DMA Medical Opinions

Note:

This document has been created as a print version of the VA EES web-based *DMA Medical Opinions* course. For digital accessibility by users of assistive technology, the document has a dynamic table of contents, electronic form fields and buttons in the knowledge checks and exercises and links in the knowledge check and exercise feedback. Public-facing URLs are hyperlinked as well, but VA intranet links **are not** active as they will not work outside of VA's network. No other interactivity exists in this document, even when referenced in the text.

Introduction

Welcome

This course is a joint presentation of the Veterans Health Administration (VHA) Office of Disability and Medical Assessment (DMA) and the Employee Education System. This program will focus on the Compensation and Pension (C&P) medical opinion. Practicing individuals from the Board of Veterans' Appeals (BVA), the Veterans Benefits Administration (VBA), and VHA contributed to this course.

Course Purpose

The purpose of this Web-based training course is to provide you with information to aid in your understanding of how to write medical opinions that are sufficient for adjudication purposes. It will address a knowledge gap by providing updated information, including procedures on how to write legally adequate medical opinions. You will successfully address the knowledge gap by achieving a score of 80 percent or higher in the Final Assessment.

Target Audience

This training is designed for C&P examiners seeking information on how to prepare for and write medical opinions that are adequate for purposes of adjudicating VA benefits claims.

Length of the Course

This course will take you approximately one and one-half hours to complete. If you must exit the course before completion, your place will be bookmarked so you can continue where you left off. However, in order for the bookmark to work, you must use the course Exit (x) button and not the browser's close button.

Please complete the lessons in the order presented so you can build on knowledge from one lesson to the next. Each lesson includes knowledge checks or exercises designed to help you apply the knowledge you gain along the way.

TACK NOTE

When you complete the entire course, you will have access to the Final Assessment. A score of 80 percent or higher on the Final Assessment is required for accreditation purposes. The final page of this course contains instructions for accessing a certificate of completion.

Course Objectives

Terminal Learning Objective

At the completion of this course, you should be able to identify the criteria and recognize the general process for writing a legally adequate medical opinion with a supporting rationale that addresses the questions and instructions on a C&P Examination Request for a Veteran's or Servicemember's claim. This includes using VBA-recommended language for the opinion and explaining the opinion with a comprehensive rationale.

Enabling Learning Objectives

There are three enabling learning objectives to help you meet the terminal objective:

1. Identify types, purposes, and the basic elements of medical opinions and rationales.
2. Describe the process and required content for a medical opinion.
3. Identify special protocols or circumstances that may impact a medical opinion.

This course will use case study narratives and scenarios to demonstrate aspects of writing a medical opinion. Select Next to learn more about case studies for this course.

Case Studies

This course will use different interactive scenarios for instruction. Several scenarios will be based on one Veteran named Dale Willow. Mr. Willow was a clerk in the U.S. Army from 1968-1970 with a deployment to Vietnam. After service, he worked in construction but he's since retired. Mr. Willow's original C&P claim will be for neck pain. The facts and clinical evidence for his claim will vary in different scenarios as we look at different purposes for medical opinions, such as resolving questions of etiology or relationships of a disability to service.

All case studies and sample opinions in this course pertain to fictitious claimants and are not intended to reflect the life or situation of any Veterans or Servicemembers, living or deceased.

This completes the introduction to this course. The first lesson begins on the next page and provides you with an overview of C&P medical opinions.

Medical Opinion and Rationale Overview

Learning Objective

This lesson begins by outlining which components are essential in formulating C&P medical opinions. You'll be given background information including the legal history of medical opinions for C&P claims and, within that context, the purposes served by medical opinions. In order to write a sufficient medical opinion, you'll need to recognize the basic elements that make up a medical opinion: the opinion itself and the supporting rationale. Since not every C&P examination requires an opinion, you will be given basic information to enable you to determine whether an opinion is required or not.

When you complete this lesson, you should be able to identify types, purposes, and the basic elements of medical opinions and rationales.

A C&P Medical Opinion Defined

For C&P purposes, a medical opinion is a conclusion made by an examiner based on the body of current medical knowledge and the evidence of record. Most commonly, you will be asked to provide a medical opinion to help with the following determinations by adjudicators:

- Determine a condition's relationship to an event, injury, illness, or disease during a claimant's military service
- Determine relationships between medical conditions
- Determine a condition's etiology
- Reconcile diagnoses

A sufficient medical opinion must be stated in the language recommended by VBA. For example, to express at least a 50 percent probability, the opinion will use the phrase “at least as likely as not.” A sufficient medical opinion always includes a well-reasoned, comprehensive supporting rationale.

IMPORTANT NOTE

Because a C&P medical opinion must apply medical knowledge, judgment, and experience to the pertinent facts of a case, different opinions can result based on a review of the same evidence by different examiners.

The Audience

The audience for your medical opinion will primarily be VA adjudicative staff, such as Rating Veterans Service Representatives (RVSRs). If a claim is appealed, the audience would include Decision Review Officers (DROs), attorneys, and judges. Please keep in mind that a medical opinion is one of multiple factors considered in deciding the Veteran’s claim. Your medical opinion is a critical part of the overall claims process but it is not the sole factor for determining entitlement to benefits.

> Writing an effective medical opinion begins with understanding how it must be used by the adjudicator. In general, it is the role of the examiner to provide information and opinions that are uniquely within his or her expertise, and it is the role of the adjudicator to take that information and apply it to the relevant legal criteria.
>
> — James Ridgway, (2012)

Why is a Medical Opinion Needed?

VA does not need an examination or a medical opinion for every service-connection claim. VA is required to provide an examination and/or a medical opinion when:

1. The record contains competent evidence that the claimant has a current disability or persistent signs or symptoms of a current disability;
2. The record indicates that the disability or signs and symptoms of disability may be associated with active service; and
3. The record does not contain sufficient information to make a decision on the claim.

Sources: 38 U.S.C. 5103A(d) and McLendon v. Nicholson, 2006.

Additionally, there are other legal cases which have impacted when a medical opinion is necessary. In 1991, the Colvin v. Derwinski court case discussed why medical opinions were required, while the Charles v. Principi case clarified when VA should request an examination and/or a medical opinion.

Colvin v. Derwinski

In 1991, the Colvin v. Derwinski case set forth this requirement: VA must consider only independent medical evidence contained in the record to support its medical findings, and not its own unsubstantiated medical expertise or judgment. In other words, where the record is incomplete, VA adjudicators may not rely on their own expertise to “fill in the blanks.” (Colvin v. Derwinski, 1991).

Charles v. Principi

In 2002, the Charles v. Principi case took requirements a step further. As a result of this legal case, when a Veteran submits a substantially complete claim, VA is obligated to request not only a VA examination, but also a medical opinion if either or both are required to fairly decide a claim. The Charles case also defined the purpose of medical opinions: to reconcile diagnoses, determine the relationship between conditions, or determine the etiology or nexus of a condition. (Charles v. Principi, 2002).

The Examiner's Medical Opinion Process

Here is an overview of the examiner's medical opinion process in three steps. We'll go into more detail later in this course.

Step One: Identify the Questions Presented

A medical opinion is requested by VBA or BVA to answer a question related to a pending claim for benefits. As an examiner, you'll start by reviewing the instructions and questions posed on the Examination Request. In the following example, the Veteran sustained a neck injury while riding in a truck during service.

The adjudicator is requesting an opinion in order to assist in determining whether any current disability is related to the injury sustained in service. Here is a sample request for an opinion as it might be seen on an Examination Request (VA 21-2507) or VERIS (Veterans Examination Request Information System) form:

Requested Opinion

The Veteran claims service connection for a cervical spine condition with pain and stiffness. Please determine whether the Veteran's current cervical spine condition is at least as likely as not (50 percent or greater probability) due to or caused by events during military service.

Benefit of the Doubt

Note that the requestor uses the phrase "at least as likely as not." This is because a unique standard of proof applies in decisions on claims for Veterans benefits. Unlike other claimants and litigants, a Veteran is entitled to the "benefit of the doubt" when there is an "approximate balance of positive and negative evidence." (38 U.S.C. 5107(b), 2002); Gilbert v. Derwinski, 1990). When there is equivalent evidence both for and against a claim, VA tips the balance in favor of the Veteran. In other words, "the tie goes to the runner."

For this requested opinion, you have three questions to answer:

1. Does the Veteran presently have a diagnosed cervical spine condition?
2. Did the Veteran have a diagnosed cervical spine condition at any time since filing his claim for benefits?
3. Is it as least as likely as not that the Veteran's claimed condition is proximately due to (caused by/etiologically related to) an event, illness, or injury during service?

Step Two: Gather and Review Evidence

Next, you gather evidence. In addition to the Examination Request and the current C&P examination report, you may need to review evidence from many sources in the claims file (C-file), to include:

- Previous C&P examinations
- Available medical records
- Lay Testimony

Sometimes the Veteran or Servicemember provides you additional evidence such as an examination report from a private provider, which should be noted and reviewed. You may need to order appropriate testing to provide data for the medical opinion and rationale. In addition to these sources, you should review relevant medical literature when applicable.

Step Three: Write the Medical Opinion

Finally, you weigh the evidence and draw upon your clinical expertise to provide a medical opinion that incorporates two elements:

1. A clear and specific medical opinion, using VBA-recommended language.
2. A comprehensive supporting rationale for the opinion

We'll discuss the opinion on this page and the supporting rationale on the next page.

The Opinion

The Examination Request often recommends this language for the opinion. State your conclusions using one of the following legally recognized phrases:

a) _____ is at least as likely as not (50 percent or greater probability) caused by or a result of_____.
b) _____ is less likely than not (less than a 50 percent probability) caused by or a result of_____.

Medical Opinion documentation protocols use similar language.

Note: Using equivocal terms such as “might,” “may be,” or “probably” as part of your opinion is unacceptable. A decision rendered by the U.S. Court of Appeals for Veterans' Claims (CAVC) provides insight into how adjudicators view these terms:

"A medical opinion phrased in terms of “may” also implies “may or may not” and is too speculative to establish a medical nexus.” (Bostain v. West, 1998)

The Supporting Rationale

A rationale is a summary of your thought process that led to the conclusion expressed in the opinion. The rationale gives a clear, understandable explanation for the decision that was offered and contains these elements:

1. A reference to reviewing the C-file and any pertinent records, and when applicable, remand instructions from the Board of Veteran’s Appeals (BVA)
2. Case-specific data reviewed in determining the opinion
3. Cited medical literature, when applicable, to support the opinion

IMPORTANT NOTE

The term “medical opinion” in this course and on the job will always mean an opinion supported by a comprehensive rationale. For C&P purposes, a medical opinion is only sufficient when supported by a comprehensive rationale.

An Unbiased Approach

VA's system of claims adjudication is non-adversarial. VA is obligated to develop the evidence needed to render an informed decision, provided the evidence is obtained in an impartial, unbiased, and neutral manner.

You will notice that VA is careful to use unbiased language for examination requests. As the examiner, you must be unbiased in your approach. You are expected to review and weigh all available evidence for and against a claim and use your clinical expertise and any pertinent medical literature to formulate and substantiate a medical opinion.

In phrasing a medical opinion, it’s essential that you use neutral language that does not suggest a desired outcome. Be impartial and unbiased in answering questions. Examination reports can be sent back for clarification if there is indication of bias, such as addressing only evidence that supports a particular conclusion and ignoring evidence that contradicts that conclusion.

While a medical opinion could be determined to be insufficient for reasons such as lacking a rationale, or if the rationale is based on inaccurate facts, a medical opinion is never “correct” or “incorrect,” per se.

STICKY NOTE

Address all pertinent evidence and not just the evidence that supports the opinion

Confine Your Opinion to Medical Issues

It’s important to remember that as a medical examiner, you cannot opine on matters outside your medical expertise. Avoid commenting on legal issues such as whether or not VA benefits should be granted, and if so, what disability rating should be assigned, since these are not medical issues. Instead, focus on what the adjudicator needs from your medical opinion.

What does the adjudicator need?

There are four considerations:

1. A clear conclusion stated in language recommended by VBA
2. A rationale for the conclusion
3. All pertinent facts were considered in forming the opinion
4. The C-file or electronic version was reviewed (when required)

You may be asked to provide several different types of medical opinions. Different types of medical opinions are discussed next.

Types of Medical Opinions

Here is a list of more commonly requested types of medical opinions. Select each opinion type for details. You may be asked questions about this material.

Direct Service Connection

A direct service connection opinion is often called a nexus opinion because it has to do with determining the relationship between a condition and the Veteran's or Servicemember's time in service. The US Code of Federal Regulations (CFR) sets forth the principles for direct service connection in 38 CFR 3.303 (Principles relating to service connection) and 38 CFR 3.304 (Direct service connection, wartime and peacetime).

Purpose of a Direct Service Connection Opinion

Determine whether a claimed disability had its onset in service or is otherwise related to service due to an event, injury, disease, or illness that occurred in service.

IMPORTANT NOTE

VBA's threshhold for requesting an opinion regarding whether a condition is related to service is, by law, very low.

Secondary Service Connection

A secondary service connection opinion concerns disabilities that are proximately due to, or aggravated beyond natural progression by a previously identified service-connected (SC) condition.

Purpose of a Secondary Service Connection Opinion

Determine whether a nonservice-connected (NSC) condition is due to, caused by, or a result of an already SC disability. Two medical opinions may be required to address the relationship between the claimed condition and the SC condition.

1. The first opinion addresses whether or not an NSC condition is directly caused by (due to) an SC disability. If yes, then there is no need for an "aggravation" opinion for that condition.
2. If the first opinion is negative (the NSC condition is not **directly** due to the SC condition), a second opinion is then needed to address whether the NSC condition has been aggravated beyond its natural progression by the SC condition. This type of medical opinion is a secondary (Allen) aggravation opinion, after the *Allen v. Brown* case.

Aggravation of a Nonservice-Connected Disability (Allen)

Allen refers to a court case heard in the United States Court of Veterans Appeals in 1995. In this case, which spanned close to 30 years and several decisions, the Court determined that service connection may be granted not only for disabilities caused by a service-connected disability, but also for conditions that merely had been aggravated by a service-connected disability. In other words, there need not be a direct causal relationship between the service-connected disability and the other condition. It is only necessary to identify that the claimed condition was permanently worsened or "aggravated beyond natural progression" by the SC condition.

Purpose of an Aggravation (Allen) Opinion

Determine whether an NSC condition has been aggravated beyond its natural progression by an SC condition.

Aggravation of a Preexisting Condition

This type of opinion addresses whether or not a condition that pre-existed entrance into service was permanently worsened due to events in service.

Purpose of an Aggravation of a Preexisting Condition Opinion

Determine whether the severity of a disorder that existed prior to service entrance was permanently worsened during service and, if so, whether the increase in severity was due to the natural progression of the disease. Temporary or intermittent flare-ups of a pre-service condition without evidence of permanent worsening are not sufficient to warrant a finding of aggravation.

Reconciliation of Conflicting Medical Opinions or Diagnoses

This type of opinion is requested when VBA needs a medical opinion to reconcile multiple conflicting diagnoses of record or to reconcile conflicting opinions. For example, there may be multiple psychiatric diagnoses of record, and it may be unclear which diagnosis is the most appropriate. Similarly, this type of opinion is requested where an opinion is needed to reconcile two opposing opinions, for example, when there is an opinion that supports the claim as well as a second opinion that does not support the claim.

An example of a reconciliation opinion is on the next page.

IMPORTANT NOTE

You may recall that because a C&P medical opinion must apply medical knowledge, judgment, and experience to the pertinent facts of a case, different opinions can result based on a review of the same evidence.

Reconciliation Opinion

The Veteran is service-connected for bipolar disorder and now has been diagnosed with schizoaffective disorder. Is the bipolar disorder related to the schizoaffective disorder?

Opinion: Veteran was service connected for bipolar disorder. He is now diagnosed with schizoaffective disorder. The diagnosis of schizoaffective disorder represents a correction of the previous diagnosis of bipolar disorder.

Rationale: For an individual to be diagnosed with bipolar disorder, an individual must have experienced a manic episode that may have been preceded by and may be followed by a hypomanic or depressive episode. A diagnosis of bipolar disorder can include many specifiers, including the specifier “with psychotic features”. From review of Veteran’s previous C&P examination, Veteran was diagnosed with bipolar disorder with psychotic features. From review of records, this diagnosis was based upon the fact that the Veteran experienced both manic episodes and depressive episodes. Additionally the diagnosis was based on the fact that during his most recent manic episode, the Veteran experienced psychotic symptoms, such as feelings of paranoia and auditory hallucinations. This diagnosis was made without the benefit of any of the Veteran’s medical records. For an individual to be diagnosed with schizoaffective disorder an individual must have “an uninterrupted period of illness during which there is a major mood

episode (major depression or mania) that is concurrent with the presence of two or more of the following: delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, and negative symptoms. During the Veteran's most recent evaluation, Veteran was diagnosed with schizoaffective disorder. From review of records, the diagnosis was based upon Veteran's most recent inpatient psychiatric hospitalization diagnosis and based on review of the last three years of the Veteran's medical records. In the case of this Veteran, it appears as if schizoaffective disorder is a more accurate diagnosis than bipolar disorder, with psychotic features. Of note, the diagnostic criteria between bipolar disorder, with psychotic features and schizoaffective disorder are extremely similar. It is often difficult for a mental health provider to differentiate between these two diagnoses, which often involve overlapping symptoms.

IMPORTANT NOTE

As it is not unusual for the diagnosis of a mental disorder to change, this is referenced in the Mental Disorders section of the VA Schedule of Ratings-Diseases found in the Code of Federal Regulations. Refer to 38 CFR 4.125.

Specialized Clinician Requirements

You may not be qualified to render certain opinions because a medical specialist is required for that particular opinion. In general, all vision, hearing, dental, and mental disorder examinations (including specific examinations for PTSD and Eating Disorders) must be conducted by a specialist. For example, there are many potential aspects of a hearing condition that may require an assessment—and possibly an opinion—from a clinical specialist.

C&P audiologic testing is a comprehensive clinical evaluation that must be performed by a state licensed audiologist. Examinations for hearing loss include audiometry (measurement of air conduction puretone thresholds, speech recognition testing, and often other audiological tests. The results of these tests are applied to the rating schedule by adjudicators to determine the appropriate level of disability, if any. Rendering audiological opinions is more complicated. For example, hearing thresholds, whether normal or not, reported in decibels at separation is only the beginning of the evidence review. The audiologist must then look for evidence of significant threshold shifts that might signify noise induced injury, as well as look for other medical conditions that may impact hearing. This review is best performed by audiologists who understand the variables that affect such measurements and the significance of such auditory changes. Unless the audiologist is instructed to perform an examination only, the documentation protocol requires an opinion on the etiology of the hearing loss.

Tinnitus opinions can be more complicated because there is no objective measure of tinnitus. Non-audiologists with sufficient knowledge and experience can opine on tinnitus etiology when the audiologist has performed an audiogram and has ruled out an association between tinnitus and hearing loss or threshold changes, e.g., hearing changes due to acoustic trauma. A generalist C&P examiner or specialty examiner could opine on the association between tinnitus and other diagnosed medical or psychological conditions. Although hearing loss is the most common condition associated with tinnitus, there are many possible conditions associated with tinnitus, e.g., ear disease, traumatic brain injury, psychological disorders, sleep disorders, vascular disorders, neurological disorders, medication use, etc.

Traumatic brain injury (TBI) is a common example where tinnitus can be one of many subjective complaints. Generalist or specialist examiners who are well versed in tinnitus literature and comfortable giving such opinions can opine on the association of tinnitus to TBI when the condition is not better explained by other factors such as hearing loss, and of course, after a complete review of the military and medical records.

Specialized Clinician Availability

Not all VA medical facilities have the resources to provide an opinion from the requisite specialist. For this reason, you'll want to be aware of your facility's resources and procedures for obtaining the required opinion. On rare occasions, such as when the Board of Veterans' Appeals (BVA) requests a specialist examination, it will be necessary to obtain an examination from the specific type of specialist BVA requested. It is the C&P program's responsibility to fulfill this requirement.

IMPORTANT NOTE

When multiple clinicians or disability examiners provide assessments for an examination that also requires a medical opinion, the examiner who writes the opinion should coordinate with the specialists involved to discuss the medical opinion before the opinion is finalized.

When to Provide an Opinion

Most of the time, you will provide a medical opinion in response to the questions stated on the examination request. However, in some circumstances, as indicated in item 3 that follows, you will be required to provide an opinion even if one is not listed on the Examination Request. Generally, you should only provide a medical opinion and rationale in three situations:

1. An opinion is requested on an Examination Request.
2. A medical opinion request is part of a documentation protocol, for example, the C&P FPOW Protocol.
3. The evidence of record requires an opinion, as explained on this and the next page.

Evidence of Record

Evidence of record refers to documents in the Veteran's or Servicemember's C-file or in other electronic VA databases. The term evidence of record is important in this discussion because you will encounter certain situations where the evidence of record requires an opinion even though an adjudicator did not request one.

SIDE NOTE

If you obtain or the claimant provides additional pertinent medical evidence for the current C&P examination, this evidence becomes part of the evidence of record and you should consider it in rendering an opinion and document the source in the examination report. As well, recommend that the claimant send a copy of his or her additional medical evidence to the regional office. This will help ensure that this evidence will be added to the C-file.

Evidence of Record Requires an Opinion

In a few specific circumstances, evidence of record for a claimant may require you to provide an opinion when the adjudicator does not request one. One example results from a finding in the *Clemons v. Shinseki* case, which pointed out that the scope of a claim is based on the claimant's description of the claimed disability, the symptoms he or she describes, the information the claimant submits, and the information that VA obtains in support of that claim (*Clemons* v. *Shinseki*, 2009). In other words, when a Veteran submits a claim for service connection, he or she is claiming service connection for the symptoms of disability regardless of the diagnosis to which the symptoms are attributed.

