

UNITED STATES DEPARTMENT OF LABOR

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ADVISORY BOARD ON TOXIC SUBSTANCES  
AND WORKER HEALTH

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

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TUESDAY, SEPTEMBER 13, 2016

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

MEMBERS

SCIENTIFIC COMMUNITY:

KENNETH Z. SILVER  
LESLIE I. BODEN

MEDICAL COMMUNITY:

STEVEN MARKOWITZ, Board Chair  
VICTORIA A. CASSANO, Subcommittee Chair

CLAIMANT COMMUNITY:

DURONDA M. POPE  
FAYE VLIENER

DEPARTMENT STAFF:

CARRIE RHOADS, Designated Federal Official  
JOHN VANCE, Policy Branch Chief, DEEOIC

A-G-E-N-D-A

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

2 1:00 p.m.

3 MS. RHOADS: Hi, everybody. Good  
4 afternoon or good morning depending on what time  
5 zone you're in.

6 My name is Carrie Rhoads and I'd like  
7 to welcome you to today's teleconference meeting  
8 of the Department of Labor's Advisory Board on  
9 Toxic Substances and Worker Health, the  
10 Subcommittee on Medical Advice for Claims  
11 Examiners Regarding Weighing Medical Evidence.

12 I'm the board's designated federal  
13 officer or DFO for today's meeting.

14 First, we appreciate the time and  
15 diligent work of our Board members in preparing  
16 for this meeting and for their forthcoming work.

17 I'll introduce the board members on  
18 the subcommittee and do a quick roll call. If  
19 everyone could just please respond when you hear  
20 your name.

21 Dr. Victoria Cassano is the chair of  
22 the Subcommittee.

1 CHAIR CASSANO: I'm here.

2 MS. RHOADS: And the members are Dr.  
3 Leslie Boden.

4 MEMBER BODEN: Hi.

5 MS. RHOADS: Ms. Faye Vlieger. I'm  
6 not hearing Ms. Vlieger. If you're on please let  
7 us know.

8 Ms. Duronda Pope.

9 MEMBER POPE: Here.

10 MS. RHOADS: Dr. Ken Silver.

11 MEMBER SILVER: Here.

12 MS. RHOADS: Dr. Steven Markowitz.

13 MEMBER MARKOWITZ: Here.

14 MS. RHOADS: And he's the Chair of the  
15 Board. And we're scheduled to meet from 1  
16 o'clock till 3 o'clock Eastern Time today.

17 In the room with me is Melissa  
18 Schroeder from SIDEM, our contractor, and John  
19 Vance, Policy Branch Chief for DEEOIC.

20 At our previous meeting the  
21 Subcommittee had requested that someone from the  
22 Program be present at the Subcommittee meetings.

1                   So, regarding the meeting today I  
2                   don't think we are going to plan to take a break  
3                   unless someone would like to. We'll just go the  
4                   full two hours.

5                   Copies of all meeting materials and  
6                   any written public comments are or will be  
7                   available on the Board's website under the  
8                   heading Meetings and the listing there for this  
9                   Subcommittee meeting.

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

13                  The Board's website can be found at  
14                  dol.gov/owcp/energy/regs/compliance/advisoryboar  
15                  d.htm. Or you can simply Google Advisory Board  
16                  on Toxic Substances and Worker Health and it will  
17                  probably be the first link you see.

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

22                  The page contains publicly available

1 materials that are submitted to us in advance of  
2 the meeting. And we will publish anything that's  
3 provided to the Subcommittee there.

4 You should also find today's agenda  
5 and instructions for participating remotely. If  
6 you are participating remotely and you're having  
7 a problem please email us at  
8 energyadvisoryboard@dol.gov.

9 If you're joining by WebEx please note  
10 that the session is for viewing only and will not  
11 be interactive. The phones will also be muted  
12 for non-Advisory Board members.

13 Please note that we do not have a  
14 scheduled public comment session today. The  
15 call-in information has been posted on the  
16 Advisory Board website so the public may listen  
17 in but not participate in the committee's  
18 discussion.

19 I've been asked about meeting minutes  
20 and transcripts also.

21 The Advisory Board voted at its April  
22 26-28 meeting that the committee meeting should

1 be open to the public. The transcript and  
2 minutes will be prepared from today's meeting.

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

6 When you begin speaking especially at  
7 the start of the meeting please state your name  
8 so we can get an accurate record of the  
9 discussion.

10 Also, I'd like to let our transcriber  
11 know -- please let us know if you're having an  
12 issue with hearing anyone or with the recording.

13 As the DFO, I see that the minutes are  
14 prepared and ensure they're certified by the  
15 chair. The minutes of today's meeting will be  
16 available on the Board's website no later than 90  
17 calendar days from today, per FACA regulations.

18 If the minutes are available sooner,  
19 we'll put them up sooner. Also, although formal  
20 minutes will be prepared, we'll also be  
21 publishing verbatim transcripts which are going  
22 to be more detailed in nature. Those transcripts

1 should be available on the Board's website within  
2 30 days.

3 I would like to remind the Advisory  
4 Board members that there are some materials that  
5 have been provided to you in your capacity as  
6 special government employees and members of the  
7 Board which are not for public disclosure and  
8 cannot be shared or discussed publicly including  
9 in this meeting.

10 Please be aware of this as we continue  
11 with the meeting today. These materials can be  
12 discussed in a general way which does not include  
13 using any personally identifiable information  
14 such as names, addresses, specific facilities  
15 where the case is being discussed, or doctors'  
16 names.

17 And with that, I convene this meeting  
18 of the Advisory Board on Toxic Substances and  
19 Worker Health Subcommittee on Medical Advice for  
20 Claims Examiners Regarding Weighing Medical  
21 Evidence.

22 And I'll turn it over to Dr. Cassano



1 who is the Chair of the Subcommittee.

2 CHAIR CASSANO: Thank you very much,  
3 Carrie. Good morning, good afternoon, everyone,  
4 including Board members and members of the  
5 public.

6 What I wanted to do first was to do a  
7 little bit of recap. This is our second -- just  
8 to go back to the agenda, this is our second  
9 Subcommittee meeting.

10 I wanted to first of all go through  
11 what we were asked to accomplish at the  
12 Subcommittee.

13 And we were asked specific questions  
14 by the Program, specific places where we could  
15 help.

16 Number one, clarifying and make  
17 recommendations regarding the assessment of  
18 medical opinions, especially about  
19 rationalization to support a particular  
20 conclusion and if there were any standardized  
21 triggers that we could come up with.

22 Second was our methodologies for

1 improving physician responsiveness.

2 Third was training resources for  
3 improving the quality of medical review of the  
4 medical evidence, and some type of guidance  
5 regarding assessing contribution or aggravation  
6 to a preexisting disease.

7 That was a pretty tall order. And in  
8 order to be able to accomplish that, we felt that  
9 we really needed a better understanding of the  
10 process that the CEs go through.

11 And in regard to that, we sent a list  
12 of action items to the Program and we got, about  
13 a month later, we got our responses. And then  
14 Dr. Markowitz and myself had a conversation with  
15 the Program, sometime late in August, so that we  
16 could do a little bit more clarification.

17 But other than seeing these results,  
18 the rest of the Board members have not had a  
19 chance yet to talk about their understanding and  
20 their appreciation of the responses that we got  
21 from the Program.

22 So I wanted to open this up, primarily

1 to the other Board members, for each of them to  
2 be able to talk about what their concerns, or  
3 whether they have additional questions, regarding  
4 the answers that we got.

5 And then myself and Dr. Markowitz can  
6 certainly chime in. We'll do a little bit of the  
7 summary of what we learned in our subsequent  
8 phone conversation.

9 And then we really need an open  
10 discussion about how to proceed from here. And  
11 to develop a real timetable for meeting with  
12 claims examiners, review of the claims process  
13 from the CEs' perspective.

14 And then you develop some type of  
15 report on our findings, concerns, issues, et  
16 cetera and then development of deliverables. So  
17 we have a lot to go through to develop this  
18 timetable.

19 And so I do really want to get  
20 started. Before I do that, Dr. Markowitz, do you  
21 have any opening comments?

22 MEMBER MARKOWITZ: No, I just -- the

1 next step is that we're going to walk through the  
2 responses from DOL and --

3 CHAIR CASSANO: Well, I'm not going to  
4 read them. But I think I'm going to talk about -  
5 - I'm going to ask that we go through each one of  
6 these answers. I'm not going to read through  
7 them. But to see if there are subsequent  
8 questions that the other board members have --  
9 because I don't think they've had an opportunity  
10 to discuss that. Does that make sense to you?

11 MEMBER MARKOWITZ: Sure, sure.

12 CHAIR CASSANO: Okay. So the first  
13 question that we asked, or the first issue that  
14 we presented, was whose responsibility is it to  
15 gather information that would support a medical  
16 opinion?

17 In other words, information from IARC,  
18 information from any of the -- EPA, scientific  
19 research studies, et cetera. And the response we  
20 got was, that's really the claimant's  
21 responsibility.

22 And after further discussion with

1       them, we found out that they actually -- if  
2       there's a treating physician who is not expert in  
3       this area, they can actually their patient to  
4       someone who is knowledgeable.

5               And that cleared up a lot for me as  
6       far as how, you know, medical research or  
7       epidemiological research is brought to the table  
8       in discussing a person's case. So I'd like other  
9       people to chime in on that one in particular, if  
10      they have any issues or questions.

