UNITED STATES DEPARTMENT OF LABOR

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ADVISORY BOARD ON TOXIC SUBSTANCES
AND WORKER HEALTH

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WORKING GROUP ON PRESUMPTIONS

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MEETING

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WEDNESDAY,
JUNE 21, 2017

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

MEMBERS

SCIENTIFIC COMMUNITY:

KENNETH Z. SILVER
LESLIE I. BODEN

MEDICAL COMMUNITY:

STEVEN MARKOWITZ, Chair
VICTORIA A. CASSANO

CLAIMANT COMMUNITY:

KIRK D. DOMINA
GARRY M. WHITLEY
FAYE VLIEGER

BOARD MEMBERS ALSO PRESENT:

KIRK DOMINA

DESIGNATED FEDERAL OFFICIAL:

CARRIE RHOADS

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

1:05 p.m.

MS. RHOADS: Hi everybody. My name's Carrie Rhoads. I'd like to welcome you to today's teleconference meeting of the Department of Labor's Advisory Board on Toxic Substances and Worker Health, the Presumptions Working Group.

I am the board's designated federal officer or DFO for today's meeting.

First of all we appreciate the time and the work of our board members in preparing for this meeting and for their time spent working after.

I'll introduce board members and take a quick roll call. Dr. Steven Markowitz is the chair of this group and chair of the advisory board.

CHAIR MARKOWITZ: Here.

MS. RHOADS: And the members are Dr. Victoria Cassano.

MEMBER CASSANO: Here.

MS. RHOADS: Ms. Faye Vlieger.

MEMBER VLIEGER: Present.

MS. RHOADS: Dr. Leslie Boden. Dr.

Boden, are you on the line?

MEMBER BODEN: Here.

MS. RHOADS: Thanks. Mr. Garry Whitley.

MEMBER WHITLEY: Here.

MS. RHOADS: Dr. Ken Silver.

MEMBER SILVER: Here.

MS. RHOADS: Dr. John Dement and Dr. Laura Welch are both in this group but could not make the call today. And Mr. Kirk Domina is also on the line with us.

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

Today's meeting is scheduled from 1 o'clock to 3:30 Eastern time. I don't know if we'll take a break. If the discussion allows and Dr. Markowitz wants to that is fine.

Copies of all meeting materials and any written public comments are or will be available on the board's website under the heading Meetings and a listing there for this meeting.

The documents will also be up on the

WebEx screen so everyone can follow along with the discussion.

The board's website can be found at dol.gov/OWCP/energy/regs/compliance/advisoryboard.htm.

When you visit the website after clicking on today's meeting you'll see a page dedicated entirely to the meeting.

The webpage contains publicly available material submitted to us in advance and we'll publish any materials that are provided to this subcommittee.

There you should also find today's PowerPoint presentation as well as instructions for participating remotely.

If you are participating remotely and you're having a problem please email us at energyadvisoryboard@dol.gov.

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

The phones will also be muted for

non-advisory board members.

If you're a speaker and you're not speaking please mute your phone because we're getting a lot of background noise right now.

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

The advisory board voted at its April 2016 meeting that the subcommittee meeting should be open to the public. A transcript and minutes will be prepared from today's meeting.

During board discussions today as we're on a teleconference line please speak clearly enough for the transcriber to understand. When you begin speaking especially at the start of the meeting please state your name so we can get an accurate record of the discussion.

And I'd like to ask our transcriber to let us know if you're having any issues with hearing or with recording.

As the DFO I see that the minutes are prepared and ensure they're certified by the chair. The minutes of today's meeting will be available on the website no later than 90 calendar days from today.

If they're available sooner we'll publish them sooner as well.

We'll also be publishing verbatim transcripts which are obviously more detailed in nature. Those transcripts should be available on the website within 30 days.

I'd also like to remind the advisory board members that there are some materials that have been provided to you in your capacity as special government employees and members of the board which are not for public disclosure and can't be shared or discussed publicly including in this meeting.

Please be aware of this as we continue with the meeting today. These materials can be discussed in a general way which does not include using any personally identifiable information such

as names, addresses, specific facilities of the cases being discussed.

And with that I convene the meeting of the Advisory Board on Toxic Substances and Worker Health, Presumptions Working Group. And I'm going to turn it over to Dr. Markowitz.

CHAIR MARKOWITZ: Thank you, Carrie. And actually, thank you Carrie for all the support work and work you do with the board. It's extremely useful.

I'd like to welcome people onto this call from the Presumptions Working Group. I'd also like to welcome any members of the public who are listening in.

We don't have a public comment period during this working group meeting or for that matter any of the subcommittee calls as Carrie mentioned.

However, we do welcome always written public comments which we read and try to take into consideration in terms of our discussions and decisions.

I think first we should probably just

go around in case there are any members of the public who aren't familiar with board members and just very briefly identify ourselves.

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

And Carrie, if you could just cite peoples' names and then they can respond. That's probably the easiest way.

MS. RHOADS: Okay. Dr. Cassano.

MEMBER CASSANO: This is Dr. Victoria Cassano. I am also an occupational and environmental medicine physician. Retired Navy physician and also worked at VA in the central office doing environmental health policy. And now have my own company. Thank you.

MS. RHOADS: Okay. Ms. Vlieger.

MEMBER VLIEGER: Faye Vlieger, former Hanford worker and worker advocate.

MS. RHOADS: Dr. Boden?

MEMBER BODEN: This is Les Boden. I'm

a professor at Boston University School of Public Health.

MS. RHOADS: Mr. Whitley?

MEMBER WHITLEY: Garry Whitley. I worked at Y-12 National Security Complex Oak Ridge for 42 years and worked with the worker health protection program.

MS. RHOADS: Dr. Silver?

MEMBER SILVER: Ken Silver, associate professor of environmental health at East Tennessee State University.

MS. RHOADS: Mr. Domina.

MEMBER DOMINA: Kirk Domina. I'm the employee health advocate for the Hanford Atomic Metal Trades Council. We're from Washington. I've been here 34 years and we represent approximately 2,600 current workers.

MS. RHOADS: Okay. Go ahead, Dr. Markowitz.

CHAIR MARKOWITZ: Thank you. So the agenda for today really is to discuss the PowerPoint which I prepared which really principally addresses

one issue which are looking at the medical criteria for the diagnosis or the use of medical information for application to claims under EEOICPA with relation to various asbestos related diseases.

And then at the end I open up the -- try and open up the discussion to consideration of other issues for the future in terms of presumptions.

Is there any other agenda item that members of the board would like to propose or discuss today?

Okay, well if something comes up I think we're going to have time because I don't think the agenda so far will occupy nearly all of our time, although I always seem to underestimate how much discussion is generated. But regardless.

And by way of taking a break we'll see how things go. In an hour or an hour and 15 minutes if it looks like we're going to go for quite a while longer then I'll call for a break.

On the presumptions we've been dealing with scientific technical medical issues that some

members of the board are much more familiar with than other members.

And I just want to reiterate that if there are issues, terms, or comments that people don't understand we can very quickly explain things in a way that allows everybody to understand.

Because everybody makes important contributions and I really don't want folks feeling shut out in any sense because the doctors are talking about medical stuff.

So we should be able to communicate in a way where everyone understands and can contribute. So I probably should have said that before, but in any event I feel that reflects the spirit of the board.

So let's go to the PowerPoint. And go to the first slide.

Now, just to summarize, this is the work we've already done on presumptions. And you see listed the first four content, either diseases or exposures.

We've mostly focused on exposure

presumptions rather than on helping DOL make a determination about how to recognize a diagnosis of disease.

We did that for asthma but we didn't really do that for COPD, for asbestos-related diseases, and we didn't weigh in on how they should look at hearing loss in terms of diagnosing hearing loss.

We did, however, weigh in on the exposure side. And then early on we had recommended actually cessation of use of a presumption for post-95 toxic exposures, a presumption which is the recommendation that DOL has accepted.

And then we earlier this week formally endorsed as a board the current presumption, so that's not a recommended change at all in how DOL treats sarcoidosis and its equivalents with CBD if a person is a covered beryllium employee. So that's the work we've done so far.

And we've concentrated on I think fairly common outcomes for which people make

claims, especially on the respiratory disease side, but also on the hearing loss. So the next slide.

So, I think it was in the last meeting when we were discussing asbestos-related diseases that someone suggested that maybe we should look at the medical side, at the diagnostic side, and see if there's some helpful suggestions that we could make to DOL in terms of how they recognize various asbestos-related disease.