For example, a Veteran may claim entitlement to service connection for posttraumatic stress disorder (PTSD) but the medical evidence shows that he or she does not meet the diagnostic criteria for a PTSD diagnosis. Instead, the evidence shows that the diagnostic criteria for major depressive disorder (MDD) are met. In such instances, you should provide an opinion addressing the relationship between MDD and service in addition to the requested opinion for the claimed PTSD condition.

The reason for this requirement is that, as held by the courts, a Veteran or Servicemember generally is not qualified to diagnose his or her condition, but is qualified to identify and explain the symptoms they observe and experience. VA may not limit the scope of the claim only to the condition stated, but rather the claim is for any condition that may reasonably be encompassed by several factors as shown in this more detailed list:

1. **Lay Diagnosis:** what the Veteran calls the claimed disorder, e.g., a specific condition such as PTSD, rather than another mental disorder
2. **Symptoms:** symptoms the Veteran describes
3. **Medications:** medications the Veteran is using
4. **Diagnostic studies:** the Veteran's diagnostic studies
5. **Information:** information the Veteran submits or that VA obtains in support of the claim

Select physical examples to view a few common examples involving physical conditions and evidence of record. Additional contexts where evidence of record requires an opinion are discussed on the next page.

Evidence of Record Examples

Remember, when a Veteran submits a claim for service connection, he or she is claiming service connection for the symptoms of disability regardless of the diagnosis to which the symptoms are attributed. The table that follows demonstrates some common examples where you must address symptoms and provide an opinion and rationale to explain the actual diagnosis based on your findings:

Claimed Condition	Evidence
Leg Condition	The Examination Request suggests a knee exam for a claimed leg condition. However, during the examination, you determine that there are symptoms for other leg problems that should be addressed, such as numbness and tingling that could be due to peripheral neuropathy and that therefore need to be diagnosed and addressed in a medical opinion.
Leg Condition	The claim is for a leg condition but the diagnosis is radiculopathy from the back.
Skin Condition	The claim is for eczema but the diagnosis is tinea.
Heart condition	The claim is for ischemic heart disease (IHD) but the diagnosis is atrial fibrillation.

Additional Contexts for Opinions Based on Evidence of Record

The evidence of record for a claimant can prompt a medical opinion in various kinds of situations discussed on this page. This list is not all-inclusive. You may be asked questions about this content.

Erroneous Diagnosis

When the history and findings do not meet criteria for the diagnosis of the service-connected condition referred to on the Examination Request, you should record the justified diagnosis for the service-

connected condition on the basis of evidence found. Explain the relationship between these so that VBA can clearly understand that the current diagnosis corrects the previous erroneous diagnosis.

For example, a diagnosis may have been made using incomplete or overlooked information in the STRs or post-service medical records. If this information comes to light during a new comprehensive review, it may be sufficient to change or update the previous, erroneous diagnosis.

SC and NSC Conditions of the Same Body System

You may need to provide an opinion when both a nonservice-connected (NSC) condition, such as rheumatic heart disease (RHD), and a service-connected (SC) condition, such as hypertensive cardiovascular disease (HCVD), are present. Then an opinion is required that separates which symptoms are attributable to each condition.

Note: If you cannot separate symptoms without resorting to speculation then you should so state and explain. An example is if both the NSC RHD and SC HCVD are present, and the question is, “Which condition is causing the current signs and symptoms?”

In-Service Condition Resolved before Initial Examination

This applies to an initial C&P examination when a claimed condition diagnosed in service has resolved and is not found to be present currently. This may apply in an additional context when a current diagnosis cannot be made, but there was a valid diagnosis during the processing of a claim. You may want to contact the regional office for instructions if either situation arises.

Relationship of Found Conditions to POW Experience

When a former prisoner of war (FPOW) examination is requested, your examination report should include an opinion with supporting reasons explaining the relationship between the Veteran’s experience as a POW and each currently diagnosed condition. This opinion is written on the FPOW documentation protocol.

Alternate or New Diagnosis for a Service-Connected Condition

When conducting an increase or review examination, if you identify an alternate or new diagnosis, you are required to provide a nexus or medical statement regarding the relationship between the new diagnosis and the service-connected condition.

Example

The Veteran is service-connected for lumbar strain and now has degenerative disc disease (DDD) of lumbar spine. Is the DDD related or not to the service-connected lumbar strain? While in most cases, these conditions will not be found to be related, you need to consider all pertinent evidence in each case to make a determination.

If you come up with a different diagnosis than the service-connected diagnosis, you need to explain the relationship of the two diagnoses.

When Not to Provide an Opinion

Never provide an unsolicited opinion. This would be an opinion that is not asked for on an Examination Request or a documentation protocol, and is not required or prompted by the evidence of record. For

example, a Veteran claims entitlement to an increased rating for the residuals of a previously SC right knee injury but also complains about a left knee condition at the C&P examination. Since the exam request is for an increase for an SC condition, this examination does not require a C-file review. VBA asked for a right-knee review only. Therefore, any opinion as to the etiology of the left knee condition would not be valid.

IMPORTANT NOTE

Please keep in mind that providing an unsolicited opinion takes more time for you and for VBA, as it may cause an unnecessary delay in the claims process.

Process and Components of a Medical Opinion Sufficient for Rating Purposes

Learning Objective

This lesson provides guidance, tips, and examples for writing a medical opinion using the recommended language, and for substantiating the opinion with a comprehensive rationale. The process begins with determining the scope of the opinion requested of you. While reviewing and weighing all evidence, you may encounter situations such as conflicting evidence or lack of evidence, so this lesson includes these topics.

Upon completing this lesson, you should be able to describe the process and required content for writing a medical opinion, including the use of legally appropriate language.

Understanding the Scope of the Opinion

The process of preparing and writing a medical opinion starts with understanding the scope of the needed opinion. Start with a review of the Examination Request. The scope of a medical opinion depends on the questions asked and the evidence that is available. The first question you'll ask is, "What is the Veteran or Servicemember claiming?" A careful review of the background, the questions asked, and the requested opinion on the Examination Request will give you an initial understanding of the scope. Which area or system of the body will be examined? What question(s) need to be answered?

On the next page, an examiner reviews a sample Examination Request.

An Examiner Reviews an Examination Request

Read below as an examiner reviews an examination request.

An Examiner Reviews and Examination Request

[highlights on Name: MORRISON, PHIL, on Requested exams currently on file and info, and Exams on this request and DBQs]

EXAMINER: What do I have here? A Veteran, Phil Morrison, will be coming in for this exam. What kind of exam? Here we go, respiratory conditions; and a medical opinion is required.

[highlights on General Remarks and CLAIMS FILE BEING SENT FOR REVIEW BY THE EXAMINER]

EXAMINER: I'll need to review the C-file.

[highlights on Disability claimed: 1. Asbestosis

EXAMINER3: So, what is this Veteran claiming? Asbestosis. Hmmm.

[highlights on MILITARY SERVICE: Navy 12/26/1944 to 12/25/1954, PERTINENT SERVICE TREATMENT RECORDS: None., PERTINENT VA RECORDS: None. PRIVATE TREATMENT RECORDS,and Records show that the Veteran was diagnosed with chronic obstructive pulmonary disease (COPD) in 2005 following]

EXAMINER: His military service was during World War II and the Korean conflict. What do his STRs say? Oh, there aren't any. Hmmm. VA Records? No. VBA says there are some private medical records, with COPD diagnosed.

[highlights on Requested Opinion: and Please determine whether it is at least as likely as not that the Veteran's current respiratory condition is due to asbestos exposure in service or due to circumstances of his military service.

EXAMINER: So, what am I going to discuss in the opinion? Let's see, they want to know if his respiratory condition is service connected...as in asbestosis or COPD? I'll need to validate his diagnosis in the C&P exam, and provide a rationale to explain if either condition is valid and connected to service.

[highlight on If you have any questions or concerns, please contact J.M. Santiago, RVSR at 858.555.7777 Email: JMSantiago@va.gov]

EXAMINER: And there is the name and phone number for any questions.

[Scene ends]

Review the Evidence

You'll need to review and weigh all evidence before you write and substantiate a medical opinion. After the examination, you will have to consider the lay statements and clinical data gathered at the examination, in addition to all of the other evidence that was already in the record. In addition, when applicable, you should conduct a review of peer-reviewed medical literature pertinent to the opinion you will write.

Terms for Evidence to be Weighed

Adjudicators use these concepts for reconciling conflict, contradictions, internal inconsistency, and implausibility in evidence:

Term	Description
Competency	The qualifications to offer evidence (education, training, experience); competency precedes credibility, such that the consideration of credibility arises only after an individual or treatise has been found to be competent
Credibility	Worthiness of belief or plausibility
Probative value	Tending to prove or actually proving; the quality of proof (qualitative versus quantitative value)
Relevancy	Applying to the matter being decided
Weight	The effect or persuasiveness of evidence in inducing belief

A document with these definitions can be accessed in course Resources.

Carefully weigh both supporting and contrary evidence. You cannot ignore evidence, so you should explain why certain evidence is more influential or significant than other available evidence. For example, one item of evidence may be supported by medical literature whereas other evidence is based on less scientific rigor. Use all of the information gathered to formulate an opinion and explain it with a comprehensive rationale.

The information to consider when developing a medical opinion comes from some or all of these sources:

1. Questions on the Examination Request
2. Facts provided on the Examination Request
3. Facts in the C-file
4. Electronic medical records
5. Lay evidence, such as a claimant's statements
6. BVA remand instructions if applicable
7. Examination findings
8. Peer-reviewed medical literature

IMPORTANT NOTE

Not every Examination Request (VA 21-2507) or VERIS (Veterans Examination Request Information System) form requires a medical examination. Sometimes you may be asked to review existing examination reports and other evidence in order to provide a medical opinion.

Addressing Lay Evidence

You must address relevant lay evidence in the medical opinion. Lay evidence is defined as statements offered by a person without specialized education, training, or experience. In other words, this is a statement provided by someone who does not have a medical background or training, e.g., is not a clinician. Generally, this evidence is provided by a person who has the knowledge of facts or circumstances and conveys matters that can be observed through the senses or via firsthand knowledge. Statements from the claimant are lay evidence. Failure to address lay evidence is one of the most common reasons for returned medical opinions.

In addition, the courts have determined a layperson other than the claimant is competent (qualified) to comment on what he or she has observed the claimant to experience, but would not be competent to describe the precise discomfort the claimant experiences. For example, a layperson other than the claimant would be competent to observe that a claimant scratched a rash, but the same layperson would not be competent to describe what the rash felt like.

According to a court decision, lay evidence is sufficient to establish a diagnosis in these three circumstances:

1. The medical condition is one that a layperson is competent to identify, for example, varicose veins.
2. The layperson is reporting a medical diagnosis he or she was given in the past, for example, "Ten years ago, I was diagnosed with arthritis."
3. The layperson is describing symptoms that support a later diagnosis by a medical professional. For example, the Veteran reports having burning in his chest and an upset stomach in service. Following service, he goes to the doctor and complains that since service, he has experienced burning and an upset stomach. An upper gastrointestinal (UGI) series results in a diagnosis of gastroesophageal reflux disease (GERD). The clinician tells the Veteran that what he was experiencing in service was also GERD.

This is not to say that the history provided by the Veteran or Servicemember or other lay evidence must be accepted without question. When lay statements from the claimant, family members, etc., are in the record, you must address them in the medical opinion whether or not you agree with the statements. If you disagree, provide a reasoned explanation.

Citing Subject Matter Expertise

As part of your preparation for writing a medical opinion, you may want to review relevant medical literature and consult subject matter experts. For example, adding references to and citations of peer-reviewed medical literature to an opinion rationale, although not always necessary, adds support to your rationale and provides additional background to adjudicators to clarify the issues you discuss. When you cite medical literature, include enough information to allow the adjudicator to access the referenced material. Notice the difference between the two statements that follow.

A weak statement in the rationale with no supporting citation:

Hypertension is by far the most potent risk factor for stroke.

A strong statement in the rationale that includes a medical literature citation:

Scientific literature, including literature from the National Institute of Neurological Disorders and Stroke, indicates that hypertension is by far the most potent risk factor for stroke and causes a two-to four-fold increase in the risk of stroke before age 80.
(http://www.ninds.nih.gov/disorders/stroke/preventing_stroke.htm)

Adjudicators would give more weight to an opinion with supporting medical citations than one without.

The Actual Opinion

In general, state your opinion in the requested format. Often, nexus language examples are shown on the Examination Request. The Medical Opinion documentation protocol indicates the suggested language for direct service connection, secondary service connection, or aggravation. Remember, avoid speculative terms such as "could" or "would" or "may be." State your conclusions using VBA-recommended language for the type of opinion required. Select each type to view sample VBA-recommended language.

Direct Service Connection

Sample phrases for direct service connection:

a. _____ is at least as likely as not (50 percent or greater probability) caused by or a result of_____.
b. _____ is less likely than not (less than a 50 percent probability) caused by or a result of _____.

Secondary Service Connection

Sample phrases for secondary service connection:

a. The claimed condition is at least as likely as not (50 percent or greater probability) proximately due to or the result of the claimant's service-connected condition.

b. The claimed condition is less likely than not (less than 50 percent probability) proximately due to or the result of the claimant's service-connected condition.

Aggravation (Allen)

Sample phrasing for aggravation of a nonservice-connected condition by a service-connected condition:

Was the Veteran's (claimed condition/diagnosis) at least as likely as not aggravated beyond its natural progression by (insert "service connected condition")?

a. Yes

b. No

Aggravation of a Preexisting Condition

Sample phrases for aggravation of a preexisting condition:

a. The claimed condition, which clearly and unmistakably existed prior to service, was aggravated beyond its natural progression by an in-service event, injury or illness.

b. The claimed condition, which clearly and unmistakably existed prior to service, clearly and unmistakably was not aggravated beyond its natural progression by an in-service event, injury or illness.

Supporting Rationale

A mere conclusion by a clinician does not provide a sufficient basis for adjudication. You may recall that VA adjudicators cannot exercise independent medical judgment in deciding a claim, so a medical opinion needs to include a supporting rationale to enable the adjudicator to weigh the evidence. As stated elsewhere in this course, part of a medical opinion is the supporting rationale, a reasoned medical explanation connecting the conclusion and the supporting data. This rationale should point out the facts applicable to the specific Veteran's or Servicemember's claimed condition and explain why those facts are or are not important to the conclusion. The rationale is a summary of the clinician's thought process that led to the conclusion expressed in the opinion. The rationale gives clear, understandable reasons for the conclusion that was offered.

Begin the rationale by repeating the question asked of you on the 2507. Then, cite the evidence reviewed and the Servicemember's or Veteran's contention. These details provide the scope for your medical opinion. Follow with a comprehensive rationale where you detail how items of evidence, clinical data, and applicable medical literature support your opinion.

Most of the probative value of a medical opinion comes from its reasoning, and not just the data and conclusions. Think of the rationale as the completion of a sentence or thought. It is answering who, what, when, where, why. For example, a rationale will finish this thought "This Veteran's respiratory condition is less likely than not due to asbestosis exposure in service BECAUSE [fill in the blank]."

Many examples of rationales are included in this course to demonstrate what is discussed on this page.

SIDE NOTE

In addition to stating your opinion in the VBA-recommended terms, such as "at least as likely as not," it would be helpful to the adjudicator if you can also state your degree of certainty in the rationale, with terms such as "unlikely" or "definitely."

VHA, VBA, and BVA Consider a Case Study Opinion and Rationale

In a video on the next page, Paul Sorisio from BVA, Greg Normandin from VHA, and Tina Skelly from VBA discuss a sample opinion, for a fictional Veteran, Phil Morrison. The Examination Request for Mr. Morrison was reviewed in a presentation earlier in this lesson. He claims entitlement to service connection for asbestosis and presents with a respiratory condition. We'll look at the questions asked, the opinion and rationale provided, and follow up with a video discussion of the opinion among VHA, VBA, and BVA participants.

Background

Phil Morrison is a Navy Veteran, now retired, who served in both World War II and the Korean conflict. He filed an original claim for disability benefits due to asbestos exposure.

On the Examination Request

Records show that the Veteran was diagnosed with chronic obstructive pulmonary disease (COPD) in 2005 following complaints of a progressive cough and shortness of breath with activities. Current medications include Advair 250/50 daily and Combivent and Albuterol inhalers as needed. The Veteran has not been hospitalized for this condition though he was treated for a COPD exacerbation four months ago with oral steroid taper and a course of antibiotics.

Requested Opinion

The Veteran is claiming service connection for a respiratory condition claimed as asbestosis due to asbestos exposure during his naval service. Please note that the Veteran's service personnel records show that he served as a cook (MOS – SC) aboard naval vessels, which suggests that the Veteran's exposure to asbestos exposure during his military service was minimal. Please note that the Veteran reports that he smoked for many years. Please determine whether it is at least as likely as not that the Veteran's current respiratory condition is due to asbestos exposure in service or due to circumstances of his military service.

TACK NOTE

The Veteran filed a claim for a respiratory condition resulting from exposure to asbestos. If the examiner reviews all evidence, interviews and examines the Veteran, and subsequently diagnoses COPD, but not asbestosis, the resulting medical opinion must address first the lack of diagnosis of asbestosis and second, whether his COPD is related to asbestos exposure or other events in service.

Round Table Discussion

What do the round-table participants have to say about the opinion that was drafted for Mr. Morrison's claim? Before you view the video on this page, please select medical opinion to review the examiner's opinion. You'll notice that actually two opinions are given, based on the need to give an opinion addressing the asbestosis claim and another opinion addressing the relationship of the Veteran's current respiratory condition to his service. Both are needed since the evidence of record and the C&P examination findings result in a diagnosis of COPD to account for the Veteran's symptoms. You may keep the window open if you'd like to refer to the opinion as you view the video. Video transcript is on page 137.

Medical Opinion for Mr. Morrison

Please determine whether it is at least as likely as not that the Veteran’s current respiratory condition is due to asbestos exposure in service or due to circumstances of his military service.

Opinion: It is less likely than not that the Veteran’s current respiratory condition is due to his active service, including alleged in-service exposure to asbestos.

Rationale: Although most asbestos-related diseases are dose dependent and latent (developing 20-30 years after the exposure to asbestos), the Veteran’s exposure to asbestos as a cook in the service was minimal. Veteran’s reported exposure to asbestos-wrapped pipes above his bunk involved undisturbed asbestos. Undisturbed asbestos (for example, in vinyl asbestos floor tile, pipe lagging, or insulation) poses almost no risk. Rather, it is the aerosolized microfibers of disturbed asbestos that are a hazard. (Asbestos Fact Sheet, web.princeton.edu.) Based upon the Veteran’s duties in service, it is unlikely that he had exposure to aerosolized microfibers of disturbed asbestos. In addition, the objective evidence of record does not support a finding that the Veteran has asbestosis, or any other asbestos-related disease. The Veteran’s current respiratory condition is COPD, which is an obstructive lung disease (characterized by expanded lung volumes) manifested by symptoms of cough, dyspnea, and sputum production, with a likely etiology of history of exposure to risk factors for the disease. The symptoms of asbestosis include cough, dyspnea, and chest pain. Asbestos, however, causes disease that is primarily manifested by restrictive lung changes (constricted lung volumes) and a reduced diffusion capacity for carbon monoxide. Asbestos-related diseases include pleural plaques and pleural effusions, asbestosis, lung cancer, and mesothelioma. As X-ray examination in this case does not demonstrate findings consistent with an asbestos-related disease, and asbestos exposure most commonly causes restrictive rather than obstructive lung changes, his alleged in-service exposure to asbestos is less likely than not the cause of his COPD.

With regard to the likely etiology of the Veteran’s COPD, medical literature indicates that it is rare to develop COPD before the age of 35 (Vitalograph): http://www.vitalograph.eu/resources/articles/differentiating-asthma-from-copd) and identifies cigarette smoking as the leading cause of COPD. The Veteran has a history of smoking two packs of cigarettes a day for many years (from age 14 until 56), with an 84 pack-year tobacco history. Although the Veteran reported episodes of breathing problems in service, at separation from service, physical examination was negative, he had no respiratory complaint, and a routine chest X-ray revealed no abnormalities, suggesting that the Veteran did not have a chronic respiratory disorder, such as COPD, at the time of his separation from service. It is also unlikely that the Veteran’s in-service symptoms were early manifestations of COPD that developed after his separation from service. Although the Veteran

experienced episodes of coughing during and after service, it is not uncommon for current smokers to have increased occurrences of upper respiratory infections and coughing. Significantly, the Veteran was not diagnosed with COPD until 2005, after he began to experience a progressive productive cough and shortness of breath with exertion. At that time, PFTs showed only a moderate obstructive defect. Given the normal lung examination and normal chest X-ray upon separation from service, the Veteran's history of smoking, and that he was not diagnosed with COPD for more than 50 years after his separation from service, it is my opinion that his COPD is due to his smoking history and is unrelated to his active service. As further support for the conclusion that the Veteran's COPD is unrelated to his active service, it is worth noting that COPD is a progressive disease. If the Veteran's COPD had had its onset in service, it is more likely than not that he would have had significant symptoms that required treatment prior to 2005 and that his COPD would have progressed to more than a moderate obstructive defect, as indicated by the 2005 PFTs, considering his lengthy history of smoking.

For these reasons, I find that it is less likely than not that the Veteran's current respiratory disorder is due to asbestos exposure in service, and although he does now meet the criteria for a diagnosis of COPD, his COPD is not related to his active service.

Medical Opinion Dashboards

Over the next several pages, interactions will demonstrate aspects of reviewing evidence and writing a medical opinion for four basic opinion types. Visit all four sections of each scenario, represented in the image on this page, to complete each Medical Opinions Dashboard interaction. The image will mark your progress through each scenario by highlighting the page you are on. We recommend that you visit each page in order to follow the examiner as he or she scopes the opinion requested, reviews and organizes evidence, and writes an opinion.

