U.S. DEPARTMENT OF LABOR

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ADVISORY BOARD ON TOXIC SUBSTANCES
AND WORKER HEALTH

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MEETING

+ + + + +

WEDNESDAY
SEPTEMBER 4, 2019

+ + + + +

The Board convened by teleconference at 1:00 p.m., Steven Markowitz, Chair, presiding.

PRESENT
STEVEN MARKOWITZ, Chair
MANIJEH BERENJI
JOHN DEMENT
KIRK DOMINA
GEORGE FRIEDMAN-JIMENEZ
RON MAHS
MAREK MIKULSKI
CARRIE REDLICH
KENNETH SILVER
CALIN TEBAY

ALSO PRESENT

DOUG FITZGERALD, Designated Federal Official
CARRIE RHOADS, Alternate Designated Federal Official
RACHEL LEITON, Director, DEEOIC
JOHN VANCE, Department of Labor

CONTENTS

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

1:11 p.m.

MR. FITZGERALD: Good afternoon, everyone, and thank you for your patience as we assembled the Board, we had some technical difficulties.

My name is Doug Fitzgerald, and I'd like to welcome you to today's meeting at the Department of Labor's Advisory Board on Toxic Substances and Worker Health. I'm the Board's Designated Federal Officer, or DFO.

On behalf of the Department of Labor, I'd like to express my appreciation to the diligent work of our Board members over the past several months in preparation for this public meeting and for their forthcoming deliberations.

I also want to thank my colleagues here at Department of Labor for all their efforts in preparing for today's meeting, in particular Carrie Rhoads and the staff and Alternate CFO. And Kevin Bird and our SIDEM contract staff, who always do a great job putting these meetings

together.

As the DFO, I serve as the liaison to the Board in the Department. I'm responsible for ensuring all provisions of the Federal Advisory Committee Act, or the FACA, are met regarding operations of the Board.

I work closely with the Board's Chair, Dr. Markowitz, and I'm responsible for approving the meeting agenda and opening and adjourning these meetings. I also work with the appropriate Agency officials to ensure that all relevant ethics regulations are satisfied.

We have a full agenda this afternoon, and it should be noted that agenda times are approximate. So we'll try as hard as we can to keep to those times, but we can't always promise to adhere to them exactly. Copies of all meeting materials and public comments are or will be available on the Board's website under the heading Meetings.

The Board's website can be found at dol.gov/owcp/energy/reg/compliance/advisoryboar

d.htm. Or you can simply Google the Advisory Board and FACA substances and worker health.

If you haven't already visited the Board's website, I encourage you to do so. You'll see there a page dedicated entirely to today's meeting. That page contains all materials submitted to us in advance of the meeting. And you'll also find today's agenda, as well as instructions for participating remotely. It should be noted that there is no public comment period scheduled for this full Board meeting today.

If you are joining by Webex, please note that the session is for viewing only and will not be interactive. During the meeting, I would request members be mindful of background noise in their locations, and to place their phones on mute when possible if you are not presenting or engaged in discussions with other members, since we're recording this meeting to produce transcripts.

I also want to remind Board members to exercise caution in discussing or referencing case-specific information and refrain from

divulging any personally identifiable information. That would also include names, injury sites, birth dates, and age. Please refer to any ages as a range, like late 40s rather than 48 years old.

The FACA requires that this, the minutes off this meeting be prepared to include a description of the matters discussed and the conclusions reached by the Board. As the DFO, I ensure that the meetings are prepared and certified by the Board's Chair.

The minutes of today's meeting will be available on the Board's website no later than 90 calendar days from today, per FACA regulations. If they're available sooner, they'll be published before the 90th day.

Also, although formal minutes will be prepared because they are required by FACA regulations, we'll be publishing verbatim transcripts, which are obviously more detailed in nature. We will work to see that those transcripts are available on the Board's website within the

next several weeks.

And with that, Mr. Chairman, I convene this meeting of the Advisory Board on Toxic Substances and Worker Health.

Dr. Markowitz.

CHAIR MARKOWITZ: Thank you, Mr. Fitzgerald. This is Steven Markowitz, the Chair. I want to echo Mr. Fitzgerald's thank-yous to various people who have worked with us from DOL and otherwise to support the Board and to make this and our other meetings happen.

I want to welcome Board members, I hope you had a good summer. I want to welcome the public, whoever's participating. We're going to try, it's a little awkward, a teleconference. We prefer the face-to-face Board meetings, but we only have those twice per year, and we do this at other periods between, these face-to-face meetings, so that we can make progress.

We try through Webex to make as much as what we're discussing available for viewing. If you don't have access to Webex, it's also on

Board site, our website. But we'll try in speaking actually to be as clear as we can with reference to what we're discussing or the terms that we're using.

We will take a break for a few minutes roughly between 2:30 and well, anyway, between 2:30 and 3:00. I should say that there are several Board members who are not here. Calin Tebay, just yesterday, not due to his own efforts, had some sort of hearing scheduled today, so he's going to be late to this meeting.

And I got a recent text from Duronda Pope, who was called away to investigate a crush injury at the workplace of one of her union members, and so she mostly likely will not be here participating.

I also want to just recognize and thank George Friedman-Jimenez for participating today. I know there's been a serious illness in his family, and so we appreciate your efforts, George. Maybe you didn't have all that much time to prepare, but we always welcome your comments now

or in the future. So that will be good.

Unless there are any other comments by Board members, I just want to spend a minute on the agenda, and then we'll look over the items of the agenda, and then we'll start in on the agenda items. Any comments?

Okay, so you have access to the agenda. Anything that is omitted or anything you think that we should add? I'll, I'm going to actually add right at the beginning of the agenda just a very quick review of the public comments that have been submitted.

Sometimes we, there is no public comment session at this Board meeting, and sometimes we don't get a chance to discuss or review the public comments. So I wanted to spend just a couple of minutes going over the few comments that we have at this time, and then we'll get into the other areas.

Okay, the public comments, there were just a few. All were, all but one is on our Board website, and the other one I will explain. It was

late in coming in. By the way, let me just say that DOL has done an excellent job posting materials for this Board meeting. Any slowness or lateness in getting the agenda or any of the materials for the meeting was due to me, not to the Department of Labor.

But in any case, so Ms. Vina Colley submitted several comments related to each other in June of this year, raising concern about exposure to neptunium at the Paducah Gaseous Diffusion Plant. Part of the concern was about the environmental exposure, which is not really the domain of the Board. But she also mentioned that there was perhaps unrecognized worker exposure at Paducah.

That relates to Task 1 of the Board, which is attention to the site exposure matrices. I did inspect the SEM for neptunium at Paducah, and I did find that there were a number of buildings, jobs and work processes associated with neptunium. I was last updated in June of 2018.

So my request to DOL is if any additional information that DOE might have since June 2018 is available, that DOL acquire that information and update the SEM if necessary. I should also think that DOL might suggest to Ms. Colley that she go through the normal route of submitting additional information to the SEM, as is on the DOL website.

Second comment came from someone named Robert Rothe. I'm not sure I'm pronouncing his name right. This had to do with Rocky Flats and a particular laboratory at Rocky Flats. And the comment was that there were some toxins missing from the SEM for Rocky Flats, and he listed a number of them.

I looked at some of them. I did find some information about those particular toxins in the SEM, so I'm not sure whether the SEM is complete or not. And I would make the same request of DOL, that they obtain any information from DOE or Mr. Rothe since their last update, which was in June 2018, to update the SEM if it's needed.

DOL might also write directly to Mr. Rothe, inform him of the, or remind him of the standard method of requesting information be added to the SEM.

Finally, there was a comment from Cody Wetier, I think it came in a just couple days, which had to do with removing a certain presumption from the procedure manual that DOL uses for the program between version 2.3 and version 3.0.

The Board has discussed this issue, and I think it's going to be subject to the next agenda item, which is a followup on our action items. Because we have the, we made the same observations and requested an explanation background impact of this change in the procedure manual. So I'm not going to say more about that comment, other than I think that we'll return to it.

So that's it for the public comments. Let's move on -- any comments so far? Okay, so let's move on to the agenda item, the review and followup on our action items from our last meeting. And Ms. Leiton is going to lead much of this.

But the first item had to do with the, this issue on asbestos, which is that the previous versions of the procedure manual briefly stated that between 1957 and 1996, that it was assumed that certain job titles had significant but low exposure to asbestos. And secondly, the assumption was that everyone else at the facility also had some exposure during that time period.

I may not have entirely summarized that properly, that's from memory. But that section was struck in the more recent version of the procedure manual. So, Ms. Leiton.

MS. LEITON: Yes, I'm here, this is Rachel Leiton. We've been through these, so I'm just going to start with the, basically I'll probably go through the highlighted ones. We can take them order of, I've got an email from you with regard to these action items. That's from Carrie, actually.

And the first one is related to this asbestos presumption and the fact that we had taken off the one section. I believe the thinking was

that there are some that would need, for that period of time it would be better to have those evaluated by an IH on a case-by-case basis. But we realized that it did have this impact on the presumption because of the lack of the significant exposure which used to place those people into the presumption.

So we are actually looking at revising that language to clarify the matter, and that will be published in our next publication of the procedure manual that should be out by the end of this month.

CHAIR MARKOWITZ: And do you think you'll restore most of the old language?

MS. LEITON: I don't know that it will be restored exactly, but I think that we will, because I think there's a certain, we believe that after a certain date, and we've discussed this date many times, that it's going to vary depending on case.

So the language about the presumptions is being evaluated to determine if that whole

period for all those should be exactly as it was, or should some of those be referred for an IH. So that's what we're deliberating on now.

CHAIR MARKOWITZ: Okay.

MS. LEITON: All right. The second question here I think we already answered. This was about the process for the Board to refer issues. It finds while reading over cases, you had indicated in the last meeting that you wanted to be able to let us know if you saw specific things.

And I think, Dr. Markowitz, you were going to work out a process for that?

CHAIR MARKOWITZ: Yes, I have some ideas. But later in this meeting I want to share them with the Board, and we can come to a decision about that.

MS. LEITON: Okay, great. So number three, the question is regarding the EEOICPA claims that may have been reopened as a result of the Board recommendations, could DOL provide a description by specific condition, personal diagnosis instead of doing three broad categories.

So we did submit to you the chart that we had, well, so it was a chart that we had originally submitted to you about these cases that we had a list of. I think you probably have them now on your website. But it's been updated.

We originally had grouped it into three groups. One was mesothelioma, ovarian cancer, and pleural plaques. Group two was hearing loss, bladder cancer. And Group three was lung cancer.

So what we have done is we provided you a list, and this was something that we gave you separately than anything that would be online, because it had PII. But we gave you a breakout of all those. They haven't been summarized by specific conditions, but they're all in there in terms of which conditions are which in our detailed summary.

We have completed since that time, we've completed all of them. I can get you the details behind our latest report, which is the one that shows that we have 100% review. But the one that we already submitted I believe was the

original list from when we submitted that to you, 4/20/18. And we'll make sure that you get any details behind our most recent updates.

That, again, is going to be the detailed listing. We grouped them this way for ease. They can be broken out, I think if you look at those Excel spreadsheets, in more detail, as much detail as you want.

CHAIR MARKOWITZ: This is Steven Markowitz. So Kevin, can you put up the two tables that have been recently provided that do not have PII that we can share. Because I just want to see if we're talking about the, you know, same thing. There were two in particular.

MS. LEITON: The one I'm talking about right now is the one with those conditions. It says at the top illness and group on the lefthand corner. That's the other one. That's the right one.

CHAIR MARKOWITZ: Okay, so this is, this was the one with broader groups that was supplied some time ago that, after which we

requested breakdown by the individual diagnoses. Is that what you said, you were saying?

MS. LEITON: Yes, yeah. But this one we've updated, the numbers have been updated because we reviewed all those cases. We had not reviewed them all when we last submitted this chart. So that when we submitted it back at the last Board meeting, we'd only done a certain percentage of them.

Now we've done all of them, so it shows 100% reviewed and the actual numbers that have been reopened by district office. This is not broken out further, but the detailed spreadsheet that I provided does break them down. All I need to do with that spreadsheet is update it to match these figures in terms of it gives you the breakout of all the cases that we reviewed by condition, but it doesn't, I don't believe it has been updated to reflect which cases were reopened on that list. We can do that. But it does provide the breakout.

CHAIR MARKOWITZ: So the other tables are listings of individual cases, right?

MS. LEITON: Yes.

CHAIR MARKOWITZ: Okay. So is, have you aggregated those individual cases by diagnosis? So for instance, between the table which shows the individual cases and what we're looking at now, one might aggregate the ovarian cancer cases. One might aggregate the mesothelioma cases and present those, the six different illness categories.

MS. LEITON: Yeah. I mean, that can be done from the detailed list. We have not done that at this point. We provided the background list that can be sorted however you want to sort it. I think I have, I think we could add to it.