Now, from their manual -- by the way, if you haven't seen the updated procedures manual, updated, the date was April 2017, you should take a look. It's very nicely organized.

I don't think the content has been changed, but it's organized in a way that makes it much easier to locate things.

So as we actually discussed in April that the current program recognizes a variety of asbestos-related diseases including those not -- that don't represent cancer, and that's asbestosis or scarring of the lung tissue itself due to asbestos. Pleural plaques and pleural thickening,

scarring of the covering of the lungs, the pleura.

They actually mentioned something which is fairly uncommon and we haven't discussed before, but sometimes asbestos after many years causes a fluid to accumulate, fluid that's elaborated by this covering of the lung, the pleura. And it's called pleural effusion. Accumulates at the bottom of the lung and then eventually resolves.

It's not a malignancy. It usually leaves behind some scarring, but it's something actually that the program and the procedure manual recognizes. So even though we didn't suggest it in April it is part of the disease spectrum of the program.

And then secondly, the various malignancies that are recognized by the program which are malignant mesothelioma, cancer of the pleura.

Now, by the way, mesothelioma occurs elsewhere in the body besides in the chest. It occurs about 10 percent of the time in the abdomen

where it's called peritoneal mesothelioma.

And then less than 1 percent of the time at other locations.

And we're not going to discuss mesothelioma outside of the chest today because the procedure manual doesn't -- I don't think it addresses mesothelioma of the abdomen or otherwise known as peritoneal mesothelioma.

And so we're just sort of skipping over that for now. It's extremely rare and there are about 250 cases total in a year among Americans, 350 million people of which there are a total of 250 cases total per year of peritoneal mesothelioma.

So we're not going to address that today.

And then the other cancers including lung cancer, and cancer of the ovary, and cancer of the larynx. Next slide.

By the way, I'll occasionally take a breath so jump in with comments, questions, or interrupt me so that this isn't a monologue.

At certain points I'll open it up for specific comments.

Now on the next few slides what I do, I simply abstracted the current language from the procedure manual on how claims examiners and the program as a whole view medical evidence of asbestosis and other conditions.

So where at the top of the slide it says the EEOICPA Procedure Manual Chapter 18 this is the language that they use.

So the claims examiner is instructed for a claim of asbestosis to look at a number of different sources of evidence.

And they look for an opinion of a qualified physician. This is presumably the treating physician, at least initially. And that that opinion is based on a chest X-ray finding, a CAT scan finding, CT scan finding, an MRI which is a fancier imaging study of the chest, pulmonary function tests or breathing tests, or lung biopsy.

Or, and/or another source of evidence is the physician report from the DOE's former worker

program.

And/or another source of evidence is the death certificate.

So, I have to say, and here I'm going to open it up for comments, I have to say I'm a little puzzled still about how this works.

The claims examiner is collecting information the claimant has sent in. They get hopefully some report from the treating physician and the treating physician say in a case of asbestosis might say this is asbestosis that the person has and they may or may not cite the evidence for that diagnosis.

And presumably the claims examiner gets a report of the chest X-ray, or the CT scan, or the biopsy.

And what I'm trying to understand is does the claims examiner look at not just the physician report, but they're looking at the chest X-ray report and the CT report, the lung biopsy report, and they're trying to see whether what they are reading in those reports constitutes

asbestosis, or there are findings that allow them with some confidence to say yes, this person's claim is for asbestosis.

Is that your -- speaking to the other board members here -- your general impression of the process of how the claims examiner works?

MEMBER CASSANO: Steve, I was kind of confused as you know from my email about the -- I'm not quite sure whether it's all -- I guess that they're saying that these are all the sources of evidence, but I don't think any of them are used definitively.

I think there's a lot of -- what's the word I'm looking for. There's a lot of interpretation allowed here.

So this is what I wrote you about, DOE WP physician findings. And that's when I asked, gee, does it mean that only -- that any other qualified MD, there has to also be chest X-rays, CT, MRI, before DOE from a worker program physician all you need is that physician's statement that it's asbestosis.

So I don't know whether you need any combination of these, or any one of these. To me it's confusing and I presume then that it's probably confusing for CEs as well. I don't know.

CHAIR MARKOWITZ: Right. Other comments?

MEMBER VLIEGER: This is Faye. What I find with asbestos diagnosis, unless it's one of the former worker physicians who's actually looking at it and saying that this is asbestosis it's very hard to get a diagnosis from your pulmonary physician because they feel unable to make a diagnosis from what they see.

And so I'm not sure how to change that. Maybe include the wording of what they're supposed to be looking for more clearly.

But even at that if you show them the document they say well, I don't know how to diagnose asbestos. And this is from qualified pulmonologists.

So I don't know if we can fix that or not.

My experience is that you have some piece of evidence, not all of them, and then you have to have a physician stating that this is what this is.

In the past the former worker program physicians were not accepted because it wasn't the attending physician. That's considered a one-time occupational medicine physician which I find appalling, but that's what they've been doing.

CHAIR MARKOWITZ: And later I'm going to show some slides of the former worker program's language that they -- or basis for their decisions.

Other comments.

MEMBER WHITLEY: This is Garry. In Oak Ridge our pulmonary doctors gives a diagnosis and writes the letter, sends it -- gives the claimant a letter and they send a letter that they've been diagnosed with asbestosis.

And usually they don't question it pretty much. And the doctors here in Oak Ridge, if you've been working with asbestos in groups that have, and they diagnose it, that's pretty much what

all has to happen.

I had a friend this week that just told me he got his claim of asbestosis and it hadn't been probably three or four months since he filed.

MEMBER CASSANO: And that was because the physician in the local area -- is that just a local physician or is that within a former worker program?

MEMBER WHITLEY: No, it's a local pulmonologist in this area. We've got several right here in Oak Ridge and they see a lot of people. They diagnose asbestos pretty often.

MEMBER CASSANO: I think people that are used to seeing individuals exposed to asbestos don't have difficulty diagnosing it. Whether you're an occupational physician, or a pulmonologist, or an internist.

But even pulmonologists who don't see it are uncomfortable diagnosing it I think. They call it either pulmonary fibrosis or they -- whatever they're going to call the small -- I'm not thinking straight for some reason, but whatever

they're going to call what they see on a chest X-ray they're uncomfortable calling it asbestosis.

A lot of times because they don't ever ask for an occupational history so they don't know the person's been exposed to asbestos.

CHAIR MARKOWITZ: For the transcriber that interchange was between Garry Whitley and Dr. Tori Cassano.

MEMBER CASSANO: Sorry about that.

CHAIR MARKOWITZ: That's okay. Garry Whitley is the one with the attractive accent so you can always recognize him.

MEMBER CASSANO: Yes, I'm the one that speaks like a doctor.

CHAIR MARKOWITZ: Other comments?

MEMBER SILVER: This is Ken. This is pretty interesting. We have two extremes laid out. One is at Oak Ridge where the pulmonologists are experienced and cooperative in making the diagnosis.

And then we have Faye's experience where they're not. And it seems an important

question for us is how much discretion do the claims examiners have between those two poles and how do they exercise it.

And they qualified in the case of Oak Ridge to overrule or are they qualified to construct a diagnosis for a Hanford worker who didn't get one from their pulmonologist.

MEMBER BODEN: This is Les Boden. I'm wondering following up on this conversation whether there ought to be some either information or guidance for the pulmonologists who are treating people.

So information might be providing them with information about whether that person worked on a job that DOE would consider to be potentially asbestos exposed, or guidance about how to think about what DOE is looking for from them which would presumably include some information about exposure to asbestos.

This is for Faye's physicians and not for Garry's I guess.

MEMBER CASSANO: What I find with

treating physicians a lot that are experienced at either primary care or the (inaudible) doc is that even if you give them all of that they're always going to waffle. I see this all the time.

They're never going to say it's at least -- it's most probably. That's the best you're going to get. You're never going to get even an at least as likely as not statement, or a definitive statement that what they're seeing on chest X-ray on the person's pulmonary function is due to asbestos.

They're going to say is consistent with asbestos, consistent with asbestos exposure, probably due to asbestos, or possibly due to asbestos.

I find that most of them aren't going to pin etiologic certainty with something that does not -- even with stuff that they are very familiar with. A lot of times they won't do it.

So I think we need to find some way of giving the CEs enough information. If they have a definitive diagnosis then that's fine, but if

they've got a chest X-ray that has fibrosis or has B reading that shows one zero B read or something like that.

I think it needs to go to a CMC. Because I don't think for the most part without something clear that says asbestosis that it goes to radiology reports or MRI, CT, or whatever that says definitively asbestosis.

