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)

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MEETING

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TUESDAY,
JULY 12, 2016

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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

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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

Officer, or DFO, for today's meeting.

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

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

Dr. Victoria Cassano, the Chair of the Subcommittee.

CHAIR CASSANO: Here. Good morning everybody.

MS. RHOADS: Thank you.

And, Members are Dr. Leslie Boden.

MEMBER BODEN: Here.

MS. RHOADS: Ms. Faye Vlieger.

MEMBER VLIEGER: Present.

MS. RHOADS: Ms. Duronda Pope.

MEMBER POPE: Here.

MS. RHOADS: Dr. Ken Silver.

MEMBER SILVER: Here.

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

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

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

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

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

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

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

The website can be found at

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

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

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

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

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

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

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

will not be interactive.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CHAIR CASSANO: Thank you very much, Carrie.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CHAIR CASSANO: Ms. Pope?

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

CHAIR CASSANO: Ms. Vlieger?

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

CHAIR CASSANO: Dr. Boden?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MEMBER BODEN: So, this is Les Boden.

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

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

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

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

Anyone else with any ideas or suggestions?

MEMBER VLIEGER: This is Faye Vlieger.

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

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

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

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

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

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

Anyone else?

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

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

(Off microphone comments.)

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

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

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

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

CHAIR CASSANO: Okay.

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

CHAIR CASSANO: Okay, thanks.

MEMBER POPE: Want me to start at the top?

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

MEMBER POPE: Read the whole thing or stop?

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

MEMBER POPE: Okay.

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

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

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

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

screening to former workers.

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

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

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

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

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

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

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

Types of medical -- go ahead.

CHAIR CASSANO: Thank you.

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

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

MEMBER SILVER: This is Ken Silver.

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

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

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

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

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

point.

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

But, that is an important comment.

And, anyone else?

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

CHAIR CASSANO: Okay. Yes.

Anyone else?

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

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

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

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

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

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

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

inclusion to make.

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

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

MEMBER BODEN: This is Less Boden.

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

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

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

causation.

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

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

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

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

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

MEMBER BODEN: It is.

CHAIR CASSANO: Okay.

Any other thoughts on that?

CHAIR MARKOWITZ: This is Steven.

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

CHAIR CASSANO: Okay.

CHAIR MARKOWITZ: -- the documents.

CHAIR CASSANO: That was Dr. Markowitz, correct?

CHAIR MARKOWITZ: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

CHAIR CASSANO: Thank you.

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

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

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

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

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

Go ahead.

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

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

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

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

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

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

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

Two, death certificates which contain

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

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

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

Oh my gosh.

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

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

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

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

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

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

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

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

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

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

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

CHAIR CASSANO: It is in the AMA Guide?

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

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

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

look at.

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

No one?

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

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

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

Because, as I understand it, not

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

Any thoughts or ideas on that?

CHAIR MARKOWITZ: This is Steven.

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

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

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

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

actually gets to the CMC.

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

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

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

CHAIR CASSANO: Yes.

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

CHAIR CASSANO: Okay, I appreciate that.

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

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

MEMBER SILVER: Excuse me. This is Ken.

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

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

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

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

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

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

MEMBER SILVER: So, it's --

CHAIR CASSANO: But --

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

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

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

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

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

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

CHAIR CASSANO: I understand.

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

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

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

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

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

Hold on, I'll get there.

Yes, the bottom of page 5 is Section 5, developing medical evidence. Is that up now? Yes, here we go, okay, you've got it.

Everybody know -- see where we are?

It says right at the bottom of page 5.

So, who wants to start going through this section?

CHAIR MARKOWITZ: This is Steven.

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

CHAIR CASSANO: Yes.

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

CHAIR CASSANO: Okay, thanks.

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

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

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

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

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

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

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

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

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

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

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

MEMBER VLIEGER: This is Faye.

I just wish it was true.

CHAIR CASSANO: Well --

CHAIR MARKOWITZ: This Steven.

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

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

this and then try to address it from there?

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

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

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

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

Anyone have any statements or issues about this statement?

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

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

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

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

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

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

deficiencies.

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

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

MEMBER BODEN: This is Les again, Les Boden.

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

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

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

CHAIR CASSANO: That's something that,

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

Thanks, Les.

Anyone else on this section?

MEMBER VLIEGER: This is Faye.

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

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

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

to work.

CHAIR CASSANO: Okay. Thank you, I understand.

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

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

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

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

that.

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

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

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

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

Anybody have any issue with this? I

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

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

CHAIR CASSANO: Okay.

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

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

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

So, who wants to read through that?

MEMBER VLIEGER: I can if they show the page.

CHAIR CASSANO: Oh, okay. Show them

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

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

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

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

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

MEMBER VLIEGER: I have it.

