



**VETERANS
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QUARTERLY PROVIDER NEWSLETTER

Spring 2025

Greetings, VES Network Providers!

Thank you for taking time out of your busy schedule to review our latest issue.

Don't forget to play our "I read the provider newsletter!" contest. Congratulations to **Optometrist Dr. Eva Buker of Montana** who won the contest in March. **The next winner could be YOU.** There are only two steps to win: 1) Read the newsletter and 2) Send a message to the Provider Help link in your portal (or e-mail vesproviderhelp@vesservices.com) with your name and mention something you learned by reading the newsletter. That's it! One lucky provider's name will be drawn on Friday, May 30th and awarded \$200.

General Reminders for All VES Providers

Comments and conversations with Veterans

On occasion, VES receives complaints from Veterans regarding their provider's comments which they felt were outside the scope of the exam. It's important for providers to stay apolitical during their VES evaluations, refraining from sharing any personal opinions on VA, the military, politics, etc.

DoxyMe

Please be advised VES's DoxyMe account may only be used to conduct VES disability examinations. VES examiners may not utilize this account for

IN THIS ISSUE

- 02** From Our Medical Director: Avoid These Errors on Heart, Neuro, and Musculoskeletal DBQs
- 05** TBI: Perspectives, Pitfalls and Pearls: Nature of VA Returns and "Guardrails" for improvement'
- 08** Mental Health: Tips on the Symptoms Section, Defining Military Sexual Trauma
- 11** Audiology: Citing Studies for Medical Opinions and Rationales within the DBQ
- 12** QCA Corner: Message from the VA Audiology Medical Officer for VES Audiologists
- 13** What our Veterans are saying

meetings with individuals seen through any other aspect of their practice, such as therapy clients or disability examinations scheduled by vendors other than VES. Examiners are



reminded they may only invite Veterans with a corresponding VES case number and scheduled TCP (Telehealth Compensation & Pension) exam to join a meeting hosted through VES's DoxyMe account, and that extraneous meetings are logged on the account history.

VES Medical Advisory Board

VES is proud to offer a multi-specialty Medical Advisory Board to support our always-growing provider network. Feel free to contact our Board Members at any time with your questions, concerns, or feedback.

National Medical Director,

General Medicine: Jeffrey Middeldorf, D.O.
Jeffrey.middeldorf@vesservices.com

Neurology: Ret. Col. Beverly Scott, M.D.
beverly.rice.scott@gmail.com

Internal Medicine: Ravindra Gopaul, M.D.
rgopaul2@gmail.com

General Practitioner: Holly Gallegos, P.A.
hgallegos5@aol.com

Psychology: Maria Baker, PhD.
MariaKBaker@gmail.com

Audiology: Lauren Simpkins, AuD.
northtxaud@gmail.com

Audiology: Jeffrey Cooper, AuD.
cooperaudiology@gmail.com

Dental: Andrew Sperle, D.D.S.
ASPERLE@msn.com

Ophthalmology: Cary Freeman, M.D.
CFREE43274@aol.com

From Our Medical Director

Hello Fellow Examiners,

Happy Spring!

For this Newsletter, we are going to continue to discuss quality issues to improve our reports. The below is based in large part on the discussion our team has had with the VA medical and quality control staff. Avoiding these errors will not only prevent reworks from our client, VA, but also addendum questions from QCAs.

Continued errors on the Heart DBQ:

1. Some of you still are listing the etiology of coronary artery disease as "plaque." This is not correct. The VA wants to know the cause, like hyperlipidemia, smoking, hypertension, Agent Orange, Diabetes, etc.
2. Some of you are putting multiple diagnoses in the Ischemic Heart Disease Box, but the problem is, you do not select coronary artery disease or arteriosclerotic heart disease. Without one of these chosen, it is not possible to have any condition secondary to ischemia.