11             MEMBER MARKOWITZ: This is Steven, let  
12      me just kick this off here. I don't confuse  
13      DOL's response that -- I'm not sure where this  
14      phrase came from, consensus documents from  
15      learned bodies, in this quote. I also don't  
16      remember where that came from.

17             The underlying issue is how the  
18      expertise that's needed on the causation side,  
19      and even frankly on the diagnosis side. How's  
20      that countered? How does that impact the process  
21      of claims review and determination?

22             And clearly it can come from the

1 claimant's position. It can come from the in-  
2 house industrial hygienist. It can come from the  
3 CMC. And the CE is kind of the focal point, the  
4 traffic person to assemble, and in some sense,  
5 make a decision based on this expert input.

6 CHAIR CASSANO: Anyone else with  
7 comments on this?

8 MEMBER BODEN: Yes, this is Les Boden.  
9 I sort of have a question about the Committee's  
10 thinking about these issues. So one of the  
11 things that I could imagine that the Committee  
12 might think about doing is trying to develop  
13 procedures that would synthesize and make the  
14 claims examiner's job easier and more  
15 transparent.

16 So I guess a question for the  
17 Committee down the road is whether, for specific  
18 covered illnesses, there should essentially be  
19 some kind of manual that describes what's in the,  
20 as we put it here, consensus documents from  
21 learned bodies.

22 It sounds like de novo each time a

1 case with a specific condition comes up, that  
2 there's going to be a presentation of received  
3 wisdom. And there's a question in my mind about  
4 whether that's the best way to do it.

5 CHAIR CASSANO: I think my  
6 understanding of this is that it has to be  
7 synthesized into an opinion by someone with the  
8 expertise. So it's not the CEs responsibility to  
9 read the IARC manual on QCE.

10 That would either be the treating  
11 physician or the -- whoever the treating  
12 physician refers to to get that medical opinion -  
13 - the industrial hygienist or toxicologist or the  
14 contracted medical consultant.

15 They would put all of the references  
16 together, and then synthesize those references  
17 and medical opinions. We might be able to  
18 develop some types of training documents for what  
19 we'll see later on their priority list, with some  
20 references, and a synthesis of those references  
21 with a generalized opinion about whether or not  
22 -- not on a specific case but in general, the

1 literature or does not support a causal  
2 relationship.

3 And that's sort of would be the first  
4 step towards quote unquote presumptions, if we  
5 were to go that far. Anybody else with comments  
6 or questions on this?

7 MEMBER MARKOWITZ: Yes, this is Steven  
8 again. So Les, could you just work through an  
9 example of what you're talking about? Because it  
10 seems like it's a way to streamline the  
11 consultation with the Haz-Map, which might make  
12 the CE's life easier and the decisions more  
13 transparent.

14 So could you just play out an example,  
15 for instance, of what you have in mind?

16 MEMBER BODEN: Well I might be able to  
17 start a discussion about it. I'm not sure I  
18 could play out a full example. But the idea  
19 would be, sort of, the CE is taking in  
20 information from various sources, whether it's  
21 the treating physician or another expert or a  
22 CMC, et cetera.



1           And the question is - wouldn't we want  
2 consistency over time, and over cases, in how  
3 various consensus documents are used?  
4 Understanding that each individual case is  
5 unique.

6           So let me give you an example from one  
7 of the sets of cases that we looked at, where a  
8 question was what was the degree of impairment of  
9 a particular individual?

10           And essentially the rule was that the  
11 doctor had to look to the AMA guides and describe  
12 something that was consistent with what the AMA  
13 guide said. So the AMA guides then, in this case  
14 it was specified in law I think, told the doctor  
15 sort of what they had to do to apply to a  
16 specific case.

17           You could imagine a similar kind of  
18 situation for deciding whether a particular  
19 illness was caused by or aggravated by work  
20 exposures, where you would pull together sort of  
21 consensus documents on the relationships between  
22 your occupational exposure and disease outcome.

1 Does that clarify at all?

2 MEMBER MARKOWITZ: Yes, well, sort of.

3 MEMBER BODEN: Yes.

4 MEMBER MARKOWITZ: It seems like, for  
5 commonly encountered conditions, an expedited  
6 form of what the Haz-Map does within the SEM.  
7 And it's conceivable, you know the devil's in the  
8 details, but it's conceivable it would make  
9 things more straightforward and probably  
10 consistent.

11 MEMBER BODEN: Yes.

12 MEMBER MARKOWITZ: But we'd have to  
13 play it out and see what one looks like and see  
14 if it makes sense.

15 MEMBER BODEN: Right. I'm not saying  
16 that this would necessarily be a one-day job, but  
17 that it might be something that would improve  
18 both the efficiency of assisting, and the  
19 consistency of how evidence is handled across  
20 cases.

21 MEMBER MARKOWITZ: Okay.

22 CHAIR CASSANO: Okay. Anyone else

1 with comments on this, and then we can move to  
2 the next?

3 MEMBER SILVER: Yes, Ken Silver here.  
4 If we do develop such a resource, I really hope  
5 it would not be bottled up in the realm of not  
6 publicly releasable documents, like many of the  
7 those that have been provided to us.

8 The reason is, if the claimants knew  
9 what target they were aiming at to persuade the  
10 claims examiner, they might work with their  
11 physician to submit a file that already contained  
12 some of that evidence.

13 CHAIR CASSANO: Okay. Can we -- now  
14 the next issue was an issue regarding the types  
15 of medical evidence, and the question was asked:  
16 does all of the medical evidence go to the CMC?

17 And the response we got was only  
18 medical evidence determined to be relevant. And  
19 I think that both Dr. Markowitz and I sort of had  
20 the question of, well how does someone without  
21 medical training determine what is relevant?

22 And I think our conjoined opinion, if

1 you would, was that the way we're going to be  
2 able to do that is to look at some of the cases  
3 and also, in talking with the CEs in the CE form,  
4 to determine, hey, why do you consider this  
5 relevant, but this not.

6 So that's something that we're going  
7 to have to find out down the road. Does anybody  
8 else have any comments about this that is  
9 different than what's been discussed?

10 (No audible response.)

11 CHAIR CASSANO: I hear none, so moving  
12 right along. And then the next question was  
13 about duty to assist. And really the answer  
14 there was, there is no regulatory duty to assist.

15 But they do help with phone calls and  
16 talking to treating physicians in trying to tease  
17 out the information that they need to answer the  
18 claim. So that one was relatively  
19 straightforward. The next one --- discussion --

20 MEMBER MARKOWITZ: It is Steven. Let  
21 me just ask a question before we move on. So I  
22 think, from our full meeting in April and then it

1 appeared again on this call, this question about  
2 duty to assist.

3 And DOL's response is there is none  
4 officially but we do it. So my question, really  
5 to the other members, is whether -- is there a  
6 problem here? Because, you know, apparently the  
7 routine procedure is that the claims examiners  
8 are assisting. And if the perception is that  
9 it's violated sometimes, or not infrequently,  
10 then maybe there's something that we should look  
11 at.

12 CHAIR CASSANO: Good point. And that  
13 would take the individual personality of the CE  
14 out of it, as well if there was some standardized  
15 regulation regarding, or at least policy maybe  
16 not regulation, regarding this is what the CEs  
17 must do to assist the claimant in developing the  
18 claim, and not just them flow around. Any other  
19 discussion on that --

20 MEMBER MARKOWITZ: This is Steven  
21 again. The procedure manual I'm sure addresses  
22 this, I haven't memorized it yet, but I'm sure

1 there's some direction given to the claims  
2 examiner about assisting.

3 Perhaps this is just one of those  
4 issues that, if we get around to looking at  
5 claims, we can look for evidence of this.

6 CHAIR CASSANO: Yes. Good point. The  
7 next one was sufficient evidence and historical  
8 wages. I think I still have an issue with trying  
9 to figure out how a doc is supposed to do that.

10 I think, in our phone conversation  
11 with the program, we were told that basically, if  
12 there's information about when the person was  
13 taken out of work, was the person put on light  
14 duty, that works if you've got a treating  
15 physician that's been around and the issue was  
16 relatively soon -- you know, relatively recent,  
17 but a lot of that information is not going to be  
18 available.

19 And so we do feel that this is still  
20 problematic and maybe not something that the  
21 clinician should really be responsible to do. It  
22 just seems more of an economic issue than a

1 clinical issue.

2 Steve, do you have any further  
3 comments? Or anybody else have any further  
4 comments?

5 MEMBER MARKOWITZ: No, I don't.

6 CHAIR CASSANO: Okay, anybody else?  
7 And the gentleman from the program that's on the  
8 call with us, if at any time you want to chime in  
9 and set us on a clearer path, please feel welcome  
10 to do so.

11 MR. VANCE: Thank you. This is John  
12 Vance. I appreciate that. I'll certainly  
13 identify anything I think that is important or  
14 noteworthy but, for the most part, I'm just going  
15 to sit and listen. And if I do hear something, I  
16 will definitely chime in. Thank you.

17 CHAIR CASSANO: Thank you. Thank you,  
18 very much. And the next is sort of a procedural  
19 thing about paper trails, telephone requests -- I  
20 don't think there's much discussion on that.  
21 It's all supposedly in the record.

22 On unavailable records, the biggest

1 question we had was -- how do you do this? Do  
2 you guys get a blanket release of medical  
3 records, so that the claims examiner can go and  
4 talk to whatever physician is on the list?

5 Or really more, again, a procedural  
6 question. And then the subsequent question is --  
7 so if you can't get any medical records, how do  
8 you decide the case? Is it just an automatic  
9 denial?

