State of West Virginia
Department of Administration
Purchasing Division
2019 Washington Street East
Post Office Box 50130
Charleston, WV 25305-0130

Solicitation

NUMBER	PAGE
INS14015	1

ADDRESS CORRESPONDENCE TO ATTENTION OF:
EVELYN MELTON
304-558-7023

RFQ COPY
TYPE NAME/ADDRESS HERE

VENDOR

SHIP TO
INSURANCE COMMISSION

1124 SMITH STREET
CHARLESTON, WV
25305-0540 304-558-3707

DATE PRINTED
03/19/2014

BID OPENING DATE: 04/02/2014 BID OPENING TIME 1:30PM

LINE	QUANTITY	UOP	CAT NO.	ITEM NUMBER	UNIT PRICE	AMOUNT
				ADDENDUM NO. 1		
				ADDENDUM ISSUED:		
				1. TO PROVIDE RESPONSES TO VENDORS' QUESTIONS REGARDING THE ABOVE SOLICITATION.		
				2. TO PROVIDE VENDORS A TRANSCRIPT SAMPLE WHICH INCLUDES TEXTS. SAMPLE TRANSCRIPT IS ATTACHED.		
				3. TO PROVIDE ADDENDUM ACKNOWLEDGMENT. THIS DOCUMENT SHOULD BE SIGNED AND RETURNED WITH YOUR BID. FAILURE TO SIGN AND RETURN MAY RESULT IN THE DISQUALIFICATION OF YOUR BID.		
				END OF ADDENDUM NO. 1		
0001	1	PG	961-72	TRANSCRIBING HEARINGS FROM DIGITAL VOICE FILES		
0002	1	PG	961-72	TRANSCRIBING DECISIONS FROM DIGITAL VOICE FILES		

SIGNATURE	TELEPHONE	DATE
TITLE	FEIN	ADDRESS CHANGES TO BE NOTED ABOVE

WHEN RESPONDING TO SOLICITATION, INSERT NAME AND ADDRESS IN SPACE ABOVE LABELED 'VENDOR'

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Solicitation

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INS14015	2

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LINE	QUANTITY	UOP	CAT. NO.	ITEM NUMBER	UNIT PRICE	AMOUNT

****** THIS IS THE END OF RFQ INS14015 ****** TOTAL:

SIGNATURE	TELEPHONE	DATE
TITLE	FEIN	ADDRESS CHANGES TO BE NOTED ABOVE

WHEN RESPONDING TO SOLICITATION, INSERT NAME AND ADDRESS IN SPACE ABOVE LABELED 'VENDOR'

SOLICITATION NUMBER: INS14015
Addendum Number: 1

The purpose of this addendum is to modify the solicitation identified as ("Solicitation") to reflect the change(s) identified and described below.

Applicable Addendum Category:

[ ] Modify bid opening date and time

[ ] Modify specifications of product or service being sought

[✓] Attachment of vendor questions and responses

[ ] Attachment of pre-bid sign-in sheet

[ ] Correction of error

[✓] Other

Description of Modification to Solicitation:

1. To provide responses to Vendors' questions.
2. To provide a Transcript sample.
3. To provide Addendum Acknowledgment.

Additional Documentation: Documentation related to this Addendum (if any) has been included herewith as Attachment A and is specifically incorporated herein by reference.

Terms and Conditions:

1. All provisions of the Solicitation and other addenda not modified herein shall remain in full force and effect.
2. Vendor should acknowledge receipt of all addenda issued for this Solicitation by completing an Addendum Acknowledgment, a copy of which is included herewith. Failure to acknowledge addenda may result in bid disqualification. The addendum acknowledgement should be submitted with the bid to expedite document processing.

ATTACHMENT A

ADDENDUM NO. 1
INS14015 – QUESTION AND ANSWER

1) Who is the current vendor servicing the contract?

   A: IMEDX, INC.

2) What rate is the State currently paying per page for Transcription of Hearings.

   A: $1.15 per transcript page

3) What rate is the State currently paying per page for Transcription of Decisions.

   A: $2.99 per decision page

4) How much did the State spend on the existing contract for these services in the most recently closed fiscal year?

   A: $40,112.46 in fiscal year 2013

5) What is the State's budget for the first year of the new contract, when awarded?

   A: Open-end contract

6) Is this RFQ open to out of state companies and if so how much preference is given to in state?