3. We see pulmonary hypertension diagnosed on a heart exam. This diagnosis would not go on a Heart DBQ but rather the Respiratory DBQ.
4. When asked about the Ischemic Heart Disease, some examiners automatically place Coronary Artery Disease (CAD) or Arteriosclerotic Heart Disease (ASHD) in that category. However, the mere presence of either of these does not automatically qualify them as IHD. There needs to be evidence that they are severely advanced enough that they have caused ischemia, such as on a stress test, or perfusion scan, and of course if they have had a stent or CABG surgery, as examples.
5. I see examiners diagnose cardiomyopathy without any objective evidence. We need documentation of testing that has proven that condition exists, like an echo for instance.
6. I see this one fairly often on the heart exam: a veteran has multiple diagnoses, such as Cardiomyopathy, Atrial fibrillation, CAD, Myocardial infarction, and Valvular disease. It is noted the VA conceded Agent Orange exposure, so noting the etiology of the CAD as due to Agent Orange is correct. What is not correct is listing Agent Orange as the etiology for all of the conditions. Many of the conditions, like the MI, would be related to the CAD, so indirectly Agent Orange, but the VA wants the direct cause.
7. Last point on the heart exam today. Thankfully, I do not see this often, but I do see it occasionally: when asked the etiology of hypertensive heart disease, the answer given is "unknown," when, of course, it is hypertension.

Continued errors on the neurological DBQs:

1. In the various neurological DBQ's, I am still seeing some of you will list the ankle dorsiflexors and plantarflexors as well as the great toe extensor as 0/5, along with an absent Ankle reflex and absent sensation in a veteran with a below knee amputation. The correct way to deal with this is to leave them all blank, and explain in the remarks why you did so. By selecting 0/5 for the muscles, the reader may assume there was a testable muscle, and it is paralyzed.
2. This week, I saw a report where the diagnosis was radiculopathy. Strength, sensation and reflexes were all normal. The only positive test was the straight leg raise. The examiner diagnosed femoral radiculopathy; however, the SLR test is only for the sciatic nerve.
3. Another case this week found the diagnosis of peripheral neuropathy in the bilateral lower extremities. There was a loss of sensation in the bilateral lower extremities, diffusely. There was 3/5 muscle weakness, diffusely. The problem was when they were asked about atrophy, they said there was atrophy, but they could not measure it as the veteran had his pants on. If true, then how was accurate sensory testing completed?
4. Another recurring error we are seeing is that there are internal inconsistencies in the exams; specifically, this happens the most in the spine and neurological DBQs. The most common error is testing the same muscle on different DBQs, and entering a different strength for them in the various DBQs. Same for sensation and reflexes.
5. Another common error on the Back DBQ is the apparent confusion over what the femoral nerve is and how it functions. I saw one case this week, which I have seen many times before,



where there was weak knee extension supplied by the femoral nerve, as well as weak ankle dorsiflexion and plantarflexion, and yet the diagnosis was sciatic radiculopathy only, without reconciling why the non-sciatic nerve supplied muscle is weak.

Continued Errors on the Joint DBQs:

Lastly, a few specific errors the VA brought to our attention on musculoskeletal exams:

1. On the Knee DBQ, Section 3A asks about the knee Range of Motion. In the error trend they are seeing "all normal" entered, yet the next question which asks if the ROM is abnormal, does it cause functional loss, the provider is answering "No." Answering "No" implies the ROM was not normal, which is an internal inconsistency.
2. On shoulder exams, a similar error trend was noted. Question 8C asks if there is a clavicle, scapula, acromioclavicular joint, sternoclavicular joint condition or other impairment? The answer was NO. Question 8D then asks if the condition affects ROM, and this was answered NO. Again, this is an internal inconsistency, as this implies the answer to the 8C was supposed to be YES.
3. Last one: the error trend example was in the Knee DBQ. Section 13D asks if there were any significant diagnostics tests. In the errors noted, the examiner answered YES, and then gave a detailed summary of the knee MRI scan. Here

Jeffrey Middeldorf, D.O.
VES National Medical Director
Jeffrey.Middeldorf@vesservices.com





is the problem: in 13E the form asks if any of the results were other than normal, indicate the relationship of the abnormal findings to the diagnosed condition. They answered “normal MRI of the knee,” however, obviously, this is internally inconsistent.