10 That's my takeaway. I think Steve --  
11 I don't know if Steve has some more takeaway from  
12 the conversation, but we do need other people's  
13 input here.

14 MEMBER MARKOWITZ: This is Steven.  
15 I'm rereading the DOL's response. I actually  
16 don't fully understand it. If no records exist,  
17 then I guess the CE goes to the treating  
18 physician to get whatever they can get about  
19 their knowledge.

20 But that means that records exist. So  
21 I'm not sure that I really get what happens when  
22 no records exist.



1                   CHAIR CASSANO: Yes, I don't know how  
2 they would proceed. I mean, I would think that  
3 if it was something that was basically common  
4 knowledge, or at least well represented in the  
5 literature.

6                   If you have a definitive diagnosis and  
7 you have a definitive exposure, then you can say  
8 the CE might be able to ask the CMC to make a  
9 decision, but if you don't even have a definitive  
10 -- I mean, you can send somebody, I guess, to  
11 another physician to get a diagnosis. And I  
12 guess the SEM would determine whether or not they  
13 were exposed.

14                   So, in that case, I guess it could go  
15 to a CMC and there could be a decision made  
16 that's -- is that the process that's used in that  
17 case? Or do they just say, you know, sorry you  
18 don't have any medical evidence, you don't have  
19 any record. We can't approve your claim.

20                   MR. VANCE: This is John Vance. I  
21 guess I'll use my permission to speak at this  
22 point.

1 (Laughter.)

2 MR. VANCE: Let me see if I can get  
3 some clarification. You have to keep in mind  
4 that these cases can identify sources of  
5 information that might not necessarily be medical  
6 from the onset.

7 So if we're talking about a survivor  
8 claim, somebody might indicate in that case --  
9 well, you know, my father or my mother was  
10 treated at a hospital outside of Denver, and this  
11 is the hospital, this is the doctor.

12 We have some information about this  
13 facility, so that may be a lead that the CE may  
14 explore to try to contact the hospital to see if  
15 those records exist, but at the end of the day,  
16 Dr. Markowitz is correct. That if we have  
17 nothing, if there's no information, if we have  
18 nothing from the employee or nothing from the  
19 survivor, there's no avenues of development and  
20 we have no further medical documentation, then  
21 that case is not going to have a positive  
22 outcome.

1           In other situations where we have  
2 various types of medical documentation, but we  
3 don't really have a clear diagnostic opinion from  
4 a physician, those are instances where, if we're  
5 talking about an individual who passed away some  
6 time ago, we're looking at historical records.

7           Well, we would send that, probably, to  
8 a CMC, asking the doctor, you know, based upon  
9 this information, is there any basis to believe  
10 that this person had a condition that contributed  
11 to their death and was associated with the  
12 process of their exposure.

13           And, you know, if you can get that  
14 type of an affirmative response from a physician.  
15 And you are able to assemble some sort of medical  
16 documentation from the doctor to opine on, and so  
17 that's what we do.

18           But you have to keep in mind that  
19 these cases are extremely disparate. They have  
20 all kinds of assemblies of information and data  
21 that can lead a CE in different directions for  
22 development, but at the end of the day, if there

1 is absolutely no medical documentation in the  
2 file to support a diagnosed condition, then we're  
3 going to be without any avenue to get to a  
4 positive outcome.

5 CHAIR CASSANO: Okay, so you -- I  
6 mean, but you could recommend to the claimant  
7 that he's got to know that he now needs to go to  
8 a doctor and get a diagnosis, yes?

9 MR. VANCE: Yes, if you're talking  
10 about a living employee --

11 CHAIR CASSANO: Right.

12 MR. VANCE: -- but if you're talking  
13 about someone who's deceased, that's not going to  
14 be a possibility.

15 CHAIR CASSANO: Yes. Okay. Any other  
16 further discussion on that? I mean, that's what  
17 we thought would happen.

18 MEMBER MARKOWITZ: This is Steven.  
19 John, does that mean -- this issue of truly  
20 unavailable medical records is mostly an issue  
21 with the survivors claims?

22 MR. VANCE: Yes, I would say that's

1 generally the case. But, you know, when you're  
2 talking about individuals that were, you know,  
3 working at these places in the forties and the  
4 fifties and then passed away in the seventies.

5 Those are the toughest cases that we  
6 encounter for obtaining medical documentation.  
7 And the only thing we generally get in a lot of  
8 those cases is the death certificate. And that's  
9 why we utilize that in a lot of those types of  
10 cases to establish diagnosis.

11 MEMBER MARKOWITZ: Thank you.

12 CHAIR CASSANO: Any other comments/  
13 questions on that? Okay. And the next issue  
14 was, again, this issue of weighing medical  
15 evidence, which is probably the stickiest wicket  
16 here.

17 We asked how are the CEs trained in  
18 weighing medical evidence. And the answer we got  
19 back was the CEs are trained to evaluate all  
20 evidence that's submitted in a case file, but we  
21 still don't have a really good answer on exactly  
22 how they're trained, what kind of training

1 materials, et cetera, to be able to tease out  
2 medical evidence.

3 The procedure manual talks about what  
4 methods to apply, but it doesn't have, I would  
5 call, an artificial intelligence to say, yes this  
6 diagnosis makes sense, this diagnosis doesn't.

7 Or, you know, the person smoked for 45  
8 years and the smoking is more relevant than the  
9 exposure. So I think the answer, again to this  
10 as far as we know, is that we're going to have to  
11 talk to more CEs about this. And there are some  
12 training documents available. But, as I  
13 understand the process and what we were told on  
14 the phone, is that it's really the senior CEs  
15 that work with the newer people and get them up  
16 to speed and help them understand how to do this.

17 And that training materials may be  
18 available, but there's no standardized training  
19 manual, I guess, other than the procedure manual.  
20 Anybody else want to chime in?

21 MEMBER VLIEGER: Good morning, this is  
22 Faye. Can you hear me?

1 CHAIR CASSANO: Yes.

2 MEMBER VLIEGER: There was a problem  
3 with me calling in. I've been attempting for  
4 nearly 20 minutes to talk, and the moderator  
5 never came on. So here I am.

6 While it's all well and good that they  
7 say that their CEs are trained, and John you can  
8 chime in any time you'd like, the training  
9 depends on the background of the individual and  
10 it is not what I would call standard.

11 While there is standardized -- the  
12 CE's work is not standardized. And the recent  
13 report that came out, the 2015 audit, found that  
14 there was more than a 10 percent error going on  
15 in the way that claims were developed and  
16 processed by the CEs. So I think it would be  
17 well worth our time in looking at those training  
18 materials.

19 CHAIR CASSANO: Yes. We asked to see  
20 them, I believe. That was during that phone  
21 call, I believe we were told that they would get  
22 what they could to us. So that's on its way. We

1 do need to look at that.

2 MEMBER MARKOWITZ: Let me just chime  
3 in.

4 CHAIR CASSANO: Yes.

5 MEMBER MARKOWITZ: I think that I  
6 remember that the training materials are limited  
7 because much of the teaching is around specific  
8 examples, which are not volunteered to be  
9 standards or standardized across positions.

10 I'm sure we can get whatever training  
11 materials exist. But it'll leave the question  
12 whether we should be looking into, you know, a  
13 more standardized stereotypic type of training,  
14 but --

15 CHAIR CASSANO: Yes.

16 MEMBER MARKOWITZ: -- not that we need  
17 to answer that now, but I suspect that that's  
18 going to be on the table.

19 CHAIR CASSANO: Yes. And I think we  
20 all agree on that. Does anybody else have any  
21 input?

22 MEMBER SILVER: This is Ken Silver



1 again. Let me just cite one more time, a few  
2 years before the board was created, Sheldon  
3 Samuels was a major influence in Washington, D.C.  
4 in occupational health policy.

5 He floated an idea on Terrie Berrie's  
6 mailing list that a career ladder ought to be  
7 created for people doing this kind of work that  
8 involves continuing education and certification.

9 Mr. Howie seemed kind of interested in  
10 that idea when we met in April. There'd be some  
11 problems involving the collective bargaining unit  
12 but, you know, a journey of a thousand miles  
13 begins with a single step.

14 And I think we should keep our eye on  
15 the idea that we can't really get educated on  
16 this stuff by reading a procedures manual and  
17 going through a couple of internal education  
18 sessions.

19 A long-term solution really requires  
20 a curriculum with advancement and recognition for  
21 people who have acquired real expertise within  
22 the Office of Workers Comp.

1                   CHAIR CASSANO: Any other comments?  
2                   Great. Yes, we'll try to set up a focus group  
3                   that's part of the agenda. We don't know what  
4                   time or anything.

5                   And then the question about the  
6                   treating physician being compensated. The answer  
7                   that we got on the phone call was, if the claim  
8                   is accepted, then that -- it's somewhat  
9                   compensated for the opinion.

10                  If the claim is accepted, then yes  
11                  there is compensation. If the claim is not  
12                  accepted, there is no method to be able to  
13                  compensate a consulting physician who was  
14                  referred to develop a medical opinion, other than  
15                  the contracted medical consultant.

16                  I think this was a question you asked.  
17                  So if you have any follow-up concerns with that,  
18                  or questions about that, or anybody else for that  
19                  matter.

