Reader's note: This has been rescinded in favor of DMA Fact Sheet 26-001, effective January 26-2026.

Veterans Health Administration (VHA)
Office of Disability and Medical Assessment (DMA)

Compensation and Pension (C&P)
Disability Examinations
Clinician's Guide

****February 15, 2021****

DMA is responsible for the technical contents of this Clinician's Guide

Questions may be referred to the DMA Corporate Mailbox
(CorporateMailbox.DMA@va.gov)

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*Note: *Information presented in this section assumes the clinician is knowledgeable with regards to obtaining an appropriate history and performing a competent physical examination and is capable of identifying and utilizing current evidence-based medicine resources.*

Abbreviations

ACE	Acceptable Clinical Evidence
BVA	Board of Veterans Appeals
CAVC	Court of Appeals for Veterans' Claims
CARC	Chemical Agent Resistant Compound
CBT	Care and Benefits Team
CG	Clinician's Guide
C&P	Compensation and Pension
DBQ	Disability Benefits Questionnaire
DLCO	Diffusion capacity of the lung for carbon monoxide by the single breath method
DM II	Diabetes Mellitus II
DMA	Office of Disability and Medical Assessment
DMZ	Demilitarized Zone
DoD	Department of Defense
DU	Depleted Uranium
FEV	Forced Expiratory Volume
FPG	Fasting Plasma Glucose
FPOW	Former Prisoner of War
FSAD	Female Sexual Arousal Disorder
FVC	Forced Vital Capacity
IBS	Irritable Bowel Syndrome
IMD	Initial Mental Disorders
LADA	Latent Autoimmune Diabetes in Adults
MEO	Military Equal Opportunity
MTF	Military Treatment Facility
MST	Military Sexual Trauma
NRI	Nasopharyngeal Radium Irradiation Therapy
NYHA	New York Heart Association
PD	Parkinson's Disease
PFT	Pulmonary Function Test
PTSD	Post Traumatic Stress Disorder
ROM	Range of Motion
SAPRO	Sexual Assault Prevention and Response Office
SC	Service Connected
TBI	Traumatic Brain Injury
TMS	Talent Management System
VA	Department of Veterans Affairs
VASRD	VA's Schedule for Rating Disabilities
VBA	Veterans Benefits Administration
VHA	Veterans Health Administration

CHAPTER 1 GENERAL INFORMATION

1.1 Purpose of the Clinicians' Guide

The Clinicians' Guide (CG) is designed to provide clinicians performing compensation and pension (C&P) examinations supplemental information which aids in the C&P evaluation process and bridges the gap between VHA's Talent Management System (TMS) C&P training resources and DBQs currently in production. C&P evaluations differ markedly from traditional "for care" medical examinations. A traditional medical examination requires documentation for treatment purposes, a C&P disability evaluation requires documentation to substantiate if a claimed disability exists and the functional effects of such disability on the veteran. The purpose of a C&P exam is to provide very specific information to ensure a proper evaluation of the claimed disability. A disability evaluation is an accurate and descriptive medical documentation of the limitation of activity imposed by the disabling condition to respond to the examination request. It is essential, in the evaluation of disability, that each disability be viewed in relation to its history. This difference reflects that the examination is not being completed to monitoring patients' health over time, treat patients, or fulfill many other duties traditionally held by clinicians. Consequently, a limited patient physician relationship should be considered to exist. A treatment examination is written for clinicians to understand, but a compensation and pension evaluation is written for use in the adjudication of veterans' claims, and is used by RVSRs, lawyers, and judges. C&P clinicians provide responses to rating specific questions presented in Disability Benefits Questionnaires (DBQ) based on a combined review of available medical evidence, history, and physical examination. These questionnaires were designed to follow VA's Schedule for Rating Disabilities (VASRD) in 38 CFR part 4. Clinicians should be aware that DBQs are formatted in accordance with VA appropriate legal language and organized differently than the standard clinical "S.O.A.P." notes. DBQs are designed to be rating specific, they provide direction to the examiner based on request for information needed for a rating purpose. Clinicians are expected to use good clinical judgment in deciding which medical tests, imaging, and exams are most appropriate to answer the specific questions asked, and they should utilize current appropriate textbooks of medicine as guidelines when providing diagnoses.

C&P evaluations are performed to document impairment, and disease processes that are incurred in, caused by or aggravated by military service or service exposures. Care should be taken to not document findings if they are not due to the above.

VHA will inform the examinee of a noted or suspicious condition or abnormal test results discovered during an examination requiring further study or treatment.
If the noted or suspicious condition is one that may require immediate medical care:

a) Direct the Veteran to the enrollment department to provide an opportunity to apply for VA health care and assistance in completing an appropriate application.

b) If emergent care is required, the Veteran should be escorted to the VA healthcare facility "walk-in clinic" or Emergency Department as indicated. The examination appointment should be rescheduled as soon as possible after the emergency is resolved, if the exam is not able to be completed.
c) Document in CPRS and on the examination report the Veteran was notified and what counsel was provided.

1.2 Acknowledgments

The Clinicians' Guide was originally written and edited by the following people, and in part excerpted from the former Physician's Guide: Marjorie Auer, Esq. (BVA), Troy Baxley (VHA), Joseph Enderle (VHA), Carol McBrine, M.D. (VBA) and Lewis R. Coulson, M.D. (VHA) in approximately 2000. This update has been provided by Mark Morris, P.A. (VHA-DMA) and Kenton Dodd, M.D. M.P.H. (VHA-DMA) in October 2020 along with contributions from other SMEs and DMA staff.

1.3 Compensation and Pension Policy and Procedures

DBQ policies, procedures, and references (ICD-10CM; disability examination CPT Codes) can be accessed from the DMA Policy and Procedures Resources page.

1.4 Examination Requests

Exam requests are communicated by VBA to VHA C&P facilities via VA Examination Request form VA 21- "2507" utilizing the CAPRI data processing system to transmit. It is important to read the entire exam request carefully. While there have been attempts to standardize these requests, there remains a degree of variability.

All General Medical examinations are intended to be comprehensive, head to toe evaluations. As such, any remarkable findings or new concerns raised by the claimant should be regarded as a newly claimed condition and evaluated when reasonable. If not reasonable, the findings should be documented, and an explanation provided as to why additional evaluation or a diagnosis was not provided.

When there is no General Medical examination involved, such as in the case of an "increase" exam, evaluate only the condition claimed in the 2507 exam request unless that specific DBQ directs the examiner to include others, such as frequently occurs with the Diabetes evaluation. For more information on C&P disability examination requests, see VBA Procedure Manual M211, Part III, Subpart iv, Chapter 3, Section A (http://www.knowva.ebenefits.va.gov).

1.5 Testing

Except for audiograms, there is no defined expiration date for clinical tests. Prior test results may be used if they remain an accurate portrayal of the claimant's current

medical condition and clinical status. However, if prior tests are utilized for this reason a statement to this effect must be made in the report. Review of the available medical records is important to avoid unnecessary testing. It remains the responsibility of the medical provider to determine the medical appropriateness of any testing and discussing any clinical risk with the patient prior to determining to proceed with any testing.

1.6 Disability Benefits Questionnaires (DBQs)

Disability Benefit Questionnaires (DBQ) can be found on-line at: http://go.va.gov/DBQ. DBQs are disease and condition specific and were developed as a documentation tool to provide the precise medical evidence needed by the Veterans Benefits Administration (VBA for the purpose of adjudicating disability claims. DBQs can also be used by VHA C&P clinicians, and primary care/specialty care providers, as a standardized format for communication of medical evidence for a Veteran's claim for VA disability benefits. C&P exam results are reported to VBA via Disability Benefits Questionnaires (DBQs), with a couple of exceptions where either legacy or standard form templates should be used. For the legacy templates, most notable is bones, for which no DBQ was designed. Aid and Attendance is an example of a standard form and is not limited to C&P.

The information within the DBQ has been designed to mirror the rating schedule as much as possible. As a questionnaire to address rating questions specifically, DBQs are not a complete documentation of the medical examination. Important findings or information not specifically noted in a DBQ can be included in one or more of the remarks sections found on all DBQs. The expectation remains that a thorough and complete examination will be provided to the claimant, even though all findings may not be requested in the DBQ but can be noted in the report remarks section if applicable.