They need that clinical interpretation.

CHAIR MARKOWITZ: This is Steve. And that's probably the way it works.

In fact, after this call I'll ask for some clarification from DOL about how this works in practice.

But we're going to get into some specific language on medical evidence which I think will help the process. Even if the process doesn't change it'll help the CE by giving more specifics about diagnosis.

It'll help the treating physician because they'll be able to look at the specifics

that by the way exist in some other aspects of the program, some of the statutory, for instance, beryllium and silica, actually in the act.

It's not in the act about asbestosis nor in the procedure manual.

So let's continue with the next slide. So this is cited from the procedures manual about the opinion of the qualified physician who states on any or all of the following, pulmonary interstitial fibrosis with or without heart enlargement, CT or MRI finding of lung scarring, pleural thickening, heart enlargement, pulmonary function test finding of restriction. That's lower lung volumes. The person can't breathe sufficiently.

And the PFT requires a physician interpretation or lung biopsy. And it mentions that lung biopsy sputum cytology which is simply looking at cells in sputum or a bronchial lavage which is putting fluid into the lung and then taking it out and looking at cells. It often shows asbestos bodies which are old asbestos fibers that

are coated with protein and have a very distinct appearance.

Those findings are helpful but not definitive. So that's kind of a summary from the manual as to how the CE and others look at the information that the treating physician provides. Next.

And/or the former worker program. And the assessment. And the language of the procedure manual says they accept the physician assessment of asbestosis or asbestos related lung disease.

And from the language frankly looks like the CE doesn't necessarily have to look at the data that we just went over in the previous slide, meaning chest X-ray, CT results or the like.

It looks like it can be based on the FWP determination. And part of the logic of that would be frankly the FWP determination is based on the chest X-ray and occupational history which we'll go over in a second.

And then the third source of evidence -- next slide -- that the CE or the claimant process

can examine is the death certificate.

And here they want to see asbestosis on the death certificate as either the cause or a contributing factor.

And if the death certificate says something other than asbestosis because it very easily could say pulmonary fibrosis, or fibrosis of the lung, or interstitial fibrosis, or something that is kind of equivalent but less specific than asbestosis then the claims examination process needs evidence, other evidence to support the diagnosis of asbestosis which makes a lot of sense.

Next slide.

And moving onto cancers. The procedure manual requires that the CE find confirmation of the diagnosis of mesothelioma of the pleura. And it's not specified exactly what that is although in practice it's almost assuredly it's going to be the pathology report, examination of the tissue of the cancer.

Again, from the procedure manual, now moving onto pleural plaques and pleural effusions

this is in the non-malignant category, plaques being the scarring of the pleura.

And then the supportive medical evidence that is examined in the claims process includes the physician diagnosis, some chest X-ray or CT, in other words some imaging evidence of pleural plaques or pleural thickening which is not due to surgery or trauma.

And we've got rounded atelectasis which is quite specific to asbestos. What happens is that the pleura sits on top of the lung and when it gets scarred, and the scarring can get exuberant or kind of aggressive, it can envelop a section of the nearby lung and kind of wrap -- the scarring of the pleura wraps around that section, a small section of the lung.

And it's called rounded atelectasis. And it has the potential to appear in the chest X-ray or CT scan as fairly specific for non-malignant asbestos related disease.

And then finally the presence of bilateral pleural effusions.

So again, these are just the pieces that are examined in the process of looking at a claim for pleural plaques or pleural effusions.

By the way these are two separate entities. This pleural plaque, the thickening, the scarring is one thing, and the pleural effusion is something separate, much less common.

MEMBER BODEN: This is Les Boden. Can I interrupt just for a second to clarify for me?

So I see these various pieces of supportive medical evidence. Is there any guidance to the CE about how to use these various pieces to come to a conclusion? And that would hold clearly for the asbestos.

CHAIR MARKOWITZ: Yes. So if you go to the previous slide just so we can look at what we were looking at.

I don't know what exists outside the procedure manual because I didn't really look at the circulars, go around the circular bulletins or any other sources of guidance. So there may be something else somewhere else, but probably not

much actually.

This is a summary of how the CE looks at these cases for claims of information.

MEMBER BODEN: Right.

CHAIR MARKOWITZ: There's no more specificity than this. Unless I somehow didn't summarize these properly, but I think I got the keywords right.

MEMBER BODEN: Okay. So I'm thinking, I'm looking at this is like how many of the four things on this list would I need before I was convinced that I should approve the claim for pleural plaques.

Or which ones are particularly convincing to me. That's not part of this, correct?

CHAIR MARKOWITZ: Not that I saw. I mean, what probably happens, my guess is that physician diagnosis, the physician cites an imaging study or the CT scan as evidence.

That would be -- predominantly in asbestos disease that would be the typical or the

expected kind of scenario.

MEMBER BODEN: Right.

CHAIR MARKOWITZ: Now, if the CE just sees a physician diagnosis without reference to a chest X-ray I'm not sure what happens.

MEMBER BODEN: I would suspect not be convincing.

CHAIR MARKOWITZ: Right. Nor frankly should it.

MEMBER BODEN: Yes, appropriately so.

CHAIR MARKOWITZ: Right, right. So, next slide.

And then there is instruction on these specific plaques and effusions that the claims examiner will consult either with the treating physician or the CMC if evidence was inconclusive.

If the pleural thickening is in an area of surgery or trauma, or if there's other -- evidence of other causes of a pleural effusion is present.

I would just tell you pleural thickening, if a person has a traumatic rib

fracture, or if the person undergoes chest surgery it would typically leave behind an area of pleural thickening in which case you wouldn't really ascribe that pleural thickening or plaque to asbestos. You would say it's due to that trauma or surgery. It's not necessarily -- all the time.

And then pleural effusions, this is item number three, pleural effusions are very common. Asbestos related, benign pleural effusion is very uncommon and so it makes a lot of sense to look for other more ready explanations for pleural effusions. Next slide.

So, just to move to what the former worker program does. These are surveillance case definitions so these are not diagnostic. These are how we identify for the purposes of reporting to DOE in large populations that we screen how we identify a case of asbestosis which is they have a history of exposure to asbestos or a job title in which it's reasonably likely to have exposure to asbestos.

And we require a B reading which is a

chest X-ray by a physician who is specially trained and passed a test given by NIOSH for reading X-rays for dust diseases.

The B reading of a standard chest film demonstrating bilateral irregular opacities in the lung tissue itself with a specific shape and size. And stu means irregular.

And the profusion score meaning a density of the lowest level or higher, the lowest level being 150 which is a relatively slight disease.

So there's some specificity. It can't exactly be transferred over to the program, but it's an example of how the former worker program looks at it.

And notice that if she's not on the film -- chest film, it doesn't discuss pulmonary function tests or any other source of evidence. Next slide.

MEMBER BODEN: Sorry, this is Les again. So it appears to me, and I don't really know this stuff that well, that this would be

somewhat more restrictive than you might get from using the other pieces of evidence that were talked about before, more consistent maybe, but maybe also more restrictive or not.

CHAIR MARKOWITZ: Well, it doesn't address the death certificate obviously. The FWP or screening program.

MEMBER BODEN: But putting the death certificate aside. So the question is at least in your opinion would it be -- would using this definition only screen in fewer cases than.

CHAIR MARKOWITZ: So it depends on -- probably not many. It could be more restrictive. It depends on how the current guidelines are applied.

For instance, notice that in this definition that it's nothing about breathing tests.

MEMBER BODEN: Right.

CHAIR MARKOWITZ: If the claims examiner is looking at a case in which a person reports asbestos exposure so that's off the table -- has a normal X-ray, or X-ray findings that are

a lot less specific than what we were looking at on the screening here, but has restriction on pulmonary function.

Would the claims examiner, the treating physician, the claims examiner or the CMC consider that to be sufficient to say it's asbestosis.

In practice they might. Would they be right? Unlikely. But they could do that.

MEMBER BODEN: The other problem with this for general use would be that you'd need to have a B reader.

CHAIR MARKOWITZ: Oh yes, yes. This is too restrictive in that sense because most people aren't going to people who are B readers. Most B readers are radiologists. They're not primary care doctors, or pulmonary specialists.

And if you send their X-ray over to Methodist Hospital in Oak Ridge, or Baptist over in Paducah there's no B reader in sight. So yes, in that sense in particular it's different.

And then the other thing in the current guidelines is lung biopsy, and obviously former

worker program isn't looking at a lung biopsy. They don't do that as part of a screening program.