   A: Yes, please refer to the Vendor Preference Certificate (page 40) of the packet

7) Most of our contacts require double spaced and 25 lines per page. I noticed that the transcripts are required to be single spaced and for hearings it should be up to 51 lines per page and decisions 53 lines per page. However, the sample transcripts show 34 lines. I need to how many lines of text per page are required so we can give you an accurate quote.

   A: The sample transcript contained 1.3 pt. line spacing allowing 34 text lines per page. Also, please note that requirements for decisions include 46 typing lines per page.

8) Approximately how many hearings are there in total in a month?

   A: In the past 12-month period, we have averaged 53 hearings per month.

9) Who is the current vendor?

A: Please refer to the answer in question number 1

10) What is the current price per page?

A: Please refer to the answers in question nos. 2 and 3

11) Would you please provide a typed transcript, text included, of each type of hearing.

A: Attached is a sample transcript including text.

12) Who is the incumbent for the current requirement of transcription services? Also, what is the current pricing for transcription services?

A: Please refer to the answers in question nos. 1, 2 and 3

13) If you are a sole proprietor do you still have to carry WC insurance in order to receive this bid?

A: The Office of Judges cannot provide legal advice concerning your requirement to carry workers' compensation coverage. Please consult with your legal counsel.

14) I see where there are approximately 275 decisions per month - approximately how many hearings per month?

A: Please refer to answer in question no. 8

WORKERS' COMPENSATION OFFICE OF JUDGES

[redacted] Claimant

and

[redacted] Employer

JCN No. [redacted]

Transcript of proceedings held in the Workers' Compensation Office of Judges Hearing Office, One Players Club Drive, Kanawha County, Charleston, WV, on the 19th day of June, 2013, for the purpose of adducing the testimony of Members of the OCCUPATIONAL PNEUMOCONIOSIS MEDICAL BOARD.

BEFORE: [redacted], Administrative Law Judge

APPEARANCES: [redacted] in person
(Not represented by counsel)

[redacted], Atty at Law
[redacted]
representing the Employer

cc: CLAIMANT
[redacted]

[redacted]

INDEX

[redacted]

JUDGE [redacted]: This is the claim of [redacted], decedent, and [redacted], Jurisdiction Case Number [redacted]. In this case, the Claimants are [redacted], son-in-law and daughter of the decedent who are requesting funeral benefits pursuant to West Virginia Code §23-4-4. They are protesting the Order of [redacted] which denied these benefits. Present for the Employer is counsel, [redacted].

Let's see, [redacted], at this time I just need to advise you of your rights, that I'm going to allow you to represent yourself today since I guess you are asking individually for funeral benefits. If you would want a lawyer, even at this late stage, I will give you a one-time postponement to obtain one. If we proceed today, it will result in a final decision by the Occupational Pneumoconiosis Board.

The transcript of today's hearing, as well as the claim file, will be sent to the Administrative Law Judge to whom this is assigned; and a decision would be made within 60 days of the Order submitting the claim, which should be issued about two weeks from today, when the transcript is returned.

The Office of Judges is completely neutral in this matter. We don't represent either the insurer or, of course, the Claimant; and I can't advise you on what evidence, you know, would be useful or anything like that. Having heard all this, do you wish to proceed with the hearing today?

[redacted]: Yes, sir.

JUDGE [redacted]: Okay. You mean yes? Okay, we'll just go off the record.

(WHEREUPON, a short break was had in the proceeding.)

The Board made an extensive viewing of the x-ray evidence; so perhaps we should start with Dr. [redacted] testifying. [redacted], let me explain how things work here. Each of the Board members testify individually. The man closest to you is Dr. [redacted], the radiologist. The man in the center is Dr. [redacted], the Chairman of the Board; and the man on the end is Dr. [redacted]. What happens is that the protesting party, which is you in this case, goes first with the examination.

[redacted]

After you're through, then Ms. [redacted] will be allowed to ask the Doctor questions. Then we'll move on to the next doctor, one by one. I'm just going to ask a few introductory questions of Dr. [redacted] just to get him started, and then I'll allow you ask any question you want.

(Board Sworn)

THEREUPON,

DR. [redacted], Chairman

and

DR. [redacted], Member

and

DR. [redacted], Member

being duly sworn, testified as follows:

CROSS-EXAMINATION OF DR. [redacted]

BY THE JUDGE:

Q So, Dr. [redacted], you've reviewed several films, both on the view box and on the CD on computer. Could you give us your impression of those films?

A Yes. The films that we have now on file are analog films from previous OP Board visits and show a minimal degree of nodular fibrosis consistent with OP. The CT scans from WVU from January, February, March of 2011, show multiple peripheral nodules, some of which are calcified in the right upper lobe which should be granulomas.

