

UNITED STATES DEPARTMENT OF LABOR

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ADVISORY BOARD ON TOXIC SUBSTANCES AND WORKER
HEALTH

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SUBCOMMITTEE ON MEDICAL ADVICE FOR CES REGARDING
WEIGHING MEDICAL EVIDENCE (AREA #2)

+ + + + +

MEETING

+ + + + +

TUESDAY,
JULY 12, 2016

+ + + + +

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

MEMBERS

SCIENTIFIC COMMUNITY:

KENNETH Z. SILVER
LESLIE I. BODEN

MEDICAL COMMUNITY:

VICTORIA A. CASSANO, Subcommittee Chair

CLAIMANT COMMUNITY:

**DURONDA M. POPE
FAYE VLIEGER**

OTHER ADVISORY BOARD MEMBERS:

**STEVEN MARKOWITZ, Board Chair
KIRK D. DOMINA**

DESIGNATED FEDERAL OFFICIAL:

CARRIE RHOADS

TABLE OF CONTENTS

	Page
Introduction	4
Purpose of Meeting	10
Define Issues and Scope of Area	14
Define Data and Informational Needs	19
Draft Initial Work Plan and Time Table	107

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
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21
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P-R-O-C-E-E-D-I-N-G-S

1:07 p.m.

OPERATOR: Welcome and thank you for standing by.

At this time, all lines are in listen only mode.

This call is being recorded. If you have any objections, you may disconnect at this time.

I would now like to introduce your host for today's call, Ms. Carrie Rhoads.

You may begin.

MS. RHOADS: Thank you.

Good morning or afternoon everybody. Sorry we're starting a few minutes late.

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

I am the Board Designated Federal

1 Officer, or DFO, for today's meeting.

2 First, we do appreciate the time and
3 work of our Board Members in preparing for this
4 meeting and for their time today and the work
5 they'll be doing after this.

6 I'll introduce the Board Members on
7 the Subcommittee and do a quick roll call.

8 Dr. Victoria Cassano, the Chair of the
9 Subcommittee.

10 CHAIR CASSANO: Here. Good morning
11 everybody.

12 MS. RHOADS: Thank you.

13 And, Members are Dr. Leslie Boden.

14 MEMBER BODEN: Here.

15 MS. RHOADS: Ms. Faye Vlieger.

16 MEMBER VLIEGER: Present.

17 MS. RHOADS: Ms. Duronda Pope.

18 MEMBER POPE: Here.

19 MS. RHOADS: Dr. Ken Silver.

20 MEMBER SILVER: Here.

21 MS. RHOADS: And, Dr. Steven
22 Markowitz, the Chair of the Board is also on the

1 line as is Kirk Domina, another Member of the
2 Board.

3 Melissa Schroder from our contractor
4 is in the room with me and we're scheduled to
5 meet from 1:00 to 4:00 p.m. Eastern Time today.

6 Just in terms of timing, we're
7 planning on taking about a ten minute break at
8 around 2:30, depending on where the discussion
9 is.

10 We'll just mute the lines at that
11 time, you should not hang up and call back in,
12 just wait and we'll reconnect after about a ten
13 minute break.

14 Copies of all the meeting materials
15 and any written public comments are or will be
16 available on the Board's website under the
17 heading Meetings and the listing after this
18 Subcommittee Meeting.

19 The documents will also be up on the
20 WebEx screen so everyone can follow along with
21 the discussion.

22 The website can be found at

1 dol.gov/owcp/energy/regs/compliance/advisoryboard.htm or simply Google Advisory Board on Toxic
2 Substances and Worker Health and it'll likely be
3 the first thing that comes up.
4

5 If you haven't already visited the
6 Board's website, I encourage you to do so. After
7 clicking on today's meeting date, you'll see a
8 page dedicated entirely to today's meeting.

9 The web page contains publically
10 available materials that were submitted in
11 advance of the meeting. These documents are also
12 on the WebEx screen.

13 We'll publish any materials that are
14 provided to the Subcommittee.

15 You should also find today's agenda as
16 well as instructions for participating, we won't
17 read that.

18 If you're participating remotely and
19 you're having a problem, please email us at
20 energyadvisoryboard@dol.gov.

21 If you're joining by WebEx, please
22 note that this session is for viewing only and

1 will not be interactive.

2 The phones will also be muted for non-
3 Advisory Board Members.

4 Please note that we do not have a
5 scheduled public comment session today. The
6 call-in information has been posted on the
7 Advisory Board's website so the public can listen
8 in but not participate in the Subcommittee's
9 discussion.

10 The Advisory Board voted at its April
11 26th through 28th meeting that Subcommittee
12 meetings would be open to the public.

13 A transcript and minutes will be
14 prepared from today's meeting. The transcriber
15 is on the line as well.

16 During voice discussions today, as
17 we're on a teleconference line, please speak
18 clearly enough for the transcriber to understand.

19 When you begin speaking, especially at
20 the start of the meeting, please state your name
21 so that we can get an accurate record of the
22 discussion.

1 Also, I'd like to ask the transcriber
2 to let us know if you're having an issue with
3 hearing anyone or with the recording.

4 As DFO, I see that minutes are
5 prepared and are certified by the Chair. The
6 minutes of today's meeting will be available on
7 the Board's website no later than 90 days from
8 today per FACA regulations.

9 But, if they're available earlier, we
10 will be publishing them earlier.

11 Although, formal minutes will be
12 prepared, we'll also be publishing the verbatim
13 transcript, which are obviously more detailed in
14 nature.

15 So, the transcript should be available
16 on the Board's website within 30 days.

17 I'd like to remind you, Advisory Board
18 Members, that there are some materials that we
19 have provided to you in your capacity as special
20 government employees and Members of the Board
21 which are not for public disclosure and cannot be
22 shared or discussed publically in this meeting.

1 Please be aware of this as we continue with the
2 meeting today.

3 With that, I convene the meeting of
4 the Advisory Board on Toxic Substances and Worker
5 Health Subcommittee on Medical Advice for Claims
6 Examiners Regarding Weighing Medical Evidence.

7 I'll now turn it over to Dr. Cassano
8 who is the Chair.

9 CHAIR CASSANO: Thank you very much,
10 Carrie.

11 Good morning everyone and welcome to
12 this meeting of the Subcommittee on Medical
13 Advice for Claims Examiners and Weighing the
14 Medical Evidence.

15 I first wanted to explain the purpose
16 of this meeting as I believe we understand it.

17 Under the Advisory Board's Charter,
18 there were four broad tasks assigned to this
19 committee to advise the Secretary of Labor
20 regarding several aspects of the program,
21 including reviewing the site exposure matrices,
22 the medical guidance for claims examiners,

1 evidence to our claims under Part B and
2 evaluating the work of industrial hygienists and
3 staff physicians.

4 What we are doing today is trying to
5 strictly stay within that second task, which is
6 medical guidance for claims examiners and
7 weighing the medical evidence.

8 Since this is the first meeting of the
9 Subcommittee, we are primarily laying a roadmap
10 for what we need to do, what we need to
11 accomplish that and how we are going to go about
12 doing that.

13 Prior to any of the Subcommittee
14 meetings, Dr. Markowitz, the Chair of the Full
15 Committee, had requested a relatively broad
16 agenda to, number one, define issues with scope
17 of area; two, define data and information needs;
18 and, three, draft an initial work plan.

19 I have added some specifics to that
20 based on what my perception is of what we're
21 supposed to do, what we need to do it and how
22 we're going to go about it.

1 That may change the discussion today,
2 but hopefully this agenda that's -- the detailed
3 agenda is really sort of a guideline as to how we
4 are going to approach this task.

5 But, before we get into the agenda, I
6 wanted to ask each of the Subcommittee Members to
7 introduce themselves and just a very brief
8 summary of their background as it relates to our
9 task and to the Committee -- the Subcommittee.

10 So, I will start. I'm Dr. Victoria
11 Cassano. I'm an Occupational Environmental
12 Physician.

13 I have spent many years working with
14 disability issues and medical issues around
15 occupational and environmental exposures
16 including radiation and toxic substances.

17 I'm -- everybody -- I'm done, just the
18 next person, so on, Dr. Silver?

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

1 Both in and out of academia, I've been
2 deeply involved for technical assistance
3 projects, so organizations, agencies and
4 individual claimants, some of them under the
5 EEOICPA program and was involved in the ground in
6 Northern New Mexico trying to get the legislation
7 passed and implemented a little over ten years
8 ago.

9 CHAIR CASSANO: Ms. Pope?

10 MEMBER POPE: Yes, Duronda Pope,
11 Retired, Rocky Flats Worker. I worked there for
12 25 years. I am currently with United Steel
13 Workers working in the capacity of responding to
14 emergency response team in either fatality or
15 critical injury.

16 CHAIR CASSANO: Ms. Vlieger?

17 MEMBER VLIEGER: Faye Vlieger, former
18 Hanford Worker, injured worker. I'm a worker
19 advocate under the Energy Employees Occupational
20 Illness Program.

21 CHAIR CASSANO: Dr. Boden?

22 MEMBER BODEN: Hi, Les Boden. I'm a

1 professor at Boston University's School of Public
2 Health. I've had long-term experience in doing
3 research on occupational injuries and Workers'
4 Compensation and occupational disease and was
5 involved in the former worker screening program
6 at Las Vegas. That'll do, I think.

7 CHAIR CASSANO: Dr. Markowitz, do you
8 have any comments to make before we start or do
9 you want to introduce yourself as the Full
10 Committee Chair?

11 CHAIR MARKOWITZ: Sure, Steve
12 Markowitz, I'm a professor at City University at
13 New York. I'm an internist, an occupational
14 medicine physician and epidemiologist.

15 And, I know a fair amount about
16 medical evidence. I don't have any other
17 comments.

18 CHAIR CASSANO: Okay, thank you.
19 Thank you, sir.

20 So, we have been given many, many
21 documents that were considered to be germane to
22 our task. And, for this meeting, I have chosen

1 somewhat, maybe not arbitrarily, but I think
2 because they give a basis for the environment in
3 which people would be working, I've chosen four
4 to review at this at this meeting.

5 And, this review will be a preliminary
6 review to determine, number one, if we think the
7 guidance is correct, if we need any changes, I'm
8 not going to parse any language today, just tag
9 those things where we think there could be
10 something added, deleted, changed or whatever.

11 And, at some point, you know, we have
12 to do this with a cognizance that there is a new
13 rule being promulgated so that some of what are
14 in these programs and directives will, obviously,
15 be changed based on the new rule when it is
16 actually finalized.

17 The four documents that we're going to
18 look at today are simply the Procedure Manual,
19 Chapter 2, Section 0800 which deals directly with
20 the weighing of the medical evidence.

21 And then, the Contracted Medical
22 Professional Statement of Work, the Claims

1 Examiner's Job Description and the final
2 adjudication Board Claim's Examiner Job
3 Description.

4 However, we have additional guidance.
5 If you could go to that advise and consent page
6 and bring that up please?

7 We do have some additional guidance on
8 the Board from DEEOIC regarding what they have
9 requested our help with.

10 And actually, if we go down to the
11 last page of that -- yes, thank you.

12 So they're asking us for clarification
13 and recommendations regarding the assessment of
14 medical opinions, especially as this is -- as it
15 relates to the rationale or the rationalization
16 supporting that conclusion.

17 Methodologies for improving physician
18 responsiveness, training resources for improving
19 quality of medical review of medical evidence,
20 and application and guidance relating to
21 assessing contribution or aggravation of office
22 questions.

1 So, these are very broad areas and I
2 still am not quite sure of how to approach all of
3 this, especially today, but I chose to do it by
4 going through some of these documents.

5 And does anybody else on the
6 Subcommittee have comments to discuss this or a
7 possible system approach to this task or first
8 thoughts? Or we should probably discuss this a
9 little bit.

10 MEMBER BODEN: So, this is Les Boden.

11 So, I'm not necessarily to discuss at
12 this time, but perhaps to keep in the back in our
13 minds, is whether we might be thinking about sort
14 of overall guidance in terms of something like
15 presumptions given certain levels of information
16 about exposure and disease that helps both speed
17 the process and potentially make final decisions
18 more consistent from individual to individual.

19 CHAIR CASSANO: I would agree with
20 that, thank you.

21 And, we can -- I think at the interim
22 we start to discuss how we approach this task. I

1 think we can certainly figure out a way to make
2 that happen because that was something that we
3 were asked to do, but it does not show up on this
4 list.

5 Anyone else with any ideas or
6 suggestions?

7 MEMBER VLIEGER: This is Faye Vlieger.

8 I was hoping that we could, in some
9 manner, avoid the what I'd call my report's
10 better than your report situation and outline
11 when the attending physician is qualified to note
12 his opinion.

13 Right now, what happens is an
14 attending physician in the appropriate specialty,
15 his report more often than not is deemed to be
16 less qualified than any contract medical
17 consultant that the Department of Labor assigns
18 to the claim.

19 CHAIR CASSANO: Yes, I hear you and I
20 understand that is an issue and I think that is
21 something that will come up in our discussions
22 because what the medical opinion, whether it's

1 the CMC or the attending physician, even if they
2 are different specialties, should be about their
3 rationale and what supporting evidence they use
4 to develop their rationale.

5 But, the rule basically also includes
6 issues about the credentials of the person who is
7 making the opinion.

8 But, that's definitely something
9 that's going to come up, so thank you very much,
10 Faye.

11 Anyone else?

12 Okay, if we could go to Chapter 2,
13 Section 0880 and if we can see that, Pat, if we
14 could just go to Section 1, which I believe is on
15 page 1535. If we can get beyond the Table of
16 Contents, thank you.

17 Okay, so let's skip up there, no we're
18 not --

19 (Off microphone comments.)

20 CHAIR CASSANO: So, what I'm going to
21 do is follow Dr. Markowitz's lead at the first
22 meeting and I'm just going to ask someone to

1 volunteer, when we look at -- to read so people
2 can follow where we are -- to read through the
3 sources of medical evidence on this section? And
4 odd job.

5 Anyone? Oh, come on. I know about
6 you all, but I don't want to do all the talking.
7 Can someone actually just read through these
8 evidence on clinical guidance and the medical
9 monitoring portions of all that?

10 MEMBER VLIEGER: I would do it, but
11 first, can I --

12 CHAIR CASSANO: Okay.

13 MEMBER POPE: I'll try it, Duronda
14 Pope.

15 CHAIR CASSANO: Okay, thanks.

16 MEMBER POPE: Want me to start at the
17 top?

18 CHAIR CASSANO: Yes, just start at the
19 top and then we can talk about whether we agree
20 with that or whether we might want to flag that
21 to look at different -- to add or embellish or
22 whatever.

1 MEMBER POPE: Read the whole thing or
2 stop?

3 CHAIR CASSANO: Well, just read the
4 whole thing, that'll be fine.

5 MEMBER POPE: Okay.

6 Sources of medical evidence, most
7 medical reports come from one of these sources:
8 claimant's healthcare provider which includes the
9 attending physician, consulting experts and
10 medical facilities.

11 The CE may consider treatment records
12 from a clinic operated at an employee facility as
13 medical evidence.

14 Department of Energy (DOE) medical
15 monitoring programs administered at certain DOE
16 facilities maintain medical examinations records
17 or exposure data on their employees.

18 For example, the DOE Former Worker
19 Medical Screening Program, FWP, began in 1996 and
20 functions to evaluate the effects of the DOE's
21 past operations on the health of former workers
22 at the DOE facilities and to offer medical

1 screening to former workers.

2 Oak Ridge Institute for Science and
3 Education, ORISE, administers the beryllium
4 screening program by providing beryllium related
5 testing at the locations across the country.

6 ORISE offers extensive testing for
7 Chronic Beryllium Disease, CBD, and medical
8 monitoring to individuals testing positive for
9 beryllium sensitivity.

10 Contract Medical Consultants, CMC,
11 furnishes medical opinions, guidance and advice
12 based on the review of a case file.

13 Moreover, the physicians provides
14 independent and rationalized responses to the CE
15 questions regarding various medical issues that
16 may arise during the case adjudication such as
17 causation, impairment, wage loss or medical
18 necessity of care.

19 Second opinion physicians are
20 physicians contracted by the Division of Energy
21 Employees Occupational Illness Compensation,
22 DEEOIC, to provide a narrative report describing

1 the findings from physical examination of a
2 patient and review of diagnostic testing or other
3 medical records.

4 Referee specialists are physicians of
5 the appropriate specialty chosen randomly to
6 examine the employee or case file and furnish a
7 rationalized medical opinion to resolve a
8 conflict of medical opinions in a case between
9 the employee's physician and a CMC second opinion
10 physician or medical specialist.

11 Types of medical -- go ahead.

12 CHAIR CASSANO: Thank you.

13 Now, does anybody on the Subcommittee
14 have any issues with these sources? Do they
15 believe that other sources should be added to
16 this or -- and the third question is, does
17 anybody have any issues with any of the language
18 utilized with any of the descriptions utilized of
19 these sources?

20 And, I'll just open it up to
21 Subcommittee Members for their input on that.

22 MEMBER SILVER: This is Ken Silver.

1 Minor issue with the wording of 2(b),
2 Medical Monitoring Programs such as the Former
3 Worker Program administered by certain DOE
4 facilities.

5 So, they're talking about two
6 entities, the Medical Monitoring Program is run
7 by the company medical unit, that's the first
8 sentence.

9 But, Former Worker Programs are not
10 administered by DOE facilities. They are, you
11 know, independent, many of them are run by
12 universities, by some of the people on this call,
13 for example.

14 So, I'm wondering if that would lead
15 a naive claims examiner to give privilege
16 consideration to the company doctor and to not
17 appreciate the independence of the Former Worker
18 Program.

19 CHAIR CASSANO: That's an interesting
20 comment and know somebody is taking notes, but
21 that is something that when we go back and with a
22 working group, we can parse language at that

1 point.

2 I think it take us too -- way too long
3 to try to parse language here. I just want to
4 get a sense of where we feel we need -- we should
5 go.

6 But, that is an important comment.

7 And, anyone else?

8 MEMBER VLIEGER: I know we aren't
9 parsing language right now, but equal weight is
10 not in that sentence anywhere. They just say
11 that they can use them. And the primaries in the
12 past have done the Former Worker medical
13 information from the screening programs has not
14 been accepted and, when the attending physicians
15 report I'm not getting equal weight.

16 CHAIR CASSANO: Okay. Yes.

17 Anyone else?

18 I have an issue with the language on
19 the Contract Medical Consultant because my
20 feeling is that, in order to form a truly
21 reasoned decision, the Contract Medical
22 Consultant should not just be answering questions

1 posed by the CE, but should be looking at all of
2 the medical evidence that is presented regardless
3 of whether the CE -- and this may be the same
4 thing that you're saying, Faye -- whether or not
5 the CE thinks it's reasonable or not.

6 I think that's something for another
7 medical provider to do.

8 So, that's something that I would want
9 to look at.

10 Anybody have any other issues with any
11 of the other two sources?

12 MEMBER VLIEGER: Just to add on to
13 that, I would like the CEs to actually go into
14 the medical records from the sites, in
15 particular, in lung diseases where they were
16 based on studies done at the beginning of the
17 worker's career and actually include those with
18 the records that are considered to show the
19 pattern of lung decline.

20 CHAIR CASSANO: Okay. We'll see if
21 that's done in types of medical evidence rather
22 than sources, but obviously, that's an important

1 inclusion to make.

2 And, that would be an additional
3 source if we determine that that's a source and
4 not a type.

5 Any thoughts about whether additional
6 sources of medical information should be utilized
7 at this point in time?

8 MEMBER BODEN: This is Less Boden.

9 Let me just ask a question here. So,
10 published studies, it seems to me, are also a
11 potential source of information, although they
12 are sort of a different kind of source from these
13 other ones.

14 In other words, I'm thinking of what's
15 the basis for which people are providing
16 independent and rationalized responses, for
17 example, to the question of whether a particular
18 exposure is a cause of or aggravates, et cetera,
19 a particular disease?

20 CHAIR CASSANO: Yes, and that's
21 something Dr. Markowitz brought up, not only as
22 far as sources for diagnosis but also goes to the

1 causation.

2 And that was something I had
3 questioned, too. Should we be adding to this
4 list consensus documents from learned bodies such
5 as IWAR and the National Academies and DPA or
6 ATSCR or NIOSH or whatever?

7 Or, does that come within the purview
8 of the different medical consultants versus the
9 CE?

10 Or, are these sources of information
11 that the CE should gather for the medical
12 consultant or second opinion physicians or
13 whatever?

14 Anybody else have any thoughts on that
15 because, we actually touched on the subject that
16 I felt was also of importance.

17 But, that's what you're talking,
18 correct?

19 MEMBER BODEN: It is.

20 CHAIR CASSANO: Okay.

21 Any other thoughts on that?

22 CHAIR MARKOWITZ: This is Steven.

1 So, you know, the kind of evidence
2 that Les is talking about is obviously critical
3 for decision making. But, I don't think it
4 really belongs in this section. Not that we are
5 necessarily trying to rewrite this Procedure
6 Manual, but this is really kind of individual
7 claimant specific disease and the specific
8 information assist claims examiners gathering --

9 CHAIR CASSANO: Okay.

10 CHAIR MARKOWITZ: -- the documents.

11 CHAIR CASSANO: That was Dr.

12 Markowitz, correct?

13 CHAIR MARKOWITZ: Yes.

14 MEMBER BODEN: Yes, so this is Les
15 Boden again.

16 So, I think that's a reasonable thing
17 to say, but then I wonder about whether it's -- I
18 want to look back at this because I thought that
19 there were things --

20 Well, maybe that's right. I had
21 thought that some of the wording in here
22 suggested that the physicians or consultants

1 might actually be providing medical evidence
2 including things about what the relationship is
3 between cause and effect.

4 If that's not the case, then I'm
5 perfectly happy with --

6 CHAIR CASSANO: Yes, I think we --
7 that's something we can look at as to whether
8 it's appropriate in this section or whether it's
9 appropriate in talking about how to evaluate what
10 the Contract Medical Consultant says versus the
11 attending physician versus a second opinion.

12 And, that becomes how you evaluate the
13 rationale. And, from the discussion, you know,
14 did they cite various papers? Did they cite
15 various learned bodies, et cetera?

16 I'm not sure it's the place of the
17 claims examiner to be able to figure out what
18 learned bodies or what papers, peer review
19 papers, et cetera should be utilized in that
20 process.

21 And, I think that's what Dr. Markowitz
22 was saying.

1 So, we will make note of that and I
2 think in our deliberations after this meeting, we
3 will talk some more about the appropriateness of
4 that.

5 Okay, who wants to go through the
6 types of medical evidence? Who wants to read all
7 of that? Don't be shy now, come on.

8 MEMBER BODEN: Let's just go around
9 the group. I'll be happy to do this one, but why
10 don't you just --

11 CHAIR CASSANO: Thank you.

12 MEMBER BODEN: -- ask one at a time
13 since we all seem to be shy.

14 Types of medical evidence. Medical
15 evidence in the EEOICPA cases consist of the
16 following major categories. A: treatment records
17 are the most prevalent form of medical evidence.
18 They consist of any record made during the
19 evaluation, diagnosis and treatment of a patient
20 by his or her healthcare providers.

21 They include: one, attending physician
22 records, for example, chart notes, reports, et

1 cetera which include records from medical
2 consultants assisting the attending physicians,
3 two, records of physicians consulted by the
4 patient or an independent medical opinion, three
5 --

6 CHAIR CASSANO: Reading with the page
7 on the website, thank you.

8 Go ahead.

9 MEMBER BODEN: The evidence of
10 diagnostic testing, for example, x-ray films,
11 electrocardiogram, tracing, et cetera and the
12 reports of medical providers interpreting the
13 tests.

14 For the purposes of interpreting
15 tests, medical providers include physicians as
16 defined in Section 30.5(dd) of the regulation.

17 Four, treatment records from
18 hospitals, hospices, in home health or
19 residential healthcare facilities.

20 B, Medical evaluations may occur for
21 a variety of reasons other than for the diagnosis
22 and treatment of the patient.

1 The purpose of the examination
2 distinguishes medical evaluation from treatment
3 records. Medical evaluations include: one,
4 evidence from the DOE's Former Worker Program,
5 for example, former worker screening records,
6 pre-employment physicals, determination
7 physicals, et cetera, two, examinations required
8 under state or federal compensation programs, for
9 example, evaluations for State Workers'
10 Compensation claims, Social Security Disability
11 examination, Veterans' Administration programs,
12 et cetera, three, medical reports or opinions
13 obtained for litigation under state or federal
14 Rules of Evidence.

15 B, reports produced in response to a
16 DEEOIC referral to a CMC, second opinion
17 physicians or referee specialists.

18 Other types of evidence include Cancer
19 Registry records may be used in some cases to
20 establish the diagnosis or cancer and date of
21 diagnosis.