The most updated numbers in terms of what's been reopened and what hasn't I'll have to, you know, we can look into breaking it out. But it can be, again, if you have, since you have the detailed list you can break it out however you want.

CHAIR MARKOWITZ: Sure.

MS. LEITON: Using the spreadsheet.

CHAIR MARKOWITZ: Okay, and then just,

this is Steven, just to make sure we understand this. In the orange, all district offices, the total, total reopened for the various groups is 26 plus 19 plus 50, which is, it's 95 out of a total number which is in the first orange column, which is close to 2000. So about, looks like by my eye, about five percent of cases in these various categories have been reopened.

MS. LEITON: Yeah.

CHAIR MARKOWITZ: Actually, that's not a question.

MS. LEITON: Okay.

CHAIR MARKOWITZ: It's just interpretation, that's all.

MS. LEITON: Yup.

CHAIR MARKOWITZ: Are there any -- yeah, go ahead.

MS. LEITON: Just keep in mind that, you know, we reviewed them all, any cases with these conditions. So some, you know, may have been denied for other reasons, and that may be why it wouldn't have been reopened, based on the

presumptions. But we did review them all for that reason. That's probably why the percentage is low.

CHAIR MARKOWITZ: Right. Any comments from the Board members? Okay, you sent us some other, at least one other table that I know we can share. I'm not sure it's with reference to this section.

MS. LEITON: It's the reference to the next question.

CHAIR MARKOWITZ: Okay.

MS. LEITON: So the next, are we ready for the next response?

CHAIR MARKOWITZ: Sure.

MS. LEITON: Okay. So the next one was how many cases are referred to an IH. And in my, in our last meeting I had indicated we had a new report on this. I'm providing that report. This report is from 2018. It is for all of 2018. And it shows, I had indicated last time that it was 26%, I was going to double check it. That is still the correct amount.

These breakouts are what we looked at, accepted only, denied only, and accepted and denied, which could be it was partially accepted, partially denied. And so basically it shows this percentage of 26%.

It is kind of low, but then when we went back to look at these, I mean, a lot of them could have been denied because of a, they didn't have enough medical evidence, there wasn't, you know, insufficient evidence to support employment. So they could have been denied for a number of other reasons besides the causation or exposures elements.

And for acceptances, you'll see that acceptance only without a prior IH, there were like 89% of them that were accepted without that, which just meant that we had enough evidence already. So these are the chart we have.

I would expect that in 2019, that will go up a little bit, because we did have training. John Vance and his team went out and did some training in all the district offices face to face

this year, just to go over, you know, what should be referred to an industrial hygienist, what kinds of things they should look at when they are not referring it to an IH, like, you know, anything submitted by the claimant. Going back to the training, position, things were that where all discussion is training.

But there was, you know, emphasis on make sure you refer to an IH if believe you need to. So this might uptick a little bit, but it's generally, it's accurate. And we could probably at the end of this fiscal year, I would think we could easily update this for fiscal year 2019 figures.

CHAIR MARKOWITZ: This is Steven, I had a question. What does accepted and denied mean?

MS. LEITON: It means that we accepted a portion of the case but not another portion of it. So for example, they filed for three conditions, we accepted two of them, we did not accept the other.

CHAIR MARKOWITZ: Okay. So my

interpretation of this is that among a very large number of accepted cases, almost 7000, only 12% were, of the claims was there a need to refer to an IH. And among the denied cases, over 5000, about 15% of the time there was need to refer to the IH. In other words, use of IH actually was similar between accepted and denied cases.

One thing of interest, we'll have to figure out whether we, the Board wants this information, but since you mentioned that there are so many reasons for denial --

MS. LEITON: Yup.

CHAIR MARKOWITZ: That the issue of whether referral to an IH is appropriate or whether it's happening often enough, as you alluded to, the cases in which there's denial on the basis of not covered employment or some other non-causation, non-exposure issue, if you remove those and just looked at the cases in which the issue was that of questions about exposure or question of causation, and then looked at the proportion of times that IHs get involved with

those cases, that would be more informative to you, I think, in terms of the information value that the referral process, if that, if I'm understandable.

MS. LEITON: Yeah, I understand what you're saying. It's not always that easy for us to do that. We can't always attach a -- because we have multiple decisions per case in some instances. So determining which decision was impacted by -- so at one point it might have not enough medical evidence. Later, it might have not enough employment. Or then it has both and it's causation.

Our data is not clean enough for us to maybe break it down that far. I'm not a data connoisseur, so I would have to check. But I understand your point, I'm just not sure we are able to break it down that way.

CHAIR MARKOWITZ: Right I --

MS. LEITON: Because -- yeah.

CHAIR MARKOWITZ: Claims, if we looked at some claims, we understand the complexity.

MS. LEITON: Yeah, sure.

CHAIR MARKOWITZ: So any Board, any comments or questions? Okay, then let's move on.

MS. LEITON: Okay, so the next question, number five, is there was some discussion last time about the industrial hygienist being able to speak to the claimant -- speak to a CE at least, or speak to the claimant. We indicated we would be able to allow that with CE involvement.

I unfortunately thought that that had been incorporated in our procedures, but it has not yet. It will be incorporated into our latest update, which is due out the end of this month.

CHAIR MARKOWITZ: And when will it start?

MS. LEITON: As soon as those procedures come out.

CHAIR MARKOWITZ: Okay.

MS. LEITON: But I don't think there's ever been any prohibition on it. I mean, there's been a prohibition against talking to contractors, but if an IH had ever wanted to have a claimant

on the line and had requested it, the only restriction would be we'd probably have to a fed, the IH federal person ask the question or be on the line. And we'd need the CE on the line, which is something we've talked about or put in our responses in the past.

So you know, if an IH really wanted to talk to a claimant, they could make it happen. But just we haven't gotten that kind of request as of yet. But we will definitely put it in our procedure manual make it so that it's very clear.

CHAIR MARKOWITZ: And the contract with Banda, the contractor who does the IH evaluations is able to accommodate this?

MS. LEITON: Again, I would have to, we have to need, we need to work out the whether they have to ask the question of our industrial hygienist to ask it, or whether the industrial federal hygienist has to be on the line. Those are things that we're trying to clarify on the contract. I do know that it can be IH to claimant with a CE involvement. It may have to be

contractually the federal IH that asks it.

CHAIR MARKOWITZ: The IH evaluations or the text of those is mostly written by a contractor industrial hygienist, right?

MS. LEITON: They write them and our federal employee's IHs review them before they are sent out.

CHAIR MARKOWITZ: So it's a little bit uncertain whether it's the federal IH who will be permitted to speak with the claimant or whether it could involve the contractor IH.

MS. LEITON: Yes.

CHAIR MARKOWITZ: You know, my only, the only reason I focus on that is I'm concerned the contractor IH is essentially, you know, doing the sort of the initial work of the exposure evaluation, and I understand it's reviewed and approved by the federal IH. But it's that assembly of the original pictures in the evaluation that's probably the most important, meaning the contractor IH. And so permitting that person to do that would probably be very valuable.

MS. LEITON: I understand. But yeah, I can't, we have certain contractual obligations, and I'm not really sure that that's something that would be allowed. But again, if they have a question, they can talk to our IH and get that IH, federal IH, to get the person on the line and ask that question.

I know the back and forth is what you're saying would be more valuable. Again, we have certain contractual obligations and laws that we have to follow, so I'm not sure we can allow that. But I will find and make sure that you're aware of exactly which direction it goes.

CHAIR MARKOWITZ: Okay, great. Actually, I'm not referring to back and forth, I'm referring to the fact that the person who's actually sitting with the occupational health interview, with the EEIII , with the SEM, with all the original data and writing up that IH report, it looks like it's the contractor IH.

And that's the person who would be in the best position to, and have the most motivation,

to actually tease out the exposure, and particularly with reference to intensity and duration. And so it would be very helpful if the contractor IH could be included in the process. But I think I've made my point.

MS. LEITON: Understood.

MEMBER DEMENT: This is John. I have a question as a followup. Given, you know, given the potential for just the federal IH to ask questions --

MS. LEITON: Yes?

CHAIR MARKOWITZ: John, if you're still speaking, we can't hear you.

MEMBER DEMENT: Okay, I just don't know how many IHs are on the federal side of DOL.

MS. LEITON: We have two.

MEMBER DEMENT: They could be very busy if there's many questions.

MS. LEITON: It could be if there are, yes.

CHAIR MARKOWITZ: Well, you know, when we discuss claims, we're going to talk about the

IH evaluations. So I think we'll probably get back to this point and why it's important to us. Any other comments from the Board? Okay, any other comments, Ms. Leiton, from, on this issue?

MS. LEITON: Well there's -- no.

CHAIR MARKOWITZ: Okay, okay.

MS. LEITON: So there are two, three -- numbers six and seven are, I'm just going to stick to the ones that are actually questions for us.

CHAIR MARKOWITZ: Sure.

MS. LEITON: So that's number eight. And this is a question about the, he says, Dr. Markowitz requests clarification on the new CMC policy that was only given to DOH CMCs and not to private practice specialists, as discussed in the comments from Terrie Barrie.

So given that we have a contract with CMC, there are certain guidelines they must follow regarding receiving referrals, writing their reports, sending in their reports, and billing DOL. So these guidelines are appropriate for us to send

to the contractors in compliance, to gain compliance with the contract.

It wouldn't be appropriate for us to send those same guidelines out to treating doctors, claimants' treating doctors. You know, the procedures and the guidelines that are followed in terms of what is causation, all of those definitions are the same ones that we apply for, that are in our procedure manual. Any guidelines that are given to the contractor regarding our procedures are not outside of the scope of what we already have out there to the publically available.

When we deal with treating physicians of claimants, we will deal with them on an individual basis. So we would ask certain questions of a doctor who's treating a claimant of ours, certain questions that are related in that claim. The guidelines we're giving CMC, they're like, some of them are procedurally related to like the administrative side that I discussed.

The rest is it's, if the contractor

itself rewords any of our procedure manual, it's reviewed by us but it's the same content. There's no separate, new, different kind of content that's given to the CMC that is not given out to the public.

CHAIR MARKOWITZ: Okay, thank you.

MS. LEITON: Okay. And I think that's the last of the questions I had on this followup action from the last meeting.

CHAIR MARKOWITZ: Yes, it's true. So just for the rest of the call, will you or Mr. Vance be on the call just in case questions arise?

MS. LEITON: Yes.

CHAIR MARKOWITZ: Okay, great. Let me then go over the other items. Number six, which is that Dr. Berenji helped with assembling a summary of recommendations. She'll be happy to know that that was done, that Ms. Rhoads and Mr. Fitzgerald's going to review the followup on the previous recommendations.

But here I got a question for Ms. Rhoads. Did we post or can we post that recommendation status on our website?

MS. RHOADS: I haven't. I can see if I can.

CHAIR MARKOWITZ: I'm sorry, I couldn't hear you.

MS. RHOADS: Sorry, it has not been posted on the website yet. I can see if I can do that.

CHAIR MARKOWITZ: Okay. Yeah, I mean, it's our preference to do that.

MS. RHOADS: Okay.

CHAIR MARKOWITZ: Because then we can all look at it and see where we're at, and the public can access that as well. So that would be a request. I understand they require some modification from what it was, but on the list.

Item seven was we requested claims for four lung conditions, and DOL has provided those with, us with those claims. We're going to review some of those later.

Item nine was the Board requested that there be someone from DOL at all of our meetings going forward, which is the, is being complied

with.

And item ten is we're getting to the next meetings. And we're going to discuss that later for the next meeting later in the agenda.

So let's move on. What is the status, Mr. Fitzgerald, of the replacement of the Board member who dropped out, Dr. Cassano?

MR. FITZGERALD: I can probably address the two items that I'm on the agenda to speak. That would be the replacement of Dr. Cassano, as well as the Board recommendations.

Well, these two issues are pending, as you probably realize, due to circumstances beyond our control with the departure of Secretary Acosta. So those are kind of caught up in the transition process here in the Office of the Secretary right now.

So nomination has been made, a recommendation has been made to fill that position. And I believe the program has responded to the recommendations, and those comments are pending review in the Office of the Secretary right now.

CHAIR MARKOWITZ: I'm sorry, our prior recommendations are pending a response from the Department, in the Secretary's Office, is that what you said?

MR. FITZGERALD: That is correct.

CHAIR MARKOWITZ: Okay. So it's hard to predict the timetable, I guess.

MR. FITZGERALD: It is, and it's really I think at the discretion of the Office of the Secretary. I think that the desire is to give a new, incoming Secretary an opportunity to make an appointment or to certify those recommendations. I think everyone's expectation and hope is that that replacement of the new Secretary will happen expeditiously, and then we can move forward.

CHAIR MARKOWITZ: Okay. Comments, questions from the Board? Okay, so let's move on.

We're going to talk about the data tables that have been provided by DOL. And Kevin, if you could bring up the first one. These are, by the way, these are available on our website and

were sent around to the Board members over the last few days.