20                  MEMBER BODEN: No, not at the moment.

21                  CHAIR CASSANO: Okay. And I think  
22                  that's how it works in a lot of other systems

1 too. But it's, you know, there are some  
2 safeguards that aren't in here. The next  
3 question ---

4 MEMBER MARKOWITZ: Sorry, this is  
5 Steven again. Causation reports can take a fair  
6 amount of time to create high quality reports.  
7 And I'm wondering whether there's actually a  
8 category of reimbursement for causation reports  
9 that recognizes something beyond the standard  
10 examination.

11 The issue really is, you know, if a  
12 physician is writing a simple, straightforward,  
13 skimpy, rationalized report, that's one thing.  
14 But if they're taking the time to actually  
15 document their statements and provide of  
16 references, et cetera.

17 I'm talking about the CMC, I'm talking  
18 about the physician that the claim goes to. That  
19 takes time. And I'm wondering if there's a  
20 recognition of that in the reimbursement system.

21 MR. VANCE: I don't want to offer an  
22 answer that I'm not 100 percent certain about.

1 All I can tell you is that what we would pay  
2 would be based on a coding structure in the  
3 billing for the services being provided by a  
4 physician.

5 So, in other words, if there's an ICD-  
6 10 classification for a reporting of that nature  
7 that can be billed to the government, that the  
8 government will reimburse that based on whatever  
9 fee schedule exists for the energy program.

10 Now I cannot specifically answer the  
11 question as to a fully-drafted comprehensive  
12 causation report. Is there a particular ICD-10  
13 code for that? I don't think so.

14 But I'm just not familiar with billing  
15 coding enough to be able to answer that question  
16 with any degree of certainty.

17 MEMBER MARKOWITZ: Okay, thanks.  
18 Well, we can just put it on the list to find out.  
19 Thank you.

20 MEMBER BODEN: Yes, so this is Les  
21 Boden. Just to clarify, it sounds -- so there  
22 is, I gather, a specific list of payments for

1 procedures that may have procedures on it that  
2 may not be in the normal procedure coding because  
3 they're specific to things like writing a  
4 causation report? It was a question mark at the  
5 end of that sentence.

6 (Laughter.)

7 MEMBER BODEN: So is that correct,  
8 that there is a reimbursement available for  
9 activities that are not normal CPT procedures?

10 MR. VANCE: Yes, that's what I was  
11 saying before. I'm not certain that -- this is  
12 John Vance again. I'm not certain as to what  
13 would be an allowed billable service by the  
14 physician, based on that type of specific process  
15 or procedure.

16 We'd have to go back and take a look  
17 at what is our ICD-9 and ICD-10 coding for that  
18 type of service. And what are the potential  
19 different types of services that a physician  
20 could bill for? Because there are innumerable  
21 classifications and procedures that a physician  
22 can charge the government against for services

1 rendered.

2 I'm just not familiar, and certainly  
3 not going to be able to answer that with any  
4 degree of certainty. And, you know, that coding  
5 classification process is a very complicated one  
6 that has a lot of, you know, complicated service  
7 and procedure codes and other types of things  
8 that are going on. So that would be one that I  
9 would not be confident answering.

10 MEMBER BODEN: Right. So this might  
11 be something that we could try to get more  
12 information about because what physicians are  
13 doing for this program is different from what  
14 physicians typically do.

15 They typically provide diagnostic  
16 services and treatment services. They're not  
17 treating here, but also the diagnostic services  
18 they're providing are somewhat different from the  
19 ones that they normally provide. So I think if  
20 there's a way of giving us that information, as  
21 Dr. Markowitz suggested, I think that would be  
22 useful to the committee.

1                   MEMBER SILVER: This is Ken Silver.  
2                   I'm particularly interested in whether there are  
3                   physicians out there essentially working on a  
4                   contingency basis doing what Dr. Markowitz  
5                   described, writing fully rationalized causation  
6                   reports of someone who's not yet in the Part E  
7                   program, the claim might be denied.

8                   Will the physician see any payment for  
9                   all of their library work and writing and re-  
10                  writing?

11                  MS. RHOADS: Why don't I pass these  
12                  questions onto the program after the meeting is  
13                  over and we'll see what we can find out?

14                  MEMBER SILVER: Great.

15                  MS. RHOADS: Dr. Cassano, did we lose  
16                  you?

17                  CHAIR CASSANO: -- and apparently, you  
18                  guys can't hear me for some reason.

19                  MS. RHOADS: Hi. We can hear you now.  
20                  We heard you come on in the middle of your  
21                  sentence.

22                  CHAIR CASSANO: Okay, great. Okay,

1 I'm here. What I was asking -- I had a follow up  
2 question for Mr. Vance, in that -- and I guess  
3 Ken asked the same thing, was -- well he asked it  
4 in a slightly different way.

5 The physicians only get compensated if  
6 the claim is accepted. So a claimant could go  
7 out and spend \$2,000-\$2,500 for a what we would  
8 call a nexus opinion, and be out that \$2,500, if  
9 the claim is not accepted, correct?

10 MR. VANCE: That is correct. And a  
11 sort of in response to Ken's question -- this is  
12 John Vance again. I am well aware that there are  
13 people being paid by claimants, and their  
14 attorneys or representatives, to provide input on  
15 these cases.

16 But the method and the methodology for  
17 payment for those services is not something that  
18 would be payable by the Department of Labor.  
19 That's sort of an external to the program.

20 So they're assembling cases by going  
21 to their own experts. And you have to think of  
22 it as not just the physician that they could seek



1 out input from. They could also be seeking out  
2 input from health scientists, toxicologists,  
3 industrial hygienists, and all of those are being  
4 paid through from fees being collected by an  
5 attorney, or however it's being arranged.

6 And those might not be payable or  
7 reimbursed by the Department of Labor, in any  
8 form, because we can only pay based on our  
9 authorized fee schedule under the method that we  
10 pay bills through the program.

11 CHAIR CASSANO: Okay, thank you. The  
12 next few -- I think the next one reviewed by CMC,  
13 again, goes back to how does the CE learn to  
14 weigh medical evidence, the CMC's report versus  
15 the training physician's report, et cetera?

16 And I think we sort of answered our  
17 own question, in that we really need to sit down  
18 with CEs and look at the training materials. So  
19 I'm not going to belabor this particular one,  
20 unless somebody else has -- or wants to address  
21 this separately from the other issue about  
22 weighing medical evidence in training materials.

1           Okay. Hearing none, I'm going to move  
2 on. Again, the next statement was assistance  
3 with rationalization, how complex, what do they  
4 want? And what we got back from the program was  
5 basically, well it's part of that whole gestalt  
6 of how the CE looks at things, whether there's  
7 enough, there isn't enough.

8           A doc saying, I'm an expert in this  
9 field and I say it's related versus a well-  
10 rationalized report. And there could be some  
11 standardization there, but I think it really is  
12 more mushy than we'd like it to be.

13           Steve, do you have any further  
14 comments about that? Or, again, I think this is  
15 something they need to learn about from speaking  
16 with the CEs. Anybody else have any discussion  
17 of this?

18           MEMBER MARKOWITZ: I do want to either  
19 put on the table -- this is Steven -- put on the  
20 or re-put on the table, I can't quite remember,  
21 that above and beyond speaking with claims  
22 examiners, looking at a number of claims

1 themselves. Individually, what the behavior is,  
2 what the CEs are doing in practice. And to have  
3 a real look at how medical evidence is  
4 interpreted and moved.

5 CHAIR CASSANO: Okay. Did we lose  
6 you? Hello? Okay.

7 MEMBER MARKOWITZ: I'm sorry. I just  
8 made a comment, could you hear me?

9 CHAIR CASSANO: I heard most of it, I  
10 think.

11 MEMBER MARKOWITZ: Oh, I'm just saying  
12 that we need to look at some claims to get a  
13 different picture. That's all.

14 CHAIR CASSANO: Okay. And the next  
15 question was the development letters, yes they  
16 will supply some of the development letters for  
17 us. And they state they're often lengthy. And  
18 physicians may not have the time or the  
19 inclination to respond, especially if they're not  
20 getting reimbursed for it.

21 Again, more about training resources,  
22 training materials. We're getting close to one

1 hour. And then I want to move on. I want to get  
2 this discussion done at the top of the hour.

3 And then again, looking for  
4 contribution or aggravation, this is something  
5 that they really need us to try to tease out for  
6 them. Again, it's hard to standardize that  
7 because it depends on quantity, length of time,  
8 dose and other contributing factors as to how  
9 much aggravation, how much contribution.

10 So that's the real question that's out  
11 there, and probably one that scientists have to  
12 answer. Quarterly reports, we will get. And we  
13 do have a list of priorities that I think answers  
14 this last -- what are the associated diseases  
15 that claimants are claiming most often? Any  
16 additional comments at this point?

17 MS. RHOADS: Hi Dr. Cassano, this is  
18 Carrie. Apparently when people were able to hear  
19 only some of the discussion, Ms. Vlieger got  
20 dropped off. Can we wait a few minutes for her  
21 to call back on?

22 CHAIR CASSANO: Sure.

1 MS. RHOADS: Thank you.

2 CHAIR CASSANO: Yes, we seem to be  
3 having some technical difficulties here.

4 MS. RHOADS: Yes, let me just check  
5 with the moderator and make sure she's calling  
6 back in, and then we'll join her back in.

