures -- sometimes the exposures these  
10 individuals that are exposed to, they're not even  
11 monitored for.

12 So, the actual IH data doesn't even  
13 exist to make that kind of a comment. So, that's  
14 where I'm confused, right?

15 I just -- it just, for me, on a daily  
16 basis seeing this comment, is really concerning.  
17 And that's where I think Ms. Dement earlier talked  
18 about the IH involvement with the actual employee.

19 Now, what we've started doing at the  
20 HVEC is telling people that they need to provide  
21 a summary of their work history and the actual --  
22 along with the OHQ, provide a summary of their

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1 actual work processes they were involved in  
2 because, let's be honest, we can tell you that most  
3 folks do not understand the exposures or know  
4 exactly all the exposures that were involved in  
5 that process.

6 The IH data is really sketchy for those  
7 processes and those jobs. So, I'm really concerned  
8 that we don't -- we're missing that piece, right,  
9 that link.

10 And that's not only -- that's not on  
11 the DOL, right, or the claims examiner, but it  
12 starts at the claimant being able to explain those  
13 processes they were involved in; but just because  
14 it's not there in the file, doesn't mean it doesn't  
15 exist or it didn't happen.

16 MEMBER DEMENT: I'll follow on with  
17 that. This is John.

18 I fully support what you're saying.  
19 And a number of these cases that I reviewed, here's  
20 the phraseology: No available evidence, paren,  
21 i.e., personal or area industrial hygiene  
22 monitoring data, paren close, to support that after

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1 the mid-1990s because exposures would have exceeded  
2 existing regulatory standards.

3 I looked at the file as well in the DAR  
4 and whatever came back. There's no data in there  
5 to support this statement.

6 So, if the IH is going to make this  
7 statement, he should be required to quote the  
8 available data to support it. Otherwise, it's a  
9 presumption on his part -- his or her part.

10 MEMBER TEBAY: We -- just to finish up,  
11 we often -- and I don't know how all sites do it,  
12 but sometimes when we work in groups, maybe one  
13 individual in that group is actually assigned some  
14 kind of monitoring equipment, right, a personal  
15 monitoring equipment.

16 Therefore, the rest of the group, if  
17 there is an exposure that's concerning that's at  
18 an action level, for instance, not even over the  
19 regulatory limit, some of the employees aren't even  
20 made aware that that level had been reached. Only  
21 the employee wearing the actual monitoring in that  
22 group was made aware.

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1           So, all of us could be in the same room,  
2           you could be wearing the monitor, but none of us  
3           would have been notified that those exposures even  
4           existed in that process that day.

5           So, the data doesn't exist when these  
6           IHs or these, you know, contracted IHs make these,  
7           you know, these summaries or provide these reviews  
8           on, really, no IH data.

9           So, my -- I think it's a little unfair,  
10          obviously, that an IH can make an assumption against  
11          the claimant, but the -- it doesn't work both ways,  
12          right?

13          So, I'm a little -- that's where my  
14          concern lies. And I know that we talked about this  
15          and it's going round and round, but ---

16                   CHAIR MARKOWITZ: Thank you.

17                   Dr. Friedman-Jimenez.

18                   MEMBER FRIEDMAN-JIMENEZ: Can you hear  
19                   me?

20                   Okay. Essentially, what we're talking  
21                   about is a presumption that there's no exposure.  
22                   In other words, when you have a workplace where

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1       there are variable levels of, let's say, asbestos  
2       and the person is a maintenance worker and you know  
3       that the levels are varying from day to day or from  
4       month to month by some amount, depending on whether  
5       it's disturbed or not, how many people are working  
6       in the room, but the industrial hygiene  
7       measurements are only done either randomly, very  
8       infrequently, or not at all, or done in response  
9       to some concern after some cleanup was done.

10                You don't know what conditions under  
11       which the industrial hygiene measurements have been  
12       done.

13                So, essentially, it's a presumption to  
14       say that there is no exposure above the standard,  
15       and that should be identified as a presumption  
16       rather than to say there's no evidence, because  
17       you can always say there's no evidence.

18                So, I think it's a little bit unfair  
19       to frame the statement in that way that gives a  
20       false scientific credibility to it as if there were  
21       data that would find the exposure if it were there,  
22       because it's not being done.

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1           We know that the sampling isn't being  
2 done very frequently and -- in medicine, we refer  
3 to it as "sensitivity."

4           In other words, if there's a disease,  
5 what's the probability that the diagnostic test  
6 will find it?

7           So, in this case, if there's an  
8 exposure, what's the probability that industrial  
9 hygiene sampling will document it?

10           It's actually pretty low. So, I would  
11 say that that kind of a phrase really should not  
12 be acceptable in ---

13           CHAIR MARKOWITZ: So, let me just jump  
14 in.

15           Circular 15-06 was rescinded and that  
16 was stated that there was a presumption that  
17 exposures 1995 -- or after 1995 were within the  
18 regulatory limits unless there was compelling,  
19 probative evidence to the contrary.

20           And the language that's currently used  
21 in the claims that we've all seen by reviewing these  
22 claims, it seems to be an extension of that circular

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1 which was rescinded.

2 So, what's the explanation? I --

3 MS. LEITON: I'm glad you brought that  
4 up.

5 So, the Circular that told claims  
6 examiners not to go to an IH after -- for cases  
7 that were after 1995, we rescinded that so that  
8 now they go to an IH.

9 There are going to be presumptions that  
10 IHs make without evidence. If you have no evidence  
11 that there was any excess, you have no records about  
12 the levels of exposure that the person might have  
13 had that would be outside of that, then our IHs  
14 are going to make some assumptions.

15 If we didn't have IHs, we'd be denying  
16 a lot more cases. 26 percent right now, I can tell  
17 you, went to IHs and were accepted after.

18 So, before you -- Dr. Dement, before  
19 you do that, I just did want to point out that in  
20 your recommendations back to us when we talked about  
21 this asbestos exposure and such, the Board said:  
22 The Board has not yet identified surveillance

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1 information that supports use of 2005 as a threshold  
2 date for presumed significant exposure -- asbestos  
3 exposure. As a default and until such information  
4 is identified, the Board recognizes that DOE Order  
5 440.1, issued in 1995, likely served as an important  
6 stimulus for change in DOE health and safety policy  
7 and procedures. The Board, therefore, agrees to  
8 the use of 1995 as a threshold date before which  
9 sufficient asbestos exposure occurred among  
10 maintenance and construction job titles, assuming  
11 the temporal requirements noted above, to meet a  
12 presumption of asbestos-related disease.

13 So, there are going to have to be some  
14 asbestos -- there's going to have to be some  
15 presumptions made when we don't have evidence to  
16 the contrary.

17 If we have the HWEC information, that's  
18 going to help us. The more information we have,  
19 the more we can do a better assessment.

20 But if we didn't have IHs at all, then  
21 -- we got the IHs to help the claim move forward.  
22 We didn't get the IHs to deny claims. We did it

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1 so that we could make some sort of exposure  
2 assessment, in the absence of any, to help these  
3 claimants with their claims.

4 So, you know, this is something we  
5 addressed -- this 1995 issue, the Circular issue,  
6 we addressed it in our recent response to the  
7 Ombudsman's report that you guys probably saw last  
8 night.

9 The one that's posted to the  
10 ombudsman's report is from 2015. This issue was  
11 addressed there. We discussed the fact that the  
12 Circular is one thing, but the threshold is a  
13 different thing, and that's why you're still seeing  
14 that language.

15 We still -- we -- that circular required  
16 claims examiners to make that assumption in every  
17 case without going to an IH. That is a requirement  
18 that was lifted.

19 CHAIR MARKOWITZ: Dr. Dement.

20 MEMBER DEMENT: I accept, and I think  
21 most hygienists would accept, that experience and  
22 knowledge of the hygienist needs to be used when

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1 appropriate.

2 But what I really object to is the  
3 statement in here that it makes -- it doesn't --  
4 the hygienist is not being forthright with regard  
5 to, I am assuming -- it makes it appear as though  
6 there's no exposures -- there actually is exposure  
7 information that will support that statement.

8 What I would like to see is the  
9 hygienist just say there's not much with regard  
10 to exposure information available; however, in my  
11 opinion, or based on my experience, or based on  
12 the published literature, exposures after this time  
13 frame would likely have been -- likely have been  
14 within, you know, regulatory exposure limits, but  
15 it doesn't, you know.

16 To me, when this goes to the CMC, the  
17 CMC takes that as a bold statement of fact when  
18 actually it's an opinion, a learned opinion, of  
19 course, but it's, nonetheless, an opinion.

20 MS. LEITON: I can look at the  
21 language. I'm pretty sure they say "likely would  
22 have been," but in terms of -- we can always look

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1 at modification on that language.

2 I do know that they say some of that  
3 language, but we can definitely look at it.

4 MEMBER TEBAY: With that, it's so  
5 important to -- what that language says, because  
6 that -- what happens, is you create a waterfall.

7 The minute that statement is put into  
8 place, it changes how the CMC reads it. It changes  
9 how -- or the ability for the claimant to respond.

10 Because once that statement is made  
11 that it's somewhat fact that it doesn't exist,  
12 you're put in a hole to try and rebut that comment  
13 to where if everybody knew that was looking at that  
14 claim that the reason they made that statement is  
15 because there was none in the file, but doesn't  
16 mean it doesn't exist, just means that I'm  
17 presuming.

18 Well, I can rebut, as a claimant, or  
19 help claimants rebut the fact that there's a  
20 presumption that there was no exposure.

21 I know claims very well at Hanford that  
22 we've used the site occupational medical director

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1 or IH on staff to say, this person working in this  
2 process as a sheet metal worker would have been  
3 exposed to these -- you know, would have been  
4 exposed to A, B, C and D significantly, which  
5 changes the whole outcome at that point.

6 Now, there's still not any IH data to  
7 document levels of the exposure, but that changes  
8 the fact that the first IH said that it doesn't  
9 exist. So, we have to be very careful with that  
10 language going forward.

11 CHAIR MARKOWITZ: Dr. Redlich.

12 MEMBER REDLICH: Carrie Redlich.

13 Let me just add one more comment to this  
14 whole discussion just from the perspective of a  
15 pulmonary or occupational medicine physician, you  
16 know, deciding whether the problem is work related,  
17 you know.

18 For the past 30 years, I -- we depend  
19 and use industrial hygiene input, but what's  
20 frequently most helpful is a knowledgeable -- you  
21 know, they're all knowledgeable -- an industrial  
22 hygienist who's knowledgeable about that

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1 particular site or process.

2 And frequently it's qualitative  
3 information that is also used in addition to  
4 quantitative in terms of, you know, the type of  
5 process, if it's spraying, welding, heating,  
6 enclosed space, the time period, and that -- and  
7 an understanding of the process that's being done.

8 And somehow that -- and the  
9 questionnaires that the workers fill out, or if  
10 they've had a transcript, actually provide  
11 sometimes more of that information than the SEM  
12 report.

13 But from -- it's almost like it's a  
14 higher standard than is the standard of care in  
15 which -- in 30 years in my practice, this clinical  
16 practice, is almost entirely patients with  
17 pulmonary disease with the specific question, is  
18 it exposure related.

19 I think the number of times that there  
20 has been quantitative exposure data from that  
21 workplace that supported -- and I do not just accept  
22 everything.

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1 I have a pretty high threshold, but the  
2 times that there's actually quantitative data that  
3 supports the exposure is so rare it's -- because  
4 that's a -- even in a workplace where sampling is  
5 done, as the point's been made, it's so sporadic.

6 So, we do want industrial hygiene  
7 input, but it's frequently more based on a  
8 qualitative understanding of the process and the  
9 time period and all that information that we've  
10 put together.

11 Unfortunately, most physicians because  
12 they know so little about the workplace or exposure  
13 data, I think over-interpret sometimes the SEM in  
14 a way that it wasn't meant to be interpreted as,  
15 like, the definitive word.

16 CHAIR MARKOWITZ: Okay. Other  
17 comments?

18 Dr. Silver.

19 MEMBER SILVER: I have an information  
20 management question about those nuggets of  
21 industrial hygiene data that do exist going back  
22 to Calin's example of a group of Hanford workers.

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1           Let's say a couple of them at this  
2 moment in time have chronic illnesses, they file  
3 claims, they don't have any exposure data, their  
4 claims are denied.

5           A few years go by and finally that one  
6 guy who does have evidence of exposure develops  
7 a chronic illness. He files a claim.

8           What happens to that exposure  
9 information: A, do you fish it out of his file  
10 and post it somewhere so that it can be generally  
11 applied to new claims, and; B, will you go back  
12 and look at the denied claims of those earlier  
13 workers in light of that exposure data?

14           MS. LEITON: Do you want me to answer  
15 that or do you want to have follow-up?

16           So, I mean, if I have one case that has  
17 a certain set of facts and I have another case that  
18 has a certain set of facts, I don't have the same  
19 claims examiner reviewing every case.

20           So, I'm not going to know, necessarily,  
21 that this person had the exact same fact pattern  
22 as this other person and be able to go back to that,

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1 unless there's something I can apply globally in  
2 making a presumption that people in this category  
3 -- then we can put it in the SEM and we can go back  
4 to the SEM and put that change in there.

5 So, that's the best way that I can do  
6 that and go and reopen a case. I can reopen a case  
7 at any time if there's new information.

8 So, if that other guy asked for a  
9 reopening and said, "I have this new information,"  
10 then I can go back to that case file, pull it out  
11 and reopen that case and accept it.

12 But unless there's something I can  
13 generalize on and go back and put in the SEM and  
14 then reopen that set of cases, which we have been  
15 able to do, that's the best we can do when it comes  
16 to that scenario.

17 MEMBER SILVER: So, if I understand,  
18 though, on my first point, you routinely fish  
19 exposure data out of individual claimant's files  
20 and add the information to the SEM?

21 MS. LEITON: If there's new  
22 information that can be added to the SEM, we

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1 absolutely do add it to the SEM.

2 CHAIR MARKOWITZ: So, do you want to  
3 continue with ---

4 MS. LEITON: Yeah. Sure.

5 Okay. So, I think we were -- well, we  
6 were still on No. 3 and this was with regard to  
7 the information sent to the industrial hygienists  
8 and the CMC.

9 Do you have further questions on that  
10 one?

11 Okay. The next one is on presumption  
12 for asbestos-related diseases. The advisory board  
13 recommends that the program add or modify  
14 presumptive standards relating to several  
15 asbestos-related diseases, the five conditions of  
16 asbestosis, asbestos-related pleural disease, lung  
17 cancer, and cancer of the ovary and larynx.

18 And the Board also recommends applying  
19 the presumption to all DOE workers who worked as  
20 a maintenance or construction worker.

21 And it has suggested that the  
22 presumption standard use 1995 as a threshold date

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1 before which sufficient exposure occurred.

2 So, we did make the changes, as you  
3 know, and we've been reopening the cases. We made  
4 some of the changes.

5 So, the existing presumption for  
6 asbestosis, that the employee must establish  
7 diagnosis of asbestosis, significant occupational  
8 exposure to asbestos for at least 250 aggregate  
9 workdays in a 10-year latency, is what we added.

10 I note that you guys have more  
11 recommendations with regard to asbestos, I believe,  
12 in your recent recommendations. So, we'll be  
13 looking at those separately.

14 Lung cancer, we added the presumption  
15 as you have suggested. The same for mesothelioma,  
16 asbestos-related pleural disease, ovarian cancer  
17 and laryngeal cancer.

18 The labor categories, again, it has  
19 been an area we've gone back and forth with you  
20 all about in terms of how we characterize them,  
21 what we add, what we don't add to that list of  
22 presumptions for labor categorizations.

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1 I also want to note that I believe your  
2 recent set of recommendations goes into further  
3 detail there, so ---

4 CHAIR MARKOWITZ: That's correct.

5 MS. LEITON: -- we'll be evaluating  
6 those as well.

7 Let's see. I think that covers that  
8 because I'm not going to talk more about the labor  
9 categories until we've evaluated your additional  
10 information.

11 No. 5, presumption for work-related  
12 asthma. The advisory board recommends language  
13 changes to procedural guidance relating to these,  
14 the presumption for occupational asthma.

15 As part of this recommendation, the  
16 Board has offered an alternative definition of the  
17 term "toxic substance."

18 Again, you've revisited this toxic  
19 substance issue in your most recent recommendation,  
20 so we will be addressing those again later.

21 We did make some changes to the asthma  
22 language in our Procedural Manual, but, as Dr.

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1 Redlich points out, maybe not all of them. We can  
2 continue to look at that.

3           Revise recommendation No. 6,  
4 presumption for COPD. The advisory board  
5 recommends modifications to the presumptive  
6 standards for evaluating claims involving COPD.  
7 Basically, this is the issue with regards to vapors,  
8 gases, dust and fumes.

9           It also recommends changing the period  
10 of exposure necessary to trigger presumption from  
11 20 to five years.

12           The SEM has some of the health effects,  
13 some of the toxic substances that are included in  
14 vapors, gases, dust and fumes that are linked to  
15 COPD, and I think that's what we mentioned here.

16           We legally have been having  
17 disagreements about the use of that term and how  
18 it can fit into our assessments because of various  
19 factors and the fact that it's a broad term.

20           I think that you've also addressed this  
21 again in your most recent, so we'll be looking at  
22 what you've provided to us there.

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1 CHAIR MARKOWITZ: Right. And we're  
2 going to be discussing COPD claims, so some of this  
3 will be revisited.

4 Dr. Friedman-Jimenez, did you want to  
5 say something?

6 MEMBER FRIEDMAN-JIMENEZ: Going back  
7 to No. 5, the asthma, what is the language that  
8 precludes using the NIH definition of a "toxic  
9 substance," which, I think, is quite well-accepted  
10 worldwide, the National Institute for  
11 Environmental Health Sciences.

12 What is it that keeps you from being  
13 able to accept this really expert body definition  
14 of a very fundamental term?

15 MS. LEITON: The statute, the way that  
16 it's written -- my understanding, from discussions  
17 with our lawyers -- is that the phrase "toxic  
18 substance" comes from the statute and they've  
19 defined it a certain way.

20 So, in order for us to -- so, we,  
21 therefore, have to define it the way that we define  
22 it.

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1           The statute and the rulemaking, they  
2           have the force and effect of law. And so, we can't  
3           consider how other entities define "toxic  
4           substance" because of the way the law is written.

5           MEMBER FRIEDMAN-JIMENEZ: I mean,  
6           we're not talking about just any other definition.  
7           We're talking about the NIH, which was created  
8           by Congress --

9           MS. LEITON: Yeah. Congress created  
10          the ---

11          MEMBER FRIEDMAN-JIMENEZ: -- defining  
12          something --

13          MS. LEITON: -- statute, too, though.

14          MEMBER FRIEDMAN-JIMENEZ: -- that  
15          Congress doesn't have the expertise to overrule,  
16          I think.

17          MS. LEITON: Well ---

18          MEMBER FRIEDMAN-JIMENEZ: So, I'm just  
19          wondering what exactly is the language that  
20          prevents you from using this better and more widely  
21          accepted definition?

22          MS. LEITON: It's the language in the

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1 statute. I can provide that to you separately.

2 CHAIR MARKOWITZ: Thank you.

3 MS. LEITON: Okay. So, on to No. 7,  
4 the OHQ.

5 CHAIR MARKOWITZ: Right. That was  
6 subject that we made a further recommendation about  
7 the OHQ.

8 MS. LEITON: Right.

9 CHAIR MARKOWITZ: So, you can skip  
10 that.

11 MS. LEITON: And then the last -- I  
12 think it's the last one. The last one is the  
13 quality assessment.

14 The Board recommends improvement to the  
15 quality of the CMC auditing. We do audits through  
16 the medical director as well as accountability  
17 reviews.

18 So, some of the recommendations  
19 surround the fact that maybe these CMCs or the way  
20 we apply the CMCs aren't being utilized correctly.

21 So, we do have what we have in place currently.

22 CHAIR MARKOWITZ: That's okay. We

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1 know we're looking at the CMCs ---

2 MS. LEITON: Yeah. Right.

3 CHAIR MARKOWITZ: -- when we're  
4 reviewing these claims. So, I'm sure we'll have  
5 further advice.

6 MS. LEITON: Okay. So, then I think  
7 that that covers it.

8 CHAIR MARKOWITZ: Okay. Any  
9 questions/comments from the Board members?

10 MS. LEITON: And I am seeking  
11 clarification on that issue that you asked me about  
12 from the Procedure Manual. I should hopefully have  
13 something soon.

14 CHAIR MARKOWITZ: Okay. Thank you  
15 very much.

16 MS. LEITON: Thank you.

17 CHAIR MARKOWITZ: Mr. Fitzgerald.

18 MR. FITZGERALD: I just want to take  
19 a couple of minutes to kind of update the Board  
20 on the kind of internal ---

21 CHAIR MARKOWITZ: Excuse me.

22 Can you hear in the back?

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1 MR. FITZGERALD: Can you hear me?

2 Can you hear me now?

3 Okay. All right. I just wanted to  
4 update the Board and the public on a couple of,  
5 like, internal issues that we're addressing right  
6 now.

7 One, is that the Board's charter, as  
8 most of you probably know, is a two-year charter  
9 and needs to be renewed every two years. So, this  
10 July is when the current charter expires.

11 We've started the process internally  
12 that the FACA -- the Federal Advisory Committee  
13 Act -- process within the Department of Labor to  
14 issue a new charter. We don't anticipate there  
15 being any significant changes to that.

16 We fully expect the charter to be in  
17 place by July when it expires now and I don't think  
18 there's anything the Board has to do.

19 It's just kind of an internal process.  
20 I just wanted it to be on record that we have started  
21 that process and we expect there will be a new  
22 charter in place by July.

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1           Also, as most of you are aware, we are  
2 shy one board member with the departure of Dr.  
3 Victoria Cassano.

4           We are actually going to be putting out  
5 -- I think, later this week or early next week in  
6 the Federal Register Notice, there will be a  
7 solicitation going out soliciting a new member for  
8 the Board either from the scientific or the medical  
9 community.

10           Because the way our composition of the  
11 Board is right now, we can kind of move members  
12 around so we can actually entertain the idea of  
13 there being a medical person or a scientific person  
14 to fill that particular slot.

15           So, that gives us a little bit more  
16 latitude in terms of, you know, the universe of  
17 people we can consider.

18           That nomination period will be open for  
19 30 days. At which time, we will close the  
20 nomination process and then start our internal  
21 processes for vetting and reviewing the candidates  
22 that are being nominated.

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1           And we hope to have somebody in place  
2 this summer, so kind of almost in tandem with the  
3 charter renewal as well. So, I just wanted to let  
4 everyone know that.

5           The third thing I wanted to -- and the  
6 last thing I wanted to just advise the Board about,  
7 is that, you know, we -- the Board has been around  
8 now for several years and we've gone through kind  
9 of like a -- probably a little bit of a learning  
10 curve in terms of how the Board requests information  
11 from the program.

12           At the last meeting, there were a number  
13 of requests for data and it kind of elevated the  
14 issue to the point where we think that it would  
15 really help the Board as well as help the program  
16 to kind of regularize the process for requesting  
17 data, particularly claims information.

18           The last data request that you all  
19 received, you see how voluminous it is and we have  
20 to be very concerned about protecting PII and those  
21 sorts of things.

22           So, we've actually created a -- kind

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1 of a very straightforward form that the chairman  
2 is going to submit to the program for requesting  
3 data, particularly claims data, so that we  
4 understand exactly what the purpose is and what  
5 the intended use is.

6 And it will help the program, I think,  
7 and the Board work together to make sure that the  
8 data requested can be fulfilled.

9 Sometimes, I think, we do this sort of  
10 request on the fly sometimes during board meetings.

11 It's like, well, we should get claims in on that.

12 And so, it's kind of found in the  
13 transcripts of the meetings, so we want to kind  
14 of formalize that request process a little bit more  
15 so we can actually determine the data that's being  
16 requested and then determine a time frame for the  
17 delivery of that data to the Board.

18 And I've talked to the chairman about  
19 that and I think we're on the same page with that.

20 It's a pretty straightforward sort of  
21 thing, but I think it will help kind of formalize  
22 and kind of, you know, bring more consistency of

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1 data requests from the program.

2 And those are the three items I just  
3 wanted to bring everybody up to speed on. Any  
4 questions?

5 CHAIR MARKOWITZ: So, I think -- this  
6 is Steve Markowitz.

7 I think -- I don't know, Carrie, do you  
8 have a copy of that form that -- okay. We're trying  
9 to bring that up so people can look at it. You can  
10 see what's being requested.

11 That's fine. We will, I think, be able  
12 to complete those forms for -- well, here's a  
13 question, actually: We made a data request --  
14 claims request December 10th. So, that's four and  
15 a half months ago.

16 Do you want us to fill out that form  
17 for -- with reference to that data request?

18 MR. FITZGERALD: Yes. In fact, I've  
19 asked Carrie to actually do kind of a first -- a  
20 first cut at that request based on the commentary  
21 that we heard from the last board meeting.

22 A lot of that -- the request, I think,

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1 was kind of, like, cobbled together in terms of,  
2 like, just a general statement, we need this and  
3 we need that.

4 The form will help us kind of, like,  
5 break that down into its component parts and so  
6 we can address it one at a time.

7 CHAIR MARKOWITZ: But if we're talking  
8 about how to facilitate the process, so we need  
9 to know what the -- understand what the challenges  
10 are in assimilating the data requests.

11 And if the problem is lack of  
12 specificity on our part, then we need to hear  
13 directly from the -- or however you want to handle  
14 it, we need to hear where the specific areas of  
15 clarity are needed.

16 The form is not necessarily going to  
17 settle that issue because there will be -- there  
18 needs to be some back and forth.

19 MR. FITZGERALD: Yes.

20 CHAIR MARKOWITZ: And so -- but that  
21 back and forth doesn't really happen that much.  
22 So, the question is, how can we make that happen

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1 so that we can -- we all can fulfill the request  
2 in a more timely fashion.

3 And then maybe that's a question for  
4 Ms. Leiton, I don't know, but I just say, you know,  
5 for having submitted a data request four and a half  
6 months ago and I haven't received any questions  
7 about what particular data we want or -- I don't  
8 -- the process is opaque to us.

9 It's a little frustrating because it  
10 doesn't, from our perspective, appear to be all  
11 that complicated.

12 I'm sure it is, but I should say the  
13 first board, we made a similar data request and  
14 we got data in a much shorter period of time.

15 And Dr. Dement did some work with this  
16 data and they were very illuminating, actually,  
17 to our processes.

18 So, I'm all for a data request form,  
19 but I don't think that's going to necessarily solve  
20 the problem because there needs to be some  
21 iteration, some back and forth, so that we can  
22 actually get to the -- a solution.

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1                   MR. FITZGERALD: I mean, I would agree  
2 and I think that this form actually helps kind of  
3 define what those requests are so there can be that  
4 kind of back and forth.

5                   I would like the back and forth to be  
6 as limited as possible, but right now it isn't  
7 really happening in a very formalized way.

8                   But I think that being able to  
9 articulate the request will elevate the issue for  
10 the program to be able to say, okay, you're asking  
11 for this information, either we have the data, or  
12 we don't have data, or it's going to be very hard  
13 to extract this data, is this what -- really what  
14 you need? We might have proxy data that we can  
15 substitute for certain things you're asking for.

16                   So, there will be a little bit of back  
17 and forth and a little more clarification, I think,  
18 of the request. And I think this form will help,  
19 you know, facilitate that conversation.

20                   MS. LEITON: This is Rachel.

21                   I think that part of it is to understand  
22 what it's going to be used for, how it relates to

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1 the mandate of the Board.

2 And if we know what it's going to be  
3 used for and how -- what you're specifically looking  
4 for, we can usually -- we can get the data in a  
5 format or in -- the information you're actually  
6 trying to get at a little bit easier. So, I think  
7 that was kind of the purpose behind it.

8 I'm hoping that we can work with Carrie  
9 to facilitate this next step fairly easily.

10 And I think that's what Doug was  
11 alluding, is that she can help frame what we're  
12 looking for in those requests as examples, correct?

13 So, Carrie will facilitate back and  
14 forth, as necessary, for this one and then -- and  
15 the additional ones.

16 CHAIR MARKOWITZ: But let me just say  
17 that the time frame has to be appropriate. So,  
18 if we submit a request December 10 and 2 weeks later  
19 we're asked, "What do you need these data for?  
20 How is it relevant to your chartered tasks?" that's  
21 fine.

22 But, frankly, to be asked that four and

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1 a half months later is not so fine. It doesn't  
2 really make sense.

3 So, we just need to shorten the time  
4 frames and have whatever back and forth is needed  
5 so that we can do the work that we're being asked  
6 to do.

7 MS. LEITON: And I'm sure that in  
8 future requests it will be a much faster turnaround.

9 CHAIR MARKOWITZ: Okay. Normally, we  
10 like to get specific and talk about numbers of days  
11 and weeks, but we will bypass that for the moment.

12 So, thank you -- oh, this is the data  
13 request form, but you can see just briefly  
14 delineation of the requested information is the  
15 first item.

16 So, I guess -- I think that, if I'm  
17 reading that correctly, it just asks for some degree  
18 of specificity.

19 The second item is statutory authority.

20 They want us to name what part of the statute,  
21 that is to say, which of our four assigned tasks  
22 the request relates to.

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1                   Whatever -- the third item is  
2 supporting rationale. That is to say it supports  
3 No. 2. Why it is that what we're requesting is  
4 needed to fulfill our function on our chartered  
5 mission.

6                   And then No. 4, there's a fourth item,  
7 which is intended use. So, it's pretty  
8 straightforward and I'm sure we can complete that.

9                   MR. FITZGERALD: And there's also  
10 just the appropriate notification about how this  
11 information is, you know, protected under the  
12 Privacy Act.

13                   So, it's just a good way to document  
14 that everybody has been informed about the privacy  
15 issues regarding the information that's about to  
16 be shared with the Board.

17                   CHAIR MARKOWITZ: Great. Okay. So,  
18 let's move on -- oh, so I would like to welcome  
19 Mr. Malcolm Nelson, who will present to us the  
20 Ombudsman report 2017.

21                   For board members, I just want to point  
22 out that sometime, I think, late last night we got

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1 -- I think it was late last night we got a -- the  
2 DOL response or comments on the Ombudsman report.

3 So, I just want to point out to you,  
4 in your email, there is some commentary from DOL  
5 about the report.

6 MS. LEITON: (Speaking off mic.)

7 CHAIR MARKOWITZ: Okay. Anyway,  
8 welcome -- welcome back, I should say.

9 MR. NELSON: Yeah. Good morning and  
10 thank you for inviting me.

11 I am Malcolm Nelson, the current  
12 Ombudsman for the Energy Employees Occupational  
13 Illness Compensation program.

14 As I said before, I want to start out  
15 by thanking you for inviting me here today, and  
16 I also want to commend the Board for its work  
17 reviewing many of the complex scientific and  
18 medical issues that underlie this program and to  
19 put forth recommendations intended to facilitate  
20 the claims process.

21 When I received this invitation, I was  
22 faced with a dilemma. And it's a dilemma I have

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1 every time I'm asked to discuss this program.