Any other comments at this moment? Okay, so just moving on FWP for pleural disease. I'm sorry, go back to the previous slide. For pleural disease due to asbestos.

What we require in the former worker program is a history of exposure to asbestos or a job title which we expect has exposure to asbestos.

And again, a B reading notation of the presence of unilateral or bilateral pleural thickening consistent with pneumoconiosis. Pneumoconiosis just means dust disease of the lung.

So mind you, we're talking about an expert looking at films, just films for occupational lung diseases.

And it's most likely that if that person sees a single pleural plaque on a side where they also see rib fractures they're probably not going to call that a pleural thickening consistent with pneumoconiosis.

So embedded in this process is an issue that the current program is more explicit about which is this issue of pleural thickening due to trauma or surgery. That's how that's dealt with. So if we could go to the next slide.

So, the next series of slides just is proposed language subject to change of course. It's a first draft about ways in which defining these entities, the kinds of evidence they're based on what would be helpful to the process.

The way I think about them is maybe -- some of these criteria may be within the reach of the claims examiner. They would certainly be in the reach of many of the treating physicians.

And this kind of specificity should certainly be helpful to the CMCs in making decisions about who has and doesn't have any of these entities.

And so that's what -- it's not supposed that a claims examiner will necessarily be able to understand and apply all of these criteria by way of their background. But to some extent they

probably could.

But in any case the intent is to give some greater specificity.

And so for asbestosis there are three slides that mimic the current procedure. One is the radiography. The other is the lung biopsy, et cetera.

But the first one is obviously history of asbestos exposure. We dealt with that in our previous recommendations so I'm not going to focus on that.

Remember we went over 30 days for mesothelioma, 250 days for the other entities. And then we sent out various job titles or the like to address exposure.

But on the disease side what we see is the chest X-ray or the CT scan which is the presence of bilateral diffuse interstitial fibrosis which affects any combination of the mid and lower lung zones. And that's what asbestosis is.

And that definition, you can look at a chest X-ray and identify whether the person has

it or not, or the CT scan.

And that's in fact what the B reader is doing. But it's also what the radiologist is doing and what the pulmonary specialist is doing in looking. And for that matter even the primary care doc should be able to do this if they have some experience in reading films.

They may not call it asbestosis, but they should be able to -- the definition should be able to be used in looking at the X-ray report and seeing whether it's bilateral, is it only in the upper zones which wouldn't be asbestosis, and is it a diffuse process as opposed to a specific scar in the mid left lung.

And then if the ILO score is used, and this is the appropriate definition, it's not expected that the ILO score is going to be used, but it should be in there as a guideline. Question, comment?

MEMBER CASSANO: Tori Cassano. I think the ILO scoring can only be used on B readings.

I think it should just be changed if

a B read chest X-ray is used then ILO scoring upgraded in one, zero, just, you know, s, t, or u, or passing for clarity.

Because should the ILO scoring on a CT scan or a regular chest X-ray.

CHAIR MARKOWITZ: Okay, so you're saying if a B reading is performed rather than if ILO scoring --

MEMBER CASSANO: Yes. If the B reading is performed then ILO scoring greater than one dash zero adds to your, you know, opacity.

CHAIR MARKOWITZ: Right. I changed it in my version. I mean, I'm not a B reader, but I will use the ILO scoring. So, that's a little odd, but we can address that.

Other comments? Next slide. So this mimics current language which is the second diagnostic criteria is what comes out of the FWP program which we went over before is very similar to what the previous slide showed.

The next slide is -- here this addresses pathology.

Now, most people who have scarring in the lung tissue don't come to biopsy. So this, I'm showing the current program and the future is going to be quite uncommon.

But sometimes if a person has severe fibrosis scarring, or if it's progressed very quickly which usually asbestosis doesn't then they may come to biopsy to see if they have something that can be treated.

So to be complete we need a criterion for that. And it's a simple definition which is when you look at cells what you see is a diffuse interstitial process in the lung.

I should say that there are -- the pathologists argue about some other things which mainly center on whether they see asbestosis fibers or asbestosis bodies and how much of that do you need.

But there's general agreement on at least the histologic evidence when you look at cells under a microscope that there needs to be a diffuse interstitial process, scarring process seen. So

that's what is here.

If you could look to the next slide. Here we favor a history of asbestos exposure. We identify exposure.

But actually when you have lung tissue you have the opportunity on asbestos to actually look at whether there are fibers or not.

Just parenthetically, this is a complicated subject because some fibers stick around and some fibers don't.

Mind you, most people with asbestosis are 20 or 30 years from their initial exposure to asbestos.

One type of asbestos, the most common type tends not to concentrate in the lung but to move onto the pleura and elsewhere.

So these are kind of complicated topics.

But if there is tissue and it can be used to support a claim then you can document exposure, meaning if you're not sure a person has a history of asbestos exposure then you can use

tissue burden of either fibers or asbestos bodies to identify the exposure.

But the history comes first. The history of asbestos exposure is sufficient. And we should probably say this actually that it is recognized as being sufficient to relate the finding of diffuse scarring for the diagnosis of asbestosis, but that in the absence of a history that exposure can be documented through finding of fibers or asbestos bodies.

Now, what you're looking at here on the slide says consistent with excessive asbestos exposure. John Dement wrote in and suggested that phrase consistent with excessive asbestos exposure be replaced by compatible with asbestosis.

Because the examining laboratories vary one to the next. And what one considers excessive is different from what others consider excessive. So he's just suggesting and I think he's right that we should simply say that they find the concentrations of asbestos fibers or asbestos bodies compatible with asbestosis by that very same

examining laboratory.

That lab has evidence. Relatively few labs do this counting of fibers and so they would have experience with asbestos related disease.

So, any comments or questions on that?

MEMBER CASSANO: I have just one comment. The only fear I have with this is that a CE in the absence of history of asbestos exposure is going to tell somebody -- that they cannot accept the finding or something.

CHAIR MARKOWITZ: Right. So --

MEMBER CASSANO: We're not even saying go get a chest X-ray, or go get a CT scan or whatever. The only alternative to the word here of asbestos exposure is a chest X-ray or CT scan according to what we're putting here is a lung biopsy.

CHAIR MARKOWITZ: Right, right. So I think it should be clear that the history is sufficient.

I don't think -- I find it hard to believe that claims examiners can direct the medical care of each individual.

But I see what you're saying. They could not fully appreciate what it means to have a lung biopsy.

So I think I should change the language here to make it clear that the history of asbestos exposure is sufficient, and that in the absence of that history.

Well, you know, if you really don't have a history of exposure, even if you have diffuse interstitial fibrosis it's hard to prove your case.

MEMBER CASSANO: I agree.

CHAIR MARKOWITZ: By the way, let me --

(Simultaneous speaking)

MEMBER CASSANO: -- exposure is a history of disease that finds it before, correct?

(Simultaneous speaking)

MEMBER CASSANO: -- working at a job it's presumed to have had asbestos exposure, correct?

CHAIR MARKOWITZ: My thinking is that if they accept our expanded definition of asbestos

exposure that we recommended previously that that should capture everybody who's got exposure.

MEMBER CASSANO: Okay.

CHAIR MARKOWITZ: Mind you, asbestosis in particular takes a fair amount of exposure. It's not occult exposure that causes asbestosis. Mesothelioma, but not asbestosis.

MEMBER CASSANO: Right.

CHAIR MARKOWITZ: Yes. But it should be clear. Yes, other comments?

MEMBER BODEN: Yes, this is Les. First of all, I think that changing excessive asbestos exposure in the way that you suggested is a very sound idea.

Also, I'm just wondering whether when we talk about a history of asbestosis exposure that in -- if we're writing a presumption that someplace in the presumption we refer specifically to what we mean by that.

CHAIR MARKOWITZ: The history?

MEMBER BODEN: Yes.

CHAIR MARKOWITZ: Yes.

MEMBER BODEN: And presumably the history also includes -- I'm trying to remember how it was worded before because I thought the wording was good, that it was a history, or having a job or task that was considered to be exposure, to have exposure to asbestos.

(Simultaneous speaking)

MEMBER CASSANO: So you could actually have two presumptions. You could have a presumption of exposure and we could list it as a presumption of exposure which is sort of what we did when we talked about history of asbestos exposure.

We might actually call it a presumption of exposure. It should be presumed that a person is exposed to asbestos if they have worked in whatever facilities, or done whatever jobs over a period of seven years for asbestosis.

MEMBER BODEN: Right.

CHAIR MARKOWITZ: Well, yes, in April we approved the exposure presumptions.

MEMBER BODEN: We just want to make

sure we incorporate it in this document.