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

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

Can I just make a comment before we go on?

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

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

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

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

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

Any other comments by anyone about this section?

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

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

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

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

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

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

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

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

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

CHAIR CASSANO: Any other comments?

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

Can -- who is going to read this for

me?

MEMBER VLIEGER: I'll do it again.

CHAIR CASSANO: Okay, thanks.

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

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

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

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

CHAIR CASSANO: Keep going, if you would.

MEMBER VLIEGER: Sure.

CHAIR CASSANO: And we're going to

need to flip the page in a couple of seconds.

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

MEMBER VLIEGER: Sure.

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

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

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

MEMBER BODEN: Okay, so this --

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

So, let us keep going and then we'll

look at this all together.

MEMBER VLIEGER: I agree.

CHAIR CASSANO: Go ahead.

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

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

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

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

MEMBER VLIEGER: Sure.

How to evaluate evidence. In

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

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

MEMBER VLIEGER: Thank you.

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

MEMBER VLIEGER: Too late.

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

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

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

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

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

(Laughter.)

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

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

CHAIR MARKOWITZ: Yes, sure.

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

malignancy.

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

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

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

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

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

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

appropriate citations or studies.

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

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

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

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

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

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

CHAIR CASSANO: What?

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

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

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

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

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

I think.

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

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

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

CHAIR CASSANO: Yes.

CHAIR MARKOWITZ: Yes, this is Steven.

So, you know, the CE is in a tough spot.

CHAIR CASSANO: Right.

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

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

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

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

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

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

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

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

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

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

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

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

very good rationale approaches.

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

Any other comments from anybody on the board?

MEMBER POPE: Duronda here.

CHAIR CASSANO: Go ahead.

MEMBER POPE: Duronda Pope here.

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

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

MEMBER VLIEGER: So, this is Faye.

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

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

MEMBER BODEN: This is Les.

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

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

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

What is the method of compensation for these reports?

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

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

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

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

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

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

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

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

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

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

in process of being accepted.

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

MEMBER BODEN: So, I guess --

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

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

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

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

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

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

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

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

Is that good for -- yes?

MEMBER BODEN: Excuse me.

CHAIR CASSANO: Yes?

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

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

MEMBER BODEN: Okay.

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

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

MEMBER BODEN: Okay.

MS. RHOADS: Okay?

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

CHAIR CASSANO: That would be fine, perfect.

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

OPERATOR: Muting the lines now.

MS. RHOADS: Okay, thank you.

OPERATOR: You're welcome.

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

MS. RHOADS: All right, thanks.

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

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

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

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

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

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

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

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

CHAIR MARKOWITZ: Sorry, is --

CHAIR CASSANO: Yes? Go ahead.

CHAIR MARKOWITZ: I had one comment.

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

CHAIR CASSANO: Yes.

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

CHAIR CASSANO: Okay.

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

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

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

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

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

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

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

I'm not going to go through them.

And, anybody have any issues with that particular statement?

Okay.

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

The decision to -- it's at the

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

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

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

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

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

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

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

MEMBER SILVER: This is Ken.

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

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

CHAIR CASSANO: Anybody know the answer to that?

MEMBER VLIEGER: This is Faye.

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

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

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

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

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

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

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

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

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

work of a CMC.

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

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

Does that clarify it?

CHAIR MARKOWITZ: Sure. Steve Markowitz.

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

CHAIR CASSANO: Okay.

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

evidence --

CHAIR CASSANO: Okay.

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

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

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

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

MEMBER VLIEGER: This is Faye.

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

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

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

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

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

CHAIR MARKOWITZ: It seems like -- Steve Markowitz.

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

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

weighed by the CE is more relevant to this committee.

CHAIR CASSANO: Okay.

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

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

Any other issues that we think are within our scope?

CHAIR MARKOWITZ: It's Steve Markowitz.

I am curious, it follows with Faye's

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

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

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

CHAIR CASSANO: It's got --

MEMBER VLIEGER: On the same basis of how they can they question the attending physician's report?

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

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

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

Okay, data sources, there are several

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

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

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

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

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

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

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

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

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

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

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

be able to do and report back to the group?

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

CHAIR CASSANO: Okay, thank you.

MEMBER SILVER: This is Ken.

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

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

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

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

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

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

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

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

MS. RHOADS: Sure.

CHAIR CASSANO: Okay, great.

CHAIR MARKOWITZ: Steve Markowitz.

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

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

And also --

CHAIR CASSANO: Okay.

CHAIR MARKOWITZ: -- just more efficient.

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

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

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

CHAIR CASSANO: Okay, okay.

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

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

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

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

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

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

But, let me proposed a different kind of idea.

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

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

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

pose questions.

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

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

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

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

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

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

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

Can we get that kind of information?