22 Two, death certificates which contain

1 information about the cause of death or date of
2 diagnosis in Section 7(f), therefore, additional
3 information regarding death certificates, three,
4 secondary evidence relied on by a physician in
5 forming an opinion. For example, a doctor may
6 rely upon the information provided by a medical
7 specialist in determining the cause of an
8 illness.

9 Four, affidavits containing facts
10 based on the knowledge of the affiant regarding
11 the date of diagnosis.

12 Four, contents of a medical report.
13 The value of findings and conclusions contained
14 in medical records varies.

15 Oh my gosh.

16 CHAIR CASSANO: So, with that -- so
17 let's not go through all of this, I don't think.

18 What of that do -- does anybody have
19 any issues with the types of medical evidence
20 included here? We still see -- and I'll go
21 around the -- just anyone on the Committee, I'm
22 going to be quiet for right now.

1 MEMBER VLIEGER: This is been from
2 experience type of issue.

3 There are types of assessment reports
4 that have been denied for years by claims
5 examiners because they didn't know about them,
6 but that didn't make them less valid.

7 And so, I would like to see something
8 here about the valid diagnostic tests that are
9 used for various portions of evaluations,
10 particularly lung disease, and when it's lung and
11 heart disease, you know, when the cardiologists
12 become involved.

13 So, just an example, a physician was
14 using the St. George's questionnaire to aid them
15 in getting information from the worker for their
16 impairment rating and the claims examiner denied
17 use of St. George's questionnaire even after they
18 were provided information that the FDA finds it a
19 valid assessment tool.

20 So, I don't know how we can word that,
21 but it is -- this needs to be in here somewhere
22 that assessment tools that are valid, you know,

1 especially by other governmental agencies, that
2 they have to accept.

3 CHAIR CASSANO: Yes, I hear what
4 you're saying. I think, however, when you're
5 talking about, and again, thank goodness this is
6 being recorded and somebody's taking notes
7 because I can't keep all this in my head.

8 I think when we're talking about
9 evaluating someone for disability, the rule is
10 that it is the AMA Guide and it is Edition 5
11 that's being used as the --

12 MEMBER VLIEGER: But, this assessment
13 tool is in the AMA Guide.

14 CHAIR CASSANO: It is in the AMA
15 Guide?

16 MEMBER VLIEGER: Yes, and it's in
17 Edition 5 of the AMA Guide, not Edition 6,
18 correct?

19 MEMBER VLIEGER: No, it's in Edition
20 5, it's referenced as an assessment tool.

21 CHAIR CASSANO: Okay, okay. We will
22 definitely -- that's something that we do need to

1 look at.

2 Anybody else have any issues as far as
3 the use of the different types of medical
4 evidence?

5 No one?

6 The only issue I have with the --
7 first of all, I have a problem with using Death
8 Certificates because Death Certificates are
9 notoriously inaccurate when it comes to the --
10 well, not the primary, but you know, a lot of
11 times, the secondary cause of death is wholly
12 inaccurate on a lot of Death Certificates.

13 What I don't see and I would like to
14 discuss is whether we need to establish some type
15 of hierarchy regarding the types of medical
16 evidence to utilize.

17 Anybody have any thoughts on that?
18 Because, the right, you know, the way the thing's
19 written here, everything seems to be on an equal
20 basis and do the CEs need guidance on what the
21 priority should be in reviewing these?

22 Because, as I understand it, not

1 everything goes from the CE to the CMC if they're
2 asking for a CMC opinion.

3 Any thoughts or ideas on that?

4 CHAIR MARKOWITZ: This is Steven.

5 I don't think there's a shortcut to a
6 hierarchical approach. You know, I think that
7 healthcare providers have acquired that hierarchy
8 through a lot of experience.

9 And, I, you know, I'm just trying to
10 imagine myself as a claims medical examiner
11 having read this job qualification that's around.
12 Trying to understand these different sources of
13 medical information and make sense of them and
14 deal with these or even interpreting the
15 information.

16 So, to ask them to follow some sort of
17 hierarchy, which they won't -- can't understand
18 the basis of, I think would really be excessive.

19 CHAIR CASSANO: Yes, the only thing
20 that I'm still not certain of is if all of the
21 medical evidence actually goes -- that is
22 corrected, whether it's good, bad or indifferent,

1 actually gets to the CMC.

2 And, I think that is a question that's
3 unanswered might help us get through this issue.

4 Is that -- anybody -- can anybody from
5 DOE answer that for me or is that not an
6 appropriate thing to do at this point?

7 CHAIR MARKOWITZ: I'm sorry, you meant
8 DOL?

9 CHAIR CASSANO: Yes.

10 MS. RHOADS: We can ask the program to
11 provide to provide an answer to that.

12 CHAIR CASSANO: Okay, I appreciate
13 that.

14 I think then really to get this
15 section on the content because that is basically
16 illustrative for the claims examiner.

17 And, let's see, let's skip down to --

18 MEMBER SILVER: Excuse me. This is
19 Ken.

20 A thought occurred to me. I've
21 suggested to some workers who thought their
22 exposures were affecting their health that DOE

1 site said that they'd start keeping a symptom
2 diary.

3 One successful claimant got the idea
4 on his own and at the early stages of this
5 program, you know, he threw everything to see
6 what would stick.

7 And, maybe his symptom diary was
8 helpful, but can someone tell me where the
9 worker's own symptom dairy would fit in the
10 different categories of evidence that we just
11 looked at?

12 MEMBER VLIEGER: My experience with --
13 this is Faye.

14 My experience with U.S. Department of
15 Labor is they state that those are symptoms and
16 not diagnosis and will not be considered, that
17 we'd consider it if the doctor references them in
18 a diagnosis, but a symptoms -- your symptoms are
19 symptoms and a doctor has to make a diagnosis
20 from the symptoms.

21 MEMBER SILVER: So, it's --

22 CHAIR CASSANO: But --

1 MEMBER SILVER: -- phrase about the
2 other records that the doctor has looked at,
3 okay.

4 MEMBER VLIEGER: Right. And then, I
5 need to backtrack just a second.

6 In the use of Death Certificates, many
7 times those are the historical claims where
8 that's the only surviving record. And so, the
9 Department of Labor accepts a Death Certificate
10 as long as there is no other way to get medical
11 evidence.

12 If there is other medical evidence,
13 then the family can provide it or the Death
14 Certificate is not very clear or if it's
15 equivocal then the family can provide medical
16 evidence if they can find it.

17 But, you know, some of the claims
18 they're dealing with are people that died in the
19 '40s, '50s and '60s and medical records aren't
20 available. And, even in the case of the family
21 trying to go back after the Cancer Registry was
22 established to try and find information, it's

1 very difficult to get the people at the Cancer
2 Registry to answer any questions.

3 CHAIR CASSANO: I understand.

4 Going back to the assessment
5 questionnaire, again, this goes back to the
6 question I asked. If all of that is collected
7 goes to the CMC because an attending physician
8 may make, if they're not truly, you know,
9 knowledgeable about all of this an attending
10 physician may not make the correct diagnosis.

11 And, if the symptom questionnaire goes
12 to the CMP who is knowledgeable, they might sit
13 there and look at these symptoms and go, gee, a
14 lot of this is, you know, sounds like this
15 particular diagnosis and may not, should they get
16 -- ask for additional information or ask for
17 additional diagnostics done.

18 So, I hear you at that point, if
19 that's possible.

20 Anyway, let's skip down to Section 5
21 which is developing medical evidence. Yes,
22 that's -- I think it's on the next page. No,

1 it's on page 6. No, where did it go? Oh, I just
2 got myself lost here.

3 Hold on, I'll get there.

4 Yes, the bottom of page 5 is Section
5 5, developing medical evidence. Is that up now?

6 Yes, here we go, okay, you've got it.

7 Everybody know -- see where we are?

8 It says right at the bottom of page 5.

9 So, who wants to start going through
10 this section?

11 CHAIR MARKOWITZ: This is Steven.

12 Is it -- is this where it says
13 although it is ultimately?

14 CHAIR CASSANO: Yes.

15 CHAIR MARKOWITZ: Yes, I can read if
16 you want.

17 CHAIR CASSANO: Okay, thanks.

18 And, we're going to need to flip the
19 page pretty quickly.

20 CHAIR MARKOWITZ: Although it is
21 ultimately the responsibility of the claimant to
22 submit medical evidence in support of his or her

1 claim the CE is to assist the claimant in
2 collecting evidence necessary to establish
3 medical illness.

4 This includes communicating with the
5 claimant to explain deficiencies in case
6 evidence, requesting supportive documentation and
7 allowing reasonable time for the claimant to
8 provide a response.

9 The CE also assists by taking
10 affirmative action to obtain medical evidence
11 through communications with treating physicians
12 and/or other medical providers.

13 Assistance can also be achieved with
14 the use of program resources to obtain clarifying
15 medical evidence putting to use the CMC, the
16 second opinion physician who will refer to a
17 referee specialist.

18 The development of medical evidence is
19 performed in various aspects of case adjudication
20 to establish diagnosis, to establish causation,
21 to determine percentage of impairment in
22 impairment claims, to establish causal

1 relationship between a covered illness and wage
2 loss, and to resolve inconsistencies and
3 conflicts in medical evidence.

4 CHAIR CASSANO: Yes, I don't think
5 we're going to talk about -- and I believe in the
6 proposed rule we went through, the definition of
7 the physician, I don't think we need to go
8 through that there.

9 Let's talk about the third paragraph,
10 though, this opening paragraph.

11 Anybody have any issues with stating
12 this statement of the duty to assist?

13 MEMBER VLIEGER: This is Faye.

14 I just wish it was true.

15 CHAIR CASSANO: Well --

16 CHAIR MARKOWITZ: This Steven.

17 So, this has come up repeatedly, this
18 issue of, you know, affirmative assistance,
19 proactive assistance.

20 So, is there some way we can actually
21 look at this formally in the claims process to
22 get some, you know, sort of a broader picture of

1 this and then try to address it from there?

2 CHAIR CASSANO: Yes, I would like to
3 be because, you know, in some ways, the CE may
4 not know what it is she actually needs. She may
5 -- or he actually needs.

6 They may be able to state what's
7 needed, but they may not be able to explain it
8 well enough for the -- either the claimant nor
9 the treating provider to be able to understand.

10 So, I think this is something, this is
11 a section we really need to look at. And, I
12 think this is also something that may lend itself
13 very much to some type of training document as
14 was asked for in the advice here for the section.

15 So, we'll flag this for now and as
16 something we will need to work on in working
17 group.

18 Anyone have any statements or issues
19 about this statement?

20 Okay, we're going to move on then. I
21 think we're going to stick Section A, decision
22 evidence and we had -- I think I'd like this read

1 because I want to know what exactly they consider
2 this issue incomplete or whatever.

3 So, have we got a -- I'll read this
4 one.

5 During adjudication of the claim,
6 there are many topics that require evaluation of
7 medical evidence including: medical diagnosis,
8 interpretation of diagnostic evidence, causal
9 relationship between illness and occupational
10 toxic substance exposure, permanent and partial
11 impairment, effect of an illness on historical
12 wages and medical necessity of care or other
13 service needs.

14 On each of these matters, legal,
15 regulatory or procedural guidance exists through
16 an online programmatic resources bulletin,
17 searches, just put in the regulation, et cetera
18 to instruct the CE on evaluating the sufficiency
19 of evidence submitted in support of claim.

20 The CE is to adhere to these
21 guidelines and direct development in a matter
22 that will best overcome evidence omissions or

1 deficiencies.

2 Yes, I think there's -- before I do my
3 spiel, anybody -- I think that this is the same
4 problem that we have in the overall introductory
5 statement.

6 But, does anybody else have any
7 further comments on this? I think this all needs
8 to be looked at.

9 MEMBER BODEN: This is Les again, Les
10 Boden.

11 So, in the first paragraph or the
12 second paragraph, it says that medical evidence
13 must be from a physician and then defines who
14 physicians are.

15 And, in the -- in paragraph B, it
16 talks about effect of illness on historical
17 wages. I don't think that any physician has any
18 -- or real expertise in understanding how illness
19 affects historical wages.

20 And, I sort of wonder what goes on
21 there in the adjudication process? I mean --

22 CHAIR CASSANO: That's something that,

1 you know, as Department of Labor would get back
2 to us in the use of how that affects -- how
3 medical people are supposed to evaluate effect on
4 historical wages and maybe this needs to be
5 someplace else. We would appreciate that.

6 Thanks, Les.

7 Anyone else on this section?

8 MEMBER VLIEGER: This is Faye.

9 When you're looking at wage loss, the
10 requirement currently is that the worker go to
11 the attending physician and ask the doctor to
12 write a letter about whether or not they're able
13 to perform work. And, that has to be pretty much
14 couched between dates.

15 And then, when the worker applies for
16 continued wage loss, then the doctor has to state
17 whether or not the worker is able to work and at
18 what rate, whether it's full-time, half-time or
19 not at all.

20 So, that's what they've used before in
21 the past. Not so much for how much the worker
22 worked, but whether or not they have the capacity

1 to work.

2 CHAIR CASSANO: Okay. Thank you, I
3 understand.

4 MEMBER BODEN: So, just to clarify, is
5 that something -- I mean, suppose you're talking
6 about somebody who lost earnings in the '60s.
7 How would they -- how is the physician examining
8 them today going to --

9 MEMBER VLIEGER: So, the wage loss is
10 when for someone who is currently alive only, and
11 that whether or not they're able to perform work.
12 And so, if the physician agreed to the person,
13 then that physician gathers what evidence they
14 can around their best opinion then they make the
15 decision.

16 In my experience, I haven't ever done
17 a wage loss going back that far because the
18 person is no longer with us.

19 If it's in the chief's colon, there's
20 a flat rate compensation to the surviving spouse
21 or any minor or disabled children. It's not
22 based on wages and no physician is involved in

1 that.

2 CHAIR CASSANO: Yes, I think what's
3 misgiving here is the word historical. Can we
4 get some clarification here from the Department
5 of Labor on what that's supposed to mean?

6 And so, at this point, we can move on.
7 Let's see, so I'm going -- I don't like, I mean,
8 who wants to read this next part -- section? Oh,
9 I'll read it.

10 In many situations, a minor deficiency
11 in the medical evidence can be easily overcome
12 with a telephone call to the physician's office
13 to request a specific document. If, however, the
14 form is not produced for immediate results, the
15 CE should send a written request.

16 I mean, that's just procedural and I
17 don't think it really -- if the physician's
18 office doesn't get the medical evidence in the
19 mail, the CE will follow up with written
20 correspondence, memorialize it and tells them I
21 have a specific document that is being requested.

22 Anybody have any issue with this? I

1 think telephone calls and -- I'd like to see a
2 paper trail on everything. So, does anybody else
3 have any statements?

4 MEMBER VLIEGER: I agree, they should
5 be providing the doctor with some written record
6 to respond to.

7 CHAIR CASSANO: Okay.

8 MEMBER VLIEGER: Yes, there's really
9 no way to track it. There's really no way to
10 track a response if you got a telephone call.

11 CHAIR CASSANO: So, I'm going to
12 briefly skim through the rest of this written
13 request because it's the same thing.

14 If somebody would talk about -- let's
15 go down to Section E here on page 7 which talks
16 about unavailable medical evidence, so
17 unavailable medical records, and see how that
18 gets adjudicated.

19 So, who wants to read through that?

20 MEMBER VLIEGER: I can if they show
21 the page.

22 CHAIR CASSANO: Oh, okay. Show them

1 -- on my -- here on the middle of page 7, right
2 before number 6 and it's Section 8. Are we
3 there?

4 MS. RHOADS: Could you just scroll to
5 adjust your view on your personal computer if you
6 can't see it because we did scroll it on that on
7 the WebEx, but sometimes it doesn't appear on
8 your page because of the personal settings you
9 have. So, try and see if you can adjust that.

10 CHAIR CASSANO: In other words, your
11 little scan bar on the side there, you need to
12 move up and down.

13 MEMBER VLIEGER: Okay. And, what
14 section again are we --

15 CHAIR CASSANO: It's right before
16 Section 6, it's number -- the letter E.

17 MEMBER VLIEGER: I have it.

18 Unavailable medical records. If the
19 CE obtains information that pertinent medical
20 records have been destroyed or are otherwise
21 unavailable, the CE should attempt to obtain from
22 the physician written confirmation which contains

1 the following information: one, an affirmation
2 that the physician treated the employee for the
3 claimed condition, two, a statement that the
4 requested medical records are no longer
5 available, three, a discussion that includes the
6 diagnosis and date of diagnosis, and four, the
7 submission signature and the date signed.

8 Can I just make a comment before we go
9 on?

10 CHAIR CASSANO: Sure, because I have
11 a funny feeling I know what your comment is going
12 to be, but go ahead.

13 MEMBER VLIEGER: Do they think that
14 this physician only ever treated one patient
15 within his entire life?

16 CHAIR CASSANO: Yes. My thought was,
17 gee, if the medical records aren't available and
18 this -- and the employee is a long-time former
19 employee, then the physician is probably not
20 available either.

21 So, I find that it sounds like, I
22 don't know, we'll look -- this is something we

1 need to look at because I think this creates a
2 lot of process that doesn't end in any value-
3 added. But, we can talk about this, too, at some
4 point.

5 Any other comments by anyone about
6 this section?

7 MEMBER SILVER: Well, it does seem
8 claimant friendly. There's a hospital in Oak
9 Ridge that had a lot of workers records that
10 mishandled them and they got destroyed.

11 And then, there are probably a lot of
12 situations like the Los Alamos County warehouse
13 where there were fragmentary medical records
14 dumped.

15 So, if you get a fragment, you can
16 take it to the physician and from memory, they
17 can spin out what's required under Part E.

18 So, I think it's, you know, coming
19 from a good place.

20 CHAIR CASSANO: Yes, I agree. But, I
21 can tell you that my own experience as a treating
22 physician, if you ask me about any patient,

1 especially in the occupational medical setting
2 where I, you know, if you ask me about any
3 patient I saw more than a couple of years ago,
4 unless they had something really outrageous, I'm
5 not going to remember even if you hand me a
6 fragment.

7 But, I think what happens is -- what
8 I don't like about this is there's no closure on
9 this, in that it doesn't say what to do if one
10 isn't available.

11 So, we'll look at that a little bit
12 more. Any other comments?

13 MEMBER VLIEGER: Just one comment. In
14 these type of situations, what I have seen the
15 family be able to do in rare occasions is go back
16 and get Medicare records that showed that, you
17 know, what Medicare paid for with the diagnosis
18 code.

19 CHAIR CASSANO: Any other comments?

20 Okay, so we're now on Section 6 which
21 is really probably the most important section.

22 Can -- who is going to read this for

1 me?

2 MEMBER VLIEGER: I'll do it again.

3 CHAIR CASSANO: Okay, thanks.

4 MEMBER VLIEGER: Weighing medical
5 evidence. When the CE receives medical evidence
6 from more than one source, he or she must
7 evaluate the relative value or merit of each
8 piece of medical evidence.

9 This is particularly important in
10 cases where there is a conflict between the
11 medical evidence received from a CMC and the
12 treating physician.

13 A thorough understanding of how to
14 weigh medical evidence will assist the CE in
15 determining when and how further medical
16 development should be undertaken.

17 The CE should also understand how to
18 assign weight to the medical evidence received.

19 CHAIR CASSANO: Keep going, if you
20 would.

21 MEMBER VLIEGER: Sure.

22 CHAIR CASSANO: And we're going to

1 need to flip the page in a couple of seconds.

2 MEMBER BODEN: Can we, as we -- I would
3 say from --

4 MEMBER VLIEGER: Sure.

5 MEMBER BODEN: This is really a
6 weighty task for somebody to undertake, and I'm
7 just wondering how this actually works in
8 practice.

9 CHAIR CASSANO: I agree that this is
10 -- I am not sure and that's why I wanted to go
11 through the whole thing to see what they're
12 saying about how you do this.

13 Because, quite frankly, I'm not sure
14 that someone -- I wanted to see how they tell
15 them to adjudicate this because I see all sorts
16 of problems here.

17 MEMBER BODEN: Okay, so this --

18 CHAIR CASSANO: Because somebody who
19 isn't a physician trying to figure out, hey,
20 which physician, number one, is citing good
21 evidence versus not good evidence, et cetera.

22 So, let us keep going and then we'll

1 look at this all together.

2 MEMBER VLIEGER: I agree.

3 CHAIR CASSANO: Go ahead.

4 MEMBER VLIEGER: I agree. Just
5 reading this, it's from a perspective of from the
6 claimant's -- I mean, from a CE. I think it's
7 totally out of the scope of their job to assign
8 that weight to that medical evidence, in my
9 opinion.

10 CHAIR CASSANO: I agree to a certain
11 -- I mean, it's one guy just saying I'm the
12 doctor and I say this is so versus somebody that
13 writes a six page report with 15 references.
14 That's sort of easy.

15 But, when you're looking at fully --
16 if you're looking at two fully developed pieces
17 of evidence, it could be a big problem.

18 But, that's why I want to see how
19 they're saying to evaluate it. So, Faye, if you
20 could keep going, I'd appreciate it.

21 MEMBER VLIEGER: Sure.

22 How to evaluate evidence. In

1 evaluating the merits of medical reports, the CE
2 evaluates the probative value of the report and
3 assigns greater value to: an opinion and complete
4 factual and medical information --

5 CHAIR MARKOWITZ: Faye, Faye, Steven.
6 I'll be glad to take over here.

7 MEMBER VLIEGER: Thank you.

8 CHAIR MARKOWITZ: So we don't have to
9 administer medical care over the phone.

10 MEMBER VLIEGER: Too late.

11 CHAIR MARKOWITZ: Factual and medical
12 information over an opinion based on incomplete
13 subjective or inaccurate information.

14 Generally, a physician who has
15 physically examined the patient is knowledgeable
16 of his or her medical history and has based the
17 opinion on an accurate factual basis has weight
18 over a physician conducting a final review.

19 For example, a physician opines that
20 his patient's lung cancer is related to exposure
21 to diesel exhaust, say diesel engine exhaust, has
22 less probative value to the opinions if the

1 opinion doesn't state no knowledge of the
2 frequency of level of exposure to diesel engine
3 exhaust.

4 Parenthetically, that example is a
5 total non-sequitur from the previous. That's
6 just my -- that's my own comment.

7 (Laughter.)

8 CHAIR CASSANO: That's why I wanted to
9 go through this line by line because there are a
10 lot of -- I've seen a lot of non-sequiturs in
11 here.

12 Sorry, Steve, do you mind just
13 finishing going through and on?

14 CHAIR MARKOWITZ: Yes, sure.

15 An opinion based on a definitive test
16 and includes the physician's findings. Some
17 medical conditions can be established by
18 objective testing. A finding from a pathology
19 report from a physician is sufficient evidence of
20 a diagnosis of cancer. However, a physician's
21 opinion that a patient has cancer is of little
22 probative value if the pathology report shows no

1 malignancy.

2 A physician's report of a positive
3 beryllium lymphocyte proliferation test or a lung
4 lavage cell showing abnormal findings is
5 sufficient evidence of a diagnosis of beryllium
6 sensitivity.

7 It is important for the CE to
8 undertake appropriate steps to work with the
9 treating physician in the collection of evidence
10 before referring the case to a CMC.

11 CHAIR CASSANO: Okay. And then, let's
12 go through the more rationed opinion and then
13 we'll talk about it and keep going.

14 Do you mind reading number three and
15 number four and then we'll go back --

16 CHAIR MARKOWITZ: No, no, I'm enjoying
17 this, actually.

18 A well-rationalized opinion over one
19 that is unsupported by affirmative evidence. The
20 term rationalized means that the statements of
21 the physician are supported by an explanation of
22 how his or her conclusions are reached, including

1 appropriate citations or studies.

2 An opinion that is well rationalized
3 provides a convincing argument where a stated
4 conclusion that is supported by the physicians
5 reasonably justified analysis of relevant
6 evidence.

7 For example, an opinion which is
8 supported by the interpretation of diagnostic
9 evidence and relevant medical or scientific
10 literature is well rationalized.

11 Conversely, an opinion which states a
12 conclusion without explaining the interpretation
13 of evidence and reasoning that led to the
14 conclusion is not well rationalized.

15 CHAIR CASSANO: Oh and just read
16 number four. I know we're going to discuss this
17 whole -- I think.

18 CHAIR MARKOWITZ: Okay, four, the
19 opinion of an expert over the opinion of a
20 general practitioner or an expert in an unrelated
21 field. For example, if a general practitioner has
22 a patient with rest tremors, balance problems,

1 and muscle rigidity, a diagnosis of alcohol abuse
2 with dehydration may be reasonable.

3 CHAIR CASSANO: What?

4 CHAIR MARKOWITZ: Wow. Okay. Now I
5 know why you wanted to read this.

6 However, if a conflicting report is
7 received from a Board Certified neurologist
8 diagnosing Parkinson's disease based on the same
9 symptoms, it would carry greater weight because a
10 neurologist is an expert in neurologic disorders.