The first one we want to look at is called the major disease data request, that is tables from DOL. The first one on our list. By way of background, and while Kevin is bringing this up, we requested data from DOL on the 20 most common accepted conditions overall. And then the ten most common accepted cancers, neurologic conditions, renal conditions, and respiratory conditions.

We also requested similar data on denied claims, and then a table we'll look at in which I took the data from the other tables and calculated the proportion of claims that were accepted. So we've, okay. Now, this is -- oh. Okay, sorry about that.

So we're looking at initially the top ten cancer codes. And on the lefthand you see the ICD, the International Classification of Disease, -9 codes. And on the righthand of the table, you see the ICD-10 codes, and the dates that were for

these are approved claims under Part E, and the dates are 2013-2019.

Let me explain that I guess there was some question on my part how these ICD-9 and ICD-10 claims related to each other. The ICD-9 claims are from a period of 2013 until near the end of 2015. And then at the end of 2015, you should keep that table up if you could, near the end of 2015, DOL started using ICD-10 to code the illnesses.

So these are mutually exclusive claims from two adjoining time periods, 2013 to most of 2015, and then 2016 to the present. On the, I only learned that recently. I mostly focused on the ICD-10 codes. But in fact if you go back and forth and look at 9 versus 10, the tables of ICD-9 versus ICD-10, you see they're very similar. And so focusing just on ICD-10, for our purposes, probably suffices.

The, what you need to remember on the cancer Part E claims is that when a cancer claim is rated under Part B, it is automatically, and it's accepted under Part B, it is automatically

accepted under Part E. So those numbers we're looking at here, there's like Part E cancer claims, some of which were inherited from a successful Part B claim, and some of which were Part E only claims.

And one of those things that I suggest we request is a replication of this table with Part E only claims. Because those claims would be made in relation to supposed toxic exposures, and that would fall within the domain of this board, not the Radiation Advisory Board. Does that make sense?

And so when we look at cancer claims here in the top ten and then when we look at the top 20 health conditions, you'll see there are a number of cancers that make that list. You have to keep in mind that that's really a mix of Part B and Part E claims.

On the ICD-10 cancers, this is from the data that DOL gave us. You'll see under the text description a few oddities, like the number two item is malignant neoplasm of the left main

bronchus. And then you don't find anywhere the right main bronchus.

So I think what happened was that someone who uses the text for the code took a very, very specific ICD code as opposed to a, more of a broader range. What should have happened, I think, is that the second column, in the table on the right, the ICD-10 category code, broader code, B-34, C-34, etc., probably is more appropriate than the code range which is shown in the fourth columns on the right.

So that said, Kevin, let's move to the next table, because what I did was, and this is the one that says ICD-10 updated, is I took the text description of these categories and made it more sensible. And if we could go -- is there a tab with the ten cancers?

Okay, in any event, you couldn't get there. Okay, well, yeah, maybe in a moment. Yeah, that's good, we can work with this one. Okay, yeah, we can work with this one.

So before, we were looking at the top

ten cancers, and here we're looking at the top 20 health conditions overall, Part E, same time period, 2013-2019, focus on ICD-10, which is where I made the text more recognizable. And you see in these top 20 health conditions, about eight of them are cancers. For some people on the phone, where it says malignant neoplasm, that means cancer.

So then almost half of the top 20 health conditions are cancers. Again, those are, some of those came under Part B and others came only under Part E. But they're now all under Part E. But I want to focus on the non-cancers.

This is information that we've been wondering about for some time, which is what constitutes much or most of the work of the claims examiners. And we can see by the number of, setting aside the cancers, COPD is the leading approved condition, 2013-2019, 811 cases.

Now, silicosis is a Part B and Part E disease. So it's similar to cancers in the sense of if it was accepted under B, Part B, it would be accepted

under Part E for a couple of DOE sites in particular. So you have to remember that whenever you see silicosis in this table.

And then we get to other interstitial lung diseases, 468 cases. And then the only condition which is not a lung disease or a cancer in the top 20 is the bilateral hearing loss.

Moving on down, we see asthma. And then we see asbestosis. So one thing of interest to me is that we have silicosis above, we have a line for asbestosis. But we have a lot of, quote, other interstitial lung diseases, end of quote. A lot of those cases, which is interesting because a priori I would have thought that many of the interstitial lung disease cases would have shown up in the rubrics of silicosis and asbestosis. But that's fine.

We also, if you go down the list skipping over the cancers for the moment and we go to encounter for a screening for respiratory disorders, a sizable number of claims. This looks like a, kind of a catch-all category, which

probably is not COPD, probably is not emphysema, probably is not asbestosis or silicosis. So it would be interesting actually to know about that.

And then pleural plaques, which of course is specific to asbestos exposure. And then, again, a sizable number of unspecified pneumoconioses. And that could be I guess mixed pneumoconiosis or the like.

Any comments? I mean, we were going to go down to the next table, the top ten respiratory, where we see much of the same thing. But any comments at this point?

MEMBER FRIEDMAN-JIMENEZ: Hi, this is George, I have a question. Can you hear me?

CHAIR MARKOWITZ: Yeah.

MEMBER FRIEDMAN-JIMENEZ: Okay. I'm looking at the hearing loss. I know there's a change from ICD-9 to -10, but there were 726 hearing loss NEC in ICD-9, and 444 conductive hearing loss bilateral in ICD-10.

Now, those are approved conditions, and typically occupational hearing loss is sensory

neural, not conductive. And I'm wondering how, what's going on with the changing of categories and the naming of these categories?

CHAIR MARKOWITZ: Yeah, this is Steven. I don't have any insight other than, you know, we kind of have to actually look at the specific ICD codes. Both in 9 and 10 they give a code range, and so the text descriptions tend to be kind of -- well, we should be aggregated, encompassing the entire code range.

But I don't know whether the text description actually represents the entire code range, or one specific code within that range. That's what I'm saying.

MS. LEITON: Dr. Markowitz, I don't think that you should rely on the description, but I think you need to rely on the range, as you had indicated, I believe that's where you're going. You know, since there is a range and we went by a range, they probably picked one and put it in there. The data people aren't always aware of so much of -- it's like we don't accept conductive

hearing loss.

As Dr. Jimenez said, that's not something, because it would be sensorineural hearing loss. And so this description in and of itself, they probably picked one and put it in there because there's a range. But it should be sensorineural hearing loss.

CHAIR MARKOWITZ: Okay, thanks, yeah that makes sense. If we work with these table further, I think we should probably ask DOL to confirm when we translate the text into what we think is, you know, the correct categories, just to confirm that that's what they had in mind.

MS. LEITON: Yeah, I mean it's very challenging, yeah. That's fine.

CHAIR MARKOWITZ: Other comments on the top 20? So let's go down to top ten respiratory. Now, I made no attempt to aggregate the apparently related categories in the top ten respiratory. In fact, I also did not change the ICD tag, code at all. I mean the text description. Because these are recognizable enough.

Some of us want, would want to take the first listing, COPD unspecified, and take the last listing, emphysema unspecified, and they represent pretty much the same condition. We probably want to aggregate them. Similarly, with other asthma and with unspecified asthma, we want to do the same thing.

But in any event, I just left it as it is, just so we could look at what DOL produced and understand sort of the magnitude of the issues here. A lot of COPD and emphysema claims accepted. There were numbers denied, you know, there were all numbers for accepted. And a fair number of dust-related diseases accepted as well.

In the top ten, it looks like there are about 250 asthma cases. There may be additional asthma cases, and they'll be on the top ten and have other ICD codes, I don't really know. But this gives us some sense of what the claims examiners are approving.

I'm going to show another table where we look at approved and denied and we can make more

sense of it. Comments? Okay, let's continue to neurologic ICD-10 codes.

You know, the top one is obstructive sleep apnea, which raises the issue of is the, we're not distinguishing in these tables between what is a primary claim, meaning a claimant is saying that their obstructive sleep apnea is due to some toxic exposures at DOE, from secondary claims to like, who are saying that I have obstructive sleep apnea, it may be related to some other condition which has been approved by DOL as part of the claims process.

That would be a secondary condition. So we didn't ask them to separate that out. I'm guessing that this is more secondary than primary, but we could ask.

MS. LEITON: Sleep apnea definitely would be, just by the way.

CHAIR MARKOWITZ: What's that?

MS. LEITON: We've accepted a lot of sleep apnea cases based on, because they're kind of consequential to something else.

CHAIR MARKOWITZ: Okay, consequential, right. Otherwise, what you see mostly is Parkinson's disease and neuropathy. Many different synonyms for various neuropathies. You know, and if you add them up, you'd probably get over 100, meaning that it's probably second to sleep apnea versus Parkinson's disease.

But not clear whether some of these neuropathies might be secondary or consequential conditions, or whether most of them are primary. From an occupational medicine point of view, it's not surprising to see neuropathy from toxic exposures.

Comments? And then to renal is the last one I think we have. And here, we're just getting synonyms from chronic kidney disease. Almost nothing specific, broken down by stages. I don't really understand that. Is, are the claims categorized by stage, Ms. Leiton, in the claims?

MS. LEITON: We normally will take diagnosis code. I mean, sometimes we'll have a

diagnosis code from the treating and/or in other cases, with the ICD-10 it's so specific that it makes you break it down by this.

So I think the claims examiners can either get that information directly from the bills or from the doctors themselves who were providing these diagnoses, or they'll look at the medical evidence and they'll put one of these in there based on what they see in the medical evidence.

But again, since ICD, ICD-9 was a little bit more flexible. You just put in kidney disease. Now, it says you have to put in the, to the stage of what it is. So it's a little bit challenging.

CHAIR MARKOWITZ: Okay. I mean, from a causation point of view, we're looking at 160 or so cases of chronic kidney disease.

MS. LEITON: Right.

CHAIR MARKOWITZ: Comments, questions? Otherwise we'll go on to the ICD-10 updated approval percentages.

MEMBER SILVER: Ken Silver. Some of those renal cases will be uranium mill and

transport workers approved under RECA and now getting Part E benefits under this law I think.

CHAIR MARKOWITZ: That's interesting. So Ms. Leiton, these numbers would include RECA claims?

MS. LEITON: Yes, we did not exclude them.

CHAIR MARKOWITZ: Okay, okay, good point. So hopefully, okay, Kevin is putting up the approved percentage. If we could go back to the first set at the top, warning conditions or the cancer or respiratory, that would be good.

MR. BIRD: Dr. Markowitz, sorry, what are you looking for? Or are you looking for the new document?

CHAIR MARKOWITZ: So what I'm looking at it says top ten renal, right, approve/deny. Is that what you're seeing, Kevin?

MR. BIRD: At the bottom of that document we were just looking at, or are we opening a new document?

CHAIR MARKOWITZ: Well, okay. The --

MR. BIRD: What we're looking at now is a new document.

CHAIR MARKOWITZ: What does your screen show? I'm seeing top ten renal approve/deny federal claims.

MR. BIRD: Yes.

CHAIR MARKOWITZ: Okay, so I do want the approve/deny table, but not the renal, I want -- that's the original table. The file says at the end approval percentage, that's what we want to look at.

MR. BIRD: Yes, that's the document we're in currently. There are several tabs within that document.

CHAIR MARKOWITZ: Right, okay, that's good. Okay, well, we can stop there.

MR. BIRD: Okay.

CHAIR MARKOWITZ: Okay, so here I combined a couple tables, and I excluded cancer claims for the moment because of the Part B, Part E issue. And so we can look here, what's new is that we're looking at approved and denied at the

same time from the same time period, 2013-2019. And we can look at the percentages approved for selected conditions.

Now, you'll see there are a bunch of non-available in the A on this. And if it's on this, that means that that condition was not in the top ten approved or denied, so that we don't have those numbers. I think the next data request will be to have those numbers. So what that means is for instance, for silicosis, there are 546 approved.

There was a number presumably denied, we don't have that number. If it's below the top ten, that means it was probably less than 100. But that's, you know, conjecture, so we're just going to ignore that for the moment and just look at the percentage approved for those conditions that we have numbers of both approved and denied.

And so we say 50% of COPD was approved. And three-quarters of other interstitial lung diseases approved and 60% of asthma. And these are sizable numbers of claims during this period,

1600 or so COPD and close to 1000 hearing loss, and 600 or so both asthma and interstitial lung diseases.

Comments or questions here? We're going to get into more specifics of the -- could you go to the next one, the respiratory. It'd be just a tab, a tab, Kevin.

MR. BIRD: Yeah, I think I'm on the next tab, the top ten respiratory ICD.

CHAIR MARKOWITZ: So I'm still seeing the top 20 health conditions.

MR. BIRD: Can you refresh your Webex at all? I'm looking at, I'm seeing the correct one I think.

CHAIR MARKOWITZ: Okay, is everybody else seeing the correct one? Got to switch on.

MS. LEITON: Yes.

CHAIR MARKOWITZ: So my computer is frozen. Does somebody want to, while I fix -- okay, yeah, they just appeared. So here actually we have more information on denied and so that we can, for some of the conditions the same data as

before, COPD about 50%, almost all the silicosis cases were approved.