There are non-calcified nodules in the mid and lower lung zones, predominantly in the lung bases which are very nonspecific. And certainly you can see nodules in complicated pneumoconiosis, or even these could be small opacities of pneumoconiosis, but they are, ultimately, atypical for that. At the same time, I would not say that I could exclude coal workers' pneumoconiosis as the cause of that.

The predominant disease on the CT's from 2011 is emphysema, with extensive lung destruction which makes it difficult to visualize a lot of the…what we call the interstitium, the normal parenchyma, the normal lung elements between the areas of destruction are not well demonstrated because there's just so much lung that's destroyed.

So again to summary the x-rays from the 1980's show nodular fibrosis consistent with simple OP. The CT's do not necessarily confirm the background of small opacities but have these larger opacities that are very nonspecific in the lung bases; and I don't believe I can exclude an OP based on the CT's.

JUDGE [redacted]: Okay. [redacted], do you have questions of Dr. [redacted]? He stated he does find evidence of black lung and cannot exclude that in the later CT's.

CROSS-EXAMINATION OF DR. [redacted]

BY [redacted]:

Q Okay, all right. And as you looked at the films versus this disc image in January to February of '11, he was very, very ill in the hospital at WVU, did you see the changes in those films?

A There are minimal changes…

Q So nodules to no opacities on the 3-24-11 disc, large size opacities…

A There is one area…

Q In the left upper lobe?

A Yes. There is one left upper lobe opacity that does not look like either a granuloma or an opacity related to occupational pneumoconiosis. It is likely an inflammatory infiltrate. It's an area of lung that's probably infected, could be atelectic (phonetic), could just be collapsed down. It's not a nodule that looks like pneumoconiosis. It doesn't look like a tumor. That opacity to me is not contributory either to confirming an OP diagnosis or excluding it.

Q And did you also see the opacity in the left upper lobe measuring 2.4 by 1.4 centimeters approximately?

A Yes.

Q And the other opacity measuring two by 1.8 centimeters in the left upper lobe also?

A Okay. I saw multiple opacities. And again I believe I've summarized those in my impressions of them. Individual opacities I can't say anything more specific about. I mean, you know, we could go through…step through each image and look at each one. And the small round opacities, small round nodules, taken in total to me are indeterminate. You can't tell what

they are.
Q And that is your opinion, right?
A That is correct.
Q Your impression?
A All of this is in my opinion.
Q Right. The nodules, is it not correct with coal workers' pneumoconiosis that as dust macules form those progress into nodules, and then those nodules in the complicated form of coal workers' pneumoconiosis go into opacities?
A Well, we describe...you're trying to split the definitions of...or define nodule opacity macule, and those are not really distinct terms. The macule is something that you see on pathology slides. Radiologists usually don't refer to macules. We don't see macules. That's a pathologist.
Q Isn't how the coal workers' pneumoconiosis...
A That is the pathologistology (phonetic), that's correct.
[redacted]: Yeah, that's how all it works.
BY [redacted]:
Q And it works...
A What I'm saying is, is you're asking me to say that a macule goes to a nodule and goes to an opacity. And that's not the way we use that terminology. A macule is for pathology. That's what the...when the pathologist cuts a tissue, he'll describe macules. We see macules as a nodule, a generic term for any area of lung that is not normally aerated can be an opacity. An opacity is a very generic term. For the purposes of OP, we talk about small round opacities which are typical of coal workers' disease. There are opacities that are typical for pneumonia or typical for a tumor. Those are all opacities to us.
Q Right.
A So what I'm seeing nodules, which generically could be called opacities. The larger opacity in the upper lobe on one of the final scans looks to me like again an inflammatory infiltrate or volume loss for some other reason. So that's not the progressive...that's not complicated pneumoconiosis. That's not a mass of...and again that's not the typical pathophysiology (phonetic) where on January you don't have the complicated large opacity or, you know, progressive massive fibrosis; then

[redacted]

in March you do. That is a much too rapid a progression of a large opacity for that to be complicated pneumoconiosis.

Q The...on the 3-24 radiology report from the WVU radiologists, I know you all don't, you know, look at that. But on the specific report indicating those opacities, the radiologist put, "These areas likely relate to development of progressive fibrosis."

A Okay. I would respectively disagree.