Dale Willow, a fictional Veteran, will be the claimant in each case. This will be a retrospective review of Mr. Willow's claims over time. There will be references to disability benefits questionnaires (DBQs), for example, as those were the documentation protocols used for some of his examinations. His C-file will expand as he files various claims and various examiners write these types of opinions:

1. Direct service connection
2. Secondary service connection-favorable and unfavorable
3. Aggravation of a nonservice-connected condition (Allen)
4. Aggravation of a preexisting condition

IMPORTANT NOTE

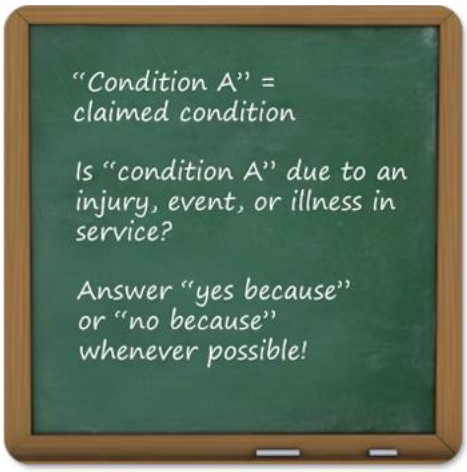
The scenarios that follow are designed for educational purposes. The medical opinion has already been written, and you'll have an opportunity to view it after you've reviewed all of the evidence. The purpose of each scenario is twofold: to show the process of a thorough review of evidence, and to demonstrate components of a properly worded opinion with a comprehensive rationale.

Direct Service Connection Review

You may remember from earlier in this course that adjudicators are not qualified to make medical determinations. An adjudicator may request a medical opinion regarding direct service connection when there is an indication that a condition may be related to service but there is insufficient evidence showing

a direct link. Remember, VBA's threshold for requesting an opinion that a condition be related to service is, by law, very low.

Example: Was “condition A” at least as likely as not (50 percent or greater probability) incurred in service; was it caused by an in-service injury, event, or illness?



IMPORTANT NOTE

A congenital or developmental defect is not considered a service-connected disease or injury for C&P purposes even if it was discovered and diagnosed for the first time when a Veteran or Servicemember was in active service. Congenital defects will be discussed in more detail later in this course. However, you may still be asked to provide an opinion as to whether there is a disease or injury that has been superimposed on the congenital defect.

Medical Opinion Dashboard 1: Direct Service Connection

Instructions: The examiner reviews an examination request for a service-connection claim. This is a first step in determining the scope of a requested opinion. Read the narrative and the opinion request from the Examination Request and then select "What does the adjudicator need" to benefit from the examiner's thoughts on what is expected of him.

Mr. Dale Willow is a 68-year-old Vietnam Veteran who filed an original direct service-connection claim for neck pain. Mr. Willow was a clerk in the U.S. Army from 1968-1970 with a deployment to Vietnam. After service, he worked in construction but he’s since retired.

On the Examination Request

Service-connected disabilities: None

Claimed disabilities: Neck pain and stiffness

Examination Requested: Cervical Spine DBQ, Medical Opinion DBQ

Requested Opinion:

The Veteran claims service connection for neck pain and stiffness. Please determine whether the Veteran's current neck pain and stiffness is at least as likely as not (50 percent or greater probability) due to or caused by events during military service.
State your conclusions using one of the following legally recognized phrases:
a. _____ is at least as likely as not (50 percent or greater probability) caused by or a result of ____.
b. _____ is less likely than not (less than 50 percent probability) caused by or a result of ____.

What Does the Adjudicator Need?[1]

Review the Evidence

Instructions: Select each folder on the screen to gather evidence that may apply. Once you've reviewed each folder, you can select the Summary of Evidence link that follows the evidence displays to view a summary of evidence for this claim. [In this print document, the folders have been designated as headings followed by their content.] You will be asked questions to give you insights into how the examiner might use this evidence.

C-file

Instructions: Select each linked item to view contents. Simplified text versions have been provided.

Service Personnel Data

DD-214 Report of Discharge or Transfer
Service dates: 08/06/1968–09/30/1970
MOS: 70A Clerk
Deployments: Vietnam 9/15/68–9/15/69

STRs

Facsimiles of the following forms are provided in the Additional Resources section of this document, beginning on page 100.

SF 88 Service Entrance Examination, July 1968

- Report of Medical History
- Report of Medical History Continued
- Report of Medical Examination
- Report of Medical Examination Continued
- Medical Examination Notes, June 1969

[1] What Does the Adjudicator Need is provided in the Additional Resources section of this document, page 115.

SF 88 Separation Examination, September 1970

- Report of Medical Examination
- Report of Medical Examination Continued

Lay Evidence

- Dale Willow, Statement in Support of Claim (Form 21-4138), January 11, 2008
- Statement from Wadena Willow, January 15, 2008

C&P Records

Form 21-526, December 2007

Dale Willow files a claim for service connection of cervical strain.

Medical e-Records

VA Medical Treatment Records

2007-2008

Veteran established care in VA in 2007 and new evaluation notes show a past history of neck pain, stiffness and headaches for many years since he was discharged from military. He was regularly taking OTC pain meds for control of headaches and neck pain mostly but was also prescribed hydrocodone/ APAP and cyclobenzaprine during acute episodes of neck pain. On March 3, 2008, Dale Willow was found to have mild tenderness over entire cervical spine and bilateral paraspinal muscles during a visit during flare-up of neck pain. At that visit Veteran also complained of frequent headaches.

Sticky note left by the examiner

No VA or private medical records indicate another neck injury since Mr. Willow was discharged.

Current C&P Exam

Current C&P examination findings documented by examiner:

- Weight: overweight to obese
- Normal C-spine X-rays in service; Veteran has painful, limited ROM of the cervical spine, and cervical muscle spasm and tenderness is noted on physical examination, c/w abnormalities found on in-service examination
- Diagnosis: Cervical strain

Medical Literature

STICKY NOTE

From the examiner: In this case, the connection of the current condition to injury in service would be considered by the medical community at large to be a progression and citing studies will not add to or further explain this determination.

Summary of Evidence[2]

[2] Summary of Evidence, Dashboard 1, is provided in the Additional Resources section of this document, page 111.

[3] Summary of Evidence, Dashboard 1, is provided in the Additional Resources section of this document, page 111.

[4] Summary of Evidence, Dashboard 1, is provided in the Additional Resources section of this document, page 111.

Dashboard 1: Review the Opinion

Instructions: Review the question requested by the adjudicator and the opinion and rationale provided by the examiner. Select What does the adjudicator need?[5] to review the examiner's understanding of what's needed from her, and select What do you think[6]? for a checklist of elements to look for in this opinion.

Opinion requested:

Please determine whether the Veteran's current cervical spine condition is at least as likely as not (50 percent or greater probability) due to or caused by events during military service.

Opinion: It is at least as likely as not that Veteran's current cervical strain is due to the neck injury during service.

Rationale: After review of C-file and in particular STRs, it is more likely than not that Veteran's cervical strain represents a continuation of the neck injury that he suffered while on active duty and has persisted and progressed in severity since. STRs indicate that Veteran presented with neck pain after stopping suddenly while riding in a truck. Previous and current cervical spine X-rays were negative for dislocation, fracture or arthritic changes, but his ability to rotate his head from side-to-side has progressively decreased since that event. At time of separation, Veteran did complain of reduced range of motion and "tightness" in neck muscles. His complaints were supported by a statement from his wife reporting that he has had difficulty turning his head while driving since he left military service and complaint of similar symptoms at VA primary care appointment. Veteran has had no additional injuries to his neck since separation from service. This Veteran's current symptoms and clinical findings remain consistent with the injury he sustained while in service.

Summary of Evidence[7]

TACK NOTE

You may see variations in the VBA-recommended language on an Examination Request (form 2507) used to express an opinion. For example, "at least as likely as not" means a 50 percent or greater probability, so if you see "more likely than not," it has a similar meaning.

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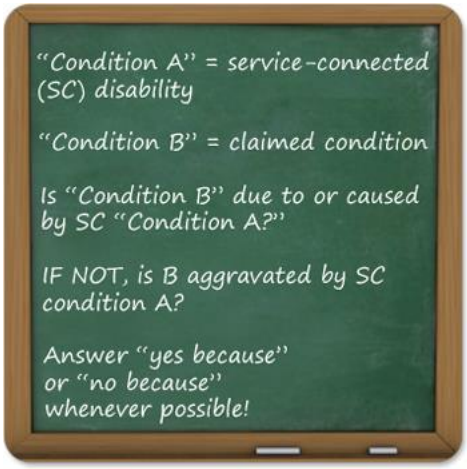
[5] What Does the Adjudicator Need is provided in the Additional Resources section of this document, page 115.

[6] What Do You Think is provided in the Additional Resources section of this document, page 115.

[7] Summary of Evidence, Dashboard 1, is provided in the Additional Resources section of this document, page 111.

Secondary Service Connection Review



A medical opinion is needed to determine whether a claimed condition is proximately due to (or a result of) an already service-connected disability. In order to be considered for secondary service connection, the Veteran must have at least one service-connected disability.

In practice, when providing a secondary causation opinion, you may need to address two different relationships of a condition to a service-connected disability: secondary service connection and aggravation (in this case, aggravation (Allen). If, in your opinion, a claimed condition is proximately due to, or the result of, an already service-connected disability, you need not address aggravation.

Step 1: Is "condition B" at least as likely as not (50 percent or greater probability) proximately due to or the result of the Veteran's service connected "condition A"? If the answer is yes, then there is no requirement to consider Step 2.

Step 2: If the answer is no, you are required to determine if "condition B" was aggravated beyond its natural progression by the Veteran's service connected "condition A."

This is to say that if you find that a claimed condition is not proximately due to an already service-connected disability, there is another relationship to address, secondary (Allen) aggravation. This is determining whether or not the claimed condition is aggravated (permanently worsened) by the service-connected condition. To make a positive determination of aggravation in these cases, the two conditions need not be otherwise medically related. Consider the following example.

Example

Service connection was previously established for essential hypertension, which has been well-controlled. Ten years after service, Veteran was diagnosed with diabetes mellitus (DM) and within two years was subsequently diagnosed with diabetic nephropathy. His kidney function rapidly deteriorated, and he claimed that his SC hypertension had aggravated his nephropathy. A medical opinion is needed. An assessment is needed to determine whether all of the increase in nephropathy is solely due to DM. If not, how much of the increase in severity is due to his SC hypertension?

This opinion requires (1) a report of current level of severity of the nephropathy, (2) its baseline level of severity, and (3) an assessment of whether any or all of the increase in severity is due to diabetes mellitus or is all due to the SC hypertension.

A scenario on the next page, another claim from Dale Willow, will focus on providing an opinion for Step 1. If the medical opinion is favorable for secondary SC, then the examiner is done.

Medical Opinions Dashboard 2: Secondary Service Connection (Favorable)

Instructions: The examiner reviews an examination request for a secondary service connection claim. This is a first step in determining the scope of a requested opinion. Read the narrative and the opinion request from the Examination Request and then select "What does the adjudicator need" to benefit from the examiner's thoughts on what is expected of her.

Mr. Dale Willow is a 70-year-old Vietnam Veteran who filed a secondary service-connection claim. He claims his headaches are due to, or a result of, his service-connected cervical strain. Mr. Willow was a clerk in the U.S. Army from 1968-1970 with a deployment to Vietnam. After service, he worked in construction but he's since retired.

On the Examination Request

Service-connected disabilities: Cervical neck strain

Claimed disabilities: Veteran claims headaches secondary to service-connected cervical neck strain.

Examination requested: DBQ NEURO HEADACHES, DBQ MEDICAL OPINIONS

Requested Opinion:

The Veteran is claiming service connection for headaches secondary to service-connected cervical neck strain. Please determine whether it is at least as likely as not that the current headaches are proximately due to, or caused by the SC cervical strain. If the current headaches are not due to the SC cervical strain, is it at least as likely as not that they have been aggravated beyond natural progression by the SC cervical strain?

State your conclusions using one of the following legally recognized phrases:

a. _____ is at least as likely as not (50 percent or greater probability) caused by or a result of _____.
b. _____ is less likely than not (less than a 50 percent probability) caused by or a result of _____.

What does the adjudicator need[12]

Dashboard 2: Review the Evidence

Instructions: Select each folder on the screen to gather evidence that may apply. Once you've reviewed each folder, you can select the Summary of Evidence link that follows the evidence displays to view a summary of evidence for this claim. [In this print document, the folders have been designated as

[12] What Does the Adjudicator Need is provided in the Additional Resources section of this document, page 115.

headings followed by their content.] You will be asked questions to give you insights into how the examiner might use this evidence.

C-file

Instructions: Select each linked item to view contents. Simplified text versions have been provided.

DD-214 Report of Discharge or Transfer

Service dates: 08/06/1968–09/30/1970
MOS: 70A Clerk
Deployments: Vietnam 9/15/68–9/15/69

STRs

Facsimiles of the following forms are provided in the Additional Resources section of this document, beginning on page 100.

SF 88 Service Entrance Examination, July 1968

- Report of Medical History
- Report of Medical History Continued
- Report of Medical Examination
- Report of Medical Examination Continued
- Medical Examination Notes, June 1969

SF 88 Separation Examination, September 1970

- Report of Medical Examination
- Report of Medical Examination Continued

Lay Evidence

- Dale Willow, Statement in Support of Claim (Form 21-4138), January 11, 2008
- Statement from Wadena Willow, January 15, 2008
- Statement from Wadena Willow, January 13, 2010

Medical Records

Private Medical Treatment Records: November 1988, June 1995, September 1995, April 1999–December 2000

Multiple complaints of neck pain, neck muscle spasm, and recurrent headaches during his private primary care provider office visits. Veteran was diagnosed with cervical strain with muscle spasm and tension headaches. Had some decreased range of motion of neck with increase in pain on turning neck to either side. Chiropractor visits note tenderness and spasm over bilateral paraspinal muscles in neck with improvement after adjustments during each visit. His pain and tenderness was moderate over the upper neck and mild over the lower neck. In April of 1999 Veteran had physical therapy for six weeks with some improvement in neck pain.

C&P Records

Form 21-526, December, 2007

Dale Willow files a claim for service connection of cervical strain.

First C&P Examination, October 2008

Dale Willow was examined by a C&P examiner in October 2008.

Service Connection Rating Decision, December 2008

VBA granted service connection to Dale Willow for cervical strain in December 2008.

C&P Examination Findings from Neck Pain Claim

Documented by examiner: Weight: overweight to obese. Normal C-spine X-rays in service. Veteran has painful, limited ROM of the cervical spine and cervical muscle spasm and tenderness is noted on physical examination, c/w abnormalities found on in-service examination. Diagnosis: cervical strain

Form 21-526, January 2010

DW files claim for service-connection of headaches.

Medical e-Records

VA Medical Treatment Records

2007-2008

Veteran established care in VA in 2007 and new evaluation notes show a past history of neck pain, stiffness, and headaches for many years since he was discharged from military. He was regularly taking OTC pain meds for control of headaches and neck pain but was also prescribed hydrocodone/ APAP and cyclobenzaprine during acute episodes of neck pain. On March 3, 2008, Dale Willow was found to have mild tenderness over entire cervical spine and bilateral paraspinal muscles during a visit during flare-up of neck pain. At that visit Veteran also complained of frequent headaches.

2009

Veteran was referred to physical therapy for stiffness and pain in neck in 2009. In December 2009, he was referred to a neurologist for evaluation of chronic headache and was diagnosed with cervicogenic headache.

Current C&P Examination

Physical exam was completely normal except for the persistent LOM of the neck. Previous X-rays of C spine were normal. Veteran's history during C&P exam was consistent with headache due to neck pain because it increased in intensity with movement of the neck, it radiated from the neck area to the head, it progressed from the occipital to the frontal region of head, and it usually occurred on the same side as the side of the neck with stiffness and pain Diagnosis: chronic cervical strain and cervicogenic muscle tension headache.

Medical Literature

Article 1

Bogduk, N., Govind, J. (2009). Cervicogenic headache: an assessment of the evidence on clinical diagnosis, invasive tests, and treatment. *The Lancet Neurology (10)*, pp. 959-968.

According to data and conclusions in this article, cervicogenic headache is characterized by pain referred to the head from the cervical spine and laboratory and clinical studies have shown that pain from upper cervical joints and muscles can be referred to the head.

Article 2

Lord, S.M., Barnsley, L., Wallis, B.J., Bogduk, N. (2001). Third occipital nerve headache: a prevalence study. *Journal of Neurology, Neurosurgery, and Psychiatry (10)*, pp. 1187-1190.

This article details a study and results from a consecutive series of 100 patients who were studied to determine the prevalence of third occipital nerve headache in patients with chronic neck pain after whiplash. Seventy one patients complained of headache associated with their neck pain. Headache was the dominant complaint of 40 patients, but was only a secondary problem for the other 31. Each patient with headache underwent double blind, controlled diagnostic blocks of the third occipital nerve. The study concludes that third occipital nerve headache is a common condition in patients with chronic neck pain and headache after whiplash.

Summary of Evidence[13]

Instructions: Review the question requested by the adjudicator and the opinion and rationale provided by the examiner. Select What does the adjudicator need?[16] to review the examiner's understanding of what's needed from her, and select What do you think?[17] for a checklist of elements to look for in this opinion.

Opinion Requested:

Is it at least as likely as not that the current headaches are proximately due to, or caused by the SC cervical strain?

Opinion: After review of the Veteran's claims file, it is at least as likely as not that this Veteran's headaches are proximately due to his SC cervical strain.

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[13] Summary of Evidence, Dashboard 2, is provided in the Additional Resources section of this document, page 112.

[14] Summary of Evidence, Dashboard 2, is provided in the Additional Resources section of this document, page 111.

[15] Summary of Evidence, Dashboard 2, is provided in the Additional Resources section of this document, page 111.

[16] What Does the Adjudicator Need is provided in the Additional Resources section of this document, page 115.

[17] What Do You Think is provided in the Additional Resources section of this document, page 116.

Rationale: The Veteran's current diagnosis for his headaches is cervicogenic headache. His STRs are silent for complaints of headaches during active service and there was no mention of headaches during discharge from military service. Therefore, his medical records are negative for any history of headaches prior to his neck injury. His VA primary care notes and chiropractor notes found in C-file mention a few occasions of headaches associated with neck stiffness and pain when turning head to one side few years ago. His medical records show that he was worked up for headaches and was diagnosed with cervicogenic headaches by a neurologist about 4-5 years ago. Veteran's history during C&P exam was consistent with headache due to neck pain because of the fact that it increased in intensity with movement of the neck, it radiated from the neck area to the head, it progressed from the occipital to the frontal region of the head and it usually occurred on the same side as the side of the neck with stiffness and pain. Peer-reviewed medical literature supports that neck pain is one of the common causes of cervicogenic headache and involvement of the C2-3 zygapophyseal joint is the most frequent source of cervicogenic headache, accounting for up to 70 percent of cases. The following articles also support that cervical strain and whiplash injury can cause cervicogenic headaches: Bogduk, N. and Govind, J. (2009), Cervicogenic headache: an assessment of the evidence on clinical diagnosis, invasive tests, and treatment. Lord, S.M., Barnsley, L., Wallis, B.J., and Bogduk, N. (1994), Third occipital nerve headache: a prevalence study. Therefore, it is concluded that this Veteran's diagnosed cervicogenic headaches are the result of his service connected cervical strain.

Summary of Evidence[18]

[18] Summary of Evidence, Dashboard 2, is provided in the Additional Resources section of this document, page 111.

[19] Opinion text is provided in the Additional Resources section of this document, page 118.

[20] Hint text is provided in the Additional Resources section of this document, page 118.

[21] Opinion text is provided in the Additional Resources section of this document, page 118.

[22] Hint text is provided in the Additional Resources section of this document, page 118.

Medical Opinion Dashboard 3: Secondary SC Opinion (Not Favorable)

Instructions: The examiner reviews an examination request for a secondary service connection claim. This is a first step in determining the scope of a requested opinion. Read the narrative and the opinion request from the Examination Request and then select "What does the adjudicator need" to benefit from the examiner's thoughts on what is expected of him.

Mr. Dale Willow is a 73-year-old Vietnam Veteran who filed a secondary service-connection claim. He contends that his lower back pain is due to, or a result of, his service-connected cervical strain. Mr. Willow was a clerk in the U.S. Army from 1968-1970 with a deployment to Vietnam. After service, he worked in construction but he's since retired.

On the Examination Request

Service-connected disabilities: Cervical neck strain

Claimed disabilities: lower back pain

Examination requested: DBQ BACK (Thoracolumbar Spine), DBQ MEDICAL OPINION

Requested Opinion: The Veteran is claiming service connection for low back pain. Please determine whether it is at least as likely as not (50 percent or greater probability) that the current low back pain is proximately due to, or caused by the SC cervical strain. If the claimed lower back pain is not due to or caused by the SC cervical strain, has the claimed condition been aggravated (permanently worsened beyond its natural progression) by the Veteran's SC cervical strain?

State your conclusions using one of the following legally recognized phrases:

a. _____ is at least as likely as not (50 percent or greater probability) caused by or a result of ____.
b. _____ is less likely than not (less than a 50 percent probability) caused by or a result of ____.

What Does the Adjudicator Need?[25]

[25] What Does the Adjudicator Need is provided in the Additional Resources section of this document, page 116.

Dashboard 3: Review the Evidence

Instructions: Select each folder on the screen to gather evidence that may apply. Once you've reviewed each folder, you can select the Summary of Evidence link that follows the evidence to view a summary of evidence for this claim. [In this print document, the folders have been designated as headings followed by their content.] You will be asked questions to give you insights into how the examiner might use this evidence.

