AMERICAN COLLEGE OF
OCCUPATIONAL AND
ENVIRONMENTAL MEDICINE

March 14, 2025

Submitted via: regulations.gov

John J. Howard, MD
Director
National Institute for Occupational Safety and Health (NIOSH)
Robert A. Taft Laboratories, MS-C34
1090 Tusculum Avenue
Cincinnati, OH 45226

RE: ACOEM Response – Expansion of NIOSH B Reader Certification Eligibility; Request for Information; Docket No. CDC-2024-0103; NIOSH-355

Dear Dr. Howard,

On behalf of the American College of Occupational and Environmental Medicine (ACOEM), I am writing to respond to the questions posed in NIOSH's December 17, 2024, Request for Information: "Expansion of NIOSH B Reader Certification Eligibility" (CDC-2024-0103; NIOSH-355). Generally, we do not support any changes to the NIOSH B Reader Program that would permit nurse practitioners and physician assistants to be eligible for the NIOSH B Reader examination and to become certified B Readers upon successfully passing the examination.

Founded in 1916, ACOEM is the nation's largest medical society dedicated to promoting worker health through preventive medicine, clinical care, research, and education. The College represents occupational and environmental medicine (OEM) physicians and other healthcare professionals devoted to preventing and managing occupational and environmental injuries, illnesses, and exposures.

In response to the specific questions in the Notice and Request for Information –

1. What is the current demand for B Readers, and would expanding the program to include nurse practitioners and physician assistants help meet this demand?

- There is a genuine need for well-qualified B readers. While changing the qualification standard may address the demand, it is unlikely to do so without potential tradeoffs regarding the clinical quality and accuracy of the service delivered. Given this, even greater capabilities are needed as we search for very early diseases, such as 0/1.

- Experience shows that pass rates for the current examination are highest among radiologists, while pulmonologists exhibit lower rates. Other physicians, such as internists and occupational medicine specialists, achieve very low pass rates. Thus, expanding the program to include additional non-physician clinician groups is not anticipated to increase the size of the pool of B-readers.

- Looking ahead, the screening of large numbers of negative radiographs will soon be handled by AI interpretation systems. This will significantly reduce the volume of negative images and enable true experts to apply their skills when most needed.

2. Are there specific geographic areas or populations that might benefit from having nurse practitioners and physician assistants certified as B Readers?

Yes, the need is likely to differ by geographic area. Locations with extensive mining operations may need more.

However, geographic constraints are no longer a concern. Images are now routinely transmitted electronically, allowing a B reader in a different area to perform the interpretation. Some state licensing requirements have also become much easier to manage for multiple locations. NIOSH may also implement an exemption for this specific activity. Currently, 37 states participate in the licensing compact, facilitating readings across numerous states.

3. Are there any potential risks associated with expanding the B Reader certification to nurse practitioners and physician assistants and, if so, how can those risks be mitigated?

There are specific risks, the mitigation of which would be highly challenging. These include:

- The current ILO form requires identifying other relevant findings defined by the codes at the bottom (e.g., pneumoconiosis and cancer). Even if capable of scoring profusion, it is unlikely that nurse practitioners and physician assistants would accurately and effectively perform this task independently.

- Costs would likely increase. In the United States, most positive radiographs lead to a CT scan. Less qualified readers may be more likely to refer for a CT scan for this purpose.

- Costs would also increase because many B readers can perform the clinical interpretation of the radiograph. A simple course in reading profusion/plaque would not eliminate the need for a clinical reading by a bona fide radiologist. Conversely, many current readers, including non-radiologists, have sufficient expertise to serve both functions.

- Use of non-physician B readers for classification is likely to significantly reduce the ability of NP/PA personnel to actually perform the surveillance examination since they would not be as capable as a physician in interpreting the radiograph clinically.

- Indirect costs due to loss of work time for repeat examinations would be significant.

- A potential risk, although its significance is uncertain, is that such readers could be associated with nonclinical entities such as worker advocacy groups, defense lawyers, plaintiff lawyers, and so on. The likelihood of a systematic bias, even unconscious, would be much greater than that of a physician with many other activities.

