

§ 79.25

affected area was the date of initial or first exposure.

§ 79.25 Proof of onset of leukemia at least two years after first exposure, and proof of onset of a specified compensable disease more than five years after first exposure.

The date of onset will be the date of diagnosis as indicated in the medical documentation accepted by the Radiation Exposure Compensation Program as proof of the claimant's specified compensable disease. The date of onset must be at least five years after the date of first exposure as determined under § 79.24(b). In the case of leukemia, the date of onset must be at least two years after the date of first exposure.

§ 79.26 Proof of medical condition.

(a) Medical documentation is required in all cases to prove that the claimant suffered from or suffers from any specified compensable disease. Proof that the claimant contracted a specified compensable disease must be made either by using the procedure outlined in paragraph (b) of this section or by submitting the documentation required in paragraph (c) of this section. (For claims relating to primary cancer of the liver, the claimant or eligible surviving beneficiary must also submit the additional medical documentation prescribed in § 79.27.)

(b) If a claimant was diagnosed as having one of the specified compensable diseases in Arizona, Colorado, Nevada, New Mexico, Utah or Wyoming, the claimant or eligible surviving beneficiary need not submit any medical documentation of disease at the time the claim is filed (although medical documentation subsequently may be required). Instead, the claimant or eligible surviving beneficiary may submit with the claim an Authorization to Release Medical and Other Information, valid in the state of diagnosis, that authorizes the Program to contact the appropriate state cancer or tumor registry. The Program will accept as proof of medical condition verification from the state cancer or tumor registry that it possesses medical records or abstracts of medical records of the claimant that contain a verified diagnosis of

28 CFR Ch. I (7-1-14 Edition)

one of the specified compensable diseases. If the designated state does not possess medical records or abstracts of medical records that contain a verified diagnosis of one of the specified compensable diseases, the Program will notify the claimant or eligible surviving beneficiary and afford that individual the opportunity to submit the written medical documentation required in paragraph (c) of this section, in accordance with the provisions of § 79.72(b).

(c) Proof that the claimant contracted a specified compensable disease may be made by the submission of one or more of the contemporaneous medical records listed in this paragraph, provided that the specified document contains an explicit statement of diagnosis and such other information or data from which the appropriate authorities with the National Cancer Institute can make a diagnosis to a reasonable degree of medical certainty. If the medical record submitted does not contain sufficient information or data to make such a diagnosis, the Program will notify the claimant or eligible surviving beneficiary and afford that individual the opportunity to submit additional medical records identified in this paragraph, in accordance with the provisions of § 79.72(b). The medical documentation submitted under this section to establish that the claimant contracted leukemia or a lymphoma must also contain sufficient information from which the appropriate authorities with the National Cancer Institute can determine the type of leukemia or lymphoma contracted by the claimant. Proof of leukemia shall be made by submitting one or more of the documents listed in § 79.16(c).

(1) *Multiple myeloma.*

- (i) Pathology report of tissue biopsy;
- (ii) Autopsy report;
- (iii) Report of serum electrophoresis;
- (iv) One of the following summary medical reports:
 - (A) Physician summary report;
 - (B) Hospital discharge summary report;
 - (C) Hematology summary or consultation report;
 - (D) Medical oncology summary or consultation report; or
 - (E) X-ray report; or

Department of Justice

§ 79.26

(v) Death certificate, provided that it is signed by a physician at the time of death.

(2) *Lymphomas.*

(i) Pathology report of tissue biopsy;

(ii) Autopsy report;

(iii) One of the following summary medical reports:

(A) Physician summary report;

(B) Hospital discharge summary report;

(C) Hematology consultation or summary report; or

(D) Medical oncology consultation or summary report; or

(iv) Death certificate, provided that it is signed by a physician at the time of death.

(3) *Primary cancer of the thyroid.*

(i) Pathology report of tissue biopsy or fine needle aspirate;

(ii) Autopsy report;

(iii) One of the following summary medical reports:

(A) Physician summary report;

(B) Hospital discharge summary report;

(C) Operative summary report;

(D) Medical oncology summary or consultation report; or

(iv) Death certificate, provided that it is signed by a physician at the time of death.