2 There's so much I would like to say,  
3 and I realize I have a limited amount of time to  
4 say it.

5 Secondly, I'm an attorney. I am an  
6 attorney and, you know, in law, a brief can be 50  
7 pages.

8 I was helped, however, because the  
9 Alliance of Nuclear Worker Advocacy Group provided  
10 the Board with a letter asking my office to outline  
11 certain issues.

12 These issues included examples  
13 surrounding the use of the SEM, issues involving  
14 the use of the language similar to the language  
15 in the now-rescinded Circular 15-06, and issues  
16 surrounding the policy regarding claims for  
17 bilateral sensorineural hearing loss.

18 For the sake of brevity, I'm going to  
19 limit my comments to those issues. However, there  
20 is one issue I do think -- or, really, two issues  
21 I really do think are important that are not related  
22 to those.

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1           First, one of the biggest problems we  
2 see with this program is that claimants -- there  
3 are many claimants who still don't know this  
4 program.

5           And so, one of the things I want to again  
6 commend this board, is for your willingness to come  
7 to different locations.

8           And it's always my hope that the  
9 publicity or the work being passed around that  
10 you're coming to these areas will help pass the  
11 word out and disseminate information about this  
12 program. So, you know, that's just something I'd  
13 like to point out.

14           Secondly, one of the biggest issues we  
15 find, is this is simply a complex program and many  
16 of the claimants we encounter simply struggle to  
17 understand this program.

18           There is an encounter I had very early,  
19 as the Ombudsman, and it's one that stuck with me  
20 ever since.

21           And in that encounter, someone called  
22 me one day to ask about the waiver form that

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1 claimants receive when they receive a recommended  
2 decision.

3 I began to explain the use of that  
4 waiver form and, as I was talking, I realized there  
5 was just total silence on the other end of the phone.

6 So, I finally stopped and I asked the  
7 claimant "Is there something wrong?" And very  
8 hesitantly they said, "I really need you to start  
9 with the beginning. You need to explain to me what  
10 the word 'waiver' means."

11 And that's really, I find, the problem  
12 with this program, that very often in this program  
13 we begin to tell claimants what to do or how to  
14 do it and, yet, they need us to start with the  
15 beginning.

16 They need someone to explain to them  
17 what a covered illness is. They hear "SEM." They  
18 need to understand what is SEM, what is that site  
19 exposure matrix. And I think that's one of the  
20 biggest problems.

21 We also see that claimants simply do  
22 not understand the claims process. They don't

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1 understand adjudication, in general, or this claims  
2 process and specifics.

3 So, we often find that claimants, you  
4 know, we're telling them, "You need to file this  
5 paper" or "You need to do this," and they really  
6 don't understand how to do that.

7 One of the biggest issues we have found  
8 now is that claimants don't understand how to  
9 develop evidence.

10 Over the years, we've talked to DOL and  
11 I will commend them. They now provide claimants  
12 with the reports prepared by the specialists. They  
13 give claimants those reports when they receive the  
14 recommended decision.

15 But one of the things we found is that  
16 claimants have no idea what to do with that decision  
17 or those reports. That we often talk to claimants  
18 and they have -- and they'll say "I went to my  
19 doctor."

20 And we say, "Well, did you take that  
21 report with you to your doctor?"

22 And they're like "No. Should I have?"

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1           And there's just that problem that  
2 claimants simply do not understand how to develop  
3 claims or don't understand the claims process.

4           And this is a problem we really see as  
5 we kind of segue into SEM, is that SEM is this tool  
6 and it's often mentioned in decisions, it's often  
7 mentioned in conversations with claimants, but  
8 claimants have no idea what SEM is.

9           Some of them don't even realize that  
10 it's an online tool. And so, you need to start  
11 at the beginning and often tell them, "This is an  
12 online tool" and to explain to them what it is.

13           Because we find that although SEM is  
14 often mentioned in decisions, claimants just kind  
15 of glaze over that because they have no idea what  
16 the SEM is.

17           In fact, one of the -- and then beyond  
18 that, what we find is that once claimants get to  
19 SEM, if they do get to SEM, we find that claimants  
20 have no idea how to navigate SEM.

21           I can't tell you how many times I've  
22 talked to a claimant and they will tell me they

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1 have printed out information from SEM and they now  
2 know the toxins they've been exposed to.

3 And, yet, when we looked at what that  
4 claimant has, all they have done is gone to SEM  
5 and they have that initial list of all the toxins  
6 that were at the facility.

7 Those claimants don't understand SEM  
8 and don't know how to refine the SEM search to start  
9 looking at labor categories, buildings and areas  
10 and things of that nature.

11 The other problem we find, as we get  
12 into SEM, is that many of the claimants question  
13 the accuracy of the information found in SEM, and  
14 we've already started to discuss some of that.

15 But the issues we hear from claimants  
16 is that, as I said before, are things that we said  
17 before, but different -- similar jobs were called  
18 different things at different facilities. So, there  
19 is that equivalency issue by claimants.

20 And so, we always hear claimants say,  
21 "Yes, I was a welder, but we did welding differently  
22 at my facility."

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1           Or, more importantly, what claimants  
2 tell us is that almost everybody's job or  
3 everybody's job description has that phrase at the  
4 end "other duties as assigned."

5           And claimants always tell us that they  
6 did a lot of other duties as assigned, and those  
7 duties simply are not written down anywhere and  
8 not recorded.

9           And so, a big problem for claimants is  
10 that there really is no process of really  
11 understanding what they do and this turns into an  
12 issue with the occupational history questionnaire.

13           We find that claimants generally take  
14 this history questionnaire very early in the claims  
15 process and that basically what the claimant is  
16 told to do is tell me everything about your job.

17           And what I find, is that claimants  
18 approach that, kind of in my mind, the way you  
19 approach your résumé.

20           You talk about -- you talk a lot about  
21 the things you're doing now, but you don't talk  
22 so much about the things you used to do years ago.

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1           And so, the problem for claimants is  
2           that they've done this occupational history  
3           questionnaire and now it's going to be used to make  
4           determinations, it's given to the IH or these other  
5           specialists in making determinations about their  
6           job.

7           And the argument by the claimants is  
8           that as this case starts to get refined, as you  
9           begin to identify the specific toxins or as you  
10          begin to focus on certain jobs I have, there needs  
11          to be some going back to the claimant so that  
12          claimant can now provide more detail about those  
13          specific issues.

14          And that's really an issue like, you  
15          know, where many claimants say that in addition  
16          to -- well, let me move back.

17          The Board has recommended that  
18          claimants -- that industrial hygienists should be  
19          able to talk to claimants.

20          Claimants agree with that, but  
21          claimants go a step further and they think that  
22          they should be able to talk to all of the specialists

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1 that are going to have input in their claims because  
2 claimants feel that they can begin to explain to  
3 these specialists the very specific things about  
4 their job.

5 And, as I said before, and especially  
6 as the case begins to narrow -- as we begin to narrow  
7 the focus of the case, claimants feel that they  
8 can provide that detailed information, information  
9 you are not going to give in a general conversation  
10 about your job, but information you may very well  
11 provide when somebody is asking you about your --  
12 this specific job or this specific exposure.

13 The other problem claimants have, you  
14 know, they often point out, is just finding records.

15 Most claimants, because they worked at  
16 these facilities, they never had access to records.

17  
18 So, there is that question from  
19 claimants, you know, "You're telling me I need to  
20 support -- you know, need to submit more evidence  
21 about my work or my exposures. Where do I find  
22 records?"

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1           And for many claimants because they  
2 don't have records, they end up having to rely on  
3 their own testimony, what is often called  
4 "self-reporting evidence," and claimants question  
5 the weight that is given to the self-reported  
6 testimony.

7           I hear complaints all the time from  
8 claimants suggesting that they took a lot of time  
9 talking to their claims examiner, telling them  
10 about their job, yet that information is not --  
11 sometimes it's not even mentioned in the decision.

12           And if it is mentioned in the decision,  
13 it's seen not to have had any impact on the decision.

14           It's often suggested -- I've had it  
15 suggested that just because the evidence is not  
16 mentioned in the decision does not mean that that  
17 evidence wasn't considered.

18           The problem for claimants, however, is  
19 that if the evidence is not addressed in the  
20 decision, they don't know if -- first of all, if  
21 it was actually reviewed.

22           And if it was reviewed, they don't

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1 understand why it was not accepted, and that leaves  
2 claimant in the position of not knowing what to  
3 do next, you know.

4 I've told -- you know, the claimants  
5 tell us "I've told the CE my job. It did not seem  
6 to impact the CE. Do I need to tell them more  
7 detail? Did they not understand what I said? Do  
8 I need to clarify what I said or is it that I need  
9 to go get more information?"

10 The feeling we hear by most claimants  
11 is that when it comes to self-reported evidence,  
12 that evidence is only going to be accepted if it  
13 is supported by other evidence in the record.

14 And, again, this troubles claimants  
15 because self-reported evidence is usually most  
16 critical in those instances where there either is  
17 no other evidence or where they feel that the  
18 evidence in the record is inaccurate.

19 So, you know -- and claimants also feel  
20 that -- there is a concern that claimants have that  
21 because they're often talking to a CE who does not  
22 fully understand that work, especially does not

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1 understand how that work was done 20, 30, 40 years  
2 ago, that they would love to talk to someone who  
3 has more experience.

4 And that's something that claimants  
5 often argue, is that when you're talking about this  
6 work -- and this goes even in talking to the  
7 industrial hygienist or when the industrial  
8 hygienist is reviewing the report -- it's not how  
9 that work is done today, it's how that work was  
10 done 20, 30, 40 years ago.

11 And not just 20, 30, 40 years ago, but  
12 was done in a closed environment behind this gate  
13 where oftentimes they were being rushed to do this  
14 work.

15 Claimants tell us that in much of --  
16 they worked in an environment -- many of these  
17 claimants tell us they worked in an environment  
18 where getting the work done quickly took precedence  
19 over following rules and regulations.

20 And so, claimants say "You have to  
21 understand that" -- and that's something I often  
22 tell claimants, "I understand."

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1           Very early in my life I worked for five  
2 summers for the Central Intelligence Agency. I was  
3 a summer employee because my parents worked here.

4           My job was to install alarm systems.

5           And the things I remember about that is, first  
6 of all, working behind that gate there was a whole  
7 different world.

8           You -- we did things behind that gate  
9 that we would not do outside of that wall because  
10 we knew we were in this insulated world.

11           Like, I tell people all the time, I was  
12 up on aluminum ladders holding a Coca-Cola in my  
13 hand and cutting wires -- live wires because that's  
14 how you got the job done, you know.

15           I didn't worry about OSHA coming in and  
16 standing over my shoulder because OSHA couldn't  
17 get behind that gate.

18           The other problem I realized was that  
19 in my old job, the rule was we -- once I started  
20 working on that alarm system, when I left, there  
21 had to be a working alarm system.

22           And I'm here to tell you I cut corners

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1 and everything else to get that alarm system  
2 working.

3 I went to whatever room I had to go into  
4 to get that alarm system working and I did whatever  
5 I had to do.

6 And that's what claimants argue about  
7 their jobs, is that you look at SEM and SEM has  
8 this job -- is based on these job descriptions or  
9 these, you know, kind of procedures, and those are  
10 the procedures -- those are nice, written  
11 procedures.

12 But on a day-to-day basis, they did not  
13 follow those procedures. They were being rushed  
14 to get that job done.

15 And to do that job, they went anywhere  
16 and everywhere they had to go and they feel that  
17 there's simply not enough consideration to that.

18 Another issue we often hear from  
19 claimants regards smoking history. It's been  
20 often suggested that smoking history is not a factor  
21 in decisions, yet claimants often come to us with  
22 decisions where the CE -- and maybe sometimes the

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1 specialist, the CMC -- has specifically referred  
2 to the claimant's smoking history and has concluded  
3 that it was the smoking as opposed to these other  
4 exposures that caused the claimant's illness.

5 And claimants just really want a  
6 clarification, you know, on exactly what does it  
7 mean and what consideration should be given to  
8 smoking history in these cases.

9 When it comes to the language in  
10 15-06 -- and, again, this is something we've already  
11 talked to -- it's been noted that -- and I think  
12 Ms. Leiton has already said it, that while this  
13 circular was rescinded, it does not mean that the  
14 use of 1995 as a threshold to indicate general  
15 exposures would not have been within regulatory  
16 limits, was not a factual statement.

17 The problem that claimants have is that  
18 -- and I think it was a question that one of the  
19 board members has already raised, is what is the  
20 impact of the fact that your exposures were within  
21 regulatory limits.

22 Under this program, you could be

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1 compensated if your exposures caused, contributed  
2 or aggravated your illness.

3 And I guess the question that claimants  
4 have is, are we saying that an illness cannot be  
5 contributed to or aggravated by regulatory -- by  
6 exposures within regulatory limits? Is that an  
7 absolute rule? And that's just the question that  
8 claimants have with that issue.

9 And also, if I can just say from my own  
10 experience, when you talk about presumptions, there  
11 are both positive presumptions as well as the  
12 negative presumptions.

13 Positive presumptions are those more  
14 common presumptions where you assume that if a  
15 person has X number of years and has certain  
16 exposures, you may presume that their illness was  
17 caused by those exposures.

18 Negative presumptions are not that  
19 common where you try to say, "Well, if you don't  
20 have this and you don't have this, then you can't  
21 have any exposures or your illness cannot be  
22 exposed."

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1           Those are fairly rare and really have  
2 to be supported by a lot of evidence, at least in  
3 my experience.

4           In this regard, we also see an issue  
5 that claimants have -- and, I think, again it's  
6 been -- everything I've said has been referred to  
7 already, but you see these industrial hygienist  
8 report where the industrial hygienist starts out  
9 by saying the person had significant exposure; but  
10 then they provide a table rating the exposures for  
11 various toxic substances.

12           And those toxic substances they rate  
13 by the extent and level of exposure. So, it could  
14 be frequent or, you know, not frequent and high  
15 or low exposures.

16           And from that, the CE concludes that  
17 the exposure is either caused or not caused --  
18 caused or did not cause the claimant's illness.

19           And claimants want to know what really  
20 are the guidelines that the CE has, and any  
21 industrial hygienist has, in determining even  
22 though you had a significant exposure, that somehow

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1 this frequent or low -- you know, there's just --  
2 it's really not very clear to claimants, you know.

3 Most of the claimants we talk to, they  
4 -- as soon as they see the word "significant  
5 exposure," they're like, "I had significant  
6 exposure."

7 So, what does that "frequent" and "low"  
8 mean and how is the CE to apply that in a case?

9 The hearing loss policy also continues  
10 to be a concern for claimants. And here, I must  
11 acknowledge that; one, the Board has been -- is  
12 already looking at this issue, but claimants  
13 question, why, if they do not meet those -- the  
14 three criteria that's been outlined by DOL, they  
15 are not given an opportunity to at least try to  
16 establish that their hearing loss was nevertheless  
17 caused, contributed to or aggravated by exposure  
18 to the list of specific toxins.

19 We hear this with a lot of hearing loss  
20 claims, but we especially hear it where the decision  
21 recognizes that the claimant had exposure to one  
22 of the listed toxins and had exposure for ten or

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1 more consecutive years; yet, the claim was denied  
2 because the claimant did not work in one of the  
3 enumerated job categories.

4 Over the years, this has troubled  
5 claimants who noted that, again, their job was --  
6 that similar jobs did not always go by the same  
7 name at different sites, as well as by those who  
8 noted that while their job description may not have  
9 included work similar to that performed by those  
10 in enumerated job categories, they -- these were  
11 duties that they were assigned, nevertheless.

12 So, essentially, claimants question  
13 whether the information concerning these job  
14 categories was so complete that it absolutely  
15 precluded the possibility that someone working in  
16 another job category could not have had hearing  
17 loss associated with the exposures.

18 Now, as it's been noted, DOL has just  
19 released a new version of a Procedure Manual and  
20 this version outlines a procedure for the CE when  
21 the claimant makes a claim that the job that the  
22 employee performed is synonymous to one of the

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1       qualifying labor categories.

2               Yet, the concerns raised by claimants  
3 still apply to those who do not have the ten  
4 consecutive years of employment in a qualifying  
5 job category prior to 1999.

6               Claimants want -- you know, claimants  
7 have raised that same question about why must it  
8 be ten consecutive years?

9               Does the medical evidence that exists,  
10 is it that clear that a claimant who has  
11 accumulative more than ten years, but somehow  
12 somewhere had a break, that there can be absolutely  
13 no impact to hearing loss?

14              But we see cases all the time where the  
15 claimant had, you know, six, seven years of  
16 exposure, then there's a break maybe of six months,  
17 maybe a year, two years, and they go back to work  
18 for maybe another seven, eight years and claimants  
19 just do not understand why that break, six months  
20 or whatever it is, is so impactful that it should  
21 say that they don't get to proceed with their  
22 hearing loss case.

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1                   We also hear similar issues about that  
2                   1990 date, and we especially hear this from  
3                   painters.

4                   And painters come to us all the time  
5                   and try to -- and tell us -- or ask us to try to  
6                   tell us -- tell them what happened in 1990 that  
7                   all of a sudden that same paint that they were using  
8                   that they applied the same way, all of a sudden  
9                   now it doesn't have an impact on them.

10                  So -- and I think, as it's been said,  
11                  you know, while this may be a generality or a  
12                  presumption, claimants feel that they should have  
13                  the opportunity to rebut their presumption and to  
14                  show that, in their jobs, there was nothing --  
15                  nothing changed in 1990.

16                  Because the Procedure Manual has been  
17                  revised a couple of times, the approach to hearing  
18                  loss has changed somewhat.

19                  But one of the things that continues  
20                  to confuse claimants is that some of the most recent  
21                  versions, on the one hand, say that a claimant --  
22                  that the claims examiner can review or should review

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1 the case even if the claimant does not have -- does  
2 not meet the criteria outlined for hearing loss.

3 But then those provisions of the  
4 Procedure Manual go on to say that if the claimant  
5 wants to challenge the criteria, the claimant has  
6 to show -- and let me try to find my language.

7 They have to show that -- the claimant  
8 has the burden of establishing through the  
9 submission of probative scientific evidence, that  
10 the criteria used by the program do not represent  
11 a reasonable consensus drawn from the body of  
12 available scientific data.

13 First of all, claimants don't -- the  
14 way the most recent provisions -- I mean, of the  
15 PM about hearing loss have been written, claimants  
16 really aren't sure of what they're supposed to do  
17 if they want to challenge a hearing loss denial.

18 But, secondly, to the extent that most  
19 of them read this as saying that they have to now  
20 show that the criteria is not based on a reasonable  
21 -- a reasonable consensus drawn from the body of  
22 available scientific data, claimants feel that

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1 that's placing a very high and costly burden on  
2 them.

3 On the one hand, claimants feel that  
4 that means that they're going to have to go find  
5 specialists who can make -- who can address that,  
6 which first means that they're going to have to  
7 get all of the evidence or all the data the DOL  
8 has relied on.

9 And, secondly, you know, claimants feel  
10 that with the give and take that will often occur  
11 when you're debating medical science, that it can  
12 get very costly to try and engage with those medical  
13 professionals.

14 I could go on and on -- like I say, I  
15 could go on and on, but I'm going to stop here to  
16 see if there are any questions that anyone has.

17 CHAIR MARKOWITZ: Comments?  
18 Questions?

19 Dr. Silver.

20 MEMBER SILVER: Thank you very much for  
21 a concise, punchy, provocative presentation.

22 Your remarks about smoking set off a

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1 little light bulb for me. One of the COPD cases  
2 we received involved a worker whose claim was  
3 denied.

4 Nowhere in the chain of evidence did  
5 anyone dispute that she smoked one to two cigarettes  
6 a day.

7 And we all know people like that, right?  
8 After a meal, on a break or just part of their  
9 daily habit.

10 Yet, when it came to the CMC's report,  
11 there was an elaborate paragraph about the  
12 contribution of smoking to COPD, and I began to  
13 wonder whether that was a cut-and-paste,  
14 boilerplate paragraph that goes into every one of  
15 the CMC's opinions on COPD.

16 Have you seen inappropriate  
17 boilerplate language in these claims?

18 In the Parkinson's case that I looked  
19 into, there was an analogous paragraph that was  
20 all about the histopathology of Parkinson's and  
21 said something about genetic risk for people under  
22 50.

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1 Well, this guy was 82. So, is that  
2 going on where --

3 MR. NELSON: Unfortunately --

4 MEMBER SILVER: -- there's kind of a  
5 mass production event that CMCs are cutting and  
6 pasting?

7 MR. NELSON: Unfortunately, my office,  
8 we don't often see a lot of the information in the  
9 claim file.

10 Every case with us is different in terms  
11 of how much information we see and are able to  
12 review. So, I'm really not in a position to try  
13 to say, oh, there's this pattern going on.

14 What we do have - I mean, we do hear  
15 from claimants with very similar - and I hope maybe  
16 it's even the same claimant, but we hear from  
17 claimants with a similar argument, is that the  
18 smoking history that seems to get passed on to the  
19 specialist, they take exception with that, you  
20 know, they say they may have smoked, you know, a  
21 lot of cigarettes in the past, but they often try  
22 to stress to the -- you know, in the occupational

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1 history that they had not smoked very heavily in  
2 the last 20, 30 years and somehow it all got kind  
3 of reduced to a heavy smoking history.

4 So, I think there are claimants who do  
5 challenge the interpretation of their smoking  
6 history.

7 CHAIR MARKOWITZ: Questions?  
8 Comments?

9 Ms. Pope.

10 MEMBER POPE: Yes, I too want thank you  
11 for your support and help with these claimants with  
12 their claims.

13 I also see the similar problems and  
14 concerns when claimants are trying to -- the burden  
15 of proof is just overwhelming in terms of them  
16 supplying all this information, but having an  
17 advocate there at the resource center or in the  
18 process of these claimants trying to provide all  
19 this information, not to mention trying to navigate  
20 through the overwhelming process of trying to  
21 figure out how to submit this information -- so  
22 they're going through the history of their job

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1 description and I notice, during one of the claims  
2 that I was reviewing, that the security guard --  
3 he was a security guard, but the CMC had -- seemed  
4 like the CMC had this assumption that he was not  
5 exposed to the different things that the claimant  
6 was saying that he was exposed to like welding fumes  
7 and diesel fumes and how he could possibly come  
8 down with the types of illness that he had presented  
9 to the claim.

10 But I think it's important to have  
11 someone to have some knowledge of that site to add  
12 to the claimant's information in order to have a  
13 -- for the CMC to have that information in the case  
14 to help to support what that claimant is trying  
15 to present.

16 MR. NELSON: It is. I mean, again,  
17 you're having this -- what I hear from claimants  
18 in the occupational history questionnaire when  
19 they're engaged in that, you know, they've been  
20 told to talk about their jobs, but, as I said, they  
21 have no idea what the -- what anybody wants, you  
22 know.

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1           I worked for the Government for 43  
2 years. If you start asking me, you know, I'm sure  
3 there's a lot I would just leave out because I have  
4 -- you know, there are things I think are important,  
5 but, you know, may not be what you're looking for.

6           And that's the problem I think the claimants have  
7 at least initially.

8           And then as the claim goes on, no one  
9 ever tells the claimant "Why don't you go back and  
10 update your occupational history questionnaire  
11 because now you can see that they're focusing on  
12 this issue or they're asking you about these dates.

13           Go back and focus on those dates."

14           One, many claimants don't think about  
15 that. That doesn't even enter their minds.

16           Secondly, a lot of claimants have  
17 honestly told me they're afraid to do that because  
18 they're afraid if they go back and try to clarify  
19 the history questionnaire, they're going to be  
20 accused of now trying to make up stuff to get  
21 benefits.

22           So, they feel like they're kind of

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1 caught in this catch 22, but -- you know, and that's  
2 why I said many claimants feel if they could talk  
3 to the IH, if they could talk to the toxicologist,  
4 here is somebody who at least has some expertise  
5 in these areas.

6 And as they begin to talk to them, they  
7 can explain, like -- you know, very often the SEM  
8 will say this person was not exposed to this toxin.

9 The claimant can tell you how they --  
10 not only that they were exposed to it, but they  
11 will explain to you how they work with it.

12 And they feel if I can talk to someone  
13 who has a basic understanding of this job and how  
14 it was carried out, I can explain to them how I  
15 can be exposed to this.

16 CHAIR MARKOWITZ: Well, you know --  
17 Steve Markowitz -- we have from -- even from the  
18 previous board, recognized -- as DOL has the  
19 limitations of the SEM and have tried to make some  
20 recommendations to improve the exposure  
21 information available for the decision-makers,  
22 including improving the OHQ and encouraging that

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1 the industrial hygienist could speak directly to  
2 the claimant. So, those would be concrete ways  
3 in which the exposure information could be  
4 improved.

5 I have a question -- and actually it's  
6 not about the work of the Board per se, but the  
7 first point you raised about people -- claimants  
8 not really understanding some of the communication  
9 they get and understanding the process.

10 So, I can express some of the claims  
11 I've read that the final decision is pretty  
12 comprehensive, actually, not written at the  
13 appropriate literacy level for many claimants.

14 And -- but the cost of being  
15 comprehensive and detailed is that it gets into  
16 language which is not readily understandable.

17 Do most people have authorized  
18 representatives?

19 Do the authorized representatives  
20 serve that function of translating those kind of  
21 communications for people?

22 Is that part of the system functioning

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1 well?

2 MR. NELSON: I can only talk about the  
3 claimants my office encounters. The majority of  
4 the claimants who I -- my office encounters either  
5 do not have an authorized rep, or if they have an  
6 authorized rep, that authorized rep is a family  
7 member who themself really do not understand the  
8 program.

9 But beyond that, another problem that  
10 claimants have -- and I'm glad you asked that  
11 question. It was something I wanted to say and  
12 had forgotten.

13 The other problem is that even when  
14 claimants have an authorized representative, that  
15 authorized representative does not always assist  
16 the claimant with every issue in the case.

17 We -- I have a guess as to why, but what  
18 we often find is that authorized representatives  
19 will help claimants in what I call get the initial  
20 benefits, but they tend to drop out of the case  
21 when those cases get to issues like medical benefits  
22 and billing issues.

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1           And the feeling is the way the statute  
2           is written, the statute is very clear that that  
3           AR gets paid for certain services and assisting  
4           the claimant with billing issues and with home  
5           healthcare-type issues, the statute is not clear  
6           or doesn't really address how that AR gets paid.  
7           So, the ARs just stay away from those issues.

8           There has also, you know, quite  
9           honestly, has been the feeling by many claimants  
10          is that because of the way the statute is written,  
11          the statute limits the amount of money that an AR  
12          will get paid in a case.

13          And so, that ARs tend to participate  
14          or represent claimants in the easier cases and they  
15          tend to avoid the complex cases.

16          So, what we tend to find is that  
17          claimants cannot find an AR in the very cases where  
18          they most need the help, which are the complicated  
19          cases.

20          And lastly -- I mean, two other things.  
21          One, as you realize, under the statute, if the  
22          claimant utilizes the services of an AR, the

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1 claimant has to pay that AR.

2 And many claimants have told us they  
3 simply don't have the money to pay the AR, and I  
4 know people come back and say, well, you'll get  
5 some money from the claim.

6 And claimant's response to that is,  
7 even if they get that money, that money generally  
8 does not cover all the costs that they paid on these  
9 claims or paid, you know, for their -- on their  
10 health so that any money they have, they need for  
11 other purposes.

12 So, many claimants just don't even  
13 pursue an AR because they don't want to have to  
14 pay.

15 And lastly, and this is one I talk  
16 about. I think it gets overlooked all the time  
17 or people don't understand, but the people we --  
18 the majority of these people who worked at these  
19 facilities, the generation they come from, they're  
20 very proud people and they're very proud about that  
21 work that they did at those facilities, and they  
22 don't want to fight the government.

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1           And so, they don't want to go get an  
2 AR because they interpret going to get an AR as  
3 going to get an attorney.

4           And they see that as fighting the  
5 government, and they just don't want to be viewed  
6 as fighting the government.

7           So, all I've got to say, in my  
8 experience, a lot of the claimants I encounter do  
9 not have an AR.

10           If they have an AR, as I said, it's a  
11 family member or, for whatever reason, they have  
12 an AR and, yet, that AR is not helping them with  
13 the issues they are having problems with when they  
14 come to us.

15           CHAIR MARKOWITZ: I have one other  
16 comment.

17           MR. NELSON: I --

18           CHAIR MARKOWITZ: Oh, go ahead. I'm  
19 sorry, I didn't meant to cut you off.

20           MR. NELSON: No, this is something I  
21 -- you know, again, as I sit here, I'm thinking  
22 of things I was supposed to do and I did not do.

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1                   And I -- initially, I was supposed to  
2 also introduce Amanda Fallon, who is here from our  
3 office as well. I didn't want to have to go back  
4 to the office without having done that.

5                   Go ahead. Sorry.

6                   CHAIR MARKOWITZ: That would be  
7 unwise, yes.

8                   MR. NELSON: Yes.

9                   CHAIR MARKOWITZ: I was also struck,  
10 reading some claims, that the physicians, the CMCs,  
11 usually talk about smoking with reference to COPD,  
12 and I don't know if DOL is ever going to be able  
13 to stop them from doing that.

14                   Maybe later after lunch, Ms. Leiton,  
15 if you could address whether DOL actively tells  
16 the CMC not to address the role of smoking in, say,  
17 COPD or another claim because -- and even if you  
18 did, frankly, I would expect the doctors to ignore  
19 -- you know, many doctors to ignore that advice  
20 because that's what we do, but -- and I can see  
21 where that would be confusing to people.

22                   I mean, it was confusing to me because

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1 I'm thinking, well, how does the CMC really thinking  
2 about that case -- if they're largely or almost  
3 exclusively attributing it to smoking, how are they  
4 thinking about the occupational exposures?

5 So, I appreciate that comment, that  
6 potential source of confusion for claimants.

7 MR. NELSON: Yeah. And just, in  
8 general, another issue that often comes up, SEM  
9 really only addresses causation.

10 And so, you know, when the specialist,  
11 the industrial hygienist or whatever, when they  
12 are looking at SEM, you know, the other question  
13 just comes to -- kind of comes to smoking, but all  
14 is to what extent are they really evaluating  
15 contribution and aggravation?

16 So, once again, you know, when that  
17 doctor is saying it's mostly or due to smoking,  
18 they're saying mostly due to smoking, you know,  
19 are they just ruling out any contribution or  
20 aggravation by these other toxins? And that's  
21 always the question that really confuses claimants.

22 CHAIR MARKOWITZ: Okay. Any other

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1 comments?

2 Dr. Friedman-Jimenez.

3 MEMBER FRIEDMAN-JIMENEZ: When we're  
4 talking about contribution to causation of a  
5 disease, I think it's completely appropriate to  
6 mention smoking and -- when you're talking about  
7 COPD, for example.

8 It probably does contribute to COPD,  
9 but that doesn't change, in any way, the  
10 contribution of other environmental causes of COPD  
11 unless there are epidemiologic data to show that  
12 smoking prevents the other exposure from causing  
13 COPD, and I haven't seen those kind of data.

14 So, I think it's pretty benign to  
15 mention smoking, but it's not benign to suggest  
16 that -- and somehow the smoking history negates  
17 the other causation of COPD.