MEMBER CASSANO: Maybe we should say an alternative for history, and we tell that history of exposure here we should say as per whatever the document is that contains our previous recommendation on how you define history of asbestos exposure.

CHAIR MARKOWITZ: Right. That's good. In fact, we might even repeat it here. I have a slide with -- in case they don't accept our previous recommendations, right?

(Laughter)

CHAIR MARKOWITZ: And that could happen, that could happen.

MEMBER BODEN: Right, in which case you can't refer back to it.

CHAIR MARKOWITZ: Exactly. Rejected recommendations. Okay, fine.

MEMBER WHITLEY: Garry here. What they're going to do -- a claims examiner going to do automatically is they're going to go to the SEM database. That's where they're going to get their

history of exposure.

So if you were a pipefitter, asbestos worker, that stuff, you're fine. If you look at the buildings that says they contain asbestos, they show all of them in the whole plant.

You go down to a supervisor or even though he worked in that building with a crew every day, if you go down to a supervisor and look up to see if he was exposed to asbestos even though he's in that building it will say no. No, no.

Claims examiners are going to use the SEM database to help you, but they're also going to use it against you if you're not listed in it.

CHAIR MARKOWITZ: Yes, I'm just trying to bring up our recommendation on asbestos exposure.

This is from our recommendation from April which is on the exposure side. We recommended at least 250 days of exposure, job title, on the presumption side any maintenance or construction worker. And this would be exposure prior to 2005 with a minimum of 15 years.

Anybody who doesn't make that presumption would be individually evaluated.

So I don't know, Garry, if that addresses the scenario that you raised here or not. But that was our discussion of documenting asbestos exposure previously, at least for asbestosis.

MEMBER WHITLEY: Garry here. I think the only way you can do it properly because you're going to be fighting against the SEM database. So, if you're not listed there you're going to have to prove it otherwise.

CHAIR MARKOWITZ: Right. You know, again, for asbestosis you need a fair amount of exposure to asbestos. So it should be provable.

And I'm not talking about industrial hygiene data. I'm talking about description of tasks, description of work that a person did, job title. In this one we're okay.

So let's move onto the next slide.

MEMBER SILVER: Before we move on, this is Ken. The lung tissue burden can also be

demonstrated on autopsy tissue.

CHAIR MARKOWITZ: Yes. It's not specific here. It could be a biopsy or autopsy.

MEMBER SILVER: Thank you.

CHAIR MARKOWITZ: Next slide. Here's for asbestos pleural disease, a history of asbestos exposure. Again that harkens back to our previous recommendation.

And then finding on chest X-ray or CT a unilateral or bilateral pleural thickening, or plaques that's not readily explained by another cause.

And that should be sufficient for most doctors to be able to make a decision as to whether it's asbestos related pleural thickening or not.

It gets tricky when a person has had heart surgery and you see diffuse or relatively extensive pleural thickening at the bottom of the lung on one side, and was that asbestos exposure or was that the surgery.

And doctors may disagree, but no amount

of definition is going to resolve that. That's just judgment.

MEMBER CASSANO: Going back to the prior slide. You don't have to go back, but just thinking about the prior slide -- why can't somebody -- if somebody has fibrosis but no history of asbestos exposure and they have pleural plaques with no other explanation for them.

I mean I have always been told and have always considered pulmonary fibrosis and pleural plaque as sort of capping -- or asbestosis.

So why can't we use the presence of pleural plaque with the fibrosis as definitive of asbestosis?

I know there's some other things that can do that, but not a whole heck of a lot.

CHAIR MARKOWITZ: Yes. That's a good idea. Let me -- I will draft some language that addresses that.

Again, it takes a lot of asbestos exposure to get asbestosis.

MEMBER CASSANO: Yes.

CHAIR MARKOWITZ: And so it's unlikely to be occult, you know, or not noticed. But if a person really isn't in the right job title, doesn't report it, but has pleural plaques and interstitial fibrosis then I would probably lean towards asbestosis as you say.

So let me add some language to reflect that. Which we don't have to draft here because we're just working this up, but when we meet.

I'll circulate another version of this before the meeting in October or November.

MEMBER CASSANO: I could give you some language, but you probably will be better at it than I.

CHAIR MARKOWITZ: I mean, I'll draft it and everybody can look at it and chime in. Or if you want to send over language that's fine too. Whichever. That works. Other comments?

Okay, so let's go -- let's see, we're at pleural disease. Any comments on this particular slide? You notice we're not quantifying how much pleural thickening. We are

leaving it open as whether it's one side or both sides. And I think that's appropriate to not get any more specific than this.

MEMBER VLIEGER: This is Faye. I have a question and it comes from the fact that I have a recent claimant that went through the IH in D.C. who we interviewed at our meeting there.

And this person was an asbestos insulator, but not for 15 years. He was there for 17, 18 months, but he was an asbestos insulator.

During the time period where they weren't required to wear masks or alternative air.

And the IH said that his exposures would have been incidental and infrequent and thereby sending it to a CMC who of course was not going to disagree with the IH.

And of course the answer came back that his lung condition, not asbestos disease, but his lung condition was not caused or contributed to his asbestos exposure.

How are we going to get away from this being sent to the IH who presumes, or has to presume

that the person worked or was exposed to asbestos? I don't know how we're going to get away from that part of the law that says you have to prove exposure. You know, you have to prove exposure.

CHAIR MARKOWITZ: This is Steven. Again, if our prior recommendation is accepted for that outcome, either pleural thickening, or pleural plaques, or asbestosis, if a person has 250 days of exposure certainly that person was an insulator, so they're like number one on the job title list.

If they had 18 months of work then they would make it as a matter of presumption.

MEMBER VLIEGER: You would think that, but the other thing that of course they threw out there again was, well, you know, smokers have this happen to them too, therefore that in a short period of work this couldn't have happened.

I don't know how we can get away from an IH and a CMC doing the same song and dance that they haven't already done here. If it gets sent to a CMC.

CHAIR MARKOWITZ: Well, there's no

amount of guidelines that we can recommend that would get around the problem of misapplication or incorrect decisions.

Although, another recommendation that we're going to take a look at, there are a number of CMC decisions or recommendations or opinions and then look at their level of accuracy.

MEMBER VLIEGER: Okay, well I'm just trying to figure a way in this wording that it doesn't have to go out to an outside source. So far these are still recommendations I understand, but somewhere in the wording it's like well, I know this is presumptive, but we haven't said don't do the other things.

They still always have the option of doing the other things.

CHAIR MARKOWITZ: Yes, but we've also in other conversations have been circumspect about the claims examiner making decisions that they're not really qualified to make.

But you know, the idea of adding more specific diagnostic criteria would also help the

treating physician because there are guideposts the treating physician could -- this is how the program looks at evidence for these entities. It's now more specific than it was previously.

And then they in their letter if it's true or cite that, okay, my decision on asbestosis is based on review of the chest X-ray which showed bilateral and diffuse interstitial fibrosis in mid and lower lung zones.

And the CE then should be able to match up what the treating physician has said with the evidence that we're recommending and say yes, that's the case. No need to send to the IH or CMC. We're done.

I think the added specificity would allow both the treating physician get a better sense of what's required, but also allow the CE to make a decision and not do what you're worried about which is sending it to an IH or CMC who's going to make the wrong decision. Does that make sense?

MEMBER VLIEGER: It does. I guess part of my frustration is we work on these things

and it's all logical and good, and then back in the trenches we're still dealing with the idiocy.

CHAIR MARKOWITZ: Well, you know, the application, should they accept these recommendations, the application, we should get around to figuring out how to help monitor the application of these things so that they're applied appropriately.

MEMBER SILVER: Ken Silver here. We might start generating a list of issues that we want to remark upon with great emphasis in our accompanying rationale.

The pathogenicity of plaques in asbestos, what smoking does and does not contribute to lung cancer and fibrosis as I understand it.

And maybe the phenomenon of short-term high-level exposure causing chronic asbestosis years later.

I think findings back from the late seventies, early eighties of lung bumps in an amosite plant you know, still cited.

So if you put a big emphasis on that

in the rationale at least advocates can say look, we told you so.

CHAIR MARKOWITZ: Also the rationale would be accessible to the physicians who are part of the process meaning the treating physician and the CMC. So it would be useful.

Yes, I haven't transferred the rationale but when I do and send it around, if it doesn't have those points, Ken, throw them in there.

MEMBER SILVER: Okay.

CHAIR MARKOWITZ: Other comments on this? So let me see. It's 2:15. Do people want to take a five-minute break? I have three or four more slides. But if people want to take a break we can.