11 This is particularly true for an
12 illness like Parkinson's disease that cannot be
13 confirmed by an objective laboratory test.

14 Conclusive statements of an expert
15 without any underlying justification other than a
16 privation of the physician's expertise are not to
17 be viewed as carrying significant probative
18 value.

19 CHAIR CASSANO: Okay. And, we can --
20 I want to put in my statement that basically I
21 think we can skip that for right now. And, let's
22 talk about -- this is a very problematic section,

1 I think.

2 And, I'd like everybody else's
3 opinions about this, please, where you think the
4 holes are. I think there are holes all over it,
5 but anyway.

6 Does somebody -- I would like other
7 people to chime in on this.

8 MEMBER VLIEGER: If this was standup
9 comedy to a physicians' conference, this person
10 would get a standing ovation.

11 CHAIR CASSANO: Yes.

12 CHAIR MARKOWITZ: Yes, this is Steven.
13 So, you know, the CE is in a tough
14 spot.

15 CHAIR CASSANO: Right.

16 CHAIR MARKOWITZ: And, this guidance
17 is to give them some general factors that they
18 can use.

19 So, the question is, what do they
20 actually do? And, how do they -- do they and how
21 do they apply these -- this guidance? And, do
22 they make the right decisions?

1 And, those are factual issues that we
2 should probably assess.

3 CHAIR CASSANO: I agree. I have great
4 problems with giving this kind of very accurate,
5 though, evaluation of medical statements to
6 actually put that burden on a CE because, you
7 know, I've seen medical opinions that have 15
8 references, all of which are not peer reviewed
9 literature, you know.

10 And, a medical opinion, some people
11 can make things sound different than the other.
12 I mean, I've seen people cite the same medical
13 evidence and one say aye, yes, then they'll cite
14 causation and another person not opine causation.

15 And, I'm not sure, Steven, we can
16 parse that out properly. So, again, I think we
17 need to see how they work with this kind of
18 stuff.

19 And, whether or not, you know, and
20 whether or not they actually can make the correct
21 decision. So, then, all those, you know, should
22 go to the CMC.

1 The other piece that I see here is
2 that the CMP, emergency attending physician that,
3 I'm not saying this to cast aspersions in any
4 way, shape or form, but I've seen IMEs that are
5 just on more companies that are biased in one
6 way.

7 And then I see IMEs, or independent
8 medical evaluations, but they're sort of the same
9 thing, that are done by advocacy boards that are
10 biased in another way.

11 And, how do you -- how does someone
12 without the proper training evaluate whether
13 each, you know, the fixed changes with references
14 and fixed changes with references have somebody
15 evaluate, "Hey who's telling the truth here?"

16 So, I think we need to look at this as
17 well.

18 And, I have problems with the opinion
19 of an expert over the opinion of the general
20 practitioner. I think it should more rely on the
21 rationale that's used. But, sometimes, people
22 that are generalists with some experience cite

1 very good rationale approaches.

2 So, I think we're good on that for
3 right now.

4 Any other comments from anybody on the
5 board?

6 MEMBER POPE: Duronda here.

7 CHAIR CASSANO: Go ahead.

8 MEMBER POPE: Duronda Pope here.

9 I was just curious as to, is there a
10 point where the CE confers with the CMC if they
11 have a question like this or if there is a case
12 that they're trying to figure out if, you know,
13 if they should proceed further?

14 Because I think this list, all this
15 language belongs in the hands of the CMC opposed
16 to the CE.

17 MEMBER VLIENER: So, this is Faye.

18 Procedurally, what happens is that the
19 CE determines what the evidence from the
20 attending physician, whether generalized or
21 specialist does not rise to the level of what
22 they consider a rationalized opinion.

1 Then, they provide that information to
2 a Contract Medical Consultant within the
3 guidelines of some very restrictive questions.
4 And, the Contract Medical Consultant is only
5 asked to opine on those particular questions and
6 nothing else. And, they very seldom go outside
7 of that arena.

8 MEMBER BODEN: This is Les.

9 I don't know if this is something we
10 can do, but I think we might learn a fair amount
11 if we were able to do something like a focus
12 group with, you know, four or five CEs in which
13 they sort of -- or even, you know, individual
14 interviews, in which they sort of describe if,
15 you know, relatively difficult cases and how they
16 dealt with them.

17 Because, you know, in a way, we have
18 our preconceived notions about how this might
19 work. But, it might -- we might learn a fair
20 amount particularly if we did do this in a, you
21 know, a private setting where they might not feel
22 particularly strained.

1 I also have a question as I read all
2 these things. I'm thinking about the burden on
3 this treating physician of writing this report
4 which could take a fair amount of time to do in a
5 really proper way.

6 What is the method of compensation for
7 these reports?

8 CHAIR CASSANO: I don't think there
9 is. Does anybody have anything --

10 MEMBER VLIEGER: There is a code. It
11 doesn't pay very much. There is a code that's
12 the same code it's been if you're filling out
13 Medicare forms of L&I forms, there is a code
14 they're allowed to charge against, but it's not
15 very much.

16 It's definitely not the same
17 compensation that a CMC gets in order to do the
18 same work.

19 And so, they're -- when the CMC's got
20 the contract that they have put out there and
21 it's a private contractor, that's the CMCs to
22 write those reports.

1 MEMBER BODEN: So, I mean, so, one of
2 the questions that we were posed in that list of
3 questions that you showed us in the beginning,
4 the meets evidence one, I think was methodologies
5 for improving physician responsiveness to data
6 requests.

7 Maybe one of the methodologies might
8 be paying them for their time. I'll just throw
9 that out there just as a thought.

10 CHAIR CASSANO: I do like your -- any
11 other thoughts on that?

12 MEMBER BODEN: Do you know that
13 compensation is contingent upon a reward of a
14 claim if the claim goes down, does the physician
15 still get paid?

16 MEMBER VLIEGER: If they're using them
17 as an expert, I believe the physician can be
18 compensated. If it's an attending or a
19 specialist physicians, that's just part of their
20 office coding for billing.

21 If it's a claim that has been denied,
22 of course, there's no billing or if the claim was

1 in process of being accepted.

2 But, if they can go back and bill, if,
3 you know, the claim is in process.

4 MEMBER BODEN: So, I guess --

5 CHAIR CASSANO: Yes, how this should
6 read and in a different arena, not in this arena,
7 is basically through the advocates to that it's
8 an advocacy group or an attorney group or
9 whatever, if I'm asked to write a medical opinion
10 for a claimant, and it's for a different general
11 department, the attorney usually pays me up front
12 and the -- and then he gets his piece if the
13 claim is approved and accepted.

14 Whether or not my fee then comes out
15 of the award for the claim is not clear. But, it
16 does pose a risk, especially if you're after some
17 medical expert's opinion, they should tell the
18 risk to their claimant that they could be further
19 out of pocket.

20 And, that's why to, get a medical
21 opinion, I find that most don't ask for an expert
22 medical opinion.

1 MEMBER BODEN: Right. It would be
2 good to find out sort of what the different
3 possibilities are in this arena. That is, I
4 assume, a question that we can pose to DOL.

5 CHAIR CASSANO: Yes. I also would
6 like to back to your first idea about a focus
7 group. And, I know that there's some private
8 reconsiderations here, but I know that almost
9 like a couple of members of the subcommittee
10 could be able to sit down with a claims
11 examination and go through, okay, this is what --
12 fi this is what the claimant sent me initially,
13 this is what I have sent back to the claimant.

14 This is what I got when we start.
15 This is what I'm sending to the industrial
16 hygienists. This is what I got back from the
17 industrial - et cetera, et cetera, et cetera, so
18 that we know from beginning to end how this
19 process really works and what -- and do pieces of
20 evidence get taken out of the file before it goes
21 to the CMC based on the CE's evaluation of that
22 evidence? That's very important.

1 We're getting close to 2:30. What I'd
2 like to do is I'm not sure we actually need to
3 online, those who dialed up, but usually we have
4 the data to establish data diagnosis. I don't
5 think we need to go through.

6 So, I think what we'll do is, since
7 we've sort of got a break point, if everybody
8 would -- we finally can take our ten minute break
9 now and then come back to Section 9, which is
10 Review by CMC.

11 Is that good for -- yes?

12 MEMBER BODEN: Excuse me.

13 CHAIR CASSANO: Yes?

14 MEMBER BODEN: Should we leave our
15 connection and our phone going? Should we call
16 back in? What's the best way?

17 MS. RHOADS: Just leave your phones.
18 The moderator will put everyone on mute and then
19 we'll resume in about ten minutes.

20 MEMBER BODEN: Okay.

21 MS. RHOADS: So just, yes, don't
22 disconnect or anything, just leave your phone

1 alone and it'll be there when you come back.

2 MEMBER BODEN: Okay.

3 MS. RHOADS: Okay?

4 All right, so should we come back at
5 2:40?

6 CHAIR CASSANO: That would be fine,
7 perfect.

8 MS. RHOADS: Okay. All right, so
9 we'll have the moderator to put everybody on mute
10 and so, about 2:40?

11 OPERATOR: Muting the lines now.

12 MS. RHOADS: Okay, thank you.

13 OPERATOR: You're welcome.

14 Please press star zero when you're
15 ready to begin again.

16 MS. RHOADS: All right, thanks.

17 (Whereupon, the above-entitled matter
18 went off the record at 2:29 p.m. and resumed at
19 2:42 p.m.)

20 CHAIR CASSANO: All right, before we
21 start it again, I just wanted to say, in the
22 interest of time because we are -- I wanted to do

1 this to get a sense of some of the information
2 that is out there.

3 But, what I want to do now, we will go
4 through paragraph 9 which is on page 10, just the
5 beginning, not any of the subsections, but then
6 the beginning of paragraph 10 which is on the
7 next page and then, leave this document.

8 And, at this point, because our time
9 is short, we've only got another hour and 15
10 minutes, I think we need to get back to what Dr.
11 Markowitz wanted us to really talk about,
12 defining the issues.

13 I think we know what information we
14 may need and then start talking about a plan.

15 So, if we finish this at 3:00, we will
16 then -- or maybe before that -- we'll spend the
17 next 20 or 30 minutes talking about what's really
18 in the scope here of this Procedure Manual and
19 the CMC documents, and then talk more about how
20 we're going to do this.

21 So, I guess for certainty's sake, I'll
22 read -- we're on page 10 of this document.

1 CHAIR MARKOWITZ: Sorry, is --

2 CHAIR CASSANO: Yes? Go ahead.

3 CHAIR MARKOWITZ: I had one comment.

4 Certainly, shouldn't we get back to
5 the bulleted items that DOL asked us to -- to
6 take our --

7 CHAIR CASSANO: Yes.

8 CHAIR MARKOWITZ: Because at least we
9 can include them as a discussion.

10 CHAIR CASSANO: Okay.

11 And, I think in some ways it's getting
12 weaved into here, but where I have circled back
13 at the end and make sure that we have a plan for
14 how we get to these.

15 So, in the interest of time, I will
16 read this.

17 DEEOIC uses the services of a
18 contractor to coordinate referrals of cases
19 involved by medical specialists. A CMC is a
20 contracted physician to specifically review of
21 case records to render opinions on medical
22 findings.

1 Medical opinions from the CMC are
2 essential to the resolution of claims due to
3 ambiguous causation, lack of medical evidence,
4 unique exposures, et cetera.

5 The function of a CMC is to provide
6 clarity to claim situations in the absence of
7 pertinent or relevant medical information from
8 other sources, and this all well and good --
9 other sources that support the claim.

10 The function of the CMC is not to
11 validate probative input by the claimant and
12 treating physician.

13 The description of appropriate reasons
14 for CMC referral include the following.

15 I'm not going to go through them.

16 And, anybody have any issues with that
17 particular statement?

18 Okay.

19 On to the next which is deciding on
20 the need for this -- where am I now? I'm still
21 on page 10.

22 The decision to -- it's at the

1 discretion of the assigned CE, and I think this
2 becomes important, and obvious in tracking case
3 evidence must assist including the absence of
4 affirmative medical evidence.

5 A CMC referral may also be necessary
6 to review of impairment or wage loss.

7 The CE should not view a medical
8 referral as an automatic requirement for each
9 claim.

10 In situations where no other
11 reasonable option exists to obtain a resolution
12 with outstanding medical requests.

13 So, I'm not going to go through the
14 rest of this. I think we have a good idea of the
15 kind of guidance that the CE gets.

16 And, I want to open the discussion now
17 as to where we think, besides this Procedure
18 Manual and other directives, do we have -- what
19 of this comes under our scope?

20 So, I will open that up to the group,
21 having read the -- some of things that we need to
22 review.

1 MEMBER SILVER: This is Ken.

2 Dr. Markowitz said earlier that the
3 claims examiner is in a tight spot is an
4 understatement. The quarterback for this process
5 is the least formally educated individual who has
6 to settle this diplomacy with a variety of
7 different better trained actors.

8 Did anyone see any evidence that the
9 claims examiner has the discretion to organize a
10 conference among those with differing opinions?
11 So, does everything pass through the claims
12 examiner one by one?

13 CHAIR CASSANO: Anybody know the
14 answer to that?

15 MEMBER VLIEGER: This is Faye.

16 I've never seen any evidence that they
17 actually have a conference before they send the
18 information to the CMC.

19 This all hinges on the claims examiner
20 deciding that a physician's statement or report
21 is not -- does not meet what they consider the
22 level of evidence. And that, from my review of

1 things that I see, tends to be subjective and not
2 objective.

3 CHAIR CASSANO: So, and I see our
4 issue and the scope is to define source and type
5 of medical information.

6 Number two, is the evaluation of the
7 medical information by the CE, and really, how
8 they determine whether or not to send something
9 to the CMC.

10 Now, in the scope of this, do we or do
11 we not feel that, looking at what the CMC gets
12 and what it, number two, looking at how the CMC
13 evaluates that is part of our scope.

14 And, I'd like some input on that
15 piece.

16 CHAIR MARKOWITZ: Could you -- I'm
17 sorry, could you just verify that phrase? Steve
18 Markowitz.

19 CHAIR CASSANO: What I'm saying is,
20 we're talking about weighing the medical
21 evidence. And, one of the -- so, one of the
22 documents that we received was the statement of

1 work of a CMC.

2 So, my feeling is that, if the CE is
3 making a decision as to whether to send something
4 to a CMC and then, when they get the opinion back
5 from the CMC, is weighing that against what
6 they've gotten from treating physician or another
7 medical expert or whatever.

8 Does evaluate mean the statement of
9 work and how the CMC interacts with the CE part
10 of our scope?

11 Does that clarify it?

12 CHAIR MARKOWITZ: Sure. Steve
13 Markowitz.

14 Well, I think it is part of the scope
15 because what we're asked to address is the
16 medical guidance for claims examiners and the
17 weighing of medical evidence of claims. And the
18 CMC --

19 CHAIR CASSANO: Okay.

20 CHAIR MARKOWITZ: -- opinion and it's
21 sent back to the CE as part of the decision
22 making process. That becomes more medical

1 evidence --

2 CHAIR CASSANO: Okay.

3 CHAIR MARKOWITZ: -- that they're
4 looking at -- that the CE is looking at.

5 CHAIR CASSANO: Okay. So, we will
6 need to then, even if -- it's up on here, we're
7 not going to get to it today, obviously, I don't
8 think. We may, but up on here is the statement
9 of work for a CMC and we will need to look at
10 that after this meeting at some point.

11 Or, maybe this will be the next thing
12 we look at. It's 29 pages long, so we're not
13 going to be able to do it today.

14 Any other issues that we have seen or
15 looked at today or haven't looked at today that
16 we feel are we in the scope of our Subcommittee?

17 MEMBER VLIEGER: This is Faye.

18 And, I'm not quite sure how to phrase
19 this. When the claims examiner has questions
20 about the evidence that's provided to them and
21 they may ask the opinion of the CMC, I don't ever
22 see anyone questioning the validity of the CMC's

1 process. I don't see anyone ever going back.

2 I don't know if there's audits done on
3 a particular rate of CMC reports to see if
4 they're valid and accurate to medical science.

5 And, the CMCs, they're not in a
6 position to question whatever they say, where
7 they can question the attending physician
8 material, they're not in a position to question
9 CMCs. It's just not part of the process and not
10 something they do.

11 So, I don't know how we could work
12 that in to what we're doing.

13 CHAIR MARKOWITZ: It seems like --
14 Steve Markowitz.

15 Let me just say the Subcommittee 4 is
16 looking at the work of the industrial hygienist,
17 staff physicians, consulting physicians to
18 ensure, quote, quality, objectivity and
19 consistency.

20 So, that piece of it, the other -- the
21 quality of the CMC work will be examined by a
22 different Subcommittee, how their decisions is

1 weighed by the CE is more relevant to this
2 committee.

3 CHAIR CASSANO: Okay.

4 MEMBER VLIEGER: Right. And so, my
5 question is, the CE has no guidelines on how to
6 evaluate what they get back from the CMC.
7 There's nothing where they say that they're
8 supposed to evaluate a CMC report for whether or
9 not it's valid or whether or not it's well
10 rationalized.

11 CHAIR CASSANO: We will look at that,
12 Faye. I think that's part of looking at the
13 statement of work to see if it covers what it's
14 supposed to cover. And, also, more important is,
15 is the CMC working with all of the relevant
16 information that the CE has obtained to render an
17 opinion? So, we will certainly look at that.

18 Any other issues that we think are
19 within our scope?

20 CHAIR MARKOWITZ: It's Steve
21 Markowitz.

22 I am curious, it follows with Faye's

1 comments, how a CE is in the position of
2 knowledge, experience, prestige to question the
3 CMC? How that would happen?

4 If they turned over with a set of
5 questions to an expert and the expert renders
6 their opinion.

7 So, how would it be that the CE could
8 question the CMC report?

9 CHAIR CASSANO: It's got --

10 MEMBER VLIENER: On the same basis of
11 how they can they question the attending
12 physician's report?

13 CHAIR MARKOWITZ: Yes, a step further
14 down the line.

15 CHAIR CASSANO: Yes. And, how do they
16 determine if they need a tiebreaker evaluation?
17 Those are all things we need to look at.

18 They are scantily written in this
19 Procedure Manual and, as we've seen, maybe not
20 the best -- maybe not the good guidance that they
21 could have at this point.

22 Okay, data sources, there are several

1 other chapters in this Procedure Manual that
2 talks about initial development. It talks about
3 eligibility. It talks about wage loss. And, it
4 talks about consequence of condition.

5 So, there's one, two, three, four,
6 five additional chapters. One, two, three, four,
7 five, six, seven bulletins and a circular back
8 DOL on a list of this is relevant to what you're
9 doing.

10 Obviously, we can't go through all of
11 that today. But, I think for starters, those are
12 our initial data resources.

13 There is also one data resource that,
14 unfortunately, we cannot discuss in public that
15 we will look at and determine if it is something
16 that we should include as one of our data
17 resources. And, that's a FECA's Office
18 directive.

19 And, I think the other -- and I don't
20 know whether you want to call it data or whether
21 you want to call it process, but I think Les's
22 comment about talking to a bunch of CEs and

1 finding out exactly how they adjudicate different
2 things at different levels, develop a data source
3 that they need.

4 Any other thoughts on how we can get
5 all of the information we need to try to help the
6 DOE in these areas that they asked us to?

7 MEMBER VLIEGER: Would it be work
8 looking at a small percentage of claims to look
9 at the process that was in when they used a CMC?

10 CHAIR CASSANO: Yes, I think that
11 looking at some claims, and I think then they
12 would have to be redacted to personal
13 information. But, I think we -- yes, I think
14 that's one.

15 And, I don't know if it would be
16 possible the DOL would get back with us, I'd
17 really like to get to a claims examining center
18 and sit down and look at how that's done.

19 I don't know if that's possible, but
20 we can -- because DOL can use -- would you be
21 able to figure out if that's something that is
22 possible for us to -- maybe one or two of us to

1 be able to do and report back to the group?

2 MS. RHOADS: Yes, I can put that on
3 the list of things to ask the program.

4 CHAIR CASSANO: Okay, thank you.

5 MEMBER SILVER: This is Ken.

6 Do we have the quarterly management
7 reports that are described in the scope of work
8 for the CMCs on page 24 of that 29-page document?

9 There are internal DOL reports that
10 track the process. They don't appear to be rich
11 in critical thinking, but at least there are some
12 numbers we can start with.

13 CHAIR CASSANO: Okay, thank you. So,
14 that's the CMC SOW, okay.

15 So, we've gotten that nailed down.
16 And, I sort of want to get, before we go back to
17 looking at any of these other documents, I want
18 to get to -- well, let me back up, before we get
19 to time line.

20 On these other documents that need to
21 be reviewed which now include the two job
22 descriptions and the statement of work and other

1 sections of the Procedure Manual and these
2 bulletins, what I'd like to do is, and again, I
3 don't know if I need to do this in the public
4 meeting or if I can send an email out, with this
5 list of bulletins and documents and ask people,
6 various people, to review them and they get back
7 to the group by other --

8 And, I don't want to -- I'm trying to
9 not have another meeting, but to put people into
10 working groups and assign these different
11 documents for them to review and then write a
12 short report back to the Subcommittee.

13 Is that something that we can do with,
14 you know, as long as we report what the outcome
15 of that is at a subsequent meeting?

16 MS. RHOADS: Sure.

17 CHAIR CASSANO: Okay, great.

18 CHAIR MARKOWITZ: Steve Markowitz.

19 Maybe it would be better to have
20 another telephone meeting for people, not to
21 write reports, but just give a short summary of,
22 you know, give a document everybody will have

1 access to documents and just give a short verbal
2 summary. That way, the public has access through
3 these phone calls of what we're saying.

4 And also --

5 CHAIR CASSANO: Okay.

6 CHAIR MARKOWITZ: -- just more
7 efficient.

8 CHAIR CASSANO: So, we could have
9 another Subcommittee meeting between now and the
10 Full Committee meeting in October?

11 CHAIR MARKOWITZ: Sure, you know, it
12 just needs six weeks' notice.

13 The other two Subcommittees that have
14 met so far in the past week are going to have
15 another telephone meeting.

16 CHAIR CASSANO: Okay, okay.

17 So, what I will do is we will look
18 through these documents sometime between now and
19 six weeks for -- sometime between now and six
20 weeks before the next meeting so that we can
21 finish.

22 It's going to have to be some time --

1 it's the middle of July already -- so, it's going
2 to have to be sometime early September. We will
3 have a second meeting and have this report back.

4 And then, we'll have to get answers
5 from DOL as far as visiting and talking with some
6 claims examiners before the next full meeting.

7 And, Steve, how much do you want from
8 us at that next full meeting? Obviously, we're
9 not going to be finished with our task.

10 CHAIR MARKOWITZ: No, no one's
11 expecting this -- Steve Markowitz -- no one's
12 expecting any Subcommittee to be finished.

13 But, let me proposed a different kind
14 of idea.

15 So, the claims examiner weighing
16 medical evidence has to confirm or not the
17 diagnosis, has to address issues of causality.

18 And, sometimes, it goes to a CMC or to
19 a SECOP, you know, an examining physician or to a
20 referee.

21 And, when they go to one of those
22 people, they have to describe -- they have to

1 pose questions.

2 So, what I'm wondering is whether
3 there are data we should request that would give
4 us a closer look into the process of decisions
5 that the CE is making? It does not take the
6 place of a focus group or, you know, get a better
7 sense of how CEs operate.

8 This is more an assessment, initial
9 assessment, of the decisions they're making, how
10 often they go to the contract specialist, on what
11 basis they go and so that we can at least --

12 I'm not sure, I think there's some
13 data. I'm not sure how much we're going to
14 learn, but it would give us an initial look and
15 might help inform our eventual decision as to
16 whether we -- whether and how we want to look at
17 a larger number of claims to examine the validity
18 of these claims -- of the medical evidence, you
19 know, evaluation process.

20 CHAIR CASSANO: Do we get that kind of
21 information as to what gets -- which claims have
22 gotten sent to a CMC and for what reason then the

1 aggregate data they're, you know, 330,000 that
2 were sent because the agency's medical evidence
3 is, you know, another 10,000 were sent through
4 because there's no good medical opinion and stuff
5 like that?

6 There is a list of reasons to send
7 things to CMC in here. Where is it? When we
8 talk about it, you know, clarification of
9 diagnosis, causation and care and onset date,
10 consequential injury treatment and, again,
11 another thing on clarification of conflict.

12 So, those are the nine areas, nine
13 reasons they would send something.

14 Can we get that kind of information?

15 MS. RHOADS: Well, if you want to
16 formulate a question that has the details that
17 you want in it, I'll pass that along to the
18 program and they can tell us what they can do and
19 what they can't do.

20 CHAIR CASSANO: Okay, that sounds
21 good.

22 MEMBER SILVER: It might be helpful

1 for the moderator to put up the planning on SOW
2 document and go to page 24 for just a moment.

3 CHAIR CASSANO: Okay.

4 MEMBER SILVER: It describes the
5 quarterly management reports that -- just an
6 aggregate and presumably they're based on this
7 aggregated individual reports.