18 It's the rule, not the exception, that  
19 diseases are caused by multiple, different factors.

20 Sometimes they add together  
21 additively, sometimes they multiply. Most often  
22 they combine in some way in between those two, but

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1 they should be considered separately.

2 And I don't think mentioning smoking  
3 adds or subtracts from the causation question for  
4 the other exposures.

5 But it is used in that way, in some  
6 settings, and I think that's what some of us are  
7 objecting to.

8 CHAIR MARKOWITZ: Yeah, Dr. Silver.

9 MEMBER SILVER: It's not benign to fail  
10 to distinguish between vanishingly low levels of  
11 smoking and heavy smoking.

12 Lord knows dose-relatedness is a big  
13 issue when it comes to chemical exposures.

14 CHAIR MARKOWITZ: Are there any other  
15 comments or questions? Otherwise, thank you very  
16 much --

17 MR. NELSON: Thank you.

18 CHAIR MARKOWITZ: -- for the talk, and  
19 you'll be around for the day if people have  
20 questions?

21 MR. NELSON; Yes, I will.

22 CHAIR MARKOWITZ: Thank you.

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1           So, just a couple of short items before  
2 we break for lunch because we've covered these --  
3 the action items from our November 2018 meeting,  
4 I think, we've discussed, for the most part.

5           We've also discussed the data and  
6 claims request from December 10, 2018. We did  
7 request a large number of claims for multiple  
8 conditions.

9           And when we were asked to try to triage  
10 that recently or, you know, in some number of weeks  
11 ago -- I can't remember the timing, exactly -- we  
12 decided to focus first on Parkinson's Disease and  
13 COPD. So, that's where we're at now and we'll  
14 continue to pursue those requests.

15           The issue of COPD -- maybe this is the  
16 first meeting, but we don't have a reformulated,  
17 revised recommendation for COPD.

18           It's -- we're at a bit of a stalemate  
19 in terms of the way we view it and the way we think  
20 the program should accommodate it, but, more  
21 importantly, actually we have claims to look at.

22           And so, we can see actually what sense

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1 our recommendations make vis-a-vis the claims and  
2 how the -- how, in the real claims, how COPD is  
3 actually considered. And that's what we're doing  
4 now by reviewing those claims.

5 So, we may yet come up with revised  
6 recommendation for COPD, but it will be after we  
7 review some claims.

8 Any comments or questions? Otherwise,  
9 we are going to break for lunch. It's 12 o'clock.

10 We will resume at 1:00 p.m.

11 (Whereupon, the above-entitled matter  
12 went off the record at 11:59 a.m. and resumed at  
13 1:09 p.m.)

14 CHAIR MARKOWITZ: Okay. Let's get  
15 started. 1:10. I'd like to thank the very  
16 faithful public who has stuck around for the  
17 afternoon session. Welcome everybody back.

18 All right. So, our next topic is going  
19 to be reviewing some claims on chronic obstructive  
20 pulmonary disease, otherwise known as COPD.

21 But before we look at individual  
22 claims, I'd like to open it up for discussion about,

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1 sort of, how we should do this, where we might expect  
2 to get to today.

3 My own feeling is that, you know, we  
4 received these claims about two weeks ago. I know  
5 that Mr. Domina has been on the road for the last  
6 two weeks and probably hasn't had a whole lot of  
7 time.

8 I know that Mr. Mahs has been involved  
9 with training activities for the past ten days,  
10 and others of us are busy.

11 So, I'm sure we haven't had the  
12 opportunity to review all the claims, even the  
13 limited number that we were asked to. So, this  
14 is an initial conversation and it will be ongoing.

15 I think our observation should be  
16 considered provisional in that sense. I'm not sure  
17 whether we're going to be able to come to any even  
18 reasonable consensus about conclusions, so other  
19 comments on how you think we should approach this?

20 Dr. Dement.

21 MEMBER DEMENT: I guess there might  
22 be some individual cases that are worthy of a group

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1 discussion, and likely are, but I think at the end  
2 of the day, as we all go through our cases and we  
3 get more experience across the board and we get  
4 some underlying observations, it might be worthy  
5 of each of us to take the time just to jot down  
6 talking points about major observations and then  
7 come back at a later date and sort of discuss our  
8 major observations and we can use cases as examples  
9 to support or not support those observations.

10 CHAIR MARKOWITZ: Okay. Other  
11 comments?

12 Dr. Silver.

13 MEMBER SILVER: We put a lot of work  
14 into recommended presumption for COPD. Even  
15 though the Department hasn't accepted it, I think  
16 a real important question to ask particularly for  
17 the denied cases is, would the outcome had been  
18 different had our presumption been accepted by DOL?

19 Or if it were to be in the future, would  
20 it have influenced the outcome of the denied COPD  
21 cases, building a record for continuing to debate  
22 the issue.

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1 CHAIR MARKOWITZ: Other comments?

2 While you're thinking, just for the  
3 moment, I want to remind the Board about our tasks  
4 and how they relate to review of claims so that  
5 it's clear what our role is.

6 The first task is to look at site  
7 exposure matrices. Obviously, those are used by  
8 the industrial hygienists and maybe the CMCs.

9 Secondly, we're asked to weigh in on  
10 the medical guidance for claims examiners. And  
11 this directly pertains to what the claims examiners  
12 provide the CMC, certainly, but also I would argue  
13 the IHs.

14 And then, finally, Task 4, and for those  
15 members who -- of the Board who are new to this  
16 board and weren't on the previous board, we did  
17 not really address, on the previous board, Task  
18 No. 4, which was to evaluate the work of industrial  
19 hygienists, staff physicians and consulting  
20 physicians, and reports of such hygienists and  
21 physicians, to ensure and hear the key words  
22 "quality," "consistency" and "objectivity."

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1           So, when you think -- when we're talking  
2 about these claims, focus on the quality. You may  
3 not agree with their conclusions, but we would look  
4 at the quality of their conclusion regardless, what  
5 it's based on.

6           The objectivity and the consistency  
7 across claims, although we're usually dealing with  
8 different IHSs, different CMCs, and so that's --  
9 can be a little challenging. But in any event,  
10 just keep -- bear that in mind when we talk about  
11 the claims.

12           Any other comments?

13           So, who wants to - I think we should  
14 start off with COPD denials. Anybody want to talk  
15 about it, walk us through a claim and what they  
16 saw and what they found?

17           Somewhere I have here a list of who was  
18 asked to look at what, but I'll be glad to start,  
19 but I need the handouts.

20           So, let me remind people that we do not  
21 mention personal identifiers. So, we obviously  
22 do not mention the names of the claimants, their

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1 addresses.

2 We can certainly mention the site  
3 because there are a lot of people who worked at  
4 each site.

5 And we don't mention the full claim  
6 number because that would identify a person, but  
7 we identify claims by the last three or five digits.

8 And so, what I've done, by way of  
9 example, is take a COPD denial and we're going to  
10 -- I've taken excerpts from the record, from the  
11 files.

12 And for those of you present who didn't  
13 have the opportunity to look or are not involved  
14 with reviewing these claims, meaning the members  
15 of the public, the files were anywhere from 500  
16 to 5,000 pages long. So, they were quite lengthy.

17 Some of them highly repetitive, the  
18 same documents appeared over and over again. They  
19 were not indexed, so you basically scrolled through  
20 until you found what you're interested in.

21 Sometimes there are multiple documents  
22 that appear to be the same. Still trying to get

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1 familiar with recommended versus final decisions,  
2 but, in any case, took some time to actually  
3 identify.

4 And I'm not sure I, for one, have  
5 identified everything in each of those files that  
6 I needed to look at, but I made an attempt to do  
7 so.

8 So, the board members are going to be  
9 looking at these excerpts from these claims. And  
10 as I walk through them, I'm going to explain what  
11 they are so that everybody in the room and anybody  
12 on the phone can follow us.

13 So, this was -- the first claim is for  
14 someone -- this -- the decision date was March 2019  
15 -- we're trying to avoid precise dates because  
16 that's -- could be personally identifiable -- and  
17 there is a final decision.

18 Now, the COPD in this case was diagnosed  
19 2003. So, the person's had COPD for a long time.

20 And the excerpt from the final  
21 decision, first, is that -- this is the  
22 communication to the claimant and it says that the

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1 EE-3, the employment history form, indicated that  
2 they worked at Oak Ridge at X-10 at K-25 and at  
3 Y-12, all three of the DOE facilities.

4 And that, totally, they were employed  
5 from 1977 until -- beyond 2010. So, they were  
6 employed for a very long time and they had begun  
7 employment a long time ago.

8 And their job titles were carpenter and  
9 machinist. So, we have a long-term  
10 carpenter/machinist from Oak Ridge who began work  
11 in 1977.

12 Next page, which is Slide 3, and the  
13 final decision mentions the occupational history  
14 interview and that they were exposed to -- that  
15 that interview indicated they were exposed to  
16 beryllium, lead, mercury, nickel, cesium, cobalt,  
17 technetium, thorium, uranium, asbestos, silica,  
18 fiberglass, wool, mineral wool fibers, PCBs,  
19 organic solvents and degreasers.

20 And then the final decision goes on and  
21 talks about the SEM and the fact that those job  
22 titles I mentioned, which were carpenter and

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1 machinist, were linked by the SEM to agents that  
2 cause COPD; endotoxin, asbestos, chlorine, coal  
3 dust, diesel exhaust, phosgene, silica, cement and  
4 wood dust.

5 So, here, the final decision is  
6 recognizing that the SEM connected the  
7 carpenter/machinist job titles to these  
8 COPD-linked exposures.

9 And then it goes on to -- this is Slide  
10 5 -- saying that the case was referred to an  
11 industrial hygienist, and the IH concluded that  
12 that person had significant exposure, as a  
13 machinist, to endotoxin and, secondly, as a  
14 machinist, to endotoxin plus asbestos, diesel  
15 engine exhaust and silica.

16 And the IH further concluded that your  
17 exposure to those toxic substances after the  
18 mid-1990s would have been within existing  
19 regulatory standards.

20 And then concluded, as well, that  
21 working as a carpenter involved significant  
22 exposure to asbestos and silica.

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1           And then there's, again, the standard  
2 statement that, quote, however, the IH stated that  
3 your exposure to those toxins after the mid-1990s  
4 would have been within existing regulatory  
5 standards, end of quote.

6           So, the case was referred to a CMC and  
7 the CMC decided that the exposure to the  
8 SEM-specific COPD agents, right, the ones I  
9 mentioned before, which were, you know, cement,  
10 chlorine, coal dust, et cetera, diesel exhaust,  
11 were not at least as likely as not to be a  
12 significant contributing factor.

13           And the CMC concluded that your  
14 long-term exposure to tobacco smoke was responsible  
15 for the COPD more than any other substance.

16           So, here, we actually have a final  
17 decision saying that -- quoting the CMC and saying  
18 tobacco smoke was responsible and that the  
19 occupational agents weren't responsible.

20           Slide 7 is a handwritten occupational  
21 history from the claimant and it's a little hard  
22 to make out and I don't want to read the whole thing,

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1 but basically the person talks about their exposure  
2 to wood dust, the conditions under which they were  
3 exposed.

4 They removed floor tile, they built  
5 forms for pouring concrete, they machine -- worked  
6 in a shop machining parts and they described that  
7 they breathed in dust on a daily basis, 2000 to  
8 2008.

9 So, Slide 9 is the occupational health  
10 interview and it says, basically, that the person  
11 was exposed to asbestos, silica, coal dust,  
12 fiberglass, glass wool and the like.

13 And, in fact, actually, I found an  
14 excerpt from the medical examiner at the Y-12 site  
15 in which between 1981 and 2000 the person says they  
16 were exposed to asbestos, chemicals, dust, noise,  
17 gases, acids and the like.

18 And if you look at the SEM for machinist  
19 and carpenter at the Oak Ridge facilities, you  
20 actually come up with, under a K-25 machinist, 23  
21 different toxins; for a Y-12 machinist, 102  
22 different toxins; and a carpenter at X-10, 15

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1 different toxins and any number of what they call  
2 work processes.

3 Those aren't all linked to COPD, but  
4 it's a listing of the toxins -- toxic substances  
5 they were exposed to.

6 So, 13 just gives you detail on how much  
7 time the -- the person was mostly a machinist with  
8 limited time -- number of years as a -- well, almost  
9 seven years as a carpenter.

10 The IH report concludes that the -- that  
11 his work as a machinist at K-25/Y-12, and carpenter  
12 at X-10, was significantly exposed to multiple  
13 toxins.

14 And then provides a table, which we've  
15 seen in multiple claims, in which -- and I'm sure  
16 others have seen this, in which the list of agents  
17 is provided, and then the frequency and the  
18 intensity level is estimated by the industrial  
19 hygienist.

20 So, in some cases, it's occasional,  
21 some cases it's frequent. Wood dust was frequent,  
22 meaning on a daily basis. Endotoxins, frequent.

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1       And the exposure level, say, for wood dust was  
2       low to moderate. For endotoxin, diesel exhaust  
3       was low to moderate and the like.

4               And then the IH says there's no  
5       available evidence to support that as part of this  
6       position after the mid-1990s, his exposures to any  
7       of these agents would have exceeded existing  
8       regulatory standards.

9               Then the IH provides references.  
10       Actually, I find the references to be interesting,  
11       because the first few references are DOL/DOE  
12       documents or databases, but the last four  
13       references are textbooks.

14               And I found this repeatedly, I don't  
15       know if you've seen this, but the IH routinely cites  
16       textbooks.

17               I know these textbooks, for the most  
18       part, and they don't -- they don't provide any sort  
19       of specificity for job title and level of exposure.

20               So, they really are not the source of  
21       their knowledge about what kind of level a machinist  
22       -- and how frequently a machinist will be exposed.

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1           The IH may be using their own personal  
2 expertise, but it's not -- you don't find that in  
3 the textbooks, for those of you that are less  
4 familiar.

5           So, I am finishing this. So, only a  
6 couple more slides.

7           So, the CMC report is fascinating  
8 because the CMC says the latest CAT scan shows no  
9 evidence of interstitial lung disease.

10          So, for those of you that don't know,  
11 interstitial lung disease is like asbestosis.  
12 It's not COPD. It's completely different from  
13 COPD.

14          So, the CT scan shows no interstitial  
15 lung disease. Quote: in essence, asbestos,  
16 cement, endotoxins and silicon dioxide crystalline  
17 can be ruled out as agents, as these agents show  
18 an interstitial lung disease pattern on chest  
19 X-ray.

20          Do any of the physicians in the room  
21 agree with that statement?

22          So, let me just finish and that is

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1 unusual. And then goes on to say there's no  
2 evidence of pleural thickening, which occurs with  
3 asbestos or with silica exposure.

4 The X-ray didn't show rounded opacities  
5 in the upper lung zones, which would occur with  
6 coal.

7 Cement dust causes interstitial lung  
8 disease, pleural thickening. We don't see that.

9 Wood dust causes hypersensitivity and  
10 pneumonitis and we don't see that.

11 So, in short, to summarize, we can rule  
12 out COPD in relation to these agents because the  
13 X-ray doesn't show these other findings of either  
14 interstitial lung disease or pleural thickening.

15 And then he -- she -- I can't remember  
16 -- goes on to say, diesel exhaust exposure was only  
17 low to moderate and the person was not involved  
18 directly in transportation so that this lack of  
19 exposure reduces their risk of COPD, ruling out  
20 diesel exhaust.

21 And endotoxin produces interstitial  
22 lung disease. On X-ray, that's not present, so

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1 we rule out endotoxin.

2 And concludes by saying, the most  
3 likely cause of the COPD was tobacco abuse. So  
4 -- and then there's further language, but  
5 essentially it comes to the same conclusion.

6 So, a long-term carpenter/machinist  
7 with a lot of exposures within the SEM are relevant  
8 to COPD, the IH concludes that those levels were  
9 of significance, and the CMC uses what I regard  
10 as unorthodox knowledge to deny the claim,  
11 basically.

12 So, that's -- I don't know if anybody  
13 else looked at this claim or has questions about  
14 it.

15 If you're looking at the particular  
16 language of the CMC and if that makes -- if I'm  
17 wrong and that makes more sense to you than to me,  
18 then, you know.

19 Any comments? Questions?

20 Yes, Mr. Domina.

21 MEMBER DOMINA: On the -- I just want  
22 to make sure on this Slide 19, it has the guy's

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1 name in it. So, make sure nobody sees that.

2 CHAIR MARKOWITZ: Okay. Okay. Thank  
3 you.

4 MEMBER DOMINA: This is one that I  
5 looked at, you know, and I noticed -- I believe  
6 it was in -- let me find it here -- 1987 he was  
7 restricted from the carbon graphite shop due to  
8 respiratory issues and a rash and swelling of his  
9 respiratory passages, that I saw when I went through  
10 it.

11 And I, you know, and so that was -- I  
12 mean, because this gentleman was still working as  
13 of 2018, you know.

14 The guy's like 82 years old, but --  
15 yeah, and I saw the same -- like, the smoking thing  
16 just like you had mentioned because --

17 CHAIR MARKOWITZ: Yeah. So, anyway,  
18 to me, the air seems to be concentrated, in the  
19 CMC's judgment.

20 And before that, you know, the  
21 information moved along in the way that you'd more  
22 or less expect.

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1                   Comments? Questions?

2                   Otherwise, let's move on to another  
3 case. We don't need to go into this level of detail  
4 in the cases, but I --

5                   MEMBER SILVER: Yes. Thank you for  
6 providing us with a really good template. Some  
7 of us probably saw similar leaps in logic, but we  
8 doubted whether we were seeing what we thought we  
9 saw and organizing into a framework like this should  
10 allow us to nail things down the way you've done.

11                   CHAIR MARKOWITZ: Yeah. I'll make one  
12 other comment, which is I couldn't tell -- and I  
13 think this is true from -- I couldn't tell from  
14 the IH report and the CMC report what they actually  
15 reviewed.

16                   The IH doesn't list -- and in subsequent  
17 claims in the CE when they made the referral and  
18 they developed their questions, I don't see a list  
19 of what was provided for them to look at.

20                   So, then you don't know what this IH  
21 has actually looked at unless they mention it in  
22 their report.

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1           The final decision seemed to mention  
2           the relevant exposure sources, but more crucial,  
3           frankly, is what the IH looked at.

4           MEMBER REDLICH:   Are we not mentioning  
5           who the CMC is or --

6           CHAIR MARKOWITZ:   No, I don't see any  
7           -- because -- I don't see any problem with that.

8           Anybody -- Is there any problem with  
9           us mentioning - how about the state?

10          Can we mention the state they live in?

11          MS. LEITON:   That's okay.

12          CHAIR MARKOWITZ:   Well, I think the  
13          question is if we see repeated issues with one or  
14          two people, right?

15          MEMBER REDLICH:   That has been a  
16          pattern.

17          CHAIR MARKOWITZ:   Okay.

18          MEMBER REDLICH:   So, I thought that it  
19          is relevant and that's not providing any  
20          information of the patient.

21          CHAIR MARKOWITZ:   Okay.

22          MR. FITZGERALD:   I think it's fair to

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1 raise that with the program independently of the  
2 meeting itself.

3 If you see a pattern, I think that's  
4 what the Board here is trying to do, is determine  
5 whether there is an ongoing, sort of, pattern of  
6 behavior across the CMC community or the IH  
7 community that we're trying to remedy in terms of  
8 the process versus looking at individuals and  
9 calling them out and saying you didn't do this  
10 right.

11 MEMBER REDLICH: And then if there is  
12 a CMC that we do identify a pattern that we think  
13 is maybe concerning --

14 MR. FITZGERALD: You should raise it  
15 with the program.

16 MEMBER REDLICH: Okay. And then what  
17 would be the process of reviewing that CMC?

18 MR. FITZGERALD: I would defer to the  
19 program on that. But in terms of elevating it to  
20 the program, I'd go through the chair to --

21 MEMBER REDLICH: Okay.

22 MS. LEITON: We'll look at it.

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1 CHAIR MARKOWITZ: Any other comments  
2 or --

3 MEMBER BERENJI: This is just a general  
4 comment. This is Mani Berenji.

5 At least from a CMC's standpoint, I'm  
6 pretty sure I've mentioned this at a previous  
7 meeting, but it's very important to have at least  
8 some sort of standardization in terms of how these  
9 CMCs are collected and identified.

10 I know they run the gamut, at least  
11 based on the cases I reviewed. They were family  
12 medicine physicians.

13 And, again, I feel that there are many  
14 competent physicians who are capable of doing this  
15 type of work, but making sure that there is some  
16 sort of training, at least to be able to complete  
17 the review in a systematic matter, you know, taking  
18 into account the SEM, but also taking into account  
19 a full occupational history.

20 And at least from my perspective -- and,  
21 again, please correct me if I'm wrong -- but it  
22 doesn't appear that the CMCs actually meet the

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1 claimants; is that correct?

2 CHAIR MARKOWITZ: That's correct.

3 MEMBER BERENJI: So, to me, I mean, I  
4 do disability reviews. I always see the claimant  
5 because I feel that unless you see the person right  
6 in front of you, it's hard to make a real good  
7 assessment as to -- first of all, you always want  
8 to make sure that the claimant, you know, is  
9 forthcoming and you want to make sure that you can  
10 verify, at least to the best of your ability,  
11 whether the events that transpired actually adds  
12 up to the particular exposure.

13 At least from my perspective and from  
14 my experience, it's really important to see these  
15 individuals face to face.

16 I'm not sure if there's any discussion  
17 among your colleagues at least with respect to,  
18 you know, evaluating CMCs.

19 Is there any potential for, you know,  
20 at least revamping the process or at least having  
21 the CMCs meet with these claimants face to face?

22 MS. LEITON: Do you want me to respond

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1 to that?

2 CHAIR MARKOWITZ: Sure. Could you?

3 MS. LEITON: We have a second opinion  
4 process where physicians will see claimants, but  
5 the amount of cases we refer to a CMC for a record  
6 review, we don't have them all over the country  
7 to meet with all these claimants.

8 There's a cadre of physicians in the  
9 contract, and so it feasibly is -- would be really,  
10 really difficult for us to -- for that to happen.

11 CHAIR MARKOWITZ: Yes, Mr. Domina.

12 MEMBER DOMINA: I just -- I was just  
13 -- and I'll just defer some of this because, in  
14 the State of Washington, we have IMEs and stuff  
15 and so there's a process.

16 So, if you have X amount of complaints  
17 against one, there's a way to do that. And the  
18 same thing -- I don't know if this process allows  
19 that and the fact that they're not in for life,  
20 they got to reapply every three years.

21 So, is there some kind of a vetting  
22 process even though it may be a different contract

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1 or has the contract, on a way to verify, you know,  
2 the person has been fully vetted and reapplies or  
3 a claimant has a way, you know, if they have a  
4 problem with the way it's done.

5 MS. LEITON: So, there is -- the  
6 contract has a vetting process. They have a  
7 vetting process for all their physicians when they  
8 come on board.

9 I would have to check on how many times  
10 they're recertified annually or whatever it is.

11 With regard to whether we can -- a  
12 claimant can object to what the physician said,  
13 they can do that through our appeals process on  
14 an individual basis.

15 With regard to a determination or  
16 multiple -- like, when we do audits, if there's  
17 a CMC that has multiple or has more than one error  
18 in different cases on a regular basis, then we have  
19 -- we will meet with the contractor and take  
20 whatever steps are necessary.

21 That may be additional training, it may  
22 be worse than that, but there are steps that we

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1 can take with the contractor.

2 We meet with them on a regular basis.

3 We have teleconference calls with all of our CMCs  
4 on a regular basis quarterly, I believe, to talk  
5 about new issues, talk about any questions they  
6 may have to make sure that they're aware of issues.

7 While I'm up here, I'll just mention  
8 the smoking. We do tell them that smoking is not  
9 something they should be taking into consideration,  
10 but, again, they're going to take it into  
11 consideration as physicians in cases like -- as  
12 Dr. Markowitz mentioned.

13 CHAIR MARKOWITZ: Dr. Berenji.

14 MEMBER BERENJI: Mani Berenji.

15 So, again, I apologize if I  
16 misunderstand the process when it comes to the  
17 industrial hygienist.

18 These are folks who work with DOE; is  
19 that correct?

20 MS. LEITON: No. The industrial  
21 hygienists work for us, for the Department of Labor.

22 MEMBER BERENJI: Okay. So, I know

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1 that there's a process to identify CMCs.

2 Has there been any thought about, you  
3 know, at least having some sort of industrial  
4 hygienist panel at least to be able to review the  
5 SEM, go through the occupational health  
6 questionnaire?

7 Because at least based on my review of  
8 both the approvals and the denials of the respective  
9 claims -- and I know Dr. Dement already alluded  
10 to this, but I feel that a lot of times the  
11 industrial hygienist is following a boilerplate.

12 And at least based on my review of the  
13 eight cases that I had the opportunity to review,  
14 it seems that, you know, that's one data point from  
15 this one particular industrial hygienist.

16 But at least from my perspective, I  
17 think it might be something worth considering in  
18 the future -- and, again, this is up for debate  
19 -- if there is a way to get some sort of consensus  
20 among industrial hygienists across the country from  
21 different disciplines, you know, both with clinical  
22 experiences, industry experiences.

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1 I'm going to leave it up to the Board,  
2 but at least from my perspective I think that would  
3 be instrumental to provide a counterpoint to the  
4 industrial hygienists from your end. Thank you.

5 MS. LEITON: Okay. I will just say  
6 that we have a contract with industrial hygienists.

7 Every IH report goes through our  
8 federal -- we have two federal employees who are  
9 industrial hygienists.

10 You will see the format being repeated  
11 because that's what they were taught to do in that  
12 format. But aside from that, I'll let you guys  
13 --

14 CHAIR MARKOWITZ: One comment on this  
15 case, by the way, the issue of cigarette smoke,  
16 it was one thing for the CMC to ascribe it to smoke,  
17 but actually in the final decision, which obviously  
18 is written by DOL, it said that -- quoting the CMC  
19 that it --

20 MS. LEITON: That's because they're  
21 quoting the CMC who provided an opinion on causation  
22 and included that as part of his opinion.

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1                   Now, if they say significant amount of  
2                   it is a result of the smoking, it's not something  
3                   we can ignore, you know.

4                   We -- unless they were -- you know, it's  
5                   very difficult to separate that out once the  
6                   physician has already gone there.

7                   CHAIR MARKOWITZ: Well, it makes it  
8                   look like you were endorsing that and that could  
9                   be very confusing to a claimant, but I'll move on.

10                  Dr. Silver.

11                  MEMBER SILVER: I think we heard in a  
12                  previous meeting that the claims examiners are  
13                  encouraged to limit the number of substances  
14                  considered to seven substances, and there was a  
15                  memo in the COPD case that I reviewed spelling that  
16                  out.

17                  It came from headquarters telling the  
18                  claims examiner to keep it to seven toxins. And,  
19                  sure enough, in this case, if you look at Slide  
20                  20, it's exactly seven substances.

21                  And if you look back all the way to Slide  
22                  8, 10, 11, a few of them bit the dust or fell out

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1 of consideration.

2 Fiberglass didn't make the cut. Gases  
3 didn't make the cut. Beryllium didn't make the  
4 cut, mercury and arsenic.

5 Now, maybe those are not the most  
6 relevant substances for COPD, but if we're going  
7 to ever have a meeting of the minds of vapors, gases,  
8 dust and fumes, you have to relax this seven  
9 substances rule, I think.

10 CHAIR MARKOWITZ: Yeah. I mean, that  
11 wasn't the challenge in this case, but I take your  
12 point.

13 Dr. Dement.

14 MEMBER DEMENT: I think your review of  
15 this case points out some interesting issues. When  
16 you look at the SEM for this job category, it lists  
17 many, many exposures. I think you've listed them  
18 on your slide. So, obviously there are many  
19 exposures that -- if you meet the job category.

20 So, the two criteria for the CE to  
21 actually refer these exposures to the IH and  
22 ultimately to the CMC, one is the job category has

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1 to be right. The other is the claimed disease has  
2 to also be in there.

3 So, only a few of the exposures that  
4 this individual would have had even from the SEM,  
5 not restricting it to seven, because it would be  
6 many more actually even made it to an assessment,  
7 when, in fact, I think the majority of the published  
8 literature suggests that for COPD we look more  
9 broadly at their cumulative exposures to these  
10 vapors, gas, dust and fumes.

11 I guess the other thing, and the  
12 clinicians need to answer this, but it relies --  
13 this opinion and some others that I looked at relies  
14 heavily on -- either on CT and -- more on chest  
15 X-ray changes, a requirement that those actually  
16 be present to support an attribution to the  
17 exposures.

18 I'm not aware that that's an actual  
19 requirement for COPD. The clinicians can answer  
20 that.

21 CHAIR MARKOWITZ: They're not -- I  
22 mean, they're certainly not for the diagnosis of

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1 COPD -- for the diagnosis of other conditions, but  
2 I've never read that you need -- any of these other  
3 conditions are prerequisites for COPD -- for  
4 ascribing COPD to the occupational agent.

5 MEMBER DEMENT: And, in fact, this is  
6 the first place I've ever seen that done.

7 CHAIR MARKOWITZ: By the way, this was  
8 a board certified occupational medicine physician.  
9 So, that didn't help us in this one.

10 Anybody have another COPD denial they  
11 want to talk about?

12 You don't have to do it in this level,  
13 but that's -- you shouldn't, actually, because  
14 we'll never get through, but -- yeah, George.

15 MEMBER FRIEDMAN-JIMENEZ: I can  
16 present a case quickly that illustrates one point.

17 This is Case No. -- 14286 are the last five digits.

18 So, a 79-year-old woman worked as an  
19 electrical mechanical inspector at the Kansas City  
20 plant from 1979 to 1981 -- 1991, 50-pack-year  
21 smoker, diagnosed with COPD in 2012 and was agreed  
22 to have had significant exposure to asbestos;

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1           however, the question of asbestosis was raised.

2                       She had several X-rays on record and  
3           apparently also had a CT scan, but the CT scan was  
4           not in the record. And so, the CMC said that it  
5           wasn't clear whether she had asbestosis or not.

6                       There was pleural parenchymal scarring  
7           mentioned on one of the chest X-rays, but it didn't  
8           say "asbestosis."

9                       And so, because there was no CT  
10          available, the CMC denied the case and said that  
11          we need to have the CT, but the CT had already been  
12          done.

13                      So, this raises the question of should  
14          a case be pursued and come to a final decision when  
15          not all of the medical evidence is present?

16                      In this case, it would have just been  
17          a matter of getting the result of a chest CT, which  
18          had been done fairly recently.

19                      If that hadn't been done, I would argue  
20          that it should even -- there should be a mechanism  
21          by which it could be ordered and that the case not  
22          be decided until you have a proper evaluation.

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1                   And apparently, the CMC just signed off  
2                   on the case and said there's -- denied it because  
3                   there was no evidence of asbestosis because there  
4                   was no chest CT on record.

5                   So, the question is: what is the process  
6                   by which a necessary diagnostic test can be either  
7                   gotten -- obtained that's already been done, or  
8                   ordered, if it hasn't already been done, in order  
9                   to complete the evaluation for a necessary  
10                  decision?

11                  This wasn't about asbestosis per se,  
12                  it was about COPD and whether asbestos contributed  
13                  to the COPD.

14                  And it's somewhat different literature  
15                  if someone has asbestosis than if they don't have  
16                  asbestosis.