MEMBER BODEN: I'm okay going on, but maybe other people --

MEMBER CASSANO: I'm okay.

CHAIR MARKOWITZ: Okay. So let's continue then. Okay, next slide then.

So this is for pleural effusion. This is a very uncommon condition and I'm a little

surprised actually to see it in the language of the manual.

But there's no definitive way of making the diagnosis. You need the history of exposure and then you need an unexplained pleural effusion.

Even in such a population 9 times out of 10 that pleural effusion is going to be caused by something else like heart failure, or inflammation, or very common causes.

So this definition should be sufficient. I don't think the claims examiner is really likely to be able to make this call, but treating physician and the CMC certainly could.

Because if a person has inflammation infection or a heart failure that should be pretty apparent from the medical record or from examining the person.

More than a dozen claims for this I'd be surprised. It's a very unusual condition especially these days.

Any comments on this? Okay. So let's go on to the next slide.

Okay, so this is important because these are common outcomes. And these are all the cancers that are recognized as being related to asbestos.

So how do we want the claims examiner to look at a case. Generally they are looking probably at present and they should look for pathology reports because there's either a biopsy, or autopsy, or surgery in which they've taken a whole bunch of tissue.

And it says on the pathology lung cancer it says mesothelioma or cancer of the ovary or larynx. It won't say asbestos, but that's not needed for this process.

The history of exposure comes from different kind of evidence.

There are some instances, particularly in older people, who aren't well enough to undergo a biopsy, or surgery, or there's no point in doing surgery.

They may not come to autopsy. And it doesn't happen very often but it does happen in

which case the physician is left trying to make the best judgment without having tissue whether the person has a cancer and what the cancer is cancer of.

And I think the claims process -- I'm not sure how it works now in terms of these claims, but it has to recognize this group of presumed diagnosis.

And this is not something that the claims examiner would do. It is something that the physician would do.

And that is just by way of example if a person comes in, they've lost weight, they're short of breath, they have fluid in their chest and they have a big mass coming from the pleura then chances are that's mesothelioma.

Or they have a big mass in the lung and no one's going to do surgery, it's too risky to do biopsy, that's going to be a lung cancer with 90 percent certainty.

So this group should be specified in the claims examination process.

Or a death certificate that mentions one of these entities somewhere on the death certificate. Usually not very far down because at least for mesothelioma, cancer of the lung, cancer of the ovary people usually die of those entities.

MEMBER CASSANO: Do we need to say something about with or without looking for a history of smoking? Just because I see a lot of times that the person smoked, they've got lung cancer, it's due to smoking, it's not due to asbestos.

CHAIR MARKOWITZ: Yes, we should put that in the rationale. Rachel has told us that the process doesn't recognize or take into account smoking, but CMCs presumably read this.

We're not quite sure whether they follow everything in the program. And the treating physicians wouldn't be downed by this either.

So in the rationale it should be explicit. Smoking does not contribute to mesothelioma. Smoking does to lung cancer, but

in a way that exacerbates the asbestos exposure, et cetera. We'll put that in the rationale.

MEMBER CASSANO: Okay, thanks.

CHAIR MARKOWITZ: So my question overall about these, is this added level of specificity and pointing out the relative utility of different ways of diagnosing or sources of evidence, would this represent an improvement over the current process.

MEMBER CASSANO: I think if they enlist the doc -- I mean, the doctor would be able to determine that.

MEMBER VLIEGER: I'm sorry, are we on slide 20? This is Faye.

(Simultaneous speaking)

MEMBER VLIEGER: -- on the WebEx.

CHAIR MARKOWITZ: Yes, we're on 20. We're on the cancer list. Yes.

MEMBER VLIEGER: So as far as all of this it looks pretty much normal the way it runs right now. I don't see any problem with it.

We don't usually have pathology. We

could make a comment on it on the death certificate. But there again we run into the same problem on death certificates as we do with diagnostic paperwork from the physicians here. Unless it's been heavily charted and documented they're not going to make any asbestos diagnosis on a death certificate unless there's been an autopsy and those are not common.

CHAIR MARKOWITZ: So Faye, does that mean if a person has a documented history of asbestos exposure it's recognized by the claims process, but then has lung cancer on the death certificate but it doesn't say anything about asbestos related lung cancer, that that wouldn't necessarily be accepted?

MEMBER VLIEGER: That's correct. That's correct. I have a case right now where the person was in the hospital, had recently been diagnosed with multiple myeloma, had one chemo treatment, went to the hospital with a blood clot and the death certificate says he died from a blood clot. Does not mention the mesothelioma. So the

death certificate is not useful at all unless it's specific.

Even if it's secondary or tertiary cause, it has to be on the death certificate.

But we have the physicians at the largest hospital in the area here for the Tri-Cities that they only put the most immediate cause of death and then to try and get a death certificate amended they refuse. So you have to go through the coroner and that can take up to a year because the coroner is busy with the most recently dead, not the more longer dead.

And in the two cases I had to have death certificates amended it took more than a year.

CHAIR MARKOWITZ: Right. Wow. Well, the problem is not DOL or the program, the problem is the healthcare system that doesn't get the death certificate right.

MEMBER VLIEGER: Well, yes, that's the problem. What I see more of a problem is that DOL has the physicians running scared because the program guidelines are not clear.

And there are no pamphlets out to the doctors that say this is what I accept for mesothelioma. This is what we accept for COPD. This is what we accept for asthma.

The department has failed to do that probably to their own benefit. So the doctors take two steps back for a couple of reasons.

First of all they did not go to school to play legal beagle.

Secondly, the state labor and industry's claims system has all of them running scared that they're going to have to spend a day of clinic time in depositions.

So the Department of Labor program because it doesn't specify and it doesn't provide an easy way for them to understand what's going on, they think it's like every other worker compensation program which is going to require them to not have office time for patients, but to have to do legal maneuvers.

So, I think the department could do some things to improve this, but right now no, they don't

make it easy.

And by the same token as when we look on the CMC side of things the CMCs are barely vetted. And as you saw in the decisions we reviewed don't even follow program guidelines because there's no clear program guidelines given to them either.

CHAIR MARKOWITZ: If we can develop some consensus diagnostic criteria I think it will be useful by all elements, the treating physicians, the CMCs, the claims examiners.

This should provide some greater basis for making decisions and more uniform as well.

Doctors not wanting to participate in legal processes, compensation systems and the like, that is a huge problem everywhere in relation to workers compensation, any federal compensation program, tort litigation, you name it. It's just universal.

You lecture first-year medical students and mention lawyers and they boo you. It's a problem.

MEMBER CASSANO: Steve, tangential to

this. A recommendation that we could make is that in these areas where there's large numbers of claimants, et cetera, that there should be some program, it doesn't have to be -- somebody should be going to the hospitals and maybe doing grand rounds, or even a lunch and learn if you will on some of these issues for the local physicians inside -- how to fix it.

It's obviously outside of our purview, but maybe it's not. Maybe it's something we could do when we do one of these meetings. Have a two-hour session for local docs in a meeting to talk about some of these issues.

CHAIR MARKOWITZ: The Department of Labor --

MEMBER CASSANO: I don't know if that's in our purview or not, but it should be done by somebody.

CHAIR MARKOWITZ: The Department of Labor has a joint task force with NIOSH and with DOE. I think it was the Ombudsman's Office to do these public meetings to discuss compensation

program, former worker program and other things.

And conceivably they could engage the former worker programs to do this kind of medical education.

MEMBER CASSANO: Yes.

CHAIR MARKOWITZ: Part of the problem is frankly we don't think the doctors would show up because they're not all that interested.

MEMBER CASSANO: Well, unless somebody gave them CME credits. Then they would.

MEMBER SILVER: This is Ken Silver. Going back to this slide. Faye if this were adopted the connecting word is "or." Would you have been able to use number 2 in your mesothelioma case where the death certificate said blood clot? Would you be able to win the claim based on number 2 on this slide?

MEMBER VLIEGER: If there's clinical evidence then they would be eligible for Part E. But under Part E the death certificate wouldn't match the clinical.

And so in order to qualify for survivor

benefits the death certificate, the reason they died has to be a covered condition or a later covered condition.

And the death certificate would not match in this case and therefore there wouldn't be no survivor benefit.

The only caveat to that is if there was a claim in place at the time of death and the department was dawdling and the person died, then the Russero ruling would come into play with the survivor claim where they would be eligible for benefits.