TBI: Perspectives, Pitfalls and Pearls: Nature of VA Returns and “Guardrails” for improvement

In my role as the VES Medical Advisory Board member on TBI and Neurology, I am often asked to help address VA Returns, especially on cases whereby the original examiner is no longer active in VES. In this letter, I will focus on the specific problems found in the submitted TBI exams identified by the VA, leading to returns.

As we have discussed in prior quarterly TBI newsletter articles, these exams are often difficult to perform accurately due to a variety of reasons. It is important to note that only a small fraction of our exams are audited, so it is not uncommon for providers to be concerned when reports are returned despite their typical exam approach and documentation style. Hopefully this review will help examiners avoid future returns with better awareness of the VA's requirements and expectations.

I will also highlight some “guardrails” for providers and QCAs, to help identify potential problems with reports prior to submission. While our QCAs do outstanding work at identifying administrative errors and inconsistencies, it is not within their scope to identify acceptable medical record evidence, flaws in diagnosis and symptom/condition attributions, and clinical reasoning to support or negate medical opinions.

There were approximately a dozen VA Returns for TBI exams over the past two months, which fell within two main categories:

1. Disparity between Diagnoses, Medical History, Section II Facets, and Section III Residual Conditions
2. Lack of medical record evidence and/or sufficient rationale supporting medical opinions regarding in-service TBI event and/or residual conditions

Several representative examples and my review and case disposition will be discussed.

Disparity between Diagnoses, Medical History, and Section II and Section III:

Case returned due to rendered TBI diagnosis, with headaches and aphasia listed in Section II, however not listed in Section III and associated DBQs not triggered.

Review: Medical record evidence supporting TBI diagnosis was limited to a discharge summary listing concussion (without any clinical details) and lack of medical history supporting TBI diagnosis in Section I. Multiple listed Section II facets and Section III residual conditions were not supported by documented medical history or medical record review.

Disposition: Case required re-assignment for re-work.

Case returned due to disparity between rendered diagnoses and MO's.

Review: Examiner rendered TBI diagnosis, citing multiple post-service head injury events, with headaches listed as current symptoms. Headache DBQ provided no details related to headaches,

rather only copied the trauma history listed in the TBI DBQ. Negative opinion was rendered by examiner for direct service connection regarding TBI and headaches, with positive opinion rendered for migraine in relation to TERA exposure, however rationale cited these headaches were most likely secondary to SC OSA due to toxic fuel exposure.

Disposition: Case required re-work due to these identified errors inconsistencies.

Case returned due to rendered TBI diagnosis with Section II.7 'three or more symptoms to TBI' listed, however only headaches listed example.

Review: Headache DBQ provided sufficient support for post-traumatic headaches with prominent migraine component, with associated photophobia and phonophobia. Multiple inappropriate examples were provided for listed Section II facets as attributable to TBI without medical record support.

Disposition: Photophobia and phonophobia were added to Section II.7. Several other Section II facets were removed.

Case returned to clarify the diagnosis of headaches and to clarify if evidence supported TBI or simply head injury.

Review: Headaches were listed as a residual condition of TBI, however headache history noted in Headache DBQ only stated 'suffering from headache pain since his head injury in 2015.'

Disposition: Limited support for TBI supported by medical record and documented medical history in the TBI DBQ supporting rendered TBI diagnosis, however there was no medical record or detailed headache history supporting the diagnosis of post-traumatic headaches.

Lack of Medical Record Evidence and Sufficient Rationale

Case returned to clarify if migraine was attributable to SC tinnitus, referencing a prior negative medical opinion for same, in addition to several predominantly post-service clinical notes





regarding headaches.

Review: The examiner rendered a positive opinion for headaches secondary to veteran's service-connected tinnitus, however rationale was limited to statement "occurred in service prior to deployments."

Disposition: The return was addressed by providing a negative opinion, while referencing lack of medical record support for migraine during military service and providing statement of lack of causal relationship between these conditions.