4. ILO classification of chest radiographs is not the same as clinical interpretation. Are there states where scope of practice and standards of care allow nurse practitioners and physician assistants to perform clinical interpretation of chest radiographs without physician oversight? In states where physician oversight is required for clinical interpretation, is it also required for ILO classification? What would be the best approach to ensuring that appropriate clinical interpretations are obtained for all contemporary chest radiographs undergoing ILO classification by nurse practitioners and physician assistants?

25 Northwest Point Boulevard, Suite 700, Elk Grove Village, IL 60007-4930
Phone:(847) 818-1800 – Fax: (847) 818-9266 – Web: www.acoem.org

This needs to be addressed for each date and entity. Significant heterogeneity is likely, making systematic administrative rules challenging. This also assumes that a clinical reading, along with the ILO interpretation, is necessary. Please refer to previous comments.

Aside from licensing, liability for the nonphysician reader and/or their supervisors would be considerable. Additional liability would be incurred by employers who opt to have a less trained individual conduct the assessment.

5. How do you anticipate different interested parties (e.g., physicians, nurse practitioners and physician assistants, industry representatives, workers, health profession boards) would view the potential expansion of the B Reader program to include non-physicians?

Based on past experience, physicians would oppose this, and NP/PA groups would support it. Health Medical licensing boards are increasingly pressed to expand the scope of practice for non-physicians.

6. What challenges might arise during the implementation of this expansion, and how could they be effectively managed?

While ACOEM does not support these proposed changes, their operational implementation should be reasonably feasible. The main complexity would lie in managing licensure, oversight, and liability issues, as well as maintaining consistency in readings, since a lack of consistency could make longitudinal assessments for individual workers infeasible. Employers should bear the responsibility of tracking the performance characteristics of their readers.

7. Do you have any other information or comments relevant to whether nurse practitioners and physician assistants should be able to become B Readers and, if so, the best way to implement that expansion?

This is the suboptimal solution for a significant problem. The proper solution would be implementing changes to the current B reader training and certification program to encourage more qualified physicians to become B readers. Appropriate steps include:

- Offer the training multiple times a year and support this through web programs instead of mandating three days of attendance for a course that is only held once annually.

- Facilitate the adjustment of the fee schedule to encourage qualified physician readers to participate in this activity. This may be supported by progressively decreasing Medicare reimbursement for interpreting chest films and by the growing influence of replacing radiologists with AI systems.

- Encourage or require the inclusion of such training in the curriculum of some or all radiology residencies. This may necessitate buy-in from ACGME or financial incentives for selected residency programs.

- Make the five-year recertification requirement simpler to fulfill without needing a mandatory trip to West Virginia. Consider establishing several regional re-examination centers instead.

25 Northwest Point Boulevard, Suite 700, Elk Grove Village, IL 60007-4930
Phone:(847) 818-1800 – Fax: (847) 818-9266 – Web: www.acoem.org

- Consider a similar approach for pulmonary and/or occupational and environmental medicine residency/fellowship programs.

- Establish a continuous quality improvement program for readers engaged in classification, such as an annual self-assessment using standardized images.

- Assess the number of former B readers who did not want to invest the effort to recertify. If this number is significant, consider offering specialized tutorials to refine their skills and encourage them to recertify. These individuals likely have a specific interest in occupational lung disease, yet the prevalence of CT scanning has discouraged routine plain film interpretation.

- Implement an ongoing mandatory quality assessment rather than determining competency only once every five years. To avoid drifting interpretation, require readers to interpret a set of standardized films, perhaps even submitted anonymously with their other cases.

- Sponsor an ongoing assessment of the applicability of second and third-generation AI methods to screen a large number of low a priori radiographs.

- Consider permitting non-US physicians to conduct interpretations within the restricted scope of classification instead of clinical diagnosis.

If you have any questions or need additional information, please contact Dane Farrell (Dane@cascadeassociates.net), ACOEM's Government Affairs Representative. Thank you for considering these comments. We look forward to collaborating with NIOSH to carry out its mission of developing new knowledge in the field of occupational safety and health and to transferring that knowledge into practice.

Sincerely,

Tanisha Taylor, MD, MPH

Tanisha Taylor, MD, MPH, MBA, FACP, CIME, FACOEM
President
American College of Occupational and Environmental Medicine (ACOEM)

25 Northwest Point Boulevard, Suite 700, Elk Grove Village, IL 60007-0030
Phone:(847) 818-1800 – Fax: (847) 818-9266 – Web: www.acoem.org