1.7 General C&P evaluation Principles:

a. The examiner should review the complaints and Veterans statements with regards to their beliefs about their injuries.

1. Remarks about the veteran's beliefs regarding their illness/injury should be documented in the history unless specific areas of the DBQ request information in the veteran's own words.
2. Other areas are reserved for clinician objective statements, do not put speculative information in those areas.

b. The evaluation should rely on currently known medical practices and physical evaluation principles, and knowledge of medical causation with respect to determination of conditions that are medically (causally) linked to the condition(s) in service or determination that such condition(s) exist.

1. The disability documented should be consistent with the disease or injury documented.
2. If the disability found and documented is not consistent with the claimed in service injury/illness, alternate cause(s) for the disability should be investigated utilizing thorough history, and review of medical records. Generally requesting additional ancillary testing that is not immediately available for this purpose is not appropriate.

c. The examination should attempt to note the difference between disabilities which clearly resulted from in-service injuries or illness as opposed to from those that are more likely than not associated with in-service injury, illness, treatment or event whenever possible.

d. Generally, the impairment from injuries are usually worse proximal to the acute injury. Thereafter, the body generally adapts, and the individual recovers some function over time, until the body reaches a point at which no further medical improvement is reasonably expected (Maximal Medical Improvement).

e. Diseases do progress and worsen if not countered by effective treatment. Osteo Arthritis is a commonly found disease that is noted to after the acute injury and present with worsening debility in C&P exams.

f. Each provided diagnosis should adhere to a medically recognized standard for the condition.

g. Regulations cannot determine that medical testing is appropriate for a condition, but they can indicate that testing should be requested by VHA. It remains the responsibility of the medical provider to determine the appropriateness of testing for a condition and safety if any clinical risk is involved. There are, however, some tests required by the rating schedule.

- Pulmonary issues: PFT Pre- and Post
- Heart issues: METS testing/or estimate
- Checking for Cardiac Hypertrophy/ Cardiomegaly with progression: Chest X-ray, ECG, ECHO.
- Peripheral Vascular disease: ABI
- Initial diagnosis of arthritis requires evidence of arthritic changes on X-ray imaging, joint abnormality or spurring. This is only required for the initial diagnosis and not in subsequent exams.

IF THESE TESTS ARE NOT PERFORMED DOCUMENTATION OF CLINICAL REASONING FOR THEIR ABSENCE IS REQURIED. For example:

- ABI not performed due to Severe Vascular disease resulting in bilateral amputation of Lower Extremities.

- Veteran with Severe Asthma: Withholding treatment to obtain pre-bronchodilator testing not indicated.

Testing that seems to be requested on the 2507 does not absolve the provider of the responsibility of medical review for appropriateness

h. It is not appropriate to provide documentation for review that does not follow common medical knowledge that is available in medical textbooks. Every attempt must be made to apply as much known medicine as possible in rendering an appropriate diagnosis and determine what pattern the disability described fits.

1.8 Specific C&P Examinations

a. Aid and Attendance

These evaluations provide documentation of medical necessity for assistance with activities of daily living, such as bathing, toileting, dressing, eating, and locomotion. Aid and Attendance examinations are to be completed on the legacy Aid and Attendance VA Form 21-2680 CAPRI template. The Aid and Attendance examinations do not require additional condition-specific DBQs. Aid and Attendance evaluations for Veterans who are homebound or are in a nursing home will be completed by the local facility Home Care division. Additional examination training is available through TMS: VA 7758 DMA Aid and Attendance and Housebound Examination.

b. Board of Veterans' Appeals (BVA)

Directly responsible to the Secretary of Veterans Affairs, the Board adjudicates de novo the decision made by a Veterans Service Center on a claim. If a claimant still disagrees with a BVA decision, he or she may appeal to the United States Court of Appeals for Veterans' Claims (CAVC). Appeals are returned (remanded) by the BVA to the Veterans Service Center or by CAVC to BVA for additional evidence or action, including new evaluations or medical opinions. Examiners must comply with any BVA remand instructions before evaluating the veteran and clearly state this fact in the written summary report. The examiner should answer all questions, if possible. CAVC has exclusive jurisdiction to review decisions of the BVA. Because of CAVC decisions, examiners are asked to respond to questions or provide information that may appear to have limited clinical application but are important from a legal standpoint. The Court's precedent decisions are binding upon the entire Department of Veterans Affairs.

c. Housebound

An additional amount of money payable monthly to a Veteran receiving compensation or pension. The housebound payment may be paid if the claimant, due to disability, is factually housebound, that is, substantially confined to his or her dwelling and the immediate premises or, if institutionalized, to the ward or clinical areas, and it is reasonably certain that the disability and confinement will continue throughout his or her lifetime. Alternatively, the housebound allowance may be paid if there is a permanent disability rated at 100 percent and there is additional disability ratable at 60 percent or

more, separate and distinct from the disability rated at 100 percent and involving different anatomical segments or bodily systems.

Additional examination training is provided through TMS: VA 7758 DMA Aid and Attendance and Housebound Examination

d. Musculoskeletal Examinations

A musculoskeletal examination requires specific detailed assessment of pathophysiology, and functioning of all areas to be examined. Include anatomical damage to muscles, joints and any atrophy or skin changes. Since disabilities of the musculoskeletal system affect the ability of the body to perform normal working movements such as excursion, strength, speed, coordination and endurance, VA regulations, as interpreted by the Courts, require every musculoskeletal examination to include the degrees of functional loss due to pain, weakened movement, excess fatigability, or incoordination (from 38 CFR 4.40, part of the basis of the Court's DeLuca v. Brown precedent opinion). The Court in Mitchell v. Shinseki has added the additional parameters of looking at that functional loss occurring after repetitive use of the joint or during a flare-up whenever possible. It is important to no longer look at the DeLuca and Mitchell decision issues separately, as they are intertwined and have common requirements for information. Both DeLuca and Mitchell look at effects on function because of pain, flare ups, and repetitive use. The Mitchell decision essentially clarifies and supplements the concepts presented in the DeLuca decision. This precedential case was followed by the Court's decision in Correia v. McDonald which asks the examiner to address the opposing joint in contrast to the affected joint, for evidence of pain with non-weight bearing and passive range of motion.

e. Non-Service Connected Pension

A Pension exam is an evaluation that is to document disease or injury that was not incurred during or permanently aggravated by an injury or illness during active duty military service.

f. Review or Increase Examination

For a review examination of an already service connected disability, only an interval history covering the period since the last examination is required.

g. Individual Unemployability

Entitlement to individual unemployability is established when a Veteran is unable to secure and maintain substantially gainful employment due to service connected disabilities. VA is not required to provide a general medical examination in connection with every individual unemployability claim. VBA will request condition-specific DBQs for the issues alleged to cause unemployability. A general medical examination will only be requested if VBA determines it is needed to fairly and fully adjudicate the claim for individual unemployability, such as for original claims for disability compensation or individual unemployability claims involving the impact of multiple service-connected and/or nonservice-connected disabilities upon employability. Examiner should comment

on the functional impairment caused solely by the service-connected disabilities. The examiner is asked to describe the functional impairment and limitations resulting from the claimed condition(s) and should not opine on if the veteran is unemployable due to his or her service-connected disabilities.

For more information on individual unemployability, see VBA Procedure Manual M21-1 Part IV, Subpart ii, Chapter 2, section F (http://www.knowva.ebenefits.va.gov)

h. Pre-discharge and IDES

A pre-discharge claim is a claim filed prior to separation or retirement from active duty or fulltime National Guard or Reserve duty. VA will advise the Servicemember and the Servicemember's local Military Treatment Facility (MTF) point of contact of any clinically significant abnormal findings or laboratory results, and note this action was taken in the examination report. Local agreements ensure the MTFs identify a POC prepared to receive call from VA examiners or dedicated VA staff indemnifying such findings or results. For policy, procedures, and questions regarding these types of examinations, visit the PreDischarge Programs page on the DMA website: http://vaww.demo.va.gov. Additional information is also available on VBA's websites on Pre-Discharge and IDES Programs: http://vbaw.vba.va.gov/vbadod/predischarge.asp

i. 38 U.S.C 1151 Examination Requests

Under 38 U.S.C. 1151, VA disability compensation benefits shall be awarded for a qualifying additional disability or a qualifying death of a Veteran disabled by VA treatment or vocational rehabilitation in the same manner as if such additional disability or death were service-connected. Claims for benefits under 38 CFR U.S.C. 1151 fall under the VBA Medical Disability Examination contract purview for completion. These should no longer be sent to VHA examiners unless under special circumstances. If a facility receives a request for a claim involving benefits under 38 U.S.C 1151, refer to the DMA Policy and Procedure Manual for further guidance. .