17                  And so, it would have been an important  
18                  thing to have in the record. So, that's the  
19                  question I wanted to raise with this case.

20                  MS. LEITON: So, this is Rachel.

21                  If it was a CT scan that was referenced  
22                  -- you said you knew there had been a CT scan --

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1 how did you know that there had been a CT scan?

2 MEMBER FRIEDMAN-JIMENEZ: It was  
3 mentioned in, I think, a PFT report.

4 MS. LEITON: Okay. So, the CMC, at  
5 that point, could have easily gone back to us and  
6 said there's reference to a CT scan. We could go  
7 to the claimant and ask for it if it had relevance  
8 to the question being asked. There is a process  
9 for that.

10 With regard to requesting that a test  
11 be done, we run into problems for cases that we  
12 haven't accepted yet. We can't guarantee that  
13 we're going to pay for that test because they're  
14 submitting it.

15 So, it could be a suggestion that the  
16 CMC makes and said, you know, if this person were  
17 to have a CT scan, they might be able to verify  
18 it, which we could relay to the claimant.

19 And if the claimant then wanted to go,  
20 you know, and get that CT scan on their own, they  
21 could, but we couldn't require them to do that or  
22 pay for that to be done.

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1                   MEMBER FRIEDMAN-JIMENEZ:    So, that's  
2 really the issue that we're raising here, is how  
3 can we make sure that a proper evaluation is done  
4 before these decisions are made?   Because that does  
5 involve paying for the diagnostic testing.

6                   And this is a catch 22 we often run into  
7 in occupational medicine.   To establish a case,  
8 you need to do a test that would need to be paid  
9 for by --

10                  MS. LEITON:   And if we did accept the  
11 case, we could retroactively pay for it, but that's  
12 hinging on whether or not we end up accepting the  
13 case, because we go retroactive to the date that  
14 they file.

15                  We can pay for whatever is related to  
16 what we accept, but that's only after the fact and  
17 it's only if we accept it.

18                  MR. FITZGERALD:   Let me just say that's  
19 standard practice in all worker's compensation  
20 systems.

21                  We don't generally get -- we generally  
22 don't pay for diagnostic testing until a case is

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1 accepted. And that's pretty much common practice  
2 in worker's compensation.

3 MEMBER REDLICH: Yeah, I also -- Carrie  
4 Redlich -- I also reviewed this case and I agree.

5 So, I think one issue that has come up sometimes  
6 is when the claim is placed for one disease. And,  
7 in this case, it was for COPD.

8 And so, I've got a couple issues. And  
9 then there is the evaluation suggests that there  
10 may be another occupational relevant disease which  
11 is not the one that the claimant had put the claim  
12 in for.

13 And in those situations, I -- usually  
14 the CMC's been asked a very specific question, you  
15 know.

16 They've been asked not does the person  
17 have a work-related respiratory condition, but do  
18 they have work-related -- you know, do their  
19 exposures contribute to COPD?

20 I think an easy solution would be they  
21 can answer that question and then is there evidence  
22 of any other relevant work-related condition,

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1 because I have seen several where the question was  
2 COPD when there was evidence of asbestos pleural  
3 plaques or another condition.

4 In this person, the concern I had is  
5 it seems like the diagnosis, from what information  
6 we had, was likely COPD.

7 The smoking history was variable, but  
8 the -- this -- it was at this Kansas City plant.  
9 And I just quickly Googled what this Kansas City  
10 plant did out of curiosity.

11 I would have called up John Dement and  
12 see if he could fill me in on -- because the person  
13 was an electrical mechanical inspector from 1979  
14 to '91.

15 And this plant was made -- I have my  
16 little notes here, but it basically was initially,  
17 starting in 1942, a Pratt & Whitney plant that made  
18 engines and made the non-nuclear warheads.

19 So, it -- and there was a little other  
20 information that it sounded like there was a lot  
21 going on in this plant besides asbestos for -- and  
22 in the period of time from '79 to '91, it sounded

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1 like there was machining operations to different,  
2 you know, plastics and adhesives and a whole range  
3 of activities that -- and it was unclear what sort  
4 of inspector.

5 She -- the questionnaire that the  
6 person filled out was not that helpful in terms  
7 of, you know, had sort of possibly checked off  
8 almost every exposure you could have, which -- but  
9 there was the question, did you -- should  
10 respiratory protection have been provided? The  
11 person answered yes.

12 It seems that some better idea --  
13 somehow the SEM that produced only asbestos as a  
14 relevant exposure was what caught my eye.

15 And knowing more about what was going  
16 on in a place that's been -- an old facility doing  
17 engine machining -- you know, making engine parts,  
18 seemed like there was potential opportunity for  
19 exposures beyond asbestos that might be relevant  
20 to COPD and hopefully an industrial hygienist would  
21 be able to determine that.

22 CHAIR MARKOWITZ: But there was an IH

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1 report in that case.

2 MEMBER REDLICH: Yes, but I think it's,  
3 again, this issue of the job category. I think  
4 a phone call or brief conversation with this person  
5 and a better understanding of what their job tasks  
6 were -- you know, if the person had only worked  
7 there for six months, I'd say let's not spend more  
8 time on this. It's unlikely that that's  
9 contributing.

10 But when we have a, you know, 20-year  
11 period of time in a, you know, facility like this,  
12 it seems that that warrants more attention.

13 CHAIR MARKOWITZ: Other comments?

14 Yeah, Calin.

15 MEMBER TEBAY: This is Calin Tebay.

16 I'm still -- I want to go back to your  
17 -- the lack of the CT or the -- that it was overlooked  
18 that the CT existed.

19 One, this is, Doug, for your  
20 information, in worker's comp, often the tests are  
21 paid for by worker's comp to aid diagnosis often  
22 before the claim is accepted. Not in Department

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1 of Labor, right, but in worker's compensation at  
2 the State level.

3 But in this case, it doesn't really  
4 matter for the simple fact that you know going into  
5 the claim that you may or may not get reimbursed  
6 depending on if the claim is accepted.

7 So, I don't quite know how we got on  
8 the conversation of why it was relevant to if we  
9 were going to pay for it or not when the simple  
10 fact is everybody knows that you're not going to  
11 get reimbursed if the claim is not accepted.

12 But I go back to the fact that if the  
13 doctor recommended denial based on the lack of a  
14 CT, why didn't we stop there and say we're missing  
15 this CT scan, let's not deny the claim or --

16 MEMBER REDLICH: Well, I --

17 MEMBER TEBAY: -- force the person into  
18 an appeal process, because appeal processes are  
19 almost impossible for a claimant to get through  
20 for the simple fact that the time frames are so  
21 short often the claim will be recommended denial  
22 and denied at the final -- at the FAB before you

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1 can even get an appointment to get that extra scan  
2 -- to get a CT scan for a claimant that needs a  
3 pulmonologist and needs to get it ordered.

4 I think -- and I don't know about in  
5 anybody else's area, but in our area it can take  
6 weeks.

7 By that time, the recommended decision  
8 has been done, the final decision is done, and then  
9 you got to appeal the final decision, and then you  
10 got to go through the reopening of the claim process  
11 to prove that you've -- I mean, so look what --  
12 the waterfall effect of creating or providing a  
13 recommended decision or a final decision based on  
14 the lack of a test for the claimant to try to go  
15 through, then, is nearly impossible to recover once  
16 that final decision or recommended decision is  
17 made.

18 The appeal process is not easy at all,  
19 and it's not time-friendly to a claimant. So, I  
20 guess my point is, is that's a claim where if we  
21 know that happens, why doesn't -- why aren't we  
22 stopping instead of saying, "Well, you can appeal

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1 it if you can get that test in the time frames we  
2 allow you before we provide a final decision."

3 Because often claims examiners just  
4 move right on forward, they don't give you extra  
5 time to go get those tests.

6 And I understand you can't just leave  
7 them all hanging, right? You can't just say,  
8 "Okay, everybody's got as much as they want to get  
9 all the information."

10 But on the other hand, when you -- you  
11 kind of -- it's not okay to deny the claim based  
12 on that was overlooked.

13 MEMBER REDLICH: I just -- one other  
14 -- I mean, and this -- one other point I did want  
15 to bring up, was that it was a CMC that there has  
16 been a pattern of -- I question some of the CMC's  
17 decisions.

18 CHAIR MARKOWITZ: Other comments on  
19 this case?

20 Other COPD denial?

21 Dr. Dement.

22 MEMBER DEMENT: Okay. This is a

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1 individual -- a claim of COPD. Worked as a graphic  
2 -- worked as a graphic illustrator at Fernald a  
3 couple periods of time, '86 to '91 and '92 to '93.

4 His occupational history questionnaire  
5 suggests that he was a photographer who obviously  
6 did things -- illustrative photographer, but he  
7 actually went into the facilities and did work in  
8 the facilities taking photographs of different  
9 equipment and operations. So, he had a fair amount  
10 of time within the facilities.

11 Doesn't go into great detail, and at  
12 some suggestion, at least, in terms of his work  
13 as a photographer, he may have had some other work  
14 that's directly related to that particular task.

15 That wasn't very well-developed either  
16 in the occupational history or in the claims  
17 process, so basically the process was to go into  
18 the SEM and look for this particular job category  
19 and some aliases of this job category.

20 And what they found was the possibility  
21 of diesel exposure, I guess, just being around  
22 diesel equipment. I don't know exactly how that

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1 would happen, but I guess all of us have some diesel  
2 exposure.

3           Anyway, that was what was established  
4 from the SEM. It went to the IH who -- for  
5 consideration.

6           The IH basically said that diesel  
7 exposures would have occurred, but back with the  
8 same comment about not approaching regulatory  
9 limits.

10           So, this claim was denied and it may  
11 well have been appropriate to have denied this  
12 claim.

13           It was -- I think this person was a  
14 smoker, but a half pack a day since age 25. That  
15 didn't come into the picture, as I could tell, in  
16 the final decision to deny.

17           I guess what I take away from this, is  
18 the -- neither the occupational history  
19 questionnaire or the development of the case, I  
20 think, actually went back to the individual --  
21 allowed the individual to elaborate on exposures  
22 that he may have had either going into these

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1 facilities and buildings or as doing the task of  
2 processing and developing film as they had on site.

3 So, it was denied and I think this is  
4 one where maybe some additional information would  
5 have informed that decision better.

6 I don't think there's any other points  
7 here about this exposure. He had two -- was  
8 actually exposed to two incidents at the plant;  
9 one for plutonium and hexafluoride.

10 So, there was an exposure incident  
11 while he was actually in the plant doing his work.

12 CHAIR MARKOWITZ: It sounds like a case  
13 where the industrial hygienist couldn't really have  
14 used the job title for --- to be very informative  
15 about diesel exhaust.

16 MEMBER DEMENT: No.

17 CHAIR MARKOWITZ: Right. So, in other  
18 words, the only way he could understand potential  
19 dose --- or likely dose is through interview.

20 MEMBER DEMENT: Yes. I don't know ---  
21 this is not a job category that if you asked me,  
22 do they have diesel exposure, I would have said

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1 yes.

2 So, for me to have assessed this  
3 exposure, I would have had to ask questions, like,  
4 how were you exposed to diesel?

5 CHAIR MARKOWITZ: Right.

6 MEMBER DEMENT: So, I don't -- to me,  
7 it just wasn't developed. The case wasn't  
8 developed.

9 CHAIR MARKOWITZ: Comments?  
10 Questions? Other COPD denial cases?

11 MEMBER MAHS: I have one that was  
12 originally a denial and then it was accepted this  
13 year.

14 In 2012 -- this was a 77-year-old former  
15 worker at --- I lost it. Pantex, I think it was.

16 CHAIR MARKOWITZ: I'm sorry, what kind  
17 of worker was he?

18 MEMBER MAHS: He was a truck driver.

19 CHAIR MARKOWITZ: Okay.

20 MEMBER MAHS: He was a truck driver at  
21 Hanford. He was exposed to arsenic, asbestos,  
22 beryllium, diesel exhaust, nickel, silver,

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1 stainless steel, and something else there. I can't  
2 read my writing.

3 He worked 19-plus years as that, but,  
4 as a truck driver, even though he was a truck driver,  
5 his work assignments included digging, spraying  
6 weeds for weeks at a time, digging in the tank farms.

7 So, he was exposed to quite a few different things.

8 And I think the first time they looked  
9 at it, he was just exposed to asbestos, is the only  
10 thing they found to start with.

11 And, anyhow, in 2012 he filed a claim  
12 for benefits. He identified chronic COPD and  
13 asthma as a medical condition related to your  
14 covered employment.

15 Submitted employment history and they  
16 confirmed that he worked at DOE for several  
17 different contractors over the years.

18 And the SEM revealed that he was exposed  
19 --- potentially exposed to asbestos, is the only  
20 one they found, as for a truck driver.

21 Medical consult, CMC, to obtain an  
22 opinion as to whether it's at least likely as not

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1 to exposure asbestos during your covered employment  
2 at Hanford with significant factor in causing or  
3 contributing or aggravating. And the CMC reviewed  
4 his case and decided it was not at least as likely.

5 They denied his claim for COPD and  
6 asthma in June of 2005. In -- November 2nd, 2017,  
7 though, his authorized representative requested  
8 a reopening of the claim for COPD and asthma to  
9 raise the -- he had additional medical evidence  
10 and they said Department of Labor erred when they  
11 forwarded the claim to the CMC for review.

12 She noted that the CMC concluded the  
13 medical evidence supported a diagnostic --  
14 diagnosis of asthma, however, it did not support  
15 a diagnosis of occupational asthma.

16 Your authorized representative stated  
17 that its referral to the CMC, the DOL should have  
18 asked the physician whether occupational exposure  
19 to a toxic substance contributed or aggravated,  
20 claim. She maintained that this was an error.

21 The District's order was issued in  
22 December 17th, which vacated the final decision

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1 on the 2012 that the condition, COPD only, and not  
2 the asthma.

3 The District office reviewed the source  
4 of documents and checked the SEM again. And with  
5 the labor category of teamster, the SEM lists COPD  
6 as a possible specific health effect of asbestos,  
7 diesel exhaust, silicon dioxide and crystalline.

8 In the IH report, your exposure to  
9 asbestos was significant and would have been  
10 frequent and at low levels. However, after 1986  
11 through the mid-'90s your exposure would have been  
12 occasional, and at very low levels. After the  
13 mid-'90s, there's no evidence to support that your  
14 exposures would have accepted the existing  
15 standards.

16 I don't know what that had to do with  
17 --- exposure to diesel exhaust was significant and  
18 would have been frequent and at very low levels  
19 through the mid-'90s. And after the mid-'90s,  
20 there is no evidence to support your exposure  
21 exceeded the standard.

22 Silicon/crystalline was significant

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1 and would have been frequent and at very low levels  
2 also.

3 In a report dated May 9th, 2018, the  
4 CMC concluded that it is at least as likely as not  
5 that your exposure to asbestos, diesel exhaust,  
6 silicon dioxide during your employment at Hanford  
7 was a significant factor contributing to your COPD.

8 And they recommended acceptance of the  
9 case this time in --- I lost the page, but there  
10 is also a page where the IH had stated the exposure  
11 to diesel exhaust would only be in passing. He  
12 was a truck driver.

13 CHAIR MARKOWITZ: But COPD was  
14 accepted, ultimately?

15 MEMBER MAHS: The second time around,  
16 yes.

17 CHAIR MARKOWITZ: Based on asbestos,  
18 diesel exhaust ---

19 MEMBER MAHS: They added a few more  
20 chemicals that he was exposed to and a little more  
21 medical evidence.

22 And the error --- I guess they explained

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1 they reopened it due to a possible error with the  
2 CMC report --- or what the CMC received.

3 CHAIR MARKOWITZ: Comments?  
4 Questions?

5 MEMBER POPE: I had a similar case.

6 My --- the case that I reviewed was a  
7 security guard, 44-year employee, COPD --- was  
8 claiming COPD, kidney disease, and those other  
9 illnesses were not recognized, but he was  
10 originally denied and then it was reversed.

11 Let's see. Denied in May, reversed in  
12 June. The only reason why, I believe, that it was  
13 reversed, is because his AR --- his attorney had,  
14 at the hearing --- there was a hearing --- had  
15 brought up the fact that there was a step that was  
16 missed between the information being passed along  
17 to the CMC and the step that was missed that they  
18 did not confer with the treating physician. And  
19 that's a step that was brought forth during the  
20 hearing.

21 Now, had his attorney not brought that  
22 information up, I'm sure that this case would have

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1 remained denied.

2 CHAIR MARKOWITZ: Comments?  
3 Questions? Dr. Redlich?

4 MEMBER REDLICH: Yes, I agree. I also  
5 reviewed that case.

6 CHAIR MARKOWITZ: Use the mic, please.

7 MEMBER REDLICH: Sorry.

8 Yes, I also reviewed that case and I  
9 agree with Duronda that it was a security guard  
10 for 44 years and I --- the two treating physicians  
11 and another physician had decided that the COPD  
12 was work-related, but --- and gave a rationale for  
13 why it was work-related, but then the case was  
14 referred to a CMC who decided it was not  
15 work-related.

16 And it was only reversed after a hearing  
17 representative and then the final decision was  
18 accepted. However, it seemed that --- and this  
19 just raised the question of when you refer to a  
20 CMC. If you have a treating physician who gives  
21 a rational --- you know, that the diagnosis is  
22 clear, they give a rational reason for why they

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1 think it was related to the, you know, work  
2 exposures, then would that --- did that need to  
3 go to a CMC?

4 And the SEM, I think, again came ---  
5 I'm trying to remember this one. I can't read my  
6 notes whether --- it was also one when you read  
7 the transcript of the description of what this  
8 security/police officer did at the Y-12 plant for  
9 40 years, it sounded like there were inhalational  
10 exposures, but I don't think the SEM had come up  
11 with much.

12 MS. LEITON: I just wanted to make a  
13 comment about that.

14 I think I mentioned earlier today that  
15 we're trying to encourage CEs to go to the treating  
16 first -- to follow up with the treating first,  
17 before going to a CMC.

18 And one of the things that we've also  
19 reiterated in recent training to them, is that  
20 causation is a much different standard than  
21 aggravation and contribution.

22 So, if a treating doctor is coming in

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1 with medical rationale for  
2 aggravation/contribution, we're looking at those  
3 in a different way than we would if they're just  
4 simply trying to say it was caused by. So, we're  
5 seeing more of that going back to a treating,  
6 clarifying, trying to understand whether they --  
7 you know, whether it's contribution, aggravation,  
8 those sorts of things.

9 I also did want to mention, I looked  
10 back at my notes from one of your recommendations  
11 early on from the previous board on talking ---  
12 the IH having the ability to talk to claims  
13 examiners --- I mean, to the claimants. And one  
14 of the things we said there, was that we would be  
15 able to allow that as long as the claims examiner  
16 was involved.

17 So, I need to look back and see if we  
18 actually got specific procedures for that. I'm  
19 pretty sure we've advised the IHs, but I'll go back  
20 and follow up on that particular issue because it  
21 is possible. It's just that we need to have --  
22 make sure that CE is involved.

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1                   MEMBER REDLICH: I guess just in terms  
2 of some of the themes that we had, this is another  
3 example where the occupational questionnaire, the  
4 occupational history that his treating physician  
5 had, and then his transcript of his hearing, gave,  
6 I think, a more accurate picture of his exposures  
7 because the SEM came up with no exposures that could  
8 cause COPD, but there was a description of welding  
9 fumes, unloading coal dust, various other exposures  
10 that had not come up in the SEM probably because  
11 a security/police officer --- but that his  
12 transcript described more accurately what he had  
13 done.

14                   And his physician, actually, which is  
15 rare, had an occupational history that also  
16 described it.

17                   CHAIR MARKOWITZ: Just commenting on  
18 the issue of IH interview, we made that  
19 recommendation and your response was that the CE  
20 should be involved and we absolutely agreed that  
21 made sense. And so, we would like to know the  
22 progress because that was --- that happened some

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1 time ago.

2 MS. LEITON: Yes, it did. It might be  
3 in there or it might be instructions to our Ihs.  
4 I need to check, but I will definitely get back  
5 to you.

6 CHAIR MARKOWITZ: I mean, the IHS  
7 presumably are used to not doing that, they're used  
8 to --- and it's easier for them just to do a paper  
9 review and do what they always do.

10 So, you may need to encourage, or there  
11 are some circumstances that they do this, to get  
12 them over that hump.

13 MS. LEITON: Could I just make one more  
14 comment?

15 I want to go back to something that I  
16 --- that Dr. Friedman-Jimenez had mentioned with  
17 regard to the definition of toxic substance. I  
18 also went back to check on that.

19 What --- we did define it in the  
20 regulations a specific way. The statute doesn't  
21 have a definition of it, but the reason that we  
22 defined it the way we did is when we got Part E

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1 in 2005, the prior process was for a --- Department  
2 of Energy used to have a panel of physicians.

3 And when they had --- they would refer  
4 cases to that panel, and that panel would recommend  
5 yes or no on whether or not it was related to  
6 exposures. There was a definition used then.

7 So, when we took over those cases and  
8 we got Part E, there was a push to be consistent.  
9 They didn't want us to have a different definition  
10 than DOE did, because then we would be treating  
11 the cases differently.

12 So, that was the underlying reasons for  
13 it being put in the regulations the way it was.  
14 I just wanted to clarify that.

15 MEMBER FRIEDMAN-JIMENEZ: Could I just  
16 put in a plug for looking at the definition that  
17 the National Toxicology Program has for toxic  
18 substance and considering changing your --- since  
19 it sounds like you're not bound by law to have that  
20 definition that you have, I think it's very, very  
21 justifiable to use the NIH definition that the  
22 National Toxicology Program has on their website

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1 and have published.

2 They really know toxicology and they  
3 know what a toxic substance is. And I think that's  
4 the strongest way to go to make this a --- and if  
5 you want to unify the definition, that would be  
6 what you want to unify it to, I think, and it makes  
7 sense. It's a very well-accepted definition of  
8 toxic substance.

9 CHAIR MARKOWITZ: Yes, let me just  
10 comment. Steve Markowitz.

11 So, you take workers who are operations  
12 or production or maintenance or laboratory or  
13 construction. The SEM, their occupational health  
14 questionnaire are full of toxic substances.

15 There's no shortage of --- as DOL  
16 currently defines. So, there's no shortage of what  
17 is called potential exposure to toxic substances  
18 for, probably, the vast majority of job titles  
19 within the complex.

20 So, I --- you know, I know this has been  
21 an issue we've gone back and forth with, but even  
22 on their own terms there's plenty of exposure that

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1 could be used to make decisions.

2 Dr. Dement?

3 MEMBER DEMENT: But the real stopping  
4 point here is the link to the outcome. They could  
5 have the job -- well, there's two places.

6 Making sure the job is searched with  
7 regard to all the different ways it could be called,  
8 and there's some --- you know, there's some places  
9 where some of these jobs are described in the  
10 presumption, for example, there's a list of jobs.

11 It's not sometimes quite clear how  
12 those are mapped back into the specific jobs in  
13 the SEM, and I think they should be. So, you have  
14 to pass that hurdle.

15 But, then, in order to get referred for  
16 even consideration in some cases, you have to have  
17 that disease link, which we've argued for and needs  
18 to be expanded.

19 And in some ways, it does relate to the  
20 definition of what toxic substance is, really.

21 MEMBER REDLICH: Well, other comments?

22 Questions?

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1                   MEMBER REDLICH: I just have one other  
2 question as far as --- this is Carrie Redlich ---  
3 as far as the process, because it seems that there  
4 have been a number of claims that eventually get  
5 to what appears to be a reasonable, final decision,  
6 but, you know, they go through multiple appeals.

7                   And does the Department sort of maybe  
8 review those cases and say, you know, what will  
9 we learn from this so that moving forward we could  
10 have come up with that decision sooner. Because  
11 it's a lot of time and money for each one of these  
12 denials and appeals and the like.

13                   So, in this case, the hearing  
14 representative agreed that the, you know, treating  
15 physician had provided a well-rationalized medical  
16 opinion, originally, and then agreed that it  
17 accepted both claims.

18                   So, is there a process where claims have  
19 sort of been reviewed and appealed and then  
20 eventually accepted to sort of, you know, as sort  
21 of a quality control to look and see whether moving  
22 forward that could have been avoided.

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1 MS. LEITON: Well, we have quality  
2 control. We have reviews on an annual basis of  
3 cases. Some that have been reopened, all final  
4 -- or a final decision, samples of final decisions,  
5 recommended decisions.

6 So, there's an audit process, but we  
7 also have 400 claims examiners around the country  
8 and they're all going to make different --- they're  
9 not all going to be exactly the same decisions.

10 Individual cases are going to then be  
11 -- they're always reviewed by a second reviewer.  
12 That's when things are caught sometimes that might  
13 not have been caught the first time. Some other  
14 reasons for reopening a case might be we got new  
15 evidence or something changed in the law. So, it's  
16 --- we don't have a system for trying to --- since  
17 they're all so case-specific, it's really hard to  
18 generalize in that manner.

19 So, we don't have a system like that,  
20 but we do --- if things like --- if there are obvious  
21 things that a hearing rep will see, oh, and this  
22 has been happening more than one time where we can

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1 make note of that, we're small enough to be able  
2 to do that and bring it to the attention of policy,  
3 but a lot of these are just really case-specific.

4 MEMBER REDLICH: So, maybe -- after we  
5 finish going through, maybe, if we are able to  
6 identify some common themes, then that would be  
7 potentially something that could be ---

8 MS. LEITON: You could bring it to our  
9 attention.

10 MEMBER REDLICH: Yes.

11 MEMBER BERENJI: Right. I'm sorry,  
12 this is Mani Berenji. I just wanted to add on to  
13 Dr. Redlich's point.

14 Having some best practices among all  
15 the claims examiners, you know, looking at, you  
16 know, specific claims with respect to respiratory,  
17 with respect to neurologic conditions, I mean, I  
18 think this is something that could help educate  
19 all the claims examiners.

20 And looking at, you know, cases that  
21 were initially denied, but then approved --- I mean,  
22 I feel that there are common themes that could

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1 potentially be identified in trying to ensure that  
2 all these cases are reviewed in a timely manner  
3 just to improve efficiency. Thanks.

4 CHAIR MARKOWITZ: I have a COPD denial  
5 claim in slide 22 if you want to follow along.  
6 I'm going to try to do it a little bit more  
7 succinctly.

8 This was a long-term instrument  
9 mechanic at X-10 in Oak Ridge. So, an instrument  
10 mechanic, 1967 to, at least, 1986. And this was  
11 a recent case. Recently --- final decision March  
12 2019.

13 So, the occupational health  
14 questionnaire lists about 20 different exposures.

15 The SEM identified asbestos as the target toxin  
16 of interest.

17 And interestingly, the --- I looked at  
18 the SEM for instrument mechanics at X-10 --- X-10  
19 is Oak Ridge National Laboratory --- and under ---  
20 in the SEM it said asbestos, but it also said cadmium  
21 as an exposure --- or potential exposure. And then  
22 I looked at the SEM for toxic substances related

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1 to COPD and it also listed Cadmium. Cadmium oxide.

2 So, there was an agent, which however  
3 we feel about it, whether cadmium causes COPD, is  
4 listed in the SEM as both being a potential exposure  
5 of this job title, instrument mechanic, and linked  
6 to COPD.

7 It was never addressed in the claim  
8 review. The focus was on asbestos --- by the way,  
9 I think asbestos is recurrently the target because  
10 the Procedure Manual has some specific guidance  
11 on asbestos. And so, it tends to, as a magnet,  
12 attract attention even though many of us would think  
13 that asbestos is probably the least of the issues  
14 with COPD.

15 In any case, this person worked as an  
16 instrument mechanic, 1967 to 1986. What that  
17 means, is that he had 20 years of exposure as an  
18 instrument mechanic.

19 And under the Procedure Manual, in that  
20 time period, that's a job listing that is said to  
21 have significant asbestos exposure.

22 And by the --- if you look at 34 ---

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1 slide 34, page 17, I took an excerpt from the  
2 Procedure Manual and it says, COPD --- this is the  
3 exposure presumption.

4 20 years of exposure, employed -- this  
5 is in item 1, employed in any of the labor categories  
6 that are listed on Exhibit 15-3 --- 4-3 or whatever.

7 Instrument mechanics are listed and he had  
8 aggregate of 20 years of exposure prior to the end  
9 of '86.

10 Now, actually, I'm not recalling all  
11 the details. It may be that he --- instrument  
12 mechanic wasn't listed. I'd have to check that,  
13 but there's a second way in which you can qualify,  
14 which is the IH looks at the exposure history.  
15 And with the 20 years of significant exposure to  
16 asbestos, than that should qualify under this set  
17 of presumptions.

18 In any case, the fact is the person did  
19 meet these 20 years and the CE sends it to the IH.

20 The IH confirms it, actually, and the IH conclusion  
21 on slide 32 was that, quote, it is highly likely  
22 that Claimant X, in his capacity as an instrument

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1 technician at the X-10 plant, was significantly  
2 exposed to asbestos. And then goes on to say that  
3 it would have been frequent --- that is to say on  
4 a daily basis --- between 1967 to 1986.

5 So, the IH confirms what -- follows the  
6 Procedure Manual guidance, returns that to the CE.

7 At that point, that should have been enough to  
8 call it --- to accept the claim. They had gone  
9 to the IH, the IH, following the Procedure Manual  
10 appropriately, kicked it back to the CE with that  
11 opinion. The CE instead refers it on to the CMC,  
12 and the CMC concludes otherwise that it's not ---  
13 it's not connected.

14 So, the errors here, one, was that  
15 cadmium was overlooked despite it being in the SEM.

16 And, secondly, that the Procedure Manual guidance  
17 followed by the IH, not followed by the CE.

18 And then the CMC, I think, didn't  
19 consult the Procedure Manual because, frankly, if  
20 he had --- it was an occupational medicine  
21 physician. If he had, he would have seen that this  
22 person should be accepted under -- specifically

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1 under the asbestos guidance.

2 Are there any other denials?

3 Yes, Carrie?

4 MEMBER REDLICH: Yeah. There was one  
5 denial that was a secretary at a plant who had also  
6 --- it was a denial for COPD. They also had a claim  
7 for skin cancer. And it looked like the major  
8 concerns were more radiation focus than concerns  
9 for COPD. So, I thought it was an appropriate  
10 denial.

11 CHAIR MARKOWITZ: Thank you.

12 MEMBER DEMENT: Steve, are the  
13 references that were included in the IH report the  
14 same references that were included in the prior  
15 report?

16 CHAIR MARKOWITZ: Yes. Yes. Yes.  
17 There's a definitely cut-and-paste mode of action  
18 on the references.

19 The industrial hygienist is obviously  
20 using their own information or their own expertise  
21 to make a decision and --- are there any accepted  
22 cases that --- Dr. Friedman-Jimenez?

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1                   MEMBER FRIEDMAN-JIMENEZ: There is a  
2 denial here that's Case No. 22846. And I'm not  
3 going to go through it in detail. I don't think  
4 it's a particularly illustrative case except for  
5 one thing that we've been talking about, and I'd  
6 like to raise this formally as an issue.