7 CHAIR CASSANO: Okay. Thank you.

8 MEMBER MARKOWITZ: So this is Steven.  
9 Can I make a comment while we're waiting for  
10 Faye?

11 CHAIR CASSANO: Yes.

12 MEMBER MARKOWITZ: The issue of  
13 aggravation --- their response to that question  
14 is --

15 CHAIR CASSANO: Hello?

16 MEMBER VLIEGER: I am here. Can you  
17 hear me?

18 MEMBER MARKOWITZ: Yes.

19 CHAIR CASSANO: Yes, I can hear you.  
20 I can't hear anybody else now.

21 MEMBER MARKOWITZ: Are you sure you  
22 can't hear anybody else?

1 CHAIR CASSANO: Okay, now I can hear  
2 you. Okay.

3 MS. RHOADS: Is Ms. Vlieger back on  
4 now?

5 MEMBER VLIEGER: You can hear me  
6 again, right?

7 MS. RHOADS: Yes.

8 MEMBER MARKOWITZ: Oh yes.

9 MEMBER VLIEGER: All right, thank you.

10 MS. RHOADS: The moderator tells me  
11 that there are seven lines active, so that should  
12 be everybody. Sorry about that, go ahead.

13 CHAIR CASSANO: Faye, did you have a  
14 comment or do you need me to repeat what we said?  
15 I'm not quite sure where you fell off.

16 MEMBER VLIEGER: I fell off about five  
17 minutes ago. I was able to call in and hear you,  
18 but not be able to speak.

19 CHAIR CASSANO: Did you want to speak  
20 to something?

21 MEMBER VLIEGER: Just in general. I  
22 don't know how many times we're going to go back

1 and talk to the Department of Labor for  
2 information before we actually have an idea of  
3 how much we need to know.

4 It's becoming very stultifying to not  
5 be able to discuss anything with people in  
6 between meetings. And we need to rectify that.

7 CHAIR CASSANO: I think, yes, it does  
8 become difficult. I think maybe we should -- we  
9 need a little bit of clarification of the rules  
10 about how we can break up into subgroups and  
11 working groups and be able to share information  
12 and collaborate in that way.

13 Carrie, is that something that we can  
14 do in a couple of minutes, so that we can move on  
15 and get our game plan put together here?

16 MS. RHOADS: Sure, we were talking to  
17 another subcommittee about this as well. You can  
18 use email to communicate with the group, as long  
19 as you copy me and Tony, on the discussion. And  
20 you can break up into working groups as well.

21 CHAIR CASSANO: Okay.

22 MS. RHOADS: Maybe I can get some

1 guidance written on that as well for the next --

2 CHAIR CASSANO: Okay, thanks. And a  
3 working group can be up to three people, or  
4 doesn't it matter?

5 MS. RHOADS: It just can't be the  
6 entire Subcommittee.

7 CHAIR CASSANO: Okay. Who's there?

8 MEMBER MARKOWITZ: This is Steven.

9 CHAIR CASSANO: Steve? Were you about  
10 to say something?

11 MEMBER MARKOWITZ: Yes. Faye, does  
12 that address what you were raising?

13 MEMBER VLIENER: You know, I'm not  
14 sure that you guys are getting to the heart of  
15 the issue. How many times do we have to ask for  
16 information before we just start making  
17 decisions?

18 CHAIR CASSANO: Well, I think we need  
19 to make sure we've got, just like the CE, all the  
20 relevant information. You know, I think we're  
21 pretty close, at this point. And that's why I  
22 want to move on now to the next step, which is



1 number five on the agenda - open discussion about  
2 how we should proceed.

3 We have a lot of information at this  
4 point. And there are -- we have been told that  
5 we can get training materials, we can meet with  
6 the CEs and we can get development letters and  
7 review those.

8 So, I think we're at the point where  
9 we can start to decide - Okay, what are we going  
10 to first? Who's going to do it? Do we break up  
11 into working groups to look at a variety of cases  
12 and report back? And that's the discussion we  
13 need to have now. So, without saying this is a  
14 free-for-all, I think we need everybody to give  
15 their input on this.

16 I could be partly directive about it,  
17 about what I think should be first and second and  
18 third, et cetera, but I want everybody to  
19 participate and especially you Faye, knowing how  
20 these things sort of work, to sort of make a  
21 sequence out of the next step.

22 MEMBER MARKOWITZ: This is Steven.

1 Maybe, before we get into that, Carrie could give  
2 us some insight into an approximate time table  
3 for the activities that Tori just listed -  
4 meetings for the claims examiner, whatever  
5 training materials you get, the development  
6 letters.

7 I know it's approximate, but do you  
8 have any sense of when we might have that?

9 MS. RHOADS: Well, for the training  
10 materials and the development letters, the  
11 Program is working on gathering them. They said  
12 a couple of weeks -- that they need to look up  
13 each one separately.

14 And the materials that you all have on  
15 your disks have cases that were provided to the  
16 Part B Lung Commission Subcommittee. And you all  
17 are welcome to go into those cases to look for  
18 examples, or to just review the process of what  
19 you can tell from those cases.

20 I will have to ask someone about a  
21 timeframe for speaking with CEs or the focus  
22 group that you're talking about, but I'll do that

1 and send out some information after the meeting.  
2 Does that cover all of your things?

3 CHAIR CASSANO: Just one question on  
4 the cases. You said they were all lung patients?

5 MS. RHOADS: They are. The first lung  
6 cases that they did were for the Part B  
7 Subcommittee, so they are listed under that  
8 Subcommittee folder.

9 But you all can go in there and look  
10 at those cases anytime.

11 MR. VANCE: Yes. This is John Vance.  
12 I was part of the group that did that work, so  
13 I'm very familiar with it. They accepted, in our  
14 cases, for beryllium disease, beryllium  
15 sensitivity and some other lung diseases like  
16 silicosis.

17 And what you have access to is medical  
18 records, copies of statements of accepted facts,  
19 any kind of CMC referral process that occurred.  
20 And some of those cases are relatively  
21 straightforward and other ones are more  
22 complicated.

1                   But I do know that some of the cases,  
2                   at least in the CBD examples with recommends to  
3                   deny, you may find cases where there were  
4                   conflicts in medical opinion and you'll see some  
5                   examples of where you had lots of differing  
6                   positions on particular situations.

7                   CHAIR CASSANO: Yes, I think that  
8                   would give us a lot of information. Beryllium  
9                   disease is very finite. And I think we really do  
10                  need to see cases from Part B because there are  
11                  so many disparate types of information.

12                  Beryllium is, compared to some of the  
13                  other stuff we may be working with, relatively --  
14                  I don't mean to disparage anybody, but relatively  
15                  simple. But when you're talking about organic  
16                  solvent mixtures plus heavy metals plus something  
17                  else, it gets very complicated.

18                  So I think we need this in certain  
19                  cases. What's the consensus out there?

20                  MEMBER VLIEGER: This is Faye. We  
21                  need to see Part B patients, not just Beryllium  
22                  patients.

1 CHAIR CASSANO: Yes.

2 MEMBER BODEN: Right. This is Les.

3 I thought, when I saw it and maybe I missed  
4 something, was three cases - they were by and  
5 large pulmonary cases, I think.

6 CHAIR CASSANO: Yes.

7 MEMBER BODEN: And my sense is,  
8 cursory at any rate with you, is that even though  
9 part of me wants not to have extra work, that  
10 three cases are not enough to tell the complete  
11 story of what's going on.

12 MS. RHOADS: Hi Dr. Boden, this is  
13 Carrie. Those three cases were in response to  
14 one of the -- someone had asked at the April  
15 meeting, that we see some examples with CMC  
16 referrals. So that's what those are.

17 MEMBER BODEN: Oh, right, okay.

18 CHAIR CASSANO: Anybody else on this  
19 issue, about getting Part B cases?

20 MEMBER MARKOWITZ: Sure. This is  
21 Steven. Yes. We have to, you know, make a more  
22 specific request. But my question is, you know,

1 just talking of the time table here, it's at five  
2 weeks before we meet in person.

3 DOL has had practice in turning around  
4 cases and settled some of the problems that they  
5 had initially. So the question is whether it's  
6 possible and people want to see some cases before  
7 our October meeting, so that we can have a better  
8 discussion.

9 Or whether we want to wait until the  
10 actual meeting, so that we can structure any of  
11 the questions of the Subcommittee. Personally, I  
12 would favor, if possible, looking at some claims  
13 before the October meeting, so that we can have a  
14 better discussion and get going.

15 But also that will help us formulate  
16 any more definitive requests.

17 CHAIR CASSANO: I would like to do  
18 that as well. I'm traveling extensively between  
19 now and then. But if we could -- Sorry, I could  
20 switch to it, but I'd like everybody to be  
21 looking at.

22 There are 14 priorities that are on

1 here. If we could get one or two cases of each  
2 of these, that would be 28 cases. We could then  
3 divide those up into working groups and have  
4 working groups review them and develop questions,  
5 at which point -- and I don't know if all -- this  
6 will probably not all get accomplished by  
7 October. We may be able to peruse them a little  
8 bit. But unless there's some time during the  
9 full Committee meeting, Steve, where we could  
10 break out and do this forum with the CEs, I don't  
11 see that happening the next full meeting.

12 MS. RHOADS: Hi, this is Carrie.

13 Before you go on, I just want everybody to know -  
14 - another subcommittee has also asked for one of  
15 each of these cases. So they're already working  
16 on that. I'll definitely share that with both  
17 subcommittees when it's finished.

18 CHAIR CASSANO: Okay, great, thank  
19 you.

20 MEMBER MARKOWITZ: Carrie, what's the  
21 timetable, roughly, for that?

22 MS. RHOADS: I think in a couple of

1 weeks. I'm not sure. I'll check with Doug and  
2 make sure.