(4) *Primary cancer of the male or female breast.*

(i) Pathology report of tissue biopsy or surgical resection;

(ii) Autopsy report;

(iii) One of the following summary medical reports:

(A) Physician summary report;

(B) Hospital discharge summary report;

(C) Operative report;

(D) Medical oncology summary or consultation report; or

(E) Radiotherapy summary or consultation report;

(iv) Report of mammogram;

(v) Report of bone scan; or

(vi) Death certificate, provided that it is signed by a physician at the time of death.

(5) *Primary cancer of the esophagus.*

(i) Pathology report of tissue biopsy or surgical resection;

(ii) Autopsy report;

(iii) Endoscopy report;

(iv) One of the following summary medical reports:

(A) Physician summary report;

(B) Hospital discharge summary report;

(C) Operative report;

(D) Radiotherapy report; or

(E) Medical oncology consultation or summary report;

(v) One of the following radiological studies:

(A) Esophagram;

(B) Barium swallow;

(C) Upper gastrointestinal (GI) series;

(D) Computerized tomography (CT) scan; or

(E) Magnetic resonance imaging (MRI); or

(vi) Death certificate, provided that it is signed by a physician at the time of death.

(6) *Primary cancer of the stomach.*

(i) Pathology report of tissue biopsy or surgical resection;

(ii) Autopsy report;

(iii) Endoscopy or gastroscopy report;

(iv) One of the following summary medical reports:

(A) Physician summary report;

(B) Hospital discharge summary report;

(C) Operative report;

(D) Radiotherapy report; or

(E) Medical oncology summary report;

(v) One of the following radiological studies:

(A) Barium swallow;

(B) Upper gastrointestinal (GI) series;

(C) Computerized tomography (CT) series; or

(D) Magnetic resonance imaging (MRI); or

(vi) Death certificate, provided that it is signed by a physician at the time of death.

(7) *Primary cancer of the pharynx.*

(i) Pathology report of tissue biopsy or surgical resection;

(ii) Autopsy report;

(iii) Endoscopy report;

(iv) One of the following summary medical reports:

(A) Physician summary report;

(B) Hospital discharge summary report;

(C) Report of otolaryngology examination;

(D) Radiotherapy summary report;

(E) Medical oncology summary report; or

§ 79.26

28 CFR Ch. I (7-1-14 Edition)

- (F) Operative report;
- (v) Report of one of the following radiological studies:
 - (A) Laryngograms;
 - (B) Tomograms of soft tissue and lateral radiographs;
 - (C) Computerized tomography (CT) scan; or
 - (D) Magnetic resonance imaging (MRI); or
 - (vi) Death certificate, provided that it is signed by a physician at the time of death.
- (8) *Primary cancer of the small intestine.*
 - (i) Pathology report of tissue biopsy;
 - (ii) Autopsy report;
 - (iii) Endoscopy report, provided that the examination covered the duodenum and parts of the jejunum;
 - (iv) Colonoscopy report, provided that the examination covered the distal ileum;
 - (v) One of the following summary medical reports:
 - (A) Physician summary report;
 - (B) Hospital discharge summary report;
 - (C) Report of gastroenterology examination;
 - (D) Operative report;
 - (E) Radiotherapy summary report; or
 - (F) Medical oncology summary or consultation report;
 - (vi) Report of one of the following radiologic studies:
 - (A) Upper gastrointestinal (GI) series with small bowel follow-through;
 - (B) Angiography;
 - (C) Computerized tomography (CT) scan; or
 - (D) Magnetic resonance imaging (MRI); or
 - (vii) Death certificate, provided that it is signed by a physician at the time of death.
- (9) *Primary cancer of the pancreas.*
 - (i) Pathology report of tissue biopsy or fine needle aspirate;
 - (ii) Autopsy report;
 - (iii) One of the following summary medical reports:
 - (A) Physician summary report;
 - (B) Hospital discharge summary report;
 - (C) Radiotherapy summary report; or
 - (D) Medical oncology summary report;
 - (iv) Report of one of the following radiographic studies:

- (A) Endoscopic retrograde cholangiopancreatography (ERCP);
 - (B) Upper gastrointestinal (GI) series;
 - (C) Arteriography of the pancreas;
 - (D) Ultrasonography;
 - (E) Computerized tomography (CT) scan; or
 - (F) Magnetic resonance imaging (MRI); or
 - (v) Death certificate, provided that it is signed by a physician at the time of death.
- (10) *Primary cancer of the bile ducts.*
 - (i) Pathology report of tissue biopsy or surgical resection;
 - (ii) Autopsy report;
 - (iii) One of the following summary medical reports:
 - (A) Physician summary report;
 - (B) Hospital discharge summary report;
 - (C) Operative report;
 - (D) Gastroenterology consultation report; or
 - (E) Medical oncology summary or consultation report;
 - (iv) Report of one of the following radiographic studies:
 - (A) Ultrasonography;
 - (B) Endoscopic retrograde cholangiography;
 - (C) Percutaneous cholangiography; or
 - (D) Computerized tomography (CT) scan; or
 - (v) Death certificate, provided that it is signed by a physician at the time of death.
- (11) *Primary cancer of the gallbladder.*
 - (i) Pathology report of tissue from surgical resection;
 - (ii) Autopsy report;
 - (iii) Report of one of the following radiological studies:
 - (A) Computerized tomography (CT) scan;
 - (B) Magnetic resonance imaging (MRI); or
 - (C) Ultrasonography (ultrasound);
 - (iv) One of the following summary medical reports:
 - (A) Physician summary report;
 - (B) Hospital discharge summary report;
 - (C) Operative report;
 - (D) Radiotherapy report; or
 - (E) Medical oncology summary or report; or
 - (v) Death certificate, provided that it is signed by a physician at the time of death.

Department of Justice

§ 79.26

- (12) *Primary cancer of the liver.*
 - (i) Pathology report of tissue biopsy or surgical resection;
 - (ii) Autopsy report;
 - (iii) One of the following summary medical reports:
 - (A) Physician summary report;
 - (B) Hospital discharge summary report;
 - (C) Medical oncology summary report;
 - (D) Operative report; or
 - (E) Gastroenterology report;
 - (iv) Report of one of the following radiological studies:
 - (A) Computerized tomography (CT) scan;
 - (B) Magnetic resonance imaging (MRI); or
 - (v) Death certificate, provided that it is signed by a physician at the time of death.
- (13) *Primary cancer of the lung.*
 - (i) Pathology report of tissue biopsy or resection, including, but not limited to specimens obtained by any of the following methods:
 - (A) Surgical resection;
 - (B) Endoscopic endobronchial or transbronchial biopsy;
 - (C) Bronchial brushings and washings;
 - (D) Pleural fluid cytology;
 - (E) Fine needle aspirate;
 - (F) Pleural biopsy; or
 - (G) Sputum cytology;
 - (ii) Autopsy report;
 - (iii) Report of bronchoscopy, with or without biopsy;
 - (iv) One of the following summary medical reports:
 - (A) Physician summary report;
 - (B) Hospital discharge summary report;
 - (C) Radiotherapy summary report;
 - (D) Medical oncology summary report; or
 - (E) Operative report;
 - (v) Report of one of the following radiology examinations:
 - (A) Computerized tomography (CT) scan;
 - (B) Magnetic resonance imaging (MRI);
 - (C) X-rays of the chest; or
 - (D) Chest tomograms; or
 - (vi) Death certificate, provided that it is signed by a physician at the time of death.