1.9 Telehealth

Telehealth is the use of telecommunications and information technologies to provide health care and examination services at a distance, to include diagnosis and treatment. Telehealth employs videoconferencing, informatics, or wireless devices for examination. Telehealth disability examinations have the capability to provide accurate and fully descriptive examinations for VBA rating purposes. VHA has continually enhanced and expanded the conduct of telehealth C&P exams to include development of a national Telehealth C&P specialty supplement jointly with the Office of Connected Care. This document provides high-level guidance on the creation and integration of C&P telehealth services and can be found on the VHA Telehealth Services specialty intranet site. VA Video Connect technology for mental health DBQs as well as to supplement ACE process reviews. DMA Fact Sheet 20-002, Telehealth for Compensation and

Pension (C&P) Examinations, March 25, 2020 can be found at: http://vaww.demo.va.gov/factsheets.asp.

1.10 Examination Guidelines

a. How to State an Opinion for Nexus (relationship to a military incident)

When asked to give an opinion as to whether a pathologic condition or disease is related to a specific incident or event during military service, the opinion should be expressed as follows:

- "is due to" (100% sure)
- "more likely than not" (greater than 50%)
- "at least as likely as not" (equal to or greater than 50%)
- "not at least as likely as not" (less than 50%)
- "is not due to" (0%)

A sixth option is "cannot state without resorting to mere speculation" which should be used with caution. When used appropriately, it indicates that there is such a general lack of information available such that no reasonable clinician would be able to provide a response without guessing based on the information available at the time.

b. What if Reported Symptoms Appear Out of Proportion to Signs or Test Results?

If the examiner feels that the claimant's symptoms are not consistent with known pathology, physical signs or test results, they should state that the physical examination or laboratory tests do not support the severity of disability suggested by the history/complaints. In this case, complaints should be recorded in the Veteran's own language within quotation marks, so that it will be clear that they are complaints and not the opinions of the examining physician.

c. What if Malingering or Misrepresentation of Facts is Suspected?

Generally malingering is not a medical determination and cannot be determined by medical testing, though it can be suspected as the reason for symptom exaggeration. If malingering is suspected, the examining clinician should document the objective findings that are clinically unusual or unreasonable, together with an explanation. Any detection of evasion or misrepresentation of facts that can be substantiated by findings should also be documented (i.e. Waddell's signs, Hoover test)

d. Clinical Photographs

Photos are no longer required for rating scars or disfiguring conditions, however, pictures may be submitted as additional evidence and documentation at the clinician's discretion. Non-retouched color photographs of skin lesions should be made and properly labeled.

References: Additional C&P policies and procedures for examination process including the DMA C&P Disability Examination Procedure Guide and DMA Fact Sheets are located on the DMA website http://vaww.demo.va.gov. Additional training courses

available in TMS include: VA 24627 DMA Medical Opinions and VA 24471 DMA Aggravation Opinions.

1.11 VA Schedule of Rating Disabilities (VASRD)

The rating schedule can be found in Code of Federal Registry (CFR) 38, Chapter 4, and is publicly available. There are additional text and online sources: https://www.knowva.ebenefits.va.gov/system/templates/selfservice/va_ssnew/help/customer/loc ale/en-US/portal/554400000001018/topic/554400000004537/Subpart-B-440-4150-Disability-Ratings

The VSARD has not been completely re-written since it was published in 1946. While there have been over 350 amendments, there are many sections which remain behind current medical standards. Notwithstanding, disability ratings are based on this schedule. Questions regarding why or how a certain topic is addressed in a DBQ can frequently be understood by referring to the appropriate section of the VASRD.

a. Types of Service Connection:

Direct service connection - The condition is due to, as a result of, or permanently aggravated by in service illness, injury, treatment or event.

Indirect service connection – A condition secondary to an already service connected condition. For example, a Veteran is service connected for diabetes mellitus type II and develops diabetic peripheral neuropathy. If that diabetic peripheral neuropathy is deemed as secondary to the service-connected diabetes, it can be deemed as indirectly due to or as a result of in-service illness, injury, treatment or event.

Presumptive service connection - In deeming a condition as being presumptive, the SECVA alleviates the Veteran of the burden of proof demonstrating that a condition arose from service. A classic example of this are the presumptive diagnoses associated with Agent Orange exposure. Once established that the Veteran was in the Republic of Vietnam (RVN) and develops one of the identified conditions, he or she will be presumed to have developed the condition a result of said exposure. It is important to note that other risk factors no longer are considered, as it should be presumed that the exposure was the cause. While RVN veterans have only to demonstrate "boots on the ground", other presumptions such as those for Camp Lejeune Contaminated Water claims have specific components, such as minimum exposure duration, that must be met.

In the cases of a presumption, it is the responsibility of VBA officials to verify that those conditions have been met and in turn will concede exposure. In cases of a presumptive diagnosis, unless otherwise specified, a medical opinion is not warranted as the nexus, or causality, has been presumed.

1.12 Sufficiency for Rating

CFR 38 §4.2, Interpretation of examination reports, states: "*Different examiners, at different times, will not describe the same disability in the same language. Features of the disability which must have persisted unchanged may be overlooked or a change for the better or worse may not be accurately appreciated or described. It is the responsibility of the rating specialist to interpret reports of examination in the light of the whole recorded history, reconciling the various reports into a consistent picture so that the current rating may accurately reflect the elements of disability present. Each disability must be considered from the point of view of the veteran working or seeking work. If a diagnosis is not supported by the findings on the examination report or if the report does not contain sufficient detail, it is incumbent upon the rating board to return the report as inadequate for evaluation purposes.*"

Please note that if information necessary for rating is omitted it is incumbent on the rater to return the examination report to the C&P clinician as being insufficient for rating. This label does not imply the examination was inadequate, but instead refers to the absence of information specifically asked for in the VASRD. Most common errors include failing to answer specific questions in a DBQ or conveyed in the 2507 exam request. Information missing that cannot be tied to the rating schedule or specific written rating policies generally should not be considered insufficient for rating.

1.13 Common Pitfalls to Avoid

It is important to remember that the VBA raters are not clinicians, and therefore may not understand concepts that are considered basic or assumed by those educated in the field of medicine. Providing narratives which can be understood by the average lay person is generally indicated. Statements regarding conditions or diagnoses should be objective, factual and not open ended. For example, it is better to state "there is no diagnosis possible based on history, physical examination and review of currently available medical evidence" rather than saying "there is no diagnosis because the claimant needs to see his or her treating clinician for a more complete work-up." Medical diagnoses should be based on current medical evidence unless medically impossible. Refrain from making statements regarding individual lack of training or skill as being inadequate to make determinations. Providers should acquire the skill or training or refer the veteran to a specialist within the medical center. Explain all abnormal findings, whether physical, laboratory, imaging or even information as they relate (or not) to the claimed condition(s).

CHAPTER 2 CONDITIONS OF THE SKIN INCLUDING SCARS

2.1 General

This chapter supplements the DBQs for the condition(s) and C&P Examination Training module VA 15958 DMA Skin & Scar Examinations.

2.2 What Objective Findings are Useful?

An important component of the Skin C&P examination is the requirement to document the degree of involvement in terms to percentage of total body surface area and sun exposed surfaces separately (estimate total body surface area by using the "rule of nines"). The later are defined as head, face, neck and hands. While not always thought of as a component of the skin, diseases of the nails follow these same evaluation guidelines.

Scars of the face, neck and other sun exposed areas require greater descriptive detail than scars of other body surfaces. Tenderness, or pain, is a specific and important component in the rating of disabilities associated with scars and failure to address this component will likely result in the exam being returned as insufficient for rating. The ratings for scars also look at a combined sum of either the length (linear) of or surface areas (non-linear or when Too Numerous To Count) recorded. While an individual scar may seem inconsequential, they should be recorded as they may impact a rating based on a total summation. Mention should be made of skin texture in the area of scarring, whether scar is elevated or depressed, whether scars are attached to underlying bone, joint, muscle, or other tissues, and whether there is loss of tissue under the scar. For scars of the face, head, and neck, the degree of disfigurement should be recorded, including a description of distortion or asymmetry of any facial features. Color photographs are not required but may be provided at the examiner's discretion.