Some of them, some portion of them are Part B cases, we don't know. And the 80% of pulmonary fibrosis, asbestosis, and unspecified pneumoconiosis were approved. Pleural plaques probably a high percentage, but we don't really know about not -- on asthma it's lower, somewhere between 50-70% of asthma was approved.

And I had one thought about this and then people can chime in. These are, in my view, fairly high rates of approval. That doesn't necessarily mean that DOL is correctly or not correctly approving them.

It simply means to me that what I'm surprised by is that the cases that are coming into DOL on these diseases are, must be pretty well documented cases on the outside, outside of the DOL claims process.

That is to say that the physicians or whomever are working with the claimants to help them submit these claims are doing a pretty good

job documenting the health condition. And someone, and ditto for the exposure. I don't think that's an over-interpretation, but anyway other thoughts?

MEMBER REDLICH: This is Carrie Redlich. I had --

MEMBER SILVER: Ken Silver. Go ahead, Carrie.

MEMBER REDLICH: Go ahead, Ken.

MEMBER SILVER: Just this simple idea that we looked at a bunch of cases within -- most of the cases, there were several diseases claimed. So what we're looking at here are the claims for a given disease. These are not unique individuals as far as people.

CHAIR MARKOWITZ: That's correct.

MEMBER SILVER: Okay.

CHAIR MARKOWITZ: Meaning some people could have multiple claims and would appear in multiple cells on this table, right?

MEMBER SILVER: Yes.

CHAIR MARKOWITZ: Okay. Dr. Redlich.

MEMBER REDLICH: Actually, that was the same sort of question I had which -- in terms of, you know, someone -- clearly there are sometimes multiple respiratory claims at the same time, but I found that the same person could be in more than one category.

CHAIR MARKOWITZ: This is Steven, but those claims are processed or at least evaluated as separate claims.

MEMBER REDLICH: But if they were -- sometimes they're -- it seems that sometimes more than one disease is processed at the same time. But if it was two times within that --- this period of time from 2013 and 2019, I think this could -- you know, these are not all unique individuals. That's my understanding. Maybe we could get clarification.

MS. LEITON: That's correct. This is Rachel. These are not unique individuals. These are by condition claims, because like you said, if there's multiple claims filed for multiple different conditions, there would be no way to pick

which one to choose for our one case. So we just -- if it was listed as a condition claim, we put it on the chart.

In addition, Dr. Markowitz, a lot of times people will file for like three different conditions on the same claim form, so we'll evaluate them all at the same time.

CHAIR MARKOWITZ: Other comments, questions?

MEMBER BERENJI: Yes, this is Mani Berenji. I was curious about the COPD with acute exacerbation which I know it's hard to get some of these numbers, especially in the columns that have N/A. I'm just curious to see, you know, if they're having acute exacerbation while they were working or was this an acute exacerbation during the time they were working. I'm just a little curious about that particular item.

MS. LEITON: I, unfortunately, can't answer that question without looking at the case file. I mean it could have just been that we accepted an aggravation of COPD and it was put in

as an acute exacerbation. It could be that, you know, we got this diagnosis after a period of time and the doctor was saying the COPD that they had was exacerbated. It's hard to tell why they would put this particular ICD 10 code in here, but again, without looking at each of those cases, I wouldn't be able to give that answer, unfortunately.

MEMBER FRIEDMAN-JIMENEZ: This is George Friedman-Jimenez. I have a related question. Has the standard of causation always been caused, contributed to, or aggravated? Or has that changed and could that explain why maybe some of the 2016, 2017 cases may have been denied for exacerbation. Because I did see a comment in one asthma case that the only asthma that is compensated is occupational asthma which is not consistent with the current procedure manual.

MS. LEITON: So the standard has not changed under Part E. It says we suspect this is not a significant factor in causing to an individual aggravating. It's always been that. But the different tier might be due to the fact

of the ICD 10 code being as specific as it is. And if you saw there was a time when we required or thought we had to require that it had to be occupational asthma, but after more recent clarification, partially due to board recommendation, that's become a little bit -- that's changed a lot in terms of asthma. And we've been accepting a lot more asthma cases that do not require the word occupational. We've clarified that in procedures since. I'm not sure exactly when that changed.

MEMBER FRIEDMAN-JIMENEZ: Okay, that would cover the COPD exacerbation also and they're now all consistent with the OSHA definition of work-related disease.

MEMBER REDLICH: This is Carrie. I compared the ICD 9 data with the ICD 10 and I think as was mentioned because of the greater specificity and more options for diagnoses, there wasn't like an acute exacerbation of COPD in the old category and the old categories tended to all have more cases, so I think what's just happened is and anyone

who has used the ICD 10 coding system, it just keeps dividing things into smaller buckets that really may not be clinically for our purposes that different. Because if -- you don't have an exacerbation of COPD unless you have underlying COPD.

MEMBER FRIEDMAN-JIMENEZ: Right.

MEMBER REDLICH: And for causation purposes, it would probably not matter.

MEMBER FRIEDMAN-JIMENEZ: Well, in a 60 pack a year smoker, they may have underlying COPD from smoking and an exacerbation due to an acute exposure to dust or fumes irritants that caused the exacerbation. That would be one.

MEMBER REDLICH: Yes, but those exposures could have contributed to their underlying COPD, too, in addition to the exacerbation.

CHAIR MARKOWITZ: If we wanted to really look at aggregate numbers, aggregating some of these columns that are kind of -- rows that are kind of artificially separated, we would request,

I think, the top 20 respiratory codes and then look at all the asthma, look at all the COPD and put them together to get a better overall understanding. We should consider that.

Kevin, can you bring up the next slide. I think it's the neurologic.

MR. BIRD: Do you see it?

CHAIR MARKOWITZ: No, I don't see it, but if everybody else sees it. Okay, it showed up now.

So again, the N/As are because they didn't appear in the top ten so that's why we have a lot of N/As, especially on -- both on the denied and the approval side. You can see about 40 to 50 percent of the neurologic conditions were approved, 42 percent Parkinson's, probably 45 on average among the neuropathy, and close to half of the sleep apneas.

And the next is renal. It's not showing up for me, but if everyone else can see it. Does anybody want to walk through this, the way I'm walking through this?

Okay, fine, the neurologic showed up. No, that's neuro -- we wanted the renal. You have the renal up, right?

MR. BIRD: Yes, correct.

CHAIR MARKOWITZ: Okay. I'm just going to go back to my own files here and -- what does it show on average acceptance for chronic renal?

Okay, Kevin, if we can move on to the last table, the reasons for denial, lung diseases, reasons for denial.

MR. BIRD: Okay. There are a few separate tables in this document.

CHAIR MARKOWITZ: Right.

MR. BIRD: Is that what you want?

CHAIR MARKOWITZ: Yes, Table 1 should say Table 1, overall approval --

MR. BIRD: Yes.

CHAIR MARKOWITZ: Okay. I'm working off my hard drive, the tables I have because the web access is not working. So if I -- okay, we're back to this.

We're looking for the reasons for denial.

MR. BIRD: So right now I have the Excel document open, data request lung diseases reasons for denial. And I'm on the first tab which is Table 1.

CHAIR MARKOWITZ: Okay.

MR. BIRD: Is that what you're looking for or are you looking for --

CHAIR MARKOWITZ: Yes, that's --

MR. BIRD: Table 3 gives reasons for denial.

CHAIR MARKOWITZ: Okay, yes. Table 3. Thank you. Okay. So just eyeballing this, there are really two major reasons throughout all these lung diseases and beryllium-related disorders, either the medical information was insufficient or negative causation result. And there's occasional other. And there's some pattern here. You can see under chronic beryllium disease, three quarters of the medical information wasn't there. For beryllium sensitivity, 80 percent, medical

information not present. It's really the dominant reason for denial rather than causation.

That begins to change somewhat for some of the other conditions, chronic silicosis, about in half the cases it was medically insufficient information. And then by the time you get to asthma, it's now negative causation is the dominant reason. COPD, negative causation, almost 70 percent of the time. Same for interstitial lung disease, closer to 60 percent, as well as sarcoidosis. Asbestosis and asbestos pleural placques, the medical information is frequently not there. So there's some variation among the chronic lung diseases that are outside of asthma and beryllium.

Any comments? Okay.

So in terms of the data and I do think there's some additional data we probably want and I propose that we form a working group that can have a discussion after this call in the near future, because it takes a while for DOL to produce data, in which we drill in a little bit on some

of the things that we didn't get to this time.

They did comply with all of our requests for data. It's just that we want the next round. Is that all right with people to have a working group? And I propose actually that when this group comes up with a plan to request additional data that we send it among the board members for comments or additions if that's permissible by the rule.

MR. FITZGERALD: Yes, I would just ask that we -- we had established a process for submitting requests for data, so try to use that form and really be kind of deliberate and specific about what you're requesting and the reason for its use. That's right out on the form that we produced. Thank you.

MS. LEITON: Doug, this is Rachel. We might want to have another conversation about the best way to request data specifically just because the data is complicated and I really would kind of -- I don't want to see the board members get together, come up with what they think they can

get in the allotted time to try to put together how to get it and then, say we can't do that.

So I don't know if we have maybe some preliminary discussion with, once you guys, once the board members know what they -- kind of have an idea what they want before giving us that formal request, maybe a conversation somewhere in there.

MR. FITZGERALD: There's nothing prohibiting a working group from having a conversation with a designated program person to kind of clarify what you're --

MS. LEITON: -- yes, I'm just think it might be easier.

MR. FITZGERALD: Yes.

MS. LEITON: Yes, it might be easier than you guys trying to formulate something that when we get it we're like well, we can't do it that way. We're not exactly sure what it means, et cetera.

So once you guys have formulated kind of an idea of what you want, maybe we can have one of our data people talk to you about it, ask you

follow-up questions, and then formulate the exact request. And then that would probably make it go faster and easier for us to process them because we'll have that initial conversation before the formal request comes in.

MR. FITZGERALD: There's nothing in the FACA that would prohibit that process from taking place.

MS. LEITON: Dr. Markowitz, does that sound reasonable?

CHAIR MARKOWITZ: That would be ideal.

MS. LEITON: Okay.

CHAIR MARKOWITZ: Who wants to be on this working group by the way? Besides myself.

MEMBER DEMENT: This is John. I'd be happy to be on it.

CHAIR MARKOWITZ: Okay. Thank you. Well, the rest can think about it and --

MEMBER SILVER: This is Ken. I have a question about kind of a sleeper row in one of these spreadsheets. Among the top 20 health conditions excluding cancer claims is encounter

for screening for respiratory disorder. And Dr. Markowitz made the point that there's a rather high rate of approval of claims for respiratory conditions.

Then we looked at the reasons for denial often being insufficient medical evidence. Could more be done at those encounters for screening for respiratory disorders to improve the sufficiency of medical evidence? What do those encounters represent? If not an impairment evaluation.

CHAIR MARKOWITZ: Is the question --this is Steven. Is the question whether claims examiners, are they getting all the medical information that's out there and that should be used in a case or is it some other question?

MEMBER SILVER: DOL is keen for encounters for screening for respiratory disorders. What is going on in that screening process to develop the medical evidence?

MS. LEITON: I think we'd have to look at the codes you're looking at. I don't see it here. Maybe it's here.

MEMBER SILVER: Top 20 non-cancer claims.

MS. LEITON: Encounters for that. I don't have the answer to that myself. I would imagine it probably is paying for some sort of impairment because a lot of times the claimant decides to get impairment ratings done by their own doctor or by one of our doctors, especially if it's a CMC. So we say you've got a bunch of these. You need to go get those tests and we'll pay for those tests. They go get those tests, submit them to us. We send them to our CMCs to review for impairment. So that's likely it. I can't guarantee you that's it, but that's the most likely possibility that I can think of right now.

MEMBER SILVER: So those are people for whom causation has already been established.

MS. LEITON: Probably yes.

CHAIR MARKOWITZ: Okay, anything else on the claims data?

MEMBER BERENJI: Yes. This is Mani Berenji. I think we should definitely pay

attention to the sarcoid items. I feel that -- we get them through the case reviews, but I feel that if we can try to pay attention to those particular cases, they do have a higher than average denial rate.

CHAIR MARKOWITZ: Okay.

MEMBER REDLICH: This is Carrie. I would second that.

CHAIR MARKOWITZ: Okay, good. Okay, so no other comments on claims data.

It's 2:35. We're going to take a five-minute break. Don't hang up. And we'll resume in about five minutes and we'll start on with the review of claims.

(Whereupon, the above-entitled matter went off the record at 2:35 p.m. and resumed at 2:44 p.m.)

CHAIR MARKOWITZ: Okay, so we're moving on to discuss some claims. As a reminder, we do this under the second and fourth tasks assigned to the Board. One is to evaluate medical guidance, claims examiners when they evaluate

claims; and secondly, to look at the work of industrial hygienists and physicians to ensure objectivity, quality, and consistency of their work.