Q "There are emphysematous changes of the lungs bilaterally." The indication for it was the shortness of breath and the pneumoconiosis. Yeah, his lungs were filled with multiple nodules. And I saw this man deteriorate. When they would take us in to see the...to view the MRI films, to view the chest x-rays, they said, "I don't know how this man is breathing the way he does because this disease has just literally burnt his lung tissue up."

You referred to the lung tissue was so poor. I mean you can see that. He had no known history, no underlying history of any metastatic disease. He had the CT of the abdomen, the pelvis. There was no lymph adenopathy. There was no change in size or anything. You know, there was no other organ involvement. It was due to that lung disease.

DR. [redacted]: I don't think anyone has said that we didn't...Dr. [redacted] I don't think has said that he didn't make a diagnosis of OP.

[redacted]: Right, right.

DR. [redacted]: What we're just saying, there are other things on the films. And so we'll relate that later, if that's okay, regarding his death. Right now we're just describing the radiologic findings that he is describing on the films.

BY [redacted]:

Q And in his opinion, he does not contribute the opacities as being indicative of progression of the coal workers' pneumoconiosis, to indicate progressive massive fibrosis. But in this radiology report, this radiologist did contribute that known to Dad's history. And, you know, he'd been there long term in the hospital the first three months of January and February and March of '11; and they saw these changes on the CT's within that length of time.

And in that length of time, physically seeing him, the

condition, how his respiratory function deteriorated. You know, you have to…you have to take the whole picture of everything.

A That's why we've reviewed as much as we have.

Q You know the size or those, size of those nodules too were increasing, that he did have some lung…on the exam there's 1.4 centimeters. Is that also not an indication of progression of fibrosis?

BY DR. [redacted]:

A A nodule of greater than one centimeter is a large opacity by ILO…by the…

Q Right.

A Organization that classifies pneumoconiosis. That is correct. So if indeed, I did not measure these nodules. I believe they're measurements of 1.2. If there's one bigger than that, I cannot, again…I think you're misinterpreting what I'm saying to some extent, because I did not say that I could tell you what those nodules were at the lung bases, and I said I could not exclude that they could be occupational pneumoconiosis.

I don't believe that the large opacity in that left upper lobe, which to me has developed in that three months, potentially less than three-month period of time, I have never seen a large opacity develop that quickly in progressive massive fibrosis. I have not seen that. I do not believe that…in my opinion, that is not a large opacity of pneumoconiosis.

The ones in the lung bases I could not…again, have not excluded that those are OP. Therefore, if there's one greater than one…if there's a 1.2 centimeter, that could be PMF(phonetic)…that could be complicated pneumoconiosis.

Q I think there is.

A It's very difficult for us to measure on here. I need to take a minute and try to measure one, and I'm happy to do that. Again, I'm not challenging their measurements from the original scale.

JUDGE [redacted]: Okay. Ms. [redacted], do you have questions of Dr. [redacted]?

DR. [redacted]: I was going to measure it here.

JUDGE [redacted]: I'm sorry.

DR. [redacted]: That would be a pretty good size, about two centimeters?

[redacted]

DR. [redacted]: Yeah, just over one, which I think is what...1.4 centimeters in the right lung base on 3-24-11, image 87. So I would agree that if...that would be a large opacity by ILO definitions.

BY [redacted]:

Q And that two in the left upper lobes?

A Do we want to measure the...

JUDGE [redacted]: If you can.

DR. [redacted]: Were they present on the other...the earlier CAT scan?

DR. [redacted]: Well, if by left upper lobe we're referring to the non-nodular opacities, there are potentially two areas...well, there may actually be one confluent (phonetic), that are not nodular in the left upper lobe, but that's what's we're asking to be measured. Judge, I'm really not certain what I'm supposed to be doing.

[redacted]: But the radiology report refers to upper lung opacity in the left upper lobe, anterior; correct?

DR. [redacted]: There's no argument that those are there.

DR. [redacted]: Right. They are there, and the measurements...those areas of opacity are larger. They're at least a couple of centimeters, if you took it in...if there's really one instead of two, it would be three or four centimeters in total dimension. And I'm not sure that they're actually distinct. Now were they on the first scan from January?

DR. [redacted]: There's no argument that those opacities exist. The argument would be, or the discussion would be, the etiology of those opacities. But opacity just meaning an area.

JUDGE [redacted]: I think your question perhaps might be better directed towards Dr. [redacted] and Dr. [redacted], which we'll take immediately after Dr. [redacted].

DR. [redacted]: And the left upper lobe opacity is new. The non-nodular configuration was not on the 1-30-2011, scan. The right lung base nodule was there. I will measure it and see if it changed any over that time period. It measures 1.2 centimeters which is essentially unchanged.