7                   This is the statement --- the recurring  
8 statement, and I'll quote, there is no available  
9 evidence, i.e., personal or area industrial hygiene  
10 monitoring data, to support that, as part of this  
11 position after the mid-1990s, his exposures would  
12 have exceeded existing regulatory standards.

13                   That statement I found so many times  
14 in ---

15                   CHAIR MARKOWITZ: It's a chorus,  
16 actually. It's the chorus.

17                   MEMBER FRIEDMAN-JIMENEZ: I'm sorry?

18                   CHAIR MARKOWITZ: It's the chorus.

19                   MEMBER FRIEDMAN-JIMENEZ: Yes. Well,  
20 I think it's problematic and it overstates the  
21 confidence that we actually have in the nonelevated  
22 levels, and I see two problems here.

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1           The first problem is that the frequency  
2           and the conditions under which sampling is done  
3           --- in other words, area or personal measurements  
4           of the toxic substance in the workplace are not  
5           --- don't necessarily ensure that this is a  
6           representative sample, that it's a good estimate  
7           of the day-to-day exposures that that worker is  
8           going to experience or has experienced over time.

9           There are not a lot of quantitative  
10          samples that are available that have been done.  
11          And, John, you know these data probably better than  
12          any of us and, please, correct me if I'm wrong on  
13          this, but my sense is that there's not a lot of  
14          sample size and, also, they're not done necessarily  
15          under random timing or conditions or active  
16          sampling that would allow us to use those as an  
17          estimate of the actual day-to-day exposure. Is  
18          that accurate?

19                   MEMBER   DEMENT:        I think that's  
20          accurate. I think --- well, the issues you've  
21          discussed, I think, are clear.

22                   I think that the problem --- and we've

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1 discussed this before this morning in here, is that  
2 it's a presumption that the IH is making about what  
3 the exposures would have been in that time frame  
4 without stating his rationale for his decision,  
5 really --- his or her decision.

6 And that, you know, judgment comes into  
7 play in all of this, but the basis of the judgment  
8 needs to be explained in the process of defining  
9 what this is. So, the CMC and the CE knows the  
10 limits of confidence they can place on the fact  
11 of no exposure.

12 The other aspect of this, even for a  
13 particular job and location, there aren't likely  
14 to ever have been very many samples ever taken.  
15 And the one thing that's always problematic is  
16 taking a job and inferring an individual's exposure  
17 from that job itself because we never know how  
18 people actually do work. And how they do work is  
19 a big factor sometimes.

20 People doing the same work can have must  
21 different exposures. Depends on how they do it.

22 MEMBER FRIEDMAN-JIMENEZ: Yes, the

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1 inter-worker variability in the exposure may be  
2 substantial.

3 MEMBER DEMENT: Yes.

4 MEMBER FRIEDMAN-JIMENEZ: So, that's  
5 one problem.

6 The second problem I see is that these  
7 standards are regulatory standards. These were  
8 developed through a scientific and medical and  
9 political and financial process for regulation of  
10 groups of people.

11 And they were developed with, what I  
12 would say, is a fairly obsolete concept of single  
13 agent causation --- in other words, how much of  
14 the substance does it take to cause the disease?  
15 Rather than a more modern and scientifically valid,  
16 I think, concept of toxic substance of interest  
17 being one of a multiple set of component causes  
18 that contribute to the causation -- to a sufficient  
19 cause of that disease.

20 And we're understanding, I think, a  
21 little better in the last 20 years of epidemiology,  
22 how causation works and how the causal mechanisms

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1 work.

2 And so --- but most regulations don't  
3 reflect that kind of concept of causation. And  
4 so, the standards have been set for single agent  
5 causation rather than contribution to causation  
6 of the disease or aggravation of the disease.

7 And so, they aren't necessarily valid  
8 and completely protective standards for that  
9 particular disease.

10 So, I think that this phrase, which --- you  
11 know, I have nothing against cut-and-paste. I do  
12 it all the time. I think it saves time. It's good.

13 But to use it as sort of a pathway of saying that  
14 there's no significant exposure, I think, is --  
15 it's sloppy sometimes and I think it does the whole  
16 process injustice. I think it's not appropriate,  
17 and it's pervasive. I've seen it in multiple  
18 reports, the same exact  
19 wording.

20 I mean, it's -- and I think that we want  
21 to strive to be medically and scientifically  
22 accurate in this process, and we also want to be

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1 perceived by both Claimants and the Department of  
2 Labor as having a fair and unbiased process. And  
3 I think this does a real disservice to both, so  
4 I would -- I would recommend that that phrase not  
5 be used as a standard phrase.

6 CHAIR MARKOWITZ: But, see, here's the  
7 issue. The industrial hygienist doesn't feel  
8 comfortable --- I'm thinking the industrial  
9 hygienist doesn't feel comfortable with what really  
10 went on after '95.

11 They don't really have data before '95  
12 to support their points of view, right, by and  
13 large, because those data don't exist, but they're  
14 comfortable in saying there was some level of  
15 exposure. Sometimes very low, could be low, could  
16 be moderate.

17 So, they're making their decisions  
18 pre-'95 based on --- not on data, but on their  
19 knowledge of the facilities, their knowledge of  
20 industrial hygiene, their knowledge of what those  
21 people do in industry by job title, right? But  
22 it's not based on data.

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1           Post-'95 because of DOE Order 440.1  
2 when things were supposed to improve, right? Now  
3 they no longer feel comfortable using their own  
4 industrial hygiene knowledge and are --- want data  
5 which don't exist.

6           So, what phrase -- what do we think  
7 would be an appropriate statement about post-1995  
8 exposures?     Something like no data, either  
9 personal or area monitoring, exists for this job  
10 title or for conditions relevant to this individual  
11 that shed any light whatsoever on levels of  
12 exposure, period.

13           In other words, don't frame it in terms  
14 of regulatory levels.   Don't suggest that the lack  
15 of data means there's lack of exposure. Just say,  
16 we don't have any data.   Is that the solution?

17           Dr. Dement?

18           MEMBER DEMENT:   Well, I think that's  
19 the appropriate approach.   I mean, the lack of data  
20 doesn't mean there's no exposure so ---

21           CHAIR MARKOWITZ:   Right.

22           MEMBER DEMENT:   The way it's phrased

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1 now, it suggests there actually is data supporting  
2 the fact there's no exposure, and I don't think  
3 that's what a hygienist really means.

4 So, yes, I think, you know, a fair  
5 presentation of the information would be --- you  
6 know, there's no actual exposure information for  
7 this particular job site. If they want to refer  
8 to, you know, when standards came into place and  
9 some published literature about how exposures  
10 dropped after implementation of standards, that's  
11 fine, but don't make it a statement of fact when  
12 it's really not there with the supporting data.

13 MEMBER FRIEDMAN-JIMENEZ: I think  
14 saying, no data, is somewhat overstating the case,  
15 also, because they're not clouds of dust visible  
16 in the air. That's data, that you can actually  
17 not see the dust.

18 But there are not sufficient data to  
19 make a reasonable estimate of what --- a  
20 representative estimate, of what the exposures were  
21 from day to day, and I think we should be honest  
22 about that because we just don't know. And to

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1 suggest that we do know that they were low, I think,  
2 is overstating it.

3 MEMBER DEMENT: Yes. I don't have a  
4 problem with saying, you know, conditions approved  
5 after 1995 with implementation of this thing that  
6 DOE cites. I mean, that's perfectly fine.

7 MEMBER FRIEDMAN-JIMENEZ: Sure.

8 MEMBER DEMENT: And we know there's ---  
9 you know, things don't happen overnight and changes  
10 take time, so ---

11 CHAIR MARKOWITZ: You know, I ---

12 MEMBER DEMENT: -- present it as it is.

13 MEMBER POPE: I think by stating  
14 there's no data, though, just means that this claim  
15 is even more so denied when you say that there is  
16 no data to support your claim of your illness.

17 CHAIR MARKOWITZ: I agree. I think  
18 some CMCs are going to interpret no data, well ---

19 MEMBER POPE: No data, you know, no  
20 help.

21 CHAIR MARKOWITZ: Dr.  
22 Friedman-Jimenez?

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1                   MEMBER FRIEDMAN-JIMENEZ:     I think  
2                   there may not be area or personal monitoring, but  
3                   the data that are used are from published,  
4                   peer-reviewed research that has done studies and  
5                   found either a disease correlates or actually done  
6                   air measurements in other settings.

7                   So, I think there are --- there is some  
8                   information available and I think the industrial  
9                   hygienist can interpret that information, but we  
10                  should be honest that this is an opinion of the  
11                  industrial hygienist based on published studies  
12                  of other populations or whatever it's based on,  
13                  but this particular wording I find potentially  
14                  misleading and potentially biased, and it's  
15                  perceived by most of us as being boilerplate that's  
16                  not appropriate.

17                  MEMBER POPE:    I think it's kind of one  
18                  in the same.   Low -- referring to it as low doses  
19                  or no data means denial, to me.

20                  If you're saying your doses are low and  
21                  environmental --- how they state it, means that  
22                  there's no data --- it would mean the same thing,

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1 to me, as saying there's no data available.

2 CHAIR MARKOWITZ: I mean, you know,  
3 much of this activity is for the CMC. The CMC is  
4 going to look at post-'95 and say, I've got no basis  
5 on which to say there was any significant exposure,  
6 so I'm going to rule it out. When the fact is we  
7 don't know what happened, right?

8 Dr. Silver?

9 MEMBER SILVER: Two things. Correct  
10 me if I'm wrong, but you have other faculties you  
11 can draw upon. The natural history of the disease  
12 is sometimes known from other case reports or case  
13 series, and sometimes there's a prodromal syndrome  
14 that's followed later by the onset of symptoms and  
15 it appears classically in persons of a certain age,  
16 after a certain duration of time in a profession.

17 Wouldn't a CMC who was drawing upon  
18 everything they learned in school, be able to infer  
19 causation even without quantitative industrial  
20 hygiene data, in some cases?

21 MEMBER BERENJI: Not necessarily. I  
22 mean, among my own colleagues, and I'm sure my

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1 occupational medicine friends here can opine to  
2 this as well, I mean, it runs the full gamut.

3 I mean, some of my colleagues are very  
4 black and white. And obviously to be able to do  
5 this type of analysis, you have to look at nuance.

6 And with these cases, there is a lot of nuance  
7 and, again, this begs the question --- and I  
8 apologize for my ignorance on this front, but at  
9 least for the CMCs to be able to do this type of  
10 work, there needs to be some sort of guidance  
11 document with the, you know, understanding that  
12 a lot of times there will not be a sufficient amount  
13 of quantitative evidence to be able to make a direct  
14 connection.

15 And I think we have to be able to, you  
16 know, make sure that the CMCs are given some sort  
17 of, you know, didactic -- a guidance document, at  
18 least some sort of basic understanding of the work  
19 that they're getting into with the understanding  
20 that there may not necessarily be, you know, a  
21 slam-dunk connection.

22 Otherwise, I feel that this is just

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1 going to keep repeating itself. We're going to  
2 keep having these conversations. We're going to  
3 keep meeting at this table. We're going to see  
4 the same pattern.

5 CHAIR MARKOWITZ: Comments?  
6 Questions?

7 MEMBER BERENJI: Do we have time to  
8 discuss one more approval or ---

9 CHAIR MARKOWITZ: Sure. And then  
10 we'll take a break.

11 MEMBER BERENJI: Okay. So, I actually  
12 had a case that was approved, and I thought this  
13 was a very good case because, at least from my  
14 perspective, everything was done right.

15 So, let me just go ahead and provide  
16 the case ID. Last four digits, 2509. Date of  
17 birth, 1930.

18 So, this was an individual who was  
19 working as an installer for telephone lines. And  
20 he worked at two different plants.

21 One was at the Portsmouth GDP, and one  
22 was at the GTE -- which I don't know what that stands

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1 for, but these are two different sites in Ohio.  
2 And he worked -- at least his work experience was  
3 from 1953 to 1992. So, that's over 40-plus years  
4 of cumulative exposures.

5 So, I felt that this case was evaluated  
6 right because a lot of things were done  
7 systematically, which I thought that was a good  
8 thing.

9 The occupational health questionnaire,  
10 I felt that, you know, there was a lot of good text,  
11 lot of good pretext information. The SEM did cover  
12 a lot of different exposures, including asbestos,  
13 cement, arsenic, chromium, silica. And, again,  
14 it's not necessarily covering all the potential  
15 exposures, but I thought at least compared to the  
16 other cases I reviewed, there was a greater capture  
17 of exposures.

18 And then I'm not sure if this is done  
19 systematically --- I may have missed how this got  
20 done, but there was a connection to the NIOSH  
21 radio/epi program. So, I'm not sure how many ---  
22 what percentage of the cases are they sent over

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1 to this particular NIOSH program. I'm not sure  
2 if there's any data on that, but they actually did  
3 dose reconstruction and they actually did do  
4 telephone interview, which I thought was good.

5 So, again, there are cases, at least  
6 in this particular instance, where I felt that there  
7 was a systematic way of collecting information.  
8 The telephone interview, I thought, was  
9 appropriate.

10 And this case ended up getting accepted  
11 and I actually thought the CMC did a good job on  
12 this one, too. The CMC provided the report stating  
13 that the claimant had sustained multiple toxic  
14 exposures over the decades.

15 And the CMC did actually account for  
16 the fact that this individual was a smoker. I  
17 forget the number of pack per day, but, again, he  
18 had actually, you know, used a well-rationalized  
19 argument that, even though it was a confounder,  
20 just given his breadth of experiences, 40-plus  
21 years at these two different plants, you know, he  
22 was actually able to come up with a good consensus

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1 that the exposures did explain a lot of his  
2 pathology.

3 And this individual was applying for  
4 not only COPD, by the way, but also for -- looks  
5 like he had lung cancer because it looks like  
6 there's a lung mass excision. And he also had  
7 multiple skin cancers.

8 So, complicated case, lot of different  
9 points to cover, but this was actually at least  
10 a good example of how incorporating various,  
11 different data points from the industrial  
12 hygienist, the NIOSH folks --- and I can't belabor  
13 this point enough, but actually doing the telephone  
14 interview, actually making contact with the  
15 claimant, getting the human side of the, kind of,  
16 picture, I think, really helps to solidify the case.

17 CHAIR MARKOWITZ: Dr. Dement?

18 MEMBER DEMENT: I have a question about  
19 the case.

20 Did --- was there chest X-ray or CT data  
21 used to support the asbestos exposure in COPD?

22 MEMBER BERENJI: In this particular

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1 case?

2 MEMBER DEMENT: Yes.

3 MEMBER BERENJI: I did see a chest  
4 X-ray. I don't recall the CT scan, but I'd probably  
5 have to go through the file again.

6 MEMBER DEMENT: Yes. I had a similar  
7 case and --- it won't take me just a moment. I  
8 had a similar case and it was an individual who  
9 worked at Fernald, you know, laborer and chemical  
10 operator for 10 or 12 years and some other work.  
11 But anyway, he had multiple claims --- COPD one  
12 of them -- but he also claimed for asbestosis and  
13 some skin cancers.

14 Originally, the asbestosis was denied,  
15 because he really had pleural changes. And so,  
16 that finally was accepted at least for medical  
17 monitoring for the pleural changes. And then the  
18 COPD came --- case came later and it was actually  
19 accepted for COPD, but largely based on the fact  
20 that he had chest X-ray changes demonstrating  
21 asbestos exposure.

22 CHAIR MARKOWITZ: Dr.

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1 Friedman-Jimenez?

2 MEMBER FRIEDMAN-JIMENEZ: This is very  
3 interesting.

4 I didn't look at this case, but could  
5 you tell us a little more about the dose  
6 reconstruction, what they did and how ---

7 MEMBER BERENJI: I'm going to be  
8 honest, I kind of skimmed through the dose  
9 reconstruction, but I probably have to go back to  
10 do a more detailed analysis.

11 At least based on my initial review,  
12 they were actually able to collect various data  
13 points to be able to make a consensus as to  
14 understanding the exposures that this particular  
15 individual had.

16 Again, I wish I could kind of explain  
17 more of the nuances. I probably have to get back  
18 to you on that.

19 MEMBER FRIEDMAN-JIMENEZ: This was the  
20 asbestos dose that the ---

21 MEMBER BERENJI: I believe this is for  
22 asbestos as well as for the arsenic.

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1 MEMBER FRIEDMAN-JIMENEZ: It was for  
2 arsenic?

3 MS. LEITON: The dose reconstruction  
4 would have been done on the cancers. NIOSH only  
5 does dose reconstruction for cancers, and it's only  
6 for Part B cases. And so, that had a Part B  
7 component and the ---

8 MEMBER FRIEDMAN-JIMENEZ: Radiation?

9 MS. LEITON: Radiation. Radiation  
10 for lung cancer. Just radiation for lung cancer  
11 --- or for other cancers.

12 MEMBER FRIEDMAN-JIMENEZ: (Speaking  
13 off mic.)

14 MS. LEITON: No. They don't do the  
15 dose reconstructions for ---

16 MEMBER BERENJI: Oh, really? Okay.  
17 I thought that was the case for ---

18 MS. LEITON: For any of the Part E  
19 conditions, just the cancer for radiation.

20 MEMBER BERENJI: Just for the  
21 radiation. Okay. Got it.

22 (Simultaneous speaking.)

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1 MS. LEITON: There would have been a  
2 dose reconstruction for skin cancer and lung cancer  
3 probably.

4 CHAIR MARKOWITZ: One more minute.  
5 Just bear with me for one COPD accept. You'll see  
6 why I want to mention this case.

7 Long-term machinist and other job  
8 titles, sheet metal laborer at Rocky Flats. This  
9 was an accepted COPD case.

10 The various exposures were recognized  
11 by the industrial hygienist as being significant,  
12 was not sent to the CMC because the claims examiner  
13 looked at the personal physician and the former  
14 worker program medical reports.

15 The personal physician said the COPD  
16 was related to work and identified some exposures,  
17 ammonia, asbestos, diesel exhaust, endotoxin, but  
18 here's, I think, what was the deciding factor.

19 The former worker program letter, and  
20 this is from National Jewish Medical Center, said,  
21 quote, in my opinion, it is at least as likely as  
22 not that exposure to dust, fumes, gases, vapors

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1 during your work at Rocky Flats aggravated,  
2 contributed, or caused your diagnosis of COPD.

3 And apparently that won the day, so I  
4 want to assure you that there is at least one claims  
5 examiner out there who is listening to us.

6 (Laughter.)

7 CHAIR MARKOWITZ: Let's take a break.  
8 We'll be back at 3:00.

9 (Whereupon, the above-entitled matter  
10 went off the record at 2:48 p.m. and resumed at  
11 3:07 p.m.)

12 CHAIR MARKOWITZ: We are going to get  
13 started. Let's get started. Okay, we're next  
14 going to switch to Parkinson's Disease. And first  
15 we'll -- Marek Mikulski will give us a summary of  
16 the work that he and the working group have done  
17 on this. And then we will discuss claims for  
18 Parkinson's-related illnesses.

19 MEMBER MIKULSKI: It did work a few  
20 minutes ago. Can everybody hear me? Thank you  
21 so very much for this opportunity to speak at  
22 today's meeting. I wanted to give you a brief

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1 update on Parkinsonism and Parkinson's Disease as  
2 it relates to the request the Board has received  
3 from the Department of Labor. Let me start with  
4 some clarifications in terms of terminology that  
5 we're going to be using today here during the  
6 presentation.

7           What is Parkinsonism? Parkinsonism is  
8 actually a generic term that is used to describe  
9 a group of clinical motor symptoms that include  
10 slowness of movement, stiffness and tightness of  
11 the limbs, and involuntary shaking movements that  
12 are most commonly present in the upper limbs,  
13 specifically in the hands and often described as  
14 pill-rolling.

15           Parkinson's Disease is actually the  
16 most common cause of all Parkinsonism cases in this  
17 country. It is estimated that up to over 2/3 of  
18 all Parkinsonism cases are the cases of Parkinson's  
19 Disease with some genetic factors that have been  
20 identified in the last few years responsible for  
21 an early onset of the disease under the age of 50.

22           By rough estimates, these add up to roughly 10

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1 percent of all Parkinson's Disease cases.

2           There's a whole spectrum of known agent  
3 exposures in diseases that present with clinical  
4 symptoms of Parkinsonism. And these include  
5 response to anti-psychotic and anti-anxiety  
6 medications, infectious agents, metabolic  
7 disorders, brain injury, as well as some  
8 occupational exposures. Studies have also  
9 identified cases of Parkinson-mimicking disorders  
10 that mimic the clinical symptomatology of the  
11 disease. However lack the response to the current  
12 available treatment.

13           From a pathologist standpoint,  
14 Parkinsonism is actually a very diverse group of  
15 symptoms. It is believed that the hallmark of the  
16 disease is the loss of dopaminergic neurons in the  
17 part of mid-brain called substantia nigra. This  
18 loss of neurons leads to a reduction in levels of  
19 dopamine, which is the main chemical  
20 neurotransmitter in the dopaminergic system that  
21 amongst all controls reward seeking fine muscle  
22 movements, as well as addictions. A few in the

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1 last years of research on the molecular level has  
2 identified two potential mechanisms involving  
3 abnormal accumulation of proteins,  
4 alpha-synucleins and tau-proteins that are now  
5 believed to be responsible for most of the  
6 Parkinsonism and Parkinson's Disease cases.

7 According to the most recent tenth  
8 revision of the medical classification list by the  
9 WHO, Parkinsonism and Parkinson's disease are  
10 actually coded under the same medical diagnosis  
11 code. The difference is beginning with coding of  
12 known secondary causes of Parkinsonism. This  
13 ICD-10 is somewhat similar to a previous coding  
14 list, ICD-9 except for major differences in  
15 recently identified causes of Parkinsonism.

16 Under the previously accepted and used  
17 Parkinson's Disease Society brain bank, diagnostic  
18 criteria for Parkinson's Disease, Parkinson's  
19 Disease is actually a diagnosis of exclusion which  
20 is supported by the response to the dopamine  
21 replacement therapy. These diagnostic criteria  
22 were put in place in late 80s originally for years

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1 in the pathology series studies. But they have  
2 been subsequently adopted by the clinical  
3 community, as well as research community. These  
4 criterias have been widely used in epidemiologic  
5 studies that look at rates and potential risk  
6 factors of Parkinson's Disease.

7 The new diagnostic system has been  
8 introduced just a few years ago by the International  
9 Parkinson and Movement Disorder Society. And it  
10 is somewhat similar to the old system as it requires  
11 a diagnosis of Parkinsonism first, which is now  
12 supported by the Unified Parkinson's Disease Rating  
13 Scale. And has been designed to help the physician  
14 assess both motor and non-motor symptoms associated  
15 with Parkinson's Disease. This new system also  
16 introduces two levels of certainty, which are the  
17 clinically established diagnosis of Parkinson's  
18 Disease that maximizes the specificity of these  
19 criteria versus the diagnosis of probable  
20 Parkinson's Disease that sort of balances between  
21 the sensitivity and specificity.

22 Parkinson's Disease as I mentioned

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1 before is the most common cause of Parkinsonism,  
2 but the exact risk factors are still very poorly  
3 understood. Most of the cases are termed  
4 idiopathic if no known etiology has been  
5 identified. Research studies have focused on  
6 identifying personal characteristics that form  
7 genetic makeups and markers, but also on exposures  
8 that may increase the risk of Parkinson's Disease.

9 Amongst those exposures are exposures that were  
10 federally at the DOE side.

11 PCBs have been widely used throughout  
12 the mid-70s due to their excellent physical  
13 chemical properties. Used in electrical  
14 equipment, starting fluids for fabrication of metal  
15 weapons parts, and has components of paints,  
16 coatings, adhesives, and gaskets. PCB exposure  
17 has been shown to result in decrease in dopamine  
18 levels in both animal models and experimental cell  
19 lines.

20 Higher concentrations of PCBs have also  
21 been found in pathology series of individuals with  
22 Parkinson's Disease as compared to controls. And

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1 a population-based study of mortality experience  
2 of workers from three electrical components plants  
3 has shown an almost threefold increase in mortality  
4 from Parkinson's Disease as an underlying cause  
5 of death amongst highly exposed female workers from  
6 three electrical capacitor producing plants. This  
7 finding was later confirmed in another pathology  
8 series that showed marked differences between the  
9 concentrations of PCBs in brain tissue of female  
10 subjects as compared to controls.

11 MEMBER BERENJI: I'm sorry. Can I ask  
12 a question?

13 MEMBER MIKULSKI: Sure.

14 MEMBER BERENJI: Can you back to the  
15 previous slide please? So I wasn't sure if you  
16 went through that last bullet about the dose  
17 reconstruction feasibility study.

18 MEMBER MIKULSKI: Yes. This is part  
19 of the Oak Ridge Reservation health study that was  
20 primarily conducted to reconstruct the radiation  
21 dose and PCBs have been identified as persisting  
22 in the environment with potential sources of

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1 exposure -- historical exposures in all those  
2 processes.

3 MEMBER BERENJI: Is this published or  
4 is this just based on --

5 MEMBER MIKULSKI: This is available as  
6 public information. There is no publication as  
7 far as I know. But this can be found and I can  
8 provide you with references for the initial  
9 preliminary reports.

10 MEMBER BERENJI: Thank you.

11 MEMBER MIKULSKI: Solvents. Solvents  
12 have been extensively used throughout the industry,  
13 as well as the Department of Energy complexes  
14 primarily as degreasing agents in cleaning parts,  
15 machining equipment and in paint thinners. Most  
16 commonly solvents used at the DOE complex include  
17 the trichloroethylene, toluene, acetone, hexane,  
18 and carbon disulfide, which has been previously  
19 addressed as potential risk factors for  
20 Parkinsonism in the DOL procedure manual.

21 The majority of the population-based  
22 studies to date have not looked at individual --

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1 the effects of individual -- exposure to individual  
2 solvents. They were mostly presented as single  
3 entity, rather than any specific exposures.

4 There are a few cluster reports to date.

5 Clusters of Parkinson Disease that present on  
6 Doppler evidence of increased risk of Parkinson  
7 Disease in those highly exposed to TCE. TCE --  
8 Oh, I'm sorry. TCE exposure has also been shown  
9 in animal models to result in loss of dopaminergic  
10 neurons and reductions in the levels of dopamine.

11 A 2012 research from UCS and  
12 Parkinson's Institute in California has shown that  
13 every exposure to trichloroethylene on at least  
14 one hour per week basis may result in sixfold  
15 increase in risk of Parkinson's Disease when  
16 compared to non-exposed control. And this last  
17 study was part of a -- of a World War II Veteran  
18 National Academy of Sciences twin study that has  
19 been going on since the 1960s. This study was  
20 particularly important as it offered advantages  
21 in adjusting for different genetic makeup between  
22 the individuals exposed to solvents.

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1           Metals have been widely used throughout  
2 the whole industry, but the most prevalent, the  
3 most common exposures at the DOE complex would have  
4 been through metal fumes or metal dusts generated  
5 during welding or machining operations. Welders  
6 have been at particular risk for exposures to a  
7 spectrum of metals in welding fumes including  
8 manganese that has been looked as a risk factor  
9 for Parkinsonism. And have been addressed in  
10 multiple epidemiologic studies before.

11           An increased risk are iron and copper.  
12 Let me start with those two. Iron and copper  
13 exposures have been found -- have been linked to  
14 reduction in dopamine levels in animal models.  
15 In a study from 1997 and 1999, an increased risk  
16 of Parkinson's Disease has been found among workers  
17 with 20 plus years of occupational exposures to  
18 copper and iron/copper combinations.

19           Finally pesticides. There's been a  
20 lot of research interest in pesticide -- in effects  
21 of pesticide exposures and the increased risk of  
22 Parkinson's Disease amongst the farmers and in

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1 general, in agricultural industry. Pesticides use  
2 was not that common at the DOE complex. However,  
3 there was a potential for bystander exposure as  
4 multiple sites have had farming operations going  
5 on during their normal production.

6 There's several classes of pesticides  
7 including insecticides, herbicides, and fungicides  
8 have been again linked to reductions in dopamine  
9 levels in experimental cell lines, as well as in  
10 animal models. Significantly higher  
11 concentrations of organochlorides, a class of  
12 insecticides have been found alongside the PCBs  
13 and brain tissue of patients diagnosed with  
14 Parkinson's Disease when compared to non-disease  
15 controls. In pooled data analysis -- in  
16 meta-analysis studies, the risk for Parkinson's  
17 Disease has been shown to be elevated for two  
18 classes of pesticides; for insecticides and  
19 herbicides, as compared to those never exposed.

20 I wanted to finish here and open the  
21 floor for discussion, questions.

22 CHAIR MARKOWITZ: Thank you, Marek.

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1 That was great. So perhaps for the benefit of some  
2 of the non-physicians in the room, we should just  
3 say that there is no particular -- you may have  
4 covered this, but maybe I missed it. There's no  
5 blood test. There's no urine test. There's no  
6 radiology study. There's no way of making the  
7 diagnosis while persons -- of Parkinson-related  
8 disorders -- while the person's alive, except for  
9 the clinical diagnosis. Meaning listening to the  
10 patient, doing a physical examination, and seeing  
11 how they respond to therapy. Is that right?

12 MEMBER MIKULSKI: That's correct.  
13 There are however several clinical tests that have  
14 shown an association with Parkinson's Disease.  
15 One of them being the loss of sense of smell has  
16 been shown to be present in over 95 percent of every  
17 case of Parkinson's Disease.

18 CHAIR MARKOWITZ: So that means that  
19 reasonable doctors can disagree about the  
20 diagnosis, particularly when it's relatively early  
21 in the course.

22 MEMBER MIKULSKI: That's correct.

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1 CHAIR MARKOWITZ: Are primary care  
2 clinicians able to make the diagnosis of  
3 Parkinson's Disease with reasonable accuracy?

4 MEMBER MIKULSKI: It has been shown  
5 that the clinical accuracy is the highest among  
6 specialists in movement disorders. Primary care  
7 physicians are probably lacking the proper  
8 training. And possibly these guidelines that have  
9 just been issued have not been updated on the most  
10 recent state of knowledge.

11 CHAIR MARKOWITZ: So Ms. Leiton, can  
12 I ask you because you know, we looked at a limited  
13 number of -- we're going to discuss those claims,  
14 but I'm sure the causation is a question. But is  
15 the question of the diagnosis of -- you know, the  
16 claims examiner is sitting there looking at medical  
17 records making some effort to decide whether to  
18 accept the medical diagnosis of Parkinson's  
19 Disease. Has that been a problem?

20 MS. LEITON: Yes. Part of the problem  
21 is that it's been called different things. And  
22 so we have certain presumptions in the procedure

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1 manual. I think it's for Parkinsonism or  
2 Parkinson's Disease. They don't know whether  
3 they're synonymous. And then there's, I think one  
4 other term that is used for Parkinsonism. And it  
5 gets a little confusing for us. That's part of  
6 the reason we wanted you guys to kind of help clarify  
7 that for us.

8 I did have a question. You said a  
9 specialist in movement, what would that mean for  
10 us if we were going to try to, you know, look for  
11 a specialist who actually would need to help clarify  
12 this? Because, would it be a neurologist?

