NIOSH OCAS Trip Report
Discussion with Administrator of Veterans' Administration "Atomic Workers" Compensation Program

Date/Location of Meeting: April 3, 2001, Veterans' Administration, Washington, D.C.

Attendees (Affiliation):
Larry Elliott, Greg Lotz, Jim Neton, Mary Schubauer-Berigan (NIOSH)
Neil Otchin, M.D. (VA)
Claudia Gangi, John Oates (Department of Justice, RECA program)

Objective: Learn about administration of the VA's "Atomic Veterans" compensation program, and the application of the probability of causation tables and models in the program.

Meeting summary: We met with Dr. Otchin and the DOJ representatives from 9:00 a.m.-12 p.m., and were given a demonstration of the use of the draft NCI/CDC probability of causation tables. We asked numerous questions about the compensation program operated by the VA, and about practical issues related to claims processing, dose assessment and probability of causation determination for radiation-exposed veterans. The information received will be extremely helpful as OCAS drafts regulations for compensation under EEOICPA.

Specific issues discussed:

1. **Who is eligible for compensation under the VA's presumption of causation (i.e., no dose assessment required)?** Those currently eligible include veterans who observed or otherwise participated in atomic tests while in the military, veterans involved in the occupation of Hiroshima and Nagasaki at the end of WWII, or veterans who worked at a DOE gaseous diffusion plant while employed by the military. Veterans who were treated with nasopharyngeal applications of radium are also included.

2. **How many compensation claims are processed per year?** The VA receives 250-300 cancer claims each year. All probability of causation determinations are made by Dr. Otchin.

3. **What kind of cancer evidence is required? Do they require physician evidence of diagnoses? Do they compensate on the basis of death certificate evidence alone?** The VA requires extensive medical documentation for the claim. Because of the unique situation of the VA, they can easily obtain VA medical records for diagnostic purposes, and examine the individual in conjunction with a claim. Because of the need for expert judgment in some situations (e.g., pre-cancerous conditions and difficult-to-classify cancers), Dr. Otchin recommended that medical officers interpret physician diagnosis. The VA rarely has to rely on death certificate information alone, but this would be considered acceptable if no other information on cancer diagnosis is available. Dr. Otchin did note that only spouse and parents are considered eligible survivors under the VA program.

4. **Does the VA compensate based on secondary cancers?** Dr. Otchin indicated the VA does not determine eligibility for compensation based on metastatic cancer site. If the primary site cannot be identified, they use expert judgment to determine the sites most likely to be primary, and then determine compensation based on the primary site producing the highest probability of causation. However, given their access to medical records through the VA hospital system, they are usually able to determine the primary cancer site.

5. **The VA appears to be using the 1985 PC tables from NIH. Do they have a computer program established to do this that NIOSH could view?** The VA actually determines probability of causation from interpolations of tables produced in the 1988 Committee on Interagency Radiation Research and Policy Coordination (CIRRPC) report "Use of Probability of Causation by the Veterans Administration in the Adjudication of Claims of Injury Due to Exposure to Ionizing Radiation" (see attachment). These tables give screening doses (in rad) associated with the upper 99% credibility limit of the 50% probability causation estimate, for various cancers and a few background factors (age at exposure, time since exposure and smoking). These tables are less detailed than the computational methods provided by the 1985 NIH report.

6. **How does VA plan to compensate for cancers not modeled in the 2001 NCI tables? How do they do it now?** The VA uses information on relative risk associated with radiation exposures, as given in the BEIR V and ATSDR reports and other sources to essentially compute a the dose associated with a doubling of risk. [Note: This approach assumes, among other things, that radiation interacts multiplicatively with all other background risk factors for the cancer. Also, it is not clear whether the point estimate or upper confidence limit on relative risk is used to estimate doubling dose.]. Literature provided by the VA to the NCI/CDC meeting on Radioepidemiological Tables (January 26, 1999) states that "The VA now recognizes all malignancies as potentially radiogenic as well as posterior and subcapsular cataracts, non-malignant thyroid nodules, parathyroid adenomas, and tumors of the brain and central nervous systems". Although the VA had hoped to obtain radioepidemiological models for all these conditions, these are not available in the current NCI revision.

7. **How does the VA classify the cancer if it overlaps more than a single modeled cancer site (e.g., myeloid leukemia of unspecified chronicity)?** The VA is usually able to obtain very precise definitions of cancer, because of the extensive use of VA facilities for diagnosis and treatment of veterans. However, where this situation does occur, the VA selects the cancer site producing the probability of causation that is most favorable to the claimant. This often does require some iterative interaction with the Defense Threat Reduction Agency to produce dose assessments for the proper organ or tissue.

8. **For VA claims, have they classified the compensable cancers by ICD-9, -8, -7 and -6 revision? If so, could we get a copy? (Also need to ask RECA for this)** Dr. Otchin indicated that the VA has not done this yet, but that it would probably be a good idea to try to standardize this process a bit more, since the new NCI PC methods include many more cancer sites.

9. **Lung cancer will be added to the list of Presumptive cancers. Does this include trachea and bronchus as well?** No, just bronchiolalveolar cancer. Dr. Otchin indicated that the basis for the addition of new cancers to the presumptive list was primarily politically-motivated.

10. **Can the VA share an example of a questionnaire given to applicants?** The VA doesn't have forms that are specific to radiation claims. There is no consistent or generic form at this time.

11. **Does the VA have special authority to add diseases to the compensable list?** Yes. According to Dr. Otchin, because of precedent set by other compensation programs, Congress delegated responsibility for this to the VA directly. The VA has proposed that five cancers (bone, brain, ovary, colon, lung) be added to the compensable list; but these regulations are still pending.

12. **What kind of public input does the VA compensation program have?** Besides the formalized involvement of the Veterans' Advisory Committee (NIOSH-OCAS representatives attended their last meeting on March 21, 2001), there is a loose network of veterans' groups involved to some degree in the program. There is also beginning to be more involvement on dosimetry issues, through the recently-established NAS panel.

13. **Does VA recommend that NIOSH-OCAS develop a dialog with the Veterans' Advisory Committee?** Dr. Otchin recommended this as a possibility to be pursued. Right now the Committee is still reviewing the revised tables, and would likely be very interested in hearing about the guidance developed by NIOSH-OCAS. The Committee is not yet aware that, for many cancers, the revised tables may produce a less favorable result for the claimant.

Other comments:

Where there is an existing NCI model, the VA appears very reluctant to make modifications or expert interpretations on use; however, for cancer sites for which no model exists (e.g., skin, male breast), much judgment is applied by the program administrator in determining the probability of causation for individual cases. The VA is supposed to take into account other exposures the claimant may have had when adjudicating a claim; however, this has proven very difficult to do in practice.

Dr. Otchin indicated that it may be politically very difficult for the VA to recommend use of the revised tables for cancers that produce less favorable estimates of probability of causation than the 1985 version; however, this discussion has not yet taken place within either the VA program or the Veterans' Advisory Committee.

The dose distributions were fairly low for most of the Atomic Veterans. Fewer than 5% received a dose of 5 rem or more. In conducting dose assessments, there is essentially no accounting for dosimetry distribution in calculated probability of causation. The VA does not appear to have much in-house dose assessment capability, but indicated they would welcome guidance from NIOSH on issues such as the variability associated with badge dosimetry readings.