It's very difficult to measure within a millimeter on a

CT. So the small nodules do not look significantly different. That larger area of opacification (phonetic) is new on the 1-30…I'm sorry, on the 3-24-11, scan.

DR. [redacted]: Does that cover everything as far as those x-ray questions?

[redacted]: I guess my point, I guess, the large opacities like you said, they could not…you cannot exclude those from being occupational pneumoconiosis on the CT's, right? I mean his opinion is that the large opacities greater than the one centimeter and the history of extensive coal mine dust exposure and his history…

DR. [redacted]: We'll get to those questions after Ms. [redacted] finishes.

[redacted]: Can I say something? Well, will we have a chance for a wrap up here?

DR. [redacted]: Oh, yes, yes.

[redacted]: Okay.

DR. [redacted]: We'll go…

[redacted]: I think her point, her point is that she was wanting…she thought she was…

DR. [redacted]: You don't have to get everything in right now.

[redacted]: All right.

DR. [redacted]: No, because they're many more questions.

[redacted]: Thank you. This is our first go around here.

DR. [redacted]: No problem.

JUDGE [redacted]: Okay, Ms. [redacted].

MS. [redacted]: Thank you.

CROSS-EXAMINATION OF DR. [redacted]

BY MS. [redacted]:

Q Dr. [redacted], can you estimate for the court how many x-rays versus CT scans you reviewed?

A A lot.

Q I mean just a rough idea.

A Probably 12 or 14 chest x-rays, between the discs between Braxton, WVU and the OP Board. And then there were the three CT scans from WVU.

[redacted]

Q Do you find it helpful to review diagnostic images…I'm sorry, these back up as early as…I think the first Board's was in the 1980, 1983?

A '83, correct.

Q So you reviewed imaging over almost 20 years?

A Well, they're almost 30…yeah, the 2011…'83 to 2011.

Q Do you find that the ability to review a series of diagnostic imaging in different media at one time is helpful?

A It's always helpful to review numerous scans or films over time, yes. Different formats unfortunately sometimes makes it more difficult, as I'm sitting in front of this and my films are all the way over there, yes.

Q But you…how do x-rays differ from CT scans?

A X-rays…typically CT scans are more sensitive for detection of disease, including the entities we're interested in here, like coal workers' or other occupational pneumoconiosis as well as emphysema.

Q And do you find it helpful that you're able to do all of this at one time rather than years apart? Looking at just one film today and a CT scan five years from now?

A Yes.

Q I take it then that you do not disagree with the findings…you have no evidence to dispute the findings that what was seen in the 1980's was due to occupational pneumoconiosis?

A That is correct.

Q And I take it you don't dispute the presence of the changes in the upper lung zones; you just don't believe those are due to coal dust exposure? It's due to an infectious process?

A The left upper lobe opacity that evolved between 1-30-2011 and 3-24-11, I would not attribute to complicated OP.

Q And you see a change in the lower lobe, and you've testified that that was an atypical presentation; is that correct?

A It is atypical to have the lower lobe disease without other…without upper lobe and without the background of smaller opacities.

Q And are there a number of possible differential diagnoses for the changes that you see in the lower lung zones?

A Yes.

[redacted]

Q And can you state with any reasonable degree of medical certainty that it's due to…those changes are due to coal workers' pneumoconiosis?
A Again, I would use the phraseology as I did, that I cannot exclude coal workers' pneumoconiosis as the diagnosis.
Q But you're not making an affirmative diagnosis of that condition?
A I am not making that, correct. Well, let me back up. On the CT scans, I am not making that diagnosis because I think the nodules are indeterminate. On the x-rays, the original x-rays, there's a background of a mild nodular fibrosis consistent with OP.
Q Could those change…could the change that you see in the lower lobe have developed irrespective of the nodular changes you see in the '80's?
A Yes.
MS. [redacted]: I don't think I have anything else, Dr. [redacted].
JUDGE [redacted]: Okay.