So before we actually get into these claims, we need to discuss what's going to happen with our comments. We're looking at claims for several reasons. One is we want to understand the claims process better. Secondly, we want to be in a position to structure a systematic look at claims so that we can make some recommendations if needed to improve the claims process.

But we also, in looking at individual claims, come up with either disagreements about the decisions or significant questions about the decisions. And we need to transmit those concerns to the Department of Labor. So I want to just briefly figure out a system for doing that.

We have some -- we were given some -- I think 80 claims or so to look at, sarcoidosis, interstitial lung, chronic beryllium disease, and asthma, and most of the claims had been looked at

by at least one person among us and we're going to discuss at least some of these, but each of us has their own, has their own look. We may agree with the claims decision or we may disagree.

And we have a few options here. One option is that if we have significant questions about the decision or frankly disagree with the decision with specific reasons, and that is decided by one board member. If that board member writes up those concerns and questions and disagreements and we submit that to DOL as an outcome of the evaluation of the claims.

The alternative is that we somehow orchestrate two board members to look at the same claim and come to agreement as to whether they disagree with the decision or have major concerns and then submit those combined comments, if necessary to DOL.

The second approach is a lot of work. I'm not sure we have the person power to do it, frankly, and this is sort of leaning me towards the first approach which is that a single board

member looks at a claim, evaluates it, provides written comments about disagreements or major questions and that is submitted to DOL.

I wanted people's ideas about this and I want to arrive on a method of how we're going to do this so that we can do this going forward. Comments?

MEMBER DEMENT: Hi. This is John Dement. I think the single write up with details about the issues and concerns and keeping the chair informed, in the loop, would be an appropriate way to go.

MEMBER REDLICH: This is Carrie. I agree.

MEMBER BERENJI: This is Mani. I agree as well.

MEMBER MIKULSKI: This is Marek, and I think it's a good idea. I assume that there would be at least another person at the DOL looking at the claim again to confirm or disagree with those disagreements. So -- is that correct?

MR. FITZGERALD: This is Rachel. I

think I would like to have a conversation with Doug about how it will be handled in terms of -- I think it's -- you guys, if you come across things that you see that you want to bring to our attention, we can review them, but going into case by case, back and forth rebuttal, I don't think that -- I think that's a little bit beyond -- that's more like an auditor role. So we can look at them, but I mean I'll talk to Doug about the scope and all that, but in terms of us responding to all of these cases about whether we agree with you or not, we're not going to get into a, you know, we agree, you disagree. Because there's an appeals process for that.

There's a line between case adjudication and what we have to do and the processes we have to go through and your role in advising on general topics. So if we start getting into case by case, oh, we think you should have done it this way. First of all, that will have to be totally something that would be not public. And second of all, we'll take the information and

review our cases, but we can't get into a debate with you guys about it, going back to you with all that.

MR. FITZGERALD: Rachel, I want to more fully understand what it is that the board wants to do here and I think we should have a conversation about it. I think the information or the perceptions you discover in review of these cases should be looking at what actions or systems or processes have led to what you might have some concerns or disagreements with, not individual decisions on cases because I do think that's kind of post-adjudication issues.

MS. LEITON: Yes.

MR. FITZGERALD: And we need to kind of make sure we separate that piece out from what the board's role is in terms of looking at overall processes and systems and policy and those sorts of things. So to the extent you identify problematic issues with cases, they should be categorized as something that would be within their purview of the board to address from a procedural

or policy standpoint.

CHAIR MARKOWITZ: Sure, this is Steven. Our obligation, I think, is just to give you feedback on individual cases that we look at where we think there were major concerns or errors. What you do with that information is up to you in terms of the individual claims, recognizing that there is a -- you have a well-established process for examining claims, reexamining claims, and the like.

MS. LEITON: Okay. That should work. Thank you.

CHAIR MARKOWITZ: I don't think any of us are interested in debates, not debates that we lose anyway.

MEMBER REDLICH: But I think that some of the cases illustrate sort of the rationale for some of our prior recommendations and I think some of them sort of highlight, you know, if it's unclear, whether -- what actually has been implemented. And I think maybe will lead us to sort of restate some prior recommendations.

MEMBER DOMINA: This is Kirk Domina. I just got a text from Calin Tebay. He's on. And also the subject we're talking about here, one of these cases and it has to do with how they did the SEM. There's a glaring issue -- I'm not saying that it may change the way the claim was adjudicated, but there's a huge problem with categorizing somebody in the wrong job title and it could have an outcome on how the SEM changed in an eight or nine month period from 100 and some chemicals to almost 3,000.

MR. FITZGERALD: Kirk, if you're in touch with Mr. Tebay, could you tell him to press *0 and the operator can --

MEMBER TEBAY: I just talked to her.

MR. FITZGERALD: Okay, great. Welcome.

MEMBER TEBAY: Thank you.

CHAIR MARKOWITZ: I think we should now discuss individual claims because that's where some of this will get real.

Any volunteers? I remind you we don't

-- give general ages. We obviously don't mention names, mention the last four digits of the claim number.

MEMBER DEMENT: This is John. I'll be glad to kick it off and see where we go.

CHAIR MARKOWITZ: Great.

MEMBER DEMENT: Ready?

CHAIR MARKOWITZ: Sure.

MEMBER DEMENT: This is an ILD case. The case number is 6115. I think the case sort of reflects many of the recommendations the board has made over the last two or three years.

This is an individual who was born in the 1930s. He worked as a sheet metal worker, for various periods of time between 1967 and 1998. So he had about 24 years of verified employment. He worked himself from journeyman to foreman to general foreman and then superintendent, so over the years, he moved away from working with the tools to being in a supervisory role, but nonetheless, in and out of many different work sites at Rocky Flats.

This individual had only a brief smoking history. His OHQ suggested he started at 16 and stopped by the age of 20, but his medical records suggest that it was not at the minimal smoking.

In 2017, the claimant developed dyspnea and nonproductive cough. He was seen by his healthcare provider and also a pulmonary consult. The PFT said he showed a restrictive disease and a low diffusing capacity and a CT showed interstitial lung disease.

The person reading the CT said just in a passing comment in a pattern most commonly related to idiopathic pulmonary fibrosis. In that particular consult, there's no evidence that the physician or the radiologist took into consideration occupational exposures in his determination. The worker filed a claim for interstitial fibrosis in 2017 based on the CT findings and restrictive lung function.

Looking at the OHQ it listed exposure to asbestos and sheet metal work, of course, and the OHQ specifically said work in and around pipe

cutting for at least two years. He also had many periods of work within buildings whereas you look at the buildings themselves, the SEM shows presence of asbestos, particularly in building materials.

The claims examiner looked apparently only at the SEM statement of accepted facts which was sent to the industrial hygienist and the CMC. The statement of accepted facts based on the SEM listed aluminum, welding carbon steel, and synthetic vitreous fibrous and silicon carbide, but did not mention asbestos.

In his referral, the referral sheet indicated that the OHQ was, in fact, sent with a package to the IH. The industrial hygienist evaluated only those specific listed compounds that were just mentioned in the review of the case. There's no evidence in the IH report that he looked at all at the OHQ.

The industrial hygienist concluded this individual had low to moderate exposures, very low to moderate exposures through the mid-1990s to the compounds and materials that I just mentioned and

didn't mention asbestos at all.

He also included this phrase that we've seen repeatedly in the IH report and it says however, there's no available evidence, i.e., personal or area industrial hygiene monitoring data to support that after the mid-1990s his exposures would exceed existing regulatory standards. This phrase is apparently something that's from a high level decided to put in because I've seen it worded almost identically in many different industrial hygienists reports. So it's something that's from a program perspective that's being put in.

The CMC issued a report also in 2017. He accepted the IH's assessment of exposures. He also looked, interestingly, the individual during the work up had some medical tests for anti-nuclear antibodies and SEL-70 for possible autoimmune response. There's no diagnosis of an autoimmune disease in the medical records that I could find.

The CMC also further noted that the IH exposure evaluation showed all exposures were below

currently accepted standards and never looked also at asbestos. The CMC says given the relatively low level of exposures to toxic substances, his likelihood of autoimmune disease and the often slash always used respiratory protection. The evidence is not adequate to infer an association of employment with his condition.

Again, there's no evidence that I could find from a diagnosis of autoimmune disease and I considered this comment of the CMC pretty much speculation. Also, I see the CMC is also using from the OHQ the checkoff of having used respiratory protection to infer that it actually provided protection for this worker which I really don't think is an appropriate use of that information out of the occupational health questionnaire.

The notice of final decision denying compensation for pulmonary fibrosis was sent in March of 2018.

Unfortunately, for this worker, the story doesn't end here. The worker had a (telephonic interference) worker medical programs

at National Jewish in August of 2017. He didn't get the report later, but (telephonic interference) program diagnosed this individual with asbestos-related disease which they attributed to his work as a sheet metal worker and exposure to asbestos at Rocky Flats.

The worker then filed another claim for asbestosis specifically in November of 2018. This time to look at the SEM looked at the labor category sheet metal worker, but looked at it across all sites and concluded that there was, in fact, potential for exposure to asbestos and the claim was awarded under the current asbestos assumption and the asbestosis assumption based on 250 days of aggregate work days, 10 years of latency.

I guess this case illustrates a couple of issues that I think are important. One is the occupational health questionnaire was not used on the first round of this worker. And I think that's really an oversight. It should have been looked at. It's also an instance where neither IH or the CMC were thorough as they looked at the information

available. They should have, first of all, looked at the OHQ and they would have seen this worker, in fact, had asbestos exposure.

The other issue is a simple look at PubMed and related to asbestos diseases in sheet metal workers. They could have found that there's a strong association with that type of work.

I think this is fortunate for this worker, they had a follow-up exam done by a former worker program that made the connection, one with sheet metal work and asbestos exposure and asbestos exposure and his lung disease based on chest x-ray alone for the worker program.

So that's my comments. Any discussion?

CHAIR MARKOWITZ: This is Steven. So John, the first claim was not -- did not mention asbestos in the claim, right?

MEMBER DEMENT: No, it did not -- well, it didn't mention asbestos in the claim. It's merely mentioned fibrotic lung disease I think is the term that was used on the EE-1.

CHAIR MARKOWITZ: So the claims

examiner, the industrial hygienist, and the CMC, all of them did not raise the issue of asbestos?

MEMBER DEMENT: No, at no point during that review was asbestos raised as an exposure or the exposure potential related to his condition.

CHAIR MARKOWITZ: Just a comment, for those of you who don't know, sheet metal work in the last 30 years is synonymous with asbestos exposure, more than 30 years. It's the only group that had regular periodic testing for asbestos-related disease since the mid-1980s and it's been documented in people who are still alive and sheet metal workers who have died and it's remarkable that the industrial hygienist and the CMC did not think pulmonary fibrosis in a sheet metal worker might represent asbestos.

Other comments?

Does someone else have another ILD claim while we're on interstitial lung disease?

MEMBER REDLICH: Yes. Let me just find it.

CHAIR MARKOWITZ: I'm sorry, is someone

looking for a case?

MEMBER REDLICH: Yes, it's Carrie again. I'm taking a second look.

CHAIR MARKOWITZ: No problem.

MEMBER REDLICH: Well, actually, I'll pass on that. I don't want to waste time.

CHAIR MARKOWITZ: I have a quick ILD case. I was thinking about it. This is Steven. Claim 1504, this is a Mound worker for decades who worked in decontamination for two years. Was a machinist for six months and then as a draftsmen/designer for 26 years. On his occupational health questionnaire he described himself as a tool and die worker.

And the claims examiner identifies from the SEM certain toxins related to pulmonary fibrosis, namely some cerium compounds and polyvinyl chloride and appropriately provides the SEM, the occupational health questionnaire, and the EE-3 to the industrial hygienist. The industrial hygienist looks at the exposures and says that they were unlikely to be significant and

ranks them as low to very low. And the CMC who did an excellent job, actually, in the report, particularly on the medical side, relies entirely on the industrial hygienist who declared that the exposures were insignificant and the claim was denied.

I have no problem with the CMC report except the fact that they relied exclusively on the industrial hygienist. The only question I have on this is I'm not entirely confident that the exposures have been fully characterized. I don't know what a tool and die worker does for 26 years at Mound and what the exposures might be. And I don't know that the decontamination work for two years was well characterized.

I think it's a really good example where an intensive industrial hygiene interview with the person would have addressed those exposures and either made them real in terms of the claim situation or put them to rest as contributing to it. So that's my only comment on that piece.

MEMBER DEMENT: This is John again.

I wonder on the industrial hygiene exposure assessment and I have been looking for this as I've gone through these. The hygienist in looking at each of these exposures that are on the questions that are addressed to him or her needs to state the basis for their determination of that exposure. And I would think minimally they would have to express some understanding of the work that was done that would result in exposure to that particular material.

A tool and die worker does a lot of different things and it's probably pretty difficult to summarize that based on a simple job description alone. And I agree with you. I think that's the situation where a 15-minute discussion with the worker would have clarified a lot of issues.

