

Basic Claims Examiner (CE) Training Course

**Chronic Beryllium Disease and
Beryllium Sensitivity**

PARTICIPANT GUIDE

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Session Description

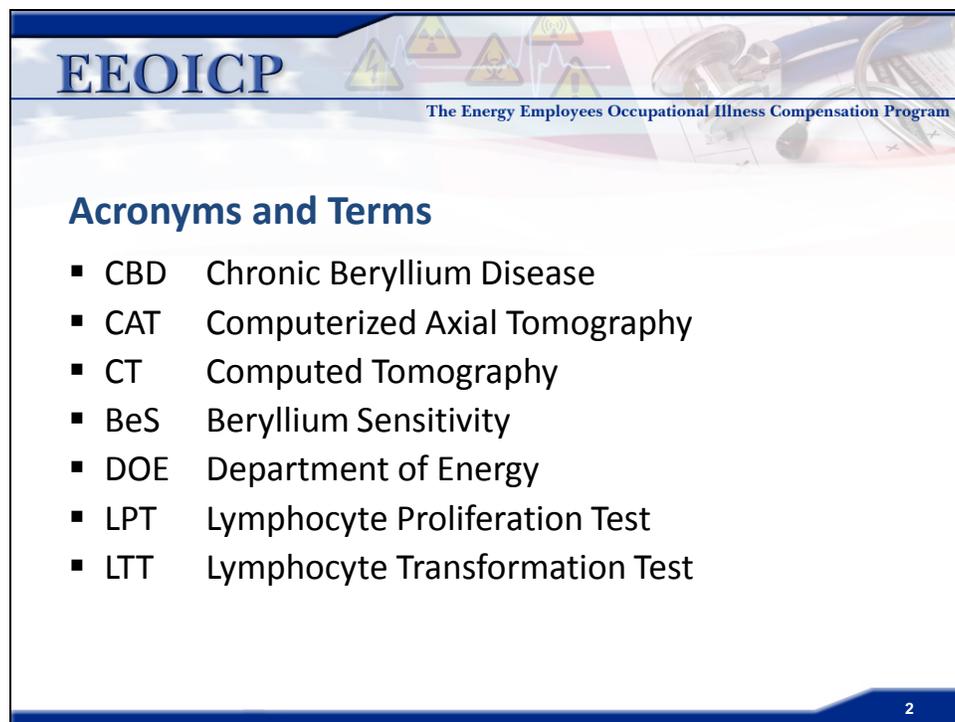
This session focuses on beryllium, specifically chronic beryllium disease (CBD) and beryllium sensitivity (BeS). Definitions, eligibility criteria and medical diagnosis/medical documentation required to support the claim are addressed in this session.

Instructional Objectives

Upon completion of this session, you will be able to:

- Explain the difference between beryllium sensitivity and chronic beryllium disease (CBD)
- Describe the eligibility requirements under Part B and Part E for CBD
- Explain the difference between pre-1993 and post-1993 statutory requirements for CBD
- Explain how to determine which statutory requirement applies to the claim
- Describe the CBD gold standard

Acronyms and Terms



The slide features a blue header with the acronym 'EEOICP' in large white letters. To the right of the acronym are several yellow radiation warning symbols. Below the header, the full name 'The Energy Employees Occupational Illness Compensation Program' is written in a smaller font. The main content area is white with a blue border, containing a list of acronyms and their corresponding terms. A small number '2' is visible in the bottom right corner of the slide.

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Acronyms and Terms

- CBD Chronic Beryllium Disease
- CAT Computerized Axial Tomography
- CT Computed Tomography
- BeS Beryllium Sensitivity
- DOE Department of Energy
- LPT Lymphocyte Proliferation Test
- LTT Lymphocyte Transformation Test

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Beryllium



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Beryllium is...

- A strong, lightweight metal used in manufacturing atomic weapons
- Also used in other industrial applications, ranging from battery contacts to jet engines
- The dangers of working with beryllium were initially unknown
- Later discovered that inhaling beryllium dust, particles or fumes could have serious health consequences

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Beryllium Doesn't Make Everyone Sick

- Most people who are exposed to beryllium will not develop a medical problem
- Some people develop immunological responses to beryllium in their lungs, which is called beryllium sensitivity (BeS)
- Usually BeS does not produce symptoms, but a person sensitized to beryllium is at significant risk of developing chronic beryllium disease (CBD)
- A single exposure to beryllium dust, particles or fumes is enough to sensitize a person to beryllium

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Part B Eligibility Requirements for CBD Benefits



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Part B Eligibility Requirements for CBD Benefits

To establish eligibility for benefits, the evidence of record must establish

- Covered employment and
- A diagnosis of CBD or BeS, that meets the statutory requirements of the EEOICPA

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Covered Employment

Employment at or physical presence at

- A DOE facility or a facility owned, operated, or occupied by a beryllium vendor because of employment by the United States, a beryllium vendor, or a contractor or subcontractor of a beryllium vendor
- During a period when beryllium dust, particles or vapor may have been present at such a facility

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Covered Employment, continued

- If employment was outside of covered time frame, DEEOIC may ask the DOE to provide additional evidence that may support enlarging the covered time period.
- If employment at a non-covered facility, DEEOIC will deny the claim under Part B and Part E because the facility is not a covered facility.

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Was Beryllium Present at the Facility?

The following resources provide information on whether beryllium was present at a facility:

- (1) DOE facility database of covered facilities - <http://www.hss.energy.gov/HealthSafety/FWSP/Advocacy/faclist/findfacility.cfm>
- (2) Site Exposure Matrices (SEM)

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Medical Diagnosis



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Part B Eligibility Requirement - Diagnosis

Written medical documentation showing a diagnosis of BeS or CBD that meets the EEOICPA statutory requirements for the diagnosis of those conditions

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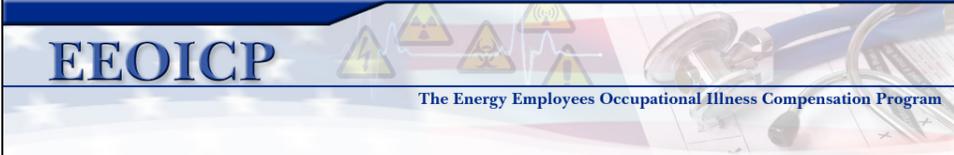
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Requirements for a Beryllium Sensitivity Diagnosis

- Beryllium sensitivity is established with
 - One abnormal beryllium lymphocyte proliferation test (BeLPT) or
 - One abnormal beryllium lymphocyte transformation test (BeLTT).
- Only a physician can designate a BeLPT/BeLTT test result as abnormal.

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Chronic Beryllium Disease (CBD) Medical Requirements



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How Does CBD Develop?

Exposed individuals develop an immune response to beryllium:

1. Inhalation of beryllium dust
2. Cells in the blood and lung proliferate (BeLPT)
3. Inflammatory response is initiated
4. Granulomas develop and eventually fibrosis

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Specific Requirements for a CBD Diagnosis

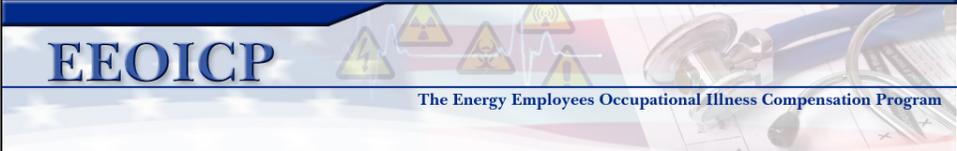
Chronic beryllium disease has two separate criteria for meeting the statutory diagnosis requirements:

- Pre-1993 Criteria – before BeLPT/BeLTT
- Post-1993 Criteria – after BeLPT/BeLTT

Either criteria may be used for all claims.