Case returned for medical record evidence to support TBI and Headaches.

Review: The examiner rendered the diagnosis of TBI and Headaches, however only stated 'headaches are common sequelae of TBI' in the MO, rather than providing medical record support for the TBI diagnosis.

Disposition: The return was addressed citing several early post-service VAMC TBI evaluations supporting the TBI diagnosis, while there was insufficient medical record or documented clinical history supporting post-traumatic headaches.

Case returned to provide medical record support for parachute related TBI.

Review: The examiner rendered positive opinion for TBI secondary to remote 1966 parachute jump with rationale limited to 'hit head on a jump while on active duty' with no medical record evidence cited, rather examiner provided a lengthy (multiple paragraphs) discussion on pathophysiology of TBI and post-concussive syndrome. Medical records showed no evidence for injury event.

Disposition: Negative medical opinion rendered, citing not only lack of medical record evidence for the remote injury event, with lack of clinical history documented in the TBI DBQ supporting TBI.

Guardrails for Providers and QCAs to avoid returns:

1. Pertinent medical record evidence should ideally be cited in the TBI DBQ, and associated DBQ Evidence text block, facilitated by using the 'copy and paste' function in MRV. (See Fall 2022 newsletter)
2. Several Section II Symptoms attributable to TBI are associated with Section III Residual conditions when supported by medical records and comprehensive interview. These facets and conditions should also ideally be discussed in Section I Medical History if deemed attributable to TBI, while considering potential impact of comorbid conditions. (See Fall 2021 newsletter)
3. TBI Medical History should describe in-service injury events to support TBI diagnosis.
4. Ensure Section II facet selections are supported by sufficient and appropriate





examples. (See Winter 2025 newsletter)

5. Chronological comprehensive headache history, ideally supported by medical record evidence if present, is required to support diagnosis of post-traumatic headaches. (See Winter 2022 newsletter)
6. Ensure the rendered medical opinion specifically addresses the requested medical opinion, with medical record evidence cited to support the opinion.
7. Lengthy MO opinions are not likely useful, especially if they do not specifically provide support for the claim.

TBI disability exams require diligent medical record review, adequate face-to-face time for comprehensive interviews, and careful documentation. Please let me know if you have any questions about this review. I am always happy to discuss these complex cases and offer guidance.

– **Beverly R. Scott, MD.**

VES Medical Advisory Board Member
TBI/Neurology
beverly.rice.scott@gmail.com

Mental Health

VES has historically provided symptom definitions intended to help guide psych examiners in determining whether or not to select a particular mental health symptom on the PTSD and Mental Disorder DBQs. As requirements, guidance, and best practices have evolved over the years, VES developed updated symptom definitions. If you have recently joined the VES provider network, you would have been trained on the updated symptom definitions. For our more seasoned examiners, we would like to inform you that the “Tips Symptoms” document currently available in the provider portal is now considered obsolete. As of now, we ask that all psych examiners begin utilizing this updated list of symptom definitions. While this document is intended to provide clinical guidance, please note that it is not a replacement for clinical judgment, which should always be exercised when completing any DBQ.

Tips for the “Symptoms” Section in the Mental Health DBQs

Depressed mood: This symptom should





be selected when clinically significant depression is present, either as a symptom of a depressive disorder or other disorder presenting with significant alterations in mood, such as a trauma related disorder. This symptom should be selected when depressed mood contributes to clinically significant distress and/or impairments.

Anxiety: This symptom should be selected when clinically significant anxiety is present, either as a symptom of an anxiety disorder or other disorder presenting with significant nervousness, panic, or worry such as a trauma related disorder. This symptom should be selected when anxiety contributes to clinically significant distress and/or impairments.

Suspiciousness: This symptom should be selected when suspiciousness, paranoia, or significant distrust is present as a clinically significant aspect of a mental disorder such as trauma disorder, psychotic spectrum disorders, or personality disorders.