MEMBER MAHS: I have one comment. This is Ron. Along with what you were saying, John and Steve. It's a short one, but it raises a lot of questions -- (telephonic interference) -- brick mason or a mason, he was working around asbestos and silica for years. If you've ever worked around

a mason, they look like a ghost by the break in the morning because most of them still to this day don't like to use water when cutting, which is their own fault. The IH determined the exposure was minimal and the doctor agreed. And they used these statements at the time that they had significant exposure but a low to very low levels. I don't understand how they could have significant exposure but at low level.

And this question I've had, because there were several of them that had this. What is the standard, the current exposure standard after 1998 had to do with something that people were exposed in the '70s and '80s? We didn't have that standard at that time. So like you were saying I like the idea of we going to have the IH contact to find it in a case like this or any other. How does he know what the exposure is? How does he know myself and guys at Oak Ridge for all these years, he didn't know my daily exposure. A lot of it's not monitored. I don't have any monitoring results or any exposure results. I think talking

to the claimant would help a lot on all of these cases and other things that I've looked at.

MEMBER DEMENT: This is John again. One of the other issues that I think for the IH exposure is substance and I think you've touched on it, too, is what does low to moderate mean without some anchor, something to relate it to, it has no real meaning from an exposure perspective. Is it related to current OSHA standards? Is it low relative to those standards? Is it low relative to historical OSHA standards or even periods of time where there were no OSHA standards.

In some ways, use of these terms low and very and moderate need to have some anchors and consistent anchors across the IH report that would at least provide some relative exposure context. Otherwise, I think it's being used by -- and sometimes appropriate and sometimes inappropriate by the CMCs and others to infer that low to moderate means de minimis which I don't think is a correct interpretation.

MEMBER FRIEDMAN-JIMENEZ: This is

George. John, I agree with you with regard to the concentration or the intensity of the exposure.

In this case, I didn't read the whole case, I'm just looking at the very beginning summary, his exposure was characterized as being two years and five months as a decontamination worker in the '60s, six months as a machinist and then 26 years as a draftsman designer.

So it may be that they're characterizing his exposure as low to moderate based on duration rather than intensity of the exposure. It's not, I haven't looked at the details of the case, but I just noticed that that's how they characterized his exposure in terms of the timing.

MEMBER DEMENT: George, most of the time the IH reports will take his job and determine what the exposure concentration or level was.

So for the draftsman it would probably, I assume the IH report, based on what I've seen on all the others, would have said incidental exposures only, if any.

CHAIR MARKOWITZ: You know the -- this

is Steven -- the IH reports have these rankings of intensity of this, what Ron points out, this contradiction between something being significant and something being low to very low. And they also raise the frequency.

I know that some of these industrial hygienists work within the Department of Energy, and that's better than not, I'm sure it helps a lot, but if you worked at Paducah it doesn't mean that you know Y-12 or Hanford. You just use a very diverse workplace.

The IH reports refer to data or data not being available. But ultimately, frankly, it just gets down to use of their own experience and professional judgment on whether the, what level of exposure there was.

And I just don't find that trustworthy in a vacuum. From a vacuum of not having spoken or gotten some detailed information from the claimants.

That's what we do in an occupational medicine evaluation. That's how we make our

judgements about causation, getting that level of detail. And I've had it, it sucks.

MEMBER DEMENT: I agree with you completely. This is John. I agree with you completely.

Lacking the ability to talk with this individual, the IH is totally relying on his or her personal knowledge. Which, in some cases, may be very complete. But given the diversity of sites and jobs and circumstances at these sites, most of the time it's very incomplete.

And it's the reason I said that the hygienist needs to state the basis of exposure determination. Does he or she in fact know this work?

What is the work of that tool and dye maker that we discussed? You know, what are the tasks that would have resulted in exposures? If they don't know, then it's purely a guestimate.

CHAIR MARKOWITZ: This is Steven. As you point out, the CMC, in some cases with some justification, just points to whatever exposure

the IH writes up and relies on that for their opinion for their assessment, so.

Let's move on, I think, to other, is there another ILD case that people want to discuss?

I would have in passing, I did look at 5318 and I had no disagreement with either the medical assessment or the exposure assessment. I thought it was the right decision. It was a denial and I thought it was a denial for a good reason, so.

There is one case I just want to mention briefly actually. It's ILD 0021. And the, and I can just very briefly discuss. It was a denial. And it relates to this question of contribution. And it's the reason why I want to just discuss it briefly.

This person was a miner, I think under RECA, who had ten years exposure but only six months of covered employment. It was six months exposure in 1970 out of total ten years exposure.

And everybody acknowledges that he had silicosis. The issue was whether six months of

representative of sufficient exposure for contribution.

And the outside physicians who were Dr. Sood from New Mexico and Dr. Kesler from also the University of New Mexico said, yes, six months meets a contributory standard. And the first CMC said, no, he doesn't even have silicosis.

But they sent it to a referee CMC. I think that's the proper term, who did an excellent job in the case. Except for the fact that he said, no, six months isn't enough to cause this disease. Not addressing the issue of contribution.

So, they went to an oral hearing. Was very involved, very long claim. But the problem is that if doctors can disagree on issues of contribution, but with some guidance from DOL, perhaps they might have agreed in this case.

Is six months out of ten years of silica exposure, did that contribute to his silicosis.

And it's a question that we could probably have a long discussion. But it's something that if DOL provided guidance on then

there could have been, I think, a more rational answer to this question.

By the way, my own personal opinion is yes, it beats the contributory standard. But in any case.

Let's go on to some other claims.

MS. LEITON: Dr. Markowitz, this is Rachel. Can we avoid using specific doctor's names, please?

CHAIR MARKOWITZ: Sure. Okay.

MS. LEITON: Thank you.

CHAIR MARKOWITZ: Yes. I did, to my credit, I did avoid the CMC names.

MS. LEITON: Yes, you did. I appreciate that.

(Laughter.)

CHAIR MARKOWITZ: But okay, fair enough.

MS. LEITON: Okay.

MEMBER REDLICH: This is Carrie. I have one quick ILD case. If it's a --

CHAIR MARKOWITZ: Go ahead. Go ahead.

MEMBER REDLICH: Okay. So it's basically someone who had a prior RECA claim for pulmonary fibrosis silicosis that had been accepted.

And it's -- the purpose of this was an impairment rating. And the records note a diagnosis of COPD on multiple medications, cough, shortness of breath, symptoms. And the oxygen at night for de-saturation.

And the pulmonary function tests are on the low end of normal. And so, the physician performing the rating says that there is no respiratory impairment based on the patient's spirometry.

There had been spirometry because this person had participated in prior surveillance back in 2004. Which showed them to be at, you know, the 120 percent predicted.

And now we're down to the low 80 percent. Which really is a substantial decline in lung function that's consistent with their symptomatology.

So, I understand that DOE was with the, in this case it was a, the rating, the impairment rating performed by the physician was problematic. And it looked like the claim, there was some comments that they were not going to appeal it at this time.

Anyway, I just, there wasn't full PFTs, and I'm surprised actually that the physician rated the person as such. But that's all.

CHAIR MARKOWITZ: Oh, okay. Any other ILD claims?

MEMBER REDLICH: It's just a, I think they just unfortunately went to someone who worked to doctor an accurate rating.

CHAIR MARKOWITZ: Okay. So let's move on.

MEMBER REDLICH: That's it.

CHAIR MARKOWITZ: Another, any other -- we can go on to other illnesses because it's 3:20. Yes.

MEMBER MIKULSKI: This is Marek. Well, I have a, unfortunately I have to leave in

literally like two minutes.

CHAIR MARKOWITZ: Okay.

MEMBER MIKULSKI: And I have a sarcoidosis case that I wanted to discuss so I was wondering if --

CHAIR MARKOWITZ: Go ahead.

MEMBER MIKULSKI: -- I should submit my observations through email or? Just briefly.

This is case 3580, D-9, sarcoidosis cases case for former chemical operator, custodian and utilities and special projects coordinator who worked for various subcontractors between Y-12 and K-25 Oak Ridge plants from 1970 all the way through 2014.

In 1978 they were diagnosed with pulmonary sarcoidosis in 2016 with prostate cancer. Subsequent to which the claimant filed Part B and Part E claim for prostate cancer. And Part E claim for sarcoidosis.

Both claims were denied in 2018. Prostate cancer based on insufficient probability of causation.

The claim examiner, however, did forward the sarcoidosis claim to the CMC and asked if the medical evidence on file supports the pre-1993 diagnosis of CBD.

And the CMC opined that the claimant meets two out of three pre-1993 criteria with 2016 CAT scan positive for interstitial fibrosis but normal PSPs with a FEV of 79 percent, an FEV1 of 72 percent. There was also a borderline lymphocyte proliferation test that was not confirmed in any further testing.

Well, there is really no record of what records were shared with the CMC. But in the files that we have received, there is evidence of all three pre-1993 criteria. This clinical course.

This worker was hospitalized for six days in a pulmonary hospital in the early 1980s. Had numerous abnormal chest x-rays between 1981 and 1991 showing diffuse reticulonodular pattern.

And this was all in the absence of any infectious disease. And multiple PFTs. Abnormal PFTs between 1976 and 1981 that showed an

obstructive airways defect.

So, the question would be whether all this information was available to CMC and what was the basis of this opinion.

CHAIR MARKOWITZ: This is Steven. So in other words, he meet all three --

MEMBER MIKULSKI: Yes.

CHAIR MARKOWITZ: -- 1993 criteria. Clinical, radiologic, physiologic, PFT.

MEMBER MIKULSKI: Exactly.

CHAIR MARKOWITZ: Yes, you should write up it.

MEMBER MIKULSKI: Okay. I'll share it. Rachel, do I send it to you or share it with you, Steven?

CHAIR MARKOWITZ: Yes, I think you should send it to me.

MEMBER MIKULSKI: Okay.

CHAIR MARKOWITZ: Keep all that, the last four digits, but otherwise all identifiers out.

MEMBER MIKULSKI: Sure.

MEMBER REDLICH: On the topic of sarcoids --

MEMBER MIKULSKI: I'm sorry, I have to leave right now.

CHAIR MARKOWITZ: Okay.

MEMBER REDLICH: Yes.

CHAIR MARKOWITZ: Thank you very much. Thank you.

MEMBER REDLICH: But thank you for --

CHAIR MARKOWITZ: Thank you.

MEMBER REDLICH: Thank you. On the topic of sarcoids, a common theme that I saw in several case was, in querying whether that person was a diagnosis of sarcoid had any exposure that could cause sarcoid.

Sarcoid is put into the SEM and it comes out with no exposures that could cause sarcoid. But if you actually go to the SEM and put in chronic beryllium disease, it comes up.

In setting for this clear exposure to beryllium, the SEM gets queried for sarcoid and says that there are no exposures that cause sarcoid.

So, a simple fix for that, first, would be that since they're indistinguishable diseases, the SEM should be queried for chronic beryllium disease.

And/or if it's apparent from the other sources of information that beryllium was exposure for widespread over the years the person was working there, then you might not even need the SEM step.

CHAIR MARKOWITZ: This is Steven.

MEMBER REDLICH: I don't know I'm being clear on that.

CHAIR MARKOWITZ: Yes, you are. I found the same thing, that there would be queries for sarcoidosis which would be the end of a dead end because there is nothing that causes sarcoidosis, that we know of, except for its relation to beryllium. So it makes no sense to make that query.

It should just be --

MEMBER REDLICH: That's right. And then that information would be said to someone as saying, this person had no exposures that caused

their disease.

CHAIR MARKOWITZ: You have a sarcoid case in which the claims examiner overcame that obstacle, did address the issue of beryllium but did so properly or improperly?

And this is a general question, I mean, for anybody who looked at a sarcoid case. It can be you, Mani, it could he John, Ron. We need to talk about cases here. Sarcoid --

MEMBER BERENJI: Yeah, this is Mani. So I had two sarcoid cases. One of them was for a survivor and the other was for an actual claimant, so I'll talk about the claimant.

So this is actually a relatively younger claimant. He was in his 50s. He actually was diagnosed with sarcoid in the early '90s.

He actually was working at the, let me check and see, he was working over at the Hanford plant. But he was primarily working as an IT specialist.

Wasn't necessarily what we considered to be working in the actual metals or anything like

that. Primarily doing IT work, instrument technologist and a supervisor.

So it was interesting to see that, you know, he had seen a couple of specialists over the years, but he didn't actually apply for benefits until like the late 2000s.

And he had multiple tests done for beryllium. And I'm actually looking at the results right now. He actually had a total of 12 tests, I'm sorry, ten tests done over the course of ten plus years.

And nine out of ten were normal, except for one that was considered, quote, uninterpretable in 2017.

So, I feel that with the sarcoid cases in general, I mean, this is just a generalization from my point of view, I feel that there might need to be some sort of addendum to the current procedure manual because I feel that there is a lot of nuance with these cases.