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Pre-1993 and Post-1993 CBD Criteria



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Pre-1993 CBD Criteria

The medical documentation must include at least three of the following:

- Characteristic chest radiographic (or computed tomography (CT)) abnormalities
- Restrictive or obstructive lung physiology testing or diffusing lung capacity defect
- Lung pathology consistent with chronic beryllium disease
- A clinical course consistent with a chronic respiratory disorder
- Immunologic tests showing beryllium sensitivity (skin patch test or beryllium blood test preferred)

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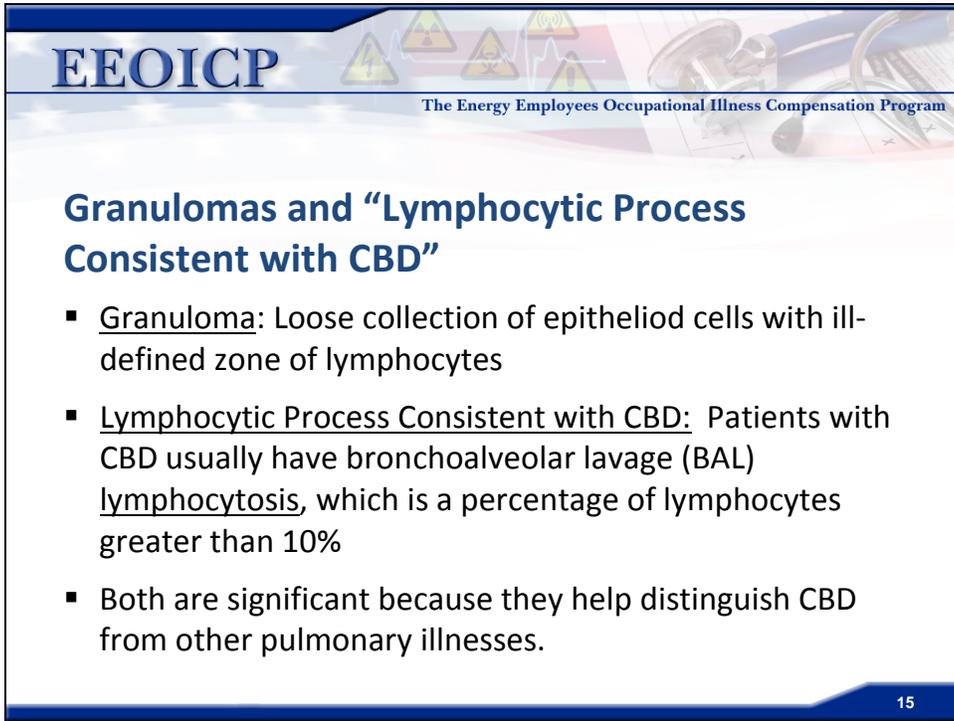
Post-1993 CBD Criteria

The medical documentation must include:

- An abnormal BeLPT/BeLTT and
- One or more of the following:
 - 1) Lung biopsy showing granuloma or a lymphocytic process consistent with CBD
 - 2) A computerized axial tomography (CAT) scan showing changes consistent with CBD
 - 3) Pulmonary function or exercise testing showing pulmonary deficits consistent with CBD

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Granulomas and “Lymphocytic Process Consistent with CBD”



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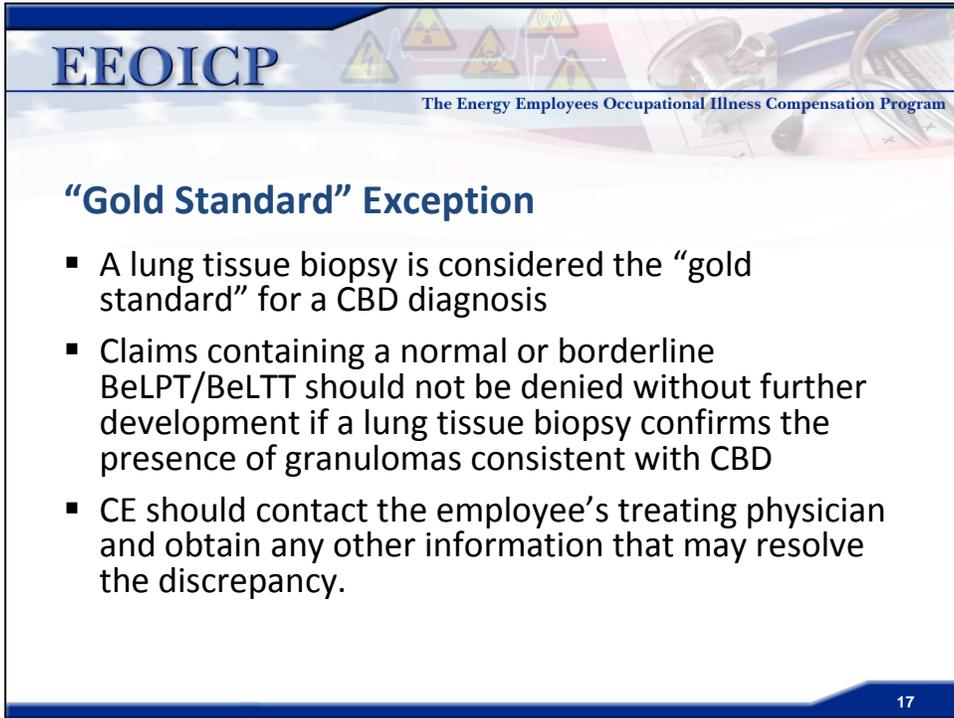
Granulomas and “Lymphocytic Process Consistent with CBD”

- Granuloma: Loose collection of epithelioid cells with ill-defined zone of lymphocytes
- Lymphocytic Process Consistent with CBD: Patients with CBD usually have bronchoalveolar lavage (BAL) lymphocytosis, which is a percentage of lymphocytes greater than 10%
- Both are significant because they help distinguish CBD from other pulmonary illnesses.

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Your Notes

“Gold Standard” Exception



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“Gold Standard” Exception

- A lung tissue biopsy is considered the “gold standard” for a CBD diagnosis
- Claims containing a normal or borderline BeLPT/BeLTT should not be denied without further development if a lung tissue biopsy confirms the presence of granulomas consistent with CBD
- CE should contact the employee’s treating physician and obtain any other information that may resolve the discrepancy.

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Your Notes

Part E Eligibility Requirements for CBD Benefits



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Criteria for Part E

Part E only requires:

- 1) A diagnosis of CBD by a qualified physician;
- 2) Exposure to beryllium during at least one day of covered employment, and;
- 3) Sufficient evidence to establish “it is at least as likely as not” that exposure to beryllium during covered employment was a “significant factor in aggravating, contributing to, or causing the illness.”

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Approving CBD under Part E

- It’s possible to approve a CBD claim under Part E even if CBD cannot be approved under Part B.
- The Part B statutory requirements need not be present.
- However, the CE should exhaust all avenues to obtain the statutory medical evidence needed for a Part B acceptance before denying CBD under Part B and accepting CBD under Part E.

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Beryllium Vendors and Beryllium Vendor Facilities



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Beryllium Vendors and Beryllium Vendor Facilities

- Atomics International
- Brush Wellman, Incorporated, and its predecessor, Brush Beryllium Company
- General Atomics
- General Electric Company
- NGK Metals Corporation and its predecessors, Kawecki-Berylco, Cabot Corporation, BerylCo, and Beryllium Corporation of America

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Beryllium Vendors and Beryllium Vendor Facilities, continued

- Nuclear Materials and Equipment Corporation.
- StartMet Corporation and its predecessor, Nuclear Materials, Inc.
- Wyman Gordon, Inc.
- Any other vendor, processor, or producer of beryllium or related products designated as a beryllium vendor for purposes of the EEOICPA

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Questions



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Case Study 1



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Case Study 1

- Survivor Claim - Review the following evidence to determine what additional evidence is needed to fully adjudicate the CBD claim, if any.

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EE-2

Claim for Survivor Benefits Under the Energy Employees Occupational Illness Compensation Program Act

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs



Note: Provide all information requested below. Do not write in the shaded areas.