8 CHAIR CASSANO: Okay. Page 24, and
9 this is the detailed report. And so, this isn't
10 making a lot of sense to me.

11 Who was that? Was that Ken?

12 MEMBER SILVER: Yes.

13 CHAIR CASSANO: Okay.

14 I'm looking at this, for each calendar
15 quarter, the contractor is to provide quarterly
16 management reports in four parts, details,
17 summary, contract medical consultation.

18 Okay, number of -- pending cessation
19 at the beginning of the quarter. It looks like
20 something we could look at.

21 Can we get copies of those -- some of
22 those reports? I don't see anything that says

1 why they were sent, but can we get some of these
2 reports? These management reports?

3 MS. RHOADS: I'll ask the program for
4 some.

5 CHAIR CASSANO: They -- any sense in
6 there of why there were sent?

7 MEMBER VLIEGER: Causation meaning
8 whether or not what the claimant is claiming
9 cause for disease is actually being the causative
10 factor, not the causation. Impairment rating is
11 another cross of referrals whether it's not
12 during impairment rating.

13 I'm looking at page 6 on the report
14 under item 1.5 and it says, for referee
15 referrals, we --

16 CHAIR CASSANO: which document?

17 MEMBER VLIEGER: I'm looking at the
18 statement of work, page 6 of 29, item 1.5, and it
19 says that they expect, out of the 5,525 opinions
20 on causation, it is estimated that approximately
21 10 will require a referee referral.

22 CHAIR CASSANO: I'm not seeing this.

1 MEMBER VLIEGER: Page 6, bottom of the
2 page.

3 CHAIR MARKOWITZ: It's not on the
4 screen.

5 CHAIR CASSANO: This is -- okay.
6 So, that only ten will require a
7 review?

8 MEMBER VLIEGER: A referee review,
9 yes.

10 MEMBER BODEN: This is referee review,
11 this is not just --

12 CHAIR CASSANO: This is the referee
13 referral, not a CMC referral.

14 MEMBER VLIEGER: Right, but the number
15 of CMC referrals they expect with this statement
16 of work is 5,525. If you go back up on page 5
17 where opinions on causation shall be provided for
18 approximately 5,525.

19 CHAIR CASSANO: Okay.

20 MEMBER VLIEGER: The numbers in the
21 beginning of the report of their expected
22 caseload.

1 CHAIR CASSANO: Yes, but that's just
2 for causation and they have a bunch of other
3 reasons.

4 MEMBER VLIEGER: Right, impairment
5 rating is a different issue.

6 CHAIR CASSANO: That is not a
7 diagnosis, yes.

8 MEMBER BODEN: Yes, so, this is Les
9 Boden. One of the things that makes this sort of
10 hard for me is that causation is very -- it lumps
11 together a whole lot of things. You know, you
12 need --

13 (Telephonic interference.)

14 MEMBER BODEN: -- diagnosis and then
15 linking the two together with presumably
16 epidemiological or other kinds of evidence or,
17 you know, particular medical tests that show
18 that.

19 And, it seems to me that it's -- it
20 just seems to me that, at least from my mind, I
21 would like to know, for example, in how many
22 cases there were problems with exposure

1 information and, you know, how many there are
2 problems with diagnosis information and how many
3 there are problems combining, you know, going
4 from exposure to causation.

5 So, you know, for certain things like
6 beryllium disease, there are specific tests.
7 But, for other kinds of illnesses, you know, lung
8 disease, you may need all three of those elements
9 separately.

10 CHAIR CASSANO: Yes, and that's
11 something we didn't discuss and maybe we should
12 talk about whether this is in scope or not.

13 Do we -- we're assuming that when
14 we're talking about the medical evidence, that
15 the piece that goes between the CE and then the
16 industrial hygienist to determine exposure has
17 already occurred.

18 And, this is why we need to get a
19 better understanding of a process because, I'm
20 not sure if examining how the CE evaluates the
21 industrial hygienist report is considered part of
22 medical evidence or not because, as we saw in the

1 full meeting, there were some real questions.
2 And, I don't want to get into the realm of the
3 people evaluating the exposure measures.

4 But, there were some real questions
5 about the diseases that they were asking the
6 industrial hygienist to relate to various
7 exposures. And we saw that there was some
8 disconnect there.

9 So, I'd like some guidance from Steve
10 or from other members of the group as to what --
11 whether we think that's part of our scope or not.

12 CHAIR MARKOWITZ: This is Steve
13 Markowitz.

14 No, I do think we need to include the
15 weighing of exposure information as part of the
16 evaluation of medical evidence there. See,
17 that's three.

18 One is, yes, there's another
19 Subcommittee that's going to look at this type of
20 exposure matrices. They will look more generally
21 at the use of quality of that tool. And, we'll
22 get into the individual exposure assessments.

1 But, the second reason is that, in the
2 way the DOL approaches this is that the -- they
3 don't always differentiate between diagnosis and
4 causation. The term covered illness.

5 And so, whereas, we may tend to think
6 distinctively that, you know, one establishes a
7 medical diagnosis based on medical information
8 and then separately evaluates causation, I don't
9 see that clear distinction all the time, at least
10 in the material that's been provided to us.

11 So, I think when our charge on this
12 Subcommittee is to look at medical guidance, the
13 weighing of medical evidence and we know that
14 causation is an important reason why claims are
15 referred to CMCs, that causation means evaluation
16 of exposures.

17 So, I think while we're looking at how
18 they weigh medical evidence, we should also
19 include exposure as part of that.

20 CHAIR CASSANO: Okay.

21 CHAIR MARKOWITZ: Does that make
22 sense?

1 CHAIR CASSANO: It makes sense to me.

2 Anyone else have comments about that?

3 MEMBER VLIEGER: My question is, I'm

4 not aware in the documents and where in the

5 Procedure Manual where it says that the CMC

6 actually weighs the industrial hygienist report.

7 I think they just accept it.

8 So, could we look at that? If they

9 actually weigh it?

10 CHAIR CASSANO: We certainly can.

11 The whole -- I think the biggest issue

12 that I see is how much discernment does the CE

13 have in ignoring some evidence and moving other

14 evidence forward to either the industrial

15 hygienist or the CMC in order to get a valid

16 opinion back?

17 And, I think that's where the guidance

18 really needs to be. So, I wanted -- I still want

19 to circle back to this advice and to talk about

20 how we develop some of these things.

21 But, I'm looking at the calendar and

22 it looks like the earliest probably we could

1 reasonably have another meeting would be some
2 time after the first week after Labor Day or the
3 second week after Labor Day.

4 And so, we would have to get these
5 reading assignments done probably sometime before
6 that. And then, figure out what we're going to
7 discuss and how we're going to discuss at that
8 meeting.

9 I don't think it's possible for us to
10 get into any claims examiners or talk to any
11 claims examiners before that within a week.

12 So, let me go back now to the
13 questions that DOE asked us to help them with.

14 And the first is, clarification,
15 recommendation regarding the assessment of
16 medical opinion, the value of rationalization
17 supporting a particular conclusion.

18 And then, standardized triggers for
19 requiring independent medical reviews by a CMC or
20 a SECOP. And, that second opinion, that's the
21 second opinion request.

22 I think that's pretty much all we've

1 been discussing right now. And, I think that's
2 one of the major ones.

3 But, just as far as process goes, how
4 do you think we should accomplish that
5 clarification or recommendation? Should we do
6 this eventually as a report? Should we do this
7 by editing, you know, the Procedure Manual and/or
8 making recommendations directly into the
9 documents? And/or is there a better way or a
10 different way? Open to suggestions.

11 Hello?

12 CHAIR MARKOWITZ: This is Steve
13 Markowitz.

14 I think we outline an approach to this
15 issue, including whatever considerations. I
16 don't think we should try to, you know, take stab
17 at rewriting the Procedure Manual or any official
18 capacity.

19 But, you know, when we read that
20 section from the Procedure Manual, it was very
21 vague. And, obviously, they realize it because
22 this was their first task with how do we address

1 this? And, we specify what rationalization.

2 So, I think that we continue to talk
3 it through and develop an approach that would be
4 useful.

5 CHAIR CASSANO: Okay.

6 And also, we discussed this, too, the
7 methodologies for approving physician responses
8 to data requests and including a review of
9 development or other outreach efforts for
10 verification.

11 So, Department of Labor, I guess we're
12 going to need -- I presume some of these
13 development letters are -- send letters and they
14 fill in what's necessary. How -- what's -- what
15 are these?

16 MS. RHOADS: These are development
17 letters that the CEs send when they need more
18 evidence for the file. You can ask -- did you
19 want to look at them? Is that what you're
20 asking?

21 CHAIR CASSANO: Yes, I think out of
22 context, they may not mean that much, but I think

1 in the context of a complete file, there -- you
2 know, we can evaluate what the CE has already
3 received and at what point they send the
4 development letter or make a phone call or do a
5 call to the provider would be very useful so that
6 we can figure out how to fix it or improve it, I
7 should say.

8 CHAIR MARKOWITZ: This is Steve
9 Markowitz.

10 Maybe they've already provided this
11 material, but maybe they could start by they want
12 us improve it, just give us what material that
13 they use, the letters, outreach reach efforts and
14 provider communications.

15 I'm not sure if they've already given
16 us those, if they have, fine, we just have to
17 find it. But, otherwise, provide us with what
18 they're currently using so we can, you know, look
19 at it.

20 CHAIR CASSANO: And, if there are
21 separate documents for them or is that basically
22 what -- do they follow the guidance in that

1 Procedure Manual?

2 MS. RHOADS: I think what you're
3 talking about are the letters that appear in
4 different files. So, let's formulate a question
5 of what it is that you want to see, if you want
6 to see a file and see how the letters are in
7 there. If you just want to see some letters and
8 then I'll pass the question on to the program and
9 see what they can do.

10 CHAIR CASSANO: Okay, thank you.

11 CHAIR MARKOWITZ: So, just to simplify
12 -- Steve Markowitz -- they asked us to in
13 bulleted items to review, quote, department
14 letters, development letters, outreach efforts
15 and provide a communication, end of quote.

16 So, that's our request, is what do
17 they want us to review? You know, provide us
18 with that and then the Committee will take a
19 look.

20 CHAIR CASSANO: And, I understood that
21 these are individual letters written in
22 individual case files by individual CEs. There

1 is no standardized letter that they write if the
2 CE's saying I need this, this, this and the other
3 thing. Correct?

4 MEMBER VLIEGER: It's done on a case-
5 by-case basis.

6 CHAIR CASSANO: Okay.

7 MEMBER VLIEGER: The CE determines to
8 these decisions. And, sometimes, it looks like a
9 canned letter. But from District Office to
10 District Office, they look different.

11 CHAIR CASSANO: Okay. Well, I think
12 for starters, we should ask for just some samples
13 of the development letters. If they don't make
14 sense out of context, then we'll probably ask for
15 case files. But, I think the initial ask will be
16 just for some development letters.

17 And, I don't know, these outreach
18 efforts, what do you -- what do you mean by that?
19 Are those the telephone calls or what?

20 MS. RHOADS: Okay, I'll ask them --
21 actually, I can just ask them what is the basis
22 for this bullet that they asked for improvement

1 on. And, they can let us know what the
2 background is for it.

3 CHAIR CASSANO: Okay, thank you.

4 And then, training resources for
5 improving quality of medical review as medical
6 evidence and by conflicting evidence.

7 MEMBER BODEN: Excuse me, can we just
8 go back to the second bullet? This is Les. I
9 was talking with my mute on, so talking to myself
10 only.

11 As you may remember earlier in the
12 conversation, I had a question about how much of
13 a burden providing these reports is for, for
14 example, for treating physicians, et cetera?
15 And, what the payment is?

16 I'd like to ask DOL to give us
17 specific information about what the physician
18 payments are for these reports.

19 And, I think, again, I don't know if
20 we have the resources or the time or the ability
21 to do this, but I'm, you know, I would be
22 interested in finding out from attending

1 physicians who have provided such reports or who
2 have been asked to and haven't, what their
3 experience of the process is and what might make
4 them feel more cooperative.

5 So, I don't know that the development
6 letters alone or whatever, I don't know what the
7 outreach efforts are, the provider communications
8 are, are really the full range of things that
9 might end up being effective or in any of those
10 things would be effective. And, I don't think we
11 can think abstractly about this and come to a
12 conclusion.

13 CHAIR CASSANO: I think, yes, I think
14 we need to see these in context of some cases
15 because, I think we need to see what they get
16 initially from an attending physician.

17 I think part of the problem is most
18 treating physicians don't know how to do this.
19 And, even if we told them how to do this, they
20 might not want to do it, not only for the reasons
21 that we say but also because it takes them away
22 from treating people which is what they want to

1 do.

2 MEMBER BODEN: Absolutely agree. But,
3 it would be good if we could actually, and again,
4 I don't know if we can do this or whether it's
5 feasible or have the resources to do it, but to
6 actually see what people who have been requested
7 to provide this information say about that.

8 CHAIR CASSANO: Okay, that's a great
9 idea.

10 Any other comments on that as far as
11 training resources?

12 On the training resources, I know they
13 ask about in weighing conflicting evidence, I'm
14 wondering if, first of all, are there any
15 training resources out there for the claims
16 examiners?

17 MEMBER VLIEGER: There are training
18 materials out there. We have to request them, I
19 doubt they're going to be released publically.

20 CHAIR CASSANO: Okay. But, if I
21 request them, we might be able to take a look at
22 them, right?

1 MEMBER VLIEGER: We should be --

2 CHAIR CASSANO: Because if they
3 necessary improve on training resources, then
4 we're going to need to see what's there, I think.
5 Any disagreement with that or concurrence or --

6 MEMBER BODEN: I agree.

7 CHAIR CASSANO: I would almost like to
8 warn you guys if we can because I think we need
9 to look at and generate some thinking -- the CE's
10 quality of medical -- including the medical
11 review of any evidence even before they determine
12 that there's something conflicting.

13 Do you have an opinion on that?

14 CHAIR MARKOWITZ: I'm sorry, could you
15 repeat the question?

16 CHAIR CASSANO: What I saying is that,
17 it says training resources for improving quality
18 of medical review of medical evidence in weighing
19 conflicting evidence.

20 I think what we see is that there are
21 lots of questions about the ability of the CEs to
22 review medical evidence before they even get to

1 something that's conflicting.

2 So, I don't know if we can broaden the
3 scope of that or not.

4 CHAIR MARKOWITZ: You know, I think
5 that we're requesting -- it can't be that
6 extensive. The question would be to see whatever
7 training resources exist whether it's to evaluate
8 medical evidence, whether it's conflicting.

9 I mean, I certainly --

10 CHAIR CASSANO: Okay.

11 CHAIR MARKOWITZ: -- the scope is
12 substance.

13 The scope of the charge to the overall
14 advisory report.

15 CHAIR CASSANO: Right.

16 And then this last application of
17 guidance relating to assessing contribution or
18 aggravation of toxic substances exposure to
19 disease.

20 That's a huge, huge area. And, I'm
21 not quite sure, again, I think we need
22 clarification. Are we talking about aggravation

1 of toxic substance to what a good thing would be
2 or are we talking about secondary diseases here?

3 And so, DOL, could you clarify that
4 for us?

5 MEMBER BODEN: This is Les.

6 You know, this, I think, is either a
7 quote or a paraphrase from the Act. So, the Act
8 basically said, it doesn't have to be the unique
9 cause, it could have contributed in some way or
10 aggravates some other condition.

11 So, I think they're asking for our
12 help, even though this is not as clearly not
13 fully a medical question about how to, you know,
14 make -- clarify in some way what aggravation and
15 contribution means.

16 CHAIR CASSANO: Okay.

17 MEMBER BODEN: So, I think it's any of
18 the above and it's what potentially makes the
19 coverage of the act much broader than it would be
20 if it just said caused.

21 CHAIR CASSANO: Yes, I think
22 contribution, and that's the sort of smoking

1 causes death then how do you cause, you know,
2 obviously, it's going to just take a therefore,
3 causation is, you know, if both of them can cause
4 and one aggravates the effect of the other.

5 But, aggravation is a little bit of a
6 different concept in that that's says to me that
7 somebody has a particular disease already and it
8 was made worse by this toxic substance.

9 Any thoughts on that?

10 MEMBER VLIEGER: I can answer this
11 from a personal perspective.

12 CHAIR CASSANO: Thank you.

13 MEMBER VLIEGER: If you -- the
14 aggravation cannot just be because of a toxic
15 substance. But, it can also be because of the
16 disease that came from the exposure.

17 So, pre-existing conditions that were
18 aggravated by the new diagnosis would be
19 something that would also be considered.

20 So, aggravation is not just a
21 causation issue, it's a pre-existing condition
22 that's been aggravated by the exposure, the new

1 disease or the treatment of the new disease.

2 CHAIR CASSANO: Is that defined
3 somewhere that you know of?

4 MEMBER VLIEGER: Other than in the
5 Act, the way it's written, I can do some research
6 and get back to you on it. I believe it's in
7 there because the standard wording and when
8 you're doing a claim is was it caused by,
9 contributed to or aggravated by and then fill in
10 the blank.

11 So, that comes up constantly and I
12 believe it's in the Act and it's covered,
13 paraphrased, in a number of places in the
14 Procedure Manual.

15 CHAIR CASSANO: Okay.

16 I mean, people have written volumes on
17 this and any good ideas on how we might start to
18 look at this? Steve? Anybody else?

19 I mean, this is a textbook in
20 occupational medicine, right?

21 CHAIR MARKOWITZ: This is Steve
22 Markowitz.

1 So, I don't remember much discussion
2 of this at our initial meeting in April, and
3 what I'd be curious about is understanding how
4 they have interpreted that specific language in
5 the past beyond, you know, generalities. How
6 have they tried to apply and use that either at
7 the CE level, the CMC level or whatever?

8 It's very difficult, so I'm curious as
9 to -- they've been charged with that in the
10 amendment in 2005, how do you do it?

11 And, at least, I would like some more
12 insight as to how they approach this. It may be
13 that they don't have a very elaborate approach
14 because it's a difficult issue. But, I would
15 like to learn more about it.

16 CHAIR CASSANO: I agree because -- and
17 I think that goes for everything on here is we
18 can't start to look at ways of improving the
19 process, improving, you know. Maybe now that we
20 understand how the process works now.

21 So, I will develop a -- we ask for the
22 information that we need and the requests that we

1 need and then send that to the Subcommittee
2 Members and Dr. Markowitz to see if they have
3 anything to add, at least just in that report to
4 the Department of Labor.

5 MEMBER VLIEGER: This is Faye.

6 Just one other thought, instead of
7 having to constantly do asks for this
8 information, is there some way the Department of
9 Labor could assign a well-qualified, well-trained
10 claims examiner, claims examiner supervisor, so
11 that during these calls, we can be referred to
12 what they use and how they use it?

13 MS. RHOADS: I can ask them if they're
14 willing to do that.

15 MEMBER VLIEGER: Thank you.

16 MEMBER BODEN: This is Les.

17 So, in a way, you know, information is
18 complicated, but in a way, it's simple. It's a
19 way of saying, you know, just because you had
20 COPD before this exposure, if the exposure made
21 it -- if it's the medical judgment of whoever is
22 providing the evidence that the exposure made it

1 worse, and the fact that you had some pre-
2 existing condition does not preclude you from
3 having an excessive claim?

4 I mean, I don't --

5 CHAIR CASSANO: Well, it --

6 MEMBER BODEN: Is this, you know, you
7 could make it that simple. But, you know, I
8 don't know. They seem to think that they've had
9 problems with this and maybe we need to try to
10 understand and we can ask them.

11 But, is the nature of their problem
12 that they're asking us to help them define it?

13 CHAIR CASSANO: Well, the biggest
14 problem I see with this from, again, a medical
15 perspective is, how, especially something like
16 COPD, how do you differentiate aggravation of a
17 disease by exposure unless it's a severe acute
18 exposure, there's a natural progression of the
19 disease.

20 And, that's a test for synthesis from
21 a physician's perspective because you really
22 can't. I mean, you can, you know, on a

1 population basis, yes, you can do that with
2 attributable risks and all of that, but on an
3 individual basis, it's very difficult.

4 Anyhow, I don't --

5 MEMBER BODEN: To this -- I don't
6 think the results of things that are, you know,
7 where on a population basis, you can say
8 something, but on an individual basis, you really
9 can't -- I mean, you do say definitively, you
10 know, this exposure caused this disease, but you
11 only really know what the relative risk is.

12 So --

13 CHAIR CASSANO: Exactly, and I run
14 into that all the time.

15 MEMBER BODEN: Right.

16 CHAIR CASSANO: When somebody says,
17 no, his bladder cancer was more likely caused by
18 his smoking than it was by exposure to TCE, well,
19 that's great on a population basis because you
20 know what the different relative risks are for
21 each.

22 But, on an individual level, you're

1 right, you cannot say that.

2 And so, anyway, it's a real dilemma
3 when you're looking at this from this kind of
4 perspective.

5 From a preventive medicine
6 perspective, it's easy. From assigning guilt, if
7 you will, not so easy.

8 The last thing I want to get to,
9 Steve, is there anything I've left out at this
10 point that you want me to address?

11 CHAIR MARKOWITZ: Well, just on the
12 list of requests from DOL. I wanted to make sure
13 we put a time frame on Ken Silver's idea for the
14 quarterly management reports that, if we wanted
15 to say the last four, you know, what are the most
16 recent calendar year, that's four quarters or
17 would --

18 CHAIR CASSANO: Okay.

19 CHAIR MARKOWITZ: You know, we specify
20 that.

21 And that we find some way of making
22 sure that -- have a process for specifying what

1 our request is around something that I mentioned,
2 asking for sort of the metrics around the claims
3 examiner, what they refer for, et cetera, some of
4 which is in the quarterly reports. But, we want
5 a quarterly management report of the CMC but we
6 want a little bit more detail.

7 So, that's --

8 CHAIR CASSANO: I think -- so today is
9 Tuesday, by the end of this week, what I will do
10 is -- and I'm going to get either the minutes or
11 the transcript back. As soon as I get minutes or
12 a transcript back, I will go through that and
13 make sure I pick out all of the asks and then
14 send a draft of that ask out.

15 DOL, how soon can you get minutes or
16 a transcript of this done, do you know?

17 MS. RHOADS: Well, that will take a
18 little time because of all the editing, but I
19 might be able to send you the recording sooner
20 than that if that would work.

21 CHAIR CASSANO: The recording is fine.
22 Just send me the recording and I'll go through it

1 and I will pick out the asks.

2 And, if we're going to meet some time
3 that first -- I'm going to say the second week of
4 September, I will get that list out within a few
5 days of getting the recording.

6 And then, I will also send out a list
7 of documents that need to be reviewed. And,
8 these are just very quick reviews. But there are
9 -- and some of them are very short, too. They're
10 bulletins, they're circulars and stuff like that.
11 And, I'll send that list out to the group.

12 And, if we can have everybody,
13 obviously, they will have to review it before the
14 meeting in September.

15 And then, we will also have after that
16 list, the documents that we get back from the
17 asks.

18 So, what I'm thinking is, you know, in
19 two weeks' time or less than two weeks' time that
20 we will have the draft of the asks to DOL back.

21 I would think that in three or four
22 weeks we would have -- I would ask people to have

1 at least have reviewed some of the documents that
2 I'm sending out now and then use the final couple
3 of weeks before the next meeting to review what
4 we've gotten back from DOL.

5 I don't think, at this point, that we
6 need to assign individual people to individual
7 documents. If it gets to the place where it's
8 too voluminous then I would certainly ask people
9 to divvy these up and then report back.

10 Any other ideas on that? Does that
11 sound good to people or --

12 (Simultaneous speaking.)

13 CHAIR CASSANO: Anybody else? Okay,
14 so hearing no dissents, I will move forward in
15 that direction.

16 Is there -- are there any other -- oh,
17 the last thing I wanted to bring up is something
18 that Les had brought up at the very beginning,
19 it's not on here, but Les asked about at the
20 meeting and that is, is there some way to
21 determine presumptions for some diseases that are
22 so obviously caused by certain toxins?

1 Number one, is that in our scope?
2 Anybody want to chime in on that?

3 MEMBER BODEN: Yes, I think the idea
4 -- I mean, obviously, I don't think we're going
5 to be able to write presumptions. So, I don't
6 think we can.

7 But, we can certainly make some
8 recommendations. Or do you think we could
9 actually write presumptions? That seems like a
10 pretty big task.

11 CHAIR CASSANO: I think initially
12 writing recommendations. I think before we even
13 get to that place, I think, obviously, outlining
14 what we could be considered when determining a
15 presumption needs to be outlined, whether we end
16 up using that to develop presumptions or we end
17 up giving that to DOL as a recommendation for
18 defining presumptions.

19 And there are lots of data that we can
20 use. We can look at some of the presumptions
21 that have been developed for other agencies. We
22 can look at information from some learned bodies,

1 again.