CROSS-EXAMINATION OF DR. [redacted]

BY THE ALJ:
Q Dr. [redacted], you've heard Dr. [redacted]' testimony regarding the radiology. Can you tell us whether or not you agree with that and also give us your impression of the remainder of the evidence?
A I do agree with his impression regarding the x-rays over the period of time. I agree that the statements he made regarding the x-rays that are on the board and the x-rays from Board exams, as well as the CT scans, that we have reviewed.
DR. [redacted]: Can I ask you one question? Your father worked in coal mining for 30 years. What was his principal job titles? What did he do principally?
[redacted]: Eventually…you can probably elaborate more on this than I can, because he…
[redacted]: Well, initially, he went to work in the coal mines as a hand loader, and he drilled a job at the face with nitrous oxide. And I'm talking about the term here of…the doctors explained to us as a type of fertilizer that you drill the chock (phonetic) with. I know they date back in the…probably the 30's, sometime in the late 40's, I don't know exactly when, the 40's or 50's, I don't know when he went to work.

[redacted]

DR. [redacted]: 40's, 50's, probably.

[redacted]: Yeah, 40's and 50's.

DR. [redacted]: Traditional mining with a cutting machine.

[redacted]: Yes. Yes, but he explained it as the nitrous oxide that they used to shoot with then put off some type of a gas. And then when it met with your lungs, it brought forth nitrous oxide...or nitric acid, and it actually burnt the lungs, is the way the doctor explained to us when he was in the hospital, that he had a great degree.

But then, you know, as time progressed on he worked on...I mean he was a mechanic. He worked at the faces of cutting machines, drilling machine or roof bolting, numerous...numerous types.

DR. [redacted]: That's what I would imagine.

[redacted]: Exposure....

DR. [redacted]: That he shot coal...that he shot coal a long time ago.

[redacted]: Yes, that's what he would have did, sir.

DR. [redacted]: And he only smoked in the surface...

[redacted]: Exposure without protection. You know, they had no protection back then. They were told they didn't need protection back then.

DR. [redacted]: So when I review the case, this gentleman at [redacted] years of age lived a fairly long life, but did die of a respiratory disease. His main cause of death was respiratory in nature. He ended up most likely having a (inaudible), whether that was active infection or just a resident that was present due to long term steroid use I'm not sure. He also was said to have severe COPD, and he had nodules in his lungs.

He had a history of congestive failure as well, although his left ventricular ejection fraction was around 50 to 55% and had previously had a pacemaker placed in his chest to control his cardiac rhythm. His pulmonary function studies done at WVU on February 1, 2011, showed total impairment, with a ratio of 39 and 37 respectively before and after bronchodilation. He was oxygen dependent. He did have severe lung disease.

He did die a respiratory death. When I reviewed the case and when we discussed it today, or this morning with the x-rays and

the CT scans, we did want to find out, because there are a lot of remarks of progressive massive fibrosis and it says specifically on 3-8-11, I guess it is, or 2-25-11, sorry, numerous nodules, overall stability in size and number, findings likely to relate to patient's history of coal workers' pneumoconiosis.

Additional considerations would include metastatic disease. Clinical correlation is requested. So radiographically those things were entertained, there could be metastatic disease. It could be pneumoconiosis or other disease that would be just granulomatous disease or infectious process or just scar tissue or inflammation. Many, many different etiologies for opacities. I do not know what those opacities were.

I cannot exclude it as being OP. I don't think they were, but I can't exclude it. It would be very unusual for someone to develop progressive massive fibrosis 30 to 40 years after their exposure has ended without some changes over the years. To suddenly just develop it within the last 3 years of life would be extremely unusual and clinically unlikely.

However, he did have a background of simple coal workers' pneumoconiosis that we can see on his x-rays from before. The process of emphysema in his upper lobes, I'm not sure what it is. I don't know the etiology. It could have been his exposure in dust and blasting and conventional mining techniques that they used in the past.

And it is a little confusing because we see usually emphysema of this type or this nature, we'll see it a lot of times in people who smoke or have that type of habit. He did not have a sufficient amount of exposure to smoke, a smoking history that would have caused it. So again a lot of things are atypical that this would all be pneumoconiosis. I think he has multiple processes going on.

I do think he had a background of pneumoconiosis. I think he died a respiratory death. I cannot explain the nodules. I don't know what they are. Most likely to me they're inflammation, but it would be unlikely to be progressive massive fibrosis. In any event, he did have simple coal workers' pneumoconiosis that we can see from before.

[redacted]

The emphysematous process may be blocking us of being able to see that on the present x-rays, because he developed significant emphysema that you can see on the CT scan. Again, I don't know the etiology. It could have been his (inaudible) or it could have been from that previous exposure back in the 40's and 50's.

In any event, in my opinion after reviewing all of the medical records that we have I would state that his occupational exposure and his occupational pneumoconiosis was a material contributing factor in his death.

MS. [redacted]: Say it was?