But that only applies if there is a claim in process that the Department of Labor has administratively dawdled on. And then Russero would come in play because the family would be eligible for the claims that would have been eligible while the claimant was alive.

In most cases when you're dealing with a claim filed posthumously and the death certificate does not match for a condition covered under Part E, and that's what asbestos would be,

then you would either have to get an autopsy done, or you would have to have your death certificate changed.

And both of those are similar to having baby elephants.

MEMBER SILVER: I believe diagnostic criteria would work for causation for like a wage loss claim, or coverage in medical benefits, but then for survivors claims someone would have to administratively extend our logic and override the death certificate requirement.

MEMBER VLIEGER: Exactly.

MEMBER SILVER: Okay.

CHAIR MARKOWITZ: This language we're looking at actually would provide the basis for that, a rational medical basis for that decision.

MEMBER SILVER: Right.

MEMBER VLIEGER: Yes. If there's enough medical evidence that it's pretty clear-cut the coroner doesn't have any problem doing the change. But we have to have the documented medical.

I haven't had to use an autopsy result to change a death certificate. I have one pending right now and I don't know what the outcome's going to be.

MEMBER CASSANO: So if it requires a medical opinion working with a -- if I'm understanding this right it works like the ABD I work with it would be a medical opinion that states that if it doesn't at the cause of death then the mesothelioma despite what -- that the contributory cause of death was mesothelioma despite what is on the death certificate. Am I correct, Faye?

MEMBER VLIEGER: That or enough evidence that they were diagnosed with it prior to their death. And as long as it was being actively treated it should have been listed on the death certificate.

MEMBER CASSANO: If it wasn't on the death certificate then -- we may be able to come up with some language that basically says if there is current evidence yada yada yada at the death certificate that's not included as a contributory

-- secondary or contributory cause then the claims examiner should forward it to the CMC for a decision.

I think that would work. And then we'd give the CMC guidance on that.

MEMBER BODEN: Can I just ask a question about this last slide just to clarify. So these are diagnostic criteria for example for cancer of the lung, not necessarily asbestos related cancer of the lung.

CHAIR MARKOWITZ: Right.

MEMBER BODEN: Right? Okay. So if then one wanted to tie it to occupation one would need additional exposure evidence.

CHAIR MARKOWITZ: Right.

MEMBER BODEN: Yes? Okay. Just to clarify for me. I wasn't sure I understood that right.

CHAIR MARKOWITZ: Right. And for the other conditions in every instance we mentioned the history of asbestos exposure because they were asbestos specific conditions like asbestosis,

pleural disease or the like.

But here I could have added a slide to say related to asbestos requires fulfilment of the criteria plus a history of exposure.

MEMBER CASSANO: Well, what about mesothelioma just for relevance.

CHAIR MARKOWITZ: You know, actually in our recommendation for mesothelioma we said 30 days and a minimum of the right job title or a history of exposure or the like.

So there should be some documentation of the asbestos exposure. But it usually doesn't require much.

MEMBER CASSANO: Okay.

CHAIR MARKOWITZ: Tori, getting back to your point, your suggested language, if you want to draft something and send it to me.

MEMBER CASSANO: I believe that's about what I was going to say. Oh it was about pleural plaque plus sarcoidosis.

CHAIR MARKOWITZ: No, this was about the issue that Faye was raising about the use of

clinical information --

MEMBER CASSANO: Okay, so --

CHAIR MARKOWITZ: -- for a physician to opine on a cause of death when the death certificate doesn't mention.

MEMBER CASSANO: Okay. I will do that.

CHAIR MARKOWITZ: Yes. I mean, it's a bit of a tough hurdle because you're seen as sort of second guessing the doctor who actually attended the death and filled out the death certificate, but it's worth putting in there I think.

MEMBER CASSANO: You know, I see a lot all the time it's cause of death heart attack. Well, the heart attack is secondary to the fact that the person had pleural -- or whatever, but the final event is always the heart stops.

So, I don't think it's difficult and I think once it's explained, the claims examiners and to the agency that it could be -- I don't think it's going to be difficult to make it happen.

CHAIR MARKOWITZ: The other thing of

course is that frequently the physician filling out the death certificate is the person who happens to be in the hospital when the person died. And they're typically being a resident.

So they may be covering for somebody else and may not even know the patient or what the patient's illnesses are.

So that's not apparent to the outside world, but it generally happens.

MEMBER CASSANO: Yes. Okay, so I can do that.

CHAIR MARKOWITZ: Okay, so if we're done with asbestos let's move onto the last slide.

And here I'm not expressing an opinion, I'm just raising issues. I went through the claims -- the procedure manual for other conditions that it mentions.

It does mention at the end of chapter 2 or whatever the new chapter is Parkinsonism without saying much about it other than treating the various synonyms for Parkinsonism meaning Parkinson's disease, Parkinson syndrome,

Parkinsonism to treat them as the same.

It doesn't weigh in in terms of exposures.

And then there's an exhibit which is an attachment or an appendix to the manual which lists -- which is an old thing I think from the beginning of the program which lists a number of different entities including peripheral neuropathy, damage to the nerves of the arms and legs caused by a toxin.

It also mentions something called toxic encephalopathy, chronic toxic encephalopathy which is brain damage due to chronic exposure to certain toxins such as metals or solvents in particular. But it doesn't really go into any detail.

And then also it just very briefly mentions chronic kidney disease.

I don't know that there are many claims for these conditions so it's hard -- we can ask DOL if there are, because if there are not I don't think there's any rationale for trying to design presumptions.

MEMBER CASSANO: Well, I just wonder if the reason there aren't any claims for them is that people don't know that organic solvents, toxic encephalopathy or Parkinson's disease.

And the literature is pretty replete now with both epidemiologic and toxicologic studies that tend to prove that association.

I think the other one might be -- and again, organic solvents, specifically benzene -- I don't know how many of these people were exposed to benzene, and acute myelogenous leukemia.

I don't think we should use how many claims are there. I mean, I don't want to open up another can of worms for the agency either, but people that have diseases that are related to their work should be compensated.

But I don't think we should start with how many claims. I think we should look at the form and see what the major toxicants are in the workplace. And if we see major toxicants that we know definitively cause disease then those are easily turned into presumptions.

And I just mentioned the two of them. There's benzene in AML and Parkinson's and both manganese -- if there's an extension of manganese, I don't know if there is.

So, primarily two to use.

MEMBER VLIEGER: This is Faye. DIAB, the board that I still chair on though it's gone kind of dark did a list of diseases most likely denied by the department. I can resurrect that list and send it.

But of the things that were more routinely denied was peripheral neuropathy, Parkinsonism, dementia, chronic encephalopathy, toxic encephalopathy.

So I can resurrect that list. But what we had done was look at the statistics from the Department of Labor and look at the things that were most likely denied.

So if you want I can resurrect that and send it out.

CHAIR MARKOWITZ: Sure.

MEMBER VLIEGER: All right, thank you.

CHAIR MARKOWITZ: The issue of whether they should come to presumptions depends on a number of factors like is there enough information to make decisions.

There may be that a number of these different conditions, either a high denial rate, or a fair number of denials, not referring to rate, that the issue of not lack of presumptions but the issue is that the SEM is incomplete or inaccurate, or the claims process doesn't recognize certain aspects of these diseases.

Or if a person has diabetes the neuropathy is always chalked up to the diabetes and never to the toxin.

That's separate from the issue of whether there should be presumptions.

So I guess we may need to figure out what the particular issues for these conditions are first before deciding whether they're appropriate to try to elaborate presumptions.

MEMBER CASSANO: You mean as far as DOL is concerned, as far as the exposure is concerned,

or what?

CHAIR MARKOWITZ: Well, it could be exposure, it could be the diagnostic criteria. It can be any aspect of the process.

MEMBER CASSANO: Okay.

CHAIR MARKOWITZ: But that may involve -- I mean, if we believe that toxic neuropathy might be an issue that's not -- that there is some suspicion it isn't being addressed properly then we could look at a certain number of cases of toxic neuropathy denied and accepted and see how the decisions are made and whether we think there's any room for improvement.

And that's what occurred before the issue of developing presumptions.

MEMBER CASSANO: Yes. We could look at the Parkinson's disease too because I don't know. I mean, I'm not -- organic solvents have to be a huge exposure issue in this area. I am assuming that. I don't know if that's true.

Can somebody educate me on that?

CHAIR MARKOWITZ: Solvents?

MEMBER VLIEGER: I'm sorry, is the question that we're --

MEMBER CASSANO: Solvent exposure has to be there in these facilities.

MEMBER VLIEGER: So I don't know if anyone goes home and plays with them on purpose.