2.3 Unique Military Skin Conditions

a. Chloracne. An acne form rash with many comedones, cysts, and pustules primarily involving the malar areas, the angles of the jaw, and the area behind the ears. It may also appear in the axillary and inguinal areas. There may be associated itching. Straw colored epidermal inclusion cysts may form that tend to progress to abscess formation. Develops after exposure to herbicides such as dioxin or certain other toxic chemicals that contain halogenated aromatic hydrocarbons. Develops a few months after swallowing, inhaling, or touching the toxic chemical and persists after exposure ends. Persistence for at least 30 years has been reported. Chloracne is distinguished from acne by the predominance of open comedones and the typical chloracne distribution.

b. Pseudo folliculitis Barbae

Chronic perifollicular papules in the beard area which develops when beard hairs become embedded in the infundibular portion of the hair follicles. A change in shaving habits often can provide relief.

CHAPTER 3 DENTAL AND ORAL DISORDERS

3.1 General Guidelines

Examinations should be performed by a dentist or oral & maxillofacial surgeon. The examination must conform to and be documented using the appropriate DBQ(s). Temporomandibular joint conditions are considered joint (musculoskeletal) examinations. They may be performed by both dentist and oral & maxillofacial surgeons as well as C&P generalists.

CHAPTER 4 EYE

4.1 General Guidelines

Examinations must be performed by a licensed vision specialist, either an optometrist or an ophthalmologist. The examination must conform to and be documented using the appropriate Eye DBQ(s).

CHAPTER 5 EAR, MOUTH, NOSE, AND THROAT DISORDERS

5.1 General

This chapter supplements the DBQ(s) for the conditions.

5.2 Sinusitis and Rhinitis

Sinusitis is a commonly over-diagnosed disease. It is important to differentiate between rhinitis and sinusitis, and if acute versus chronic. Radiographic studies are helpful in confirming the presence or absence of sinus disease. Routine sinus films should include an AP Water's view unless recent documentation of sinus X-rays or CT exists in the medical records.

5.3 Examining the Sense of Smell

Testing Olfaction. Substances used for testing olfaction should have a commonly identifiable odor. Coffee, benzaldehyde, tar, and oil of lemon are recommended. Each

side of the nose should be tested separately, and the odor should be named. The receptacles for the odors may be a test tube or the barrel of a 10-ml. syringe. The examinee is asked to sniff as he/she is exposed to the test substance. Regression of the sense of smell is commonly associated with advancing age > 40. Frequently, either all or none of the test odors are identified. Since there is a marked deviation of threshold in normal individuals, the qualitative (Pass/Fail) tests for the presence, reduction (hyposmia) or absence of smell (anosmia) are of limited value.

5.4 Examining the Sense of Taste

The principal nerves of taste are the chorda tympani branch of the facial nerve and the glossopharyngeal nerve. The former supplies taste buds over the anterior two-thirds of the tongue, and the latter is distributed to the posterior one-third.

5.5 Testing Sense of Taste

The basic taste modalities are sweet, sour, bitter, and salt. The recommended test substances are sugar/sucrose, dilute acetic? or citric acid, quinine HCL, and sodium chloride. A cotton-tipped applicator moistened with each substance is applied to the lateral borders and vallate papillae of the tongue. Responses from each side of the tongue are compared. The test for the qualitative presence or absence of taste is of limited value.

CHAPTER 6 HEARING LOSS

6.1 General Guidelines

Examination for hearing impairment must be conducted by a licensed audiologist. The examination must conform to and be documented using the appropriate DBQ(s). Specifics for performing Hearing Loss and Tinnitus evaluations can be found at https://vbaw.vba.va.gov/bl/21/rating/Medical/docs/cphandbook.pdf .

6.2 Hearing Loss Classification

The types of hearing loss may be described as conductive, mixed, sensorineural, or central. Conductive hearing losses are due to lesions that reduce transmission of sound through the external auditory canal, tympanic membrane, or middle ear. In purely conductive hearing losses, cochlear function is normal. Sensorineural hearing losses occur in lesions of the cochlea and auditory nerve. Mixed hearing losses involve both conductive and sensorineural components. Central hearing losses occur in lesions of the central nervous system from the brainstem to the auditory cortex. Audiologists are qualified to perform site of lesion tests to differentiate these types of hearing loss. The most common causes of sensorineural hearing loss are aging and traumatic noise exposure. Sensorineural loss may also result from drug-induced ototoxicity. The most

common ototoxic factors are antibiotics such as streptomycin, neomycin, kanamycin, vancomycin, polymixin B, and gentamicin, salicylates (aspirin), platinum-based anti-neoplastic drugs such as cisplatin, and loop diuretics such as ethacrynic acid. Sensorineural loss may also result from temporal bone fracture or closed head injuries, labyrinthitis, syphilis, other viral and bacterial infections, vascular disease, meningitis, autoimmune disorders, tumors of the cerebellopontine angle, and endolymphatic hydrops (Meniere's Disease).

Audiograms performed for C&P require using the pre-recorded Maryland CNC Word List for measuring speech discrimination scores to be sufficient for rating purposes. This word list is no longer used in the non-C&P setting. It is therefore important a to keep in mind that although a claimant may have had a recent hearing test (audiogram), it is highly probable that the Maryland CNC was not used to measure speech discrimination and that the audiogram is therefore not sufficient for use in the VA rating evaluation.

CHAPTER 7 RESPIRATORY DISORDERS

7.1 General

This chapter supplements the DBQ(s) for the condition and C&P Examination Training module VA 15957 DMA Respiratory Examinations.

a. Occupational and environmental history:
Describe any exposure to dusts, gases, toxins, smoking (amount, duration, quit date), secondhand-smoke, etc. both in the military and before and following service.

b. Usual laboratory studies

1) **Chest x-ray** is routine for lower respiratory conditions, unless report of an X-ray or CT done in the recent past is available in the medical record and remains indicative of current medical condition.

2) **Pulmonary Function Tests (PFT)** is routine unless already carried out in the recent past and available in the medical record and remains indicative of current medical condition. Most respiratory conditions are evaluated primarily based on the results of pulmonary function tests. Spirometric pulmonary function testing should include FVC, FEV-1, and the FEV-1/FVC ratio (ratio of Forced Expiratory Volume in one second to Forced Vital Capacity). A DLCO (diffusion capacity of the lung for carbon monoxide by the single breath method) is included in a routine battery of pulmonary function tests in some medical facilities but not in all. Unless an explanation for its omission is provided, the DLCO should be done and is a must for diagnosed restrictive conditions. Both pre- and post-bronchodilation test results should be reported. If post-bronchodilation is not done, an explanation of why it was not done should be given; otherwise, the examination will not be considered adequate for rating purposes. PFTs are not required when the veteran is receiving outpatient oxygen therapy; has had one or more episodes of ARF; has been diagnosed with cor-pulmonale, right ventricular hypertrophy or pulmonary hypertension; has diminished

exercise capacity testing; or if medically contraindicated. An explanation of why it was not done should be given; otherwise, the examination will not be considered adequate for rating purposes.

3) **Disparity in PFTs.** If there is a disparity between the results of different elements of the pulmonary function tests, e.g., if the FEV-1 indicates good functioning and the DLCO is abnormal, the examiner should indicate which parameter is most likely to accurately reflect the extent of impaired pulmonary functioning due to the claimed condition and why. At times the tests may need to be repeated for clarification, for example, if there is doubt about the effort expended, or if there were technical difficulties.

7.2 Specific Information for Certain Respiratory Conditions

a. Interstitial lung diseases

These include diffuse interstitial fibrosis (interstitial pneumonitis, fibrosing alveolitis), desquamative interstitial pneumonitis, pulmonary alveolar proteinosis, eosinophilic granuloma of lung, drug-induced pulmonary pneumonitis and fibrosis (Gleveec[Imatinib]), radiation-induced pulmonary pneumonitis and fibrosis, hypersensitivity pneumonitis (extrinsic allergic alveolitis), pneumoconiosis (silicosis, anthracosis, etc.), and asbestosis. Provide PFTs, specifically the FVC and DLCO.

b. Cor pulmonale, right ventricular hypertrophy, or pulmonary hypertension Should be confirmed by a cardiac Echo or cardiac catheterization. They should not be diagnosed on clinical findings or X-rays only.