DR. [redacted]: Yes, in my opinion. Do you have any questions for me?

[redacted]: As part of the death certificate, it all relates back to the cause of death as severe pneumoconiosis/COPD.

JUDGE [redacted]: Okay, Ms. [redacted].

CROSS-EXAMINATION OF DR. [redacted]

BY MS. [redacted]:

Q Dr. [redacted], the Board had reviewed all of those medical records at the time they you prepared your findings initially?

A Yes.

Q You were aware that he had occupational pneumoconiosis radiographically?

A We were aware that we had made a diagnosis. We did not have the x-rays.

Q And you've indicated that the radiographic presentation is atypical for a coal dust…for a coal workers' pneumoconiosis?

A No, I indicated that the CT scan nodules were atypical for coal workers' pneumoconiosis.

Q That's what we're looking at today. And you…

A We're looking at radiographs that span quite a period of history.

Q And has his radiographs between 1983 until the last time the Board saw him I believe in 1999, do they show any progression of the simple?

A No.

Q So his radiographic picture remains stable from 1983 until 1999, on the x-rays?

A With regards to the simple CWP…

Q Yes.

[redacted]

A Yes. But there was development. We do not have CT scans in '99. That would be a nice thing to have.
Q We only had x-rays, okay. And he had last worked in 1982?
A Yes.
Q So his radiographic picture was stable over those years?
A Yes.
Q And from his pulmonary function picture, you found no increase over those three times? I think you gave him a no increase over the subsequent evaluations?
A From...you mean the '80's?
Q Yes.
A The last one being '88?
Q Yes.
A Or '90...I'm sorry, the last one being '99, I think it was. Or was it '88? I'm sorry.
Q I think...
A I thought...in '99 he was given 30%.
Q I only have '83 to '88.
A 5-7-99 in claim number [redacted], 30%, which is a 20% increase, ALJ Order 8-22-01. 8-13-88 was a 20%, no increase. And 11-83 was a 20%.
Q So the additional award was granted by an ALJ?
A I'm sorry.
Q The additional award was granted by an ALJ?
A It actually just says 5-27-99, claim number [redacted], 30%, which represents a 20% increase. And then it has a dash, ALJ Order of 8-22-01, silicosis.
JUDGE [redacted]: The 8-22-01 would be the Second Injury Life Award, a permanent total disability award was granted to him.
MS. [redacted]: Okay.
Q So the Board...when the Board assessed and rendered a...pretty much his picture had remained relatively stable from the time that he ceased mining until at least 1988, and we're unclear what happened in '99 when he died from the total?
A Correct.
Q The changes that you saw radiographically, could they be due to...like you've indicated, could be due to a number of conditions?

[redacted]

A Yes.
Q The clinical course that you saw between January of 2011 and March of 2011, is that typical clinical presentation you see in someone with simple coal workers' pneumoconiosis?
A No. I do not know the exact etiology of the nodules or the emphysema found in this gentleman's lungs. I do know that he had a stable pneumoconiosis that accounted for approximately 20% earlier. We found 20% during his living claim. He died a respiratory death. I'm not saying that pneumoconiosis was the main cause of his death. I'm just saying it was a material contributing factor in his death.
Q And based on what...I mean 20% impairment, is that a significant amount of impairment?
A It can be, yes.
Q And between no further dust exposure in 1982 until he died in 2011, with his condition remaining relatively stable, why do you believe that OP was a material contributing factor?
A If he'd had that 20% of lung function, he may have lived another year or two. I don't know and to me that's significant.
Q Do you have any...what is the clinical basis for believing that it did progress due to OP as opposed to any of these other conditions?
A I didn't say he progressed due to OP. I said he had a 20% impairment during his living claim. I do not know what the other conditions were. I cannot tell you what the diagnosis was. Entertainment of progressive massive fibrosis, in my opinion, is not clinically sound because you do not see progressive massive fibrosis as we've discussed develop in that short a period of time after that many years of loss with a lack of exposure.

So what his current process was at the time of his death I'm not sure. He did have an aspergillus cultured that grew positive. He had infection and had been treated with steroids. It could have been some other infection that we don't have. We don't have the pathology to state what that was. We don't know. I don't know what his emphysema was in his upper lobes.

It could have been from a lot of different causes, but the most common cause we see as cigarette smoking isn't there. His

emphysema could have been contributed by his previous dust exposure. I can't state that with reasonable medical certainty that it is, but it is a possibility. In the final analysis, this gentleman died a respiratory death.