3 MEMBER MARKOWITZ: Okay, but that  
4 means a couple of weeks before the October  
5 meeting. That's good.

6 MS. RHOADS: Hopefully, yes. I think  
7 the beginning of October was what they talked  
8 about, but I need to check before saying for  
9 sure.

10 CHAIR CASSANO: And, Carrie, we're  
11 going to be getting these by disk, correct?

12 MS. RHOADS: Yes, because there'll be  
13 cases that'll have PII on them.

14 CHAIR CASSANO: Okay. So if we get  
15 these by the first of October, we can divvy them  
16 up. I can divvy them up and maybe -- I don't  
17 know, we're now two weeks before the 16th.

18 And maybe right before the meeting on  
19 the 16th, we can have a little bit of a  
20 discussion about what we found, generally, in  
21 these cases. And that would move that bit along.

22 I think once we see these -- I think



1 it's important to see these cases before -- and  
2 to look at the training materials and the  
3 development letters before we have our focus  
4 group with the CEs. Other thoughts about that?

5 MEMBER BODEN: Just a question. Is  
6 there a specific time, maybe I missed this, that  
7 we plan to have these focus groups?

8 CHAIR CASSANO: Not yet. We need to  
9 figure that out.

10 MEMBER BODEN: Okay.

11 CHAIR CASSANO: But I don't see it  
12 happening before the next full meeting.

13 MEMBER BODEN: No.

14 CHAIR CASSANO: Because I think it  
15 would have to be an open meeting, correct Carrie?

16 MS. RHOADS: Yes. If you want to have  
17 another Subcommittee meeting, we have to publish  
18 that in the Federal Register and everything.  
19 Yes, but you can discuss it by email or some  
20 other method.

21 CHAIR CASSANO: Okay, so we can do  
22 that. So if we get these by October 1st, I will

1 make sure I'll divide them among the group,  
2 somewhat equitably.

3 And maybe by the 10th, I have to look  
4 at my calendar, let me go back in my calendar --  
5 let's see, so if we get these by the 1st, which  
6 is a Thursday, the Subcommittee meeting is -- I'm  
7 in September, wait a second. October.

8 No. There we go. So, the first is a  
9 Saturday. So if we get them sometime around  
10 there, probably the week of the 11th, 12th and  
11 13th, we can have some -- obviously, if we're  
12 going to be talking via email, we have to talk in  
13 generalizations, so we'll have to code Case 1,  
14 and just put diagnosis, no PII, no nothing.

15 And then the working group that's  
16 working on that will submit questions, issues,  
17 concerns they have about how the case worked, so  
18 that we can may be able to finish that work by  
19 the time of the full meeting.

20 And then maybe at the full meeting,  
21 after the full meeting, we can discuss the  
22 training materials and the development letters.

1 And then, obviously, we would need a six weeks  
2 lead team before we could have a focus group?

3 And I'm not sure how we would work  
4 that. Would we travel to meet? I don't think on  
5 the phone would work very well. Any suggestions  
6 on that?

7 MEMBER VLIEGER: I don't know why we  
8 couldn't do write ups and then compare the write  
9 ups, or at least be able to have small work  
10 groups discussions.

11 CHAIR CASSANO: Yes.

12 MEMBER VLIEGER: I don't see a problem  
13 doing small work group discussions over the  
14 phone.

15 CHAIR CASSANO: Yes, you can do that.  
16 But I think that the focus group --

17 MEMBER BODEN: Those are separate  
18 issues, actually.

19 CHAIR CASSANO: Okay.

20 MEMBER BODEN: One would deal with  
21 claims and work groups --

22 CHAIR CASSANO: Yes, you can do that.

1 We can discuss those over the phone that week,  
2 right before the full meeting. And then,  
3 probably within two weeks of that full meeting,  
4 have discussions about the training materials and  
5 development letters.

6 Maybe put some type of a report  
7 together. And then set up a focus group meeting.

8 MEMBER BODEN: Can I ask a question?  
9 This is a, really, and Advisory Committee rules  
10 question. I have a concern about CEs feeling  
11 comfortable having full and open discussions  
12 about issues in their jobs in a public setting.  
13 But I don't know if anything else is consistent  
14 with Advisory Committee rules.

15 MEMBER MARKOWITZ: This is Steven. It  
16 hadn't occurred to me that the focus group would  
17 be open public access.

18 CHAIR CASSANO: Yes, I was hoping it  
19 would be.

20 MEMBER BODEN: That's what I was  
21 hoping also. But I just wanted to be sure that  
22 we could do that.

1                   MEMBER MARKOWITZ: It could be a  
2 subset of a subcommittee.

3                   CHAIR CASSANO: Yes. I mean, as long  
4 as one person on the subcommittee didn't go, it's  
5 not a full subcommittee meeting. And, therefore,  
6 we can do it in private, right? Carrie?

7                   MS. RHOADS: I think so. But I have  
8 to ask about focus groups, specifically. I'll  
9 make sure I don't forget.

10                  CHAIR CASSANO: And the other reason  
11 for doing that is because we wouldn't want to  
12 inadvertently publicly blab PPI as we're talking  
13 about a particular case. I think it's scary to  
14 do it that way.

15                  MS. RHOADS: Absolutely.

16                  CHAIR CASSANO: So I'm not sure if you  
17 can suspend the rules for that. If different  
18 people on the Subcommittee worked with a couple  
19 of CEs, and then another group worked with  
20 another couple of CEs, then -- I'm not trying to  
21 be not be transparent here, but there is some  
22 legitimate concerns with PPI, et cetera.

1                   And people talking about whether or  
2 not they feel they have the information they need  
3 to do their job. That's something -- we want  
4 people to be honest with us about this. So I  
5 would prefer not to have it public if we can.

6                   MEMBER MARKOWITZ: This is Steven.  
7 Not to mention that it wouldn't work for  
8 Subcommittee members to be present at a focus  
9 group. It would inhibit the discussion.

10                  CHAIR CASSANO: Right.

11                  MEMBER MARKOWITZ: So, inevitably,  
12 it's going to be a relatively small subset of the  
13 Subcommittee that would be present. And again, I  
14 agree that it's not a question of subverting the  
15 rules, it's a question of effectively getting  
16 information.

17                  CHAIR CASSANO: Yes. So going back  
18 now to the agenda, we should have had a vague  
19 timetable of how we're going to advance. We're  
20 going to get cases, we're going to look at cases,  
21 we're going to have our big meeting, we're going  
22 to then look at training materials and

1 development letters. And then we're going to  
2 meet the CEs.

3 MEMBER MARKOWITZ: This is Steven.  
4 Let me ask you a question about that. Talking  
5 about the Subcommittee agenda for the October  
6 meeting. We should be in the position of sharing  
7 with the larger Committee, our review of  
8 development letters.

9 We should be in the position of  
10 reviewing the training materials and reporting  
11 back to the committee on that. And it sounds  
12 like we'll have some claims to look at. And we  
13 can have the beginning of a discussion about what  
14 we found the claims at the full board meeting.

15 CHAIR CASSANO: Yes.

16 MEMBER MARKOWITZ: Is that realistic?  
17 Is that right?

18 CHAIR CASSANO: Steven, I don't think  
19 it is that realistic at this point. I know you  
20 want some kind of report, but I think a report on  
21 getting to this point and what we are looking at  
22 and how we're going to move forward and

1 discussing the claims at the next meeting, is  
2 probably as much as -- I only have one week where  
3 I'm not traveling between now and the  
4 Subcommittee meeting. So I'm freaking out a  
5 little bit.

6 MEMBER MARKOWITZ: No, I wasn't saying  
7 that a report should be produced. I was saying  
8 that the discussion at this Subcommittee has with  
9 the full Committee would include having looked at  
10 some of the development letters, having looked at  
11 whatever training materials have been given to  
12 us.

13 And then having an open discussion  
14 about that. Not having settled on any sort of  
15 position or even the next steps about that. But  
16 bring that discussion to the full Committee.

17 CHAIR CASSANO: I mean, we could.  
18 What does everybody else think? I mean, I think  
19 we have to have somewhat of a discussion about  
20 our evaluation of the procedure manuals and some  
21 of the other stuff.

22 You know, we've been in on this



1 subcommittee and they understand how we got here  
2 from where we were. But the full Committee isn't  
3 going to understand that.

4 So I think we have a lot to present up  
5 to that point. We can certainly try to look  
6 briefly at some of the development letters and  
7 see the low hanging fruit that may be there, as  
8 well as the training materials.

9 But I don't think we can do a deep  
10 dive into any of it before that meeting. Other  
11 comments? I mean, you know, I don't see us being  
12 able to do a very comprehensive evaluation.

13 MEMBER MARKOWITZ: Right, yes, okay.  
14 You know, we've got time.

15 CHAIR CASSANO: We'll talk about that.

16 MEMBER MARKOWITZ: We'll see where  
17 we're at. Yes. We'll see how far we get.  
18 Obviously, my job is to move the process along.  
19 But not faster than we can.

20 So we'll revisit the agenda of this  
21 Subcommittee in the larger full Committee meeting  
22 in a few weeks.

1                   CHAIR CASSANO: Okay. Yes, it also  
2 depends on how soon we get the material. You  
3 know, if it takes until October 1st to get the  
4 material, we can do a very cursory evaluation of  
5 it, and present that.

6                   But we can talk offline or email back  
7 and forth about that. Any other comments about  
8 how much we should look at before the full  
9 Committee meeting?