7.3 Important Elements for Sleep Apnea

Sleep Apnea includes intermittent cessation of airflow at the nose and mouth during sleep. Obstructive is due to collapse and occlusion of the upper airway of the oropharynx, and snoring is a common symptom but not diagnostic. Central is due to a transient abolition of central ventilatory drive, which causes a chronic alveolar hypoventilation. Mixed sleep apnea combines features of both types. The description of symptoms has a negative verses positive predictive value for a medical diagnosis of obstructive sleep apnea. A sleep study interpreted in isolation of the clinical picture may over or under diagnose obstructive sleep apnea. Consequently, a sleep study is not indicated in cases where the clinical picture is not consistent with a positive clinical probability of obstructive sleep apnea. Therefore, sleep studies should be obtained only when clinically appropriate.

CHAPTER 8 CARDIOVASCULAR DISORDERS

8.1 General

This chapter supplements the DBQ(s) and C&P Examination Training module VA 15955 DMA Heart Examination.

8.2. Stress Testing and METS

a. Meaning of METS

One MET is the energy cost of standing quietly at rest and represents an oxygen uptake of 3.5 milliliters per kilogram of body weight per minute. This is the resting energy requirement. With progressive activity, the number of METs required progressively increases. For example, a workload of between three and five METs represents such activities as light yard work (weeding), mowing lawn (power mower), brisk walking (4 mph). METS are a measurement of total body ability to function and not simply cardiac function. Care should be taken to note other factors impacting METs if medically appropriate such as physical impairments to locomotion (amputation). If possible METs should be given with respect to cardiac disfunction only and not to other impairments.

b. Stress Testing

For cardiac impairment assessments exercise stress testing is very useful if already of record. However, given the risks associated with exercise stress tests they are no longer required. Use of estimated METs is suggested when a stress test is not of record.

c. Estimation of METS

When stress testing is medically contraindicated, the examiner must then provide an estimate of the level of activity expressed in METs that results in cardiac symptoms. Charts that associate METs levels with various activities used for estimates are available in standard medical textbooks and online.

8.3 Reporting a Diagnosis by NYHA Criteria?

Nomenclature and Criteria established by the New York Heart Association are commonly used to classify patients' heart failure according to the severity of their symptoms.

Class	Patient Symptoms
I	No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, dyspnea (shortness of breath).
II	Slight limitation of physical activity. Comfortable at rest. Ordinary physical activity results in fatigue, palpitation, dyspnea (shortness of breath).
III	Marked limitation of physical activity. Comfortable at rest. Less than ordinary activity causes fatigue, palpitation, or dyspnea.
IV	Unable to carry on any physical activity without discomfort. Symptoms of heart failure at rest. If any physical activity is undertaken, discomfort increases.

8.4 Ischemic Heart Disease in Former Prisoners of War?

Beriberi heart disease is a condition that is presumptively service connected for former prisoners of war. A regulation has established that beriberi heart disease includes ischemic heart disease if the former prisoner experienced edema of the feet or legs during captivity. There is no requirement that there was ever an actual diagnosis of beriberi. Therefore, you may be asked to determine whether ischemic heart disease is present in a former prisoner of war. You need not determine the etiology in these cases, only whether ischemic heart disease is present, and the current findings. The ischemic heart disease may be either absolute (e.g., coronary artery disease) or relative (e.g., cardiomyopathy with a greatly enlarged heart).

8.5 Hypertension and Isolated Systolic Hypertension?

a. Diagnosis

Multiple blood pressure (BP) readings are required to establish the diagnosis of hypertension. Blood pressure results may be obtained from existing medical records or through scheduled visits for blood pressure measurements. There must be 2 or more readings on at least 3 different days. However, once hypertension has been established, readings on multiple days are not required for follow-up examinations. If the

Veteran is on treatment for hypertension at the initial exam, multiple readings on different days are not necessary because they would not be useful.

b. Classification

For VA disability rating purposes, the term hypertension means that the diastolic blood pressure is predominantly 90mm or greater, and isolated systolic hypertension means that the systolic blood pressure is predominantly 160mm or greater with a diastolic blood pressure of less than 90mm. Which differs from current clinical diagnostic criteria. The American College of Cardiology and American Heart Association published revised guidelines for diagnosis of hypertension in November 2017.

- Normal: Less than 120/80 mm Hg,
- Elevated: Systolic between 120-129 and diastolic less than 80,
- Stage 1: Systolic between 130-139 or diastolic less than 80,
- Stage 2: Systolic at least 140 or diastolic at least 90 mm Hg,
- Hypertensive crisis: Systolic over 180 and/or diastolic over 120, with patients needing prompt changes in medication if there are no other indications of problems, or immediate hospitalization if there are signs of organ damage.

CHAPTER 9 DISORDERS OF THE DIGESTIVE SYSTEM

9.1 General

This chapter supplements the DBQ(s) for the conditions.

9.2 Irritable bowel syndrome

a. General

Formerly also known as functional bowel disease, spastic colitis or mucous colitis. The term "colitis" is a misnomer since both inflammation and an organic component are lacking. Irritable bowel syndrome (IBS) is a functional disorder of the gastrointestinal tract characterized by chronic abdominal pain and altered bowel habits.

b. Symptoms

Symptoms of IBS include diarrhea, constipation, alternating diarrhea and constipation, or normal bowel habits alternating with either diarrhea and/or constipation. Abdominal pain in IBS is usually described as a cramping sensation with variable intensity and periodic exacerbations.

The location and character of the pain can vary. The pain is frequently related to defecation. Patients with IBS frequently report abdominal bloating and increased gas production in the form of flatulence or belching. Certain types of food and emotional stress (Gut-Brain axis) may precipitate symptoms

c. Diagnosis

According to the Rome IV criteria, IBS is defined as recurrent abdominal pain, on average, at least one day per week in the last three months, associated with two or more of the following criteria:

- Related to defecation
- Associated with a change in stool frequency
- Associated with a change in stool form (appearance)

Usually there is a well-nourished appearance despite a history of frequent loose stools daily. Physical examination is often completely normal. A clinical diagnosis of IBS requires the fulfillment of symptom-based diagnostic criteria and a limited evaluation to exclude underlying organic disease

d. Alternative Etiology

Features concerning for underling organic disease include:

- Age of onset after age 50 years
- Rectal bleeding or melena
- Nocturnal diarrhea
- Progressive abdominal pain
- Unexplained weight loss
- Laboratory abnormalities (iron deficiency anemia, elevated C-reactive protein or fecal calprotectin)
- Family history of inflammatory bowel disease or colorectal cancer

9.3 Hepatitis C Infection

a. Diagnosis

The diagnosis of chronic HCV infection is usually made in a patient with a reactive HCV antibody test and a positive molecular test that detects the presence of HCV RNA.

b. Opinions

The examiner may be asked to determine whether a current Hepatitis C infection is related to hepatitis of known or unknown type during active service. In these cases, a battery of hepatitis serologic tests may be needed, because clarifying this issue is critical to determining the relationship to service. An examiner will frequently be asked to provide an opinion as to whether Hepatitis C is related to service, in the absence of any indication of hepatitis in service. In such cases, the examiner should consider and fully discuss all pertinent risk factors before, during, and after service (organ transplant, transfusions of blood or blood products before 1992; hemodialysis; accidental exposure to blood by health care workers [to include combat medic or corpsman]; intravenous drug use or intranasal cocaine use; high risk sexual activity; other direct percutaneous exposure to blood), and should give an opinion as to whether it is at least as likely as not that a risk factor related to service is the primary etiology. After a needlestick or

sharps exposure to HCV-positive blood, the risk of HCV infection is 0.1% reported by the CDC.

9.4 Radiographic and Endoscopic Studies

Radiographic and endoscopic studies of record are especially useful. Air contrast barium swallow studies are sometimes listed. These are generally of poor diagnostic reliability due to a high rate of false negatives. If this study is requested but not provided, it is important to provide a discussion of why this study was not clinically indicated (likely due to a high false negative rate).