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

CHAIR CASSANO: Okay, that sounds good.

MEMBER SILVER: It might be helpful

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

CHAIR CASSANO: Okay.

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

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

Who was that? Was that Ken?

MEMBER SILVER: Yes.

CHAIR CASSANO: Okay.

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

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

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

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

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

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

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

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

CHAIR CASSANO: which document?

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

CHAIR CASSANO: I'm not seeing this.

MEMBER VLIEGER: Page 6, bottom of the page.

CHAIR MARKOWITZ: It's not on the screen.

CHAIR CASSANO: This is -- okay.

So, that only ten will require a review?

MEMBER VLIEGER: A referee review, yes.

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

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

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

CHAIR CASSANO: Okay.

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

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

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

CHAIR CASSANO: That is not a diagnosis, yes.

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

(Telephonic interference.)

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

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

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

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

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

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

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

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

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

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

CHAIR MARKOWITZ: This is Steve Markowitz.

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

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

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

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

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

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

CHAIR CASSANO: Okay.

CHAIR MARKOWITZ: Does that make sense?

CHAIR CASSANO: It makes sense to me.

Anyone else have comments about that?

MEMBER VLIEGER: My question is, I'm not aware in the documents and where in the Procedure Manual where it says that the CMC actually weighs the industrial hygienist report. I think they just accept it.

So, could we look at that? If they actually weigh it?

CHAIR CASSANO: We certainly can.

The whole -- I think the biggest issue that I see is how much discernment does the CE have in ignoring some evidence and moving other evidence forward to either the industrial hygienist or the CMC in order to get a valid opinion back?

And, I think that's where the guidance really needs to be. So, I wanted -- I still want to circle back to this advice and to talk about how we develop some of these things.

But, I'm looking at the calendar and it looks like the earliest probably we could

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

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

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

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

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

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

I think that's pretty much all we've

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

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

Hello?

CHAIR MARKOWITZ: This is Steve Markowitz.

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

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

this? And, we specify what rationalization.

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

CHAIR CASSANO: Okay.

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

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

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

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

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

CHAIR MARKOWITZ: This is Steve Markowitz.

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

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

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

Procedure Manual?

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

CHAIR CASSANO: Okay, thank you.

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

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

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

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

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

CHAIR CASSANO: Okay.

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

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

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

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

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

CHAIR CASSANO: Okay, thank you.

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

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

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

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

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

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

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

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

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

do.

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

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

Any other comments on that as far as training resources?

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

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

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

MEMBER VLIEGER: We should be --

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

MEMBER BODEN: I agree.

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

Do you have an opinion on that?

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

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

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

something that's conflicting.

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

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

I mean, I certainly --

CHAIR CASSANO: Okay.

CHAIR MARKOWITZ: -- the scope is substance.

The scope of the charge to the overall advisory report.

CHAIR CASSANO: Right.

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

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

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

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

MEMBER BODEN: This is Les.

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

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

CHAIR CASSANO: Okay.

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

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

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

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

Any thoughts on that?

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

CHAIR CASSANO: Thank you.

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

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

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

disease or the treatment of the new disease.

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

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

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

CHAIR CASSANO: Okay.

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

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

CHAIR MARKOWITZ: This is Steve Markowitz.

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

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

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

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

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

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

MEMBER VLIEGER: This is Faye.

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

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

MEMBER VLIEGER: Thank you.

MEMBER BODEN: This is Les.

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

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

I mean, I don't --

CHAIR CASSANO: Well, it --

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

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

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

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

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

Anyhow, I don't --

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

So --

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

MEMBER BODEN: Right.

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

But, on an individual level, you're

right, you cannot say that.

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

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

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

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

CHAIR CASSANO: Okay.

CHAIR MARKOWITZ: You know, we specify that.

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

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

So, that's --

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

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

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

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

and I will pick out the asks.

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

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

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

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

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

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

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

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

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

(Simultaneous speaking.)

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

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

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

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

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

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

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

again.

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

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

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

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

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

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

3:50 p.m.)

CHAIR CASSANO: Hello?

(Chorus of hello.)

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

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

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

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

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

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

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

CHAIR MARKOWITZ: Steve Markowitz.

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

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

Does that make sense?

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

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

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

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

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

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

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

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

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

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

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

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

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

MEMBER BODEN: Oh great.

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

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

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

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

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

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

least asks about exposures and jobs they had.

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

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

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

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

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

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

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

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

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

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

us know.

CHAIR CASSANO: Okay.

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

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

CHAIR CASSANO: Okay.

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

Any thoughts on that?

Hello?

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

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

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

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

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

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

CHAIR MARKOWITZ: No.

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

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

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

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

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

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

(Chorus of thank you.)

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

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

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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 true and accurate record of the proceedings.

Neal R. Gross

Court Reporter