10                  MEMBER VLIEGER: I would hope that we  
11 would have at least a plan, going forward, of how  
12 we're going to attack things for the timeline  
13 when we're at the October meeting.

14                  CHAIR CASSANO: Yes. And I was going  
15 to try to pin some of that down today. And  
16 that's what we were doing, as far as looking at  
17 the cases and then getting the training materials  
18 and looking at that.

19                  And then, I was hoping we could  
20 develop some kind of a report, maybe not an  
21 official report, but sort of consolidate some of  
22 our findings on the procedure manual and the

1 training materials. And maybe some cursory  
2 recommendations for process improvement. And  
3 then we'll talk about the development of  
4 deliverables. This is all on the agenda.

5 But the first thing is to get all of  
6 the relevant information. And then go on from  
7 there. I can send out a timetable after this  
8 meeting, based on when we're going to get all of  
9 the additional information, and send that out to  
10 everybody.

11 MEMBER VLIEGER: Couldn't we at least  
12 start on the documents that we have that are for  
13 the perspective of the Subcommittee? And at  
14 least start working on those in some Subcommittee  
15 groups?

16 CHAIR CASSANO: Which documents are  
17 you talking about? Well, we already have cases  
18 that we can look at for how they weighed medical  
19 evidence in our hands. So I don't know why we  
20 couldn't do some subcommittee work with what we  
21 already have, and then just add the additional  
22 cases as they come.

1                   MEMBER VLIEGER: How many cases are on  
2 that disk? They're just the three pulmonary  
3 cases?

4                   MS. RHOADS: There are three pulmonary  
5 cases from the April meeting and then there's  
6 about 50 cases on there.

7                   CHAIR CASSANO: Oh there are? But  
8 they're all pulmonary, correct? They're all  
9 beryllium cases?

10                  MS. RHOADS: They're all lung cases,  
11 right?

12                  MR. VANCE: They are all Part B lung

13 --

14                  CHAIR CASSANO: Okay.

15                  MEMBER VLIEGER: Well there's also the  
16 cases from the Cleveland office. There's three  
17 cases from the Cleveland office with referrals to  
18 CMC.

19                  CHAIR CASSANO: Those are still Part  
20 B cases?

21                  MEMBER VLIEGER: Yes, but it goes to  
22 referring to the weighing of medical evidence.

1                   CHAIR CASSANO: We can certainly do  
2 that but, again, we're going to be re-doing work  
3 because we're going to have to look at the Part E  
4 plans as well.

5                   But certainly we can look at them and  
6 have discussions and I can divide people up into  
7 subgroups. And we can get some of that done.

8                   MEMBER VLIEGER: My point is of  
9 starting on some of this is, I don't think we're  
10 going to see a big difference in what we already  
11 have in our hands versus any new -- only the  
12 difference in the disease and how it's handled.  
13 So that's why I'd at least like to start on what  
14 we have.

15                   CHAIR CASSANO: We certainly can do  
16 that. What's the consensus on this? Should we  
17 wait a couple of weeks to get the other cases, or  
18 should we have discussions on the beryllium cases  
19 that we have?

20                   MR. VANCE: This is John Vance. Let  
21 me interject really quick. The 50 cases that  
22 Carrie Rhoads just mentioned. When we did that

1 pool, that would be -- it was focused primarily  
2 on Part B lung diseases.

3 CHAIR CASSANO: Right.

4 MR. VANCE: A vast majority of those  
5 cases will also have a Part E component to it,  
6 just to let you guys know.

7 CHAIR CASSANO: Okay.

8 MR. VANCE: Like I said before, some  
9 of those cases, as Faye mentioned, will have CMC  
10 referrals. I know a couple of cases that I  
11 specifically pulled for that actually did have  
12 conflicts of medical opinion in there. And so  
13 that would relate to both the Part B and E case.

14 CHAIR CASSANO: Okay. So what we'll  
15 do is we'll take a look at those cases, and I  
16 will have to take a look at them. And what I'll  
17 do is I'll pull the ones that seem to be -- that  
18 have Part E components to them -- and we can have  
19 some discussions on them. And then I'll divvy  
20 them up. Does that make sense to everybody?

21 MEMBER SILVER: Sure.

22 MEMBER VLIIEGER: Yes.

1                   CHAIR CASSANO: And then we'll get the  
2 additional 28 cases, or whatever we're going to  
3 get from the others. So, after this meeting, I  
4 will send out a timeline for how that will be  
5 accomplished, and how we're going to synthesize a  
6 discussion of that.

7                   Does everybody want to write a  
8 synopsis of the case? We're going to have to  
9 number the cases and just do it Case No 1,  
10 contention and views, et cetera, and then we're  
11 going to have to put down your concerns or the  
12 issues or the questions that you have.

13                  MEMBER BODEN: This is Les. I don't  
14 know exactly how to do this, but I think it would  
15 be advisable to have a sort of common, straight,  
16 general template --

17                  CHAIR CASSANO: Okay.

18                  MEMBER BODEN: So that we're all  
19 discussing the same things.

20                  CHAIR CASSANO: Okay, I can get that  
21 done.

22                  MEMBER BODEN: That would be great.

1 That would be great.

2 CHAIR CASSANO: Okay. So we're going  
3 to look at the preliminary cases and the,  
4 probably over the next two weeks, before we get  
5 the other ones, and we'll set up some way of --  
6 some standardized template to look at them and  
7 add specific questions and then move on from  
8 there to the new cases that you're getting.

9 And if we get the training materials  
10 and the development letters, we'll certainly take  
11 a look at those. And, also, people will document  
12 their issues or concerns on that. And we can  
13 bring that to the full committee.

14 MEMBER POPE: This is Duronda Pope.

15 CHAIR CASSANO: Yes.

16 MEMBER POPE: So just to be clear.  
17 We're going to be looking at those cases as a  
18 full committee, not as focused committees?

19 CHAIR CASSANO: No, we cannot -- I  
20 will divvy those cases. I will look at the  
21 cases. And so that people aren't just picking  
22 one case or two cases that seem interesting to



1       them, I will pick the cases that I think we get  
2       the most bang for the buck out of.

3               MEMBER POPE:   Okay.

4               CHAIR CASSANO:   And then I will put  
5       that list out, and what suggestions on who should  
6       look at them or what working group would look at  
7       them - probably an industrial hygienist, either  
8       you or Faye, and either me or Dr. Markowitz, if I  
9       can impress him, so that we have a civilian, an  
10       industrial hygienist and a physician on each of  
11       these.

12              MEMBER POPE:   Okay.

13              CHAIR CASSANO:   Does that make sense?

14              MEMBER POPE:   Yes.

15              CHAIR CASSANO:   Okay.   So I'll put  
16       that together and we can go from there.   And I'll  
17       send out a little bit of a timetable of how we're  
18       going to get that done.

19              MEMBER POPE:   Okay.

20              CHAIR CASSANO:   Now I also think, even  
21       though we have some of this documented, we need  
22       to put out some type of synthesized document on

1 what we found regarding the procedure manual and  
2 the training materials. What do other people  
3 think about that?

4 So that a year from now, when we're  
5 going back to try to work on process improvement,  
6 we understand what our concerns were at the  
7 beginning. And especially if new people come on,  
8 or people leave the committee, we need to have  
9 some documentation other than the minutes and the  
10 summaries of the meeting. Comments?

11 MEMBER VLIEGER: I have a question.

12 CHAIR CASSANO: Yes.

13 MEMBER VLIEGER: This is Faye. The  
14 question I have is - How are we going to provide  
15 the summaries, other than to ourselves and the  
16 Department of Labor? Are any of these summaries  
17 going to be uploaded?

18 CHAIR CASSANO: I think once they are  
19 finalized, yes, but I think they can be used as a  
20 work product. If we can communicate by email,  
21 then we can put a document in that email that's a  
22 working document or a draft or something,

1 correct?

2 MS. RHOADS: You can. If you are  
3 summarizing cases, just make sure that there's no  
4 PII in your summary.

5 CHAIR CASSANO: Right.

6 MS. RHOADS: Just be able to do that  
7 without putting identifiers in there.

8 CHAIR CASSANO: Right. And that's  
9 what I'm going to do with these cases, is I may  
10 actually -- I will code them or number them. I  
11 don't know if it's acceptable -- I haven't opened  
12 the disk to see if I can blank out PPI in it or  
13 not, which would make it a little bit easier.

14 But I don't want to be sending cases  
15 back and forth, that's for sure. It's just going  
16 to have to be Case No. 1, TCE, Parkinson's  
17 Disease.

18 MS. RHOADS: Right, you shouldn't be  
19 sending anything from the disk or changing  
20 anything on the disk.

21 CHAIR CASSANO: Okay.

22 MS. RHOADS: If you want to make

1 summaries, just make sure you don't transfer any  
2 PII into your summary.

3 CHAIR CASSANO: Okay, okay. And  
4 that's why we need to number them and code them  
5 and move from there. But then the report would  
6 obviously have -- the synopsis would not have any  
7 of that.

8 It would just say -- you would try to  
9 synthesize it, I think. In our discussion and  
10 our evaluation of these cases, these are the  
11 general problems that we've had, while we're  
12 talking about specifics.