13 MEMBER MIKULSKI: It would be a  
14 neurologist with training, especially in these last  
15 --

16 MS. LEITON: Wow --

17 MEMBER MIKULSKI: -- most recent  
18 guidelines at this point.

19 CHAIR MARKOWITZ: But Parkinson's  
20 Disease is bread and butter for the average  
21 neurologist. Right?

22 MEMBER MIKULSKI: Yes.

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1                   MEMBER REDLICH:    My father died of  
2                   Parkinson's, so I think anyone who's had a relative  
3                   is going to be more knowledgeable about this  
4                   disease.    There are some cases that are very  
5                   classic in presentation with the various --

6                   FEMALE PARTICIPANT:   Your mic.

7                   MEMBER REDLICH:    Oh, I'm sorry.   I was  
8                   just saying that just having a relative who passed  
9                   away from Parkinson's, I became much more familiar  
10                  with the disease even though I'm not a neurologist.

11                  There's just a wide spectrum of presentations in  
12                  the realm of different movement disorders.   And  
13                  there's some cases that are sort of quite classic.

14                  And then there are others that there's an overlap  
15                  that may take a neurologist years to diagnose.  
16                  So it's really more I think a spectrum of diseases.

17                  So I'm not surprised that it's challenging to  
18                  diagnose.   Challenging enough that I told Steve,  
19                  could he please review my Parkinson's cases.

20                  CHAIR MARKOWITZ:    Thank you.    Dr.  
21                  Silver?

22                  MEMBER SILVER:    A non-physician with

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1 a maybe simplistic question. So if a worker has  
2 the three categories of motor symptoms, but their  
3 condition does not improve with drug therapy,  
4 Levodopa, does that tilt in favor of xenobiotic  
5 exposure causing the movement disorders?

6 MEMBER MIKULSKI: Possibly. I don't  
7 think that this would be -- in favor of diagnosing  
8 Parkinson's Disease, but definitely some other  
9 secondary agents.

10 CHAIR MARKOWITZ: And that would be  
11 categorized as Parkinsonism.

12 MEMBER MIKULSKI: As a secondary  
13 Parkinsonism panel.

14 MEMBER SILVER: Thank you.

15 CHAIR MARKOWITZ: Dr.  
16 Friedman-Jimenez?

17 MEMBER FRIEDMAN-JIMENEZ: How strong  
18 is the evidence for PCBs? I noticed that you had  
19 the PCB slide, the Chorigon study. The numbers  
20 were the same for the PCBs and for the  
21 organochlorines. Is that for PCBs? And how  
22 strong a study is that because there were small

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1 numbers.

2 MEMBER MIKULSKI: That was actually a  
3 pathology series that was a very small case -- a  
4 very small study. I believe roughly between ten  
5 and 20 cases. And those were actually identified  
6 parallel and parallel. So PCBs and  
7 organochlorines in the brain tissues and of the  
8 same cases of Parkinson's Disease.

9 MEMBER FRIEDMAN-JIMENEZ: I wasn't  
10 able to tell how strong it was from the numbers  
11 that you had. The second numbers in the  
12 parentheses, were those tissue levels?

13 MEMBER MIKULSKI: There were no tissue  
14 levels.

15 MEMBER FRIEDMAN-JIMENEZ: What was  
16 that 70 to 85 versus 50 to 72?

17 MEMBER MIKULSKI: Those were the age  
18 ranges.

19 MEMBER FRIEDMAN-JIMENEZ: Oh, those  
20 were the age ranges. Okay.

21 MEMBER MIKULSKI: And the ratio of male  
22 to female subjects. They have had -- They've

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1 extended the age range to include younger controls  
2 as well. The cases of age of death was anywhere  
3 between 70 and mid-80s as I recall. But for the  
4 controls, they used several subjects younger than  
5 that.

6 MEMBER BERENJI: I have a question --  
7 I'm sorry.

8 CHAIR MARKOWITZ: Yes, Dr. Berenji.

9 MEMBER BERENJI: Do you have any data  
10 about the use of imaging, specifically PET imaging  
11 to be able to diagnose early signs of Parkinson's?  
12 Because I know the data has been equivocal, but  
13 I wasn't sure if you had any specific information  
14 on that.

15 MEMBER MIKULSKI: I have not come  
16 across any of this.

17 CHAIR MARKOWITZ: Dr.  
18 Friedman-Jimenez?

19 MEMBER FRIEDMAN-JIMENEZ: Another  
20 question on manganism. Okay, that's the Parkinson  
21 presentation due to manganese. And I've read  
22 studies that have found imaging changes in the

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1 globus pallidus on MRI that aren't found in  
2 Parkinson's Disease. What's your -- What have you  
3 found on that? Is there anything new on that or  
4 any developments in imaging that can distinguish  
5 manganese from primary Parkinson's Disease?

6 MEMBER MIKULSKI: I honestly have not  
7 looked at the effects of manganese specifically.  
8 We assume that since this is also covered under  
9 the cards on files and we're not going to do any  
10 more research in that area. But certainly this  
11 is something to look into in the future. Manganese  
12 is a very controversial exposure, at least to say  
13 some studies have found a correlation where some  
14 others have not. So this is definitely something  
15 to be cautious about and possibly look into it in  
16 the future.

17 CHAIR MARKOWITZ: But the DOL approach  
18 to this class of disorders is to -- if I understand  
19 the procedure manual correctly is to include all  
20 the relevant ones with the ICD codes that contain  
21 Parkinson as being equivalent. So they don't carve  
22 out manganese as a separate diagnosis. If at all,

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1 they're erring on the side of being inclusive --  
2 very inclusive in at least the way the procedure  
3 manual reads.

4           You know the -- I'm having -- I can't  
5 -- I'm having a hard time imagining a CMC second  
6 guessing the diagnosis of a primary care physician  
7 of Parkinson's Disease. A neurologist, that's easy  
8 because the neurologist is the expert. The primary  
9 care physician has fairly frequent contact with  
10 Parkinson's Disease because it's fairly common.  
11 They may or may not be correct in the diagnosis.  
12 But I'm trying to imagine a CMC doing a paper review  
13 being more correct than the primary care doctor  
14 who's seeing the patient for this condition. So  
15 I'm wondering if you -- what your view of that  
16 because you've been thinking more about this than  
17 I have.

18           MEMBER MIKULSKI: I think it all  
19 depends on the level of expertise of CMC. Most  
20 CMC probably -- most CMCs probably have not had  
21 that level of expertise to be able to question the  
22 neurological degenerative disorders. I'd

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1 probably caution against using a CMCs opinion as  
2 a cardinal or final opinion in making this  
3 diagnosis, especially where there is evidence of  
4 medical deficits presented and diagnosed by the  
5 primary care physician who honestly at this point  
6 may not be using the most recent classification  
7 as this is so recent. And still operating under  
8 the old guidelines, which are perfectly fine in  
9 terms of clinical accuracy.

10 CHAIR MARKOWITZ: Well these  
11 guidelines that you went over, the new ones, these  
12 are very complicated for the clinician because you  
13 have to have certain positive findings. You can't  
14 have -- certain findings absolutely rule it out.

15 Other findings serve as red flags and argue against  
16 it. It's --

17 MEMBER MIKULSKI: And another  
18 complicating factor here is that these are  
19 guidelines formulate by the organization that's  
20 specifically interested in erring on the side of  
21 diagnosing Parkinson's Disease. As an example,  
22 this unified scale of Parkinson's is a scale that

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1 helps assess the both motor and non-motor symptoms  
2 of Parkinson's Disease is something that you  
3 actually have to purchase before you can start using  
4 it. Which sort of shows the direction that this  
5 may be going on in terms of clinical diagnosis.

6 I don't know how well will this be  
7 adopted in the future. There's really no say.  
8 There are validity studies. Studies that look at  
9 the external validity of the scale versus the old  
10 scale and compared to the gold standards of  
11 diagnosis being the pathology series. But I think  
12 it's really too early to sort of limit yourself  
13 to this -- to this particular one set of criteria  
14 that are now being recommended by an organization  
15 that is vitally interested in the -- in the  
16 potential outcome.

17 CHAIR MARKOWITZ: Any other comments  
18 or questions? Otherwise, we'll move to reviewing  
19 the claims for Parkinson's Disease and we can  
20 reiterate the same discussion. Yes, Dr. Silver?

21 MEMBER SILVER: It may be an  
22 oversimplification, but for our population of

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1 former workers 70 to 80 years old this 2x2 table  
2 is jelling in mind. One row is Parkinson's  
3 Disease. The other is secondary Parkinsonism.  
4 And the columns are yes job exposures, no job  
5 exposures. So Parkinson's Disease could be caused  
6 by job exposures.

7 MEMBER MIKULSKI: Exactly.

8 MEMBER SILVER: All right? But a lot  
9 of it is idiopathic. And then the lower row of  
10 the table, Parkinsonism similarly it could be  
11 caused by job exposures or maybe drugs, metabolic  
12 disorders --

13 MEMBER MIKULSKI: Exactly.

14 MEMBER SILVER: -- and infections.

15 MEMBER MAHS: Anything that can be  
16 explained.

17 CHAIR MARKOWITZ: All right. So let's  
18 discuss some Parkinson's-related claims. Anybody  
19 want to start?

20 MEMBER MAHS: Are these accepted or  
21 denied?

22 CHAIR MARKOWITZ: Oh yes, sure. We

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1 can go with either.

2 MEMBER MAHS: Well since we're here,  
3 I've got one on Savannah River that's denied --

4 CHAIR MARKOWITZ: Oh, hit the mic.

5 MEMBER MAHS: Since we're here, I have  
6 one at Savannah River that was denied. It was a  
7 laborist. Worked there a little a little over ten  
8 years. Works labor as an inspector. And I'm kind  
9 of -- anyhow, she was denied on October 19th. They  
10 had her appeal. They denied her claim for  
11 Parkinson's Disease and pulmonary fibrosis. Final  
12 decision notably does not discuss the testimony  
13 provided during the previous hearing in October  
14 from her and co-worker concerning the kinds of  
15 exposure to toxic substances she experienced at  
16 SRS. Further states that after this evidence was  
17 submitted, the District Office undertook  
18 development of the claim by searching the SEM for  
19 potential exposures.

20 District Office determined at a search  
21 in December revealed that a Labor, DI mechanic,  
22 and Quality Inspector had potential for exposure

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1 to aluminum, bronze, microtalc, antimony hydride,  
2 silica gel, and synthetic vitreous fibers. In  
3 December, revealed certain potential exposures to  
4 carbon monoxide and stainless steel, which are  
5 associated with Parkinson's Disease.

6 The final decision states these  
7 potential exposures were referred to an industrial  
8 hygienist to evaluate the nature. He opined that  
9 there was significantly exposed to stainless steel.

10 It was highly unlikely that she was exposed to  
11 carbon monoxide at a level specified in the  
12 procedure manual.

13 For discussion, her representative  
14 respectfully requested to reconsider the final  
15 decision denying her claim which is prematurely  
16 and erroneously issued. And the denial of her  
17 claim denies due process law as discussed above.  
18 Neither her nor her attorney, an authorized  
19 representative of record, received the recommended  
20 decision. In fact, they were not aware of the  
21 recommended decision until they received the final  
22 decision. So they had no time to find out what

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1 the problem was.

2 Failing to give notice of the  
3 recommended decision, the Department of Labor  
4 failed to properly develop her claim of pulmonary  
5 fibrosis. And neither the recommended decision,  
6 nor the final decision considered the full extent  
7 of exposure related to her employment at Savannah  
8 River. She was exposed to including asbestos,  
9 aluminum, and other metal dust silicone, dioxide  
10 including cement dust, coal dust, loading fumes,  
11 exhaust fumes.

12 She had testimony from two different  
13 co-workers that she'd worked in the steam plant  
14 and was exposed to the coal dust and asbestos and  
15 stuff. And it wasn't used in the final  
16 recommendation either. The hygiene records from  
17 SRS state that as a laborer, she was exposed to  
18 cement dust, coal dust, slag, fiberglass, diesel  
19 and gasoline exhaust, fumes, asbestos, and coal  
20 dust. And that's just about the same thing that  
21 the SEM said she could be exposed to.

22 In addition, she ran a jackhammer that

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1 exposed her to cement dust and diesel exhaust.  
2 And again, she was sent to the power house for three  
3 years. Her co-workers confirmed it and that  
4 testimony was not used, I think I mentioned.

5 However, chronically daily exposure to  
6 dust and fumes for more than ten years employment  
7 as a labor mechanic. The most prominent hazards  
8 at capacity were her exposure to cement, silicon  
9 dioxide, coal dust, asbestos, welding fumes, metal  
10 dust, aluminum oxide, which she had chronic  
11 exposure and likely some instances of acute or heavy  
12 exposure.

13 Occupational exposure to the discussed  
14 toxin substances was most significant risk factor  
15 of her development of pneumoconiosis, however you  
16 say that, and resulting pulmonary fibrosis. Also  
17 my opinion to a reasonable degree of medical  
18 certainty, it's at least as likely as not that her  
19 occupational exposure to these hazardous chemicals  
20 were possibly responsible.

21 In November 2018, they denied her claim  
22 benefit based on Parkinson's Disease, pulmonary

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1 fibrosis and the advice of reconsideration request  
2 will be assigned to the Jacksonville office. And  
3 again, for the reasons stated below, the Department  
4 of Energy verified they worked at the plant. On  
5 July 6th, 2017, District Office issued a  
6 recommended decision to deny your claim under Part  
7 E based on a condition of Parkinson's Disease and  
8 pulmonary fibrosis because you failed to submit  
9 medical evidence, which I just read.

10 On February 9th, 2018, FAB issued a  
11 remand order that after you submitted additional  
12 medical evidence to support that you were diagnosed  
13 with pulmonary fibrosis and Parkinson's Disease.

14 Medical evidence you submitted included medical  
15 report, which showed a diagnosis, a CT scan, and  
16 reviewed by her MD and showed pulmonary fibrosis  
17 -- just repeating itself. And they find that your  
18 occupational exposure to airborne particulates,  
19 dust fumes including coal, dust, and asbestos  
20 caused or contributed to your pulmonary fibrosis.

21 The industrial hygienist on February  
22 27th and May 8th of 2018, the potential exposure

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1 at Savannah Riverside that you have had to carbon  
2 monoxide and stainless steel as an EI mechanic from  
3 September 23rd '85 to April '92 to aluminum, bronze,  
4 microtalc. And as a laborer from February '85 to  
5 September '85 to antimony hydride, silica gel, some  
6 synthetic vitreous fibers, metallic as an EI  
7 mechanic from September '85 to 30th.

8 He opined that in your job as an EI  
9 mechanic you were significantly exposed to  
10 stainless steel. Exposure would have been  
11 incidental in nature and in passing. Highly  
12 unlikely that you were exposed to carbon monoxide  
13 at levels specified in the EEOICPA procedure  
14 manual. There was no evidence that you were ever  
15 rendered unconscious as a result of this exposure  
16 to that agent. Do you have to be unconscious to  
17 be exposed to carbon monoxide? Pardon?

18 MS. LEITON: It's in our presumption  
19 of carbon monoxide.

20 MEMBER MAHS: All right. Anyhow, so  
21 in the event that you did ask for an revision because  
22 of the problems of things that didn't get turned

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1 over or reviewed. And I guess they sent it to the  
2 Jacksonville office to see if they're going to  
3 review it.

4 CHAIR MARKOWITZ: Comments,  
5 questions? So do they -- Did they accept the medical  
6 diagnosis of Parkinson's disorder and the issue  
7 was the exposure?

8 MEMBER MAHS: Yes, well that was her  
9 doctor suggesting it was exposure to these fumes.

10 CHAIR MARKOWITZ: Right. Her doctor  
11 said she had Parkinson's?

12 MEMBER MAHS: Yes.

13 CHAIR MARKOWITZ: But did the DOL  
14 claims process accept the medical diagnosis or is  
15 that still in contention or was it --

16 MEMBER MAHS: That was another part.  
17 He did not submit probative scientific evidence  
18 of a fully rationalized medical report showing that  
19 your occupational exposure to toxic substance at  
20 Savannah Riverside was a significant factor and  
21 aggravating, contributing, or causing your  
22 pulmonary fibrosis and Parkinson's Disease. And

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1 so they deny your claim for benefits based on  
2 Parkinson's Disease and pulmonary fibrosis is  
3 appropriate. You did not establish that toxic  
4 substance exposures was a significant factor in  
5 aggravating, contributing to, or causing claimed  
6 conditions of Parkinson at least as likely as not.

7 CHAIR MARKOWITZ: Okay, thanks.  
8 Comments, questions?

9 MEMBER DOMINA: I have a case we can  
10 do. It's an accept case. If you still have that  
11 handout, if you go to Page 36 or Slide 72. It's  
12 not a long case. And it's a chemist actually who  
13 worked for 40 years as a chemist at Hanford and  
14 PNNL. And was exposed in the IH report to manganese  
15 and potassium permanganate at very low to low  
16 levels. And the IH concluded that it was highly  
17 likely that in his work as a chemist or scientist  
18 at Hanford PNNL, he was significantly exposed to  
19 multiple toxins, though not after the mid-1990s.

20 He was a chemist for 40 years beginning  
21 in the 1960s -- or in actually 1955, so for a long  
22 time. And the referral to the CMC was that his

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1 exposure to manganese or permanganate as a chemist  
2 cause, contribute, or aggravate his Parkinson's  
3 disorder -- the disease was accepted -- the medical  
4 diagnosis was accepted. That wasn't in contest.

5 It was just the question of exposure.

6 And the CMC said yes, he or she did  
7 believe that this person's exposure to manganese  
8 permanganate was sufficient. And it was at least  
9 as likely as not. And cited some references  
10 including several which are specific to Parkinson's  
11 Disease and environmental exposures. So a chemist  
12 40 years, named exposure to manganese permanganate,  
13 recognized by the IH, recognized by the CMC was  
14 approved. So that's an example of an approval for  
15 Parkinson's.

16 CHAIR MARKOWITZ: Yes?

17 MEMBER FRIEDMAN-JIMENEZ: That was one  
18 of the ones you gave me that I looked at also.  
19 And I noticed that they also accepted his COPD and  
20 his Parkinson's at the same time a few years back.

21 And they deferred his neuropathy and his chronic  
22 kidney disease. But also what Dr. Mikulski talked

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1 about earlier, he had a loss of smell since 1995  
2 in which they denied. And so --

3 CHAIR MARKOWITZ: Yes. You're saying  
4 that was part of the Parkinson's -- that's an  
5 attribute of Parkinson's Disease.

6 MEMBER FRIEDMAN-JIMENEZ: It's a  
7 supportive criteria for the diagnosis of  
8 Parkinson's according to the most recent --

9 MS. LEITON: This is Rachel and that's  
10 part of the reason we need help. Because we don't  
11 -- there's not -- That for example is something  
12 that we wouldn't have known otherwise. Doctors  
13 don't always put it in as a part of Parkinsonism.

14 We've got some of these manganese, carbon monoxide  
15 in our procedural manual. But a lot of times they  
16 come back and say idiopathic. And you know then  
17 -- so those are the jumbles of different issues  
18 and problems with he have Parkinsonism, Parkinson's  
19 Disease, manganese. All those are kind of jumbled  
20 together and they're not as well known. So it's  
21 one area of education that would --

22 MEMBER DOMINA: One other thing on that

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1 case because the guy -- because it showed him from  
2 55 to 65 working for GE and there was no records.

3 I mean the case file is 1,415 pages long. And  
4 there's no records from 55 to 65 in his case file.

5 And so for me, that's a little bit troubling on  
6 some of the things that maybe they denied him on.

7 Because he also talked about working with  
8 beryllium and lead basically daily too. And so,  
9 because I went back and skimmed through it again  
10 when I couldn't find any 55 to 65 records. I  
11 thought that was kind of odd.

12 CHAIR MARKOWITZ: And this was kidney  
13 disease. And what was the other one you said he  
14 was --

15 MEMBER DOMINA: Neuropathy --

16 CHAIR MARKOWITZ: Neuropathy.

17 MEMBER DOMINA: -- and his loss of  
18 smell, yes.

19 CHAIR MARKOWITZ: I have to confess,  
20 I was focusing on Parkinson's.

21 MEMBER DOMINA: Well I know, but see  
22 for me it's like you know, these four letter words

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1 I can work with. And so it's kind of like you know  
2 --

3 CHAIR MARKOWITZ: I know. You want to  
4 address the whole person. I get that.

5 MEMBER DOMINA: Yes.

6 CHAIR MARKOWITZ: Other comments,  
7 questions? All right, any other cases? Dr.  
8 Dement? Oh yes, of course. Dr. Mikulski.

9 MEMBER MIKULSKI: Yes. So I have a  
10 denied case of Parkinson's Disease that looks like  
11 it's been in the works for a good decade or so.  
12 The Case ID No. is 7158. And this is a 65-year-old  
13 gentleman at the time of diagnosis of Parkinson's  
14 Disease, now 77, who worked almost 20 years --  
15 non-consecutive years as a project engineer and  
16 construction engineer at the Portsmouth GDP.

17 His initial claim, he has no family  
18 history of Parkinson's Disease. His initial claim  
19 was denied based on the lack of medical evidence.

20 Further medical evidence was submitted. The  
21 claim was accepted for review. And final decision  
22 has been the lack of causation given the lack of

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1 information -- specific job information and the  
2 SEM.

3 It looks like the claim examiner had  
4 went to great lengths of trying to identify these  
5 exposures, but could not find any information in  
6 the DOL resources. Accepted the medical  
7 condition; however, did not take into consideration  
8 the occupational health questionnaire that  
9 specifically listed exposures to solvents, metals,  
10 and other substances.

11 Anything else about this claim? There  
12 was no referral either to the industrial hygiene  
13 or CMC in this case. And the case was basically  
14 denied by the FAB decision early, early last year.

15 Hence my series of questions earlier today about  
16 the level of decision making in terms of having  
17 the CMCs look at the available evidence.

18 MS. LEITON: So for Parkinsonism, we  
19 do have that -- In Exhibit 15.4, we have some very  
20 specific criteria that we're looking for. And so  
21 that might be part of -- so he didn't have evidence  
22 of manganese or carbon monoxide or certain

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1 substances. You said that we couldn't find much  
2 either. That may be why it wasn't referred to an  
3 IH. There just wasn't enough to refer or it didn't  
4 line up with some of our presumptions. So that's  
5 one of the variations you'll find.

6 MS. LEITON: He had a medical diagnosis  
7 of Parkinson's Disease from both primary care --  
8 his primary care physician, as well as a second  
9 opinion from the neurologist as well.

10 MS. LEITON: Right. The disease  
11 wasn't in question. It was the causation --

12 CHAIR MARKOWITZ: Yes.

13 MS. LEITON: -- and exposure.

14 CHAIR MARKOWITZ: What was his job  
15 title?

16 MEMBER MIKULSKI: Project engineer and  
17 construction engineer. It looks like there were  
18 several phases -- plant operations. Because he  
19 worked at -- he first worked during the main  
20 operations. Then during remediation, and finally  
21 when the plant was -- when the plant was on cold  
22 standby. He was not part of the medical

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1 screenings, so he didn't have any other records  
2 available in terms of employment.

3 But what was really interesting is that  
4 his occupational health questionnaire was  
5 administered by the Resource Center caseworker.  
6 Which my impression from looking at the records,  
7 had very little expertise with regards to the  
8 specific site. And basically just went over the  
9 general categories of exposures and flagged them  
10 as he was told.

11 CHAIR MARKOWITZ: What was that case  
12 number?

13 MEMBER MIKULSKI: 7158.

14 CHAIR MARKOWITZ: But was there any  
15 mention in the SAM analysis or in the occupational  
16 health questionnaire of carbon monoxide, any  
17 manganese-related -- any steel, any welding, any  
18 alloy?

19 MEMBER MIKULSKI: No. The only  
20 mention was of exposure to radiation, as well as  
21 solvents, metals, gasses.

22 CHAIR MARKOWITZ: Because as far as I

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1 can tell --

2 MEMBER MIKULSKI: It was very general.

3 CHAIR MARKOWITZ: -- the ballpark of  
4 relevant exposures as in the procedure manual or  
5 in the SEM if you look up Parkinson's, are those  
6 the ones I just mentioned; CO, a bunch of alloys,  
7 weldings, various steel materials, and various  
8 manganese or elements that contain manganese? And  
9 if you don't have one of those exposures, then you  
10 know, you're not going to qualify because you don't  
11 -- because there's no relationship according to  
12 -- is the way the system seems to look at it. Dr.  
13 Redlich?

14 MEMBER REDLICH: You know, this is  
15 quite different than the pulmonary cases where  
16 we've -- we have, you know, more -- in pulmonary  
17 cases where we know that asbestos causes, you know,  
18 asbestos and the diseases and causation have been  
19 established. So we're just addressing in an  
20 individual whether there's, you know,  
21 clarification of the disease and if there's  
22 sufficient exposure. So it seems here we first

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1 need clarification based on the current literature.

2 And that's what you were trying to do is do we  
3 think that any additional categories of exposure  
4 should be added to the current list?

5 And I mean the other thing as far as  
6 the respiratory diseases, there may be some  
7 disagreement about the -- We have some idea in  
8 addition to what exposures will cause which  
9 diseases. We also have some idea of the magnitude  
10 of exposure or a ballpark. You know, how many  
11 years? You know, we know beryllium, you need less  
12 -- potentially less exposure than, you know,  
13 asbestosis.

14 So is there -- Do we have a consensus  
15 of whether the current list is adequate and whether  
16 --

17 CHAIR MARKOWITZ: For myself, I would  
18 say not yet. But we're getting there.

19 MEMBER MIKULSKI: We're working on it.

20 CHAIR MARKOWITZ: But I think there are  
21 two issues. One's general causation we're trying  
22 to address.

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1 MEMBER REDLICH: That's right.

2 CHAIR MARKOWITZ: And the other is  
3 specific causation. How well is the system working  
4 as it defines relevant exposures? Which is similar  
5 to what the COPD claims review was. So I think  
6 it's legitimate that --

7 (Simultaneous speaking.)

8 CHAIR MARKOWITZ: -- parallel go to  
9 both -- go both ways. Comments, questions on this  
10 case? Is there another case? Do you have a case  
11 Dr. Dement?

12 MEMBER DEMENT: I have one that's sort  
13 of -- Let me do this again. It's sort of  
14 interesting.

15 CHAIR MARKOWITZ: What number is it?

16 MEMBER DEMENT: It's 0177.

17 CHAIR MARKOWITZ: Okay.

18 MEMBER DEMENT: This is a case of an  
19 individual who at the time of his case review was  
20 in his mid-70s. Was born in 1940. He had  
21 Parkinson's, but several other things that were  
22 filed for; hearing loss, some skin cancers, a

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1 thyroid nodule, a lung nodule. And his work  
2 history wasn't watched well. He was a pipefitter  
3 welder. And that seemed to be well-established.  
4 The timeframe, some of it in the early 70s. And  
5 then again in the mid-90s. And then a period of  
6 '91 to '98, so inclusive.

7 There was some question. Again his  
8 work history, whether or not he had more exposure  
9 at Oak Ridge. His OHQ was to work in both X10 and  
10 occasionally E5. So but that didn't -- the request  
11 for records didn't verify that exposure. But  
12 nonetheless, there was a question about it. So he  
13 had a long experience of being a pipe fitter/welder.

14 Some of which was at Oak Ridge. Some question  
15 about how much time. I think they allotted about  
16 eight years.

17 So the diagnosis of Parkinson's was  
18 accepted and that was from the treating doctor.  
19 The SEM was consulted. And the exposures that the  
20 SEM identified of course were the things that Steven  
21 just spoke of. And those were carbon and stainless  
22 steel, as well as welding. And specifically use

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1 of manganese growing rods. So that was sent to  
2 the IH. He reviewed it and said that he concurred  
3 that there would have been exposure to carbon and  
4 stainless steel, as well as welding fumes and dust  
5 during his work history. He saw the same phrase  
6 that we've heard all along with regard to regulatory  
7 standards after the mid-90s. So that was per the  
8 intake -- the review. It didn't really address  
9 the welding and rod issue, which I wondered why.

10 It seems like he should have addressed his use  
11 of the welding rod with magnesium. The OHQ listed  
12 some other metals, specifically lead and mercury.

13 That weren't addressed in the IH assessment or  
14 given to the IH for assessment.

15 So the claim was actually -- was denied.

16 And the CMCs review of it, he accepted the fact  
17 that Parkinson's was diagnosed. Then he opines  
18 that it's only linked to high sustained exposures  
19 to manganese in particular. And he stated that  
20 seven year of work is a relative short duration.

21 And the estimated baseline from low to moderate  
22 levels of exposure is not a high dose associated

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1 with the development of Parkinson's.

2 So here we have a situation where in  
3 my view, you have a long-term pipefitter welder.  
4 Okay, he has those exposures; some of which are  
5 at the DOE side. He would be a case that I think  
6 if you were to look at his total work history and  
7 review it, you would say yes. When you start  
8 separating apart and trying to allocate only a piece  
9 of it to the DOE side, then this seems like they're  
10 falling apart based on the CMCs review. In my  
11 opinion, if I were reviewing this case, I think  
12 I would just say his Parkinson's Disease is likely  
13 caused by his exposures to these materials. And  
14 the DOE side exposures contributed to that outcome.

15 Comments?

16 MEMBER POPE: And that was an accepted?

17 CHAIR MARKOWITZ: Denied.

18 MEMBER POPE: It was denied?

19 MEMBER BERENJI: I actually had this  
20 case as well. And I just wanted to reiterate what  
21 Dr. Dement just mentioned. At least from my  
22 perspective, I mean I deal with this in my clinical

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1 practice where you're dealing with a particular  
2 individual who's, you know, coming in, claiming  
3 that he or she had this exposure while working at  
4 this particular employer site. But if you take  
5 a full comprehensive occupational history, it turns  
6 out that they worked at various different locations  
7 over a period of decades. So at least in this case,  
8 I know he was working at this particular location  
9 1970 to 1973.

10 I might have missed this. I'm not sure  
11 if John may have gotten this. But it would be  
12 interesting to be able to parse out what exactly  
13 he was doing in those three particular years.

14 MEMBER DEMENT: I believe in those  
15 years he was in the same job category; pipefitter  
16 welder. He actually spent a lot of time in the  
17 fab shop doing a lot of welding.

18 CHAIR MARKOWITZ: Right, so at least  
19 if -- I'm not sure if that may have made it to this  
20 statement of accepted facts or at least made it  
21 to the questionnaire, I mean if there's a way where  
22 there could be kind of you know, brought up to the

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1 CEs attention, I felt that, that could have helped  
2 at least to make a better case for this particular  
3 claimant.

4 MEMBER REDLICH: Yes, during that  
5 timeframe in particular -- and I think Kirk has  
6 pointed out an important point. You weld. You have  
7 a variety of different materials that you weld.  
8 The base materials, as well as the welding rods  
9 that you use, which contribute to the exposure.  
10 Then you turn around and you grind the weld off  
11 when you get it down to make it nice and smooth  
12 and clean. So there's lot of different exposures,  
13 rather than just the welding fumes itself.

14 CHAIR MARKOWITZ: This is Steve  
15 Markowitz. I just want to point out, John, with  
16 reference to the welding rods, the SEM under  
17 Parkinsonism relates it to a work process which  
18 is entitled, "Use manganese-containing welding  
19 rods." And lists welding fumes as at least  
20 potential exposure to welding fumes as related to  
21 Parkinsonism. Comments or questions?