- (14) *Primary cancer of the salivary gland.*
 - (i) Pathology report of tissue biopsy or surgical resection;
 - (ii) Autopsy report;
 - (iii) Report of otolaryngology or oral maxillofacial examination;
 - (iv) One of the following summary medical reports:
 - (A) Physician summary report;
 - (B) Hospital discharge summary report;
 - (C) Radiotherapy summary report;
 - (D) Medical oncology summary report; or
 - (E) Operative report;
 - (v) Report of one of the following radiology examinations:
 - (A) Computerized tomography (CT) scan; or
 - (B) Magnetic resonance imaging (MRI); or
 - (vi) Death certificate, provided that it is signed by a physician at the time of death.
- (15) *Primary cancer of the urinary bladder.*
 - (i) Pathology report of tissue biopsy or surgical resection;
 - (ii) Autopsy report;
 - (iii) Report of cytology, with or without biopsy;
 - (iv) One of the following summary medical reports:
 - (A) Physician summary report;
 - (B) Hospital discharge summary report;
 - (C) Radiotherapy summary report;
 - (D) Medical oncology summary report; or
 - (E) Operative report;
 - (v) Report of one of the following radiology examinations:
 - (A) Computerized tomography (CT) scan; or
 - (B) Magnetic resonance imaging (MRI); or
 - (vi) Death certificate, provided that it is signed by a physician at the time of death.
- (16) *Primary cancer of the brain.*
 - (i) Pathology report of tissue biopsy or surgical resection;
 - (ii) Autopsy report;
 - (iii) One of the following summary medical reports:
 - (A) Physician summary report;
 - (B) Hospital discharge summary report;

§ 79.27

- (C) Radiotherapy summary report;
- (D) Medical oncology summary report; or
- (E) Operative report;
- (iv) Report of one of the following radiology examinations:
 - (A) Computerized tomography (CT) scan;
 - (B) Magnetic resonance imaging (MRI); or
 - (C) CT or MRI with enhancement; or
- (v) Death certificate, provided that it is signed by a physician at the time of death.
- (17) *Primary cancer of the colon.*
 - (i) Pathology report of tissue biopsy;
 - (ii) Autopsy report;
 - (iii) Endoscopy report, provided the examination covered the duodenum and parts of the jejunum;
 - (iv) Colonoscopy report, provided that the examination covered the distal ileum;
 - (v) One of the following summary medical reports:
 - (A) Physician summary report;
 - (B) Hospital discharge summary report;
 - (C) Report of gastroenterology examination;
 - (D) Operative report;
 - (E) Radiotherapy summary report; or
 - (F) Medical oncology summary or consultation report;
 - (vi) Report of one of the following radiologic studies:
 - (A) Upper gastrointestinal (GI) series with small bowel follow-through;
 - (B) Angiography;
 - (C) Computerized tomography (CT) scan; or
 - (D) Magnetic resonance imaging (MRI); or
 - (vii) Death certificate, provided that it is signed by a physician at the time of death.
- (18) *Primary cancer of the ovary.*
 - (i) Pathology report of tissue biopsy or surgical resection;
 - (ii) Autopsy report;
 - (iii) One of the following summary medical reports:
 - (A) Physician summary report;
 - (B) Hospital discharge summary report;
 - (C) Radiotherapy summary report;
 - (D) Medical oncology summary report; or
 - (E) Operative report; or

28 CFR Ch. I (7-1-14 Edition)

- (iv) Death certificate, provided that it is signed by a physician at the time of death.

§ 79.27 Indication of the presence of hepatitis B or cirrhosis.

- (a)(1) If the claimant or eligible surviving beneficiary is claiming eligibility under this subpart for primary cancer of the liver, the claimant or eligible surviving beneficiary must submit, in addition to proof of the disease, all medical records pertaining to the claimant listed below from any hospital, medical facility, or health care provider that were created within the period six months before and six months after the date of diagnosis of primary cancer of the liver:
 - (i) All history and physical examination reports;
 - (ii) All operative and consultation reports;
 - (iii) All pathology reports; and
 - (iv) All physician, hospital, and health care facility admission and discharge summaries.
- (2) In the event that any of the records in paragraph (a)(1) of this section no longer exist, the claimant or eligible surviving beneficiary must submit a certified statement by the custodian(s) of those records to that effect.
- (b) If the medical records listed in paragraph (a) of this section, or information possessed by the state cancer or tumor registries, indicates the presence of hepatitis B or cirrhosis, the Radiation Exposure Compensation Program will notify the claimant or eligible surviving beneficiary and afford that individual the opportunity to submit other written medical documentation or contemporaneous records in accordance with § 79.72(b) to establish that in fact there was no presence of hepatitis B or cirrhosis.
- (c) The Program may also require that the claimant or eligible surviving beneficiary provide additional medical records or other contemporaneous records, or an authorization to release such additional medical and contemporaneous records, as may be needed to make a determination regarding the indication of the presence of hepatitis B or cirrhosis.