2 You know, you say asbestos, I say
3 mesothelioma, you know, if, as far as, you know,
4 somebody's exposed to asbestos and they have
5 mesothelioma, do we, you know, do we really need
6 to go through three-year process to determine
7 that it's causal related to their occupation? I
8 don't think so.

9 And then when you start to get AML
10 benzene, AML nitrate compound, you know, they're
11 all -- and then you get into the really weird
12 ones, you know, the stuff that you're not so sure
13 about like, you know --

14 MS. RHOADS: Dr. Cassano, we can't
15 hear you any more.

16 OPERATOR: Excuse me, it looks like
17 Dr. Cassano's line has disconnected.

18 MS. RHOADS: Okay, I'm sure she'll
19 dial back in. Let's just give her a couple
20 minutes.

21 (Whereupon, the above-entitled matter
22 went off the record at 3:46 p.m. and resumed at

1 3:50 p.m.)

2 CHAIR CASSANO: Hello?

3 (Chorus of hello.)

4 CHAIR CASSANO: So, I don't know what
5 happened, sorry about that. I knew I was going
6 to do that at some point.

7 Do you know where I was? I was -- we
8 were talking about presumptions and I was asking
9 about the method or some input because I didn't
10 hear.

11 CHAIR MARKOWITZ: I'm sorry, your
12 comment didn't or question didn't come through
13 that clearly.

14 CHAIR CASSANO: Okay. I was asking --
15 we were talking about presumptions, as I
16 remember, and we were talking about the ones
17 developed in guidance for how you would determine
18 presumptions. There's just actually helping to
19 establish presumptions.

20 But, I was sort of rambling and I
21 don't know where in the ramble I got disconnected
22 -- about some things are no-brainers like, you

1 know, you say mesothelioma, I say asbestos. I
2 don't say it enough. And that there are others
3 that are not quite so obvious.

4 And, I wanted to ask you, number one,
5 what do you think that this does -- part of the
6 scope of this particular Subcommittee or is it
7 something for the whole Committee or if there is
8 a part of it that we should be able to do?

9 CHAIR MARKOWITZ: Steve Markowitz.

10 So, you know, I think this is a
11 crosscutting issue that we should keep in mind
12 and explore where we can. I don't think it's
13 central to this Subcommittee. But, I don't think
14 any particular committee has the problem.

15 So, I think we should not forget about
16 it, keep it on the radar, but I think we need to
17 get further into, you know, our understanding of
18 how the system works before we can really move
19 much further on that.

20 Does that make sense?

21 CHAIR CASSANO: It makes perfect sense
22 to me. I think that's something that is very far

1 down the road, but something that I think needs
2 to be addressed and I think there are lots of
3 Subcommittees that may have a piece of it. And
4 so, I would agree with that.

5 Any other -- we're almost to the end
6 of this, so any last thoughts or questions that
7 people have or any other issue that people want
8 to bring up at this point?

9 MEMBER BODEN: So, actually -- this is
10 Les.

11 One of the things, I do think,
12 actually, that this is kind of central to what
13 our task is because our task is evaluating
14 medical evidence and this is one way of making it
15 easier to evaluate it.

16 But, also, I would be interested to
17 know what are the exposures and/or diseases that
18 people are submitting the requests to.

19 So, how many of the x-thousands in the
20 year are exposures to silica? I would just pick
21 a substance. How many of the x-thousand a year
22 are for COPD?

1 So, I don't have any sense. So, if we
2 were going to think eventually about
3 presumptions, it would be good to know which
4 substances or diseases or substance/disease
5 combination were actually high on the list?

6 Because, if you could, you know,
7 prioritize presumptions, then you'd want to do
8 them where they would actually help the most.

9 So, I think it would be -- that is a
10 request that I would like us to make to --

11 CHAIR CASSANO: I think we can do that
12 because think -- yes?

13 CHAIR MARKOWITZ: Let me just break in
14 here. This is Steve Markowitz.

15 The issue of the frequency of
16 diagnoses in claims, that another Subcommittee
17 has requested.

18 MEMBER BODEN: Oh great.

19 CHAIR MARKOWITZ: So, we will get that
20 when it's available.

21 There has not been a request for -- to
22 look at a frequency of exposures.

1 MEMBER BODEN: Okay, so we could add
2 that request. I will hold unless there's --

3 CHAIR CASSANO: Department of Labor,
4 does -- when a claimant submits a claim, do they
5 just submit a claim for the particular medical
6 condition or do they have to say I have
7 mesothelioma and I was exposed to asbestos? Do
8 they have to add a causative agent to the medical
9 condition or they get somebody -- the medical
10 condition and say, I believe this happened
11 because of work and you find the exposure that
12 most fits?

13 MS. RHOADS: The claim form has to
14 state a condition and it also has to say -- it
15 has to show their employment. It doesn't -- I
16 don't think it has to list, you know, exposure
17 agents on there unless they know.

18 CHAIR MARKOWITZ: Well, the
19 occupational health questionnaire which, I don't
20 know if it's administered to all claimants or
21 not, but it does contain information beyond the
22 site of employment, including job title and at

1 least asks about exposures and jobs they had.

2 I'm sure there's a whole spectrum of
3 information of substance on claims.

4 MEMBER VLIEGER: But, when the claim
5 is made and the claims examiner is doing
6 development, we often go back to the worker and
7 say, well, what were you exposed to that could
8 cause this?

9 And then, the worker, in order for
10 that information to be accepted, has to have a
11 doctor's note or it's well rationalized that says
12 that these exposures could cause this to be.

13 If the claims examiner, through their
14 site exposure matrix search doesn't come up with
15 a good answer, then -- and the doctor reports are
16 not concluded well rationalized, then they take
17 the supplied answer from the matrix and go to an
18 industrial hygienist and then the industrial
19 hygienist report comes back.

20 And then, their industrial hygienist
21 report and the work ups from the claims examiner
22 goes to the Contract Medical Consultant.

1 So, you have the claims -- the worker
2 is asked for information at some point but it's
3 usually after the development to the site
4 exposure matrix.

5 CHAIR CASSANO: Okay, thanks. That's
6 important to know.

7 MEMBER SILVER: Going back to
8 presumptions for a moment -- Ken Silver here.

9 I think it's a very useful organizing
10 principle. We were discussing aggravation a
11 little while ago and the easiest way out of that
12 might be to list diseases like asthma and, you
13 know, those things that can aggravate it and
14 start developing slam dunk presumptions other
15 than the cancers that were mentioned.

16 And, I've been asking everybody and
17 their brother for the last few months, whatever
18 happened to the sentinel health
19 events/occupational lists developed by Hawthorne
20 and Melius in the '80s updated by Mullan in the
21 '90s? That would be very useful updated list to
22 have at our fingertips. So, if anyone know, let

1 us know.

2 CHAIR CASSANO: Okay.

3 Okay, since he raised it, since he
4 raised the issue, we have to try to figure out
5 whether that's a viable document and whether
6 somebody's updated it since.

7 MEMBER SILVER: All right, I'll get
8 with our author, Steve, or surveillance issues
9 and maybe Les has a lead to it as well.

10 CHAIR CASSANO: Okay.

11 I'm glad Dr. Markowitz mentioned the
12 occupational history questionnaire because I
13 think in our deliberations, I would think that's
14 something we need to look at to see if we can
15 straighten that up a little bit to help the
16 claims examiner.

17 Any thoughts on that?

18 Hello?

19 MEMBER VLIENER: I think the
20 occupational history questionnaire has issues,
21 but in order to figure out how to correct it, I
22 think if we look at the former worker medical

1 screening program, they do a very comprehensive
2 review with the workers. And, their reports
3 actually show toxins that would normally be
4 associated with labor categories for these DOE
5 cites.

6 I think if we were going to change the
7 occupational history questionnaire in any way, we
8 should look at the reports that come from the
9 interviews of the workers to the former worker
10 program like Building Trades Medical Screening.

11 CHAIR CASSANO: Okay. And, I submit
12 that I probably -- you can ask Laura Welch for
13 some redacted reports from there as well as
14 whatever Department of Labor has for the
15 company's medical information. So we can look at
16 that and email back to be better utilized by the
17 CE.

18 Are there any other thoughts,
19 questions, comments, et cetera that you want to
20 ask DOL for?

21 Nothing? Dr. Markowitz, anything that
22 you want to ask?

1 CHAIR MARKOWITZ: No.

2 CHAIR CASSANO: Carrie, anything
3 further you wish to add?

4 MS. RHOADS: No, I think we're good.

5 CHAIR CASSANO: Okay. I think this is
6 good, thank you all again for joining us. Thank
7 you to the people that were patiently listening
8 to us try to run our way through all of this.

9 And, we say two weeks, we will be
10 having another meeting in early September.

11 I appreciate all the input. I
12 appreciate the Members of the Subcommittee being
13 here. I appreciate all of the work done by
14 Department of Labor to get us ready to go.

15 Okay, that's it. Everybody have a
16 great evening and we'll be back in touch.

17 (Chorus of thank you.)

18 OPERATOR: This concludes today's
19 call. You may disconnect at this time.

20 (Whereupon, the above-entitled matter
21 went off the record at 4:02 p.m.)

22

A

ability 109:20 112:21
able 30:17 46:6,7,9
 49:12,17 50:11 56:15
 69:11 73:10 83:13
 88:21 89:1 111:21
 122:19 125:5 128:8
abnormal 62:4
above-entitled 75:17
 126:21 136:20
absence 78:6 79:3
Absolutely 111:2
abstractly 110:11
abuse 64:1
academia 13:1
Academies 28:5
accept 36:2 102:7
accepted 25:14 72:1,13
 132:10
accepts 41:9
access 91:1,2
accomplish 11:11
 104:4
accurate 8:21 60:17
 66:4 84:4
achieved 44:13
acquired 38:7
act 114:7,7,19 116:5,12
action 44:10
actors 80:7
acute 119:17
add 20:21 26:12 118:3
 131:1,8 136:3
added 11:19 15:10
 23:15 55:3
adding 28:3
additional 16:4,7 27:2,5
 34:2 42:16,17 87:6
address 46:1 82:15
 92:17 104:22 121:10
addressed 129:2
adhere 47:20
adjudicate 58:15 88:1
adjudicated 52:18
adjudication 16:2 22:16
 44:19 47:5 48:21
adjust 53:5,9
administer 60:9
administered 21:15
 24:3,10 131:20
administers 22:3
Administration 33:11
advance 7:11
advice 1:5 4:20 10:5,13
 22:11 46:14 102:19
advise 10:19 16:5
advisory 1:3 2:3 4:18
 7:2 8:3,7,10 9:17 10:4

10:17 113:14
advocacy 67:9 72:8
advocate 13:19
advocates 72:7
affiant 34:10
affidavits 34:9
affirmation 54:1
affirmative 44:10 45:18
 62:19 79:4
afternoon 4:14
agencies 13:3 36:1
 125:21
agency's 94:2
agenda 7:15 11:16 12:2
 12:3,5
agent 131:8
agents 131:17
aggravate 133:13
aggravated 115:18,22
 116:9
aggravates 27:18
 114:10 115:4
aggravation 16:21
 113:18,22 114:14
 115:5,14,20 119:16
 133:10
aggregate 94:1 95:6
aggregated 95:7
ago 13:8 56:3 133:11
agree 17:19 20:19 52:4
 55:20 58:9 59:2,4,10
 66:3 111:2 112:6
 117:16 129:4
agreed 50:12
ahead 23:11 32:8 54:12
 59:3 68:7 77:2
aid 35:14
Alamos 55:12
alcohol 64:1
alive 50:10
allowed 70:14
allowing 44:7
AMA 36:10,13,14,17
ambiguous 78:3
amendment 117:10
AML 126:9,10
amount 14:15 69:10,20
 70:4
analysis 63:5
and/or 44:12 104:7,9
 129:17
answer 39:5,11 42:2
 80:14 115:10 132:15
 132:17
answering 25:22
answers 92:4
anybody 17:5 23:13,17
 26:10 28:14 34:18

37:2,17 39:4,4 45:11
 48:3,6 51:22 52:2
 68:4 70:9 78:16 80:13
 116:18 124:13 125:2
anyway 42:20 65:5
 121:2
appear 53:7 89:10
 107:3
application 16:20
 113:16
applies 49:15
apply 65:21 117:6
appreciate 5:2 24:17
 39:12 49:5 59:20
 136:11,12,13
approach 12:4 17:2,7
 17:22 38:6 104:14
 105:3 117:12,13
approaches 68:1 101:2
appropriate 18:14 23:5
 30:8,9 39:6 62:8 63:1
 78:13
appropriateness 31:3
approved 72:13
approving 105:7
approximately 96:20
 97:18
April 8:10 117:2
arbitrarily 15:1
area 1:6 3:5 11:17
 113:20
areas 17:1 88:6 94:12
arena 69:7 72:6,6 73:3
argument 63:3
asbestos 126:2,4 128:1
 131:7
asked 18:3 42:6 46:14
 69:5 72:9 77:5 82:15
 88:6 103:13 107:12
 108:22 110:2 124:19
 133:2
asking 16:12 38:2
 100:5 105:20 114:11
 119:12 122:2 127:8
 127:14 133:16
asks 118:7 122:13
 123:1,17,20 132:1
aspects 10:20 44:19
aspersions 67:3
assess 66:2
assessing 16:21
 113:17
assessment 16:13 35:3
 35:19,22 36:12,20
 42:4 93:8,9 103:15
assessments 100:22
assign 57:18 59:7
 90:10 118:9 124:6

assigned 10:18 79:1
assigning 121:6
assignments 103:5
assigns 18:17 60:3
assist 29:8 44:1 45:12
 57:14 79:3
assistance 13:2 44:13
 45:18,19
assisting 32:2
assists 44:9
Associate 12:19
associated 135:4
assume 73:4
assuming 99:13
asthma 133:12
ATSCR 28:6
attempt 53:21
attending 18:11,14 19:1
 21:9 25:14 30:11
 31:21 32:2 42:7,9
 49:11 67:2 68:20
 71:18 84:7 86:11
 109:22 110:16
attorney 72:8,11
attributable 120:2
audits 84:2
author 134:8
automatic 79:8
available 6:16 7:10 9:6
 9:9,15 41:20 54:5,17
 54:20 56:10 130:20
avoid 18:9
award 72:15
aware 10:1 102:4
aye 66:13

B

B 11:1 32:20 33:15
 48:15
back 6:11 17:12 24:21
 29:18 41:21 42:4,5
 49:1 50:17 56:15
 62:15 72:2 73:6,13,16
 74:9,16 75:1,4 76:10
 77:4,12 82:4,21 84:1
 85:6 87:7 88:16 89:1
 89:16,18 90:6,12 92:3
 97:16 102:16,19
 103:12 109:8 116:6
 122:11,12 123:16,20
 124:4,9 126:19 132:6
 132:19 133:7 135:16
 136:16
background 12:8 109:2
backtrack 41:5
bad 38:22
balance 63:22
bar 53:11

based 11:20 15:15
22:12 26:16 34:10
50:22 60:12,16 61:15
64:8 73:21 95:6 101:7
basically 19:5 39:15
64:20 72:7 106:21
114:8
basis 15:2 27:15 37:20
38:18 60:17 86:10
93:11 108:5,21 120:1
120:3,7,8,19
began 21:19
beginning 26:16 71:3
73:18 76:5,6 95:19
97:21 124:18
believe 10:16 19:14
23:15 45:5 71:17
116:6,12 131:10
belongs 29:4 68:15
benzene 126:10
beryllium 22:3,4,7,9
62:3,5 99:6
best 47:22 50:14 74:16
86:20
better 18:10 80:7 90:19
93:6 99:19 104:9
135:16
beyond 19:15 117:5
131:21
biased 67:5,10
big 59:17 125:10
biggest 102:11 119:13
bill 72:2
billing 71:20,22
bit 17:9 56:11 115:5
122:6 134:15
bladder 120:17
blank 116:10
board 1:3 2:3,4 4:18,22
5:3,6,22 6:2 7:2 8:3
8:10 9:17,20 10:4
16:2,8 64:7 68:5
Board's 6:16 7:6 8:7 9:7
9:16 10:17
boards 67:9
Boden 1:18 5:13,14
13:21,22,22 17:10,10
27:8,8 28:19 29:14,15
31:8,12 32:9 48:9,10
50:4 58:2,5,17 69:8
71:1,12 72:4 73:1
74:12,14,20 75:2
97:10 98:8,9,14 109:7
111:2 112:6 114:5,17
118:16 119:6 120:5
120:15 125:3 129:9
130:18 131:1
bodies 28:4 30:15,18

125:22
Boston 14:4
bottom 43:4,8 97:1
break 6:7,13 74:7,8
130:13
brief 12:7
briefly 52:12
bring 16:6 124:17 129:8
broad 10:18 11:15 17:1
broaden 113:2
broader 45:22 114:19
brother 133:17
brought 27:21 124:18
Building 135:10
bullet 108:22 109:8
bulleted 77:5 107:13
bulletin 47:16
bulletins 87:7 90:2,5
123:10
bunch 87:22 98:2
burden 66:6 70:2
109:13
by-case 108:5

C

calendar 95:14 102:21
121:16
call 4:7,11,17 5:7 6:11
18:9 24:12 51:12
52:10 74:15 87:20,21
106:4,5 136:19
call-in 8:6
calls 52:1 91:3 108:19
118:11
cancer 33:18,20 41:21
42:1 60:20 61:20,21
120:17
cancers 133:15
canned 108:9
capacity 9:19 13:13
49:22 104:18
cardiologists 35:11
care 22:18 47:12 60:9
94:9
career 26:17
Carrie 2:6 4:11,16
10:10 136:2
carry 64:9
carrying 64:17
case 22:12,16 23:6,8
30:4 41:20 44:5,19
62:10 68:11 77:21
79:2 107:22 108:15
case- 108:4
caseload 97:22
cases 31:15 33:19
57:10 69:15 77:18
98:22 110:14

Cassano 1:14,20 5:8,10
10:7,9 12:11 13:9,16
13:21 14:7,18 17:19
18:19 19:20 20:12,15
20:18 21:3 23:12
24:19 25:16 26:20
27:20 28:20 29:9,11
30:6 31:11 32:6 34:16
36:3,14,21 38:19 39:9
39:12 40:22 42:3
43:14,17 45:4,15 46:2
48:22 50:2 51:2 52:7
52:11,22 53:10,15
54:10,16 55:20 56:19
57:3,19,22 58:9,18
59:3,10 61:8 62:11
63:15 64:3,19 65:11
65:15 66:3 68:7 70:8
71:10 72:5 73:5 74:13
75:6,20 77:2,7,10
80:13 81:3,19 82:19
83:2,5 85:3,11 86:9
86:15 88:10 89:4,13
90:17 91:5,8,16 93:20
94:20 95:3,8,13 96:5
96:16,22 97:5,12,19
98:1,6 99:10 101:20
102:1,10 105:5,21
106:20 107:10,20
108:6,11 109:3
110:13 111:8,20
112:2,7,16 113:10,15
114:16,21 115:12
116:2,15 117:16
119:5,13 120:13,16
121:18 122:8,21
124:13 125:11 126:14
127:2,4,14 128:21
130:11 131:3 133:5
134:2,10 135:11
136:2,5
Cassano's 126:17
cast 67:3
categories 31:16 40:10
135:4
causal 44:22 47:8 126:7
causality 92:17
causation 22:17 28:1
44:20 66:14,14 78:3
94:9 96:7,10,20 97:17
98:2,10 99:4 101:4,8
101:14,15 115:3,21
causative 96:9 131:8
cause 27:18 30:3 34:1,7
37:11 96:9 114:9
115:1,3 132:8,12
caused 114:20 116:8
120:10,17 124:22

causes 115:1
CBD 22:7
CE 21:11 22:14 26:1,3,5
28:9,11 38:1 44:1,9
46:3 47:18,20 51:15
51:19 53:19,21 57:5
57:14,17 59:6 60:1
62:7 65:13 66:6 68:10
68:16,19 79:1,7,15
81:7 82:2,9,21 83:4
85:1,5,16 86:1,7 93:5
99:15,20 102:12
106:2 108:7 117:7
135:17
CE's 73:21 108:2 112:9
cell 62:4
center 88:17
central 128:13 129:12
certain 17:15 21:15
24:3 38:20 59:10 99:5
124:22
certainly 18:1 77:4
85:17 102:10 113:9
124:8 125:7
certainty's 76:21
Certificate 41:9,14
certificates 33:22 34:3
37:8,8,12 41:6
certified 9:5 64:7
CEs 1:5 26:13 37:20
69:12 87:22 93:7
105:17 107:22 112:21
cessation 95:18
cetera 27:18 30:15,19
32:1,11 33:7,12 47:17
58:21 73:17,17,17
78:4 109:14 122:3
135:19
Chair 1:14,20 2:4 5:8,10
5:22 9:5 10:8,9 11:14
13:9,16,21 14:7,10,11
14:18 17:19 18:19
19:20 20:12,15,18
21:3 23:12 24:19
25:16 26:20 27:20
28:20,22 29:9,10,11
29:13 30:6 31:11 32:6
34:16 36:3,14,21 38:4
38:19 39:7,9,12 40:22
42:3 43:11,14,15,17
43:20 45:4,15,16 46:2
48:22 50:2 51:2 52:7
52:11,22 53:10,15
54:10,16 55:20 56:19
57:3,19,22 58:9,18
59:3,10 60:5,8,11
61:8,14 62:11,16
63:15,18 64:3,4,19

- 65:11,12,15,16 66:3
68:7 70:8 71:10 72:5
73:5 74:13 75:6,20
77:1,2,3,7,8,10 80:13
81:3,16,19 82:12,19
82:20 83:2,3,5 84:13
85:3,11,20 86:9,13,15
88:10 89:4,13 90:17
90:18 91:5,6,8,11,16
92:10 93:20 94:20
95:3,8,13 96:5,16,22
97:3,5,12,19 98:1,6
99:10 100:12 101:20
101:21 102:1,10
104:12 105:5,21
106:8,20 107:10,11
107:20 108:6,11
109:3 110:13 111:8
111:20 112:2,7,14,16
113:4,10,11,15
114:16,21 115:12
116:2,15,21 117:16
119:5,13 120:13,16
121:11,18,19 122:8
122:21 124:13 125:11
127:2,4,11,14 128:9
128:21 130:11,13,19
131:3,18 133:5 134:2
134:10 135:11 136:1
136:2,5
change 12:1 135:6
changed 15:10,15
changes 15:7 67:13,14
Chapter 15:19 19:12
chapters 87:1,6
charge 70:14 101:11
113:13
charged 117:9
chart 31:22
Charter 10:17
chief's 50:19
children 50:21
chime 65:7 125:2
Chorus 127:3 136:17
chose 17:3
chosen 14:22 15:3 23:5
Chronic 22:7
circle 102:19
circled 77:12
circular 87:7
circulars 123:10
citations 63:1
cite 30:14,14 66:12,13
67:22
cites 135:5
citing 58:20
City 14:12
claim 18:18 44:1 47:5
47:19 71:14,14,21,22
72:3,13,15 78:6,9
79:9 116:8 119:3
131:4,5,13 132:4
Claim's 16:2
claimant 2:1 29:7 40:3
43:21 44:1,5,7 46:8
55:8 72:10,18 73:12
73:13 78:11 96:8
131:4
claimant's 21:8 59:6
claimants 13:4 131:20
claimed 54:3
claiming 96:8
claims 4:20 10:5,13,22
11:1,6 15:22 24:15
29:8 30:17 33:10 35:4
35:16 38:10 39:16
41:7,17 44:22 45:21
73:10 78:2 80:3,9,11
80:19 82:16,17 83:19
88:8,11,17 92:6,15
93:17,18,21 101:14
103:10,11 111:15
118:10,10 122:2
130:16 132:3,5,13,21
133:1 134:16
clarification 16:12 51:4
94:8,11 103:14 104:5
113:22
clarify 50:4 82:11 114:3
114:14
clarifying 44:14
clarity 78:6
clear 41:14 72:15 101:9
clearly 8:18 114:12
127:13
clicking 7:7
clinic 21:12
clinical 20:8
close 74:1
closer 93:4
closure 56:8
CMC 19:1 22:10 23:9
33:16 38:1,2 39:1
42:7 44:15 57:11
62:10 66:22 68:10,15
70:17 73:21 74:10
76:19 77:19 78:1,5,10
78:14 79:5 80:18 81:9
81:11,12 82:1,4,5,9
82:18 83:9,21 84:3,21
85:6,8,15 86:3,8 88:9
89:14 92:18 93:22
94:7 97:13,15 102:5
102:15 103:19 117:7
122:5
CMC's 70:19 83:22
CMCs 70:21 84:5,9 89:8
101:15
CMP 42:12 67:2
code 56:18 70:10,11,12
70:13
coding 71:20
cognizance 15:12
collected 42:6
collecting 44:2
collection 62:9
College 12:20
colon 50:19
combination 130:5
combining 99:3
come 18:21 19:9 20:5
21:7 28:7 31:7 45:17
74:9 75:1,4 110:11
127:12 132:14 135:8
comedy 65:9
comes 7:4 37:9 72:14
79:19 116:11 132:19
coming 55:18
comment 8:5 24:20
25:6 54:8,11 56:13
61:6 77:3 87:22
127:12
comments 6:15 14:8,17
17:6 19:19 48:7 55:5
56:12,19 68:4 86:1
102:2 111:10 135:19
committee 10:19 11:15
12:9 14:10 34:21 85:2
91:10 107:18 128:7
128:14
communicating 44:4
communication 107:15
communications 44:11
106:14 110:7
COMMUNITY 1:17,19
2:1
companies 67:5
company 24:7,16
company's 135:15
compensated 71:18
compensation 14:4
22:21 33:8,10 50:20
70:6,17 71:13
complete 60:3 106:1
complicated 118:18
compound 126:10
comprehensive 135:1
computer 53:5
concept 115:6
concluded 132:16
concludes 136:18
conclusion 16:16 63:4
63:12,14 103:17
110:12
conclusions 34:13
62:22
Conclusive 64:14
concurrence 112:5
condition 54:3 87:4
114:10 115:21 119:2
131:6,9,10,14
conditions 61:17
115:17
conducting 60:18
conference 4:17 65:9
80:10,17
confers 68:10
confirm 92:16
confirmation 53:22
confirmed 64:13
conflict 23:8 57:10
94:11
conflicting 64:6 109:6
111:13 112:12,19
113:1,8
conflicts 45:3
connection 74:15
consensus 28:4
consent 16:5
consequence 87:4
consequential 94:10
consider 21:11 40:17
47:1 68:22 80:21
consideration 24:16
considerations 104:15
considered 14:21 26:18
40:16 99:21 115:19
125:14
consist 31:15,18
consistency 84:19
consistent 17:18
constantly 116:11
118:7
consultant 18:17 25:19
25:22 28:12 30:10
69:2,4 132:22
consultants 22:10 28:8
29:22 32:2
consultation 95:17
consulted 32:3
consulting 21:9 84:17
contain 33:22 131:21
contained 34:13
containing 34:9
contains 7:9 53:22
content 39:15
contents 3:1 19:16
34:12
context 105:22 106:1
108:14 110:14
contingent 71:13
continue 10:1 105:2

continued 49:16
contract 18:16 22:10
 25:19,21 30:10 69:2,4
 70:20 93:10 95:17
 132:22
contracted 15:21 22:20
 77:20
contractor 6:3 70:21
 77:18 95:15
contributed 114:9
 116:9
contribution 16:21
 113:17 114:15,22
convene 10:3
conversation 109:12
Conversely 63:11
convincing 63:3
cooperative 110:4
coordinate 77:18
COPD 118:20 119:16
 129:22
copies 6:14 95:21
correct 15:7 28:18
 29:12 36:18 42:10
 66:20 108:3 134:21
corrected 38:22
correspondence 51:20
couched 49:14
country 22:5
County 55:12
couple 56:3 58:1 73:9
 124:2 126:19
course 71:22
cover 85:14
coverage 114:19
covered 45:1 101:4
 116:12
covers 85:13
creates 55:1
credentials 19:6
critical 13:15 29:2
 89:11
cross 96:11
crosscutting 128:11
curious 68:9 85:22
 117:3,8
currently 13:12 49:10
 50:10 106:18