Submit Reset Print OMB Number: 1215-0197
Expiration Date: 08/31/2010

Deceased Employee Information (Please Print Clearly)

1. Name (Last, First, Middle Initial)		2. Sex <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	3. Social Security Number
4. Date of Birth Month Day Year		5. Date of Death Month Day Year	
6. Was an autopsy performed on the employee? <input type="checkbox"/> YES - List Medical Facility: _____ <input checked="" type="checkbox"/> NO <input type="checkbox"/> DON'T KNOW			

Survivor Information (Please Print Clearly)

7. Name (Last, First, Middle Initial)		8. Sex <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	9. Social Security Number 000-00-0000
10. Date of Birth Month Day Year		11. Your relationship to the deceased employee <input checked="" type="checkbox"/> spouse <input type="checkbox"/> child <input type="checkbox"/> step child <input type="checkbox"/> parent <input type="checkbox"/> grandparent <input type="checkbox"/> grandchild <input type="checkbox"/> Other: _____	
12. Address (Street, Apt. #, P.O. Box) (City, State, ZIP Code)		13. Telephone Numbers a. Home: () - b. Other: () -	

14. Identify the Diagnosed Condition(s) Being Claimed as Work-Related (check box and list specific diagnosis)

	15. Date of Diagnosis		
	Month	Day	Year
<input type="checkbox"/> Cancer (List Specific Diagnosis Below)			
a. _____			
b. _____			
c. _____			
<input type="checkbox"/> Beryllium Sensitivity			
<input checked="" type="checkbox"/> Chronic Beryllium Disease (CBD)			
<input type="checkbox"/> Chronic Silicosis			
<input checked="" type="checkbox"/> Other Work-Related Condition(s) due to exposure to toxic substances or radiation (List Specific Diagnosis Below)			
a. Chronic Obstructive Pulmonary Disease	01	17	1984
b. _____			
c. _____			

Awards and Other Information

16. Did the employee work at a location designated as a Special Exposure Cohort (SEC)?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
17. Have you or the deceased employee filed a lawsuit seeking either money or medical coverage for the claimed condition(s)?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
18. Have you or the deceased employee filed any workers' compensation claims in connection with the claimed condition(s)?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
19. Have you, the deceased employee, or another person received a settlement or other award in connection with the above claimed condition(s)?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
20. Have you either pled guilty or been convicted of any charges connected with an application for or receipt of federal or state workers' compensation?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
21. Have you or the employee applied for an award under Section 5 of the Radiation Exposure Compensation Act (RECA)? If yes, provide RECA Claim #: _____	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
22. Have you or the employee applied for an award under Section 4 of the Radiation Exposure Compensation Act?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO

Next Page

Form EE-2
April 2005

EE-3

Employment History for a Claim Under the Energy Employees Occupational Illness Compensation Program Act		U.S. Department of Labor Employment Standards Administration Office of Workers' Compensation Programs			
Note: Please provide as much information as possible. Do not write in the shaded areas.			OMB No. 1215-0197 Expiration Date: 08/31/2010		
Employee's Information (Print clearly)		<input type="button" value="Submit"/> <input type="button" value="Reset"/> <input type="button" value="Print"/>			
1. Employee's Name (Last, First, Middle Initial)	2. Former Name (e.g. Maiden/Legal Change)	3. Social Security Number (if known)			
Contact Information for Person Completing this Form (Print clearly)					
4. Name (Last, First, Middle Initial)		5. Claim Type (check one) <input type="checkbox"/> Employee <input checked="" type="checkbox"/> Survivor			
6. Address (Street, Apt. #, P.O. Box)		7. Telephone Number(s)			
(City, State, ZIP Code)		a. Home: () - ()			
		b. Other: () - ()			
Employee's Work History (Provide as much information as known - if necessary attach a separate sheet)					
In chronological order, starting with the most recent period of employment , provide the complete work history of the employee named above. Provide as much identifying information as known concerning the name of the employer and location (city & state) where the employee performed the work. If you require additional space to explain or clarify a point, attach a signed supplemental statement to this form.					
Employer - 1		Start Date: (02) (08) (1955)	End Date: (10) (01) (1986)	Work Schedule (check one) <input checked="" type="checkbox"/> Full-time <input type="checkbox"/> Part-time	
Facility Name (spell out name) Kansas City Plant		Specific Location (building/site/mine/mill)		City/State where worked performed Kansas City, Missouri	
Contractor/sub-contractor or Vendor name(s) Allied Bendix Aerospace / Bendix KC Division		Type of Facility/Employer (check one) <input checked="" type="checkbox"/> Department of Energy Facility <input type="checkbox"/> Atomic Weapons Facility <input type="checkbox"/> Beryllium Vendor <input type="checkbox"/> Unknown <input type="checkbox"/> Uranium Miner/Miller/Transporter			
Position Title or Mine/Mill Activity Storekeeper/Safety Crib		Was a dosimetry badge worn while employed? <input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> Unknown			
Work Identification Number		If known, provide the Dosimetry Badge Number:			
Description of Work Duties (Describe in detail)					
Issued glasses and shoes - collected and sorted laundry-delivered back to the departments. Most of his job duties were "classified". This is all I know					
Describe or list the work conditions/exposures you believe caused or contributed to the claimed work illness(es) at this facility					
Laundry could have been contaminated. To my knowledge Doyle was not issued or required to wear space clothing while performing her assigned duties.					
Indicate whether the employee participated in any employer health programs or unions at this facility (check all that apply)					
<input type="checkbox"/> Former Worker Program (FWP)		<input type="checkbox"/> Radiation Exposure Screening and Education Program (RESEP)		<input type="checkbox"/> Other Medical Study	
<input type="checkbox"/> Other Medical Surveillance Program		<input type="checkbox"/> Union Member		<input type="checkbox"/> Other (specify):	
<input type="button" value="Next Page"/>				Form EE-3 April 2005	

Doctor's Report



SAINT LUKE'S SOUTH
PRIMARY CARE

- Douglas S Anderson, MD
- Kristie R. Baker, MD
- Jennifer P. Bernard, MD
- Richard R. Dailey, DO
- Shelley Garland, MD
- Annette Hughes, MD
- Alan Z. Kessler, DO
- Kenneth R. Kopp, MD
- Susan Lee, MD
- Jennifer A. McKinsey, MD
- Salder Mohsin, MD
- Michael L. Munger, MD
- Bradley Palmer, DO
- Timothy C. Pasowicz, DO
- Dawn M. Peterson, MD
- Marsha M. Weaver, MD
- Arthur S. Wientzen, MD

March 4, 2003

Re: [REDACTED]
DOB: [REDACTED]

To Whom It May Concern:

The aforementioned individual was under my care until his death in 1990. I began taking care of Mr. [REDACTED] in 1985 and at that time, he was noted to have significant chronic obstructive pulmonary disease. The patient had x-ray findings of which a report is included in his previous records, consistent with COPD along with consistently reduced Wright peak flow readings to 1/2 - 1/3rd of the expected for a man his age and size. These are also documented in his previous records. The patient had a significant disability related to his COPD and ultimately died from complications thereof. The patient's overall course is indeed consistent with chronic Beryllium disease.

For more information, please refer to attached medical records.

Sincerely,

[REDACTED SIGNATURE]

Enclosures

ENDOCRINOLOGY &
DIABETES

Jeffrey D. Kallsen, MD

Death Certificate

THE FACE OF THIS DOCUMENT HAS A COLORED BACKGROUND – NOT A WHITE BACKGROUND

244000 *Missouri Department of Health*
FORM VS No 1-A *Certificate of Death* File #: 116_2008

098765
(rev. 5/02)

Decedent	1. Decedent's Name (First, Middle, Last)			2. Sex Male		3. Date of Death (Month, Day, Year) April 4, 1990			
	4. Social Security No. 000-00-0000		5a. Age Last Birthday 59		5b. Under 1 year		6. Date of Birth Dec. 30, 1930		
	7. Birthplace (City/State) Springfield, MO		8. Was decedent ever in US armed services? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						
	9a. Place of Death (check only one) <input checked="" type="checkbox"/> Hospital Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> Other <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						9b. Facility Name St. Joseph Health Center		
10. Marital Status Married			11. Surviving Spouse (if wife give maiden name)		12a. Decedent's occupation Store Keeper		12b. Kind of business/industry Non-nuclear component		
13a. Residence--state Missouri		13b. County Jackson		13c. City, Town, or Location Anytown		13d. Street and Number 210 Main Street			
13e. Inside City limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		13f. Zip Code 42000		14. Was decedent of Hispanic Origin? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		15. Race American Indian, Black, White, etc. (specify) White		16. Decedent's Education (specify only highest grade completed) Elem/Sec (0-12) College 1-4 or 5+ 12	
Parents			17. Father's Name (First, Middle, Last)					18. Mother's Name (First, Middle, Last)	
Informant			19a. Informant's Name					19b. Mailing Address 210 Main Street, Anytown, MO 64030	
Disposition			20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Removal from state <input type="checkbox"/> Other (explain)		20b. Place of Disposition (Name of Cemetery, crematory or other place) Anytown Memory Gardens		20c. Location (City or Town) Anytown, MO		
Certifier			21a. Signature of Funeral Service Licensee Adam Mortician					22. Name and Addressee of Facility	
Cause of Death			23a. To the best of my knowledge, death occurred at the time, date, place and due to the causes stated					23b. date signed (Month, Day, Year) 04/04/90	
			Signature and Title Wayne E. Person						
			24. Name and address of Person who completed cause of death (item 23) Wayne E. Person, MD 110 South 129th Street, Anytown, MO 62030						
			25. Time of Death 7:40 AM		26. Date Pronounced Dead (Month, Day, Year) April 4, 1990		27. Was Case referred to Medical Examiner/Coroner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
			28. Part I: Enter the diseases, injuries, or complications that caused death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					Approximate interval between onset and death 12 hours	
			IMMEDIATE CAUSE (Final disease or condition resulting in death)		a. acute respiratory failure due to (or as a consequence of)				
			Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death)		b. Chronic Obstructive Pulmonary Disease due to (or as a consequence of)		undetermined		
			c. _____ due to (or as a consequence of)		d. _____ due to (or as a consequence of)				
			Part II: Other significant conditions contributed to death but not resulting in the underlying cause given in Part I. Pneumothorax Cardiac Arrhythmia		28a. if female, was there a pregnancy in the past 12 mos? <input type="checkbox"/> Yes <input type="checkbox"/> No		28b. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
			28c. Were autopsy findings available prior to cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Did the deceased have Diabetes? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		28e. Was Diabetes an immediate, underlying or contributing cause of or condition leading to death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
			29. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending		30a. Date of injury (Month, Day, Year)		30b. Time of injury		
			Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> could not determine <input type="checkbox"/> Homicide		30c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No		30d. Describe how injury occurred		
			30e. Place of injury – At home, farm, street, factory office building, etc. (Specify)		30f. Location (street and number, city or town)				
Registrar			32. Date Filed (Month, Day, Year) April 4 1990						