CHAPTER 10 GENITOURINARY DISORDERS

10.1 General

This chapter supplements the DBQ(s) for the conditions and C&P Examination Training module VA 15954 DMA Genitourinary Examination.

10.2 Anatomical Loss or Loss of Use of Creative Organ

a. The details of loss of a creative organ may be in the service medical records, but the examiner should still describe lost and remaining portions of the penis, scrotum, and testes (often the result of a GSW, SFW or IED).
b. Impotence, sterility, or retrograde ejaculation should be reported, and the etiology stated (e.g., Peyronie's disease causing impotence or TURP for BPH causing retrograde ejaculation).
c. If a vasectomy was performed, the examiner should report when it was done and the reason.

CHAPTER 11 GYNECOLOGICAL CONDITIONS AND DISORDERS OF THE BREAST

11.1 General

This chapter supplements the DBQ(s) for the conditions. It is encouraged that a same sex chaperone should be present regardless of the clinician's gender performing the evaluation.

11.2 Female Sexual Arousal Disorder

VA introduced a new diagnostic code for Female Sexual Arousal Disorder (FSAD), in order to achieve gender parity. FSAD refers to the continual or recurrent inability of a woman to accomplish or maintain an ample lubrication-swelling reaction during sexual

intercourse. This lack of physical response may be either lifelong or acquired, and either generalized or situation specific. VHA examiners and clinicians have indicated that they routinely observe, consult, and treat a fair number of veterans for this non-psychiatric form of FSAD.

While the diagnostic criteria are found in DSM-5, for the purposes of C&P evaluations address only the physiological component of FSAD. Provide medical evidence to make the diagnosis. The gynecological examination with the physiological component of FSAD should not trigger a mental health evaluation. Undiagnosed physical symptoms, such as pelvic pain, will require a gynecologic or pelvic exam.

FSAD language is currently in the GYN DBQ, and will be added to the following DBQs:

a) Diabetes Mellitus
b) Parkinson's Disease
c) ALS
d) Central Nervous System and Neuromuscular Diseases
e) Multiple Sclerosis (MS)

CHAPTER 12. MUSCULOSKELETAL DISORDERS

12.1 General

This chapter supplements the musculoskeletal DBQ(s) and C&P Examination Training modules VA 6086 DMA Foot Examination; VA 6552 DMA Muscle Injuries Examination; VA 6556 DMA Hand and Fingers Examination; VA 24507 DMA Cervical (Neck) and Thoracolumbar (Back) Spine Examinations.

12.2 Examination for Disease or Injury of the Musculoskeletal System

Goniometer of appropriate size for the joint to be evaluated is required by the Rating Schedule for all ROM measurements. While an inclinometer might be easier to use and more accurate for some joints, use does not comply with VBA requirements. A hand dynamometer is not utilized for strength testing. However, both instruments can be used as part additional clinical information obtained.



12.3 Range-of-Motion Testing

a. Accurate assessment of joint range-of-motion (ROM) is extremely important. The "anatomic position" is defined as the patient standing erect with feet flat on the floor, heels together, arms at the sides, palms facing forward, fingers and thumbs extended parallel to hands, and chin straight forward.

b. Use a goniometer to measure both passive and active ROM, including movement against gravity and resistance. Provide ROM in degrees; it is not acceptable simply to note that range of motion is "normal" or "within normal limits."

c. ROM of the contralateral "normal" joint is required unless medically contraindicated or not possible (i.e. amputation, casted/splinted, etc.).

d. Ankylosis of a joint means immobility and consolidation of a joint due to disease, injury, or surgical procedure according to Dorland's Medical Dictionary (2012).

12.4 Functional Assessment of Joints

There are three precedential case decisions of the Court of Appeals for Veterans Claims (CVAC) that have significant impact on the musculoskeletal examinations and are based on interpretations of 38 CFR § 4.59: "Painful motion. With any form of arthritis, painful motion is an important factor of dis-ability, the facial expression, wincing, etc., on pressure or manipulation, should be carefully noted and definitively related to affected joints. Muscle spasm will greatly assist the identification. Sciatic neuritis is not uncommonly caused by arthritis of the spine. The intent of the schedule is to recognize painful motion with joint or periarticular pathology as productive of disability. It is the intention to recognize actually painful, unstable, or misaligned joints, due to healed injury, as entitled to at least the minimum compensable rating for the joint. Crepitation either in the soft tissues such as the tendons or ligaments, or crepitation within the joint structures should be noted carefully as points of contact which are diseased. Flexion elicits such manifestations. The joints involved should be tested for pain on both active and passive motion, in weight-bearing and non-weight bearing and, if possible, with the range of the opposite undamaged joint."

a. **DeLuca v. Brown**, 8 Vet. App. 202 (1995). Additional factors must be considered for each joint examined and includes:

- pain which limits function during a. repetitive use,

- flare-ups,
- weakness against varying resistance,
- excess fatigability,
- incoordination.

Each of these issues should be assessed and the amount the joint is additionally limited (if any) resulting from one or more of these factors should – if possible –be reported in degrees of additional loss of motion. The absence of any (or all) of these factors should also be noted. Be specific as to where (i.e., from flexion or extension) any additional losses should be subtracted. For example, if knee pain on ROM testing prevents full flexion and an additional ROM loss for pain of 20 degrees is warranted, specifically state the additional limitation of flexion due to pain ("Because of pain on movement, the ROM is estimated to be 0 to X rather than 0 to Y found on range of motion without taking pain into consideration."). At present there are no guidelines as to which tests should be used to determine the strength and endurance for the various joints. These tests should be individualized, keeping in mind patient safety.

Example: If shoulder abduction is 0 to 180 degrees against gravity, but there is evidence of pain (verbal complaint, facial grimace, etc.) between 120 degrees and 180 degrees, this should be documented. If further testing for endurance against resistance (e.g., 10 repetitions using a 5-pound dumbbell) reduces shoulder abduction to 90 degrees, this should be reported. If more than one factor is contributing to loss of ROM, state – if possible – which has the major functional impact. This can be done as a comment. For the above example, this might read: "**Comment:** While shoulder abduction against gravity is full, 0 to 180 degrees, because of the combined effects of pain and lack of endurance, the Veteran's functional ROM is best estimated to be 0 to 90 degrees."

Describe the patient's functional disability as to effects on daily activities (eating, dressing, walking, breathing, etc.) and employment**.**

b. Mitchell v Shinseki 25 Vet. App. 32 (2011). The Mitchell case is a clarification of DeLuca and states that when there is pain noted on range of motion, or a history of pain associated with flare-ups or repetitive use of the joint, the pain itself could limit function of that joint. Therefore, looking only at the loss of function associated with three repetitions of ROM in a person with pain on range of motion testing may not always be an accurate indication of loss of function due to pain associated with repetitive use. The court in the Mitchell case also states that loss of function due to pain during flare-ups must also be addressed. Similar in nature to an opinion, both subjective and objective evidence must be evaluated. It is important to note that many times the subjective component of claimant's history will play an equal, if not larger, role than the objective findings.

There are essentially two things that should prompt a clinician to address the issues raised by the Mitchell case: 1) Complaints of pain associated with repetitive use of the joint (based on history and not dependent on objective findings of pain with repeated

ROM testing) and 2) Reports of flare ups. This triggers the examiner to comment as to what expected loss of ROM would be attributable to pain during flare-ups, in terms of degrees ROM when reasonable. If not reasonable, a description of the decreased function should be given. Although the court did not specifically speak to any of the other DeLuca criteria (such as excess fatigability, weakened movement, etc.), it is reasonable to assume that if a Veteran complains of any of these problems on ROM testing, whether or not the Veteran actually has any additional loss of ROM on repetitive testing, the examiner should describe, in degrees range of motion, the effect of such problems on function during repetitive use.

If such opinion is not feasible, state accordingly and provide an explanation as to why the opinion regarding additional limitation during flare-up or when the joint is used repeatedly over a period of time cannot be rendered. As noted in the discussion regarding opinions, use of the option of being unable to opine without resorting to mere speculation should be used with caution, as it is intended for cases where no reasonable clinician would be able to provide an opinion and not based on the individual examiners personal ability.

c. Correia v McDonald. In Correia v. McDonald, the court found VA examinations must include joint testing for pain on both active and passive motion, in weight-bearing and non-weight-bearing and, if possible, with range of motion measurements of the opposite undamaged joint.