D

D 2:4
d.htm 7:2
dairy 40:9
data 3:6 11:17 21:17
 71:5 74:4,4 86:22
 87:12,13,16,20 88:2
 93:3,13 94:1 105:8
 125:19

date 7:7 33:20 34:1,11
 54:6,7 94:9
dates 49:14
Day 103:2,3
days 9:7,16 123:5
deal 38:14
dealing 41:18
deals 15:19
dealt 69:16
death 33:22 34:1,3 37:7
 37:8,11,12 41:6,9,13
 115:1
deciding 78:19 80:20
decision 25:21 29:3
 46:21 50:15 66:21
 78:22 82:3,21 93:15
decisions 17:17 65:22
 84:22 93:4,9 108:8
decline 26:19
dedicated 7:8
deemed 18:15
DEEOIC 16:8 22:22
 33:16 77:17
deeply 13:2
deficiencies 44:5 48:1
deficiency 51:10
define 3:5,6 11:16,17
 81:4 119:12
defined 32:16 116:2
defines 48:13
defining 76:12 125:18
definitely 19:8 36:22
 70:16
definition 45:6
definitive 61:15
definitively 120:9
dehydration 64:2
deleted 15:10
deliberations 31:2
 134:13
denied 35:4,16 71:21
department 1:1 4:18
 18:17 21:14 40:14
 41:9 49:1 51:4 72:11
 105:11 107:13 118:4
 118:8 131:3 135:14
 136:14
depending 6:8
describe 69:14 92:22
described 89:7
describes 95:4
describing 22:22
description 16:1,3
 78:13
descriptions 23:18
 89:22
Designated 2:5 4:22
destroyed 53:20 55:10

detail 122:6
detailed 9:13 12:2 95:9
details 94:16 95:16
determination 33:6
determine 15:6 27:3
 44:21 81:8 86:16
 87:15 99:16 112:11
 124:21 126:6 127:17
determines 68:19 108:7
determining 34:7 57:15
 125:14
develop 19:4 88:2
 102:20 105:3 117:21
 125:16
developed 59:16
 125:21 127:17 133:19
developing 42:21 43:5
 133:14
development 44:18
 47:21 57:16 87:2
 105:9,13,16 106:4
 107:14 108:13,16
 110:5 132:6 133:3
DFO 5:1 9:4
diagnoses 130:16
diagnosing 64:8
diagnosis 27:22 31:19
 32:21 33:20,21 34:2
 34:11 40:16,18,19
 42:10,15 44:20 47:7
 54:6,6 56:17 61:20
 62:5 64:1 74:4 92:17
 94:9 98:7,14 99:2
 101:3,7 115:18
diagnostic 23:2 32:10
 35:8 47:8 63:8
diagnostics 42:17
dial 126:19
dialed 74:3
diary 40:2,7
died 41:18
diesel 60:21,21 61:2
different 19:2 20:21
 27:12 28:8 37:3 38:12
 40:10 66:11 72:6,10
 73:2 80:7 84:22 88:1
 88:2 90:10 92:13 98:5
 104:10 107:4 108:10
 115:6 120:20
differentiate 101:3
 119:16
differing 80:10
difficult 42:1 69:15
 117:8,14 120:3
dilemma 121:2
diplomacy 80:6
direct 47:21
direction 124:15

directive 87:18
directives 15:14 79:18
directly 15:19 104:8
disability 12:14 33:10
 36:9
disabled 50:21
disagreement 112:5
discernment 102:12
disclosure 9:21
disconnect 4:8 74:22
 100:8 136:19
disconnected 126:17
 127:21
discretion 79:1 80:9
discuss 17:6,8,11,22
 37:14 63:16 87:14
 99:11 103:7,7
discussed 9:22 105:6
discussing 104:1
 133:10
discussion 6:8,21 8:9
 8:22 12:1 30:13 54:5
 77:9 79:16 117:1
discussions 8:16 18:21
disease 14:4 17:16 22:7
 27:19 29:7 35:10,11
 64:8,12 96:9 99:6,8
 113:19 115:7,16
 116:1,1 119:17,19
 120:10
diseases 26:15 100:5
 114:2 124:21 129:17
 130:4 133:12
disorders 64:10
dissents 124:14
distinction 101:9
distinctively 101:6
distinguishes 33:2
District 108:9,10
Division 22:20
divvy 124:9
doctor 24:16 34:5 40:17
 40:19 41:2 49:11,16
 52:5 59:12 132:15
doctor's 132:11
document 46:13 51:13
 51:21 76:7,22 89:8
 90:22 95:2 96:16
 134:5
documentation 44:6
documents 6:19 7:11
 14:21 15:17 17:4 28:4
 29:10 76:19 81:22
 89:17,20 90:5,11 91:1
 91:18 102:4 104:9
 106:21 123:7,16
 124:1,7
DOE 21:14,15,18,22

24:3,10 39:5,22 88:6
103:13 135:4
DOE's 21:20 33:4
doing 5:5 11:4,12 14:2
84:12 87:9 116:8
132:5
DOL 39:8 73:4 77:5
87:8 88:16,20 89:9
92:5 101:2 109:16
114:3 121:12 122:15
123:20 124:4 125:17
135:20
dol.gov/owcp/energy...
7:1
Domina 2:4 6:1
doubt 111:19
DPA 28:5
Dr 5:8,13,19,21 10:7
11:14 12:10,18 13:21
14:7 19:21 27:21
29:11 30:21 76:10
80:2 118:2 126:14,17
134:11 135:21
draft 3:7 11:18 122:14
123:20
due 78:2
dumped 55:14
dunk 133:14
Duronda 2:2 5:17 13:10
20:13 68:6,8
duty 45:12

E

E 52:15 53:16 55:17
earlier 9:9,10 80:2
109:11
earliest 102:22
early 40:4 92:2 136:10
earnings 50:6
easier 129:15
easiest 133:11
easily 51:11
East 12:21
Eastern 1:14 6:5
easy 59:14 121:6,7
editing 104:7 122:18
Edition 36:10,17,17,19
educated 80:5
Education 22:3
EEOICPA 13:5 31:15
effect 30:3 47:11 48:16
49:3 115:4
effective 110:9,10
effects 21:20
efficient 91:7
efforts 105:9 106:13
107:14 108:18 110:7
either 13:14 46:8 54:20

102:14 114:6 117:6
122:10
elaborate 117:13
electrocardiogram
32:11
elements 99:8
eligibility 87:3
else's 65:2
email 7:19 90:4 135:16
embellish 20:21
emergency 13:14 67:2
employee 21:12 23:6
54:2,18,19
employee's 23:9
employees 9:20 13:19
21:17 22:21
employment 131:15,22
encourage 7:6
Energy 13:19 21:14
22:20
energyadvisoryboard...
7:20
engine 60:21 61:2
enjoying 62:16
ensure 84:18
entire 54:15
entirely 7:8
entities 24:6
environment 15:2
environmental 12:11
12:15,20
epidemiological 98:16
epidemiologist 14:14
equal 25:9,15 37:19
equivocal 41:15
especially 8:19 16:14
17:3 36:1 56:1 72:16
119:15
essential 78:2
establish 33:20 37:14
44:2,20,20,22 74:4
127:19
established 41:22
61:17
establishes 101:6
estimated 96:20
et 27:18 30:15,19 31:22
32:11 33:7,12 47:17
58:21 73:17,17,17
78:4 109:14 122:3
135:19
evaluate 21:20 30:9,12
49:3 57:7 59:19,22
67:12,15 82:8 85:6,8
106:2 113:7 129:15
evaluates 60:2 81:13
99:20 101:8
evaluating 11:2 36:9

47:18 60:1 100:3
129:13
evaluation 31:19 33:2
47:6 66:5 73:21 81:6
86:16 93:19 100:16
101:15
evaluations 32:20 33:3
33:9 35:9 67:8
evening 136:16
events/occupational
133:19
eventual 93:15
eventually 104:6 130:2
everybody 4:14 5:11
12:17 43:7 65:2 74:7
75:9 90:22 123:12
133:16 136:15
evidence 1:6 4:21 10:6
10:14 11:1,7 14:16
15:20 16:19 19:3 20:3
20:8 21:6,13 26:2,21
29:1 30:1 31:6,14,15
31:17 32:9 33:4,14,18
34:4,19 37:4,16 38:21
40:10 41:11,12,16
42:21 43:5,22 44:2,6
44:10,15,18 45:3
46:22 47:7,8,19,22
48:12 50:13 51:11,18
52:16 57:5,5,8,11,14
57:18 58:21,21 59:8
59:17,22 61:19 62:5,9
62:19 63:6,9,13 66:13
68:19 71:4 73:20,22
78:3 79:3,4 80:8,16
80:22 81:21 82:17
83:1,20 92:16 93:18
94:2 98:16 99:14,22
100:16 101:13,18
102:13,14 105:18
109:6,6 111:13
112:11,18,19,22
113:8 118:22 129:14
exactly 47:1 88:1
120:13
examination 23:1 33:1
33:11 73:11
examinations 21:16
33:7
examine 23:6 93:17
examined 60:15 84:21
examiner 16:2 24:15
30:17 35:16 38:10
39:16 80:3,9,12,19
83:19 92:15 118:10
118:10 122:3 132:5
132:13,21 134:16
Examiner's 16:1

examiners 4:20 10:6,13
10:22 11:6 29:8 35:5
82:16 92:6 103:10,11
111:16
examining 50:7 88:17
92:19 99:20
example 21:18 24:13
27:17 31:22 32:10
33:5,9 34:5 35:13
60:19 61:4 63:7,21
98:21 109:14
excessive 38:18 119:3
Excuse 39:18 74:12
109:7 126:16
exhaust 60:21,21 61:3
exist 113:7
existing 119:2
exists 47:15 79:11
expect 96:19 97:15
expected 97:21
expecting 92:11,12
experience 14:2 35:2
38:8 40:12,14 50:16
55:21 67:22 86:2
110:3
expert 63:19,20 64:10
64:14 67:19 71:17
72:21 82:7 86:5,5
expert's 72:17
expertise 48:18 64:16
experts 21:9
explain 10:15 44:5 46:7
explaining 63:12
explanation 62:21
explore 128:12
exposed 126:4 131:7
132:7
exposure 10:21 17:16
21:17 27:18 47:10
60:20 61:2 98:22 99:4
99:16 100:3,15,20,22
101:19 113:18 115:16
115:22 118:20,20,22
119:17,18 120:10,18
131:11,16 132:14
133:4
exposures 12:15 39:22
78:4 100:7 101:16
129:17,20 130:22
132:1,12
extensive 22:6 113:6

F

FACA 9:8
facilities 21:10,16,22
24:4,10 32:19
facility 21:12
fact 119:1

factor 96:10
factors 65:17
facts 34:9
factual 60:4,11,17 66:1
fair 14:15 69:10,19 70:4
family 41:13,15,20
 56:15
far 27:22 37:2 50:17
 91:14 92:5 104:3
 111:10 126:3 128:22
fatality 13:14
Faye 2:2 5:15 13:17
 18:7 19:10 26:4 40:13
 45:13 49:8 59:19 60:5
 60:5 68:17 80:15
 83:17 85:12 118:5
Faye's 85:22
FDA 35:18
feasible 111:5
FECA's 87:17
federal 2:5 4:22 33:8,13
fee 72:14
feel 25:4 69:21 81:11
 83:16 110:4
feeling 25:20 54:11
 82:2
felt 28:16
fi 73:12
field 63:21
figure 18:1 30:17 58:19
 68:12 88:21 103:6
 106:6 134:4,21
file 22:12 23:6 73:20
 105:18 106:1 107:6
files 107:4,22 108:15
fill 105:14 116:9
filling 70:12
films 32:10
final 16:1 17:17 60:18
 124:2
finalized 15:16
finally 74:8
find 7:15 41:16,22
 54:21 72:21 73:2
 106:17 121:21 131:11
finding 61:18 88:1
 109:22
findings 23:1 34:13
 61:16 62:4 77:22
finds 35:18
fine 21:4 75:6 106:16
 122:21
fingertips 133:22
finish 76:15 91:21
finished 92:9,12
finishing 61:13
first 5:2 7:4 10:15 11:8
 17:7 19:21 20:11 24:7

37:7 48:11 73:6 103:2
 103:14 104:22 111:14
 123:3
fit 40:9
fits 131:12
five 69:12 87:6,7
fix 106:6
fixed 67:13,14
flag 20:20 46:15
flat 50:20
Flats 13:11
flip 43:18 58:1
focus 69:11 73:6 93:6
follow 6:20 19:21 20:2
 38:16 51:19 106:22
following 31:16 54:1
 78:14
follows 85:22
forget 128:15
form 25:20 31:17 51:14
 67:4 131:13
formal 9:11
formally 45:21 80:5
former 13:17 14:5
 21:18,21 22:1 24:2,9
 24:17 25:12 33:4,5
 54:18 134:22 135:9
forming 34:5
forms 70:13,13
formulate 94:16 107:4
forward 102:14 124:14
found 6:22
four 10:18 15:3,17
 32:17 34:9,12 54:6
 62:15 63:16,18 69:12
 87:5,6 95:16 121:15
 121:16 123:21
fragment 55:15 56:6
fragmentary 55:13
frame 121:13
frankly 58:13
frequency 61:2 130:15
 130:22
friendly 55:8
front 72:11
full 11:14 14:9 91:10
 92:6,8 100:1 110:8
full-time 49:18
fully 59:15,16 114:13
function 78:5,10
functions 21:20
funny 54:11
furnish 23:6
furnishes 22:11
further 48:7 57:15
 68:13 72:18 86:13
 128:17,19 136:3
FWP 21:19

G

gather 28:11
gathering 29:8
gathers 50:13
gee 42:13 54:17
general 63:20,21 65:17
 67:19 72:10
generalists 67:22
generalities 117:5
generalized 68:20
generally 60:14 100:20
generate 112:9
George's 35:14,17
germane 14:21
getting 25:15 35:15
 74:1 77:11 123:5
give 15:2 24:15 65:17
 90:21,22 91:1 93:3,14
 106:12 109:16 126:19
given 14:20 17:15
 106:15
giving 66:4 125:17
glad 60:6 134:11
go 11:11,22 16:5,10
 19:12,14 23:11 24:21
 25:5 26:13 31:5,8
 32:8 34:17,20 41:21
 42:13 43:1,6 45:7
 49:10 52:15 54:8,12
 56:15 58:10 59:3 61:9
 62:12,15 66:22 68:7
 69:6 72:2 73:11 74:5
 76:3 77:2 78:15 79:13
 87:10 89:16 92:21
 93:10,11 95:2 97:16
 103:12 109:8 122:12
 122:22 126:6 132:6
 132:17 136:14
goes 27:22 38:1,21
 42:5,7,11 48:20 71:14
 73:20 92:18 99:15
 104:3 117:17 132:22
going 11:11,22 12:4
 15:8,17 17:4 19:9,20
 19:22 34:22 42:4 43:9
 43:18 45:5 46:20,21
 50:8,17 51:7 52:11
 54:11 56:5,22 57:19
 57:22 58:22 59:20
 61:13 62:13 63:16
 74:15 76:20 78:15
 79:13 83:7,13 84:1
 91:14,22 92:1,9 93:13
 99:3 100:19 103:6,7
 105:12 111:19 112:4
 115:2 122:10 123:2,3
 125:4 127:5 130:2
 133:7 135:6

good 4:14 5:10 10:11
 38:22 55:19 58:20,21
 68:1,2 73:2 74:11
 78:8 79:14 86:20 94:4
 94:21 111:3 114:1
 116:17 124:11 130:3
 132:15 136:4,6
goodness 36:5
Google 7:2
gosh 34:15
gotten 82:6 89:15 93:22
 124:4
government 9:20
governmental 36:1
great 66:3 90:17 111:8
 120:19 130:18 136:16
greater 60:3 64:9
ground 13:5
group 24:22 31:9 46:17
 69:12 72:8,8 73:7
 79:20 89:1 90:7 93:6
 100:10 123:11
groups 90:10
guess 72:4 76:21
 105:11
guidance 10:22 11:6
 15:7 16:4,7,20 17:14
 20:8 22:11 37:20
 47:15 65:16,21 79:15
 82:16 86:20 100:9
 101:12 102:17 106:22
 113:17 127:17
Guide 36:10,13,15,17
guideline 12:3
guidelines 47:21 69:3
 85:5
guilt 121:6
guy 59:11
guys 112:8

H

half-time 49:18
hand 56:5
hands 68:15
Hanford 13:18
hang 6:11
happen 18:2 86:3
happened 127:5 131:10
 133:18
happens 18:13 56:7
 68:18
happy 30:5 31:9
hard 98:10
Hawthorne 133:19
head 36:7
heading 6:17
health 1:3 4:19 7:3 10:5
 12:20,21 14:2 21:21

32:18 39:22 131:19
133:18
healthcare 21:8 31:20
32:19 38:7
hear 18:19 36:3 42:18
126:15 127:10
hearing 9:3 124:14
heart 35:11
hello 104:11 127:2,3
134:18
help 16:9 39:3 88:5
93:15 103:13 114:12
119:12 130:8 134:15
helpful 40:8 94:22
helping 127:18
helps 17:16
hey 58:19 67:15
Hi 13:22
hierarchical 38:6
hierarchy 37:15 38:7,17
high 130:5
hinges 80:19
historical 41:7 47:11
48:16,19 49:4 51:3
history 60:16 134:12,20
135:7
hold 43:3 131:2
holes 65:4,4
home 32:18
hopefully 12:2
hoping 18:8
hospices 32:18
hospital 55:8
hospitals 32:18
host 4:11
hour 76:9
huge 113:20,20
hygienist 84:16 99:16
99:21 100:6 102:6,15
132:18,19,20
hygienists 11:2 73:16

I

idea 40:3 73:6 79:14
92:14 111:9 121:13
125:3
ideas 18:5 38:3 116:17
124:10
ignoring 102:13
illness 13:20 22:21 34:8
44:3 45:1 47:9,11
48:16,18 64:12 101:4
illnesses 99:7
illustrative 39:16
imagine 38:10
IMEs 67:4,7
immediate 51:14
impairment 22:17

35:16 44:21,22 47:11
79:6 96:10,12 98:4
implemented 13:7
importance 28:16
important 25:6 26:22
56:21 57:9 62:7 73:22
79:2 85:14 101:14
133:6
improve 106:6,12 112:3
improvement 108:22
improving 16:17,18
71:5 109:5 112:17
117:18,19
inaccurate 37:9,12
60:13
include 26:17 31:21
32:1,15 33:3,18 77:9
78:14 87:16 89:21
100:14 101:19
included 34:20
includes 19:5 21:8 44:4
54:5 61:16
including 10:21 12:16
30:2 47:7 62:22 79:3
104:15 105:8 112:10
131:22
inclusion 27:1
incomplete 47:2 60:12
inconsistencies 45:2
independence 24:17
independent 22:14
24:11 27:16 32:4 67:7
103:19
indifferent 38:22
individual 13:4 17:18
17:18 29:6 69:13 80:5
95:7 100:22 107:21
107:22,22 120:3,8,22
124:6,6
individuals 22:8
industrial 11:2 73:15,17
84:16 99:16,21 100:6
102:6,14 132:18,18
132:20
inform 93:15
information 8:6 11:17
17:15 25:13 27:6,11
28:10 29:8 34:1,3,6
35:15,18 38:13,15
41:22 42:16 53:19
54:1 60:4,12,13 69:1
76:1,13 78:7 80:18
81:5,7 85:16 88:5,13
93:21 94:14 99:1,2
100:15 101:7 109:17
111:7 117:22 118:8
118:17 125:22 131:21
132:3,10 133:2

135:15
Informational 3:6
initial 3:7 11:18 87:2,12
93:8,14 108:15 117:2
initially 73:12 110:16
125:11
injured 13:18
injuries 14:3
injury 13:15 94:10
input 23:21 78:11 81:14
127:9 136:11
insight 117:12
Institute 22:2
instruct 47:18
instructions 7:16
interactive 8:1
interacts 82:9
interest 75:22 77:15
interested 109:22
129:16
interesting 24:19
interference 98:13
interim 17:21
internal 89:9
internist 14:13
interpretation 47:8 63:8
63:12
interpreted 117:4
interpreting 32:12,14
38:14
interviews 69:14 135:9
introduce 4:10 5:6 12:7
14:9
Introduction 3:3
introductory 48:4
involved 13:2,5 14:5
35:12 50:22 77:19
issue 9:2 18:20 24:1
25:18 35:2 37:6 39:3
45:18 47:2 51:22 81:4
98:5 102:11 104:15
115:21 117:14 128:11
129:7 130:15 134:4
issues 3:5 11:16 12:14
12:14 19:6 22:15
23:14,17 26:10 34:19
37:2 45:11 46:18 66:1
76:12 78:16 83:14
85:18 92:17 134:8,20
it'll 7:3 75:1
item 96:14,18
items 77:5 107:13
IWAR 28:5

J

job 16:1,2 20:4 38:11
59:7 89:21 131:22
jobs 132:1

joining 7:21 136:6
judgment 118:21
July 1:10 92:1
justification 64:15
justified 63:5