He had three main processes that I would point out in his lungs. He had some nodules in the lower lobes that I'm not sure were pneumoconiosis, but probably were inflammatory or some other disease. He had a severe amount of emphysema in his upper lobes that was present, and I'm not sure of the etiology of that. And he had simple coal workers' pneumoconiosis.

So it's difficult for me to say that his simple pneumoconiosis wasn't a material contributing factor when you review the CT scans and the x-rays in conjunction with his clinical history.

MS. [redacted]: I have no further questions of Dr. [redacted].

CROSS-EXAMINATION OF DR. [redacted]

BY THE ALJ:

Q Dr. [redacted], you've heard the testimony of Dr. [redacted] and Dr. [redacted]. Do you agree with it and also give us your opinion of the evidence of record?

A I think it's been reviewed quite extensively. I think the determining factor is that we don't have a great etiology of the emphysema and whether his coal dust, other exposures during his working process, caused the emphysema. I think it's the portion that gives us cause to give the Claimant the benefit of the doubt. I would agree with their opinions otherwise.

JUDGE [redacted]: Okay. [redacted], do you have any questions of Dr. [redacted]?

[redacted]: Yeah.

CROSS-EXAMINATION OF DR. [redacted]

BY [redacted]:

Q With his clinical history, with his course of the long term exposure to the coal dust, just because, do you agree, that just because, you know, he retired in '82, that dust exposure may have subsided at that time; but that disease progression does not subside, it continues?

A It can continue. It doesn't always continue.

Q And the emphysematous changes, taking into consideration his clinical history,

[redacted]

his long term history again of the dust exposure, you're affirming that he did have a simple coal workers' pneumoconiosis. Can you say that those emphysematous changes within his lungs are not related directly to progression of the disease?

A That is the...that in lies the question, and we're saying we cannot state that. That if he had smoked 20 years, we wouldn't even be talking about this.

Q Right, he hadn't.

A So obviously the etiology of that, those emphysematous changes, is a big question mark. And because we don't have another etiology, we're giving him the benefit of the doubt.

Q Because Dad, his smoking history was virtually nil (phonetic)?

A I agree.

Q He was honest and, you know, it was back many, many...it was virtually nothing.

JUDGE [redacted]: Okay. Is there anything further? Okay, Ms. [redacted].

CROSS-EXAMINATION OF DR. [redacted]

BY MS. [redacted]:

Q Dr. [redacted], in the interest of time if I asked you the same questions as I did Dr. [redacted] and Dr. [redacted], would your testimony be substantially the same?

A Yes, ma'am.

Q In light of the date of last exposure and the atypical presentation clinically and radiographically and the fact that you are not able to state within a reasonable degree of medical certainty as to the cause of those radiographic changes and the emphysema, do you still remain of the opinion that OP was a material contributing factor in this gentleman's death?

A Yes, ma'am.

Q And are smoking and coal dust exposure the only known causes of emphysema?

A No, ma'am.

MS. [redacted]: I have no additional questions.

JUDGE [redacted]: Okay. In that case, the hearing is concluded and an Order will be issued submitting the claim upon receipt of the transcript. Thank you all for coming in.

[redacted]

STATE OF WEST VIRGINIA,
WORKERS' COMPENSATION OFFICE OF JUDGES, to wit:

I hereby certify that the foregoing proceeding was transcribed from a digital recording.

This, the 25th day of June, 2013.

[redacted]

[redacted]

ADDENDUM ACKNOWLEDGEMENT FORM
SOLICITATION NO.: INS14015

Instructions: Please acknowledge receipt of all addenda issued with this solicitation by completing this addendum acknowledgment form. Check the box next to each addendum received and sign below. Failure to acknowledge addenda may result in bid disqualification.

Acknowledgment: I hereby acknowledge receipt of the following addenda and have made the necessary revisions to my proposal, plans and/or specification, etc.

Addendum Numbers Received:
(Check the box next to each addendum received)

[ ] Addendum No. 1	[ ] Addendum No. 6
[ ] Addendum No. 2	[ ] Addendum No. 7
[ ] Addendum No. 3	[ ] Addendum No. 8
[ ] Addendum No. 4	[ ] Addendum No. 9
[ ] Addendum No. 5	[ ] Addendum No. 10

I understand that failure to confirm the receipt of addenda may be cause for rejection of this bid. I further understand that any verbal representation made or assumed to be made during any oral discussion held between Vendor's representatives and any state personnel is not binding. Only the information issued in writing and added to the specifications by an official addendum is binding.

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Revised 6/8/2012