THE BACK OF THIS DOUCMENT CONTAINS AN ARTIFICIAL WATERMARK – HOLD AT AN ANGLE TO VIEW

DOE Facility List printout

Energy Employees Occupational Illness Compensation
Program

Home | Health and Safety

Facility List

There was one record found for the facility: Kansas City Plant .

1 - Kansas City Plant

State: Missouri **Location:** Kansas City

Time Period: 1949-present

Facility Type: Department of Energy

Facility Description: The Kansas City Plant was constructed in 1942 to build aircraft engines for the Navy. After World War II, it was used for storage. In 1949, the AEC asked the Bendix Corporation to take over part of the facility and it began manufacturing nonnuclear components for nuclear weapons. Electrical, electromechanical, mechanical, and plastic components are manufactured or procured by this facility.

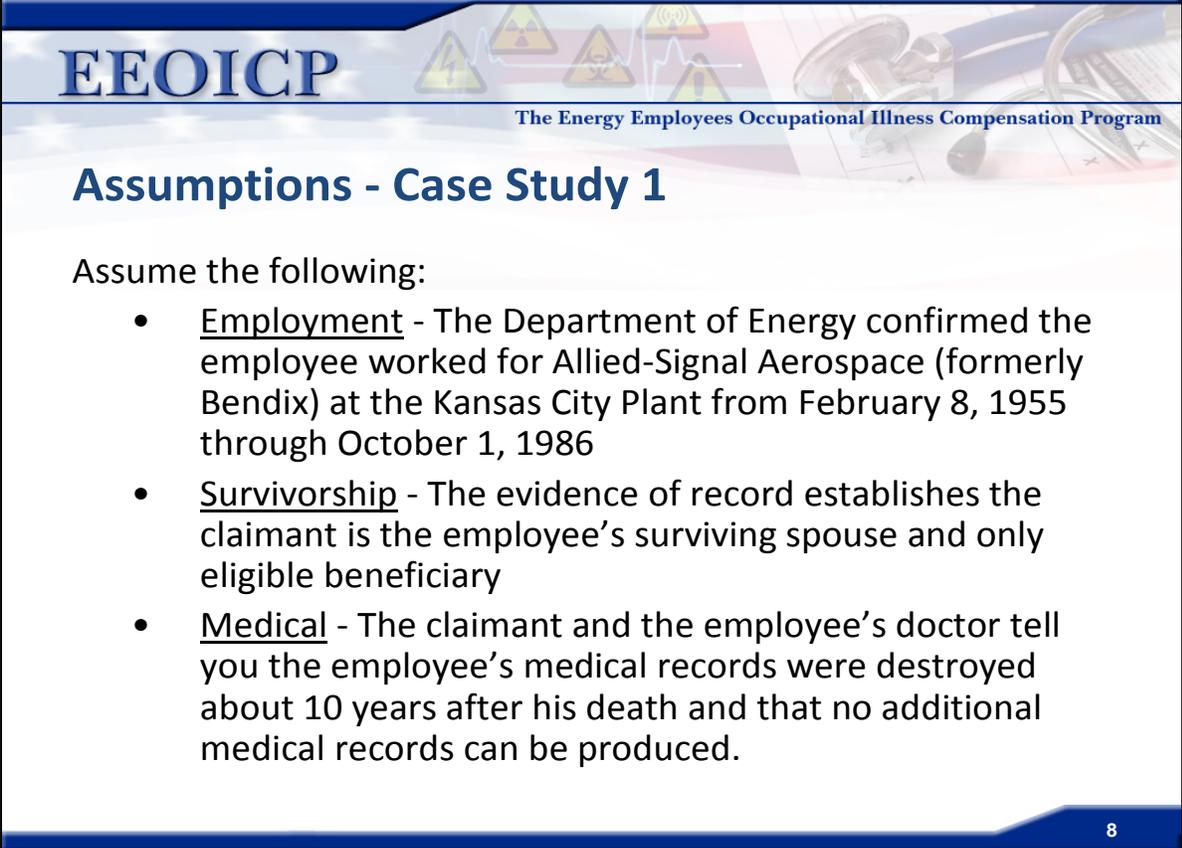
In 1993, the Department of Energy officially designated the Kansas City Plant as the consolidated site for all nonnuclear components for nuclear weapons.

As of 1996, production activities at the site were still occurring and expected to continue indefinitely.

Throughout the course of its operations, the potential for beryllium exposure existed at this site, due to beryllium use, residual contamination, and decontamination activities.

CONTRACTORS: Honeywell FM&T (1999-present); Allied-Signal Aerospace (formerly Bendix) (1949-1999)

Case Study 1 Assumptions



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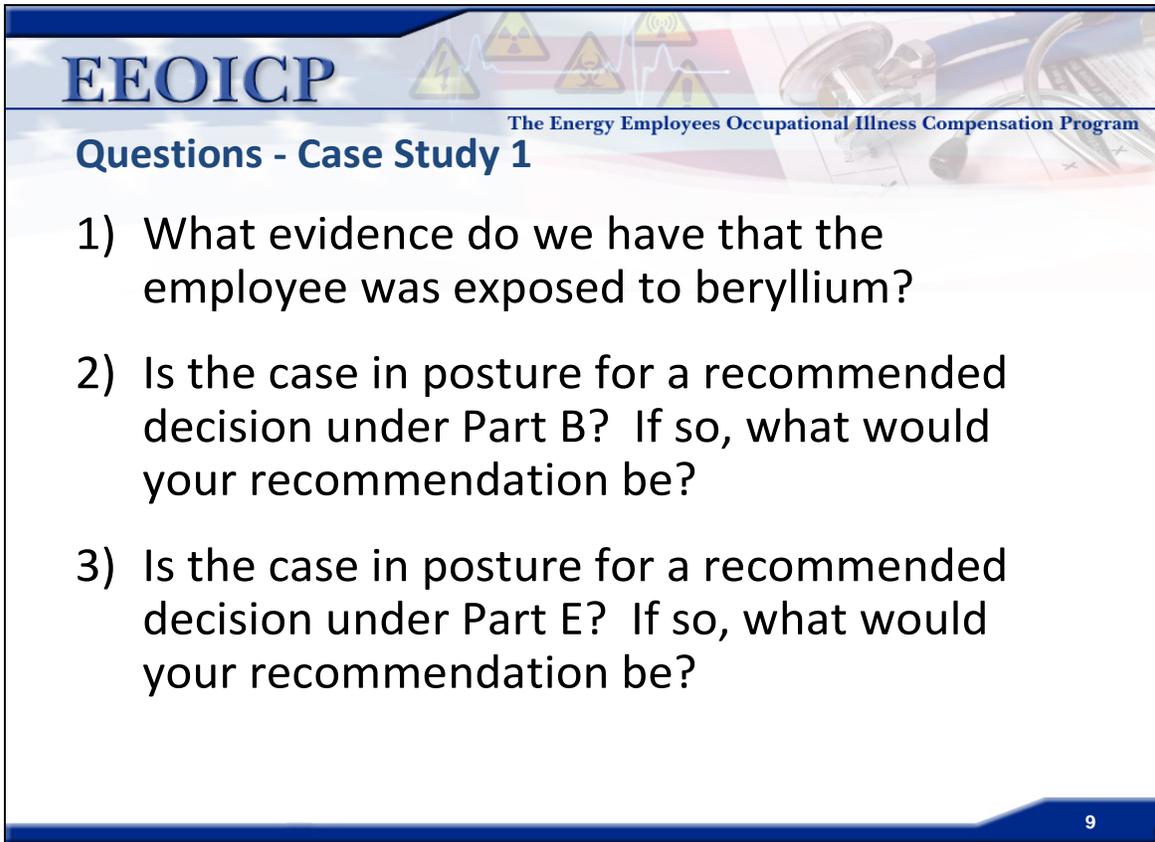
Assumptions - Case Study 1

Assume the following:

- Employment - The Department of Energy confirmed the employee worked for Allied-Signal Aerospace (formerly Bendix) at the Kansas City Plant from February 8, 1955 through October 1, 1986
- Survivorship - The evidence of record establishes the claimant is the employee's surviving spouse and only eligible beneficiary
- Medical - The claimant and the employee's doctor tell you the employee's medical records were destroyed about 10 years after his death and that no additional medical records can be produced.