MEMBER CASSANO: Excuse me?

MEMBER VLIEGER: Yes, it would have to be occupational. Like I said, I don't know of anybody that goes home and plays with these things on purpose.

MEMBER CASSANO: Yes, I mean people work on their own cars, they use degreasers, they ship furniture at home, et cetera. So some of it can be from home, but usually that's incidental. It's not chronic low-level or chronic moderate level.

So, I think we need to know how -- I think looking -- and that's something I guess Rosie's group and my group could do once we get past our next meeting is start looking at these neuropathy and the Parkinson's disease claims and

see whether the evaluation specifically by the CMC and/or the industrial hygienist are appropriate.

I hate to make more work for Rosie.

CHAIR MARKOWITZ: I think that makes sense. I think we need to understand some of the issues better with some of these entities before deciding which recommendations we might make.

MEMBER CASSANO: I was only looking at it from out of these things what is the definitively proved as a causal. That's all I was looking at. I wasn't looking at it from the perspective of the agency.

MEMBER SILVER: Kidney disease is interesting. This is Ken Silver. In that there's a lot of diabetes out there and there's a lot of uranium at these sites and many organic chemicals have been shown to cause various kinds of kidney damage in animals in particular.

And there's evidence of synergistic effects.

So if the statistics from DOL suggest that kidney disease looms large, the issue is them

getting people to take a look at that.

MEMBER CASSANO: Well, certainly, yes, kidney disease and adrenal carcinoma is another one related to organic solvents. Specifically CTE.

MEMBER SILVER: And we did look at a claim that was pretty much a slam dunk a few months ago. It was paid, but -- teasing apart kidney disease due to diabetes versus uranium exposure.

There were two cases at Los Alamos. Both had happy endings for the claimants. But it's a very small sample.

A much larger n in the DOL system.

MEMBER CASSANO: That's part of the problem with how we look at these cases is that they're not randomly picked. And I think we saw that when we went to Seattle.

So, I'm not sure if there's some way to get a list of what's been adjudicated this month and randomly pick rather than having each district office pick the ones they want to send to us.

Faye, you may want to elaborate on that

a little bit more based on our meeting in Seattle. But we'll deal a lot more with that on Tuesday I think is when we meet, correct?

MEMBER VLIEGER: The 27th, isn't that Monday?

MEMBER CASSANO: The 27th.

CHAIR MARKOWITZ: That's Tuesday, 11:30 a.m.

MEMBER VLIEGER: Yes, Tuesday. This seems, and I don't know how random random is when you're doing a specific district office and we're looking at claims from that district office.

It just seems that the claims process is becoming so convoluted that anything we can do to keep it from becoming as convoluted as it is.

Maybe taking out as much as possible the individual decision-making.

I agree that when we went to Seattle -- the people seemed to generally know what they were doing. What we were working with was pretty picked.

CHAIR MARKOWITZ: Pretty what?

MEMBER CASSANO: Yes, there wasn't anything really controversial that we saw. It was one case that they actually agreed was adjudicated incorrectly and they were going to take another look at it.

So I'm not sure if we saw the best of what there was, or whether -- I know it wasn't a random sample because they picked them based on their medical interests from the supervisor's position.

I don't know that we could get really down and dirty in looking at these, other than to say send me a list of numbers of all the Parkinson's disease cases who have been adjudicated this month and I'll just randomly pick numbers.

I don't need the files initially, I just need the case numbers and I'll just randomly pick numbers, or somebody will randomly pick numbers. And that's a little bit better than somebody -- I'm hoping they're not cherrypicking them, but they probably are a little bit.

MEMBER WHITLEY: This is Garry. If

you do Parkinson's you need to do current cases because if you go back three to five years ago they didn't pay for Parkinson's at all.

MEMBER CASSANO: Right. Because there was not a lot of definitive evidence that organic solvents caused it.

MEMBER WHITLEY: Right. But recently they have been paying for a few at least in our area that I see Parkinson's.

Neuropathy they used to not pay at all. Now they're paying some neuropathy cases if there's no signs of diabetic even in the family -- of diabetes even in the family.

If there's any signs of diabetes they'll throw it out in a hurry.

The one they won't touch is pancreatic cancer. I don't know anybody that's been paid for pancreatic cancer. I could be wrong, but everybody I know, they get back a letter that says there's no evidence of any chemicals that cause pancreatic cancer.

MEMBER VLIEGER: To clarify, that's

only under E for toxic exposure, not Part B.

MEMBER CASSANO: There is some limited evidence for I forget what it is, an association, but it's pretty darn weak for pancreatic cancer. Unless -- could arguably disagree I don't think with not compensating pancreatic cancer. There's just not enough -- there's nothing practically out there about toxic etiology of pancreatic cancer. From what I've been able to see.

CHAIR MARKOWITZ: I agree.

MEMBER SILVER: So in terms of a process we could ask DOL for more systematic sampling, or counts of cases where these issues may come up.

Another thing we might do is if the advocates who are listening to weigh in with, you know, helpful one-page emails to flesh out where we might be useful on developing new presumptions.

MEMBER VLIEGER: I want to agree with Garry that Parkinson's disease even with adequate information is a hit or miss entity to get it accepted.

And recently I had a case accepted that had been pending for more than a year.

I cannot tell you the difference between the information provided in that claim and the other claims that got accepted and five others got denied.

It just seems very eclectic with what they accept and don't accept. And it hinges on the contract medical consultant report.

MEMBER CASSANO: Probably hinges a lot on the knowledge of the CMC.

MEMBER VLIEGER: I'm not willing to cast any aspersions but I totally agree with you.

MEMBER CASSANO: Because -- and it changes every month practically.

CHAIR MARKOWITZ: So we have just five minutes left, and I wanted to try to see if we could figure out what our next steps are.

And I would actually think that the report that Faye talked about a while back which was cases frequently denied, even though it would -- you couldn't publish the results in a journal

it might actually be useful to us.

Because we certainly want to try to pick up on diseases that were controversial but where there were enough cases that our presumption would help more than a couple of people.

And then if we pick diseases that we want to look at next that we ask for a listing of all the cases in a certain time period where this disease was at issue, just the case numbers, and then we pick a random sample and take a look.

MEMBER CASSANO: I think that's a good idea.

MEMBER VLIEGER: This is Faye. I have a copy of the data that was assembled by the Institute of Medicine for the program under -- by request from the Department of Labor.

And I'm going to be sending that to Carrie shortly.

In the top 10 are a number of malignant neoplasms of different places. But something that is commonly denied as emphysema. I've seen a turnaround in that.

So I will send this out. And this is from -- IOM was contracted by the Department of Labor. So this is from 2011 but I know I've got another list that DIAB and NTAC put together as part of what we would need to recommend things to the Department of Labor.

I'm sorry, I'm still looking for that one.

MEMBER CASSANO: I can get the full IOM report as well. I mean, anybody can. It's nid.edu and just send it out.

MEMBER BODEN: One other thing that we have to remember is it may be that particular entities that are frequently denied are actually denied for good reason. So it is an -- we have to keep in mind.

CHAIR MARKOWITZ: And we should ask or re-ask DOL if they have a list of the frequency of denied conditions.

I think we've asked that before but I don't recall the specifics. But we should at least try or try again if they have information on that.

So, is there anything -- I think we've pretty much discussed most of the things that are relevant and even other things. No? Talk is good.

Are there any other things relating to presumptions that we need to discuss today? Otherwise we should adjourn.

Okay. So I'm going to -- let's see, I think Tori is going to send me some suggested language. I'm going to modify some of the things based on comments on the call. Then John Dement's written comment.

I'll draft a rationale to go along with this and then circulate this before our fall meeting.

I don't think that we have enough business to call for another presumptions working group meeting prior to our fall meeting. Does anybody think otherwise?

MEMBER SILVER: Is following up with DOL to see how they're receiving our recommendations something for the working group or something for the full board?

CHAIR MARKOWITZ: That's for the full board. Doug gave us a brief report on Monday that things are either within the program being worked on or in the Secretary's office. And that's all we know at this point.

But we'll continue to monitor it. And continue to send in new recommendations.

MEMBER BODEN: Okay, well Steven, your fear of not having to end well before our designated time has been allayed.

CHAIR MARKOWITZ: Okay, that's good. Okay, thank you and we'll continue to communicate around this particular presumption medical section for asbestos related disease.

And then we're going to set the schedule for the full meeting in October or November so you'll hear from Carrie. Thank you.

(Whereupon, the above-entitled matter went off the record at 3:00 p.m.)