C-file

Instructions: Select each linked item to view contents. Simplified text versions have been provided.

DD-214 Report of Discharge or Transfer

Service dates: 08/06/1968–09/30/1970
MOS: 70A Clerk
Deployments: Vietnam 9/15/68–9/15/69

STRs

Facsimiles of the following forms are provided in the Additional Resources section of this document, beginning on page 100.

SF 88 Service Entrance Examination, July 1968

- Report of Medical History
- Report of Medical History Continued
- Report of Medical Examination
- Report of Medical Examination Continued
- Medical Examination Notes, June 1969

SF 88 Separation Examination, September 1970

- Report of Medical Examination
- Report of Medical Examination Continued

Lay Evidence

-
- Statement from Wadena Willow, January 15, 2008

  Dale Willow, Statement in Support of Claim (Form 21-4138), January 11, 2008

Medical Records

- Statement from Wadena Willow, January 13, 2010

Private Medical Treatment Records: November 1988, June 1995, September 1995, April 1999–December 2000

Multiple complaints of neck pain, neck muscle spasm, and recurrent headaches during his private primary care provider office visits. Veteran was diagnosed with cervical strain with muscle spasm and tension headaches. Had some decreased range of motion of neck with increase in pain on turning neck to either side. Chiropractor visits note tenderness and spasm over bilateral paraspinal muscles in neck with improvement after adjustments during each visit. His pain and tenderness was moderate over the upper neck and mild over the lower neck. In April of 1999 Veteran had physical therapy for six weeks with some improvement in neck pain.

Private Medical Treatment Records 2011

Chiropractic records in April and May 2011: Low back pain for several years. On exam, has mild tenderness over lower lumbar spine, with pain at extremes of motion. Mildly limited motion. X-rays show degenerative joint disease at L5-S1 with disc space narrowing and minor osteophytes of other lumbar vertebrae. Diagnosis: Lumbar spondylosis with facet joint dysfunction. Treatment: Spinal adjustments x5, with moderate relief noted.

C&P Records

Form 21-526, December 2007

Dale Willow files a claim for service connection of cervical strain.

First C&P Examination, October 2008

Dale Willow was examined by a C&P examiner in October 2008.

Examination findings documented by examiner: Weight: overweight to obese. Normal C-spine X-rays in service. Veteran has painful, limited ROM of the cervical spine, and cervical muscle spasm and tenderness is noted on physical examination, c/w abnormalities found on in-service examination. Diagnosis: cervical strain

SC Rating Decision, December 2008

VBA granted service connection to Dale Willow for cervical strain in December 2008.

Form 21-526, January 2010

Dale Willow files a claim for secondary service connection for headaches in January 2010.

Second C&P Examination, May 2010

Dale Willow was examined by a C&P examiner in May 2010.

Examination Findings: Physical exam was completely normal except for the persistent LOM of the neck. Previous X-rays of C spine were normal. Veteran's history during C&P exam was consistent with headaches due to neck pain because it increased in intensity with movement of the neck, it radiated from the neck area to the head, it progressed from the occipital to the frontal region of head, and it usually occurred on the same side as the side of the neck with stiffness and pain Diagnosis: chronic cervical strain and cervicogenic muscle tension headache

SSC Rating Decision, November 2010

VBA granted secondary service connection to Dale Willow for cervicogenic headaches in November 2010.

Form 21-526, March 2013

Dale Willow files a claim for secondary service connection for lower back pain in March 2013.

Medical e-Records

VA Medical Treatment Records

2007-2008

Veteran established care in VA in 2007 and new evaluation notes show a past history of neck pain, stiffness, and headaches for many years since he was discharged from military. He was regularly taking OTC pain meds for control of headaches and neck pain but was also prescribed hydrocodone/ APAP and cyclobenzaprine during acute episodes of neck pain. On March 3, 2008, Dale Willow was found to have mild tenderness over entire cervical spine and bilateral paraspinal muscles during a visit when he was experiencing a flare-up of neck pain. At that visit Veteran also complained of frequent headaches.

2009

Veteran was referred to physical therapy for stiffness and pain in neck in 2009. In December 2009, he was referred to a neurologist for evaluation of chronic headache and was diagnosed with cervicogenic headache.

2012

VAOPC 2012: Seen for severe neck pain and stiffness for past 5 days. Is SC for cervical strain, but has had only occasional mild pain and stiffness since the early 70s. Today has marked LOM (limitation of motion) of cervical spine, especially on lateral rotation, with diffuse spasm and some tenderness of cervical muscles. No recent injury. Dx: cervical strain. Treatment: Hot packs, cyclobenzaprine HCl, and ibuprofen (600 mg qid for 10 days).

Current C&P Examination

SC Cervical Condition

Medical history: SC for cervical strain following minor truck accident in 1969. After service, he worked in construction for 30 years and was active in sports. He is now retired. Has had no additional neck injuries since the 1969 incident. States that he has limited ability to turn his head from side to side. Was seen at VA outpatient clinic for acute neck pain in 2012, and has had constant mild pain and moderate stiffness since. Veteran says that stiffness is worse during flare-ups, which he has 2 to 3 times a year, mainly in the winter months. During flare-ups, which last an average of 4-7 days each, he has only minimal motion of his neck, with severe pain. He uses local heat, OTC pain medication, and a prescribed muscle relaxant for relief (as of 2012). Between flare-ups he mainly uses NSAIDS as needed, and feels that his neck problem is worsening in the past few years.

Physical examination: Veteran is overweight. He is 5 feet nine inches tall and weighs 181 pounds. BP is 138/80. P is 78. Diffuse cervical muscle spasm and tenderness is noted. ROM examination of cervical

spine shows moderate to severe restriction of motion with findings of: forward flexion 0 to 40 degrees, extension 0 to 35 degrees, left lateral flexion 0 to 35 degrees, right lateral flexion 0 to 35 degrees, left lateral rotation 0 to 30 degrees, right lateral rotation 0 to 35 degrees. All motions are accompanied by pain, most marked at extremes of motion. There is no change in pain or limited motion on repetitive use. Neurologic examination is normal. Cervical spine X-rays continue to show no evidence of arthritis.

Diagnosis: Cervical strain

Low Back Pain

Medical history: Is claiming that his SC cervical strain has worsened his low back condition. States that he has had more or less steady low back pain, with gradual worsening, over the past 12 years. The pain is worse after heavy lifting or with other back exertion. Pain does not radiate. He feels that his SC cervical condition is related to his low back pain and makes it worse. His first medical visit for low back pain was to a chiropractor in 2011. He received several spinal adjustments, resulting in some relief of pain. However, the low back pain did continue and is now worse than it has ever been. His back pain increases during damp weather, usually lasting no more than a day or two, but has not required any specific treatment other than an occasional OTC NSAID. He has no leg pain.

Physical exam: Has pain on the extremes of flexion, extension, and rotation of thoracolumbar spine, which worsens slightly on repetitive use. ROM examination shows forward flexion of 0 to 80, extension of 0 to 20, left lateral flexion 0 to 30, right lateral flexion 0 to 30, left lateral rotation 0 to 20 and right lateral rotation of 0 to 20. After three repetitions of ROM, all of the ranges of motion are about 5 degrees less. There is no tenderness or spasm of the thoracolumbar area. Straight leg raising and reflexes are normal.

X-rays: Thoracolumbar spine X-rays show small osteophytes of the lower thoracic vertebrae and all of the lumbar vertebrae with mild narrowing of the L5-S1 disc space.

Diagnosis: Osteoarthritis (DJD) of the lumbar spine.

Medical Literature

Sticky Note from the Examiner

Veteran's neck was impacted in service; STRs are silent for any lower back problems or complaints. Majority of peer-reviewed articles do not mention cervical strain or sprain as a cause of lumbar osteoarthritis or as a factor that worsens it. Medical literature citations can indicate for the adjudicator that lower spine conditions are not thought to be caused by cervical strain.

Article 1
Complications of cervical strains and sprains include instability, nerve damage, headache, stiffness, and referred pain.(MD Guidelines. (2014). *Sprains and strains, cervical spine (neck)*. Retrieved on February 18, 2015, from http://www.mdguidelines.com/sprains-and-strains-cervical-spine-neck/complications)

Article 2 (Chapter 5 of an Edited Book)
The main complication from the injury itself is chronic intractable pain leading to permanent loss of cervical range of motion and functional disability (Hudgins, T.H. et al.(2008). Cervical sprain or strain. In Frontera, W.R. (Ed.), *Essentials of Physical Medicine and Rehabilitation, 2nd Ed.* Philadelphia: Elsevier.)

Articles 3 and 4
The most common risk factors for osteoarthritis are:

- Being older than 50 or 60 years old
- Having OA run in your family
- Being overweight
- Injury to the joint
- History of inflammatory joint disease
- Metabolic or hormonal disorders, such as hemochromatosis and acromegaly
- Bone and joint disorders present at birth
- Repetitive stressful joint use, such as athletes or construction workers might have
- Deposits of uric acid crystals in joints

(Source citation 1: http://www.mayoclinic.org/diseases-conditions/osteoarthritis/basics/risk-factors/con-20014749)
(Source citation 2: Osteoarthritis_ University of Maryland Medical Center http://umm.edu/health/medical/altmed/condition/osteoarthritis#ixzz2yEe6J4Dr)

Sticky Note

Veteran has at least three of the listed risk factors: older age, being overweight, and having a history of repetitive stressful joint use as a construction worker.

[26] Summary of Evidence, Dashboard 3, is provided in the Additional Resources section of this document, page 112.

[27] Summary of Evidence, Dashboard 3, is provided in the Additional Resources section of this document, page 112.

Dashboard 3: Review the Opinion

Instructions: Review the question requested by the adjudicator and the opinion and rationale provided by the examiner. Select What does the adjudicator need?[28] to review the examiner's understanding of what's needed from ___, and select What do you think?[29] for a checklist of elements to look for in this opinion.

Opinion requested:

Please determine whether it is at least as likely as not that the current low back pain is proximately due to, or caused by, the SC cervical strain. If the current low back pain is not due to the SC cervical strain, is it at least as likely as not that it has been aggravated beyond natural progression by the SC cervical strain?

Opinion: After review of the C-file and available medical records, including notes in CPRS (computerized patient record system) electronic medical treatment , it is less likely than not that this Veteran's degenerative joint disease (DJD) of the lumbar spine (claimed as low back pain) is due to or caused by, his SC cervical strain.

Rationale: The Veteran's current diagnosis for his low back pain is DJD of the lumbar spine, confirmed by X-ray. Peer-reviewed medical literature does not provide support for the concept that cervical strain causes DJD of the lumbar spine (http://www.mdguidelines.com/sprains-and-strains-cervical-spine-neck/complications and Frontera (Ed). (2008). Essentials of Physical Medicine and Rehabilitation, (2nd ed.) *Cervical Sprain or Strain* by T. H. Hudgins, MD. et. al). The literature does state that the most common risk factors for DJD of the lumbar spine include advancing age (>45), obesity, and jobs or hobbies that place repetitive stress on the lumbar joints (http://www.mayoclinic.org/diseases-conditions/osteoarthritis/basics/risk-factors/con-20014749) This Veteran is 73 years of age, obese, and after his active duty service period worked in construction, which is an occupation with high probability for developing DJD of the lumbar spine. Therefore, it is less likely than not that Veteran's DJD of the lumbar spine is due to or caused by his SC cervical strain.

Summary of Evidence[30]

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[28] What Does the Adjudicator Need is provided in the Additional Resources section of this document, page 116.

[29] What Do You Think? is provided in the Additional Resources section of this document, page 116.

[30] Summary of Evidence, Dashboard 3, is provided in the Additional Resources section of this document, page 112.

The examiner's opinion must separately address each of the following five medical issues for this type of claim (38 CFR 3.310(b)):

1. Can the examiner determine a baseline level of severity of the NSC condition before it was potentially aggravated by the SC condition?
2. What is current level of severity of the NSC condition?
3. How much, if any, of the increase is due to the natural progression of the NSC condition?
4. How much, if any, of the increased level of severity (current minus the baseline severity) of the NSC condition is proximately due to or caused by the SC disability?
5. The examiner must explain the medical considerations and evidence supporting an opinion that increased manifestations of the NSC condition are due to natural progression of the NSC condition or are due to the SC condition.

Adjudicators will then determine the baseline and current levels of severity under the Schedule for Rating Disabilities (38 CFR part 4) and determine the extent of aggravation by deducting the baseline level of severity, as well as any increase in severity due to the natural progress of the disease, from the current level.

TACK NOTE

The examiner must be familiar with the NSC condition and potential natural progression.

Medical Opinion Dashboard 4: Aggravation (Allen)

The need to consider Aggravation (Allen) is part of the requested opinion for Dale Willow's claim for low back pain. You may recall that the requested opinion for this claim asks about both secondary service connection and aggravation.

Requested Opinion:

The Veteran is claiming service connection for low back pain. Please determine whether it is at least as likely as not (50 percent or greater probability) that the current low back pain is proximately due to, or caused by the SC cervical strain. If the claimed lower back pain is not due to or caused by the SC cervical strain, has the claimed condition been aggravated (permanently worsened beyond its natural progression) by the Veteran's SC cervical strain?

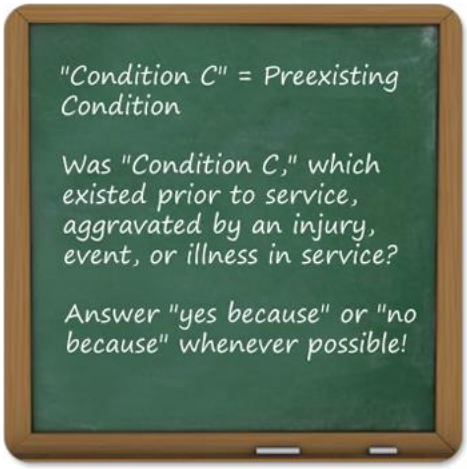
State your conclusions using one of the following legally recognized phrases:

a. _____ is at least as likely as not (50 percent or greater probability) caused by or a result of _____.
b. _____ is less likely than not (less than 50 percent probability) caused by or a result of _____.

What does the adjudicator need?[33]

[33] What Does the Adjudicator Need is provided in the Additional Resources section of this document, page 116.

Aggravation of a Preexisting Condition



Aggravation is present when a preexisting injury or disease that was diagnosed at the time of the entrance examination or before entry to service is considered to be permanently made worse by active service, and there is no finding to indicate that the current level of disability is due to natural progression of the disease or injury. Note: Temporary or intermittent flare-ups in service of a preexisting condition do not constitute aggravation.

The examiner's opinion must separately address each of the following five medical issues for this type of claim:

1. The baseline severity of the condition at the time of entrance into service, i.e., the status of the preexisting condition
2. The severity of the preexisting condition at separation from service
3. Determination of how much, if any, of the worsening of the pre-existing condition during service was due to natural progression
4. Current severity of the preexisting condition
5. Whether a preexisting condition was permanently aggravated beyond its natural progression.

Example

Was “condition C”, which clearly and unmistakably existed prior to service, aggravated (worsened beyond its natural progression) by an in-service injury, event, or illness?

The difference between the terms aggravation of a preexisting condition and secondary (Allen) aggravation is that the former refers to permanent worsening **during service** of an injury or disease that existed at entrance to service. By comparison, secondary (Allen) aggravation refers to permanent worsening of an injury or disease **at any time** by a service-connected condition.

TACK NOTE

Although it may be difficult at times to determine the exact baseline level of severity for a preexisting condition, every attempt should be made to establish the level of severity as close as possible to the claimant's entrance into service.

Medical Opinion Dashboard 5: Aggravation of a Preexisting Condition

Instructions: The examiner reviews an examination request for a claim of aggravation of a preexisting condition. This is a first step in determining the scope of a requested opinion. Read the narrative and the opinion request from the Examination Request and then select "What does the adjudicator need" to benefit from the examiner's thoughts on what is expected of her.

Narrative: Mr. Dale Willow is a 74-year-old Vietnam Veteran who filed a claim for aggravation of his preservice flatfoot condition during service. Mr. Willow was a clerk in the U.S. Army from 1968-1970 with a deployment to Vietnam. After service, he worked in construction but he's since retired.

On the Examination Request

Service-connected disabilities: Cervical neck strain, cervicogenic headaches

Claimed disabilities: Aggravation of flatfoot

Examination requested: DBQ Foot, including Flatfoot (Pes Planus), DBQ Medical Opinion

Requested Opinion:

Veteran claims aggravation of his flat feet, which clearly and unmistakably existed prior to service. Please determine whether or not Veteran's bilateral pes planus increased to any degree during service. If so, was any increase in service beyond the natural progression of the condition? If you determine that the pes planus was aggravated, then please also state the baseline of the condition before onset of aggravation.

What Does the Adjudicator Need?[41]

[41] What Does the Adjudicator Need is provided in the Additional Resources section of this document, page 117.

Dashboard 5: Review the Evidence

Instructions: Select each folder on the screen to gather evidence that may apply. Once you've reviewed each folder, you can select the Summary of Evidence link that follows the evidence to view a summary of evidence for this claim. [In this print document, the folders have been designated as headings followed by their content.] You will be asked questions to give you insights into how the examiner might use this evidence.

C-file

Instructions: Select each linked item to view contents. Simplified text versions have been provided.

Service Personnel Data

DD-214 Report of Discharge or Transfer

Service dates: 08/06/1968–09/30/1970
MOS: 70A Clerk
Deployments: Vietnam 9/15/68–9/15/69

STRs

Facsimiles of the following forms are provided in the Additional Resources section of this document, beginning on page 100.

SF 88 Service Entrance Examination, July 1968

- Report of Medical History
- Report of Medical History Continued
- Report of Medical Examination
- Report of Medical Examination Continued

  Sticky note from examiner:
  Veteran at entrance exam, “I’ve always had flat feet.”

- Medical Examination Notes, June 1969

SF 88 Separation Examination, September 1970

- Report of Medical Examination
- Report of Medical Examination Continued

Sticky note from examiner:
STR’s are silent for foot complaints other than noted in the entrance and separation examination reports.

Lay Evidence

- Dale Willow, Statement in Support of Claim (Form 21-4138), January 11, 2008
- Statement from Wadena Willow, January 15, 2008
- Statement from Wadena Willow, January 13, 2010

Medical Records

Private Medical Treatment Records: November 1988, June 1995, September 1995, April 1999–December 2000

Multiple complaints of neck pain, neck muscle spasm, and recurrent headaches during his private primary care provider office visits. Veteran was diagnosed with cervical strain with muscle spasm and tension headaches. Had some decreased range of motion of neck with increase in pain on turning neck to either side. Chiropractor visits note tenderness and spasm over bilateral paraspinal muscles in neck with improvement after adjustments during each visit. His pain and tenderness was moderate over the upper neck and mild over the lower neck. In April of 1999 Veteran had physical therapy for six weeks with some improvement in neck pain.

Private Medical Treatment Records 2011

Chiropractic records in April and May 2011: Low back pain for several years. On exam, has mild tenderness over lower lumbar spine, with pain at extremes of motion. Mildly limited motion. X-rays show degenerative joint disease at L5-S1 with disc space narrowing and minor osteophytes of other lumbar vertebrae. Diagnosis: Lumbar spondylosis with facet joint dysfunction. Treatment: Spinal adjustments x5, with moderate relief noted.

C&P Records

Form 21-526, December, 2007

Dale Willow files a claim for service connection of cervical strain in December 2007.

First C&P Examination

Dale Willow was examined by a C&P examiner in October 2008. Examination Findings: Current C&P examination findings documented by examiner: Weight: overweight to obese. Normal C-spine X-rays in service; Veteran has painful, limited ROM of the cervical spine, and cervical muscle spasm and tenderness is noted on physical examination, c/w abnormalities found on in-service examination. Diagnosis: Cervical strain

SC Rating Decision, December 2008

VBA granted service connection to Dale Willow for cervical strain in December 2008.

Form 21-526, January 2010

Dale Willow files a claim for secondary service connection for headaches in January 2010.

Second C&P Examination, May 2010

Dale Willow was examined by a C&P examiner in May 2010. Examination Findings: Physical exam was completely normal except for the persistent LOM of the neck. Previous X-rays of C spine were normal. Veteran's history during C&P exam was consistent with headaches due to neck pain because it increased in intensity with movement of the neck, it radiated from the neck area to the head, it progressed from the occipital to the frontal region of head, and it usually occurred on the same side as the side of the neck with stiffness and pain Diagnosis: Chronic cervical strain and cervicogenic muscle tension headaches.

SSC Rating Decision, November 2010

VBA granted secondary service connection to Dale Willow for cervicogenic headaches in November 2010.

Form 21-526, March 2013

Dale Willow files a claim for secondary service connection for lower back pain in March 2013.

Third C&P Examination, April 2013

Dale Willow was examined by a C&P examiner in April 2013.

SC Cervical condition

Medical History: SC for cervical strain following minor truck accident in 1969. After service, he worked in construction for 30 years and was active in sports. He is now retired. Has had no additional neck injuries since the 1969 incident. States that he has limited ability to turn his head from side to side. Was seen at VA outpatient clinic for acute neck pain in 2012, and has had constant mild pain and moderate stiffness since. Veteran says that stiffness is worse during flare-ups, which he has 2 to 3 times a year, mainly in the winter months. During flare-ups, which last an average of 4-7 days each, he has only minimal motion of his neck, with severe pain. He uses local heat, OTC pain medication, and a prescribed muscle relaxant for relief. Between flare-ups he mainly uses NSAIDS as needed, and feels that his neck problem is worsening in the past few years.