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Case Study 1 Questions



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Questions - Case Study 1

- 1) What evidence do we have that the employee was exposed to beryllium?
- 2) Is the case in posture for a recommended decision under Part B? If so, what would your recommendation be?
- 3) Is the case in posture for a recommended decision under Part E? If so, what would your recommendation be?

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Case Study 2



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Case Study 2

- Employee Claim - Review the following evidence to determine what additional evidence is needed to fully adjudicate the CBD claim, if any.

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EE 1

Claim for Benefits Under the Energy Employees Occupational Illness Compensation Program Act		U.S. Department of Labor Employment Standards Administration Office of Workers' Compensation Programs			
Note: Provide all information requested below. Do not write in the shaded areas.				OMB Number: 1215-0197	Expiration Date: 08/31/2010
Employee Information (Please Print Clearly)			Submit	Reset	Print
1. Name (Last, First, Middle Initial)		2. Social Security Number			
3. Date of Birth		4. Sex		5. Dependents	
<input type="text"/> / <input type="text"/> / <input type="text"/> <small>Month Day Year</small>		<input type="checkbox"/> Male <input type="checkbox"/> Female		<input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Children <input type="checkbox"/> Other: <input type="text"/>	
6. Address (Street, Apt. #, P.O. Box)			7. Telephone Number(s)		
<input type="text"/>			a. Home: (<input type="text"/>) <input type="text"/> - <input type="text"/>		
<small>(City, State, ZIP Code)</small>			b. Other: (<input type="text"/>) <input type="text"/> - <input type="text"/>		
8. Identify the Diagnosed Condition(s) Being Claimed as Work-Related (check box and list specific diagnosis)					
<input type="checkbox"/> Cancer (List Specific Diagnosis Below)				9. Date of Diagnosis	
				Month	Day
a. <input type="text"/>				<input type="text"/>	<input type="text"/>
b. <input type="text"/>				<input type="text"/>	<input type="text"/>
c. <input type="text"/>				<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Beryllium Sensitivity				<input type="text"/>	<input type="text"/>
<input checked="" type="checkbox"/> Chronic Beryllium Disease (CBD)				<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Chronic Silicosis				<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Other Work-Related Condition(s) due to exposure to toxic substances or radiation (List Specific Diagnosis Below)				<input type="text"/>	<input type="text"/>
a. <input type="text"/>				<input type="text"/>	<input type="text"/>
b. <input type="text"/>				<input type="text"/>	<input type="text"/>
c. <input type="text"/>				<input type="text"/>	<input type="text"/>
Awards and Other Information					
10. Did you work at a location designated as a Special Exposure Cohort (SEC)?				<input checked="" type="checkbox"/> YES	<input type="checkbox"/> NO
11. Have you filed a lawsuit seeking either money or medical coverage for the above claimed condition(s)?				<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO
12. Have you filed any workers' compensation claims in connection with the above claimed condition(s)?				<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO
13. Have you or another person received a settlement or other award in connection with a lawsuit or workers' compensation claim for the above claimed condition(s)?				<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO
14. Have you either pled guilty or been convicted of any charges connected with an application for or receipt of federal or state workers' compensation?				<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO
15. Have you applied for an award under Section 5 of the Radiation Exposure Compensation Act (RECA)?				<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO
If yes, provide RECA Claim #:				<input type="text"/>	
16. Have you applied for an award under Section 4 of the Radiation Exposure Compensation Act (RECA)?				<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO
Employee Declaration					
Any person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of fraud to obtain compensation as provided under EEOICPA or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both. Any change to the information provided on this form once it is submitted must be reported immediately to the district office responsible for the administration of the claim. I hereby make a claim for benefits under EEOICPA and affirm that the information I have provided on this form is true. If applicable, I authorize the Department of Justice to release any requested information, including information related to my RECA claim, to the U.S. Department of Labor, Office of Workers' Compensation Programs (OWCPL). Furthermore, I authorize any physician or hospital or any other person, institution, corporation, or government agency, including the Social Security Administration to furnish any desired information to the U.S. Department of Labor, Office of Workers' Compensation Programs.				Resource Center Date Stamp 	
<input type="text"/> Employee Signature					
<input type="text"/> 12/10/2007 Date					
Next Page					

Form EE-1
April 2005

EE 3

Employment History for a Claim Under the Energy Employees Occupational Illness Compensation Program Act		U.S. Department of Labor Employment Standards Administration Office of Workers' Compensation Programs		
Note: Please provide as much information as possible. Do not write in the shaded areas.			OMB No. 1215-0197 Expiration Date: 08/31/2010	
Employee's Information (Print clearly) Submit Reset Print				
1. Employee's Name (Last, First, Middle Initial)		2. Former Name (e.g. Maiden/Legal Change)		3. Social Security Number (if known)
[Redacted]				
Contact Information for Person Completing this Form (Print clearly)				
4. Name (Last, First, Middle Initial)			5. Claim Type (check one) <input checked="" type="checkbox"/> Employee <input type="checkbox"/> Survivor	
6. Address (Street, Apt. #, P.O. Box) [Redacted]			7. Telephone Number(s)	
(City, State, ZIP Code) [Redacted]			a. Home: () - b. Other: () -	
Employee's Work History (Provide as much information as known - if necessary attach a separate sheet)				
In chronological order, starting with the most recent period of employment , provide the complete work history of the employee named above. Provide as much identifying information as known concerning the name of the employer and location (city & state) where the employee performed the work. If you require additional space to explain or clarify a point, attach a signed supplemental statement to this form.				
Employer - 1		Start Date: <input type="text"/> / <input type="text"/> / <input type="text"/> 1983 End Date: <input type="text"/> / <input type="text"/> / <input type="text"/> 1985		Work Schedule (check one) <input checked="" type="checkbox"/> Full-time <input type="checkbox"/> Part-time
Facility Name (spell out name) Rocky Flats Plant		Specific Location (building/site/mine/mill) Building 881; Research and Dev.		City/State where worked performed Golden, Colorado
Contractor/sub-contractor or Vendor name(s) Rockwell		Type of Facility/Employer (check one) <input checked="" type="checkbox"/> Department of Energy Facility <input type="checkbox"/> Beryllium Vendor <input type="checkbox"/> Unknown <input type="checkbox"/> Atomic Weapons Facility <input type="checkbox"/> Uranium Miner/Miller/Transporter		
Position Title or Mine/Mill Activity Research Engineer		Was a dosimetry badge worn while employed? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Unknown		
Work Identification Number		If known, provide the Dosimetry Badge Number: 502XXX		
Description of Work Duties (Describe in detail) Beryllium Weapon parts (Brazing machined parts of beryllium).				
Describe or list the work conditions/exposures you believe caused or contributed to the claimed work illness(es) at this facility				
[Redacted]				
Indicate whether the employee participated in any employer health programs or unions at this facility (check all that apply)				
<input type="checkbox"/> Former Worker Program (FWP) <input type="checkbox"/> Radiation Exposure Screening and Education Program (RESEP) <input type="checkbox"/> Other Medical Study <input type="checkbox"/> Other Medical Surveillance Program <input type="checkbox"/> Union Member <input type="checkbox"/> Other (specify):				
[Redacted]				
Next Page				Form EE-3 April 2005