Panic attacks that occur weekly or less often: This symptom should be selected when the Veteran meets DSM-5 criteria for panic attacks which have occurred more than a couple of times within the past 12 months, weekly or less.

Panic attacks more than once a week: This symptom should be selected when the Veteran meets DSM5 criteria for panic attacks which have occurred more than once per week over recent months.

Near-continuous panic or depression affecting the ability to function independently, appropriately and effectively: This symptom should be selected when depression or panic are contributing to such severe impairment that the Veteran is spending much of the day in bed and/or unable to independently carry out many activities of daily living due specifically to severity of depression or panic symptoms.

Chronic sleep impairment: This symptom should be selected when clinically significant sleep impairments are found to be psychologically-induced and not otherwise fully explained by other conditions or factors such as sleep apnea, substances, or chronic pain. If selecting this symptom, sleep impairments should be present most days per week and should be contributing to clinically significant





distress and/or functional impairment. This symptom can apply to both insomnia and hypersomnia.

Mild memory loss, such as forgetting names, directions or recent events: This symptom should be selected when evidence of impaired recall is evident upon exam, or when a Veteran's history reveals mild memory related impairment in recent social or occupational functioning.

Grossly inappropriate behavior: This symptom should be selected when the Veteran meets criteria for a severe mental health disorder that is directly contributing to a display of behavior that is likely to result in immediate intervention such as hospitalization or incarceration. Examples include behavior displayed during a manic episode, a psychotic episode, or in the context of severe behavioral disturbances in a neurocognitive disorder.

Persistent danger of hurting self or others: This symptom should be selected if the Veteran is found to be an imminent danger to self or others and should generally be accompanied by a detailed risk assessment, documentation of all actions taken, and a report to VES to alert them of the risk assessment results and steps taken to promote safety.

Neglect of Veteran's appearance and hygiene: This symptom should be selected if hygiene neglect is a direct result of a specific mental health symptom, such as depression with low motivation, or other conditions characterized by lack of initiation for self-care. It should not be selected if hygiene impairments are better attributed to mobility or medical conditions.

Intermittent inability to perform activities of daily living, including maintenance of minimal Veteran's hygiene: This symptom should be selected if a mental health disorder is directly contributing to a Veteran's inability to perform basic activities of daily living due to severe symptoms such as psychosis, disorientation, or severe depression, such as with psychomotor retardation. This symptom should be supported by aspects of the Veteran's history such as ongoing need for a caregiver.

Disorientation to time or place: This symptom should be selected if the Veteran meets criteria for a severe mental health disorder such as a major neurocognitive disorder or schizophrenia that is characterized by a level of disorientation that would suggest necessity for immediate intervention such as hospitalization or other increased level of care.

Defining Military Sexual Trauma

VA provides us with a specific definition for Military Sexual Trauma that all psych examiners must utilize when determining whether or not a stressor should be considered "MST" for examination purposes. VA defines MST as ***"sexual assault or sexual harassment experienced during military service. MST includes any sexual activity during military service in which (the Veteran) is involved in against (their) will or when (they) are unable to say no."*** In the past, we have often considered "military service" to mean active-duty service, however, VA reminds us that, per 38 U.S.C. § 101(2) and (24), ***An individual who suffers from post-traumatic stress disorder as a result of a sexual assault that occurred during inactive duty training may be considered disabled by an "injury."*** This means that occurrence during an active duty service period is not a requirement for MST.

We have recently been provided with updated procedures for ensuring that this code is followed.

1. The examiner is asked to consider a claimed stressor to constitute MST if it meets the definition above and if it occurred during any military service period per the Veteran's report, even if the stressor falls outside of the active duty service dates provided.



2. VA reminds us that it is VA's ultimate responsibility to determine if an MST stressor occurred during a period of qualifying service.
3. VA will make this determination AFTER examiners have completed the I-PTSD exam and MST opinions. This means that VA requests that we complete the MST opinions even if we suspect that a claimed MST stressor occurred outside of active duty.