K

keep 17:12 36:7 57:19
58:22 59:20 62:13
128:11,16
keeping 40:1
Ken 5:19 12:19 23:22
39:19 80:1 89:5 95:11
121:13 133:8
KENNETH 1:18
kind 27:12 29:1,6 66:4
66:17 79:15 92:13
93:20 94:14 121:3
129:12
kinds 98:16 99:7
Kirk 2:4 6:1
knew 127:5
know 9:2 14:15 15:11
20:5 24:11,20 25:8
29:1 30:13 35:5,11,20
35:22 37:10,18 38:6,9
40:5 41:17 42:8,14
43:7 45:18,22 46:3,4
47:1 49:1 54:11,22
55:18 56:2,17 63:16
64:5 65:13 66:7,9,19
66:21 67:13 68:12
69:9,12,13,15,17,21
71:12 72:3 73:7,8,18
76:13 80:13 84:2,11
87:20 88:15,19 90:3
90:14,22 91:11 92:19
93:6,19 94:1,3,8
98:11,17,21 99:1,3,5
99:7 101:6,13 104:7
104:16,19 106:2,18
107:17 108:17 109:1
109:19,21 110:5,6,18
111:4,12 113:2,4
114:6,13 115:1,3
116:3 117:5,19
118:17,19 119:6,7,8
119:22 120:6,10,11
120:20 121:15,19
122:16 123:18 126:2
126:3,3,5,10,12,13
127:4,7,21 128:1,10
128:17 129:17 130:3
130:6 131:16,17,20
133:6,13,22 134:1
knowledge 34:10 61:1
86:2
knowledgeable 42:9,12

60:15

L**L&I** 70:13**labor** 1:1 10:19 18:17
40:15 41:9 49:1 51:5
103:2,3 105:11 118:4
118:9 131:3 135:4,14
136:14**Labor's** 4:18**laboratory** 64:13**lack** 78:3**language** 15:8 23:17
24:22 25:3,9,18 68:15
117:4**larger** 93:17**Las** 14:6**late** 4:15 60:10**Laughter** 61:7**Laura** 135:12**lavage** 62:4**laying** 11:9**lead** 19:21 24:14 134:9**learn** 69:10,19 93:14
117:15**learned** 28:4 30:15,18
125:22**leave** 74:14,17,22 76:7**led** 63:13**left** 121:9**legal** 47:14**legislation** 13:6**lend** 46:12**Les** 13:22 17:10 29:2,14
48:9,9 49:6 69:8 98:8
109:8 114:5 118:16
124:18,19 129:10
134:9**Les's** 87:21**Leslie** 1:18 5:13**let's** 19:17 31:8 34:17
39:17,17 42:20 45:9
51:7 52:14 62:11

64:21 107:4 126:19

letter 49:12 53:16 106:4
108:1,9**letters** 105:13,13,17
106:13 107:3,6,7,14
107:14,21 108:13,16
110:6**level** 61:2 68:21 80:22
117:7,7 120:22**levels** 17:15 88:2**life** 54:15**line** 6:1 8:15,17 61:9,9
86:14 89:19 126:17**lines** 4:5 6:10 75:11**linking** 98:15**list** 18:4 28:4 68:14 71:287:8 89:3 90:5 94:6
121:12 123:4,6,11,16
130:5 131:16 133:12
133:21**listen** 4:5 8:7**listening** 136:7**listing** 6:17**lists** 133:19**literature** 63:10 66:9**litigation** 33:13**little** 13:7 17:9 53:1156:11 61:21 115:5
122:6,18 133:11
134:15**locations** 22:5**long** 25:2 41:10 83:12
90:14**long-term** 14:2**long-time** 54:18**longer** 50:18 54:4**look** 15:18 20:1,21 26:9
29:18 30:7 37:1 42:13
45:21 46:11 54:2255:1 56:11 59:1 67:16
83:9,12 85:11,17

86:17 87:15 88:8,18

91:17 93:4,14,16

95:20 100:19,20

101:12 102:8 105:19

106:18 107:19 108:10

111:21 112:9 116:18

117:18 125:20,22

130:22 134:14,22

135:8,15

looked 40:11 41:2 48:8
83:15,15**looking** 26:1 49:9 59:15
59:16 81:11,12 83:4,4
84:16 85:12 88:8,11

89:17 95:14 96:13,17

101:17 102:21 121:3

looks 95:19 102:22

108:8 126:16

Los 55:12**loss** 22:17 45:2 49:9,16
50:9,17 79:6 87:3**lost** 43:2 50:6**lot** 37:10,12 38:8 42:14
55:2,9,11 61:10,10
95:10 98:11**lots** 112:21 125:19

129:2

lumps 98:10**lung** 26:15,19 35:10,10
60:20 62:3 99:7**lymphocyte** 62:3**M****M** 2:2**mail** 51:19**maintain** 21:16**major** 31:16 104:2**making** 19:7 29:3 82:3

82:22 93:5,9 95:10

104:8 121:21 129:14

malignancy 62:1**management** 89:6 95:5

95:16 96:2 121:14

122:5

manner 18:9**Manual** 15:18 29:6

76:18 79:18 86:19

87:1 90:1 102:5 104:7

104:17,20 107:1

116:14

Markowitz 2:4 5:22

11:14 14:7,11,12

27:21 28:22 29:10,12

29:13 30:21 38:4 39:7

43:11,15,20 45:16

60:5,8,11 61:14 62:16

63:18 64:4 65:12,16

76:11 77:1,3,8 80:2

81:16,18 82:12,13,20

83:3 84:13,14 85:20

85:21 86:13 90:18,18

91:6,11 92:10,11 97:3

100:12,13 101:21

104:12,13 106:8,9

107:11,12 112:14

113:4,11 116:21,22

118:2 121:11,19

127:11 128:9,9

130:13,14,19 131:18

134:11 135:21 136:1

Markowitz's 19:21**material** 84:8 101:10

106:11,12

materials 6:14 7:10,13

9:18 111:18

matrices 10:21 100:20**matrix** 132:14,17 133:4**matter** 47:21 75:17

126:21 136:20

matters 47:14**mean** 48:21 50:5 51:5,7

51:16 59:6,11 66:12

71:1 82:8 105:22

108:18 113:9 116:16

116:19 119:4,22

120:9 125:4

meaning 96:7**means** 62:20 101:15

114:15

meant 39:7**measures** 100:3**medical** 1:5,6,19 4:20

4:21 10:5,6,12,14,22

11:6,7 12:14 14:16

15:20,21 16:14,19,19

18:16,22 20:3,8 21:6

21:7,10,13,14,16,19

21:22 22:7,10,11,15

22:17 23:3,7,8,10,11

24:2,6,7 25:12,19,21

26:2,7,14,21 27:6

28:8,11 30:1,10 31:6

31:14,14,17 32:1,4,12

32:15,20 33:2,3,12

34:6,12,14,19 37:3,15

38:10,13,21 41:10,12

41:15,19 42:21 43:5

43:22 44:3,10,12,15

44:18 45:3 47:7,7,12

48:12 49:3 51:11,18

52:16,17 53:18,19

54:4,17 55:13 56:1

57:4,5,8,11,14,15,18

59:8 60:1,4,9,11,16

61:17 63:9 66:5,7,10

66:12 67:8 69:2,4

72:9,17,20,22 77:19

77:21 78:1,3,7 79:4,7

79:12 81:5,7,20 82:7

82:16,17,22 84:4

92:16 93:18 94:2,4

95:17 98:17 99:14,22

100:16 101:7,7,12,13

101:18 103:16,19

109:5,5 112:10,10,18

112:18,22 113:8

114:13 118:21 119:14

129:14 131:5,8,9

132:22 134:22 135:10

135:15

Medicare 56:16,17

70:13

medicine 14:14 116:20

121:5

meet 6:5 80:21 123:2**meeting** 1:8 3:4 4:17

5:1,4 6:14,18 7:7,8,11

8:11,14,20 9:6,22

10:2,3,12,16 11:8

14:22 15:4 19:22 31:2

83:10 90:4,9,15,20

91:9,10,15,20 92:3,6

92:8 100:1 103:1,8

117:2 123:14 124:3

124:20 136:10

meetings 6:17 8:12

11:14

meets 71:4

Melissa 6:3
Melius 133:20
Member 5:14,16,18,20
 6:1 12:19 13:10,17,22
 17:10 18:7 20:10,13
 20:16 21:1,5 23:22
 25:8 26:12 27:8 28:19
 29:14 31:8,12 32:9
 35:1 36:12,16,19
 39:18 40:12,21 41:1,4
 45:13 48:9 49:8 50:4
 50:9 52:4,8,20 53:13
 53:17 54:13 55:7
 56:13 57:2,4,21 58:2
 58:4,5,17 59:2,4,21
 60:7,10 65:8 68:6,8
 68:17 69:8 70:10 71:1
 71:12,16 72:4 73:1
 74:12,14,20 75:2 80:1
 80:15 83:17 85:4
 86:10 88:7 89:5 94:22
 95:4,12 96:7,17 97:1
 97:8,10,14,20 98:4,8
 98:14 102:3 108:4,7
 109:7 111:2,17 112:1
 112:6 114:5,17
 115:10,13 116:4
 118:5,15,16 119:6
 120:5,15 125:3 129:9
 130:18 131:1 132:4
 133:7 134:7,19
members 1:16 2:3 5:3,6
 5:13 8:3 9:18,20 12:6
 23:21 73:9 100:10
 118:2 136:12
memorialize 51:20
memory 55:16
mentioned 122:1
 133:15 134:11
merit 57:7
merits 60:1
mesothelioma 126:3,5
 128:1 131:7
met 1:13 91:14
method 70:6 127:9
methodologies 16:17
 71:4,7 105:7
metrics 122:2
Mexico 13:6
microphone 19:19
middle 53:1 92:1
mind 61:12 62:14 98:20
 128:11
minds 17:13
minor 24:1 50:21 51:10
minute 6:7,13 74:8
minutes 4:15 8:13 9:4,6
 9:11 74:19 76:10,17

122:10,11,15 126:20
misgiving 51:3
mishandled 55:10
mode 4:6
moderator 74:18 75:9
 95:1
moment 95:2 133:8
monitoring 20:9 21:15
 22:8 24:2,6
months 133:17
morning 4:14 5:10
 10:11
move 46:20 51:6 53:12
 124:14 128:18
moving 102:13
Mullan 133:20
muscle 64:1
mute 6:10 74:18 75:9
 109:9
muted 8:2
Muting 75:11

N

nailed 89:15
naive 24:15
name 4:16 8:20
narrative 22:22
National 28:5
natural 119:18
nature 9:14 119:11
necessarily 17:11 29:5
necessary 44:2 79:5
 105:14 112:3
necessity 22:18 47:12
need 11:10,10,21 15:7
 25:4 36:22 37:14,20
 41:5 43:18 45:7 46:11
 46:16 53:11 55:1 58:1
 66:17 67:16 74:2,5
 76:10,14 78:20 79:21
 83:6,9 86:16,17 88:3
 88:5 89:20 90:3 98:12
 99:8,18 100:14
 105:12,17 108:2
 110:14,15 112:4,8
 113:21 117:22 118:1
 119:9 123:7 124:6
 126:5 128:16 134:14
needed 46:7
needs 3:6 11:17 35:21
 46:4,5 47:13 48:7
 49:4 91:12 102:18
 125:15 129:1
neurologic 64:10
neurologist 64:7,10
never 80:16
new 13:6 14:13 15:12
 15:15 115:18,22

116:1
nine 94:12,12
NIOSH 28:6
nitrate 126:10
no-brainers 127:22
non- 8:2
non-sequitur 61:5
non-sequiturs 61:10
normally 135:3
Northern 13:6
note 7:22 8:4 18:11
 31:1 132:11
notes 24:20 31:22 36:6
notice 91:12
notions 69:18
notoriously 37:9
number 11:16 15:6 53:2
 53:16 58:20 62:14,15
 63:16 81:6,12 93:17
 95:18 97:14 116:13
 125:1 128:4
numbers 89:12 97:20

O

Oak 22:2 55:8
objections 4:8
objective 61:18 64:13
 81:2
objectivity 84:18
obtain 44:10,14 53:21
 79:11
obtained 33:13 85:16
obtains 53:19
obvious 79:2 128:3
obviously 9:13 15:14
 26:22 29:2 83:7 87:10
 92:8 104:21 115:2
 123:13 124:22 125:4
 125:13
occasions 56:15
occupation 126:7
occupational 12:11,15
 13:19 14:3,4,13 22:21
 47:9 56:1 116:20
 131:19 134:12,20
 135:7
occur 32:20
occurred 39:20 99:17
October 91:10
odd 20:4
offer 21:22
offers 22:6
office 16:21 51:12,18
 71:20 87:17 108:9,10
Officer 5:1
official 2:5 104:17
oh 20:5 34:15 43:1 51:8
 52:22 63:15 124:16
 130:18
okay 14:18 19:12,17
 20:12,15 21:5 25:16
 26:20 28:20 29:9 31:5
 36:21,21 39:12 41:3
 43:6,17 46:20 50:2
 52:7,22 53:13 56:20
 57:3 58:17 62:11
 63:18 64:4,19 73:11
 74:20 75:2,3,8,12
 77:10 78:18 82:19
 83:2,5 85:3 86:22
 89:4,13,14 90:17 91:5
 91:16,16 94:20 95:3,8
 95:13,18 97:5,19
 101:20 105:5 107:10
 108:6,11,20 109:3
 111:8,20 113:10
 114:16 116:15 121:18
 124:13 126:18 127:14
 131:1 133:5 134:2,3
 134:10 135:11 136:5
 136:15
omissions 47:22
one's 92:10,11
ones 27:13 104:2
 126:12 127:16
online 47:16 74:3
onset 94:9
open 8:12 23:20 79:16
 79:20 104:10
opening 45:10
operate 93:7
operated 21:12
operations 21:21
OPERATOR 4:3 75:11
 75:13 126:16 136:18
opine 66:14 69:5
opines 60:19
opinion 18:12,22 19:7
 22:19 23:7,9 28:12
 30:11 32:4 33:16 34:5
 38:2 44:16 50:14 59:9
 60:3,12,17 61:1,15,21
 62:12,18 63:2,7,11,19
 63:19 66:10 67:18,19
 68:22 72:9,17,21,22
 82:4,20 83:21 85:17
 86:6 94:4 102:16
 103:16,20,21 112:13
opinions 16:14 22:11
 23:8 33:12 60:22 65:3
 66:7 77:21 78:1 80:10
 96:19 97:17
opposed 68:15
option 79:11
order 25:20 70:17
 102:15 132:9 134:21

organizations 13:3
organize 80:9
organizing 133:9
ORISE 22:3,6
outcome 90:14
outline 18:10 104:14
outlined 125:15
outlining 125:13
outrageous 56:4
outreach 105:9 106:13
 107:14 108:17 110:7
outside 69:6
outstanding 79:12
ovation 65:10
overall 17:14 48:4
 113:13
overcome 47:22 51:11

P

P-R-O-C-E-E-D-I-N-G-S
 4:1

p.m 1:14 4:2 6:5 75:18
 75:19 126:22 127:1
 136:21
page 3:2 7:8,9 16:5,11
 19:15 32:6 42:22 43:1
 43:4,8,19 52:15,21
 53:1,8 58:1 59:13
 76:4,7,22 78:21 89:8
 95:2,8 96:13,18 97:1
 97:2,16
pages 83:12
paid 56:17 71:15
paper 52:2
papers 30:14,18,19
paragraph 45:9,10
 48:11,12,15 76:4,6
paraphrase 114:7
paraphrased 116:13
Parenthetically 61:4
Parkinson's 64:8,12
parse 15:8 24:22 25:3
 66:16
parsing 25:9
part 11:1 51:8 55:17
 71:19 81:13 82:9,14
 82:21 84:9 85:12
 99:21 100:11,15
 101:19 110:17 128:5
 128:8
partial 47:10
participate 8:8
participating 7:16,18
particular 26:15 27:17
 27:19 42:15 69:5
 78:17 84:3 98:17
 103:17 115:7 128:6
 128:14 131:5

particularly 35:10 57:9
 64:11 69:20,22
parts 95:16
pass 80:11 94:17 107:8
passed 13:7
Pat 19:13
pathology 61:18,22
patient 23:2 31:19 32:4
 32:22 54:14 55:22
 56:3 60:15 61:21
 63:22
patient's 60:20
patiently 136:7
pattern 26:19
pay 70:11
paying 71:8
payment 109:15
payments 109:18
pays 72:11
peer 30:18 66:8
pending 95:18
people 15:3 20:1 24:12
 27:15 41:18 42:1 49:3
 65:7 66:10,12 67:21
 90:5,6,9,20 92:22
 100:3 110:22 111:6
 116:16 123:22 124:6
 124:8,11 129:7,7,18
 136:7
percentage 44:21 88:8
perception 11:20
perfect 75:7 128:21
perfectly 30:5
perform 49:13 50:11
performed 44:19
permanent 47:10
person 12:18 19:6
 50:12,18 65:9 66:14
personal 53:5,8 88:12
 115:11
perspective 59:5
 115:11 119:15,21
 121:4,6
pertinent 53:19 78:7
phone 60:9 74:15,22
 91:3 106:4
phones 8:2 74:17
phrase 41:1 81:17
 83:18
physical 23:1
physically 60:15
physicals 33:6,7
physician 12:12 14:14
 16:17 18:11,14 19:1
 21:9 23:9,10 30:11
 31:21 34:4 35:13 42:7
 42:10 44:16 45:7
 48:13,17 49:11 50:7

50:12,13,22 53:22
 54:2,14,19 55:16,22
 57:12 58:19,20 60:14
 60:18,19 61:19 62:9
 62:21 67:2 68:20 70:3
 71:5,14,17 77:20
 78:12 82:6 84:7 92:19
 105:7 109:17 110:16
physician's 51:12,17
 61:16,20 62:2 64:16
 80:20 86:12 119:21
physicians 11:3 22:13
 22:19,20 23:4 25:14
 28:12 29:22 32:2,3,15
 33:17 44:11 48:14
 63:4 71:19 84:17,17
 109:14 110:1,18
physicians' 65:9
pick 122:13 123:1
 129:20
picture 45:22
piece 57:8 67:1 72:12
 81:15 84:20 99:15
 129:3
pieces 59:16 73:19
place 30:16 55:19 93:6
 124:7 125:13
places 116:13
plan 3:7 11:18 76:14
 77:13
planning 6:7 95:1
please 7:19,21 8:4,17
 8:20 10:1 16:6 65:3
 75:14
pocket 72:19
point 15:11 25:1 27:7
 39:6 42:18 51:6 55:4
 68:10 74:7 76:8 83:10
 86:21 106:3 121:10
 124:5 127:6 129:8
 133:2
Pope 2:2 5:17,18 13:9
 13:10,10 20:13,14,16
 21:1,5 68:6,8,8
population 120:1,7,19
portions 20:9 35:9
pose 72:16 73:4 93:1
posed 26:1 71:2
position 84:6,8 86:1
positive 22:8 62:2
possibilities 73:3
possible 17:7 42:19
 88:16,19,22 103:9
posted 8:6
potential 27:11
potentially 17:17
 114:18
practice 58:8

practitioner 63:20,21
 67:20
pre- 119:1
pre-employment 33:6
pre-existing 115:17,21
preclude 119:2
preconceived 69:18
preliminary 15:5
prepared 8:14 9:5,12
preparing 5:3
Present 5:16
presented 26:2
presiding 1:14
press 75:14
prestige 86:2
presumably 95:6 98:15
presume 105:12
presumption 125:15
presumptions 17:15
 124:21 125:5,9,16,18
 125:20 127:8,15,18
 127:19 130:3,7 133:8
 133:14
pretty 43:19 49:13
 103:22 125:10
prevalent 31:17
preventive 121:5
prevention 61:5
primaries 25:11
primarily 11:9
primary 37:10
principle 133:10
Prior 11:13
prioritize 130:7
priority 37:21
private 69:21 70:21
 73:7
privation 64:16
privilege 24:15
proactive 45:19
probably 17:8 54:19
 55:11 56:21 66:2
 102:22 103:5 108:14
 135:12
probative 60:2,22 61:22
 64:17 78:11
problem 7:19 37:7 48:4
 59:17 110:17 119:11
 119:14 128:14
problematic 64:22
problems 58:16 63:22
 66:4 67:18 98:22 99:2
 99:3 119:9
procedural 47:15 51:16
Procedurally 68:18
Procedure 15:18 29:5
 76:18 79:17 86:19
 87:1 90:1 102:5 104:7

104:17,20 107:1
116:14
proceed 68:13
process 17:17 30:20
45:21 48:21 55:2 72:1
72:3 73:19 80:4 82:22
84:1,9 87:21 88:9
89:10 93:4,19 99:19
104:3 110:3 117:19
117:20 121:22 126:6
produced 33:15 51:14
Professional 15:22
professor 12:20 14:1
14:12
program 10:20 13:5,20
14:5 21:19 22:4 24:3
24:6,18 33:4 39:10
40:5 44:14 89:3 94:18
96:3 107:8 135:1,10
programmatic 47:16
programs 15:14 21:15
24:2,9 25:13 33:8,11
progression 119:18
projects 13:3
proliferation 62:3
promulgated 15:13
proper 67:12 70:5
properly 66:16
proposed 45:6 92:13
provide 22:22 39:11,11
41:13,15 44:8 69:1
78:5 95:15 106:17
107:15,17 111:7
provided 7:14 9:19 34:6
35:18 83:20 97:17
101:10 106:10 110:1
provider 21:8 26:7 46:9
106:5,14 110:7
providers 31:20 32:12
32:15 38:7 44:12
provides 22:13 63:3
providing 22:4 27:15
30:1 52:5 109:13
118:22
public 6:15 8:5,7,12
9:21 12:21 14:1 87:14
90:3 91:2
publically 7:9 9:22
111:19
publish 7:13
published 27:10
publishing 9:10,12
purpose 3:4 10:15 33:1
purposes 32:14
purview 28:7
put 47:17 64:20 66:6
70:20 74:18 75:9 89:2
90:9 95:1 121:13

putting 44:15

Q

qualification 38:11
qualified 18:11,16
quality 16:19 84:18,21
100:21 109:5 112:10
112:17
quarter 95:15,19
quarterback 80:4
quarterly 89:6 95:5,15
121:14 122:4,5
quarters 121:16
question 23:16 27:9,17
39:2 42:6 65:19 68:11
70:1 73:4 84:6,7,8
85:5 86:2,8,11 94:16
102:3 107:4,8 109:12
112:15 113:6 114:13
127:12
questioned 28:3
questioning 83:22
questionnaire 35:14,17
42:5,11 131:19
134:12,20 135:7
questions 16:22 22:15
25:22 42:2 69:3,5
71:2,3 83:19 86:5
93:1 100:1,4 103:13
112:21 129:6 135:19
quick 5:7 123:8
quickly 43:19
quiet 34:22
quite 17:2 58:13 83:18
113:21 128:3
quote 84:18 107:13,15
114:7