EE 3 PAGE 2

Employer - 2		Start Date: <input type="text"/> / <input type="text"/> / <input type="text"/> 1975 Month Day Year	End Date: <input type="text"/> / <input type="text"/> / <input type="text"/> 1982 Month Day Year	Work Schedule (check one) <input checked="" type="checkbox"/> Full-time <input type="checkbox"/> Part-time	
Facility Name (spell out name) Rocky Flats Plant		Specific Location (building/site/mine/mill) Building 776; Res. & Dev.		City/State where worked performed Golden, Colorado	
Contractor/sub-contractor or Vendor name(s) Rockwell		Type of Facility/Employer (check one) <input checked="" type="checkbox"/> - Department of Energy Facility <input type="checkbox"/> - Atomic Weapons Facility <input type="checkbox"/> - Beryllium Vendor <input type="checkbox"/> - Uranium Miner/Miller/Transporter <input type="checkbox"/> - Unknown			
Position Title or Mine/Mill Activity Res. Engineer; Dev. Specialist; Manufacturing Master Tech.		Was a dosimetry badge worn while employed? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Unknown			
Work Identification Number		If known, provide the Dosimetry Badge Number: 502XXX			
Description of Work Duties (Describe in detail) Weapon Parts of Beryllium - cut samples					
Describe or list the work conditions/exposures you believe caused or contributed to the claimed work illness(es) at this facility					
Indicate whether the employee participated in any employer health programs or unions at this facility (check all that apply) <input type="checkbox"/> Former Worker Program (FWP) <input type="checkbox"/> Radiation Exposure Screening and Education Program (RESEP) <input type="checkbox"/> Other Medical Study <input type="checkbox"/> Other Medical Surveillance Program <input type="checkbox"/> Union Member <input type="checkbox"/> Other (specify):					
Employer - 3		Start Date: <input type="text"/> / <input type="text"/> / <input type="text"/> 1967 Month Day Year	End Date: <input type="text"/> / <input type="text"/> / <input type="text"/> 1974 Month Day Year	Work Schedule (check one) <input checked="" type="checkbox"/> Full-time <input type="checkbox"/> Part-time	
Facility Name (spell out name) Rocky Flats Plant		Specific Location (building/site/mine/mill) Building 777 and 771		City/State where worked performed Golden, Colorado	
Contractor/sub-contractor or Vendor name(s) Dow Chemical		Type of Facility/Employer (check one) <input checked="" type="checkbox"/> - Department of Energy Facility <input type="checkbox"/> - Atomic Weapons Facility <input type="checkbox"/> - Beryllium Vendor <input type="checkbox"/> - Uranium Miner/Miller/Transporter <input type="checkbox"/> - Unknown			
Position Title or Mine/Mill Activity Manufacturing Master Technician		Was a dosimetry badge worn while employed? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Unknown			
Work Identification Number		If known, provide the Dosimetry Badge Number:			
Description of Work Duties (Describe in detail) Weapon parts were ground and polished; Brazing (out of beryllium)					
Describe or list the work conditions/exposures you believe caused or contributed to the claimed work illness(es) at this facility					
Indicate whether the employee participated in any employer health programs or unions at this facility (check all that apply) <input type="checkbox"/> Former Worker Program (FWP) <input type="checkbox"/> Radiation Exposure Screening and Education Program (RESEP) <input type="checkbox"/> Other Medical Study <input type="checkbox"/> Other Medical Surveillance Program <input type="checkbox"/> Union Member <input type="checkbox"/> Other (specify):					
Declaration of the Person Completing this Form Any person who knowingly makes any false statement, misrepresentation, concealment of fact of any other act of fraud to obtain compensation as provided under EEOICPA or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both. I affirm that the information provided on this form is accurate and true. I also authorize the Department of Justice, Social Security Administration, any Former Worker Program, union, medical study or medical surveillance program (or any other person, institution, corporation, or government agency) identified on this form to furnish any desired information to the U.S. Department of Labor, Office of Workers' Compensation Programs.				Resource Center Date Stamp	
<input type="text"/> (Signature)				<input type="text"/> 08/23/2007 (Date)	
<input type="button" value="Next Page"/> <input type="button" value="Prev Page"/>				Form EE-3 April 2005	

Report from National Jewish Page 1

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#1 Respiratory Hospital in the U.S.
U.S. News and World Report

Fri Jul 27, 2007 9:33 AM



Name [REDACTED]
MRUN 019-07-32 Acct #: 695761
DOB [REDACTED] Age: 83
OCCUPATIONAL AND ENVIRONMENTAL MEDICINE FOLLOW UP SUMMARY
REVISED FINAL

DATE(S) OF SERVICE: July 11, 2007

ATTENDING PHYSICIAN: [REDACTED]

CHIEF COMPLAINT:
Post bronchoscopy followup.

INTERIM HISTORY:
Mr. [REDACTED] is an 83-year-old gentleman, with beryllium sensitization, here for followup after his bronchoscopy, performed on 05/30/2007. Mr. [REDACTED] reports that he had some wheezing after his bronchoscopy. He saw his primary care physician, and at the time of his visit he was not wheezing. He was not given any medication for treatment. Mr. [REDACTED] wife reports that he has had swelling in his feet. Of note, Mr. [REDACTED] has a history of an abnormal bronchoalveolar lavage beryllium lymphocyte proliferation test in the past.

REVIEW OF SYSTEMS:
Constitutional: He denies fever or chills, no sweats.
Allergy/Immunology: Mr. [REDACTED] reports no rhinitis or sore throat.
Ears/Nose/Mouth/Throat: He complains of some hoarseness, no postnasal drip. Respiratory: No significant change compared to his previous visit. Cardiovascular: Mr. [REDACTED] reports worsened edema. Other: With regards to sleep, he has restless sleep. No snoring.

PAST MEDICAL HISTORY (UPDATE):
Mr. [REDACTED] wife reports that he has an appointment with his cardiologist in 1 month.

Report from National Jewish Page 2

CURRENT MEDICATIONS:

Current medications were reviewed. No changes compared with the 05/30/2007 visit.

PHYSICAL EXAMINATION:

Vital signs: Reviewed. See chart. General appearance: A well-developed, well-nourished, well-groomed gentleman in no acute distress. Neurological/Psychological: Mr. [REDACTED] has a normal mood and affect.

NATIONAL JEWISH MEDICAL AND RESEARCH CENTER TEST DATA:

Spirometry: Mr. [REDACTED] spirometry is significant for restriction, with an FVC of 2.55 L or 66.2% of predicted, FEV1 is 2.21 L or 81.7% of predicted, and the FEV1/FVC ratio is 87%.

Bronchoscopy with transbronchial biopsies and bronchoalveolar lavage. The bronchoalveolar lavage revealed a good recovery of 65.8%, absolute white blood cells were high at 39.5 (normal equals 29.4 to 35.2), macrophages were 83%, and lymphocytes were high at 16%. This indicates a lymphocytosis, consistent with chronic beryllium disease. This is increased, compared with 02/2006, when Mr. [REDACTED] lymphocyte count was 3%. This likely indicates progression to chronic beryllium disease. Mr. [REDACTED] bronchoalveolar lavage beryllium lymphocyte proliferation test was not performed secondary to a laboratory error. However, it was abnormal in 02/2006. The abnormal bronchoalveolar lavage beryllium lymphocyte proliferation test, in combination with a lymphocytosis at this time, is consistent with chronic beryllium disease. Pathology report from the transbronchial biopsies indicated patchy mild lymphoplasmacytic inflammation within the submucosa, and no granulomas. The AFB and gram stains were negative for mycobacteria and fungi.

IMPRESSION:

1. Mr. [REDACTED] is an 83-year-old gentleman, with beryllium sensitization, who at this time, has progressed to chronic beryllium disease, given his previously abnormal bronchoalveolar lavage beryllium lymphocyte proliferation test and his lymphocytosis seen on bronchoscopy at this time. This indicates a lymphocytic inflammation consistent with chronic beryllium disease (CBD). Mr. [REDACTED] also has abnormal pulmonary function testing, satisfying Department of Labor (DOL) Energy Employees Occupational Illness Compensation Program (EEOICOP) criteria for CBD.
2. Possible aortic stenosis.
3. Hoarseness, question aspiration versus postnasal drip.
4. Diabetes, for which Mr. [REDACTED] should continue to follow up with his primary care physician.