It is important to provide examinations of both joints, when they are a paired set, as the court has addressed the ability to compare the two joints. For example, even when only one knee is claimed, the examination for both knees must be documented. It is also important to note whether the opposing joint is undamaged. If the examiner determines the joint is damaged, it would be helpful for the sake of comparison to provide an explanation as to why that is so. It is also important to document whether there is pain with weight bearing and non-weight bearing as well as pain with both active and passive ranges of motion.

All joints should be considered. There are some special circumstances such as with temporomandibular joint dysfunction. In this case since both sides are joined by the mandible, documentation of the movement of the jaw may represent the motion for both joints. With no opposing or bilateral joints, the need for looking at the joints as a paired set is not applicable, however all other parameters, such as joint testing for pain on both active and passive motion, in weight-bearing and non-weight-bearing must be addressed. The same holds true for the spine, where there is no contralateral component and the bilateral aspect does not apply, however, all the other factors can and should be addressed.

12. Imaging Studies

a. In general, the least invasive and least harmful means of objectively documenting pathology, such as arthritic changes and/or structural defects, is preferred. If the disability examination request regarding a joint describes a more general contention, such as "joint pain," X-ray studies are only to be ordered if the examiner determines X-ray studies are clinically indicated, including if arthritis is suggested. If the examiner determines X-ray studies are not needed, an explanation for the determination must be provided in the remarks section of the DBQ. X-ray studies should only be ordered after the examiner has reviewed the available records and examined the Veteran, rather than prior to the scheduled examination. Obtaining pre-examination X-rays based solely on the list of contentions in the examination may expose the Veteran to radiation unnecessarily.

b. The diagnosis of degenerative or post-traumatic arthritis of a joint requires x-ray confirmation one time only. Once the diagnosis of arthritis has been confirmed in a joint, further imaging studies of that joint are generally not required because benefits are determined by the amount of functional impairment and not by the severity of x-ray or other imaging study findings. For example, if the examination request specifies a Veteran's left knee for examination, and the request notes that the Veteran is already service-connected (SC) for "left knee degenerative arthritis," then additional x-rays are not required. On the other hand, if the Veteran is only claiming service-connection for left knee degenerative arthritis and is not yet service-connected, AND no past imaging studies are available documenting arthritic changes, then appropriate x-ray studies should be obtained and the results reported and included with the examination report.

c. Review all requested imaging tests, include them in the examination report, and correlate them with clinical findings before finalizing the diagnosis and returning the DBQ to VBA.

CHAPTER 13 NEUROLOGIC EXAMINATION

13.1 General

This chapter supplements the DBQ(s) and C&P Examination Training modules VA 9238 DEMO Traumatic Brain Injury (TBI) Examination and VA 15956 DMA Neurology Including Peripheral Nerves Examination.

13.2 What are general considerations in conducting a neurologic examination for compensation and pension purposes?

a. Diagnosis

Every effort should be made to arrive at a single unifying diagnosis whenever possible. Multiple diagnoses, particularly one neurologic or "organic" and one psychiatric, adds complexity for the raters that are trying to rate the disability. This will necessitate a complete general physical examination and a psychiatric study as well as a detailed

neurologic examination. Some examinees will, however, clearly have two (or more) separate and unrelated disorders and should be diagnosed accordingly.

b. Assessment

An observant clinician can gain considerable information concerning the neurological status of the patient during the history-taking interview. The state of the muscular system can be evaluated to some extent by observing the gait as he/she walks into the consulting room. The nature of spontaneous movements, the presence or absence of involuntary movements, and the presence or absence of normal associated movements will be revealed, at least in part, as the applicant sits through the interview. The facial expression, hearing acuity, quality of voice, type of speech, and the status of the eye movements should be noted. A fair idea of the intellectual and emotional capacity of the patient, as well as his/her motivation, may be gained during the taking of this history. The ease or clumsiness with which the patient handles buttoning or unbuttoning clothes, disrobing, tying shoelaces, removing articles from pockets or other simple routine movements may be most revealing of the presence or absence of disturbed function in the central or peripheral nervous system.

13.3 Traumatic Brain Injury

Traumatic Brain Injury (TBI) may happen from a blow or jolt to the head or an object penetrating the brain. When the brain is injured, the person can experience a change in consciousness that can range from becoming disoriented and confused to coma. The individual might also report a loss of memory for the time immediately before or after the event that caused the injury. Not all injuries to the head result in a TBI.

Research has demonstrated that identification of mild traumatic brain injury may be overlooked. Considering this, Veterans presenting for **initial TBI disability examinations without a previous diagnosis of TBI will require a diagnosis of TBI made by VHA physicians who are Board certified or Board eligible in physiatry, neurology, neurosurgery, or psychiatry** prior to the completion of the disability evaluation. Once the diagnosis is established, either the same specialist or a certified C&P examiner that has completed the appropriate DMA TBI training modules can complete the residuals component of the TBI evaluation.

The TBI evaluation differs from other C&P neurologic evaluations in that careful attention is given to cognitive and subjective symptoms. Known as the ten facets of TBI, these include:

1. memory, attention, concentration or executive functions,
2. judgment,
3. social interaction,
4. orientation,
5. motor activity (with intact motor and sensory system),
6. visual spatial orientation,
7. subjective symptoms,

8. neurobehavioral effects,
9. communication,
10. consciousness.

Not infrequently, claims for TBI are also associated with mental health claims, such as PTSD. In these cases, it is generally recommended that the TBI evaluation precede the mental health one to avoid conflicting information regarding the diagnosis of TBI. The mental health clinician is also asked to delineate, if possible, symptoms related to the mental health diagnosis verses those of the traumatic brain injury. **Current science does not allow for a clinician to assign percentages.** It is preferable for the examiner to indicate either 1) they are not able to differentiate what portion of the occupational and social impairment is caused by the TBI versus the mental health condition or 2) for the examiner to state that it appears as if the occupational difficulties are more likely attributable to the mental health condition OR TBI (without providing a percentage) and then documenting the supporting information (i.e. the Veterans occupational functioning is impacted as he has frequent absenteeism from work due to feelings of depression and lack of motivation). Information from the TBI evaluation may be of benefit.

For TBI examination and diagnosis guidance, see DMA Fact Sheet 14-004, TBI Disability Examination Providers, May 8, 2014, on the DMA website on the Policy and Procedures Resources page (http://vaww.demo.va.gov).

13.4 Parkinson's Disease

The diagnosis of idiopathic Parkinson's disease (PD) can be challenging. Symptoms and signs of parkinsonism (i.e., tremor, bradykinesia, rigidity, and postural instability) can be prominent in neurodegenerative disorders other than idiopathic PD, including dementia with Lewy bodies, corticobasal degeneration, multiple system atrophy, and progressive supranuclear palsy collectively named Parkinson-plus syndromes. Essential tremor may also be confused with PD. Distinguishing PD from parkinsonian syndromes can be difficult, particularly in the early stages of disease. A response to dopaminergic therapy is an important supportive feature for establishing an accurate diagnosis of idiopathic Parkinson's disease from a condition with parkinsonism features.

13.5 Characteristics of Fibromyalgia

Fibromyalgia (FM) is a common cause of chronic widespread musculoskeletal pain, often accompanied by fatigue, cognitive disturbance, unrefreshing sleep and mood problems. The etiology of the syndrome is unknown, and the pathophysiology is uncertain, but it's thought to be related to abnormal levels of certain chemicals in the brain and changes in the way the central nervous system (the brain, spinal cord and nerves) processes pain. The diagnosis of FM is based primarily upon the patient's symptoms and should be suspected in patients with chronic pain of at least three months' duration without another identified cause. There is no diagnostic laboratory test or radiographic or pathologic finding, and testing should be kept to a minimum and

performed only when an alternative etiology is suggested (inflammatory disease, thyroid dysfunction, or autoimmune disorders, etc.).

13.6 Peripheral Nerves

The VASRD does not differentiate between motor and sensory function, referring to both jointly as paralysis. If a nerve is completely paralyzed, check the box for "complete paralysis." If the nerve is not completely paralyzed, check the box for "incomplete paralysis" and indicate severity (mild, moderate, or severe). When nerve impairment is wholly sensory (normal motor function), the classification should be mild, or at most, moderate.