Just going based on the regular protocol, you know, checking the SEM, I feel that

it doesn't do these folks justice because there could be some other exposures that haven't been really looked at.

And it's still kind of an evolving disease. We still don't know, at least from a medical standpoint, if it's related to any other type of exposures that might not be identifiable in the SEM.

CHAIR MARKOWITZ: Was he on steroids for those ten years, do you know offhand?

MEMBER BERENJI: He was put on steroids when he was first diagnosed in the '90s. And then when he was claiming for, applying for benefits through Part E, essentially the claims examiner denied, at least the final decision came on, came in to early 2019.

And essentially he was denied because of sarcoid that was spread to the right paratracheal lymph node. I mean, that was the, that specific, those specific parameters. Not just sarcoid, but sarcoidosis of the right paratracheal lymph node.

So I thought that was interesting

because I felt that kind of missed the point. I mean, obviously this gentleman has had issues for a very long time. He was first diagnosed in the early '90s. The disease evolved over time.

And unfortunately, his clinician, and again, this is just another side note with respect to organization of the files that were sent.

It's hard to be able to kind of understand what a person has been through if some of the medical records are truncated. So this is just a side note for Rachel and the folks who compile these records because it's hard to make any type of assessments if we're not given full medical records or parts of the medical record are truncated.

CHAIR MARKOWITZ: This is Steven. Just one last question. Was this a pre-1993 case?

Was this considered a pre-1993 case or a post-1993, do you remember?

MEMBER BERENJI: Yes. So this man actually started working in the late '80s. Let me see if I can get an exact date.

CHAIR MARKOWITZ: No, the issue is when he was diagnosed with sarcoidosis.

MEMBER BERENJI: Was diagnosed in 1990, can I give an exact year, is that okay?

CHAIR MARKOWITZ: Sure.

MEMBER BERENJI: Okay. He was diagnosed in 1994.

CHAIR MARKOWITZ: Okay. Any comments?

MS. LEITON: Dr. Markowitz, I just want to say, we provide, all the records that we provide are the records that are provided to us. So we can only provide you guys what we have.

CHAIR MARKOWITZ: Thanks.

MEMBER BERENJI: But it's hard to make determinations when parts of a medical record are truncated. I mean, this is just a general comment.

It would be helpful to actually have sorted records, so we don't have to kind of decipher things for hours and hours on end. But that's just a side comment.

MEMBER REDLICH: But this is someone who had a diagnosis of sarcoid based on the tissue

biopsy, correct, and had beryllium exposure?

MEMBER BERENJI: Yes, that is correct.

MEMBER REDLICH: But the issue was a negative BeLPT and was done when the person was on steroids?

MEMBER BERENJI: That I can't comment on. He had multiple tests done for beryllium over the course of ten-plus years. I can't tell you for a fact if he was on steroids at any one of those testing times.

MEMBER REDLICH: Okay. So, I guess, when we're done with that case.

CHAIR MARKOWITZ: Yes, I think we're done.

MEMBER REDLICH: It's on the other theme of sarcoid. There was one woman who worked at the Pantex plant from 1979 to 2005. And in various sort of control clerk, accounting clerk, the administrative clerks.

And had a diagnosis of sarcoid. There was only one thing that was performed after she had been on steroids that was negative.

And so, the -- then basically queried again, her job title as not having exposure. But she clearly could have worked in multiple sites over those many years at this plant.

So it does seem that, another thing I've seen on several cases is that people with administrative titles, but that are physically in multiple sites at some of these settings, are labeled as that job category not having beryllium exposure.

She did have hearing testing done the whole time she was there. And she had past barometry done as part of workplace surveillance. So, that would suggest that she was around noise and someone felt there should be barometry done.

From reviewing a number of these cases, it does appear that some administrative type of jobs are still in areas where one can have beryllium exposure. And it's been well documented that administrative assistants and non-production workers that are in the vicinity can get beryllium disease.

So, I think it's an example where the funds, again, is sort of assuming that it's like a office that is not anyway connected to the facility. And that doesn't appear to be the case.

CHAIR MARKOWITZ: Question. This is Steven. This is a post-'93 case, right? Did she ever have a positive BeLPT?

MEMBER REDLICH: No. She only had one done when she was on steroids.

CHAIR MARKOWITZ: Oh, only on steroids. Okay. But, did she need the other criteria? Post-'93 criteria.

MEMBER REDLICH: Yes. Yes, she had granulomatous lung disease. And her pulmonologist wrote that he thought it was consistent with beryllium disease.

CHAIR MARKOWITZ: And she was denied?

MEMBER REDLICH: Yes.

CHAIR MARKOWITZ: That just sounds like an incorrect decision because, maybe I'm misremembering the evolution of the procedure manual, but it seems to me that it acknowledges

the steroid use detail.

MEMBER REDLICH: Yes. His wording might have been slightly different but I think it was more semantics. I don't have it right in front of me.

He suspects occupational related lung disease. The findings were the dissimilar pattern on biopsies if it was beryllium related.

So, anyway --

CHAIR MARKOWITZ: Yeah.

MEMBER REDLICH: So, I think if that pulmonologist had understood that there could be a false BeLPT, and again, also the SEM was sort of then came out that this person had no exposure to anything that could cause sarcoid.

CHAIR MARKOWITZ: Ms. Leiton, can you remind us post-'93 case, post-1993 cases of sarcoid. Is the instruction on the procedure manual that they be treated as beryllium cases until proven otherwise?

MS. LEITON: There are circumstance which that is the case. I don't want to, I mean,

I'd have to look at the exact language of the procedure manual, which I can pull up in a minute.

But yes, we will consider sarcoidosis beryllium disease when there is a positive beryllium test.

CHAIR MARKOWITZ: Sure.

MS. LEITON: And there are other evidence. So it basically, it really, it's easier to do that with pre-'93 because there are certain tests that are required and it's not necessarily a diagnosis at all.

For post-1993, if you just give me a second --

CHAIR MARKOWITZ: Sure. Sure.

MS. LEITON: -- I'm probably going to bring John in here for one second.

CHAIR MARKOWITZ: Carrie, was this, Steven, was this -- CMC look at this case or just the claims examiner?

MS. LEITON: Yes, CMC did. And see, the statement of accepted fact says occupational toxic exposure, there are no toxic chemicals linked

to job titles responsibilities.

CHAIR MARKOWITZ: Oh.

MEMBER BERENJI: I'm sorry, I pulled up the, I'm actually looking at the procedure manual right now. So if you look at Section 1810, presumption of CBD, diagnosis of sarcoid.

If you actually look at the third paragraph, let's see, hold on one second. It says here, for Part E claims, a CE can evaluate a pulmonary sarcoid claim as CBD.

So that's actually in the procedure manual.

MEMBER REDLICH: So I think that the CE was probably influenced by the statement of facts, which said there were no toxic chemicals linked to job titles and responsibilities for this claimant.

Despite many, many years of employment in a plant that I looked at the claimant. It just had beryllium in multiple different places in her questionnaire comments on beryllium exposure. The occupational questionnaire.

So I think, again, it's where the SEM, it seems with the sarcoid, there are two issues with it. One is, as we already mentioned, that sarcoid shouldn't be put in as a diagnosis into a SEM because it will always come up with no exposure.

But also in a facility that there is felt to be widespread opportunity for beryllium for clerical workers, I think there needs to be a look at that. You know, if that person was truly in a physical location where there was no contact with any of the sites with beryllium.

And that just, and frequently the questionnaire comments on that, that I, my job took me to all the multiple different buildings. I walked through production areas. So the questionnaire, actually, did some idea that yes, even though it was a clerical job they were physically in production areas.

MS. LEITON: Dr. Markowitz, can I say something?

CHAIR MARKOWITZ: Sure.

MS. LEITON: Can we just, we run into problems with sarcoids and beryllium disease because you can file for sarcoidosis all by itself under Part E and maybe in some cases, like in AWE facility, they're not entitled to Part E.

Or in other cases, they will specifically say sarcoidosis. We're looking at under Part E.

We couldn't determine that it was CBD under Part B. And therefore, we're looking at just sarcoidosis because we couldn't make that determination.

When we get back to the procedure manual, she is correct that it does say you have to have a positive BeLPT. But I'm going to let John, so we've had this discussion with other physicians about sarcoidosis versus beryllium disease.

So, I'm going to let John explain it a little further.

MR. VANCE: Yes. Okay, good afternoon, everyone, it's John Vance. You're

lucky I sit right down the cubicle hallway here.

Yes. So, what you need to understand for sarcoidosis is, and I think that this is where people need to understand, it's a wonderful, technical reality of our legislation is that what we have done is carved out an exception for sarcoidosis.

We are basically saying that sarcoidosis, in some instances, could have been a misdiagnosis. In other words, that the sarcoidosis actually represents chronic beryllium disease.

Okay, so when you think of, think of it as like an exception under our process whereby we generally would look at CBD as just what it is. But if we see sarcoidosis, the CE should be looking at it and saying, okay, this could possibly be a misdiagnosis of CBD.

And they begin going through the requirements under the law to determine whether or not they have evidence that meets the other set criteria under the law for establishing CBD.

Because then what they do is they basically say, depending on the pre or the post, under Part B, they're going to say, if I've got the necessary criteria met and a diagnosis of sarcoidosis, I can accept the case as CBD. Okay.

What you need to think about though, is that under Part E, you could actually have a misdiagnosed, a sarcoidosis misdiagnosis of CBD being accepted, or you could be looking at sarcoidosis in and of itself. Because, again, a person can file for any condition that they think is work related under Part E.

If we're not looking at sarcoidosis as a misdiagnosis of, if we're not treating it as a misdiagnosis of CBD, we're going to look at it purely as a claimed sarcoidosis. And that's why when you look at it in the site exposure matrices as sarcoidosis, you're not going to see any health effects because we don't have any established humanistic epidemiology that says, oh, sarcoidosis, in and of itself, is known to be associated with exposure to X, Y or Z toxin.

So then what we do is we would turn to a physician and say, okay, do you believe that this condition is related to some toxic substance by way of aggregation, contribution or cause. So then we leave it specifically to the physician.

So just think of it as, sarcoidosis can be a misdiagnosis of CBD or it can be a condition on its own right.

MEMBER REDLICH: Yes. So I think it's, I think in this case there was taking into account that many, many years of time periods a person worked, the location and I think clear beryllium exposure.

I had seen other similar cases, I reviewed quite a few where there was a statement from the physician that they felt that this was a false negative BeLPT because the person was on steroids. And the manual says you can state that.

MS. LEITON: Yes. If you have a lung biopsy to support it.

MR. VANCE: Right. And that, the reason that that exists, that standard of steroidal

medication, is because under the law we need to have an abnormal BeLPT. The one carve out that existed, the existence of this prescription for steroidal medication, because that's basically saying that the abnormality in the BeLPT is being masked by the medication usage.

MEMBER TEBAY: This is Calvin Tebay.

MEMBER REDLICH: It's just a lot of CMCs and physicians are not necessarily aware of that.

MEMBER TEBAY: Yes, this is --

MEMBER REDLICH: In fact --

MEMBER TEBAY: -- Calvin Tebay. Oh, go ahead. Go ahead.

MEMBER REDLICH: Okay.

MEMBER TEBAY: This is Calvin Tebay. And I agree with what Mr. Vance has said, and everybody else, regarding this topic. And this is my fourth year attending these meetings and now on the board.

And what I don't agree with though is the abnormal. What we just talked about as abnormal.

Some of the sarcoidosis CBD issue would alleviate itself if we had, we need to start talking about borderline test results again.

MS. LEITON: Okay, we can't do that legally. We've been over that so many times with our lawyers and --

MEMBER TEBAY: But the problem is that this conversation is somewhat invalid because we're not talking about the standardized diagnosis process of CBD, which affects sarcoidosis.

So, we're kind of talking around everything instead of really talking about what is being used to diagnosis CBD and having that sarcoidosis factor.

So, I guess this conversation can happen over and over, but we're not going to solve anything until somebody starts talking about what we talked earlier. The procedure manual needs some adjustment on diagnosis criteria. And that's going to help alleviate some of the confusion between sarcoids and CBD.

MEMBER REDLICH: Well, and there have

been cases that I have reviewed that have been indeterminate and a letter was written explaining that they felt that this indeterminate was actually a reason for being indeterminate. They felt it was positive and then it was accepted.

So, I think that there are one or two knowledgeable physicians who write what it takes for a situation like this, where steroids or a testing factor, might be involved. But unfortunately, most, either CMCs or patient pulmonologists reviewing these cases don't know that that's possible.

So it then also creates inconsistency in how some of these are adjudicated. And I think this is a, you know, and I also weigh in terms of looking at the extensive exposure, the time period.

So I think people need to remember that sarcoid is not a common disease. It's much less common then the prevalence of beryllium disease in beryllium exposed workers.

CHAIR MARKOWITZ: So, this is Steven. We've got about --

MEMBER REDLICH: Yes.