Physical examination: Veteran is overweight. He is 5 feet nine inches tall and weighs 181 pounds. BP is 138/80. P is 78. Diffuse cervical muscle spasm and tenderness is noted. ROM examination of cervical spine shows moderate to severe restriction of motion with findings of: forward flexion 0 to 40 degrees, extension 0 to 35 degrees, left lateral flexion 0 to 35 degrees, right lateral flexion 0 to 35 degrees, left lateral rotation 0 to 30 degrees, right lateral rotation 0 to 35 degrees. All motions are accompanied by pain, most marked at extremes of motion. There is no change in pain or limited motion on repetitive use. Neurologic examination is normal. Cervical spine X-rays continue to show no evidence of arthritis.

Diagnosis: Cervical strain

Low Back Pain

Medical History: Is claiming that his SC cervical strain has worsened his low back condition. States that he has had more or less steady low back pain, with gradual worsening, over the past 12 years. The pain is worse after heavy lifting or with other back exertion. Pain does not radiate. He feels that his SC cervical condition is related to his low back pain and makes it worse. His first medical visit for low back pain was to a chiropractor in 2011. He received several spinal adjustments, resulting in some relief of pain. However, the low back pain did continue and is now worse than it has ever been. His back pain increases during

damp weather, usually lasting no more than a day or two, but has not required any specific treatment other than an occasional OTC NSAID. He has no leg pain.

Physical Examination: Has pain on the extremes of flexion, extension, and rotation of thoracolumbar spine, which worsens slightly on repetitive use. ROM examination shows forward flexion of 0 to 80, extension of 0 to 20, left lateral flexion 0 to 30, right lateral flexion 0 to 30, left lateral rotation 0 to 20 and right lateral rotation of 0 to 20. After three repetitions of ROM, all of the ranges of motion are about 5 degrees less. There is no tenderness or spasm of the thoracolumbar area. Straight leg raising and reflexes are normal. X-rays: Thoracolumbar spine X-rays show small osteophytes of the lower thoracic vertebrae and all of the lumbar vertebrae with mild narrowing of the L5-S1 disc space.

Diagnosis: Osteoarthritis (DJD) of the lumbar spine.

SSC Rating Decision, June 2013

VBA does not grant Dale Willow SSC for DJD of the lumbar spine in June 2013.

Form 21-526, March, 2014

Dale Willow files a claim for aggravation of preexisting pes planus in March of 2014.

Medical e-Records

VA Medical Treatment Records

2007-2008

Veteran established care in VA in 2007 and new evaluation notes show a past history of neck pain, stiffness, and headaches for many years since he was discharged from military. He was regularly taking OTC pain meds for control of headaches and neck pain but was also prescribed hydrocodone/ APAP and cyclobenzaprine during acute episodes of neck pain. On March 3, 2008, Dale Willow was found to have mild tenderness over entire cervical spine and bilateral paraspinal muscles during a visit when he was experiencing a flare-up of neck pain. At that visit Veteran also complained of frequent headaches.

2009

Veteran was referred to physical therapy for stiffness and pain in neck in 2009. In December 2009, he was referred to a neurologist for evaluation of chronic headache and was diagnosed with cervicogenic headache.

2012

VAOPC 2012: Seen for severe neck pain and stiffness for past 5 days. Is SC for cervical strain, but has had only occasional mild pain and stiffness since the early 70s. Today has marked LOM (limitation of motion) of cervical spine, especially on lateral rotation, with diffuse spasm and some tenderness of cervical muscles. No recent injury. Dx: cervical strain. Treatment: Hot packs, cyclobenzaprine HCl, and ibuprofen (600 mg qid for 10 days).

Current C&P Examination

Findings documented by the examiner:

- Mr. Willow reported increasing pain in his feet during the medical history interview.
- Weight: overweight to obese
- Diagnosis: Moderate bilateral pes planus

Medical Literature

Sticky note left by the examiner:

In this case, the diagnosis of mild bilateral pes planus is the same in the Service Entrance Examination and Service Separation Examination reports, so the medical studies are not needed to explain this determination for the adjudicator.

Opinion: The Veteran's preexisting bilateral pes planus was not aggravated beyond natural progression by events in service.

Rationale: Entire C-file was reviewed, particularly STRs and private medical records. At time of induction, Veteran self-reported that he always had “flat feet.” This was confirmed on both the enlistment and separation exams and reported as “mild bilateral flexible pes planus, normal variant, no functional limitations.” There was no evidence of increase in the degree of pes planus between entrance and exit exams, STRs are silent for foot complaints, Veteran has only recently sought medical treatment for his feet (decades after leaving service), and he has excess weight and worked in construction. The Veteran's preexisting bilateral pes planus was not aggravated by events in service, but rather it progressed due to age, occupation and body habitus. In the recent past, he has had increasing foot pain and was recently prescribed orthotics for moderate bilateral pes planus. Exacerbation of flat feet is associated with an increase in age, obesity, occupations requiring standing or walking for extended periods of time, or carrying heavy loads. Therefore the evidence strongly supports that the pre-service flat foot condition was not aggravated by events in service, but was aggravated after separation from service.

Additional Topics

We just covered the basic types of medical opinions in-depth, so the rest of this lesson will cover three more considerations for medical opinions:

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[42] Summary of Evidence, Dashboard 5, is provided in the Additional Resources section of this document, page 114.

[43] Summary of Evidence, Dashboard 5, is provided in the Additional Resources section of this document, page 114.

[44] What Does the Adjudicator Need is provided in the Additional Resources section of this document, page 117.

[45] What Do You Think? is provided in the Additional Resources section of this document, page 117.

[46] Summary of Evidence, Dashboard 5, is provided in the Additional Resources section of this document, page 114.

[47] Opinion text is provided in the Additional Resources section of this document, page 118.

[48] Hint text is provided in the Additional Resources section of this document, page 119.

1. Medical opinions for reconciliation of conflicting diagnoses
2. Opinions across multiple specialties
3. Military Sexual Trauma and markers for evidence

There are also situations such as these that impact medical opinions:

- Addressing the absence of evidence
- Addressing conflicting evidence
- How to avoid an insufficient opinion

Reconciliation opinions are discussed on the next page.

Reconciliation of Conflicting Diagnoses

Earlier in this lesson, we discussed the need to provide an opinion when you determine a new or alternate diagnosis for a claimant's condition. It may be that adjudicators notice conflicting diagnoses in a claimant's records. When this happens, an adjudicator may ask you to provide an opinion to help him or her reconcile what appear to be different diagnoses for the same conditions in a claimant's records. The difference in diagnoses may have to do with a possible error in diagnosis by one examiner that is not explained by a subsequent examiner, or the difference might be due to the progression of a condition. An example follows for a Veteran who separated from service in 2006.

Opinion requested:

Veteran was service connected for PTSD and was recently re-examined for disability. The most recent exam did not diagnose the Veteran with PTSD, however diagnosed the Veteran with Depressive Disorder. Please provide an opinion regarding these conflicting diagnoses.

Opinion: It is at least as likely than not that the Veteran's current diagnosis of Depressive Disorder represents progression of the prior diagnosis, PTSD, and is not in fact a conflicting diagnosis.

Rationale: Veteran was diagnosed with PTSD in a 2011 C&P evaluation. The 2011 C&P report clearly described how Veteran met diagnostic criteria for PTSD. While not formally diagnosed, review of records indicate that Veteran's symptoms in 2011 were also consistent with a diagnosis of a Depressive Disorder. This is very common as PTSD is often co-morbid with other mental health conditions. Research shows that individuals with PTSD are 80% more likely than those without PTSD to have symptoms that meet diagnostic criteria for at least one other mental disorder (DSM-5). Additionally, there is a high rate of comorbidity between the diagnoses of PTSD and Depression (Kessler et al, 1995). In 2013, Veteran's C&P evaluation did not diagnose the Veteran with PTSD, however did diagnose the Veteran with a Depressive Disorder. From review of Veteran's medical records, Veteran participated in Prolonged Exposure (PE) treatment for PTSD in 2012. PE is an evidence-based psychotherapy for PTSD which has high rates of success in reducing PTSD symptomatology (Schnurr et. Al; JAMA 2007; 297(8)). Since completing PE, objective testing data found in CPRS indicates that while Veteran does still experience some symptoms of PTSD, he no longer meets full diagnostic criteria for PTSD. However, review of records and 2013 C&P exam indicate that Veteran's current mental health difficulties are now better accounted for by a diagnosis of a Depressive Disorder. For these reasons, it is the opinion of the current reviewer that the Veteran's diagnosis of Depression does not represent a conflicting diagnosis but rather is indicative of a mental health diagnosis that he had in 2011. Many of the symptoms and functional limitations of PTSD and Depression overlap, (i.e. difficulty with sleep, difficulty with concentration, and difficulty with relationships) and this Veteran is still experiencing these symptoms.

An Opinion across Multiple Specialties

As explained in an earlier lesson, you may encounter the need to get input from one or more medical specialists before you develop an opinion and rationale. For example, if eye symptoms related to a claim for headaches need to be evaluated, an eye specialist must perform the eye assessment and provide you the results. The examiners across specialties should talk to each other in order to sort symptoms before finalizing the disability examination report, including the medical opinion.

For example, what if cognitive symptoms might be related to a mental health condition as opposed to being related to a traumatic brain injury (TBI)? In this case, a mental health disability examiner would need to assess symptoms in addition to the C&P examiner who conducts the overall TBI examination.

Narrative

Dates of service: 2006-2011. Veteran reported having experienced several blast events during his deployment to Iraq from March 2007 to March 2008, two of which were reportedly significant including one in which he lost consciousness for more than ten minutes per his report. He was also involved in a motorcycle accident in May of 2009 that also likely resulted in a concussion. Furthermore, soon after his return from Iraq his typical drinking pattern increased. He started drinking every day up to a six pack each day. Veteran reported he drank to help dull the pain from the frequent headaches he was having. Veteran reported no pre or post-military concussions or head trauma, no drinking or drug abuse, and no exposure to other traumatic events. When Veteran left the military in January 2011, he returned to his job at a local factory. He indicated that he had trouble with his short-term memory and headaches. He would call in a couple times a month and miss work due to these headaches. The Veteran also missed some family gatherings due to his headaches. His memory gradually improved. At the time of this evaluation, the Veteran reported headaches, irritability, memory problems, combat-related nightmares, avoidance of combat movies, and difficulty in expressing tender feelings to his wife. The Veteran's drinking had decreased dramatically to one time a week and two drinks per occasion.

Requested Opinion

Veteran claims service connection for both traumatic brain injury (TBI) and posttraumatic stress disorder (PTSD). The Veteran was confirmed by the neurologist to have residuals of a mild TBI, including headaches and memory impairment. Veteran also served in a combat capacity for two deployments in Iraq and was exposed to hostile and terroristic fire. The stressor is conceded by VA.

To the extent possible, state which emotional/behavioral signs and symptoms are part of a co-morbid mental disorder; and which represent residuals of TBI? If it is not possible to make such a determination without resorting to speculation, so state.

Next, an example opinion and rationale based on this narrative demonstrate how multiple specialties can work together to sort memory symptoms for a C&P TBI examination.

Example Opinion across Specialties

To the extent possible, state which emotional/behavioral signs and symptoms are part of a co-morbid mental disorder; and which represent residuals of TBI? If it is not possible to make such a determination without resorting to speculation, so state.

Opinion from a certified C&P TBI examiner: It is at least as likely as not that the Veteran's headaches are attributable to the TBI.

Opinion from a C&P mental health examiner: It is at least as likely as not that the Veteran's emotional/behavioral signs and symptoms are attributable to PTSD.

The most common form of TBI is mild (mTBI). Research conducted by the Congressional Budget Office (CBO) in 2012 indicated that of Veterans who served in Iraq and Afghanistan and were subsequently treated by the VA: about 21 percent were diagnosed with PTSD (but not TBI), 2 percent had TBI (but not PTSD), and 5 percent had both diagnoses. CBO's analysis of VA found that 75 percent of patients with a TBI diagnosis also had PTSD whereas 20 percent of patients with a PTSD diagnosis also had a TBI diagnosis. Although most cases with mild TBI improve within a few months of the event, residual effects of the mild TBI may persist after 12 months for 5 to 20 percent of the cases. There is some evidence that a diagnosis of PTSD explains most or all symptoms in Veterans with mild TBI. (Hoge, et al., Mild traumatic brain injury in U.S. soldiers returning from Iraq: *NEJM,* 2008).

In the above case, headaches began shortly after the blast, have persisted since that time and are not included as a PTSD symptom in DSM-5. Therefore, this symptom "at least as likely as not" may be attributed to the TBI and appears to have resulted in a mild level of impairment to the Veteran's occupational and social functioning. This was confirmed by the neurologist completing the TBI protocol. The other mentioned symptoms such as irritability, nightmares, avoidance of trauma-related stimuli, and difficulty in expressing emotions—but not memory problems—are "at least as likely as not" attributable to the Veteran's PTSD as they are all contained within the current list of symptoms that define PTSD in DSM-5. With regard to memory problems, based on current science, it is impossible to determine whether the memory difficulties are due to mTBI or PTSD. While memory problems are not listed as a diagnostic symptom of PTSD, memory problems are often caused by difficulty with sleep and difficulty with concentration, which are PTSD diagnostic criteria. While memory problems can be a residual of mTBI, most instances of neurocognitive impairment (memory problems) after mild TBI resolve within days to weeks (*Mild traumatic brain injury and postconcussion syndrome*, Michael A. McCrea, American Academy of Clinical Neuropsychology, 2008). As the Veteran does have both PTSD and mTBI residuals (headaches), it is impossible based on current science to determine whether the memory problems are related to PTSD or mTBI.

Military Sexual Trauma and Markers for Evidence

VA is aware that due to the personal and sensitive nature of military sexual trauma (MST), it is often difficult for a Servicemember to report or document the event when it occurs. In cases of PTSD secondary to MST, current regulations provide multiple means to establish an occurrence of MST. A few examples of documentation that can help to corroborate the Servicemember's or Veteran's account of the incident include: statements from family members and fellow Servicemembers and documentation from mental health counseling centers. Additionally, evidence of behavior changes, such as request for transfer to another military duty assignment or change in performance can be utilized as circumstantial evidence that MST occurred.

In cases of MST where there is not documentation of a stressor, but a claim of PTSD is filed and there is circumstantial evidence, a mental health professional will be asked to opine as to whether the in-service stressor occurred. The mental health professional's opinion can establish the occurrence of the claimed stressor. With respect to other disabilities based on MST (to include physical disabilities as well as mental health disabilities), VBA will request that the medical examiner provide an opinion as to whether it is at least as likely as not that the current disability is related to the in-service event. This opinion will be considered as evidence in making a determination about service connection.

An Opinion for an MST-Related PTSD Claim

Are there sufficient markers to support the Veteran's contention that an assault occurred?

Opinion: The Veteran's PTSD due to sexual trauma was at least as likely as not (50 percent or greater probability) incurred in or caused by a rape that occurred in 1993 while she was in the military.

Rationale: Sexual assault is an accepted Criterion A stressor per DSM-5 diagnostic criteria for PTSD. Markers identified in the records are sufficient to substantiate the claim that a sexual assault occurred (e.g., Veteran reported that she was raped in 1993 by a known perpetrator while stationed in Germany, STRs show that in 1993 veteran was diagnosed with chlamydia; records indicate that veteran overdosed on prescription medications and was hospitalized in 1995). Having a sexually transmitted disease and drinking or drug use may be considered markers of a Criterion A stressor for a diagnosis of PTSD secondary to having experienced Military Sexual Trauma (MST).

Addressing the Absence of Evidence

Events, illness, and injury that occur in service are not always documented in service treatment records (STRs), perhaps because it was a combat-related situation, or records were lost or destroyed. The absence of documentation for a condition in the claimant's STRs is not always a reason to opine against the relationship of a claimed condition to service, as there is no requirement that a claimant's lay testimony must be supported by documentation in the claimant's STRs.

The requirement to seek and weigh other sources of evidence comes from the *Buchannan v. Nicholson* court case:

> In crafting a comprehensive rationale in support of your opinion, you may be required to address the absence of evidence where (1) there are no STRs (i.e., destroyed and/or missing) or (2) there are STRs, but the Veteran's in-service symptoms or complaints were not documented. In such circumstances, the Veteran's lay statements concerning the type and duration of the symptoms he had in service must be considered. By law VA cannot deny a claim solely because the claims file does not contain supporting in-service evidence. If an injury, disease, or related symptoms reported by the Veteran are of a nature that they would ordinarily have been recorded had they occurred, you should note this and explain why. For example, a comminuted or compound fracture would ordinarily have been recorded. This information would be helpful to adjudicators in determining the trustworthiness of the Veteran's statements. (*Buchanan* v. *Nicholson*, 2006)

Addressing Conflicting Evidence

There are a variety of situations where there is conflicting evidence of record that you will need to assess. The most common situation is where the evidence of record contains conflicting medical evidence from different clinicians, but there are other possibilities as follows. When conflicting evidence is present, VBA or BVA adjudicators will request that you review all of the evidence and provide an explanation as to what evidence is most accurate or reflective of the Veteran's current condition. They may ask if the new or different evidence requires a modification of previous examination conclusions.

Example of Conflicting Evidence from Clinicians

For example, clinician A finds that the Veteran has pain and weakness of the left shoulder with limited abduction, while clinician B reports that the Veteran had a prior left shoulder dislocation and has some mild pain but has no limitation of motion.

The conflict may also be between diagnostic studies, for example, when there are diagnostic studies that were done at two different places on dates that are in close proximity, with each reporting different findings that could significantly impact the Veteran's rating. Here is an example of conflicting diagnostic reports in evidence:

Example of Conflicting Diagnostic Reports

An echocardiogram done on 12/2/13 showed a left ventricular ejection fraction of 55% and an echocardiogram done on 5/15/14 showed a left ventricular ejection fraction of 45%. The examiner indicated in the 5/15/14 examination report that there has been no change in the Veteran's heart condition since the 12/2/13 examination. A request may then be sent to the examiner to ascertain which of these echocardiograms more accurately reflects the Veteran's current cardiac condition (via EF%) and provide a supporting explanation for the decision.

Speculative Opinions

There are circumstances when a medical opinion cannot be provided, such as when a condition has multiple possible etiologies, or where limitations of the medical field prohibit provision of the requested opinion.

In either of these circumstances, you may find that you cannot provide the requested opinion without resorting to speculation. You should know, however, that there is a high legal threshold for determining whether an opinion truly cannot be provided without resorting to speculation. The phrase "without resort to speculation" should reflect the limitations of knowledge in the medical community at large, and not those of a particular examiner. This should be an assessment arrived at after all due diligence in seeking relevant medical information that may have a bearing on the requested opinion, not a first impression of an uninformed examiner. Determining that you are unable to provide an opinion without resorting to speculation is a medical conclusion as much as a firm diagnosis. Therefore, you must explain the basis for such an opinion. If possible, you should clearly identify precisely what facts cannot be determined.

It must be clear from the examination report that you considered all procurable and assembled data by obtaining all tests and records that might reasonably explain your medical analysis. If there are insufficient facts or data, you may need to conduct a medical literature search, depending upon the evidence of record at the time of the examination.

How to Avoid an Insufficient Opinion

Medical opinions may be returned as insufficient (or inadequate, although the VBA-recommended language is "insufficient") for a few main reasons:

1. The opinion does not have proper VBA-recommended phrasing.
2. The question or questions on the 2507 are not answered or are answered vaguely.
3. The opinion is not accompanied by a well-reasoned rationale showing how the conclusion was reached.

To avoid having a medical opinion returned to you, remember that your medical conclusion or opinion statement should never be qualified with terms like "probably" or "may be." Use the recommended language to ensure that adjudicators can use your opinion. Next, compare your finished opinion with instructions on the Examination Request. Is your medical opinion a good match for the scope and the questions asked?

Insufficient opinions slow down the overall claims process by delaying adjudication of a claim while awaiting an appropriately completed report. They are also noted as a negative mark for the facility's overall C&P performance measures.

Select Medical Opinion Checklist for a quick review of errors you need to search for and correct if you find them.

Medical Opinion Checklist

Before you submit your medical opinion, check it to ensure none of these problems are present:

1. The opinion does not use the VBA-recommended language.
2. The opinion and rationale do not address all aspects of the 2507and answer all questions posed. (To prevent this, it may be helpful to number all questions asked on the 2507 and answer them in order, especially if multiple opinions are required.)
3. There is a change of diagnosis in the examination report without an explanation in the opinion and rationale (e.g., a diagnosis of service-connected left knee instability is addressed in an opinion as patellofemoral syndrome without explanation).
4. The rationale is inadequate for these reasons:
    a. The rationale is absent or incomplete.
    b. The rationale is based on inaccurate facts such as improper associations.
    c. The rationale does not address all pertinent facts.
    d. Explanations are unclear.
    e. There are internal inconsistencies.
    f. The rationale is based on an incomplete record review.
    g. The rationale fails to consider relevant lay statements.
5. There is no statement about having reviewed the C-file when required, or it's not checked off on a medical opinion documentation protocol.

A Returned Medical Opinion

A medical opinion is most commonly determined to be inadequate, or insufficient (these terms are synonymous), because it lacks a well-reasoned, comprehensive rationale. In the video on this page, a supervisor approaches an examiner with a medical opinion that was returned as insufficient. The examiner wants to share the notes he takes as the supervisor explains the importance of reviewing the evidence and how the evidence can be used in a rationale.

Inadequate Medical Opinion: The Problem

[Onscreen text: RVSR at a Regional Office]

[AD: RVSR at a Regional Office]

RVSR thinking: Okay, here's the opinion. Let's see. Veteran's right knee osteoarthritis is at least as likely as not related to service based on evidence in service treatment records.

[ONSCREEN TEXT: "Veteran's right knee osteoarthritis is at least as likely as not related to service based on evidence in service treatment records."]

RVSR thinking: Well, that's not entirely complete. This opinion has an incomplete rationale.

RVSR thinking: I can't rate it because it doesn't tell me which documentation the examiner is basing his opinion on. And there's no discussion of other evidence after service.