R

radar 128:16
radiation 12:16
raised 134:3,4
ramble 127:21
rambling 127:20
randomly 23:5
range 110:8
rare 56:15
rate 49:18 50:20 84:3
rating 35:16 96:10,12
98:5
rational 16:15 19:3,4
30:13 67:21 68:1
rationalization 16:15
103:16 105:1
rationalized 22:14 23:7
27:16 62:20 63:2,10
63:14 68:22 85:10
132:11,16

rational 62:12
reach 106:13
reached 62:22
read 7:17 20:1,2,7 21:1
21:3 31:6 38:11 43:15
46:22 47:3 51:8,9
52:19 56:22 63:15
64:5 70:1 72:6 76:22
77:16 79:21 104:19
reading 32:6 59:5 62:14
103:5
ready 75:15 136:14
real 48:18 100:1,4
121:2
realize 104:21
really 12:3 29:4,6 38:18
39:14 46:11 51:17
52:8,9 56:4,21 58:5
70:5 73:19 76:11,17
81:7 88:17 102:18
110:8 119:21 120:8
120:11 126:5,11
128:18
realm 100:2
reason 93:22 101:1,14
reasonable 26:5 29:16
44:7 64:2 79:11
reasonably 63:5 103:1
reasoned 25:21
reasoning 63:13
reasons 32:21 78:13
94:6,13 98:3 110:20
received 57:11,18 64:7
81:22 106:3
receives 57:5
recommendation
103:15 104:5 125:17
recommendations
16:13 104:8 125:8,12
reconnect 6:12
reconsiderations 73:8
record 8:21 31:18 41:8
52:5 75:18 126:22
136:21
recorded 4:7 36:6
recording 9:3 122:19
122:21,22 123:5
records 21:11,16 23:3
26:14,18 31:16,22
32:1,3,17 33:3,5,19
34:14 41:2,19 52:17
53:18,20 54:4,17 55:9
55:13 56:16 77:21
redacted 88:12 135:13
refer 44:16 122:3
referee 23:4 33:17
44:17 92:20 96:14,21
97:8,10,12

referenced 36:20
references 40:17 59:13
66:8 67:13,14
referral 33:16 78:14
79:5,8 96:21 97:13,13
referrals 77:18 96:11
96:15 97:15
referred 101:15 118:11
referring 62:10
regarding 1:5 4:20 10:6
10:20 16:8,13 22:15
34:3,10 37:15 103:15
regardless 26:2
Registry 33:19 41:21
42:2
regulation 32:16 47:17
regulations 9:8
regulatory 47:15
relate 100:6
related 22:4 60:20
126:7
relates 12:8 16:15
relating 16:20 113:17
relationship 30:2 45:1
47:9
relative 57:7 120:11,20
relatively 11:15 69:15
released 111:19
relevant 63:5,9 78:7
85:1,15 87:8
relied 34:4
rely 34:6 67:20
remember 56:5 109:11
117:1 127:16
remind 9:17
remotely 7:18
render 77:21 85:16
renders 86:5
repeat 112:15
repeatedly 45:17
report 18:10,15 22:22
25:15 34:12 59:13
60:2 61:19,22 62:2
64:6 70:3 80:20 85:8
86:8,12 89:1 90:12,14
92:3 95:9 96:13 97:21
99:21 102:6 104:6
113:14 118:3 122:5
124:9 132:19,21
report's 18:9
reports 21:7 31:22
32:12 33:12,15 35:3
60:1 70:7,22 84:3
89:7,9 90:21 95:5,7
95:16,22 96:2,2
109:13,18 110:1
121:14 122:4 132:15
135:2,8,13

request 51:13,15 52:13
93:3 103:21 107:16
111:18,21 122:1
130:10,21 131:2
requested 11:15 16:9
51:21 54:4 111:6
130:17
requesting 44:6 113:5
requests 71:6 79:12
105:8 117:22 121:12
129:18
require 47:6 96:21 97:6
required 33:7 55:17
requirement 49:10 79:8
requiring 103:19
research 14:3 116:5
residential 32:19
resolution 78:2 79:11
resolve 23:7 45:2
resource 87:13
resources 16:18 44:14
47:16 87:12,17 109:4
109:20 111:5,11,12
111:15 112:3,17
113:7
respond 52:6
responding 13:13
response 13:14 33:15
44:8 52:10
responses 22:14 27:16
105:7
responsibility 43:21
responsiveness 16:18
71:5
rest 52:12 63:22 79:14
restrictive 69:3
results 51:14 120:6
resume 74:19
resumed 75:18 126:22
Retired 13:11
review 15:4,5,6 16:19
22:12 23:2 30:18
60:18 74:10 77:20
79:6,22 80:22 90:6,11
97:7,8,10 105:8
107:13,17 109:5
112:11,18,22 123:13
124:3 135:2
reviewed 66:8 89:21
123:7 124:1
reviewing 10:21 37:21
reviews 103:19 123:8
reward 71:13
rewrite 29:5
rewriting 104:17
Rhoads 2:6 4:11,13,16
5:12,15,17,19,21
39:10 53:4 74:17,21

75:3,8,12,16 89:2
90:16 94:15 96:3
105:16 107:2 108:20
118:13 122:17 126:14
126:18 131:13 136:4
rich 89:10
Ridge 22:2 55:9
right 18:13 25:9 29:20
34:22 37:18 41:4 43:8
53:1,15 64:21 65:15
65:22 68:3 73:1 75:4
75:8,16,20 85:4 97:14
98:4 104:1 111:22
113:15 116:20 120:15
121:1 134:7
rigidity 64:1
rise 68:21
risk 72:16,18 120:11
risks 120:2,20
road 129:1
roadmap 11:9
Rocky 13:11
roll 5:7
room 6:4
rule 15:13,15 19:5 36:9
45:6
Rules 33:14
run 24:6,11 120:13
136:8

S

sake 76:21
samples 108:12
saw 56:3 99:22 100:7
saying 26:4 30:22 36:4
58:12 59:11,19 67:3
81:19 91:3 108:2
112:16 118:19
says 30:10 43:8,12
48:12 95:22 96:14,19
102:5 112:17 115:6
120:16 132:11
scan 53:11
scantily 86:18
scheduled 6:4 8:5
School 14:1
Schroder 6:3
science 22:2 84:4
scientific 1:17 63:9
scope 3:5 11:16 59:7
76:18 79:19 81:4,10
81:13 82:10,14 83:16
85:19 89:7 99:12
100:11 113:3,11,13
125:1 128:6
screen 6:20 7:12 97:4
screening 14:5 21:19
22:1,4 25:13 33:5

135:1,10
scroll 53:4,6
search 132:14
searches 47:17
second 11:5 22:19 23:9
28:12 30:11 33:16
41:5 44:16 48:12 92:3
101:1 103:3,20,21
109:8 123:3
secondary 34:4 37:11
114:2
seconds 58:1
SECOP 92:19 103:20
Secretary 10:19
section 15:19 19:13,14
20:3 29:4 30:8 32:16
34:2 39:15 42:20 43:4
43:10 46:11,14,21
49:7 51:8 52:15 53:2
53:14,16 55:6 56:20
56:21 64:22 74:9
104:20
sections 90:1
Security 33:10
see 7:7 9:4 19:13 26:20
34:20 35:7 37:13
39:17 40:5 43:7 51:7
52:1,17 53:6,9 58:11
58:14,15 59:18 66:17
67:1,7 80:8 81:1,3
83:22 84:1,3 85:13
95:22 100:16 101:9
102:12 107:5,6,6,7,9
110:14,15 111:6
112:4,20 113:6 118:2
119:14 134:14
seeing 96:22
seen 56:14 61:10 66:7
66:12 67:4 80:16
83:14 86:19
seldom 69:6
send 51:15 80:17 81:8
82:3 90:4 94:6,13
105:13,17 106:3
118:1 122:14,19,22
123:6,11
sending 73:15 124:2
sense 25:4 38:13 76:1
93:7 95:10 96:5
101:22 102:1 108:14
128:20,21 130:1
sensitivity 22:9 62:6
sent 73:12,13 82:21
93:22 94:2,3 96:1,6
sentence 24:8 25:10
sentinel 133:18
separate 106:21
separately 99:9 101:8

September 92:2 123:4
123:14 136:10
service 47:13
services 77:17
session 7:22 8:5
set 86:4
setting 56:1 69:21
settings 53:8
settle 80:6
seven 87:7
severe 119:17
shape 67:4
shared 9:22
she'll 126:18
short 76:9 90:12,21
91:1 123:9
shortcut 38:5
show 18:3 26:18 52:20
52:22 98:17 131:15
135:3
showed 56:16 71:3
showing 62:4
shows 61:22
shy 31:7,13
side 53:11
signature 54:7
signed 54:7
significant 64:17
silica 129:20
Silver 1:18 5:19,20
12:18,19,19 23:22,22
39:18 40:21 41:1 55:7
80:1 89:5 94:22 95:4
95:12 133:7,8 134:7
Silver's 121:13
simple 118:18 119:7
simplify 107:11
simply 7:2 15:18
Simultaneous 124:12
sir 14:19
sit 42:12 73:10 88:18
site 10:21 40:1 131:22
132:14 133:3
sites 26:14
situation 18:10
situations 51:10 55:12
56:14 78:6 79:10
six 59:13 87:7 91:12,19
91:19
skim 52:12
skip 19:17 39:17 42:20
64:21
slam 133:14
small 88:8
smoking 114:22 120:18
Social 33:10
somebody 24:20 50:6
52:14 58:6,18 59:12

65:6 67:14 115:7
120:16 131:9
somebody's 36:6 126:4
134:6
someplace 49:5
somewhat 15:1
soon 122:11,15
sooner 122:19
sorry 4:15 39:7 61:12
77:1 81:17 112:14
127:5,11
sort 12:3 17:13 27:12
38:16 45:22 48:20
59:14 67:8 69:13,14
73:2 74:7 89:16 98:9
114:22 122:2 127:20
sorts 58:15
sound 66:11 124:11
sounds 42:14 54:21
94:20
source 27:3,3,11,12
57:6 81:4 88:2
sources 20:3 21:6,7
23:14,15,19 26:11,22
27:6,22 28:10 38:12
78:8,9 86:22
SOW 89:14 95:1
speak 8:17
speaking 8:19 124:12
special 9:19
specialist 23:10 34:7
44:17 68:21 71:19
93:10
specialists 23:4 33:17
77:19
specialties 19:2
specialty 18:14 23:5
specific 29:7,7 51:13
51:21 99:6 109:17
117:4
specifically 77:20
specifics 11:19
specify 105:1 121:19
specifying 121:22
spectrum 132:2
speed 17:16
spend 76:16
spent 12:13
spiel 48:3
spin 55:17
spot 65:14 80:3
spouse 50:20
St 35:14,17
stab 104:16
staff 11:3 84:17
stages 40:4
standard 116:7
standardized 103:18

108:1
standing 4:4 65:10
standup 65:8
star 75:14
start 8:20 12:10 14:8
17:22 20:16,18 40:1
43:9 73:14 75:21
76:14 89:12 106:11
116:17 117:18 126:9
133:14
starters 87:11 108:12
starting 4:15
state 8:20 12:21 33:8,9
33:13 40:15 46:6
49:16 61:1 131:14
stated 63:3
statement 15:22 45:12
46:19 48:5 54:3 64:20
78:17 80:20 81:22
82:8 83:8 85:13 89:22
96:18 97:15
statements 46:18 52:3
62:20 64:14 66:5
states 1:1 63:11
stating 45:11
stay 11:5
Steel 13:12
step 86:13
steps 62:8
Steve 14:11 61:12
81:17 82:12 84:14
85:20 90:18 92:7,11
100:9,12 104:12
106:8 107:12 116:18
116:21 121:9 128:9
130:14 134:8
Steven 2:4 5:21 28:22
38:4 43:11 45:16 60:5
65:12 66:15
stick 40:6 46:21
stop 21:2
straighten 134:15
strained 69:22
strictly 11:5
studies 26:16 27:10
63:1
stuff 66:18 94:4 123:10
126:12
subcommittee 1:5,13
1:14,20 4:19 5:7,9
6:18 7:14 8:11 10:5
10:12 11:9,13 12:6,9
17:6 23:13,21 73:9
83:16 84:15,22 90:12
91:9 92:12 100:19
101:12 118:1 128:6
128:13 130:16 136:12
Subcommittee's 8:8

Subcommittees 91:13
129:3
subject 28:15
subjective 60:13 81:1
submission 54:7
submit 43:22 131:5
135:11
submits 131:4
submitted 7:10 47:19
submitting 129:18
subsections 76:5
subsequent 90:15
substance 47:10
113:12 114:1 115:8
115:15 129:21 132:3
substance/disease
130:4
substances 1:3 4:19
7:3 10:4 12:16 113:18
130:4
successful 40:3
sufficiency 47:18
sufficient 61:19 62:5
suggested 29:22 39:21
suggestions 18:6
104:10
summary 12:8 90:21
91:2 95:17
supervisor 118:10
supplied 132:17
support 43:22 47:19
78:9
supported 62:21 63:4,8
supporting 16:16 19:3
103:17
supportive 44:6
suppose 50:5
supposed 11:21 49:3
51:5 85:8,14
sure 14:11 17:2 30:16
54:10 57:21 58:4,10
58:13 59:21 61:14
66:15 74:2 77:13
82:12 83:18 90:16
91:11 93:12,13 99:20
106:15 113:21 121:12
121:22 122:13 126:12
126:18 132:2
surveillance 134:8
surviving 41:8 50:20
symptom 40:1,7,9
42:11
symptoms 40:15,18,18
40:19,20 42:13 64:9
synthesis 119:20
system 17:7 128:18

Table 3:1,7 19:15
tag 15:8
take 25:2 55:16 60:6
70:4 74:8 77:6 93:5
104:16 107:18 111:21
115:2 122:17 132:16
taken 73:20
takes 110:21
talk 20:19 31:3 45:5,9
52:14 55:3 62:13
64:22 76:11,19 94:8
99:12 102:19 103:10
105:2
talking 20:6 24:5 28:17
29:2 30:9 36:5,8 50:5
76:14,17 81:20 87:22
92:5 99:14 107:3
109:9,9 113:22 114:2
127:8,15,16
talks 48:16 52:15 87:2,2
87:3,4
task 11:5 12:4,9 14:22
17:7,22 58:6 92:9
104:22 125:10 129:13
129:13
tasks 10:18
TCE 120:18
team 13:14
technical 13:2
teleconference 8:17
telephone 51:12 52:1
52:10 90:20 91:15
108:19
Telephonic 98:13
telephonically 1:13
tell 40:8 55:21 58:14
72:17 94:18
telling 67:15
tells 51:20
ten 6:7,12 13:7 74:8,19
97:6
tend 101:5
tends 81:1
Tennessee 12:21
term 62:20 101:4
terms 6:6 17:14
test 61:15 62:3 64:13
119:20
testing 22:5,6,8 23:2
32:10 61:18
tests 32:13,15 35:8
98:17 99:6
textbook 116:19
thank 4:3,13 5:12 10:9
14:18,19 16:11 17:20
19:9,16 23:12 31:11
32:7 36:5 50:2 60:7
75:12 89:4,13 107:10

T

109:3 115:12 118:15
136:6,6,17
thanks 20:15 43:17
49:6 57:3 75:16 133:5
they'd 40:1
thing 7:4 21:1,4 26:4
29:16 38:19 39:6
52:13 58:11 67:9
83:11 94:11 108:3
114:1 121:8 124:17
thing's 37:18
things 15:9 29:19 30:2
66:11 70:2 79:21 81:1
86:17 88:2 89:3 94:7
98:9,11 99:5 102:20
110:8,10 120:6
127:22 129:11 133:13
think 14:6 15:1,6,9
17:21 18:1,20 25:2
26:6 29:3,16 30:6,21
31:2 34:17 36:4,8
38:5,6,18 39:2,14
42:22 45:4,7 46:10,12
46:21,22 48:2,3,7,17
51:2,17 52:1 54:13
55:1,18 56:7 59:6
63:17 64:21 65:1,3,4
66:16 67:16,20 68:2
68:14 69:10 70:8 71:4
74:5,6 76:10,13 77:11
79:1,14,17 82:14 83:8
85:12,18 87:11,19,21
88:10,11,13,13 93:12
100:11,14 101:5,11
101:17 102:7,11,17
103:9,22 104:1,4,14
104:16 105:2,21,22
107:2 108:11,15
109:19 110:10,11,13
110:13,15,17 112:4,8
112:20 113:4,21
114:6,11,17,21
117:17 119:8 120:6
122:8 123:21 124:5
125:3,4,6,8,11,12,13
126:8 128:5,10,12,13
128:15,16,22 129:1,2
129:11 130:2,9,11,12
131:16 133:9 134:13
134:13,19,22 135:6
136:4,5
thinking 17:13 27:14
70:2 89:11 112:9
123:18
thinks 26:5
third 23:16 45:9
thorough 57:13
thought 29:18,21 39:20

39:21 54:16 71:9
118:6
thoughts 17:8 27:5
28:14,21 37:17 38:3
71:11 88:4 115:9
129:6 134:17 135:18
three 11:18 32:4 33:12
34:3 54:5 62:14 87:5
87:6 99:8 100:17
123:21
three-year 126:6
threw 40:5
throw 71:8
tiebreaker 86:16
tight 80:3
time 1:14 3:7 4:5,9 5:2
5:4 6:5,11 17:12 27:7
31:12 44:7 70:4 71:8
75:22 76:8 77:15
89:19 91:22 101:9
103:2 109:20 120:14
121:13 122:18 123:2
123:19,19 136:19
times 37:11 41:7
timing 6:6
title 131:22
today 5:4 6:5 8:5,16 9:8
10:2 11:4 12:1 15:8
15:18 17:3 50:8 83:7
83:13,15,15 87:11
122:8
today's 4:11,17 5:1 7:7
7:8,15 8:14 9:6
136:18
told 110:19
tool 35:19 36:13,20
100:21
tools 35:22
top 20:17,19
topics 47:6
total 61:5
totally 59:7
touch 136:16
touched 28:15
tough 65:13
toxic 1:3 4:19 7:2 10:4
12:16 47:10 113:18
114:1 115:8,14
toxins 124:22 135:3
tracing 32:11
track 52:9,10 89:10
tracking 79:2
Trades 135:10
trail 52:2
trained 80:7
training 16:18 46:13
67:12 109:4 111:11
111:12,15,17 112:3

112:17 113:7
transcriber 8:14,18 9:1
transcript 8:13 9:13,15
122:11,12,16
treated 54:2,14
treating 44:11 46:9
55:21 57:12 62:9 70:3
78:12 82:6 109:14
110:18,22
treatment 21:11 31:16
31:19 32:17,22 33:2
94:10 116:1
tremors 63:22
tried 117:6
triggers 103:18
true 45:14 64:11
truly 25:20 42:8
truth 67:15
try 20:13 25:3 41:22
46:1 53:9 88:5 104:16
119:9 134:4 136:8
trying 11:4 13:6 29:5
38:9,12 41:21 58:19
68:12 90:8
Tuesday 1:10 122:9
turn 10:7
turned 86:4
two 11:17 24:5 26:11
32:3 33:7,22 54:3
59:16 81:6,12 87:5,6
88:22 89:21 91:13
98:15 123:19,19
136:9
type 27:4 35:2 37:14
46:13 56:14 81:4
100:19
types 23:11 26:21 31:6
31:14 33:18 34:19
35:3 37:3,15

U

U.S. 40:14
ultimately 43:13,21
unanswered 39:3
unavailable 52:16,17
53:18,21
underlying 64:15
understand 8:18 10:16
18:20 37:22 38:12,17
42:3 46:9 50:3 57:17
117:20 119:10
understanding 48:18
57:13 99:19 117:3
128:17
understatement 80:4
understood 107:20
undertake 58:6 62:8
undertaken 57:16

unfortunately 87:14
unique 78:4 114:8
unit 24:7
United 1:1 13:12
universities 24:12
University 12:22 14:12
University's 14:1
unrelated 63:20
unsupported 62:19
updated 133:20,21
134:6
ups 132:21
use 19:3 25:11 35:17
37:3 41:6 44:14,15
49:2 65:18 88:20
100:21 106:13 117:6
118:12,12 124:2
125:20
useful 105:4 106:5
133:9,21
uses 77:17
usually 72:11 74:3
133:3
utilize 37:16
utilized 23:18,18 27:6
30:19 135:16

V

vague 104:21
valid 35:6,8,19,22 84:4
85:9 102:15
validate 78:11
validity 83:22 93:17
value 34:13 57:7 60:2,3
60:22 61:22 64:18
103:16
value- 55:2
varies 34:14
variety 32:21 80:6
various 22:15 30:14,15
35:9 44:19 90:6 100:6
Vegas 14:6
verbal 91:1
verbatim 9:12
verification 105:10
verify 81:17
versus 28:8 30:10,11
58:21 59:12
Veterans' 33:11
viable 134:5
Victoria 1:14,20 5:8
12:10
view 53:5 79:7
viewed 64:17
viewing 7:22
visited 7:5
visiting 92:5
Vlieger 2:2 5:15,16

13:16,17,17 18:7,7
 20:10 25:8 26:12 35:1
 36:12,16,19 40:12
 41:4 45:13 49:8 50:9
 52:4,8,20 53:13,17
 54:13 56:13 57:2,4,21
 58:4 59:2,4,21 60:7
 60:10 65:8 68:17
 70:10 71:16 80:15
 83:17 85:4 86:10 88:7
 96:7,17 97:1,8,14,20
 98:4 102:3 108:4,7
 111:17 112:1 115:10
 115:13 116:4 118:5
 118:15 132:4 134:19
voice 8:16
volumes 116:16
voluminous 124:8
volunteer 20:1
voted 8:10

W

wage 22:17 45:1 49:9
 49:16 50:9,17 79:6
 87:3
wages 47:12 48:17,19
 49:4 50:22
wait 6:12
want 14:9 20:6,16,20
 25:3 26:8 29:18 43:16
 47:1 59:18 64:20 76:3
 79:16 87:20,21 89:16
 89:17 90:8 92:7 93:16
 94:15,17 100:2
 102:18 105:19 106:11
 107:5,5,7,17 110:20
 110:22 121:8,10
 122:4,6 125:2 129:7
 130:7 135:19,22
wanted 10:15 12:6
 58:10,14 61:8 64:5
 75:21,22 76:11
 102:18 121:12,14
 124:17 128:4
wants 31:5,6 43:9 51:8
 52:19
warehouse 55:12
warn 112:8
way 18:1 25:2 37:18
 41:10 45:20 52:9,9
 67:4,6,10 69:17 70:5
 74:16 91:2 101:2
 104:9,10 114:9,14
 116:5 118:8,17,18,19
 121:21 124:20 129:14
 133:11 135:7 136:8
ways 46:3 77:11 117:18
we'll 6:10,12 7:13 9:12

26:20 46:15 54:22
 56:11 58:22 62:13,15
 74:6,19 75:9 76:16
 92:4 100:21 108:14
 136:16
we're 4:15 6:4,6 8:17
 11:20,22 15:17 19:17
 36:8 43:18 45:5 46:20
 46:21 56:20 57:22
 63:16 68:2 74:1 76:20
 76:22 81:20 82:15
 83:6,12 84:12 91:3
 92:8 93:13 99:13,14
 101:17 103:6,7
 105:11 112:4 113:5
 123:2 125:4 129:5
 136:4
we've 74:7 76:9 86:19
 89:15 103:22 124:4
weaved 77:12
web 7:9
WebEx 6:20 7:12,21
 53:7
website 6:16,22 7:6 8:7
 9:7,16 32:7
week 91:14 103:2,3,11
 122:9 123:3
weeks 91:19,20 123:22
 124:3 136:9
weeks* 91:12 123:19,19
weigh 57:14 101:18
 102:9
weighed 85:1
weighing 1:6 4:21 10:6
 10:13 11:7 15:20 57:4
 81:20 82:5,17 92:15
 100:15 101:13 111:13
 112:18
weighs 102:6
weight 25:9,15 57:18
 59:8 60:17 64:9
weighty 58:6
weird 126:11
Welch 135:12
welcome 4:3,17 10:11
 75:13
well-qualified 118:9
well-rationalized 62:18
well-trained 118:9
went 45:6 75:18 126:22
 136:21
wholly 37:11
willing 118:14
wish 45:14 136:3
wonder 29:17 48:20
wondering 24:14 58:7
 93:2 111:14
word 35:20 51:3

wording 24:1 29:21
 116:7
words 27:14 53:10
work 3:7 5:3,4 11:2,18
 15:22 46:16 49:13,17
 50:1,11 62:8 66:17
 69:19 70:18 82:1,9
 83:9 84:11,16,21
 85:13 88:7 89:7,22
 96:18 97:16 122:20
 131:11 132:21 136:13
worked 13:11 49:22
worker 1:3 4:19 7:3
 10:4 13:11,18,18,18
 14:5 21:18 24:3,9,17
 25:12 33:4,5 35:15
 49:10,15,17,21 132:6
 132:9 133:1 134:22
 135:9

worker's 26:17 40:9
workers 13:13 21:21
 22:1 39:21 55:9 135:2
 135:9
Workers' 14:3 33:9
working 12:13 13:13
 15:3 24:22 46:16
 85:15 90:10
works 58:7 73:19
 117:20 128:18
worse 115:8 119:1
Wow 64:4
write 49:12 70:22 72:9
 90:11,21 108:1 125:5
 125:9
writes 59:13
writing 70:3 125:12
written 6:15 37:19
 51:15,19 52:5,12
 53:22 86:18 107:21
 116:5,16

X

x-ray 32:10
x-thousand 129:21
x-thousands 129:19

Y

year 121:16 129:20,21
years 12:13 13:7,12
 35:4 56:3
York 14:13

Z

Z 1:18
zero 75:14

0

0800 15:19

0880 19:13

1

1 19:14
1.5 96:14,18
1:00 1:14 6:5
1:07 4:2
10 3:4 76:4,6,22 78:21
 96:21
10,000 94:3
107 3:7
12 1:10
14 3:5
15 59:13 66:7 76:9
1535 19:15
19 3:6
1996 21:19

2

2 1:6 15:19 19:12
2(b) 24:1
2:29 75:18
2:30 6:8 74:1
2:40 75:5,10
2:42 75:19
20 76:17
2005 117:10
2016 1:10
24 89:8 95:2,8
25 13:12
26th 8:11
28th 8:11
29 83:12 96:18
29-page 89:8

3

3:00 76:15
3:46 126:22
3:50 127:1
30 9:16 76:17
30.5(dd) 32:16
330,000 94:1

4

4 3:3 84:15
4:00 6:5
4:02 136:21
40s 41:19

5

5 36:10,17,20 42:20
 43:4,5,8 97:16
5,525 96:19 97:16,18
50s 41:19

6

6 36:17 43:1 53:2,16
 56:20 96:13,18 97:1

60s 41:19 50:6

7

7 52:15 53:1

7(f) 34:2

8

8 53:2

80s 133:20

9

9 74:9 76:4

90 9:7

90s 133:21

C E R T I F I C A T E

This is to certify that the foregoing transcript

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

Before: Toxic Substances and Worker Health Adv. Bd.

Date: 07-12-16

Place: teleconference

was duly recorded and accurately transcribed under
my direction; further, that said transcript is a
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Court Reporter

NEAL R. GROSS

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