CHAIR MARKOWITZ: -- eight, nine more minutes.

MEMBER REDLICH: Sorry.

CHAIR MARKOWITZ: No, no, no problem at all. We want to discuss claims. Clearly, we want to discuss claims more.

MEMBER REDLICH: But I guess also the, it seems to me the point that we've made, I'm not sure that everyone is in agreement that, to put sarcoid into the SEM is, you know, if it has granulomatous lung disease that's been misdiagnosed as sarcoid, then it would make sense if your querying exposures to put beryllium disease in and not sarcoid and at least see what comes out.

CHAIR MARKOWITZ: This is Steven. I think that would help. The Page 175 of the procedure manual, quote, for a Part E claim, the CE can evaluate a pulmonary sarcoidosis claim as CBD, end of quote. And then it goes on to say that they will require a BeLPT.

So, the fact that sarcoid is not linked

to any exposure in the SEM may, for some people, steer them along the wrong path.

So we need to close out the discussion on claims.

MEMBER MAHS: Can I ask one question, Steven?

CHAIR MARKOWITZ: Sure. Sure.

MEMBER MAHS: It has to do with sarcoid. And a number of the cases that I reviewed, it appears to have predominately cutaneous sarcoid.

But some suggestions based on CT pulmonary involvement, particularly the mediastinal lymph nodes, and some others. But this is a question for the medical doctors.

At what point would you say that's inconsistent with recent pulmonary involvement?

MEMBER REDLICH: So you're saying if there is skin involvement and, what's the extent of this pulmonary involvement too?

MEMBER MAHS: Some pulmonary involvement. It doesn't appear great in terms of the presentation of the granuloma per se, but there

is certainly some suggestions based on the interpretation of the CT. Possibly related to beryllium.

MEMBER REDLICH: Well, you can have people that, for some reason, have more of a predominant of a skin presentation then pulmonary. I think it makes sense to have evidence of pulmonary disease.

But in those settings, I mean, I'd also read some cases where there was clear pulmonary involvement. But for convenience purposes and safety purposes, the skin is biopsied.

But based on either CT imagining or lung function there was clear involvement. And I think that that is very consistent with chronic beryllium disease. Even if we, you know, the skin is the more dominant.

MEMBER MAHS: Yes. Some of the cases I reviewed I would say that they, and I would agree with CMCs interpretation, the pulmonary involvement was not like there. And so they made a negative determination of CBD sarcoid

relationship.

MEMBER REDLICH: Well, I think if there is no suggestion at all of any pulmonary involvement, that that would be the unit goal given, in this setting. If there was a BeLPT that was positive, then there also could be pulmonary involvement with normal PFTs in a normal CT scan.

But I'm assuming these are situations where the BeLPT was negative.

MEMBER MAHS: Yes. And that's the other, so the quandary that the BeLPT is negative is clear cutaneous sarcoid based on pathology. Some suggestions on CT that there is also pulmonary involvement but this lack of a positive BeLPT, the case is denied.

And so you're sort of in a quandary, what does the claimant do in the case? Because clearly they're on steroids already.

MEMBER REDLICH: Yes. I guess the ones I've seen that has basically had some evidence of pulmonary disease based on either PFTs or imaging.

CHAIR MARKOWITZ: Okay, so this is

Steven. We need to close this case out. But I'm sure we're coming back to beryllium again.

MEMBER REDLICH: I had one very quickie that is just on the subject of SEMs.

CHAIR MARKOWITZ: Very quick question. Quick question for Carrie and Doug. If we go literally beyond 4:00 p.m. cut off by a few minutes is that permissible?

MR. FITZGERALD: Yes, we're okay.

CHAIR MARKOWITZ: Okay. Okay, go ahead.

MEMBER REDLICH: Well, just very quickly. This was a case for asthma COPD and pulmonary fibrosis.

There was clear asbestos exposure. And this was at K-25 and Oak Ridge for many years. And then it said that asbestos, the SEM said that asbestos, there was no exposure that causes pulmonary fibrosis.

So I'm not sure how pulmonary fibrosis and asbestos would not be linked in this case.

MEMBER SILVER: Carrie, this is Ken,

I read the same case and that jumped out at me as well. The doctor followed up with a stiff letter to the claims examiner rebutting that contention.

I think Fitzgerald stated that we should transmit our observations about the cases related to the categories of the board's purview. And since the SEM is front and center, I think we could really fill up that category with claims examiner overreliance on the SEM by just typing in sarcoid and flying blind or believing that there is no link between pulmonary fibrosis and asbestos or underreliance on the SEM.

Probably in some of the other cases that we've seen. I think DOL would get a lot of good feedback from us if we put all of those observations in the right category.

I didn't mean to cut you off, were you going to elaborate more on this case?

MEMBER REDLICH: No, no. I think this is a easily fixable issue. Because then what happens, that information gets fed to a CMC that says that there was no exposure that could cause

pulmonary fibrosis.

CHAIR MARKOWITZ: What's the case number, by the way? Is it an ILD case?

MEMBER REDLICH: It was --

MEMBER SILVER: 91 --

MEMBER REDLICH: Yes, go ahead.

MEMBER SILVER: COPD 9190. Are we talking about the same one, 9190?

MEMBER REDLICH: This is a different one.

MEMBER SILVER: Oh.

MEMBER REDLICH: Oh no, I think, let's see. Yes, 9190.

CHAIR MARKOWITZ: So, when you write up your comments on the particular cases, if SEM is an issue then you should be specific in addressing it.

Anything else on that case, by the way? Okay, so I'm going, we're going to move on.

We've reviewed, by my method, at least 80 percent of the cases given to us. At least one person has reviewed. We've probably discussed

eight of them here. So there is a lot more that we can look at.

The question is, how do we move forward on this? We've got a meeting in 11 weeks. I think we need a group that can continue this discussion, for one.

If that's a subcommittee then that means it would be an open meeting scheduled at least six weeks in advance with an open telephone line to the public, which is fine, as opposed to working group in which we don't need to publish that meeting in the literature, in the federal register. And it doesn't have to be open.

For me it's a practical question. Our preference always is we have open meetings. They're open to the public. The challenge here is determining, because we need to make some progress.

And so, people want to weigh in on this issue?

MEMBER DOMINA: Hey, this is Kirk Domina. I think we ought to just do a working group

so that way we can get stuff and then the public will be able to hear it when we meet in November because it is a pressing issue.

CHAIR MARKOWITZ: Other comments?

MS. LEITON: Dr. Markowitz, this is Rachel.

CHAIR MARKOWITZ: Yes, sure.

MS. LEITON: I just wanted to mention that we will be, I think we're scheduling some meetings with, with the Board to talk about cases with our hearing reps, like we've done in the past. So, I just want to put that out there.

I think that they're already being schedule or Carrie, can you --

PARTICIPANT: Next week.

MS. LEITON: The first one's next week. So, the purpose of that is just so that you can get from the hearing reps' perspective what they look at and what process they go through and to answer any questions about cases that you guys already have. So I just want to put that out there.

CHAIR MARKOWITZ: Okay, thank you. I

think I would agree with Kirk here that we should probably go with the working group because we have to, we may need to meet more than once by phone because we need to work out some categories of concerns on these claims so that we can make progress on kind of an overall framework. That we can plug the claim review into.

It's sort of a chicken and egg thing. We've have a review claims done to understand what the possible categories are, but now we have a better sense of that.

So --

MEMBER REDLICH: I mean, I think we could, not right now but I think based on what we've done we could all propose some general categories. And I bet there would be a lot of overlap.

CHAIR MARKOWITZ: Sure.

MEMBER REDLICH: One can compile that. And then I think that would just help organize it.

CHAIR MARKOWITZ: Good idea. Who wants to serve on this group?

MEMBER DOMINA: This is Kirk, I'm in.

CHAIR MARKOWITZ: Okay.

MEMBER REDLICH: I'll be willing to since there is so many pulmonary cases. I think it just also should be noted that we're obviously focusing on the ones that we thought there were issues with. I think we've already have claimed that we thought were reasonably adjudicated and we agreed with.

CHAIR MARKOWITZ: That's --

MEMBER REDLICH: I don't want it to seem like we, at least I did not, you know, there were a number I agreed with. And I suspect that's true for others.

CHAIR MARKOWITZ: That was true -- Steven. Other volunteers?

MEMBER FRIEDMAN-JIMENEZ: This is George. I'd like to be in the group.

CHAIR MARKOWITZ: Okay. Okay.

MEMBER DEMENT: Steven, this is John.

CHAIR MARKOWITZ: Yes.

MEMBER DEMENT: I'm not sure I

understand what the subgroup is going to do not having the input from those that are not on the subgroup with regard to claims that they've reviewed and have concerns about.

I don't know how we capture the group, our Board's collective experience based on the subgroup.

CHAIR MARKOWITZ: Well, if we could agree on a sort of draft set of categorical concerns, then we can, and through soliciting input from everybody, and then send the initial set out to the broader group for input, that would allow some vocal attention at the same time it will get broader input. Does that make sense?

MEMBER DEMENT: Yes. Yes, to be honest with you, most of my concerns have related to things we've already made recommendations on.

MEMBER REDLICH: I agree.

MEMBER DEMENT: You know, we can beat it to death but we've already made recommendations on 90 percent of the groups who were put together.

CHAIR MARKOWITZ: You know, and I

understand that, but I think that there's additional concerns. I think, for instance, we haven't really focused on the medical input very much in our recommendations to date.

MEMBER FRIEDMAN-JIMENEZ: This is George. I think it's valuable to have concrete examples of what we have talked about in the abstract in the past. I think that makes it more clear and more real, and I think it's valuable.

MEMBER DEMENT: I agree with you George. I think that would be helpful.

CHAIR MARKOWITZ: So we've heard actually, this is Steven, we could come up with these initial set of categories and then tag them with individual claims that demonstrate what we're talking about.

Other comments? Okay, so we have a working group, unless I hear otherwise. I haven't heard anybody in favor of performing a subcommittee.

And there will be an opportunity to, for you to have second thoughts and join these two

working groups. But the next step then will be to schedule a call for this group to secondly solicit some categories of issues that people should send in to the Board Members.

And thirdly, on the individual claims that you reviewed, if you could provide a, for the ones that you agreed with and have some comments, that's fine.

For those that you had some concerns about, if you could write up those concerns and send them to me. And I'll sort them through with the working group and figure out how to get them over to DOL from there.

Does that sound all right?

MEMBER REDLICH: Yes. And I would also just say that if there are ones that one agrees with but took a lot of effort to come up with the final adjudication, that might also be worth noting.

CHAIR MARKOWITZ: Yes, I would say that all the ones that we agreed with we should state whether it was complicated or not.

Okay, any further --

MEMBER REDLICH: Okay.

CHAIR MARKOWITZ: -- discussion on the issues of claims, otherwise we just went a couple minutes on the next board meeting in November?

So, next board meeting is scheduled November 20th and 21st. And we had talked about, last time, about doing this in Nevada, the Nevada Test Site, but actually I looked through the numbers of claims by site and we've been going down them in descending, by descending numbers ranking.

And the next one actually is Paducah, Kentucky. Which has the additional advantage that it's not a renovated site so that the tour would allow us, actually, to see a fair amount of a history of a gaseous diffusion plant.

There were three. One at Portsmouth, one at Oak Ridge and one at Paducah.

So, Paducah is not the easiest place to get to but it is next in line. So does anybody have any comments on that?

MEMBER DEMENT: So, George, would we

do a tour on the 19th and the meeting on the 20th and 21st?

CHAIR MARKOWITZ: Correct. And there's a chance, we'll look, when we get closer to the schedule, we'll look at whether we can make a, Thursday the 21st, whether we can do our work in a half day with the idea of getting out of there later in the day. But it depends on the agenda. It depends on how much we have to accomplish.

I know people, that things arise. For one Board Member I know there is an issue with the 21st, and so if someone has to leave early, someone has to participate by phone, then that's fine. That's the nature of what we're doing here.

Do save time for the Quilt Museum in Paducah, it's a spectacular museum.

So, any closing comments or questions?

MEMBER REDLICH: Just one. Well, I think it would be helpful if people do notice, let's say, an issue with the SEM if they, sometimes it's helpful to just print out the example. I mean, something like this.

I've gone to the website, the SEM website. So if people haven't, I think it's actually helpful.

CHAIR MARKOWITZ: Okay. Doug, any closing comments?

MR. FITZGERALD: No. I mean, if we're concluded here I would just say we're concluded and thank you very much for all your efforts on behalf of the Department of Labor.

CHAIR MARKOWITZ: Okay, and I echo the thanks. Thank you to Ms. Leiton and Mr. Fitzgerald, Ms. Rhoads, Mr. Vance for participating and to the Board Members and to the public.

And we will elaborate an action list. I think probably some items. And get back to you about the working groups and the follow-up activities. Thank you very much.

(Whereupon, the above-entitled matter went off the record at 4:12 p.m.)