Report from National Jewish Page 3

PLAN/TREATMENT:

1. I counseled Mr. [REDACTED] and his wife on his progression from beryllium sensitization to chronic beryllium disease. I advised Mr. [REDACTED] to contact the Department of Labor claims examiner that he is assigned to, to notify them of the change. He will also forward them information regarding his bronchoscopy and this clinic visit, so that they can change his diagnosis in their system and compensate him accordingly.
2. Mr. [REDACTED] should consider starting Flovent 110 mcg metered dose inhaler at two puffs twice daily, and albuterol 2 puffs as needed up to four times daily for his chronic beryllium disease. He should use the albuterol if he is experiencing any shortness of breath or cough.
3. Mr. [REDACTED] should follow up with his cardiologist regarding possible aortic stenosis and any further treatment necessary.
4. Mr. [REDACTED] should follow up with his primary care physician regarding his hoarseness. He should be evaluated, and his primary care physician may want to consider ordering a swallow study.
5. We will avoid steroid treatment for chronic beryllium disease, given his history of diabetes.
6. Mr. [REDACTED] should follow up with us in 1 year. At that time, we will repeat pulmonary function testing, exercise tolerance testing, chest x-ray, and laboratories. He should follow up with us sooner if there is any significant change in his respiratory symptoms.

[REDACTED]

[REDACTED]

Enclosures: The bronchoscopy results, including pathology report, BAL cell count and differential, and BAL LPT.

Pulmonary Function Test

013-05-16 05/29/2007							
Performed Date/Time: 05/29/2007 3:15 PM Ordered By: BODY PLETHYSMOGRAPHY							
BODY PLETHYSMOGRAPHY:							
Pulmonary Physiology Unit				Body Plethysmography Report			
Race: Other		Height: 177 cm		Weight: 100 kg			
Location: OCC MED PATIENT		Date: 05/29/2007		Time: 04:45:11PM			
Lung Volumes							
		Pred	Pre	%Pred	Post	%Pred	%change
TLC	[l]	6.23	5.82	93	5.73	92	-2
IC	[l]	2.38	3.04	128	3.14	132	3
FRC-pleth	[l]	3.85	2.78	72	2.60	67	-7
ERV	[l]	1.70	0.31	18	0.21	12	-33
RV	[l]	2.15	2.47	115	2.39	111	-3
VCmax	[l]	3.85	3.35	87	3.34	87	0
RV / TLC	[%]	34.5	42.5	123	41.7	121	-2
FRC-pleth / TLC	[%]	61.80	47.77	77	45.29	73	-5
Forced Expiration							
		Pred	Pre	%Pred	Post	%Pred	%change
FVC	[l]	3.85	3.08	80	2.39	62	-23
FEV 1	[l]	2.70	2.48	92	2.36	87	-5
FEV 1 / FVC	[%]	70	80	114	99	141	23
FEF 25-75	[l/s]	1.80	2.75	153	5.77	321	110
PEF	[l/s]	6.78	6.31	93	7.64	113	21
FEF 25	[l/s]	7.05	6.31	89	7.64	108	21
FEF 50	[l/s]	5.57	4.92	88	6.75	121	37
FEF 75	[l/s]	2.65	0.76	29	3.14	118	313
PIF	[l/s]	4.12	4.56	111	6.09	148	34
FEF50 / FIF50	[%]	153	115	75	112	74	-2
Additional Studies							
		Pred	Pre	%Pred	Post	%Pred	%change
Raw	[cmH2O*s/l]	1.69	1.94	115	1.74	103	-10
sGaw	[l/(cmH2O*s)]	0.194	0.186	121	0.221	144	19
DLCO SB	[ml/min/mmHg]	29.12			19.25	66	
DLCOc SB	[ml/min/mmHg]				19.2		
VA	[l]	6.84			4.98	73	
DLCO/VA	[ml/min/mmHg/l]	4.26			3.86	91	
DLCOc/VA	[ml/min/mmHg/l]				3.86		
PI max Average	[cmH2O]	71					
PE max Average	[cmH2O]	111					
		Pred	Pre	%Pred	Post	%Pred	%Change

Weight (kg)							
TLC *	[l]	6.23					
FRC-Pleth *	[l]	3.85					
A	[l]	6.23					
A - B	[l]						
K	[l/cmH2O]	0.162					
Rel 100% TLC	[cmH2O]	31.7					
Coef. Retraction	[cmH2O/l]	5.09					
Compliance st	[l/cmH2O]						
R upstream	[cmH2O/(l/s)]						

BronchoAlveolar Lavage (BAL) Page 1

Performed Date/Time: 05/30/2007 1:45 PM Ordered By: BAL CELL COUNT		
BAL CELL COUNT : RESULTED		
Resulted Components:		
% RECOVERY	(61.1 - 62.9) %	65.8H
RECOVERY ML	MLS	158
ABS. RBC	x10E6	45.0
ABS. WBC	(29.4 - 35.2) x10E6	39.5H
ABS. EPI CELLS	x10E6	0.0
% MACROPH	(87 - 89)	83L
		Comment: CORRECTED ON 05/30 AT 1633: PREVIOUSLY REPORTED AS 84
ABS NO. MACROPH		32.8
	x10E6	Comment: CORRECTED ON 05/31 AT 0937: PREVIOUSLY REPORTED AS 33.2
% NEUT	(1.5 - 2.1)	0L
ABS NO. NEUT.	x10E6	0.0
% LYMPHS	(8.9 - 10.1)	16H
ABS NO. LYMPHS	x10E6	6.3
% EOS	(0.3 - 0.5) x10E6	0.0
		Comment: CORRECTED ON 05/30 AT 1633: PREVIOUSLY REPORTED AS 0
ABS NO. EOS		0.4
	x10E6	Comment: CORRECTED ON 05/31 AT 0937: PREVIOUSLY REPORTED AS 0.0
COMMENT:		
		[MEAN +/- S.E.M.] DATA BASED ON 191 NORMAL SUBJECTS (INCLUDES EX SMOKERS AND NEVER SMOKERS) AM. REV. RESPIR. DIS (MAY) 1990; 141:S163-S202. NOTE: DEMOGRAPHIC FACTORS AND SMOKING HISTORY MUST BE TAKEN INTO ACCOUNT WHEN COMPARING SUBJECTS. IN SMOKERS: TOTAL WBC = 59.9 +/- 0.9 NEUT. 1.6 +/- 0.2; EOS. 0.56 +/- 0.13.
Back to top		

BronchoAlveolar Lavage (BAL) Page 2

Performed Date/Time: 02/07/2006 9:30 AM Ordered By: BAL CELL COUNT

BAL CELL COUNT : RESULTED

Resulted Components:

% RECOVERY	(61.1 - 62.9) %	71H
RECOVERY ML	MLS	170
ABS. RBC	x10E6	134.3
ABS. WBC	(29.4 - 35.2) x10E6	68.9H
ABS. EPI CELLS	x10E6	0.0
% MACROPH	(87 - 89)	96H
ABS NO. MACROPH	x10E6	66.1
% NEUT	(1.5 - 2.1)	1L
ABS NO. NEUT.	x10E6	0.7
% LYMPHS	(8.9 - 10.1)	3L
ABS NO. LYMPHS	x10E6	2.1
% EOS	(0.3 - 0.5) x10E6	0L
ABS NO. EOS	x10E6	0.0

COMMENT:

[MEAN +/- S.E.M.] DATA BASED ON
 191 NORMAL SUBJECTS (INCLUDES
 EX SMOKERS AND NEVER SMOKERS)
 AM. REV. RESPIR. DIS (MAY) 1990;
 141:S163-S202.
 NOTE: DEMOGRAPHIC FACTORS AND
 SMOKING HISTORY MUST BE TAKEN INTO
 ACCOUNT WHEN COMPARING SUBJECTS.
 IN SMOKERS: TOTAL WBC = 59.9 +/- 0.9
 NEUT. 1.6 +/- 0.2;
 EOS. 0.56 +/- 0.13.