22 MEMBER SILVER: How old was he when the

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1 disease was diagnosed, do you remember?

2 MEMBER DEMENT: I don't know if I have  
3 it recorded on my notes here. I don't seem to have  
4 it on my notes.

5 MEMBER BERENJI: I don't have it either  
6 but I can look that up.

7 CHAIR MARKOWITZ: Okay, thank you.

8 MEMBER POPE: I'm just having a problem  
9 trying to distinguish between the one that you had  
10 Dr. Markowitz and that was accepted right?

11 CHAIR MARKOWITZ: The chemist?

12 MEMBER POPE: Yes.

13 CHAIR MARKOWITZ: The chemist was --  
14 40 years as a chemist, yes.

15 MEMBER POPE: Forty years and the  
16 welder. So the cases that I looked at with the  
17 Parkinson's, a lot of the welders were coming down  
18 with Parkinson's and a lot of those cases were  
19 denied. But I had a problem trying to distinguish  
20 why that yours was accepted and theirs were denied.

21 MEMBER BERENJI: Again, I think Dr.  
22 Dement already mentioned this. But it looks like

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1 it has to do with the number of years that this  
2 particular individual is working at the DOE site.

3 MEMBER DEMENT: Yes, the CMT basically  
4 said that the duration/intensity of exposure wasn't  
5 enough for him to attribute to the Parkinson's to  
6 the DOE site where -- Yes, I did find it --

7 MEMBER POPE: Maybe that's why it was  
8 the chemist.

9 CHAIR MARKOWITZ: Yes, exactly.

10 MEMBER POPE: Yes, that was my  
11 question.

12 MEMBER DEMENT: It was based on his  
13 treating doctor. He was symptomatic since about  
14 2005. So would have been about 65.

15 CHAIR MARKOWITZ: Well I have another  
16 accept case that might help. But I don't want to  
17 move on to it unless -- Well this can brief --  
18 accepted November 2018. And this was a machinist  
19 janitor for ten years, machinist for 23 years.  
20 And the claims examiner -- Well let me just move  
21 straight to the IH report. The IH said highly  
22 likely as a machinist to be significantly exposed

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1 to multiple toxins.

2 And among those toxins, relevant to the  
3 issue of Parkinsonism was carbon steel occasional  
4 low to moderate, Bonnell occasional low, steel  
5 occasional low to moderate. And as machinist 23  
6 years. And the CMC said that's enough. That's  
7 enough exposure to manganese and copper. I'm not  
8 sure where the copper came in exactly, but I think  
9 Marek knows. But in any case, they accepted the  
10 case. So there's an example of a different job,  
11 the machinist, longer term 23 years. Janitor on  
12 top of that, but the steel exposure was probably  
13 machinist mostly, which was accepted.

14 MEMBER POPE: Now is there any  
15 connection between -- because everybody's  
16 different, right -- as far as the disease taking  
17 a short amount of time to develop opposed to  
18 somebody that has been exposed over a long period  
19 of time?

20 CHAIR MARKOWITZ: Well I think  
21 actually, Steve Markowitz -- I think one of the  
22 things we need to do is to look at the

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1 manganese-related and welding-related literature  
2 that demonstrates Parkinsonism. And look at  
3 duration of people and intensity of exposure --  
4 level of exposure to see what levels it's been  
5 documented to be related to Parkinsonism. Because  
6 that's where you'd be able to tease out what kind  
7 of dose you need.

8           Because clearly that's what's going on  
9 in these -- you know, assuming they're all acting  
10 in -- the various CMCs are acting in sync. It's  
11 a big assumption, but they're calculating dose.  
12 Right? And based on job title, based on different  
13 exposures. And we need to figure out, I guess,  
14 and help advise on what are the dose circumstances  
15 that are appropriate for compensation.

16           MEMBER MAHS: I've got a short denied  
17 and probably rightly so. It was denied twice.  
18 A 77-year-old, had been a project engineer. He  
19 was denied in 2015 and again in 2018 for basically  
20 the same reasons. They didn't provide sufficient  
21 medical evidence to show exposure to toxic  
22 substance while employed under covered DOE facility

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1 was a significant factor. He was diagnosed with  
2 Parkinson's in 2007. And again in 2015, a final  
3 decision based on submission of medical evidence.

4 None was submitted that establishes a causal  
5 relationship between Parkinson's Disease and  
6 exposure. The SEM found no potential link between  
7 claim Parkinsonism and any toxins at the Portsmouth  
8 Gaseous Diffusion Plant.

9 And again on December 17th and January  
10 2018, they notified of the evidence required to  
11 establish a claim. We had time to come up with  
12 more evidence and didn't. In response, they  
13 submitted medical evidence that had nothing to do  
14 with showing any causal reasons. So they denied  
15 the claim again in 2018 for lack of medical  
16 evidence. And he was given time to find some.

17 CHAIR MARKOWITZ: Mani's got another  
18 one. Dr. Berenji?

19 MEMBER BERENJI: Yes. Thank you, Dr.  
20 Markowitz. I do have a case. It was actually very  
21 interesting because it's gone through multiple  
22 iterations over the years. Let me go ahead and

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1 give you the Case ID, last four 2701, date of birth  
2 1943. So this is a gentleman who was initially  
3 working as a "cafeteria helper" from 1966 to '68.

4 Then transitioned over to maintenance mechanic.

5 And he was working in that particular function  
6 from 1968 through 2000. And he was working at Oak  
7 Ridge X-10 was the primary location.

8 So the occupational health  
9 questionnaire revealed a lot of exposures including  
10 mercury, lead, arsenic. And then there's a  
11 question of trichloroethylene. The SEM was done  
12 on this case. And again, I have a hard time reading  
13 the SEM. I feel like it kind of -- at least from  
14 kind of going through these for the first time,  
15 it's very hard to delineate all the various  
16 subcategories. But at least I felt that there was  
17 a discrepancy between the occupational health  
18 questionnaire and the SEM.

19 So this gentleman had the fortune of  
20 having an AR, had legal representation, which I  
21 think was helpful in this particular instance. And  
22 actually had the benefit of having not one, but

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1 two very good neurologists, at least with respect  
2 to the particular diseases in question.

3 So just to make sure I got the  
4 chronology correct. He actually applied for  
5 multiple diseases including Parkinson's,  
6 neuropathy, hearing loss, restless leg syndrome,  
7 insomnia, hypertension. And it's actually  
8 interesting that he recently filed for ALS in 2018.

9 And at least based on my review, it looks like  
10 there's been a deferred decision on the ALS  
11 component of his claim as of March 15th of 2019.

12 So I actually -- again from a clinical  
13 perspective, I felt that the records in this case  
14 were very well done. Because I felt that there  
15 was actually good treating physician notes. From  
16 my perspective, it's excellent to have those  
17 resources to really gain a sense as to what this  
18 particular individual was exposed to.

19 So the first neurologist who was  
20 assessing this claimant was really evaluating him  
21 for peripheral neuropathy. And I believe this was  
22 diagnosed in the early 2000s, I might be mistaken,

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1 but that was the general timeline on that front.

2 And he had been seeing this particular claimant  
3 for a number of years. And he was really -- you  
4 know, he did a full work-up and was able to do the  
5 EMGs and all the respective testing.

6 He then transitioned on to a different  
7 neurologist in the mid 2000 teens. And this  
8 particular neurologist did an excellent job. He  
9 really took the SEM but took it to the next level  
10 by correlating with the claimant's clinical  
11 manifestations. And he actually made great  
12 references. He was able to do an extensive  
13 literature review. And he actually put those  
14 references in his clinical notes.

15 So to me, this guy is the gold standard  
16 when it comes clinical documentation. And I think  
17 this guy is somewhere in Tennessee. But I mean  
18 this guy --- at least from a neurologic perspective,  
19 this guy should set the standard for occupational  
20 neuropathy. I feel he did an outstanding job  
21 really getting into the nuts and bolts with respect  
22 to carbon steel, looking at the PCBs, n-Hexane.

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1           And he was literally able to find, not  
2           only animal studies, but human epidemiological  
3           studies that were relevant.     And that in  
4           conjunction with the fact that this individual had  
5           legal representation really kind of helped get his  
6           Parkinson's approved.     Actually this was recently.  
7           This was as of March 15th, 2019.

8           The thing that really kind of gets  
9           interesting is the fact that now he's filing for  
10          ALS.     So I actually did a literature review earlier  
11          today just to kind of see what number of individuals  
12          who are identified as having Parkinson's actually  
13          have ALS.     And right now, I mean the jury's still  
14          out.     It's a very, very small percentage of folks  
15          who actually have the pathophysiology because with  
16          the individuals diagnosed with Parkinson's, they  
17          have the Lewy bodies.     But with the folks  
18          identified as having ALS, they actually have what  
19          are called Veny bodies.     So essentially all these  
20          expensive proteins in their brain that accumulate.

21                 So right now, at least based on the most  
22          recent EMG that was done, he did have clinical,

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1 as well as diagnostic evidence of having ALS, as  
2 well as Parkinson's. But as of March 15th of 2019,  
3 the DOL has essentially put the ALS kind of on a  
4 deferred bucket, if you will.

5 So it will be interesting to see what  
6 ends up happening at least from the ALS perspective.

7 I'm sure the neurologist is going to provide some  
8 excellent resources and evidence. But I feel like  
9 this case is very interesting because there's so  
10 many different layers to this individual's  
11 presentation. And how his pathology has evolved  
12 over the years. And combining multiple  
13 neurodegenerative diseases really kind of it makes  
14 it an interesting case.

15 CHAIR MARKOWITZ: Was this case then  
16 ever sent to the CMC or did the treating physician's  
17 report suffice?

18 MEMBER BERENJI: I believe there was  
19 a CMC, but I mean at least from my review, I really  
20 honed in on the treating physicians --

21 CHAIR MARKOWITZ: Right, right.

22 MEMBER BERENJI: -- because they did

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1 such an excellent job. I mean -- again, I can't  
2 remember if there was a CMC involved.

3 CHAIR MARKOWITZ: Okay, okay. That's  
4 fine.

5 MEMBER BERENJI: In this case, the  
6 treating physicians did a stellar job.

7 CHAIR MARKOWITZ: Comments,  
8 questions? Okay, we're going to take a five minute  
9 break and we're going to start up at 4:30, public  
10 comment. Well probably if it's all right, the  
11 public comment period, there aren't that many.  
12 How many people, Carrie --

13 Ms. Rhoads: Four.

14 CHAIR MARKOWITZ: Four. So it  
15 probably won't be all that long. We might consider  
16 continuing while we're on this claims review for  
17 a little bit, so that we can come to some closure.

18 But we'll decide in a bit. So 4:30, that's seven  
19 minutes.

20 (Whereupon, the above-entitled matter  
21 went off the record at 4:22 p.m. and resumed at  
22 4:31 p.m.)

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1 CHAIR MARKOWITZ: Okay, if the board  
2 members could take their seats.

3 OPERATOR: Welcome and thank you for  
4 standing by. I'd like to inform all parties that  
5 your lines have been placed on a listen only mode.

6 This call is also being recorded. If you  
7 disagree, you may disconnect at this time. I would  
8 now like to turn the call over to Dr. Steven  
9 Markowitz. Thank you and you may begin.

10 CHAIR MARKOWITZ: Sure, thank you.  
11 Welcome to the public comment session. We have  
12 four people who -- Excuse me -- five people who  
13 have requested time to make comments. So let me  
14 give you the orders so you know when to expect to  
15 be called to the front. We have two people on the  
16 phone. But the first will be -- Hold on, don't  
17 come up yet. But the first will be Ms. Terrie  
18 Barrie. Second will be Faye Vlieger. Third will  
19 be Ms. Vina Colley. Fourth will be Ms. D'Lanie  
20 Blaze. And fifth will be Ms. Angel Little.

21 So just to remind public commenters,  
22 it's not really a back and forth question and answer

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1 session. It's really a statement, which we listen  
2 carefully to. So welcome, Ms. Barrie. Oh and also  
3 I want to say while you're sitting down is please  
4 limit your comments to seven to ten minutes.

5 MS. BARRIE: Good evening, everyone;  
6 Dr. Markowitz and members of the Board. It's a  
7 pleasure to be here again. And to listen to this  
8 wonderful conversation and debates about the issues  
9 with the program and your ideas on how to fix it.

10 My name is Terrie Barrie and I'm a  
11 founder member of the Alliance of Nuclear Worker  
12 Advocacy Groups. I want to thank you for this  
13 opportunity to address the Board. And more  
14 importantly to thank you for the dedicated work  
15 you put in to try to improve this program. I  
16 emphasize the word "try" because you cannot  
17 possibly fulfill your duties mandated by Congress  
18 if the Department of Labor does not provide you  
19 with the necessary tools and documents you need  
20 to do the job.

21 You've asked for a support contractor  
22 twice without the response from Department of

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1 Labor. And you know, recently we just learned that  
2 the claims that you requested back in December were  
3 only provided to you a few weeks ago. I admire  
4 you for getting through them so you can have the  
5 lively discussion today about the two types of  
6 cases.

7 Which reminds me, do you remember the  
8 statement that Ms. Rachel Leiton said to you during  
9 the April 26, 2016 meeting? You can find that on  
10 Page 92 of the transcript. I quote, "I'm actually  
11 really looking forward to having a group of people  
12 who have worked there; scientists and doctors, to  
13 help us with some of these complicated issues."

14 And Ms. Hearthway did the same thing  
15 on November 14th, 2018. "I commend all of you,  
16 the past Board, for your future service, the new  
17 members for tackling this area. It's critically  
18 important and is a difficult area. It's an  
19 ambitious area. But I thank you for your public  
20 service on this." And I feel that too. But I can't  
21 help but feel that this is nothing more than lip  
22 service. You've asked for contractors to help you

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1 review the claims, to help you review the SEM, which  
2 still needs, you know, some improvement. And they  
3 won't provide it for you -- or to you.

4 And then the issue today of not getting  
5 the claims that you asked for 4-1/2 months ago.  
6 And the other problem I have and why I think it's  
7 lip service is you've made excellent  
8 recommendations, you know, some of which have been  
9 accepted. You know, and I appreciate Department  
10 of Labor for doing that. But they're relying on  
11 their experts -- their internal experts who as far  
12 as we know, do not have the qualifications that  
13 you have. Sorry, I mean that's the basic fact.

14 We have well-educated, you know, the  
15 PhDs and you know, multiple whatever that word is.

16 I can't think of it offhand. And it just doesn't  
17 seem right that they just say well we're going to  
18 rely on our experts because they don't agree with  
19 you. They do not give you the reasoning behind  
20 that, but say our experts don't agree. However,  
21 they don't provide you, well here's the science  
22 and the medical literature and the studies that

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1 my expert -- our experts found that disagree with  
2 you.

3 And I understand the Department of  
4 Labor is practicing due diligence. They should  
5 review your recommendations and not just accept  
6 them out of hand. That's their responsibility.  
7 But they haven't provided the evidence to refute  
8 your recommendations and your findings. And I'm  
9 sorry, but that's wrong.

10 The Department of Labor requires you  
11 to submit, you know, your authorities. They should  
12 have the common courtesy to do the same for you.

13 That way it can be an open debate, you know? The  
14 NIOSH Board does this. You know, NIOSH doesn't  
15 always agree with the Board's contractor and  
16 there's a debate. And the Board comes to a  
17 consensus and then makes a recommendation to the  
18 secretary. Which the secretary normally accepts.

19  
20 But there's a debate before that. And  
21 I realize that this Board is different than an NIOSH  
22 Board, but you're still -- you still operate under

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1       FACA. So there is similarities. You have the same  
2       purpose, to advise the secretary. It should  
3       operate the same way to a degree.

4                I was kind of disappointed that during  
5       the teleconference of February 28th, that there  
6       was no one on the call from the Department of Labor.

7       You had a simple question. There was nobody there  
8       to answer it. I could have answered it. I had  
9       it up on my screen. But that's not my  
10      responsibility. It's the Department of Labor.  
11      They should be attending each and every one of these  
12      meetings and they should be communicating with you.

13      It's just that simple. I'm sorry.

14               When they say that we appreciate  
15      everything you do, well they need to show it in  
16      action. You request materials. If they have an  
17      issue with it, they have to come back to you and  
18      say what do you mean by this? Why do you need this?

19      And the form is fine, you know, but you can't wait.

20      They're wasting the Board's time and energy.  
21      They're wasting tax payers money because the Board  
22      cannot get their work done because they're dragging

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1 their feet.

2 And I don't understand the idea of past  
3 Board. It's nonsense to me. Congress is sitting  
4 at the Board until 2024. DOL owes it to the  
5 stakeholders and the Board an explanation and legal  
6 justification why they can interrupt the Board's  
7 work every two years. There's no continuity.  
8 Thankfully a lot of you have been reappointed.  
9 I appreciate that and you can catch the new members  
10 up. But you should have been working all this time  
11 unless there was cause. But nobody understands  
12 why there was a break in the Board's work. There  
13 is no such thing going on with the NIOSH Board.  
14 It shouldn't happen here. You all have important  
15 work to do.

16 And so please don't get discouraged  
17 Board members. It's obvious to us that the  
18 Department of Labor is digging in their heels and  
19 they're not cooperating as well as they should.  
20 I personally think they're being derelict in their  
21 responsibilities to the Board for their support.

22 And normally I would call upon DOL to

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1 improve the relationship with the Board and to  
2 attend the Board meetings without a special  
3 invitation. And provide resources to the Board  
4 when they request it in a timely manner. But I  
5 think that request would also fall on deaf ears.  
6 If DOL didn't listen to the Board and the hundreds  
7 of individuals from the public on the final rules,  
8 I doubt they would listen to this request.

9 So instead, I call upon Congress to  
10 intervene. I want Congress to investigate this  
11 program, tighten or expand the statute as needed.  
12 Hearings need to be held. The workers who develop  
13 disabling and often fatal diseases in their work  
14 to protect their country deserve nothing less.  
15 They were exposed to toxic substances without their  
16 knowledge and sometimes without proper protection  
17 by the DOE contractors.

18 I would like to remind Department of  
19 Labor that this compensation program was intended  
20 to correct the decades of injustice perpetrated  
21 against the workers and their survivors. It must  
22 return to the congressional intent. And

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1           apparently the only way to get that done is to have  
2           Congress involved.

3                       And one thing I forgot to mention that  
4           was in the body of this.   Since Department of Labor  
5           has not provided the Board with their citations  
6           of scientific studies that they used to reject some  
7           of your recommendations, ANWAG will file a Freedom  
8           of Information Act request for that.   And I also  
9           have here some correspondence between Secretary  
10          Acosta -- well ANWAG and Secretary Acosta about  
11          providing the Board with what they need if anybody  
12          would be interested in that.

13                      So thank you again.   And I appreciate  
14          the work.   Thank you.

15                      CHAIR MARKOWITZ:   Thank you.   Next is  
16          Ms. Faye Vlieger.

17                      MS. VLIEGER:   Good afternoon.

18                      CHAIR MARKOWITZ:   Good afternoon.

19                      MS. VLIEGER:   Good afternoon.

20                      CHAIR MARKOWITZ:   Good afternoon.

21                      MS. VLIEGER:   As I introduced myself  
22          at the beginning of the meeting today, I am Faye

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1 Vlieger, a former Member of the Board, and I work  
2 as an advocate under EEOICPA.

3 I'm disconcerted about the lack of  
4 weight and consideration given to the previous  
5 Board's recommendations. I would ask the current  
6 Board to add to its agenda tomorrow the re-approval  
7 of all of the open recommendations sent to the  
8 Department of Labor by the previous Board.

9 I have been instructed that that is  
10 allowed and that will ensure that those  
11 recommendations are actually looked into and  
12 replied to.

13 Of note and discussed earlier today is  
14 the Department of Labor's non-adherence to the  
15 rescission of Circular 1506, Occupational Toxic  
16 Exposure Guidance.

17 The Circular was rescinded on  
18 February 2nd, 2017, the Circular 1704. Despite  
19 the revision of Circular 1506, the Department of  
20 Labor still uses the language of the Circular to  
21 deny claims.

22 This either represents the cavalier

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1 attitude that the Department of Labor holds for  
2 the Board, and the EEOICPA worker claims, or the  
3 Department's inability to understand the  
4 instructions of the Advisory Board.

5 While I was on the Advisory Board,  
6 myself and other Members worked diligently and  
7 succinctly to demonstrate that the language of  
8 Circular 1506 was not based in fact.

9 To that point, it was shown to the  
10 Department of Labor that they were not -- that there  
11 were not only toxic exposures after the mid-1990s  
12 above regulatory standards, but also that there  
13 was no evidence to support the Circular in  
14 scientific studies.

15 While I was on the Board, evidence was  
16 presented to the Department of Labor that DOE was  
17 not consulted in the creation of the Circular.  
18 Nor did they provide any input to the Circular's  
19 creation.

20 In addition, DOE's own audits of safety  
21 and toxic exposure issues from that period of time  
22 show that while it was issued, it issued the

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1 Regulation 440.1 to limit toxic exposures on  
2 September of 1995, it was not being instituted or  
3 followed.

4 You remember Mr. Domina's comments that  
5 you have to have money to do these things. And  
6 while they instituted the rule, there was no money  
7 for the instruction, implementation, and the  
8 scientific instruments to do it.

9 This is why the Board proposed that the  
10 Circular be rescinded and it supposedly was. But  
11 was it? In my opinion, no. Sorry. IH and CMC  
12 reports are still using this language as fact and  
13 using it to deny claims that you all read in the  
14 claims that you were given.

15 No basis is given for the denial other  
16 than that flat statement of fact, which in fact,  
17 is not fact. I'm not satisfied with Ms. Leiton's  
18 explanation of how the rescission of Circular 1506  
19 did not affect the use of this exclusionary  
20 language.

21 I would like an active question placed  
22 before Department of Labor. What exact references

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1 are the IHS and CMCs using to justify these  
2 boilerplate statements?

3 If the scientific evidence is not  
4 forthcoming, I would like assurances from the Board  
5 and the Department of Labor that all of the claims  
6 denied using this language will be re-adjudicated.

7 I'm also concerned that the selection  
8 in which toxics should be evaluated for a claim,  
9 are submitted, are shunted and reduced by a small  
10 group of contractors who appear to have a conflict  
11 of interest. A case in point, is a claim I am  
12 currently reviewing.

13 When the contractor who administers,  
14 updates, and manages the site exposure matrix named  
15 Paragon was also asked to provide their opinion  
16 on which toxin should be sent to the IHS/CMC to  
17 be considered for particular claim, Paragon's  
18 recommendation was used and the claim was denied.

19 The issue then becomes that a  
20 contractor that sets the list of which toxins are  
21 present at a DOE site should not then be allowed  
22 to decide which toxins are considered for an

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1 individual claim. It's very much, as I told you  
2 before when I was on the Board, like letting the  
3 fox watch the hen house.

4 In conclusion, I want to commend the  
5 Board on its continued diligence. I am concerned  
6 that the good works and recommendations of the  
7 Advisory Board are being ignored, subverted, and  
8 sidestepped with Departmental wordsmanship in  
9 order to blunt any affect that their decisions would  
10 have.

11 It is disingenuous to the Advisory  
12 Board and the affected workers under EEOICPA for  
13 the Department of Labor to continue to face  
14 claimants with platitudes of support, but when  
15 you're out of sight, undermine the program and  
16 individual claims. I thank you for the opportunity  
17 to present my comments.

18 CHAIR MARKOWITZ: Thank you. Next we  
19 have Ms. Vina Colley on the phone. Ms. Colley?

20 MS. COLLEY: Here.

21 CHAIR MARKOWITZ: You're welcome.

22 MS. COLLEY: Thank you for allowing me

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1 to speak on behalf of National Nuclear Workers for  
2 Justice and Portsmouth-Piketon Residents for  
3 Environmental Safety and Security. We wanted to  
4 ask this Board and DOL, again, to hold a meeting  
5 here in Portsmouth, Ohio.

6 You have a lot to learn about this site.

7 And as I listened today, it's very obvious, that  
8 you have not been told about the facility --

9 (Telephonic interference.)

10 MS. COLLEY: -- by getting turned down  
11 from the SEC site. We were one of --

12 CHAIR MARKOWITZ: Ms. Colley, hold on,  
13 hold on one second because we're getting some  
14 feedback. Can you turn your phone down a little  
15 bit?

16 MS. COLLEY: Yes. I can try.

17 CHAIR MARKOWITZ: Yes, yes, that's  
18 better.

19 MS. COLLEY: Does that help?

20 CHAIR MARKOWITZ: Yes, that's good.

21 MS. COLLEY: Portsmouth is one of three  
22 sites that was an SEC site. Workers are getting

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1 --

2 (Telephonic interference.)

3 CHAIR MARKOWITZ: We're getting some  
4 more feedback, actually.

5 OPERATOR: This is the Operator, do you  
6 have, do you have a TV or another phone, or a radio  
7 on in your background?

8 MS. COLLEY: This is the only phone I  
9 have.

10 OPERATOR: Okay.

11 CHAIR MARKOWITZ: Are you, Ms. Colley,  
12 are you on speaker phone?

13 MS. COLLEY: Yes.

14 CHAIR MARKOWITZ: Could you just get  
15 directly on the phone? Maybe that'll solve it.

16 MS. COLLEY: Okay. Is that any  
17 better?

18 CHAIR MARKOWITZ: So far, so good.

19 MS. COLLEY: Okay. I can hear  
20 something in the background. I said -- okay. I  
21 think I've lost my concentration.

22 CHAIR MARKOWITZ: That's okay.

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1 MS. COLLEY: Anyway, anyway. We would  
2 like to invite the Board to come to Portsmouth,  
3 Ohio and the Department of Labor to come and talk  
4 to these workers. I don't think they have a true  
5 understanding of what Portsmouth is.

6 We also would like to know if DOE and  
7 DOD have turned over the secret documents to help  
8 get these claims approved. We just released  
9 records about plutonium and transuranics on the  
10 site on March 19th, here in a public forum.

11 Saturday, the Health Department is  
12 holding a meeting about neptunium being in the local  
13 schools. Many children have died from cancer that  
14 attended that school. What happened to the ---  
15 we would like to know what has happened to the  
16 records that the union put together for the sick  
17 workers in the SEM database at Piketon. They  
18 worked for hours on what was in each of the  
19 buildings.

20 One big problem is we don't have anyone  
21 in the Resource Centers that, that can help put  
22 the sick workers claims together before it is turned

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1 in and turn down.

2 There should be an advocate person  
3 there who can help look at these workers' records  
4 and make sure that they have their ducks in a row  
5 before the claims are turned in.

6 What happens when consultants are given  
7 misinformation? My case, the consultants were  
8 told lies about me. One, and I will read you part  
9 of this thing that I wrote.

10 Dr. Dhara, D-H-A-R-A, claimed that I  
11 worked at the Paducah Gaseous Diffusion Plant.  
12 I have never worked at the Paducah, this Paducah  
13 plant. I was employed at Piketon, Ohio.

14 Dr. Dhara claims I smoke one pack of  
15 cigarettes a day for 20 years. I have never smoked  
16 cigarettes in my life. And if there is any mention  
17 in my medical records stating otherwise, it is  
18 false.

19 Per Dr. Dhara's letter, it states, a  
20 Dr. Rhodes' report has, not having any documents  
21 on my pulmonary edema. In the absence of a  
22 diagnosed documentation, my claim for toxic

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1 exposure could not be verified.

2           However, I had been treated, and  
3 currently still treated for 30-some years for  
4 pulmonary edema. Also, Dr. Rhodes' report was  
5 declared non credible in 2008 by Dr. Marvin  
6 Reznikov, and DOL's third-party Dr. Christopher  
7 Vrenenman [sic].

8           So this is just one example of how our  
9 records are being falsified, or not completely  
10 given to the CMC to, to give us a proper diagnosis  
11 or our claims. We had a fire a couple of weeks  
12 ago in the X-320 -- I, I can hear a lot of feedback.

13           CHAIR MARKOWITZ: No, no. You're  
14 going --

15           MS. COLLEY: Is it still kicking back  
16 like this?

17           CHAIR MARKOWITZ: You're, you're  
18 coming through loud and clear.

19           MS. COLLEY: Okay. I don't know. I  
20 think there's one, one, big problem is, we don't  
21 have anyone -- okay in the Resource Center, I did  
22 that. What happened when the consultant, I did

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1       that one.

2                   We had a fire a couple weeks ago in the  
3 X-326 Building. It wasn't reported until our  
4 meeting on March 19th. It wasn't reported to the  
5 public for almost another week and half.

6                   I'm getting calls from the other  
7 employees that are sick from the decommissioning  
8 of the plant. Many are hard, past the cut off  
9 period. They're reporting that they have kidney  
10 and cancer problems already and less, some have  
11 been there less than ten years.

12                   The work going on at the plant now is  
13 very hazardous because of the holdup material plus  
14 possible explosions. These workers need to be  
15 covered under the compensation bill. We need  
16 someone to sit with us and explain the jobs here,  
17 so we can explain the jobs.

18                   You all don't have a clue of the  
19 exposure here. Portsmouth is the largest plant  
20 in the world. We did weapons-grade material. We  
21 are a DOE and DOD facility.

22                   I've listened to your reports today,

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1 and it sounds like reports are being copycat and  
2 turned down. I want to remind this Board, that  
3 we have some the highest exposure according a DOE  
4 report in 1985.

5 Also, you talked about the PCBs and I  
6 submitted a paper on PCBs. In the process  
7 building, the PCBs are 290,000 parts per million  
8 after an event system. And by the time it reaches  
9 the floor, we don't know what kind of chemical you  
10 will be getting.

11 Not only is the PCB oil, PCB oil, but  
12 this oil was radioactive. We worked in these  
13 buildings for eight hours at a time with no  
14 protective equipment. We weren't even told that  
15 we were working with radioactive PCB oil.

16 And there is a Congressional hearing  
17 on that oil. We claim this oil, also the electrical  
18 equipment, the trichloroethylene. We worked many  
19 times beside, beside waters without any protection  
20 on.

21 They should rub, rub the PCB oil with  
22 siphons at the facility. I have the name of the

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1 workers. I have the, the results. And most these  
2 workers tested high for PCB oil.

3 I have been fighting for a long, long  
4 time. Matter of fact, I was one of the persons  
5 who, who broke the story about plutonium being in  
6 the gas diffusion plant, at the St. Simon Paducah  
7 workers den.

8 I know that they did release some  
9 records for the Paducah facility because I went  
10 to Oak Ridge and got all records back in that, that  
11 time in 1999.

12 But Portsmouth has never had their  
13 records released and workers are being denied.  
14 And I'm even getting people who, who got, who worked  
15 there back in the early years that have been denied  
16 for breast cancer, lung cancer, and liver cancer.

17 And this is just one lady with all the  
18 illnesses that she had. Her family were turned  
19 down for survivor fees. So we, we need to come  
20 to Portsmouth.

21 We need to make you aware of exactly  
22 what's going on, the PCB oil. I have three tumors,

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1 a hysterectomy, and one thing after another. I  
2 was a healthy person when I went to work there.

3 And they keep putting on all these  
4 stipulations on the compensation bill. And we're  
5 all getting turned down. We -- something has to  
6 happen. We can't let this continue.