RVSR thinking: I think I'll have to call the lead clinician to discuss this further.

Lead clinician: Hello, this is Doctor Jones.

RVSR: Hi Dr. Jones, this is Tina Wilson. I'm calling from the regional office.

Lead clinician: Oh, good morning. What can I do for you?

RVSR: I'd like to discuss an exam that one of your examiners submitted. It's on Mr. Green, G1234.

RVSR: Just so you know, it's an original examination request for knee-trauma arthritis to the Veteran's right knee done by Dr. Smith recently.

Lead clinician: Okay. Yeah, I have the exam up on my computer. What part would you like to discuss?

RVSR: Well, the examination is complete, but the rationale is not. There's no indication of the documentation on which the opinion is based and no mention of other evidence after service.

Lead clinician: Okay, let's see. Veteran's right knee osteoarthritis is at least as likely as not related to service based on evidence in service treatment records.

Lead clinician: Yes, I agree. The rationale is almost missing. We need to address this. I will talk to Dr. Smith, the examiner who performed the examination and wrote the report. I know that he's new, so he may not know what constitutes a complete opinion with rationale. I'll make sure he gets on this right away.

RVSR: Oh, great! Thanks for looking at this so quickly.

Lead clinician: I really appreciate your calling for clarification instead of sending this back as an insufficient exam. Thank you so much.

[AD: RVSR hangs up phone. Scene changes to Dr. Smith's office; Dr. Smith is at his desk, typing into his computer; a knock on the door.]

[ONSCREEN TEXT: C&P Examiner at a VAMC]

[AD: Dr. Smith answers the door. Lead clinician steps in. She is holding a paper file.]

Dr. Smith: Hello Dr. Jones.

Lead clinician: Hi, Dr. Smith. Do you have a few minutes?

[AD: Dr. Smith closes the door, returns to his seat.]

Dr. Smith: So, what can I do for you today?

Lead clinician: I just want to talk to you about a recent exam report that you had sent to VBA.

Dr. Smith: Oh, okay.

Lead clinician: The regional office called this morning and we discussed your exam on Mr. Green. VBA is requesting more information and further clarification.

Dr. Smith: Yes, Mr. Green. I remember that case. What was wrong with the report?

Lead clinician: Well, most of it is actually just fine. But I would like to go over some aspects of the medical opinion and the rationale with you.

Lead clinician: I know you are a pretty new C&P examiner, and for that you have done a great job with the exam itself.

Dr. Smith: Thank you.

Lead clinician: And it's complete. But the medical opinion part is the portion that I want to revise with you.

[AD: She opens file to the opinion, turns the document so that Dr. Smith can read it.]

Lead clinician: So, Veteran's right knee osteoarthritis...

Dr. Smith: Right.

Lead clinician: ...is at least as likely as not related to service...

Dr. Smith: Right.

Lead clinician: ...based on evidence in service treatment records.

Dr. Smith: It looks pretty good to me.

Lead clinician: Yeah, but the thing is that the rationale is incomplete.

Lead clinician: So, as you know, if the medical opinion does not include the complete and robust rationale, the RVSR cannot accept the opinion for rating purposes. And then it delays the claim processing for the Veteran, the delivery of the benefit to the Veteran -- and you may remember some of this from the initial training -- but I want to go over this with you over again, okay?

Dr. Smith: Sure. Sure, that's fine with me. It appears that I can really use some help in this part of the report. Is it okay if I take notes?

Lead clinician: Yes. Please, okay. So, first, there are a few things you should know about these exams.

Dr. Smith: Okay.

Lead clinician: That, you know, "insufficient exam" is one of the performance measures for C&P.

Lead clinician: And we are lucky that our regional office called us directly and gave us this opportunity to correct this before sending -- instead of sending us the insufficient exam ...

Lead clinician: ... back to us. We would like to provide a response as soon as possible, most probably by the end of today.

Lead clinician: And by improving communication, the claim is processed quicker, and the patients will know what benefits they're getting, and then they can go on with their life. So every medical opinion has actually two parts.

[ONSCREEN TEXT: There are 2 parts to every opinion, the stated opinion and the supporting rationale.]
Dr. Smith: Uh huh.

Lead clinician: Okay, so one is the stated opinion, and the other is the supporting rationale.

Dr. Smith: Okay.

Lead clinician: Then you need both parts for a medical opinion to be considered adequate and complete enough for rating purposes.

Dr. Smith: Okay.

Lead clinician: Okay. So, the opinion you wrote didn't actually have a comprehensive rationale.

Dr. Smith: Oh, I see.

Lead clinician: So for adjudicators, the rationale is an integral part of the opinion.

Dr. Smith: Uh huh.

Lead clinician: And in your rationale, you must identify the key pieces of evidence that you used from all available sources, okay?

[ONSCREEN TEXT: Identify key pieces of evidence from all available sources.]

Lead clinician: So in many cases, this will include information like from medical literature also. And finally, you should validate your opinion by showing or explaining your thought process ...

Lead clinician: ... in putting all these pieces together, and how you arrived at your medical conclusion.

[ONSCREEN TEXT: Validate your opinion by showing or explaining your thought process.]

Lead clinician: So, I cannot emphasize strongly enough that how critical it is to provide a really thorough and well thought-out rationale to support your opinion. And doing that will be the best way to avoid having your exams bounce back.

The Examiner's Notes

List the evidence

- Cite appropriate medical literature
- Validate the opinion—explain the thought process used

Evidence: all medical treatment records in the C-file, STRs, incl. private and VA treatment records, physical treatment records, medications, e.g., anti-inflammatory agents, etc. Any care documentation.

Look for lay evidence, perform a medical literature review or review findings with a specialist

- Use plain, simple language!

Dr. Smith's Takeaway

Dr. Smith checks his understanding of what's needed in the video on this page. Select Play to watch as Dr. Smith and the lead clinician agree on how to correct the medical opinion for Mr. Green.

Inadequate Medical Opinion: Dr. Smith's Takeaway

Dr. Smith: Okay, so what I need to do then is...

[He looks at his notes.]

Dr. Smith: ...make sure I list the evidence, cite appropriate medical literature... Lead clinician:

Um hm.

Dr. Smith: ...validate my opinion by explaining the thought process I used?

Lead clinician: Yes, you've got it.

Lead clinician: So, for example, you can look at the STRs -- you know, the service treatment records -- and then private treatment records, VA treatment records, all available records that's in the C-file. Then you should take note about any treatments like physical therapy visits, all the pain medications the Veteran is on like non-steroidal anti-inflammatory agents, or other joint infections. Like in this case, you can look for documentation of chronicity of the symptoms and for any care by private or any other clinician: VA clinician or outside clinician. You should also check for lay evidence, in statements made by the Veteran himself or by his close family, close friends, about his care and symptoms in the past.

Lead clinician: And think about performing a medical literature review, okay? So...or review your findings with a medical specialist if you need to.

Lead clinician: So then once you have all these pieces together, then you need to connect the dots. So, what I mean is you have to explain how all these evidences that you used are connected.

Dr. Smith: Okay.

Lead clinician: And summarize your thought process; how you arrived at your medical conclusion.

Dr. Smith: Alright.

Lead clinician: Okay? And you should list the facts, and the medical expertise or the literature that you used to arrive at your conclusion. And you write your opinion in very plain, simple language.

Dr. Smith: That sure seems like it might take a lot of time to do this. As you know, we're awfully busy as examiners.

Lead clinician: I know. I know you are busy, but the thing is that once you understand how to write a valid medical opinion and you do some more of these, you get more efficient at it.

Lead clinician: Now let's look at an opinion that has all the right stuff in it.

[ONSCREEN TEXT: Begin with opinion request, questions on 2507, review C-file and available evidence of record.]

Examiner: Okay, so, we reviewed the process, beginning with the opinion request, and reviewing all questions on the 2507 request, and reviewing the C-file again, and all available evidence of record, like STRs, the private and VA medical records, as well as the lay statement. Then you should cite the medical literature when it applies. In this case, you may research the difference between traumatic arthritis and arthritis from other etiologies, okay?

Dr. Smith: Okay.

Lead clinician: So, any ...any questions you have at this point?

Dr. Smith: No, no, you explained it quite well, thank you very much. So, what I'll do is look at that C-file and expand on my rationale to include the pertinent information from the service treatment records, as well as any post-service private or VA treatment records.

Lead clinician: Yes, and once you have finished revising the medical opinion, and write the rationale, can you please send it to me for review before you send it to the regional office?

Dr. Smith: Sure. Sure, I'll get it to you as soon as I can. And I really appreciate you taking the time to review this opinion with me before sending it back to VBA.

Lead clinician: Great, sure. I also encourage you to contact VBA directly whenever you have questions regarding an exam request. So remember, the more VBA and VHA communicate, the more Veteran-centric service we can provide.

Dr. Smith: Sure, sure ... got it. Well, I'll fix this report, and now I understand much better what's required for a valid medical opinion; and again, I thank you so much for taking the time to explain that to me.

Lead clinician: You are very welcome. And I really appreciate your good work.

Dr. Smith: Thank you.

Lead clinician: And our Veterans deserve it!

[Scene fades.]

Inadequate Opinion Revised

Instructions: Select the in-text links to see best practices at work in the opinion and rationale that follow.

This Veteran's right knee post-traumatic arthritis (1) is at least as likely as not related to his active military service.

Rationale: The above opinion is based on thorough review of (2) C-file, history, physical exam, tests and medical literature. Review of (3) C file reveals that the entrance (enlistment) exam is negative for any right knee problem. (4) STRs show that he fell while running during physical training when he was in active service. He also has (5) several treatment records related to the right knee in his private medical records, starting within a year after discharge from service, with primary care and orthopedics for right knee pain, local injections in right knee and physical therapy. This Veteran's (6) right knee X-ray showed evidence of degenerative arthritis at an early age of 38 and his left knee X-ray at that time was within normal limits by comparison. Since then, (7) several X-ray reports in his private medical records showed progression of the arthritis in his right knee and his (8) current X-ray report shows advanced arthritis in the same joint. (9) His records are negative for any other trauma to his right knee. (10) Medical literature shows that post-traumatic arthritis is caused by the wearing out of a joint that has had any kind of physical injury and about 12% of osteoarthritis of knee is caused by post-traumatic arthritis (online article by Cleveland Clinic). Joint trauma can lead to a spectrum of acute lesions, including osteochondral fractures, ligament or meniscus tears, and damage to the articular cartilage. This is often associated with intraarticular bleeding and causes post-traumatic joint inflammation. Although the acute symptoms resolve and some of the lesions can be surgically repaired, joint injury triggers a chronic remodeling process in cartilage and other joint tissues that ultimately manifests as osteoarthritis in a majority of cases. (Article by Martin K Lotz; Department of Molecular and Experimental Medicine, The Scripps-Research Institute, 10550 North Torrey Pines Road, La Jolla, CA 92037, USA) Arthritis Research & Therapy 2010, (12), 211. (11) As the Veteran developed right knee degenerative arthritis at an early age, and his left knee is within normal limits, it is at least as likely as not that this Veteran's current advanced degenerative joint disease in right knee (also called traumatic arthritis) has a direct causal relationship to the initial right knee injury sustained in active military service.

Best Practices at Work in the Opinion and Rationale

(1) The examiner used VBA-recommended language, at least as likely as not, for the opinion.
(2) The examiner lists the evidence he reviewed: the C-file, history from the C&P exam, examination findings from the C&P exam, test results and peer-reviewed literature.
(3) The examiner cites specific evidence from the C-file, the entrance examination, with no findings of a knee problem.
(4) The examiner is clear that he's discussing evidence from STRs regarding a fall in service.
(5) The examiner cites specific evidence from private medical treatment records and notes that the records start a year after service.
(6) The examiner discusses a specific finding from private treatment records: X-ray results for the left knee shows degeneration while X-ray results for the right knee do not show degeneration.
(7) The examiner cites specific evidence, X-rays, from other private medical treatment records that show a process of degeneration in the left knee.
(8) The examiner discusses X-ray results from the current C&P examination that indicate advanced degeneration of the left knee.
(9) The examiner discusses the silence for any additional injury to the right knee in any records reviewed.
(10) Citing two reports from peer-reviewed medical literature to support the claim and give the adjudicator the benefit of information from the larger medical community.
(11) The medical examiner provides the medical conclusion that is supported by evidence.

Revised Opinion Reviewed

Select Play to watch as the lead clinician and the RVSR review the same revised opinion as you reviewed on the last page.

Title: Inadequate Medical Opinion: The Robust Rationale

Lead clinician thinking: Let's see, this is the revised opinion for Mr. Green's report. Hmmm. So, yeah, he's listing all the key points of the evidences that he has used. Okay, so he's explaining his thought process, and here he justifies his opinion, how he reached the conclusion. This really looks great! Wow! Let me call Dr. Smith, and we can send it to VBA right away.

[She picks up the phone and dials Dr. Smith's number.]

Lead clinician: Hey, Dr. Smith? I just reviewed your opinion and rationale, and it looks great! Thank you so much for doing such great work, and taking care of it so promptly. Okay? Can you please send it immediately to the regional office? Thanks, bye.

[She replaces receiver. Fade out.]

[RVSR sits at her desk, reading her computer screen.]

RVSR thinking: Okay, here's the revised medical opinion for the knee examination for Mr. Green. Oh, this is excellent! The opinion didn't change. It's the same as before, but now a robust explanation is here. Here's the list of evidence that the examiner reviewed and how he reached his conclusion. That's exactly the kind of supporting rationale we need to be able to rate this case.

[The RVSR turns and closes an open file on her desk. Scene fades.]

Lesson Summary

This lesson covered the process of developing and writing medical opinions for adjudicators to use in determining basic service connection and reconciling previous medical opinions and/or diagnoses for a disability claim. We also covered how to avoid an inadequate opinion. Opinions required by the evidence of record were discussed in detail, and so was the unsolicited opinion.

Now that you've completed this lesson, you should be able to describe the process and required content for writing a medical opinion, including the use of legally appropriate language.

Special Circumstances

Learning Objective

Special protocols such as a remanded opinion or special circumstances such as a change in medical standards may affect your usual process for developing and writing a medical opinion.

When you are done with this lesson, you should be able identify special protocols or circumstances that may impact a medical opinion.

Remand Medical Opinions

If the Board of Veterans' Appeals has made a determination that it needs additional evidence in order to fully or fairly adjudicate an appeal, the Board will issue a remand. A remanded appeal is an appeal that has been returned by BVA to VBA for the development of additional evidence, for reasons of due process, or for reconsideration of issues. When the remand instructs that an examination or opinion be obtained, VBA will ask for a medical opinion or examination using an Examination Request.

When you provide a remand medical opinion, you must exactly follow all of BVA's remand instructions on the Examination Request, which may require information beyond what is required on a Disability Benefits Questionnaire (DBQ) or other documentation protocol. You must answer all questions in the remand instructions as well, since VBA is required to obtain all requested information (*Stegall v. West*, 1998).

Remand Instructions

Here is an example of remand instructions from BVA that would be included on an Examination Request:

Schedule the Veteran for an examination to determine the current nature, extent, severity, and manifestations of his service-connected left plantar fasciitis. The entire claims file (i.e., both the paper claims file and any medical records contained in Virtual VA and VBMS) and a copy of this remand must be made available to and be reviewed by the examiner. All orthopedic, muscular, and neurologic impairments found to be present and attributable to the plantar fasciitis disability should be noted. Any appropriate diagnostic testing needed to accomplish this should be completed.

Following examination, interview of the Veteran, and review of the claims folder, the examiner is requested to answer the following questions:

Is it at least as likely as not (50 percent or greater probability) that the neuroma of the left foot noted in VA and private treatment records was (a) caused by or (b) chronically aggravated by the heel injury the Veteran sustained in service as a result of jumping from a tank?

Finally, if feasible, the examiner should attempt to distinguish between the disability/symptoms attributable to the Veteran's service-connected plantar fasciitis and the neuroma. If such a distinction is not feasible, the examiner should specifically so state, and explain the reasons why such a distinction cannot be made.

Comprehensive explanations for all opinions must be included in the examination report. If the examiner cannot provide the above opinion without resorting to speculation, it must be so stated, and the examiner must provide the reason(s) why an opinion would require speculation.

Section 1151 Claims

You may be directed by the Examination Request to provide a medical opinion for an 1151 claim (referring to 38 U.S.C. 1151, Benefits for persons disabled by treatment or vocational rehabilitation). These cases typically concern whether there is an additional disability that was proximately caused by carelessness, negligence, lack of proper skill, error in judgment, or similar instance of fault on the part of VA in furnishing treatment. To determine whether a Veteran has an additional disability, VA compares the Veteran's condition immediately before the beginning of the hospital care, medical or surgical treatment, examination, training and rehabilitation services, or compensated work therapy (CWT) program upon which the claim is based to the Veteran's condition after such care, treatment, examination, services, or program has stopped. VA considers each involved body part or system separately. (38 CFR 3.361 (b))

Compensation may also be granted under Section 1151 for additional disability that was caused by an event not reasonably foreseeable. The event need not be completely unforeseeable or unimaginable but must be one that a reasonable health care provider would not have considered to be an ordinary risk of the treatment provided.

Less frequently, the Examination Request will ask you to provide an opinion regarding whether or not there was a causal relationship between a claimed injury (or injuries) sustained by a Veteran and an occurrence on the physical premises controlled and maintained by VA (*Viegas v.* Shinseki, (2013).

Example of a Sec. 1151 Requested Opinion

Here is an example of what you might see on the 2507 request:

> Please opine as to whether it is at least as likely as not that the Veteran's hepatitis C was the result of carelessness, negligence, lack of proper skill, error in judgment, or similar instances as the result of VA treatment. Veteran claims that he contracted hepatitis C after a screening colonoscopy.

Retrospective Medical Opinions

On rare occasions, you may be asked to provide an opinion based on historical information. This is known as a retrospective medical opinion. This most often arises when the Veterans Benefits Administration (VBA) or the Board of Veterans' Appeals (BVA) grants an effective date of service connection many years prior to the present date, and the record lacks sufficient medical information to determine a proper rating for the condition from the effective date of service connection until a later date, or such time as the medical information of record may be sufficient for rating. The Veteran's lay statements regarding the severity of his condition over time in such cases are extremely important, as his or her statements will frequently be the only information you have to consider in assessing the severity of the condition. You should, of course, also review any medical evidence that is available.

The need for retrospective medical opinions arises more commonly in mental disorders issues. A retrospective opinion example is shown on the next page.

Retrospective Opinion Example

Select each topic to read the requested retrospective opinion and the opinion and rationale that resulted.

Opinion Requested

Please render an opinion regarding the severity of the Veteran's PTSD for the period from March 16, 1973, to May 15, 1985. The examination report should include discussion of the Veteran's documented medical history and assertions. All signs and symptoms of the Veteran's PTSD should be reported in detail. The examiner should also describe the impact of the Veteran's PTSD disability on his occupational and social functioning. Because there are no clinical records available throughout this period, the examiner should specifically consider the itemized statement of earnings from the Social Security Administration and the statements of the Veteran, his friends, family members, and former employer regarding the severity, frequency, and duration of his symptoms during this time period and the resultant impact on his occupational and social functioning. The examiner should set forth all examination findings, together with the complete rationale for the comments and opinions expressed, in the report.

Opinion and Rationale

Opinion: It is at least as likely as not that the Veteran’s PTSD significantly impacted the Veteran’s occupational and social functioning from 1973 to 1985.

Rationale: Despite the fact that there is no clinical evidence of treatment for PTSD prior to 1985, the record contains substantial lay evidence regarding the severity of the Veteran's PTSD over the years and of the impact of his PTSD on his employability. Evidence from the Social Security Administration corroborates these assertions. The first clinical evidence of treatment for psychiatric symptoms of record is dated in 1995, however many individuals with PTSD do not seek treatment despite an impact on occupational and social functioning due to the stigma of receiving treatment for a Mental Health Diagnosis (Kim et. al Psychiatric Services 2010). The evidence of record shows that the Veteran was only marginally employed from January 1973 to December 1985 (See Social Security Administration Itemized Statement of Earnings from these dates). The Veteran, his friends, and his family members assert that his marginal employment was a direct result of the severity of his PTSD, which prohibited him from maintaining and obtaining employment. A November 2007 statement from one of the Veteran's former employers supports these assertions. In numerous written statements submitted in support of his claim for an increased initial rating, the Veteran, his friends, and his family members attested to the chronicity and severity of his PTSD symptoms since his active service. The Veteran was not married during this time period. Lay statements from his daughter indicate that the Veteran was not able to maintain any long-term intimate relationships and stated that her father was not involved during her early childhood as he wanted to isolate from others (which is characteristic of an individual with a PTSD diagnosis). Additional information from Veteran’s brother asserted that the Veteran had received treatment for his psychiatric symptoms at a community clinic in the mid 1970’s. However, in a September 2006 written statement, the Veteran's brother indicated that the clinic that had treated the Veteran in the 1970’s was now closed, and that the associated treatment records were no longer available.

Service Connection for Dependency and Indemnity Compensation

Dependency and Indemnity Compensation (DIC) may be granted to eligible survivors of Veterans whose death resulted from a service-related injury or disease. You may be asked to provide a medical opinion regarding the relationship of the decedent’s terminal condition to an in-service event, injury, or disease. An example follows.

Was the Veteran’s death, caused by stage IV nodular malignant melanoma with metastasis to the brain, a progression of a scalp lesion that was treated in service?

Opinion: Veteran's Stage IV Nodular Malignant Melanoma, with metastasis to the brain, which was stated on his death certificate as the cause of death, was at least as likely as not a progression of the scalp lesion first noticed while the Veteran was on active duty.

Rationale: Entire C-file reviewed.