13 MS. RHOADS: And just to be clear, no  
14 one should have to redact anything on the disks  
15 either.

16 CHAIR CASSANO: Okay.

17 MS. RHOADS: I don't think you'd be  
18 able to do it, but just don't even try.

19 CHAIR CASSANO: Don't even try. Yes,  
20 ma'am.

21 MS. RHOADS: Right.

22 CHAIR CASSANO: Thank you. I heard

1 you loud and clear. And then, farther on down,  
2 once we have a great handle on how this was done  
3 and what our issues and question and problems  
4 are, we can start to develop our recommendations,  
5 which is Number D under the timetable.

6 And then we can have a discussion on  
7 whether we're going to develop training materials  
8 and/or try to work on developing presumptives.  
9 But I think the presumptive issue is more for the  
10 full committee than for us. Other comments?

11 MEMBER SILVER: Tori, this is Ken. I  
12 splashed a little bit around in some of the case  
13 files. When the template is developed and sent  
14 out, it would be helpful if it emphasized the key  
15 issues we should hone in on.

16 The files are so voluminous, it seems  
17 like our success will be largely determined by  
18 what we decide not to look at.

19 CHAIR CASSANO: Right. And I know  
20 that from winding my way through 6,000 page case  
21 files myself, that you learn very quickly what's  
22 important and what isn't important.

1                   MEMBER SILVER: Yes, so if you could  
2 steer us towards these three, four or five main  
3 issues, that would be most helpful.

4                   CHAIR CASSANO: Okay. I will do my  
5 best. I may need Steve's input on this as well,  
6 but I will do my best.

7                   MEMBER MARKOWITZ: We are sure you  
8 will. So there is an issue that we need to make  
9 sure stays on our agenda here, which is something  
10 that DOL asked us about, however difficult the  
11 issue is, which is how to really operationalize  
12 the legal requirements under the statute, the  
13 aggravation, contributions, disease be  
14 incorporated into the claims process.

15                   CHAIR CASSANO: Yes.

16                   MEMBER MARKOWITZ: Have those words  
17 defined, et cetera. So I'm not saying that I  
18 have an answer to that, but we need to figure out  
19 a way how to further that discussion.

20                   CHAIR CASSANO: That's on my down more  
21 on the bottom of my deliverables. I don't think  
22 we understand this. I mean, I'm getting a better

1 understanding. But I don't think I understand it  
2 enough yet, until I look through a bunch of cases  
3 to see how they're put together, to see how we  
4 incorporate that.

5 I think that's one of the last things,  
6 you know, we can get to. I've actually gotten  
7 through this agenda. I can't believe it. I  
8 would like some other comments from individuals  
9 on anything that seems to have been missed,  
10 anything that we glossed over, anything that you  
11 think needs a little bit more solid discussion.

12 MEMBER VLIEGER: I think we need to  
13 review the Department of Labor's responses to our  
14 questions, in light of how we find the evidence  
15 in the files.

16 I don't find that all of the district  
17 offices actually do the claims processes the same  
18 way. They have different checklists for doing  
19 things. They have different form letters.

20 And it think that, in order to make  
21 this program as uniform as possible, we need to  
22 examine what DOL thinks is going on versus what

1 we find in those files.

2 CHAIR CASSANO: Yes. I mean, I think  
3 that's obvious that we need to do that. But in a  
4 non --

5 MEMBER VLIEGER: I was strictly doing  
6 it for information because when I deal with  
7 different district offices, and they say well we  
8 always do it this way, and I haven't seen it with  
9 other district offices, then I actually question  
10 whether the training materials are actually  
11 uniform.

12 CHAIR CASSANO: They're not. Well  
13 they've already told us they're not.

14 MEMBER VLIEGER: Yes, they told us  
15 that there's basic materials that are uniform,  
16 but that the individual training is not. But I  
17 think some of the basic materials are not uniform  
18 either.

19 CHAIR CASSANO: I think we'll find  
20 that out when we get the training materials. I  
21 want to -- our discussion is to enlighten or to  
22 help DOL move this process forward.



1                   It's not to say, you know, you think  
2                   this is what's happening, but this is what's  
3                   really happening. I think we just report on what  
4                   we see is happening.

5                   And I think DOL can make its own  
6                   conclusions in some way to be able to say, gee we  
7                   didn't realize it was happening this way. In  
8                   order to make sure that -- you know, we're an  
9                   advisory committee, we're not the Inspector  
10                  General, we're not the auditors. I think we need  
11                  to do that.

12                  MEMBER MARKOWITZ: This is Steven. I  
13                  just want to remind you. Our charter is to make  
14                  recommendations to the Secretary of the  
15                  Department of Labor regarding four areas and,  
16                  specifically, how to make improvements in those  
17                  areas.

18                  So that's our chartered mission and  
19                  that's what we're aiming for.

20                  CHAIR CASSANO: Right. Thank you,  
21                  Steve. You said it --

22                  MEMBER VLIENER: I don't have anything

1 different in mind, it's just that I want to make  
2 sure that we don't necessarily take what we get  
3 and not review.

4 CHAIR CASSANO: I don't think that's  
5 anybody's intention.

6 MEMBER VLIEGER: Okay.

7 MEMBER MARKOWITZ: Yes. I mean there  
8 is, in a way, a more difficult issue beyond the  
9 training materials, which is, chances are the  
10 regional or district offices have developed some  
11 limited variation in how they do things, that is  
12 probably not captured or reflected in the  
13 training materials. And the only way we could  
14 really look at that is by systematically looking  
15 at things across different offices.

16 CHAIR CASSANO: Yes.

17 MEMBER MARKOWITZ: And we may get  
18 there, but right now that's in the back of our --

19 CHAIR CASSANO: Yes.

20 MEMBER MARKOWITZ: We need to keep  
21 that on the radar.

22 CHAIR CASSANO: Yes. Any other

1        comments, suggestions, questions?  If not -- if  
2        we're done for right now, can we close the  
3        meeting, Carrie?

4                    MS. RHOADS:  Sure, if there's nothing  
5        else to be done, we can definitely do that.

6                    CHAIR CASSANO:  Okay, because I think  
7        it's going to take a little bit of clarification  
8        on my part to put together the timetable to get  
9        through the cases that we have, and do the  
10       templates.

11                   My job -- I will reiterate what I've  
12        been asked to do.  I've been asked to take an  
13        initial look at these cases, pull ten or fifteen  
14        that probably are most relevant to Part E,  
15        including some with referrals, some without  
16        referrals, et cetera, divide those up into two or  
17        three -- probably three subcommittees -- two  
18        working groups, excuse me.

19                   And then develop a template for what  
20        we should look for in those cases.  Is that  
21        correct?  Did I miss anything?

22                   MEMBER MARKOWITZ:  No.  And this is

1 Steven. So, Carrie, are you the one who  
2 assembles the to-do list from this meeting?

3 MS. RHOADS: Yes, I usually right up a  
4 list and then I send it to Dr. Cassano, and she  
5 adds her input.

6 MEMBER MARKOWITZ: And then you  
7 distribute it to the Subcommittee?

8 MS. RHOADS: Right.

9 MEMBER MARKOWITZ: Okay.

10 CHAIR CASSANO: So I will try to have  
11 that done, let's say -- today is Tuesday -- I'll  
12 try to have that stuff out to you by Friday. And  
13 we can go from there. And Dr. Markowitz, am I  
14 allowed to entice you into service on one of the  
15 working groups as a physician representative?

16 MEMBER MARKOWITZ: Sure.

17 CHAIR CASSANO: Thank you. Any  
18 closing comments from anybody? Mr. Vance?

19 MR. VANCE: Well, Carrie, when you  
20 actually use -- or Steven -- When you assemble  
21 the action list, if you know by then when you  
22 have a target date for the developing letters or

1 the training materials or whatever, if you could  
2 add that to that, that would be great.

3 MS. RHOADS: Yes, I will. Thank you.

4 MR. VANCE: And this is John Vance. I  
5 don't really have anything else to add, other  
6 than just thanking you for allowing me the  
7 opportunity to participate.

8 CHAIR CASSANO: Oh, we appreciate --  
9 you're going to be participating a lot more, I  
10 think.

11 MR. VANCE: I have been participating  
12 behind the scenes, collecting information for you  
13 guys, so I already am helping.

14 CHAIR CASSANO: Okay, great. And, if  
15 there's stuff that you want to put together, to  
16 send to us that might enlighten us a little bit,  
17 please do.

18 I guess Carrie -- you guys will figure  
19 out how that gets done, within the rules, et  
20 cetera.

21 MS. RHOADS: Sure.

22 CHAIR CASSANO: Thanks.

1 MS. RHOADS: Okay then, if there's  
2 nothing else, do you want to go ahead and close  
3 the meeting?

4 CHAIR CASSANO: I would -- if there  
5 are no objections, I will close the meeting.  
6 Thank you all for participating. I appreciate  
7 it. Those members of the public that listened,  
8 thank you as well.

9 I want to thank the Program, I want to  
10 thank Mr. Vance and Carrie, the transcriber and  
11 all of the members of the Subcommittee.

12 (Whereupon, the above-entitled matter  
13 went off the record at 2:44 p.m.)  
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**56** 2:8

**6**

**6,000** 77:20

**7**

**8**

**83** 2:20  
**86** 2:22

**9**

**90** 7:16



C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Medical Advice for CEs Regarding  
Weighing of Medical Evidence

Before: Toxic Substances and Worker Health Adv. Bd.

Date: 09-13-16

Place: teleconference

was duly recorded and accurately transcribed under  
my direction; further, that said transcript is a  
true and accurate record of the proceedings.



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Court Reporter

**NEAL R. GROSS**

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