7 The records that we've released at our  
8 meeting, one was forensics, radioactive industry  
9 of the public inspection samples. And it was done  
10 by Lawrence Livermore National Laboratory. And  
11 it talks about Portsmouth and Paducah both having  
12 smuts of plutonium and transuranic waste.

13 Also we have the NIOSH dose  
14 reconstruction. And they also submitted that we  
15 were exposed to neutrons and radiation in all these  
16 process buildings. So we have been under,  
17 underestimated for the exposures here and the work  
18 that we did.

19 And it's, it is heartbreaking to watch  
20 everyone see their families pass away and still  
21 fighting for exposures, for Parkinson's disease,  
22 for, for prostate cancer, for -- just about

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1 everything these workers are getting turned down  
2 for.

3 We did have a good result not too long  
4 ago here where a widow was finally compensated for  
5 Lou Gehrig's disease. So that is one step in the  
6 right way. But we're, we're a long ways from doing  
7 the right thing and trying to help these workers.

8 So if you could have a meeting here,  
9 we could sit down. We'll take you out there and  
10 show you the buildings and all of these 25,000  
11 depleted uranium cylinders that have set on the  
12 site that has given off neutron exposures. The  
13 asbestos that these buildings are made of --

14 Are going to put in plutonium, and  
15 transuranic, if we don't stop it, and it's on top  
16 of our aquifer. And it's the largest aquifer in  
17 the Midwest. So many people and many workers have  
18 been, been exposed from working here at this site.

19 There's a lot more that I could tell  
20 you. And I did send in and submitted the 297,000  
21 parts per million of the PCB oil that was in the  
22 ventilated system. So it is on your webpage, I

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1 saw it.

2 And we would appreciate it if we could  
3 get you to come. And the DOL, I hear they're going  
4 to New York to help these workers file their claims.

5 And I think that that's great for the New York  
6 workers.

7 So why aren't they here helping us?  
8 Why are they fighting us? Why are they falsifying  
9 our records? And the reason that we are -- I heard  
10 somebody mention about the data. No data is the  
11 reason, Portsmouth and Paducah became the SEC site  
12 because they didn't keep data. What data they  
13 kept, they shredded, and they falsified our  
14 records. And that's why they burned the proof.

15 It wasn't on us. It was on the  
16 Department of Labor. Jim Richardson says that.  
17 I have his video tape that says, the burden of proof  
18 belongs on them, not us. And now, all of a sudden,  
19 it's shifted to the burden of proof on us. Thank  
20 you for letting me speak.

21 CHAIR MARKOWITZ: Thank you, very  
22 much. Next is Ms. D'Lanie Blaze, who's on the

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1 phone.

2 MS. BLAZE: Hi guys. This D'Lanie  
3 Blaze.

4 CHAIR MARKOWITZ: Welcome.

5 MS. BLAZE: Can everyone hear me okay?

6 CHAIR MARKOWITZ: Yes. That's fine.

7 MS. BLAZE: Great. I represent  
8 workers of Santa Susana and its associated work  
9 sites, Canoga and DeSoto Facilities.

10 And today, I just want to express  
11 concern about the IH reports, which I believe are  
12 routinely misinterpreted by CEs and the CMCs who  
13 neglect to read the body of the report, and then  
14 just base their opinions, or their decisions solely  
15 on the IH conclusion that's provided at the end  
16 of the document.

17 I recently reviewed an IH report for  
18 a metal fabricator, pipefitter, welder, site  
19 remediation worker employed at Santa Susana from  
20 1979 to 2009.

21 And the IH described his aggressive  
22 work processes involving routine and significant

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1 exposures to lead, cadmium, and mercury. All of  
2 which have established casual links to chronic  
3 kidney disease.

4 And throughout the discussion of the  
5 report, the IH repeatedly acknowledged that the  
6 data supported significant pre-1995 exposure. But  
7 the boilerplate text of the conclusion contained  
8 several problems.

9 The first was a typo. While the  
10 discussion of the documents stated it was highly  
11 likely that the employee received significant  
12 exposure before 1995, the conclusion stated that  
13 it was highly unlikely. And that typo alone  
14 changed the course of the claim and its outcome.

15 So now we're lost in the process of  
16 lengthy objections, hearings, and we're awaiting  
17 a final decision. But meanwhile, this worker is  
18 clearly in need of help and he is deserving of  
19 assistance.

20 The other concerns that I have about  
21 the conclusion of the IH report is that there's  
22 a table that shows exposure levels to lead, cadmium,

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1 and mercury. But the levels that indicated are  
2 inconsistent with the IH's opinions that are  
3 provided throughout the body of the report.

4 And then the conclusion's final  
5 statement doesn't even mention pre-1995 exposure.  
6 It just implies that only insignificant exposure  
7 occurred in passing.

8 So anyone who actually read the entire  
9 three-page IH report would have caught the typo  
10 and the inconsistency. But it seems the CE and  
11 the CMC only read the conclusion, so it's no  
12 surprise that the claim was recommended for denial  
13 based on the idea of insignificant exposure.

14 So in an effort to find some clarity  
15 on it, I contacted the IH directly. And I asked  
16 for her help. Either helping me understand or if  
17 necessary, issuing a correction to that typo in  
18 the conclusion.

19 And that IH confirmed that the employee  
20 did have significant pre-1995 exposure that was  
21 intended to be acknowledged in IH report. But the  
22 IH stated that the conclusion could have been

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1 misinterpreted due to what she called clunky  
2 language. Quote, that is just the language they  
3 have use.

4 So I assume that the IH was referring  
5 to either the IH contractor or to the national  
6 office, whoever comes up with the boilerplate  
7 language that's currently used to format these IH  
8 reports.

9 So in this case, the national office  
10 confirmed the existence of the typo and verified  
11 that the conclusion should have stated that it was  
12 highly likely that the employee was significantly  
13 exposed.

14 But then the national office emphasized  
15 that the exposure levels are provided in the table,  
16 which again, are inconsistent with the rest of the  
17 document. They state the exposure was low. And  
18 then the national office failed to acknowledge the  
19 pre-1995 exposure had been left out of the last  
20 paragraph entirely.

21 So this leaves tremendous room for  
22 misinterpretation and for a severely diminished

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1 perception of the worker's exposure, particularly  
2 when a CE or CMC only looks at the conclusion.

3 So obviously, I'm troubled by general  
4 laziness that's exhibited by failure to read a  
5 three-page IH report, which would have taken about  
6 five minutes. This led to further delays for the  
7 claimant. The inability to obtain needed help  
8 under this program.

9 And it also led to unnecessary  
10 administrative costs for Department of Labor, which  
11 included an in-person hearing with a Jacksonville  
12 representative who had to fly all the way to Los  
13 Angeles in order to hear our case.

14 Now the national office has made so many  
15 changes in this program in order increase  
16 expediency. But I fail to see the logic in making  
17 a series of bad decisions fast and then having to  
18 revisit the issue again with all of the additional  
19 wait time and administrative efforts and associated  
20 costs, et cetera.

21 So I'm troubled by the boilerplate  
22 language that seems to have been carelessly

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1 constructed and that it requires the IHs to punch  
2 in relevant information in several places in an  
3 IH report. And that makes it pretty easy to miss  
4 a relevant place.

5 And one missed insertion of copy and  
6 pasted text could change the context and the  
7 direction of the entire claim, so. And then too,  
8 obviously the boilerplate conclusions that omit  
9 information about pre-1995 exposure, that's just  
10 alarming.

11 So ultimately, it seems like IH reports  
12 are pretty tight and short. And there shouldn't  
13 be a need to summarize them. There seems to be  
14 no need to add a confusing table. Or even to add  
15 a conclusion.

16 A solution might be to recommend  
17 removing the conclusion entirely, which would at  
18 least ensure that the CE and the CMC are forced  
19 into reading the entire document.

20 And then it would enable the IH to be  
21 thorough one time instead of having to insert little  
22 bits and pieces of relevant text in several places

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1 in the report.

2           Anyway, that's it from me and as always,  
3 it's a privilege to address the Board and to  
4 represent workers under EEOICPA. Thanks for the  
5 opportunity to comment.

6           CHAIR MARKOWITZ: Our next speaker is  
7 Ms. Angel Little.

8           MS. LITTLE: Good evening, everyone.

9           CHAIR MARKOWITZ: Good evening.

10           MS. LITTLE: As you know, I'm an Angel  
11 Little and I'm a daughter of a Cold War patriot.  
12 His name is Earl A. Brown, Jr. He lives in  
13 Knoxville, Tennessee.

14           He is a Navy veteran retired. Also he  
15 is retired from ORNL. Amongst the jobs he had,  
16 he initially started as a guard. However, he rose  
17 through the ranks always being trained, was trained  
18 through the fire safety.

19           So of course, he was at every plant in  
20 Oak Ridge, Tennessee. Upon his retirement,  
21 however, he was administration at ORNL, but he was  
22 based at Y-12.

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1                   My father now suffers with berylliosis.

2                   This berylliosis also has damaged several things  
3 that are going on with him to include renal failure.

4                   He has been approved for berylliosis, however,  
5 he was denied for kidney failure.

6                   And that very much distresses me  
7 because my father was a very robust man while he  
8 was working for the Department. We have talked  
9 with several people. We have seen several doctors.  
10                  He is three days a week in dialysis now.

11                  And we keep seeing, oh he, because he  
12 had high blood pressure. But it was okay for him  
13 to have high blood pressure when he was working  
14 for the Department. It didn't keep him from coming  
15 to work every day. It didn't keep him from doing  
16 his job every day to protect this United States  
17 of America.

18                  It didn't take him anything, but to get  
19 up every morning and make sure he was at work every  
20 day to support his family, put me through college,  
21 support his wife, be her care giver.

22                  But it distresses me that this room is

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1 not full. It distresses me that I, who live here  
2 in Augusta, Georgia have to go to Oak Ridge to call  
3 people long-distance to make sure that things are  
4 taken care of for my father.

5 He is currently being serviced by a  
6 professional case management. And that is a daily  
7 chore within itself. I've talked with the people  
8 out in Oak Ridge. I've been out there to Oak Ridge.

9 And I have to run and jump through hoops  
10 just to get things taken care of. From picking  
11 up his medicines, from making sure he has  
12 transportation. I should be case manager.  
13 However, I'm not. I'm his daughter, the one that  
14 loves him.

15 Also with all the research and I am just  
16 at awe at this Advisory Board and the time that  
17 you take to review things. That berylliosis has  
18 some effects on your kidney, on your liver. He  
19 has neuropathy.

20 So I'm still trying to figure out, what  
21 is the problem that my father is still fighting  
22 these days, with my assistance, long distance, 350

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1 miles away in trying to get services for him? I  
2 don't know if I need to fly to D.C. with you, which  
3 I will. I don't need -- hey, I got gas in the car,  
4 I'll do it.

5 And I teach high school and I teach my  
6 students every day. Do what's right. Do for you  
7 to make this world a better place. And make sure  
8 you get your education because nobody can take that  
9 away from you.

10 However, my father has things that are  
11 taking it away from him. He's ill. Just this past  
12 week, on Thursday, he had two mini-strokes. And  
13 by God's help and the weather we had last weekend,  
14 I was able to go 350 miles in less than 5 hours  
15 without a ticket.

16 I was able to get to my father and by  
17 God's help and some great neurologist that I'm going  
18 to look up again, they changed some medications,  
19 they were able to do some assessments, and he is  
20 at his house.

21 Also with my assistance, I got a  
22 hospital bed in there. I got everything he needs

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1 in there. But I couldn't get that unless I did  
2 it, nobody else. My father is worthy of everything  
3 that he deserves. And he deserves more than he's  
4 getting from this United States of America.

5 I am charging you, the Advisory Board  
6 to look up Earl A. Brown, Jr. His birthday is  
7 October 19, 1936, born in Rockwood, Tennessee.  
8 And pull his case file, look at him because he's  
9 ill now, and we need help.

10 Tell me what I need to do. It's not  
11 a question and answer session. But I'm here as  
12 an advocate. If I don't do it and you don't do  
13 it, who's going to do it? I'm available any and  
14 every day. My cell phone is 24/7.

15 My high school students know I have an  
16 ill parent, who has recently lost his wife, who  
17 is an ill person who worked for the Department of  
18 Labor, who worked for the Department of the Navy,  
19 who served at the Pentagon, served in Vietnam.

20 So I think my father deserves more and  
21 better, and he shouldn't have to fight, nor I to  
22 get the benefits that are due to him. So in

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1 closing, my cell phone number is 706-294-0357.  
2 I'm here in Augusta, Georgia. If you need to see  
3 me, just call me.

4 And I have a daughter who would like  
5 to know that her grandfather has been done right.  
6 That her biology degree that helps me research and  
7 help her grandfather is not in vain. That she will  
8 not have to go through these things as her  
9 grandfather is.

10 She sees him suffering now. She sees  
11 that and it's really, really sad that this Board  
12 even has to convene for things like this. It's  
13 really sad that family has to be here.

14 But I appreciate the time, the effort  
15 and the knowledge that sits here in this room.  
16 And again, I am Angel Little, here in Augusta  
17 Georgia and I'd like to thank you.

18 CHAIR MARKOWITZ: What did you say your  
19 cell phone number was?

20 MS. LITTLE: 706-294-0357.

21 CHAIR MARKOWITZ: Okay. Thank you.

22 MS. LITTLE: Thank you.

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1 CHAIR MARKOWITZ: Are there any other  
2 people who would like to make a public comment?  
3 We do have a little time, so if -- okay, and there's  
4 no one else waiting on the phone, right?  
5 Do you want me ask her? Yes.

6 To the moderator on the phone, is there  
7 anyone else in the phone who has somehow  
8 communicated that they would like to make a public  
9 comment?

10 OPERATOR: No. Should I let, give  
11 them an option on how to do that?

12 CHAIR MARKOWITZ: Yes.

13 OPERATOR: If anyone on the phone would  
14 like to make a comment, please press star zero.

15 We have a couple, so one moment, please.  
16 The first one is Stephanie Carroll.

17 You may go ahead. Just one moment  
18 please. Let them open their line, one by one.  
19 Start with Stephanie Carroll. Comment.  
20 Stephanie Carroll, you may go ahead.

21 MS. CARROLL: Thank you, very much.  
22 Thank you. I deeply appreciate the Board and the

1 opportunity to make a comment. I didn't prepare  
2 anything formally.

3 But just wanted to note, especially for  
4 the Board reviewing SEM that being an authorized  
5 rep who specializes in beryllium disease, I'm  
6 always interested in the documentation proving  
7 workers are exposed to beryllium.

8 And I haven't had as many problems here  
9 in the Rocky Flats claims or Nevada Test Site.  
10 But I had the opportunity last night to review the  
11 SEM for Portsmouth. And I was shocked to see that  
12 Portsmouth had three buildings related to  
13 beryllium.

14 And just with a very quick review  
15 online, I found formal worker programs, these --  
16 (Telephonic interference.)

17 MS. CARROLL: -- reports, which showed  
18 beryllium in multiple buildings. I think I was  
19 at eight or nine buildings that it was in.

20 And so I was shocked to see the  
21 difference between evidence that should be being  
22 used for the SEM, and the actual SEM that claims

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1 examiners are using.

2 Another thing I noticed is that the  
3 claimant I was, I was researching on had a job  
4 category of welder and maintenance mechanic. He  
5 said no exposure to beryllium on any of those job  
6 titles. And the buildings he, he was in didn't  
7 show exposure to beryllium.

8 This is the thing, when I read the  
9 formal worker program needs assessment, it clearly  
10 right of the bat noted that there were beryllium  
11 welding rods used late into the 90s. And, and  
12 that's not even, you know, documented in the site  
13 exposure matrix.

14 What we've been told by the Department  
15 of Labor is that beryllium isn't included  
16 throughout SEM related to Part E. But I also show  
17 a lot of beryllium exposure in SEM, even as it  
18 relates to Part E.

19 Illnesses related like dermatitis,  
20 which known to be related to beryllium, weren't  
21 even listed in the Portsmouth SEM. Beryllium has  
22 no illness related to its exposure in the SEM there.

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1           So I was shocked to see that and I wanted  
2           to note that with the Board. And I appreciate all  
3           the work that you're doing. And wish I could  
4           attend. Thank you, so much.

5           CHAIR MARKOWITZ: Thank you. To the  
6           moderator, is there another person on the phone  
7           who wants to speak?

8           MR. REAVIS: Yes. This is Rick  
9           Reavis. Rick Reavis wants to speak.

10          CHAIR MARKOWITZ: Go ahead.

11          MR. REAVIS: Are you, are you talking  
12          to Rick Reavis now, Doctor?

13          CHAIR MARKOWITZ: Yes. We can hear  
14          you fine.

15          MR. REAVIS: Okay. Thank you, very  
16          much. I want to thank you. I want to thank  
17          everybody else who sat there listening. I want  
18          to thank the people that are getting up there  
19          talking. It takes a lot to do that.

20                 I want to say that I thoroughly,  
21                 thoroughly believe in what Terrie Barrie said about  
22                 Congress needs to look into this program. If you

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1 go back to when program was initiated in 2000, it  
2 was to correct a wrong.

3 Because the government had to admit  
4 what they did to these people, exposed them to  
5 radiation without their knowledge. It's a  
6 terrible thing. So the President wanted to make  
7 amends. Initially the program said, if got one  
8 of the 22 cancers and worked at one these company,  
9 you were to get compensation.

10 That's turned into a big boondoggle.

11 And if you think of it, in 2003, DOE had that  
12 program from 2000 to 2003. And it was so corrupt,  
13 and I do mean corrupt, that they had to take it  
14 away from DOE and give to DOL.

15 And for all these years, all the way  
16 going to 2019, that's a long time even for the  
17 government to try and correct a wrong. I don't  
18 think the problem has been corrected. I can tell  
19 you, and I am by the way disappointed that I can't  
20 ask questions.

21 Because I have questions I know the  
22 answers to. But I get those answers via the

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1 government and DOL, DOE, and NIOSH. And I'd like  
2 to ask those questions so they could be answered  
3 where people could actually have it on tape.

4 But one lady was talking about false  
5 information. My God, you talk about false  
6 information. People need to go look up Texas City  
7 Chemical. You're supposed to have 250 days of  
8 processing, producing something that emits  
9 radiation, was used a bomb, in order to qualify  
10 for an SEC.

11 Texas City Chemical only produced for  
12 three months, October, November, December 1953.  
13 NIOSH was looking for an SEC for that and in 2008,  
14 they said that they could do a dose reconstruction.

15 And they gave five years time that they  
16 said covered for the SEC. Five years. For some  
17 reason, in 2010, actually 2009, somebody put a lot  
18 of pressure on NIOSH. And the pressure caused them  
19 to reevaluate and revisit Texas City Chemical.

20 Now what they said they could do in five  
21 years, to a dose reconstruction, no longer could  
22 they do that when reduced it to two years. You would

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1 think the logical thinking that if you reduced it  
2 down from five years to two years, you would still  
3 be able to do a dose reconstruction.

4 They come back and they say, well it's  
5 because the, the question was asked, what changed?

6 Well there were two different things. And we  
7 found out about the, the lawsuit. And we found  
8 out there was a bankruptcy. What's bankruptcy got  
9 to do with Texas City Chemical and their dose  
10 reconstruction?

11 So anyway, the bottom line is nothing  
12 changed. There was nothing changed. But yet they  
13 reduced it to two years, gave an SEC for Texas City.

14 Those people got paid. My feeling is that those  
15 people should have got paid.

16 They were lied to like all the other  
17 people across this country, thousands of them.  
18 And there's many of them that you need 250 days  
19 to qualify for an SEC. Well, I've heard of some  
20 that had 249, didn't get paid.

21 Well if you look at Texas City, again,  
22 they should have got paid. But they only had 60

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1 days of production. Something's wrong with that.

2 And I, I strongly feel the people should take a  
3 look at TCC. Look at the records on TCC, what they  
4 did.

5 Another thing I believe, a lot of people  
6 -- I just mentioned, in fact, there's a problem  
7 with DOL. There has been a problem with the DOL.

8 It's been ongoing. I got a letter from DOL, 2018,  
9 trying to explain away Texas City. They've been  
10 --- I've been asking this question for going on  
11 nine years. They're trying to explain away. And  
12 the best they can ever come up with, is well, you  
13 know, it's difficult to explain, one company versus  
14 another one.

15 Well how difficult can it be to explain  
16 what the difference is between Texas City and the  
17 company my father-in-law worked for, Blockson?  
18 And he worked there 25 years and didn't get paid.

19 And people at Texas City, two years, actually three  
20 months.

21 There, you put all this stuff together,  
22 and you look at this 2018 letter that I got from

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1 the Department of Labor. And they're saying, well,  
2 the difference with Texas City is because we did  
3 not have, at that time, in 2010, the information  
4 that we had to grant the SEC.

5 Well, the problem with that is I have  
6 numerous records. And I, and I really would like  
7 to have people call me just like Angel Little.  
8 My cell phone number is 815-791-3991.

9 Now, Department of Labor told me that  
10 they did not have that information. Well, listen,  
11 I can go back to 2007, 2008, 2010. I have all kinds  
12 of records on Texas City.

13 I have an ombudsman for the government,  
14 I don't want to mention names, but he also agrees  
15 something's wrong. They, they pulled out a  
16 document, the document received a U308, other  
17 domestic sources.

18 According to the government if there's  
19 any problem with the document, the benefit goes  
20 to the claimant. Well this document, I counted  
21 nine errors, provable errors. But yet, DOL, NIOSH,  
22 and Department of Energy from what I've read, all

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1 agree, all agree that this document is good.

2 If you look at this document for Texas  
3 City, I told you that they produced October,  
4 November, December 1953. That is correct. And  
5 Tom Tomes, I know he's probably sitting there.

6 He could tell you that Jim Netton asked  
7 him that back in 2010. And he said, October,  
8 November, December '53. Netton said, is that  
9 correct? He said, yes, that's correct. All  
10 right.

11 If you look at this document that is  
12 so good, it's got Texas City, nobody mentions that.

13 With the Oversight Committee and all the way up  
14 to HHS, I know nothing was told about the document  
15 other than the fact that it says, Blockson Chemical  
16 quit producing in the 1960.

17 Yes, indeed it does say that. But it  
18 also says that Texas City produced only one month,  
19 March 1954. That's just one mistake. There's  
20 nine mistakes. If in fact, the government stands  
21 by and NIOSH says, best available science, fair,  
22 consistent, best available science.

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1           And if there's any problem with the  
2 document, then the benefit goes to the claimant.  
3 Well how come the benefit didn't go to the claimant  
4 in my father-in-law's case? According to the  
5 document, it only produced Texas City, one month.

6           I'll tell you something else about my  
7 father-in-law and then I'll wrap it up. And  
8 believe me, I got a whole lot more to say so anybody  
9 out there listening, please call that number,  
10 815-791-3991.

11           My father-in-law was also at Pearl  
12 Harbor. He survived the West Virginia. I always  
13 tell people, what the government couldn't do, or  
14 what Japanese couldn't do to my father-in-law, the  
15 government did. With that, I'll let you go. You  
16 know why. Thank you. Bye.

17           CHAIR MARKOWITZ: Thank you. There's  
18 one more? Okay.

19           OPERATOR: Yes. We have one more.  
20 Ms. Donna Hand.

21           CHAIR MARKOWITZ: Okay.

22           OPERATOR: You may go ahead.

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1 MS. HAND: Thank you, very much. I'll  
2 try to be brief, and hopefully not take very long.

3 I have some issues that I need to address and in  
4 today's talk and everything, it was said, that it  
5 was legally use of the term, is broad, when you  
6 use vapors, gases, dusts and fumes.

7 Well the Part E is, is to be broad.  
8 And the actual documentation of a toxic substance  
9 definition also says, means, any material that has  
10 the potential to cause illness or death because  
11 of its radioactive, chemical, or biological nature.

12 And that was in the Federal Registry  
13 in 2006 as the goal. And that's what they had  
14 decided to use. So if you have vapors, gases, dusts  
15 and fumes that is the definition of toxic substance  
16 according to their own definition, as well, OSHA.

17 OSHA has air contaminants.  
18 Particulate contaminants include dust, fumes,  
19 mists, aerosols, and fibers. Liquids changed into  
20 vapors. Vapors are the volatile form of  
21 substances. Vapors are the gaseous form of  
22 substances. Then they have too much --

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1 (Telephonic interference.)

2 MS. HAND: -- the degree of worker risk  
3 from exposure to any given substance depends on  
4 the nature and potency of the toxic effect and the  
5 magnitude and duration of exposure.

6 They also have been, you know,  
7 biological hazards. Some of these chemicals react  
8 differently once it gets into the body. So these  
9 are issues here that should have been addressed.

10 And back in 2006, they were aware of  
11 these issues, but somehow have been forgotten  
12 about. In fact, their own D&C Handbook says that  
13 the legal standard for acceptance of a claim under  
14 the EEOICPA is less than stringent than that of  
15 other venues.

16 Medical opinions are to solidly based  
17 on the facts, as accepted by the CE and expressed  
18 in the Statement of Accepted Facts, and on the  
19 state-of-the-art medical knowledge. They should  
20 be as objective as possible.

21 The appropriate legal requirements,  
22 and I quote, a case should be accepted if the

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1 evidence in a particular case shows that there was  
2 plausible relationship between the exposure at the  
3 workplace and the employee's illness, or in some  
4 cases, death.

5 And that's on Page 7 of their own  
6 handbook, D&C Handbook, which is now the Contract  
7 Medical Consultants Handbook. They define  
8 causation as the legal standard of certainty of  
9 causation, falls between the preponderance of  
10 evidence and a reasonable suspicion.

11 So it's greater than a reasonable  
12 suspicion, but it's less than more likely than not.

13 Because that's the preponderance of evidence.  
14 So you're at least as likely as not, is more than  
15 a reasonable suspicion, but less than 50 percent.

16 The workplace exposure can contribute  
17 to an increased risk of an illness. That's  
18 acceleration. And contributing, also caused,  
19 increased, the likelihood of suffering and harm  
20 and results in an earlier onset of a condition,  
21 such as person having prostate cancer at an earlier  
22 age, than what's normal in the public.

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1           That's on page 9 of the D&C Handbook.  
2           Aggravation, defined as worsening of a previous  
3           existing disease. It also is whether workplace  
4           exposures aggravates a condition that may have  
5           remained latent or inactive.

6           So contributing then, aggravation is  
7           not being addressed at all in any of the decisions  
8           that the Contract Medical Consultant is supposed  
9           to be addressing, as well as, the Case Examiners  
10          are supposed to be addressing.

11          And if the causation standard is more  
12          than a reasonable suspicion, but less than 50  
13          percent, that's not a medical certainty standard.  
14          That's way less than that for causation.

15          The Contract Medical Consultants are  
16          to consider the nature, frequency, and duration  
17          of exposure. As well as the intensity and wrath  
18          of exposure, if, if this information is available.

19          A lot of the regulations have also said  
20          that the proof of exposure to toxic substance may  
21          be established by the submission of any appropriate  
22          document or information that is evidence that such

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1 substance was present at the facility, in which  
2 the employee was employed and that the employee  
3 came into contact with such substance.

4 It does not address at all that it has  
5 to be a significant level. So if you have  
6 significant factor, meaning any factor, and it  
7 doesn't, you just have to have the nature, duration,  
8 and frequency. That's all that the IH can address.

9 And all these subjective statements  
10 such as smoking and exceeding the regulations,  
11 they're not relevant underneath the program. The  
12 level is a subjective statement that is not  
13 relevant.

14 And again, even in the AIHA study,  
15 A-I-H-A, they have a exposure assessment rating  
16 speed. And in there they have a certainty  
17 description, that's a Category 3, health effect,  
18 you know, substance of the air, but reversible,  
19 that's Category 2.

20 If it's life threatening or disabling  
21 injury, that's a Category 4. You know, and they  
22 said, this is it. It doesn't have the level. And

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1 they also talk about similar exposure groups.

2 So if the Industrial Hygiene has  
3 similar exposure groups, then they know that every  
4 single one of them would be exposed to this chemical  
5 during this process, if they did this process, such  
6 welders or soldering, et cetera.

7 So you could have a presumption with  
8 the IHs. The IHs and also the Contract Medical  
9 Consultants never include or address the skin  
10 absorption of these chemicals.

11 Because you inhale it, you ingest it,  
12 you absorb it through your skin, as well as if you  
13 had any wounds, it go directly also to the  
14 bloodstream.

15 Basically, the Global Initiative for  
16 Chronic Obstructive Lung Disease in their 2018  
17 report, which is their pocket guide, that uses it.

18 Says that, dust and vapors.

19 So to say that it's a legal constraint  
20 to use dust, vapors, and mists for COPD or any  
21 pulmonary because it's too broad, well  
22 internationally everybody uses that for COPD.

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1           The other issue that I have is that the  
2 biokinetics of chronic beryllium disease is not  
3 just related to the lung. Chronic beryllium  
4 disease includes from the biokinetics of it, the  
5 liver and the skeleton, as well as those other  
6 organs that -- but that's definitely found that  
7 it goes to the liver and the goes to the skeleton.

8       So when you, somebody is accepted for chronic  
9 beryllium disease, those two other organs and body  
10 systems should be addressed as well.

11           And it's -- since the Department of  
12 Labor has already found consequential illnesses  
13 for chronic beryllium disease, that's been  
14 determined by their doctor, why should a claimant  
15 again go and get their doctor who has nothing, knows  
16 nothing about chronic beryllium disease to say that  
17 yes, these are consequential illnesses?

18           These, you know, they've -- these are  
19 issues that we're finding more and more of, that  
20 you're not using the language or the definition  
21 that comes in the statute. Such as the IH says,  
22 well the significant high-level, significant

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1 low-level.

2 Well no, significant means any factor.

3 So if there's any level, that's it. And again,  
4 the level, you can address if you have, it's a high  
5 uncertainly because of the exposure judgement made  
6 without any available exposure monitoring data.

7 Adverse effects are uncertain because  
8 you don't have any information. And that's from  
9 the Industrial Hygiene Association, itself. Thank  
10 you, again, for your time. If there's anything  
11 that I can do to help, or further, you know, I can  
12 do that.

13 I also want to point out that we did  
14 request an IH interview on a particular case with  
15 occupational disease in the eye. And they refused  
16 to let us have that interview with that IH.

17 When we had the hearing, the claimant  
18 told the hearing officer the level of exposure to  
19 nitric acid, as well as plutonium oxide directly  
20 to his eye.

21 And in the final decision, the hearing  
22 officer said, even though you explained that your

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1 level was higher than the IH, it had no bearing  
2 on his decision and he still denied the case. So  
3 again, thank you, and have a nice evening.

4 CHAIR MARKOWITZ: Okay. Thank you,  
5 very much. Okay. That ends the public comment  
6 session. So we've been here for a while. So maybe  
7 we should close for the day and start up again  
8 tomorrow at 8:30.

9 And I think we'll probably start off  
10 with how we're going to categorize and organize  
11 our claims review and move forward. And then on  
12 the Parkinson's disease, how to move forward on  
13 the topics that Marek raised.

14 So, thank you, very much. And the  
15 meeting is adjourned for the day.

16 (Whereupon, the above-entitled matter  
17 went off the record at 5:41 p.m.)  
18  
19  
20