1. Veteran was seen for a scalp lesion while in service. A review of the separation physical examination indicated that the site of the lesion is consistent with the same area of the skin cancer site diagnosed 4 years later.
2. Medical literature supports that some of the characteristics of the skin lesion noted during service (dark brown, irregularly-bordered on one side, slightly raised, pencil eraser-sized) are consistent with criteria for suspecting malignant melanoma. (http://emedicine.medscape.com/article/1130783-overview) (http://www.cancer.gov/cancertopics/wyntk/skin/page6)
3. The notes in service indicated that the examiner attributed the irregular border to the recurrent trauma from the haircuts the Veteran had received. This irregular border was at least as likely as not early evidence of the melanoma.
4. The biopsy of the same skin lesion that was described in service was consistent with Nodular Malignant Melanoma. The enlarged lymph nodes at the time of referral for the biopsy were an indicator of metastasis. The Veteran was subsequently diagnosed with Nodular Malignant Melanoma with metastasis to the brain.

Gulf War General Medical Examination Opinions

Based on 38 U.S.C. 1117 and 38 CFR 3.317, there are four disability patterns, or categories, that may apply to conditions associated with service in the Southwest Asia theater of operations:

(1) undiagnosed conditions,

(2) a diagnosable but medically unexplained chronic multi-symptom illness of unknown etiology,

(3) a diagnosable chronic multi-symptom illness with a partially explained etiology, and

(4) a disease with a clear and specific etiology and diagnosis.

If you, the examiner, determine that the Veteran's disability pattern is either (3) a diagnosable chronic multi-symptom illness with a partially explained etiology, or (4) a disease with a clear and specific etiology and diagnosis, then service connection cannot be granted under 38 CFR 3.317 on a presumptive basis; and may only be granted if the medical evidence is sufficient to establish service connection on a direct basis. For this reason, for either category 3 or 4, you must give a medical opinion and a supporting rationale as to whether it is "at least as likely as not" that the disability pattern or diagnosed disease is related to a specific exposure event experienced by the Veteran during service in Southwest Asia.

IMPORTANT NOTE

This requirement for the Gulf War General Medical examination is another example of when an opinion is required based on the evidence of record.

Camp Lejeune

Veterans who served at U.S. Marine Corps Base Camp Lejeune, North Carolina, were potentially exposed to contaminants present in the base water supply between 1957 and 1987. The chemical

compounds involved have been associated by various scientific organizations with the possible development of certain chronic diseases. Veterans are filing claims based on exposure to Camp Lejeune contaminated water. Each individual claim deserves a complete and comprehensive evaluation based upon best medical science. Due to the complexities of gathering detailed exposure history and assessment of exposure burden, a team of subject matter experts (SME) has been organized to provide advisory medical opinions (AMO) for all cases generated from service at Camp Lejeune related to exposure to contaminated water. This team will provide opinions only. If VBA accepts the opinion and grants the claim, there may be a need for an examination for residual impairment. Requests for examinations for residual impairment may be sent to you for examination only, with no opinion requested. The opinion will already be in the claims file. Please do not provide additional opinions regarding Camp Lejeune contaminated water contentions even if asked to do so by the Veteran. All opinions are to be deferred to the SME panel.

The appendices to VBA training letter 11-03 provide additional information useful to examiners. Select Resources on the course navigation bar to access and view this information.

In addition, you can view a report from the National Research Council report, *Contaminated Water Supplies at Camp Lejeune: Assessing Potential Health Effects* (2009), can be accessed at this National Academies Press website: http://www.nap.edu/catalog.php?record_id=12618.

Combat-Related Considerations

Certain laws and regulations direct VA to recognize that service treatment records (STRs) may not record events, illnesses, or injuries incurred during combat. If service personnel records, for example, indicate the claimant was likely in combat situations, the evidence for events, illness, or injuries may have to come from other sources. The purpose of this evidentiary rule is to accommodate the unarguable difficulty a Veteran encounters in gathering conclusive evidence of an injury or increase in the severity of a preexisting condition sustained under the rigors of combat or as a prisoner of war.

When a Veteran or Servicemember has had combat service, verified by VBA and usually noted on the Examination Request form, his or her lay evidence becomes an even more important source of evidence for a medical opinion. You must consider this lay evidence regarding signs or symptoms that occurred during combat even if there is nothing in the STRs documenting the claimed in-service event, injury, or disease.

Laws and Regulations

U.S. Code and Code of Federal Regulations references for combat-related considerations:

Consideration to be accorded time, place, and circumstances of service, 38 U.S.C.1154(b) (2014).

Direct service connection; wartime and peace time,38 CFR 3.304(d).

Aggravation of preservice disability, 38 CFR 3.306(b)(2) (2014).

Active and Inactive Duty for Training

In general, when you are asked to conduct an examination and/or provide a medical opinion, VBA will first have determined that the Veteran or Servicemember has basic eligibility for benefits because of having served on active duty in the Armed Forces. According to 38 U.S.C. 101(10) and (21), the Armed Forces consist of the Army, Navy, Marine Corps, Air Force, and Coast Guard, plus their reserve components

(Army, Naval, Marine Corps, Air Force, and Coast Guard Reserves, and the National and Air National Guard of the United States).

However, some other types of activities have also been determined to constitute active duty under certain circumstances. Additional information about these activities may address questions that might arise when you are asked to provide an opinion for an individual, for example, who has only inactive duty training, and you are unclear why he or she might be eligible for benefits.

VA statutes and regulations (38 U.S.C. 101 (22), (23), and (24), and 38 CFR 3.6(a)) state that activities that are also considered to be active military, naval, or air service, include, among others:

1. active duty for training (ACDUTRA) during which an individual was disabled or died from a disease or injury incurred or aggravated in the line of duty (including during travel directly to and from the training)
2. inactive duty training (INACDUTRA) during which an individual was disabled or died (including during travel directly to and from the training)
    a. from an injury incurred or aggravated in line of duty, or
    b. from an acute myocardial infarction, a cardiac arrest, or a cerebrovascular accident (these are the only covered diseases for INACDUTRA)

In addition, VA's Office of General Counsel has provided the following precedential opinions concerning certain other conditions related to INACDUTRA.

If a disabling condition occurs as a result of anthrax vaccination during INACDUTRA, the individual may be considered to be disabled by an "injury." (VAOPGCPREC 4-2002)

If PTSD develops due to sexual assault during INACDUTRA, the individual may be considered to be disabled due to "injury." (VAOPGCPREC 8-2001) By definition (in 38 CFR 3.6), disability due to injury or disease as a result of military sexual trauma during ACDUTRA would also be considered to have been incurred during active service.

You may be asked to provide a medical opinion about any of these types of disabilities. You should call the Regional Office if a question concerning active or inactive duty arises while you are preparing a medical opinion.

Presumption of Soundness

Presumption of soundness is core to all disability claims. Presumption of soundness is a legal assumption that VA employs for the benefit of the Veteran, whereby VA will consider a Veteran to have been in sound condition, i.e., good health, when examined, accepted and enrolled for service, except as to defects, infirmities, or disorders noted at entrance into service, or where clear and unmistakable (obvious or manifest) evidence demonstrates that an injury or disease existed prior thereto and was not aggravated by such service (38 U.S.C. 1111 and 38 CFR 3.304(b)).

How Presumption of Soundness Works for the Veteran

The presumption of soundness shields the Veteran from a finding that the disease or injury preexisted (and therefore was not incurred in) service by requiring VA to prove by clear and unmistakable evidence that a disease or injury manifesting in service both preexisted service and was not aggravated by service.

What if the claimant was examined upon entering active duty service, but the report of examination is missing or lost? In this case, VA will presume the Veteran to have been sound at entrance. However, if

there is no report of examination on entrance to all other types of service, for example, inactive duty training (INACDUTRA), VA will not presume the claimant to have been sound at entrance.

How Presumption of Soundness May Affect a Disability Claim

VBA will have considered presumption of soundness for a claim before requesting an examination and/or a medical opinion from you. If a condition such as pes planus manifests during service, a claimant may be considered for direct service connection if all evidence shows that the claimant was sound upon entering the service. If the claimant was noted to have pes planus and accepted for service, and available evidence indicates a permanent worsening of the condition during service, VBA would consider aggravation of a preexisting condition.

As an examiner, you may be asked to apply your clinical knowledge to help determine if a condition existed before service. For example, if pes planus was not noted on the service entrance examination but the claimant reports that this condition existed before service and provides medical evidence, you may be asked by an adjudicator to determine if the pes planus existed before service and was not aggravated by such service.

Select presumption of soundness for a more detailed discussion.

Presumption of Soundness

In providing an opinion, especially regarding aggravation of a condition that preexisted the Veteran's entrance into active service, you may need to take into account whether the Veteran was "sound," or may be "presumed" to have been sound, at the time of his entry into service. Notably, you need only make such a determination when VBA or the Board asks in the opinion request that you address whether a condition existed prior to service.

The basic principles relating to the presumption of soundness are found in 38 U.S.C. 1111 and 38 CFR 3.304(b). These sections state that a Veteran or Servicemember will be considered to have been in sound condition when examined, accepted and enrolled for service except, as to defects, infirmities, or disorders noted at entrance into service, or where clear and unmistakable (obvious or manifest) evidence demonstrates that an injury or disease existed prior thereto and was not aggravated by such service. Only such conditions as are recorded in examination reports are to be considered as noted.

A determination as to the Veteran's soundness at the time of his or her entrance into service is significant. When no preexisting condition is noted at entrance into service, the burden falls on the VA to rebut the presumption of soundness by clear and unmistakable evidence showing that the disease or injury:

- existed prior to service, **and**
- was not aggravated by service.

The presumption of soundness applies only when the Veteran underwent a physical examination at the time of entry into active service, and only the conditions that are recorded in the examination report are to be considered as noted. In other words, when no preexisting medical condition is noted upon entry into service, a Veteran is presumed to have been in sound condition upon entry (38 U.S.C. 1111; *Wagner v. Principi,* 2004). This is a very onerous standard, as will be discussed next.

Clear and Unmistakable Standard

In order to rebut the presumption of soundness, there must be clear and unmistakable evidence (obvious, manifest, or undebatable) that the Veteran's condition both preexisted his or her entrance into service **and**

was not aggravated by service (*Wagner,* 2004 and VA OGC Prec. Op. No. 3-2003, 2003). This determination, made by an adjudicator, almost always requires input from a clinician.

It is important to note that in providing an opinion when the presumption of soundness is called into question by VBA or BVA, the Clear and Unmistakable Evidence standard is required for both parts of the medical opinion: The examiner must use the "clear and unmistakable evidence standard" for both parts of the question – that is, that the disability preexisted service AND was not aggravated by service. This is a legal, evidentiary standard.

Put another way, if an examiner believes the condition existed prior to service, but the evidence does not clearly and unmistakably show that the condition existed prior to service, the examiner must address whether the disorder manifested in service. Significantly, there is a difference between the examiner's clinical judgment about something existing prior to service, even if it is clear and unmistakable to them, clinically, and the evidentiary requirements for VA to rebut the presumption of soundness.

A medical opinion for aggravation of a condition that clearly and unmistakably existed prior to service must be phrased to say that the claimed condition "was" or "was not" aggravated beyond its natural progression by an in-service injury, event, or illness. If the opinion is equivocal, it will be considered to be insufficient. Examples of unacceptable phrases include these:

1. "there are signs which indicate " that a condition existed prior to service;
2. it was "probable, but not absolutely certain," that a condition existed prior to service;
3. "it is impossible to say";
4. "could have accelerated";
5. "most likely";
6. "more likely"; and
7. "not significantly aggravated."

The reason the distinction of whether a condition preexisted service is so important is because the legal standards for granting the claim are different: If the presumption of soundness applies, then the Veteran's claim becomes one for direct service connection, not one for aggravation. Your opinion will allow the adjudicator to know which legal standard applies. This is why you may encounter a request asking you to provide multiple opinions.

Presumptive Conditions

Under certain specific circumstances, VA will consider a condition to have been incurred in or aggravated by service even though there is no evidence of such disease during the period of service. This is known as presumptive service connection, and the specific condition allowed is called a presumptive condition. Since this results in presumptive service connection, the legal burden of a Veteran to prove a relationship of one of the specified conditions to a certain exposure or experience in service is removed. Therefore, you would not have to provide a nexus opinion. For example, if a former prisoner of war has irritable bowel syndrome or dysthymia, the condition will be presumed to be related to service.

Although you may not be asked to provide a nexus opinion, you may be asked to provide a different kind of opinion. For example, you may be asked to give an opinion regarding whether or not a chronic disease manifested to a certain degree by a specific date.

Conditions listed in 38 CFR 3.309 http://www.ecfr.gov/cgi-bin/text-idx?rgn=div5&node=38:1.0.1.1.4#se38.1.3_1309

and 38 CFR 3.317 http://www.ecfr.gov/cgi-bin/text-idx?rgn=div5&node=38:1.0.1.1.4#se38.1.3_1317, including:

- Chronic diseases
- Tropical diseases
- Prisoner of war related diseases
- Diseases associated with radiation exposure
- Diseases associated with exposure to certain herbicide agents

The presumption of service connection for a condition may be rebutted by affirmative evidence of record to the contrary, such as the effect of intercurrent injury or disease, as noted in 38 CFR 3.307(d).

Willful Misconduct

Willful misconduct as detailed in the Code of Federal Regulations is a legal determination that addresses specific behaviors. Lifestyle choices, including eating or exercising habits are not considered as willful misconduct. Willful misconduct for C&P purposes means an act involving conscious wrongdoing or known prohibited action and involves deliberate or intentional wrongdoing with knowledge of or wanton and reckless disregard of its probable consequences. VBA will usually make any determination as to willful misconduct prior to requesting an examination or opinion. If your review of evidence suggests that willful misconduct may have taken place, you should contact VBA.

According to the Code of Federal Regulations, while the simple drinking of alcoholic beverage is not of itself willful misconduct, when the drinking of a beverage to enjoy its intoxicating effects results proximately and immediately in disability or death, the disability or death will be considered the result of the person's willful misconduct. However, organic diseases and disabilities which are a secondary result of the chronic use of alcohol as a beverage, whether out of compulsion or otherwise, will not be considered of willful misconduct origin (38 CFR 3.301(c)(2)).On the other hand, 38 CFR 3.301(d) (*Line of duty; abuse of alcohol or drugs*) indicates that an injury or disease incurred during active military, naval, or air service shall not be deemed to have been incurred in line of duty if such injury or disease was a result of the abuse of alcohol or drugs. This includes the use of alcoholic beverages over time. Therefore, while the long term effects of diseases and disabilities secondary to the chronic use of alcohol are not considered willful misconduct, they may not be service connected since they are not deemed to have been incurred in the line of duty.

For drugs, the Code of Federal Regulations differentiates between the isolated and infrequent use of drugs and the progressive and frequent use of drugs to the point of addiction. Only the latter is considered willful misconduct.

Substance Abuse Secondary to a Service-Connected Condition

Even though service connection for disabilities associated with substance abuse may not be granted on a direct basis, service connection may be granted on a secondary basis if the substance abuse is secondary to a service-connected condition, such as PTSD. Therefore, if substance abuse is an issue in a case, the examiner should be careful to precisely state the level of use and whether any usage was secondary to another condition.

The examiner should assess the pattern of drug/alcohol abuse during the time prior to the onset of the disorder. After the onset of the disorder, the examiner should asses the pattern of drug/alcohol use in the time period afterwards. Most importantly, inquire about the role of substance use in one's life at that time or the perceived benefits of using. If the Veteran's drinking increased following the onset of PTSD symptoms, it may be as likely as not that the Veteran's alcohol dependence could be rated as secondary to PTSD for a variety of reasons (e.g., the Veteran used alcohol to improve sleep, forget or suppress traumatic memories, etc.) (Driessen, et al., (2008); Jakupcak, McDermott, Hunt, and Simpson (2010); Simons, Gaher, Jacobs, and Johnson-Jimenez (2005); Stewart, Mitchell, Wright, and Loba (2004)). This

situation would not be considered willful misconduct by VBA. Remember VBA, not the examiner would make this determination.

Willful Misconduct Not Found

The evidentiary requirements for VBA to determine willful misconduct are stringent. The following story and explanation are provided to give you an idea of how VBA might look at a claim in order to determine whether or not willful misconduct applies.

Narrative

The Veteran served in the Army from February 2009 to February 2013. In July 2013, the Veteran applied for compensation for residuals of injuries due to a 2012 automobile accident. His injuries included fractures of his pelvis and left femur, a ruptured bladder, and collapse of his left lung. He was hospitalized for 2 months and underwent rehabilitation for 3 more months.

Circumstances of the accident are as follows: On July 12, 2012 the claimant drove 2 of his buddies to a bar a few miles from their base for a celebration. They stated they had 3 or 4 drinks each, and left around 10:30 to return to the base. It was a rainy night, and the rural road back to base was dark and winding. A large truck appeared ahead as they rounded a curve, and it seemed to be heading straight toward them. The driver swerved to the left to avoid the truck, crossed the left side of the road, went through a guardrail, and finally stopped after hitting a tree. The truck continued on its way. The other 2 soldiers suffered lesser injuries. The ambulance driver noted a strong odor of alcohol on the men. They were awake and able to discuss the accident, and agreed on what had happened, although the driver was in shock and less able to discuss the accident. The police report estimated that the speed of the car was approximately 55-65 miles per hour, although the posted speed limit on the road was 40 miles per hour. It noted that the road was wet, was unlit, and was narrow and winding. No mechanical failure of the car was found. Blood alcohol level of the driver was .08%.

The Army also prepared an accident report that indicated that excessive speed and alcohol both contributed to the accident, as well as the unlit, wet, narrow, and winding road and the near-collision with the truck, but did not give an opinion concerning whether the accident was in the line of duty or occurred as a result of willful misconduct.

Explanation

VBA had to make a determination concerning willful misconduct before moving to adjudicate the Veteran’s claim, since alcohol was named as a factor in the accident. VBA noted the multiple contributing factors. A blood ethanol level of .08% indicates that the driver’s judgment would have been impaired. However, VBA stated that it was not clear, based on all the contributing factors noted, that if the driver had not been impaired by alcohol, the accident would not have occurred. Therefore, the situation does not satisfy VA's definition of willful misconduct, i.e., "deliberate or intentional wrongdoing with knowledge of or wanton and reckless disregard of its probable consequences," and VBA determined that the accident was not due to willful misconduct.

When a claim requires a determination of whether willful misconduct was the cause of disability or death, the determination will normally have been made before adjudication of a claim proceeds and therefore before a C&P examination is requested. Although you, as an examiner, may question the determination or wonder why such a determination has not even been made, the issue is an adjudicatory one based on VA statutes and is not a determination for an examiner to make. If you receive an examination request, you can assume that the issue of willful misconduct has already been resolved.

Medical Opinions Due to Changes in Medical Standards

An opinion may be required to explain the relationship to service for a condition due to a change in medical standards. One example of a change in medical standards is the medical community's recognition of the Hepatitis C virus in 1989, and another is VA's recognition of the Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) in 2013.

A Veteran's STRs may show a diagnosis of non-A, non-B hepatitis for a Veteran during active service who was later on diagnosed with hepatitis C. As a result, you may be asked to provide an opinion regarding any connection between the Veteran's hepatitis in active service and his current diagnosis of hepatitis C. You may be asked whether the hepatitis with which the Veteran was diagnosed in service was hepatitis C, or if there is any relationship between the hepatitis diagnosed in service and his or her currently diagnosed hepatitis C.

The three most common types of viral hepatitis in the U.S. are hepatitis A (formerly known as infectious hepatitis), hepatitis B (formerly called serum hepatitis), and hepatitis C (formerly known as non-A, non-B hepatitis). Hepatitis A virus is abbreviated as HAV, hepatitis B virus as HBV, and hepatitis C virus as HCV.

The nomenclature "non-A, non-B hepatitis" was proposed in 1975 to indicate hepatitis not due to A or B because the specific virus causing the infection had not been identified, although it was known to be neither type A nor type B. It was not until 1989 that a test for antibodies to HCV became available that allowed HCV to be specifically identified.

In fact, research and published studies indicated hepatitis C to be the major cause of all previously diagnosed non-A, non-B hepatitis. Blood screening began testing for HCV in 1990, but a more sensitive and effective test was used starting in 1992.

In a similar way, VA's recognition of DSM-5 may result in a need to address what appear to be different diagnoses of record in the Veteran's STRs or other medical records. On the next page, an opinion requested and an opinion in response from a mental health disability examiner explains the relationship of a former diagnosis to the current diagnosis based on DSM-5.

Opinion to Address a Change in Medical Standards

OPINION REQUESTED: This Veteran is service connected for Anxiety Disorder Not Otherwise Specified and was recently examined for disability purposes. The current examiner diagnosed the Veteran with Other Specified Trauma- and Stressor- Related Disorder. Please provide an opinion as to whether the diagnosis of Other Specified Trauma- and Stressor- Related Disorder represents a new or changed diagnosis.

OPINION: It is less likely than not that the Veteran's current diagnosis of Other Specified Trauma- and Stressor- Related Disorder is a new or changed diagnosis from the previous diagnosis of Anxiety Disorder Not Otherwise Specified.

RATIONALE: This Veteran was diagnosed with Anxiety Disorder Not Otherwise Specified (NOS) in two previous disability examinations. In both of these previous examinations, the Veteran exhibited a significant subset of Posttraumatic Stress Disorder (PTSD) symptoms but did not meet full DSM-IV criteria. In addition, combat related stressors had been conceded and described by the Veteran. In DSM-IV, PTSD was classified as an Anxiety Disorder and Anxiety Disorder NOS was defined as follows. "This category includes disorders… that do not meet criteria for a specific Anxiety Disorder…to include…. situations in which the disturbance is severe enough to warrant a diagnosis of an Anxiety Disorder but the individual fails to report enough symptoms for the full criteria for any specific Anxiety Disorder to have

been met…" As the Veteran exhibited a significant subset of PTSD symptoms but did not meet full DSM-IV criteria, a diagnosis of Anxiety Disorder NOS was appropriately and correctly rendered during the two previous examinations.