Lymphocyte Transformation Test – BronchoAlveolar Lavage from Jewish Hospital



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U.S. News & World Report

Lymphocyte transformation test: Bronchoalveolar Lavage

PATIENT NAME: _____
 NJC #OR ID: _____
 DATE OF TEST: 02/07/08
 REFERRING PHYSICIAN: _____
 TECH: _____

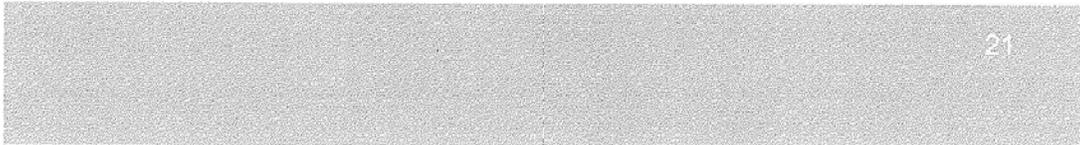
<u>RESULTS:</u>	<u>MEAN STIMULATION INDEX</u>		
	<u>DAY 3</u>	<u>DAY 4</u>	<u>DAY 6</u>
<u>MITOGENS</u>			
Phytohemagglutinin	24.8		
Concanavalin A		3.9	
<u>BERYLLIUM SULFATE:</u>			
1 X 10 ⁻⁴ M	2.7	1.0	0.6
1 X 10 ⁻⁵ M	3.9	2.0	1.5
1 X 10 ⁻⁶ M	1.9	1.3	1.7

INTERPRETATION:

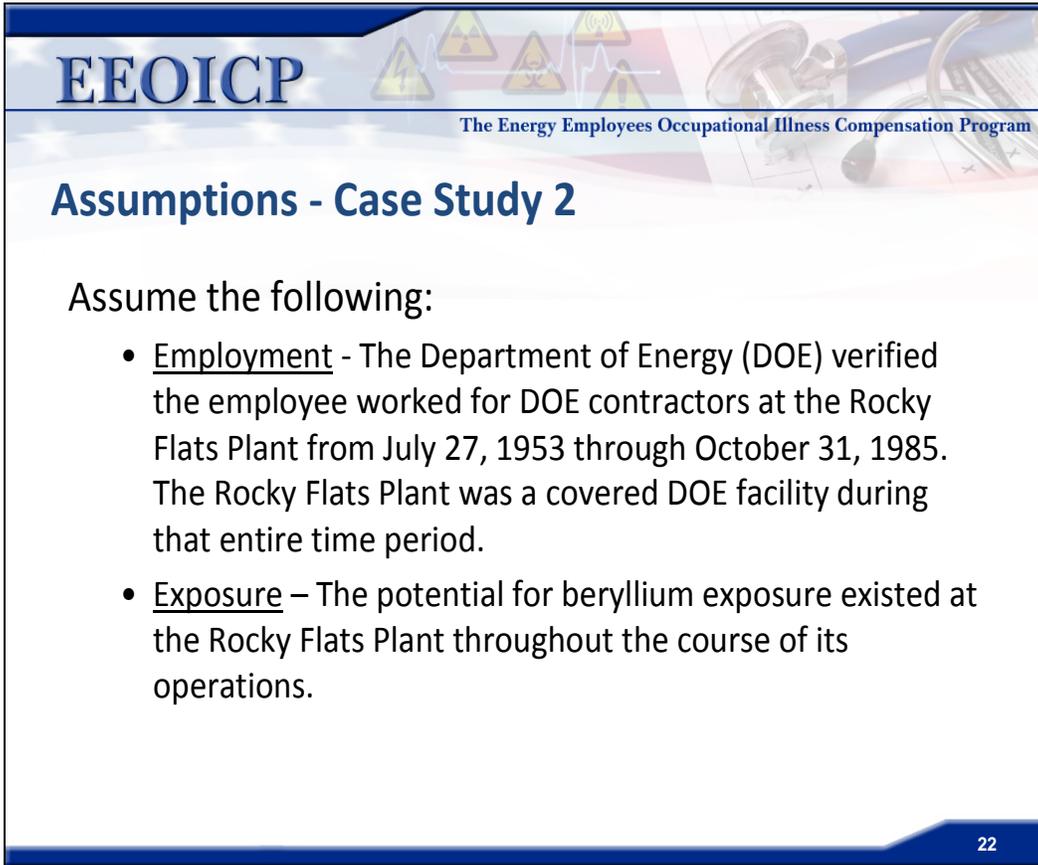
Normal response to mitogen. (Mitogen normal: >3.0)
 Abnormal lymphocyte proliferation to beryllium sulfate.
 Note: An abnormal result is 2 or more beryllium sulfate values above the cut-off value of 2.5.
 This assay is used for clinical purposes and was developed, and its performance characteristics determined by National Jewish Clinical Reference Laboratories. It has not been cleared or approved by the US Food and Drug Administration. The FDA has determined that such clearance or approval is not necessary. This laboratory is certified under the Clinical Laboratory Improvement Amendments of 1988 (CLIA-88) as qualified to perform high complexity clinical laboratory testing.



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Case Study 2 Assumptions



EEOICP
The Energy Employees Occupational Illness Compensation Program

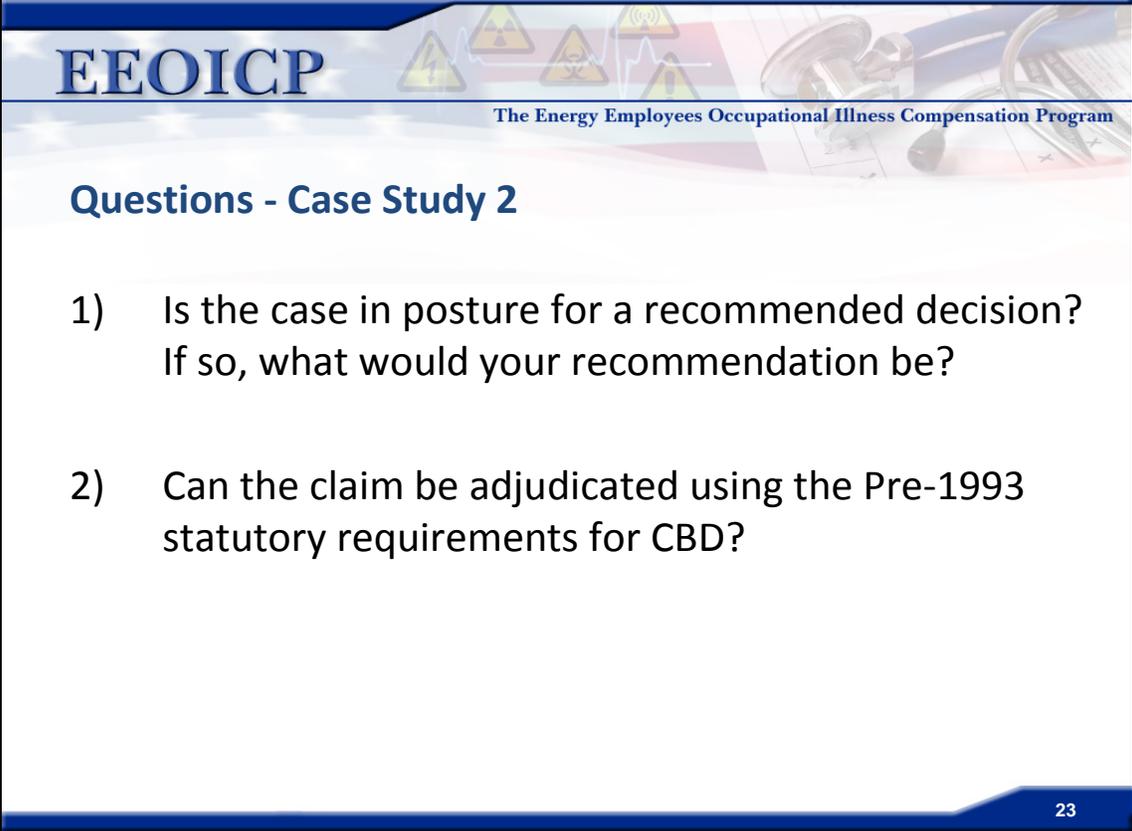
Assumptions - Case Study 2

Assume the following:

- Employment - The Department of Energy (DOE) verified the employee worked for DOE contractors at the Rocky Flats Plant from July 27, 1953 through October 31, 1985. The Rocky Flats Plant was a covered DOE facility during that entire time period.
- Exposure – The potential for beryllium exposure existed at the Rocky Flats Plant throughout the course of its operations.

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Case Study 2 Questions



EEOICP
The Energy Employees Occupational Illness Compensation Program

Questions - Case Study 2

- 1) Is the case in posture for a recommended decision?
If so, what would your recommendation be?
- 2) Can the claim be adjudicated using the Pre-1993 statutory requirements for CBD?

23

Answers

Your Answers

Evaluation Form

We value your opinion. Please rate the following:

	Poor	Fair	Good	Excellent
Organization of subject matter				
Explanation of key concepts				
Presenter's knowledge of subject				
Presentation was clear and understandable				
Appropriate pace for training				
Relevance of training material				
Correct level of detail				
Exercise content was appropriate				
Examples were clear and helpful				
Which topics were most beneficial to you?				
Which topics were least beneficial to you?				