Therefore, if a Veteran reports that an MST stressor occurred during their military service (be it active duty, reserve service, guard service, etc), please consider this to meet the "during service" requirement indicated in VA's definition of MST. As always, this update addresses just a small piece of what is required when completing examinations for Military Sexual Trauma; for more information, please review the Fall 2024 Newsletter Article entitled Evaluation of Sexual Assault and the Summer 2021 Newsletter Article entitled MST Medical Opinion Update. Thank you for your close attention to this complex area of our work, and for incorporating this guidance into your practice!

– Maria K. Baker, PhD.

VES Medical Advisory Board Member
Mental Health
mariakbaker@gmail.com

Audiology: Citing Studies for Medical Opinions and Rationales within the DBQ

Hello, fellow Audiologists!

Recent feedback from the VA has touched on the topic of citing research studies for medical opinions and rationales. VA guidance for the inclusion of studies to support these opinions for service-connected tinnitus and/or hearing loss for our Veterans emphasizes the use of human studies only. To be clear, any scientific research literature used in these opinions should be based on human models or subjects and not solely on animal studies.

Can I cite research literature as part of the medical opinion or rationale? Yes! These cited studies should be based on human subjects as much as possible, and not solely on animal studies. Medical research literature can be a supportive piece of evidence, especially when other evidence is sparse or not available.

When should I cite research for a medical opinion or rationale? Use of medical research based on human subjects should be used whenever necessary. As mentioned above, if there is a lack of evidence such as military audiometric data, DD214s, or anything else pertinent to establishing an opinion for service-connected hearing loss and/tinnitus, then the use of medical literature based in human studies may be helpful.

Please keep in mind:

- Use of human studies related to noise exposure and veteran populations can be useful,

especially if other forms of evidence are sparse

- Such studies are often limited as far as evidence showing patterns of delayed onset hearing loss or tinnitus (see below)

While many studies looking at the effects of noise have been carried out using animal models, these types of studies are not ideal for supportive evidence in medical opinions and rationales for service-connected hearing loss and/or tinnitus. As summarized in the 2006 Noise and Military report, "There is not sufficient evidence from longitudinal studies in laboratory animals or humans to determine whether permanent noise-induced hearing loss can develop much later in one's lifetime..." (Humes, Joellenbeck, & Durch, 2006 Noise and Military Service).

Warm regards,

– Jeffrey Cooper, AuD.

VES Medical Advisory Board Member
Audiology
cooperaudiology@gmail.com



QCA Corner: Message from the VA Audiology Medical Officer for VES Audiologists

When a hearing loss etiology opinion is provided, the examiner's rationale should not **solely** discuss that hearing was normal at the times of the Veteran's enlistment and separation. When there is a current diagnosis of hearing loss, the examiner should explain how the provided opinion was reached. This includes discussing all pertinent objective evidence in the Veterans records, lay testimony from the Veteran, and scientific literature that either refutes or supports a relationship between the current hearing loss and an event, injury, or disease during military service. This would also include discussion to address delayed onset hearing loss, and post service pertinent factors.

Decision makers are being instructed to not deny service connection for hearing loss based on an examiner's etiology opinion rationale **solely** discussing that hearing was normal during service. The examination report will be returned due to an insufficient medical opinion rationale, and the examiner will be asked to discuss how the evidence refutes a nexus.

Thank you for your continued collaboration in improving Hearing Loss and Tinnitus exams for our Nation's Heroes!



What our **Veterans are saying!**

“

My visit was very upbeat and to the point. I found the Dr. and her staff very kind, courteous, and very helpful. I thank them for the help they provided!

”

“

I was very impressed with the clinic, there was no wait and Dr. Makia actually started my exam early which was helpful. Raynie and Claudia were attentive and sweet and everyone made me feel safe and well looked after. Especially at the end of the exam when my vertigo started kicking in a little. I appreciate all of you so much, truly. Thanks for helping me with this stressful process, I left with a big smile.

”

“

Excellent professionalism. I was impressed with their professionalism. They had all my paperwork ready and the receptionist took me back to get started.

”