In May, 2013 DSM-5 was published and replaced DSM-IV and VA has adopted DSM-5 as the current standard for mental disorder diagnoses for disability purposes. In DSM-5, PTSD is no longer classified as an Anxiety Disorder and is found under Trauma- and Stressor-Related Disorders. Therefore, an individual who does not meet full criteria for PTSD can no longer be diagnosed with Anxiety Disorder NOS using DSM-5 as PTSD is no longer classified as an Anxiety Disorder. DSM-5 does include a diagnosis of Other Specified Trauma- and Stressor-Related Disorder which is defined as "presentations in which symptoms characteristic of a trauma- and stressor-related disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the trauma- and stressor-related disorders diagnostic class." In this specific case, the individual Veteran's mental health condition has remained relatively stable, with the Veteran continuing to exhibit a significant subset of PTSD symptoms but not meeting full DSM-5 criteria. Therefore, the Veteran's mental disorder is appropriately diagnosed as a trauma- and stressor related disorder using DSM-5 criteria.

For these reasons, it is the opinion of the current reviewer that the Veteran's diagnosis of Other Specified Trauma- and Stressor- Related Disorder does not represent a new or changed diagnosis but rather the same diagnosis as previously rendered using the current nomenclature of DSM-5.

Congenital or Developmental Defects

This topic will cover congenital or developmental defects and congenital, developmental, hereditary, or familial diseases. The categories of "congenital or developmental defects" and "congenital, developmental, hereditary, or familial diseases" may on the surface seem similar, but VA makes a clear distinction between them for purposes of disability compensation. You may be asked to clarify whether a condition is a congenital defect or disease.

Congenital or Developmental Defects

Under VA regulations, congenital or developmental defects, which include such conditions as absent, displaced or supernumerary parts, refractive error of the eye, personality disorders, and mental deficiency are not considered to be diseases or injuries that can be service-connected. A few other examples of conditions that fall into this category are spondylolysis, incomplete sacralization, congenital hernia of the diaphragm, and congenital diastasis of the rectus abdominus.

The Code of Federal Regulations provides guidance in 38 CFR 4.9.

38 CFR 4.9 Congenital or developmental defects

Mere congenital or developmental defects, absent, displaced or supernumerary parts, refractive error of the eye, personality disorder and mental deficiency are not diseases or injuries in the meaning of applicable legislation for disability compensation purposes.

Although congenital and developmental defects may not be service connected, acquired conditions superimposed upon them may be subject to service connection. An example is spondylolisthesis (acquired condition) that develops in service after trauma and is superimposed on spondylolysis (congenital defect). The spondylolisthesis, but not the spondylolysis, may be service connected. As an examiner, you may be asked for an opinion about how much of a disability is due to a congenital defect and how much is due to a superimposed condition. This may or may not be easy to determine. As with

any opinion, you would need to provide a clear rationale for your opinion, including in situations where you feel unable to make such a determination.

Congenital, Developmental, Hereditary, or Familial Diseases

Multiple opinions from VA's Office of the General Counsel have addressed the category of congenital, developmental, hereditary, or familial diseases. (Op.G.C. 1-85 (3-5-85), Op.G.C. 8-88 (11-7-88), and VAOPGCPREC 1-90 (3-16-90)) In essence, they state that these are diseases that are capable of improvement or deterioration. This is in contrast to congenital defects, which are structural or inherent abnormalities that are incapable of improvement or deterioration. In other words, they are generally static. Examples of congenital, developmental, hereditary, or familial diseases are retinitis pigmentosa, polycystic kidney disease, sickle cell disease, and Huntington's chorea. These diseases may be service connected if they first become manifest in service.

VBA's adjudication manual (M21-1MR) states that even if the individual is almost certain to eventually develop a disease, a genetic or other familial predisposition does not constitute having the disease and that only when actual symptomatology or signs of pathology are manifest may he or she be said to have developed the disease.

The conclusions of the General Counsel opinions, which are binding on all VA employees (see 38 CFR 14.507(b)), are that diseases of congenital, developmental or familial (hereditary) origin are subject to:

- direct service connection,
- aggravation during service, if they progress at an abnormally high rate during service, and
- service connection by presumption, if they develop during the applicable presumptive period following discharge from service.

In summary, some of the determinations you may be asked to provide regarding claimed conditions include these:

1. If a condition is a congenital defect or a congenital, developmental, hereditary, or familial disease
2. If there is an acquired condition superimposed upon a congenital defect
3. If a congenital, developmental, hereditary, or familial disease was first manifest in service or aggravated in service

For example, bicuspid aortic valve is a congenital structural defect, not a disease. Once a condition such as aortic stenosis (AS) is superimposed on the bicuspid aortic valve and is associated with symptoms, the Veteran would then be considered to have a disease, namely AS. You may be asked to answer any of the three questions above regarding the relationship between the congenital defect (bicuspid aortic valve) and the disease (AS).

38 CFR 14.507(b)

A written legal opinion of the General Counsel involving veterans' benefits under laws administered by the Department of Veterans Affairs which, in the judgment of the General Counsel or the Deputy General Counsel acting as or for the General Counsel, necessitates regulatory change, interprets a statute or regulation as a matter of first impression, clarifies or modifies a prior opinion, or is otherwise of significance beyond the matter at issue, may be designated a "precedent opinion" for purposes of such benefits. Written legal opinions designated as precedent opinions under this section shall be considered by Department of Veterans Affairs to be subject to the provisions of http://www.gpo.gov/fdsys/pkg/USCODE-2012-title5/html/USCODE-2012-title5-partI-chap5-subchapII-sec552.htm. An opinion designated as a precedent opinion is binding on Department officials and employees in subsequent matters involving a legal issue decided in the precedent opinion, unless there has been a material change in a controlling statute or regulation or the opinion has been overruled or modified by a subsequent precedent opinion or judicial decision.

Lesson Summary

C&P examinations and medical opinions are guided by laws, regulations, and VA policies. This lesson covered several concepts, regulations, and policies that affect the medical opinions that you write.

Now that you've finished this lesson, you should be able to identify special protocols or legal circumstances that may impact a medical opinion.

This is the last lesson. If you've completed all lessons in this course, select Next to view the course summary and to access the final assessment.

Course Summary

Course Summary

Congratulations! You've completed all lessons of this DMA Medical Opinions course. Here is a summary of each lesson in the course. You may use the course menu to navigate to lessons for additional review or select Next to access the Final Assessment.

The First Lesson

This lesson, Medical Opinion and Rationale Overview, introduced the examiner's process for writing a medical opinion. This lesson defined the C&P medical opinion and described elements needed for a sufficient medical opinion. Different types of opinions were discussed in terms of purpose and context:

1. Direct service connection
2. Secondary service connection
3. Aggravation (Allen)
4. Aggravation of a preexisting condition
5. Reconcile conflicting diagnoses or opinions

Opinions prompted by the evidence of record and additional contexts that require medical opinions were also covered.

The Second Lesson

The second lesson, Process and Components of a Medical Opinion Sufficient for Rating Purposes, provides guidance, tips, and examples for writing a medical opinion using the recommended language, and for substantiating the opinion with a comprehensive rationale. The process of writing a medical opinion includes determining the scope of the opinion requested of you, and weighing all evidence. Since you may encounter situations such as conflicting evidence or lack of evidence, this lesson includes these topics. Opinions required by the evidence of record were discussed in detail, and so was the unsolicited opinion.

The Third Lesson

The third lesson, Special Circumstances, covered how special protocols may affect your usual process for developing and writing a medical opinion. This lesson covered several concepts, regulations, and policies that affect medical opinions, including:

1. Remand medical opinions
2. Section 1151 claims
3. Willful misconduct
4. Presumption of soundness
5. Presumptive conditions
6. A change in medical standards
7. Gulf War protocols
8. Camp Lejeune
9. Combat-related considerations
10. Active and inactive duty for training
11. Congenital defects and congenital, hereditary, and familial diseases

Glossary

A

ACDUTRA

This abbreviation refers to active duty for training.

AMC

The Appeals Management Center (AMC) is a centralized office within the Veterans Benefits Administration (VBA) to which most remands are sent by the Board of Veterans' Appeals (BVA) instead of being sent back to the local VA regional office for additional development, to include C&P examinations, or promulgation of certain issues prior to appellate decision. The AMC performs all of the same functions as a regional office. The purpose of having this specialized central office in VBA to handle remands is to allow for quicker handling of remands, which is something that is required by law.

Adjudicate

To adjudicate means to decide judicially. For the Veterans Benefits Administration (VBA), adjudication is the process of weighing all evidence for a claim and determining the outcome.

Aggravation

Based on 38 CFR 3.306 and U.S.C. 1153, aggravation is defined as permanent worsening of a) a pre-service condition during service or b) a nonservice-connected condition at any time by a service-connected condition. In either situation, the permanent worsening of the condition is not due to the natural progression of the condition.

B

BVA

The Board of Veterans' Appeals (BVA) is charged with making final decisions on behalf of the VA Secretary on appeals of benefit claims determinations made by local VA offices. The Veterans Law Judges who issue these decisions are attorneys experienced in veterans law and in reviewing benefit claims. Staff attorneys, also trained in veterans law, review the facts of each appeal, and prepare a draft decision for signature by a Veterans Law Judge.

C

C&P

Compensation and Pension Compensation is a monthly tax-free monetary benefit paid to Veterans disabled by injury or illness incurred in or aggravated during active military service. Disability compensation amounts vary with the degree of disability and the number of the Veteran's dependents. Pension benefits are tax-free monetary payments, specified by law, provided to wartime Veterans with limited or no income who are either aged 65 or older or who are permanently and totally disabled due to a nonservice-connected cause. Seriously disabled or

housebound Veterans receiving Pension may also qualify for an additional Aid and Attendance or Housebound benefit.

Compensation and pension (C&P) also refers to the VHA entity that performs disability evaluations, examinations, or opinions for Veterans and Servicemembers as part of the adjudication of a claim for VA disability benefits, if an evaluation, examination, or opinion is necessary to decide the claim. A disability evaluation is an assessment of the medical evidence, which may involve conducting an examination, providing an opinion, or both. A disability examination is a medical professional's personal observation and evaluation of a claimant. It can be conducted in person or by means of telehealth technologies. An opinion refers to a medical professional's statement of findings and views, which may be based on review of the claimant's medical records or personal examination of the claimant, or both.

C-file

The C-file is the claims file, property of VBA, the legal records for a Veteran's claim(s). The C-file can be paper, electronic, or both.

CAVC

U.S. Court of Appeals for Veterans' Claims

CFR

Code of Federal Regulations

D

DBQ

A Disability Benefits Questionnaire (DBQ) is a documentation protocol used to record C&P examination findings and pertinent history. DBQs are documentation tools tailored to the VA Schedule for Rating Disabilities (Rating Schedule). A DBQ is more forensic than clinical as a medical report. DBQs enable VA to access resources of the private medical community and streamline the disability examination process.

DIC

Dependency and Indemnity Compensation (DIC) may be granted to eligible survivors of Veterans whose death resulted from a service-related injury or disease.

DMA

The Office of Disability and Medical Assessment (DMA) is a VA national office that facilitates the disability examination process to support field compensation and pension (C&P) clinics and the Integrated Disability Evaluation System (IDES). DMA also provides advisory medical opinions for Veterans Benefits Administration and expert medical opinions for the Board of Veterans' Appeals in coordination with subject matter experts throughout the enterprise.

DRO

Decision Review Officer

Documentation Protocol

A documentation protocol is a form used to gather data during a C&P examination for reporting purposes. A documentation protocol can be a DBQ or an examination worksheet. Electronic documentation protocols are becoming more prevalent. Most documentation protocols can also be accessed and used as a paper document.

E

Evidence of Record

Evidence of record is documented evidence already in the Veteran's or Servicemember's C-file or in other electronic VA databases.

F

Form 21-4138

VA Form 21-4138 is a Department of Veterans Affairs form that a claimant or spouse or friend can use for lay statements. The form is filled out, signed and returned to VBA for inclusion in the claims file.

Form 21-526

VA form 21-526, Veteran's Application for Compensation and/or Pension, is filled out by the claimant in order to start a C&P claim with VBA.

Form DD-214

The DD-214 is the Armed Forces of the United States Report of Transfer or Discharge. The same form is used for all branches of service.

Form SF-88

Standard Form (SF) 88, Report of Medical Examination, is used to document examination findings for service entrance and service exit examinations.

I

IDES

Integrated Disability Examination System

INACDUTRA

This abbreviation refers to inactive-duty training.

M

Medical Statement

A medical statement is a medical conclusion that does not need to be written on a Medical Opinion documentation protocol. The medical statement always includes a comprehensive explanation just like a formal medical opinion, but it is not necessary to use VBA-recommended language.

N

NSC

Nonservice-connected

P

Preexisting

Preexisting refers to a condition that preexisted service. Either the condition was noted on an entrance examination by the examiner, or there is clear and undebatable proof that a condition preexisted service.

Probative Value

Adjudicators will look for the probative value of a rationale. In other words, a rationale that tends to prove or actually proves; the quality of proof (qualitative versus quantitative value)

Proximately due to

As used in the Code of Federal Regulations, proximately due to means a condition is caused by or etiologically related to another for purposes of service connection.

R

RO

Regional Office

RVSR

Rating Veterans Service Representatives (RVSRs) serve as decision makers for claims involving rating decisions. Rating Veterans Service Representatives are responsible for analyzing claims, applying VA's Schedule for Rating Disabilities (Rating Schedule) and preparing rating decisions. These employees inform the Veterans Service Representatives (VSR) and/or claimant of the decision and the basis and reasons for the decision.

Remand

If the Board of Veterans' Appeals has made a determination that it needs additional evidence in order to fully or fairly adjudicate an appeal, the Board will issue a remand. A remanded appeal is an appeal that has been returned by BVA to VBA for the development of additional evidence, due process, or reconsideration of issues. The Request for Examination for a remanded examination will contain instructions from BVA for the examiner that must be followed, even if needed data goes beyond what is asked on a documentation protocol.

S

SC

Service connected

STRs

VBA defines Service Treatment Records (STRs) as the military health records for each Veteran. The STRs typically include some or all of the following information:

- Physical examinations and records, including entrance and separation physical examinations
- The Veteran's medical history
- All dental examinations and records
- Clinical record cover sheets and summaries
- Entries from outpatient medical and dental treatments
- Physical profiles
- Medical board proceedings
- Prescriptions for eyeglasses and orthopedic footwear

Service Connection

From 38 CFR 303(a) Service connection connotes many factors but basically it means that the facts, shown by evidence, establish that a particular injury or disease resulting in disability was incurred coincident with service in the Armed Forces, or if preexisting such service, was aggravated therein.

U

U.S.C.

United States Code

V

VA

United States Department of Veterans Affairs

VBA

The Veterans Benefits Administration (VBA) is responsible for providing a wide variety of benefits and services to Veterans and Servicemembers through Regional Offices. Major benefits provided

by VBA and authorized by Congress include service connected disability compensation, nonservice-connected disability pension, burial assistance, survivors' benefits, rehabilitation and employment assistance, education and training assistance, home loan guarantees, and life insurance coverage.

VHA

The Veterans Health Administration (VHA) governs the medical treatment facilities within the Department of Veterans Affairs. With nationwide medical centers (VAMCs), VHA provides health care for Veterans. VHA manages one of the largest health care systems in the United States. VAMCs within a Veterans Integrated Service Network (VISN) work together to provide efficient, accessible health care to Veterans in their areas.

VSR

Veterans Service Representatives (VSR) counsel claimants on eligibility for Veteran's benefits, process claim and non-claim actions, and control and process incoming and "at once" mail. Veterans Service Representatives prepare administrative decisions and process rating and non-rating decisions.

W

Weigh

The Merriam Webster dictionary defines weigh as to think carefully about (something) in order to form an opinion or make a decision, or to consider carefully especially by balancing opposing factors or aspects in order to reach a choice or conclusion: evaluate (m-w.com, 2014).

Asbestos Opinion Discussion

VBA: Have you both had time to review the 2507 request?

BVA: Yes, I have.

VHA: I have as well. I'd like to make a few comments on this.

[AD: The focus changes to three persons sitting around a table, each with an open file showing the sample Examination Request. The attorney from BVA wears a suit. The examiner from VHA is wearing a white jacket, and the administrator from VBA wears a gray dress. All are wearing their VA identification cards on lanyards.]

VHA: I find it very helpful that VBA provides this type of information in the statement on the 2507. It says, "Please note that the Veteran's service personnel records show that he served as a ship's cook aboard naval vessels, which suggests that the Veteran's exposure to asbestos during his military service was minimal, according to the Asbestos MOS Handout."

[ONSCREEN TEXT: Please note that the Veteran's service personnel records show that he served as a ship's cook aboard naval vessels, which suggests that the Veteran's exposure to asbestos during his military service was minimal, according to the Asbestos MOS Handout.]

VHA: Providing this type of information on the 2507 is quite important for the examiner because he can incorporate this detailed information into his opinion and rationale. And since it's a legal determination, not a medical one, medical examiners would not necessarily know the significance of the MOS, as well as what level of exposure that MOS is associated with. If, for example, VBA stated that with the Veteran's MOS he had a high or moderate exposure probability to asbestos, that could change the rationale and the opinion quite dramatically depending on the circumstances.

[AD: BVA attorney nods as VHA examiner speaks.]

VHA: One cannot assume because of the MOS being a cook, that he'd have a low exposure to asbestos.

[AD: VHA examiner looks at VBA administrator. She nods.]

VBA: Right, thanks for that feedback. How about we move on and discuss the opinion and rationale now?

BVA: It seems to me there is so much emphasis on "Don't provide any opinions other than what's requested," yet legally, sometimes more is required. The opinion here asks for a current respiratory condition and what we have is COPD. VA's duty to assist involves a further obligation to really think about what the Veteran's claiming. The Veteran doesn't file a claim to receive benefits for a particular diagnosis, but rather for an affliction which is causing them harm. This opinion right here shows the examiner thoroughly reviewed the record and considered the Veteran's broad intention of filing a claim, not just limiting it to the medical evidence of asbestos exposure.

VBA: Right. And that's why this opinion was so good: because the examiner addressed the Veteran's lay evidence, or his own personal beliefs, about his coughing and his symptoms.

VHA: Could you explain more what you mean by "lay evidence"?

BVA: He even cited diagnostic evidence, such as X-rays, which is helpful to an adjudicator.

VBA: Right, and that's what makes this opinion so good, because the examiner discussed it from all possible angles.

VHA: I concur.

VBA: Another thing I liked about the opinion was the examiner's use of the phrase, "less likely than not," because it follows the legally accepted phrasing. "Less likely" to me means the majority of the evidence was actually against this being established, and it was a firm medical opinion using the proper phrasing.

VHA: I agree. We should always use the legally acceptable phrases. For example, if the preponderance of evidence supports the claim, then the legally accepted phrase of "it is at least as likely as not" should be used; and if the preponderance of evidence does not support the claim, then "it is less likely than not" should be used.

BVA: One of the cases the Board looks to in determining the probative value of the medical opinion is the Nieves-Rodriguez case. In that case, one of the factors is whether the expert provided a fully articulated opinion. In this case, the opinion is not equivocal, it's not speculative, it provides a degree of certainty. It is very easy for an adjudicator to make a determination. I notice the length of this opinion stretches several paragraphs. As a clinician, does this length concern you?

[AD: BVA attorney looks at the VHA examiner.]

VHA: Not really, when I have a new examiner in training, I stress that we cannot skimp on the thoroughness of our explanation. It's very important to take the evidence into account and explain it in great detail, if necessary. A thorough, concise, robust rationale touching on all the pertinent facets of the opinion is what's needed. This is the ideal in what we're striving for.

VBA: Yes, this is exactly what we're looking for, too: concise, detailed rationales. As long as the examiner addresses all the issues, that's what's important to VBA.

BVA: And of course, I like the references to the medical literature, too. This goes to the rationale for the opinion and lets the adjudicator know the probative weight we can assign to the opinion. If the examiner were to just give an opinion without any reference to any medical literature, it wouldn't just be as strong as an opinion with a reference to medical literature. This way we can see what the examiner is basing their opinion on and know it's just not their unfounded opinion.

BVA: No offense to examiners, but sometimes doctors just say, "... because I'm a doctor," and this isn't good enough from a legal perspective.

[AD: BVA attorney looks at the VHA examiner.]

VHA: Right. We understand that's no longer acceptable. Every opinion must be accompanied by a robust rationale.

[AD: VHA examiner looks at BVA attorney.]

VHA: I have a question regarding citing medical literature. If I was doing this examination, I would direct my research to see if there's an association between asbestos exposure and COPD. I wouldn't expect to find much in that field, but that's how my research would be directed. Would it be acceptable or useful if I included a statement after not finding any association, such as, "After researching peer-reviewed medical literature, no association between asbestos exposure and COPD could be found?"

[ONSCREEN TEXT: "After researching peer-reviewed medical literature, no association between asbestos exposure and COPD could be found."]

VHA: Does this carry enough weight to be included in the examination as part of the rationale?

BVA: I do think it carries some probative value. We like to see that, as an adjudicator to know that it's not just your opinion solely. But that the whole medical community at large has found no connection. What's nice in this opinion is that it looks at the differences between obstructive lung disease and restrictive lung disease.

VHA: Excellent, thank you.

VBA: And that's very helpful to an adjudicator because we just don't have that type of knowledge. But it makes it very, very clear why the examiner is making the right connection in this particular case. Well, I guess, let's go on to the next case, which is for a complicated spine injury.

VHA: Okay.

[AD: All three participants open their folders to find a new document to discuss. Scene fades.]