CHAPTER 14 MENTAL DISORDERS, MILITARY SEXUAL TRAUMA AND PTSD.

14.1 General

This chapter supplements the DBQ(s) for the conditions and C&P Examination Training modules VA 5497 DMA Initial Post Traumatic Stress Disorder (PTSD) Examination; VA 5522 DMA Initial Mental Disorders (IMD) Examination; VA 23409 DMA Military Sexual Trauma and the Disability Examination Process.

a. These examinations must be performed by a licensed psychiatrist or psychologist, or board eligible clinician under the supervision of a licensed psychiatrist or psychologist. The examination must conform to and be documented using the appropriate DBQ(s).

b. A definitive diagnosis or diagnoses based on whole history and current examination shall be provided. Terminology and the basis of the diagnosis must conform to the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (DSM- 5); otherwise the report will be returned. The report should explain how the Veteran meets the DSM- 5 diagnostic criteria for the mental disorder(s) diagnosed.

c. Whenever the history and findings of the examination do not confirm a diagnosis that has been previously made, the examiner should record the diagnosis which, in his/her opinion is justified based on all the evidence, but should relate a current diagnosis to a former one, so that the rating boards may clearly understand whether:
- A current diagnosis corrects an old (erroneous) one.
- If current diagnosis represents a mere change in nomenclature, include diagnosis from the old and new Diagnostic Statistical Manuals.
- A current diagnosis reflects a new phase or later development of a condition formerly diagnosed differently.
- A current diagnosis represents a new clinical entity not related to an earlier diagnostic entity.

d. An examination report which is the basis for a diagnostic conclusion of "No disease, following observation (or careful examination) for psychiatric disorder" should reflect the same careful consideration and thorough examination as required for the diagnosis of a psychiatric disease.

e. The examiner may be confronted with the absence of any present findings attributable to a disorder previously reported. If he/she believes the subsequent course disproves the earlier diagnosis, he/she should so state. If the examiner reaches the conclusion that the formerly diagnosed condition existed at some earlier date but that the Veteran has recovered, he/she should so state. In either case, reasons for such a conclusion must be recorded.

14.2 Military Sexual Trauma

VA's definition of MST comes from federal law, based on 38 U.S.C. 1720D. which refers to "psychological trauma, which in the judgment of a mental health professional employed by the Department [VA], resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the Veteran was serving on active duty or active duty for training," and is regardless of the geographic location, the gender of the Servicemember, or the relationship to the perpetrator. Both men and women can experience MST. Servicemembers and Veterans from all eras of service have reported experiencing MST. Of note, the Department of Defense (DoD) does not use the term MST, instead addressing sexual harassment and sexual assault separately. MST can occur on or off base, while a Servicemember is on or off duty, while perpetrators can be men or women, military personnel or civilians, superiors or subordinates in the chain of command, strangers, friends, or intimate partners.

As an examiner, please remember that while the focus in MST is frequently the psychological component, there are a variety of physical conditions that may occur secondary to an experience of MST. It is important to document not just the physical findings and the experience of MST, but to document the relationship between the MST experience and the diagnosis. In addition, not all MST experiences have an associated diagnosis, and even those that do have a diagnosis may not have a compensable disability based on VA regulations. Recognizing that many individuals that experience sexual trauma do not disclose their experiences unless asked directly, it is VA policy that all Veterans seen for healthcare are screened for MST. Note that MST is an interpersonal trauma. The perpetrator is often a friend, intimate partner, or other trusted individual. MST may be particularly difficult in the military context, where the Servicemember relies on others to be "Servicemembers in arms." It may have significant implications for survivors' subsequent relationships and understanding of themselves. Additionally, those who experience MST may continue to have interactions with their perpetrator(s), eating, working, relaxing in the same areas as the perpetrator(s). There may be no safe-haven as sleeping quarters may be with the perpetrator(s) in situations of same gender assaults or there may be ongoing potential

for repeat victimization. MST can increase feelings of helplessness and of being trapped.

A history of sexual assault has also been shown to be associated with an increased risk for several mental health disorders, including these to include posttraumatic stress disorder (PTSD), depression, substance use disorders, panic disorder and generalized anxiety disorder. The importance of strength and self-sufficiency are emphasized as part of the culture and training for active-duty Servicemembers. These values can influence perceptions about MST for the man or woman who experiences MST in the following ways. He or she may have strong feelings of self-blame and feel "weak" or may try to "keep it together" and "be strong" to stay true to warrior values while being reluctant to acknowledge the impact of MST experience and pretend everything is okay. Sexual trauma survivors frequently report additional problems such as self-blame and shame, difficulty trusting others, and low self-esteem. This may be manifested by body image issues, anger, impulsivity, confusion about gender identity or sexual orientation, intimacy and sexuality, difficulties at work, difficulties in relationships, legal difficulties, self-sabotage and difficulties with medical and dental procedures (i.e., a rectal or vaginal exam, or any other procedure that could feel invasive).
DoD has two options for reporting related to sexual assault. Restricted reports are confidential but not anonymous, and unrestricted reports are shared with the commander in the reporting location and with the Military Criminal Investigation Organization (MCIO). Servicemembers can file a confidential "restricted" report with the proper DoD authorities, which only specific individuals can access. An unrestricted report lacks that protection or privacy.

Support programs are available in both DoD and VA. DoD has three programs which assist service members who experience MST: 1) Safe Helpline, https://www.safehelpline.org, 2) the Sexual Assault Prevention and Response Office (SAPRO) http://www.sapr.mil and 3) the Military Equal Opportunity (MEO) program. SAPRO handles sexual assault reports, while MEO handles sexual harassment. VHA's Mental Health Services (MHS) has a national MST Support Team to perform national monitoring, coordinates MST-related education and training, and promote best practices in the field. Every VA healthcare system has an MST Coordinator who serves as a point person for MST issues at the facility and who ensures that MST-related monitoring, treatment, education and training occur. The MST Coordinator is the best point of contact for assistance in getting Veterans into MST-related care or for responding to any questions about local services.

a. Being Sensitive

In consideration of frequently not knowing who does and does not have a trauma history, it is good clinical practice to conduct **all examinations** in a trauma-sensitive manner. The Veterans Health Administration (VHA) encourages practices that can benefit the Servicemember or Veteran who has experienced MST. For example, VHA encourages the practice of allowing an examinee to request an examiner of a specific gender when feasible. Other suggestions include:

- Whenever possible, have conversations while the Servicemember or Veteran is fully dressed.
- Sit at the same level as the Servicemember or Veteran preferably without a desk in between you.
- Make eye contact.
- Give the Servicemember or Veteran options and choices whenever possible.
- Be transparent, explaining your reasoning for the questions you need to ask.
- Ask permission before touching,
- Let the Servicemember or Veteran know you will stop if he or she asks,
- Keep a running commentary of exactly what you are doing and what you are about to do. For example: "Okay, as you can see, I am picking up an instrument now. This is for looking in your ears; it shouldn't hurt. I am going to move close to you and briefly touch your ears while I am looking at your inner ear, is that okay?"
- Periodically ask how he or she is doing.

b. Disclosure

Disclosure of MST can be a delicate but very important matter. Except for mental health professionals providing psychotherapy, providers are discouraged from requesting or recording a detailed account of what happened during the MST. The reason is that asking the patient to recount the details of the assault, particularly with a stranger, can cause him or her to reexperience the trauma or experience significant distress. This process should be left to mental health professionals with expertise in these techniques, as the mental health clinician typically explores details of the trauma only after multiple sessions to carefully lay the groundwork.

However, document any information that is spontaneously disclosed by the Veteran. The Servicemember should be aware, but may not be, of the implications of disclosing MST during the Separation Health Assessment (SHA). If a Servicemember has already filed a restricted report about a sexual assault and you document this in the SHA, the confidentiality of the report may be compromised. If this is the case, he or she should file a claim for their MST-related conditions after separating from the service, rather than disclosing at the SHA. It is thus in the Servicemember's best interest that you point out the information-sharing aspect of the SHA, especially if he or she is reluctant to report MST experiences to a military authority.

c. SHA Information Packet

At the close of a SHA examination, you'll give the Servicemember a packet of information that has information about MST-related resources, among others. You are asked to provide this information because it informs the Servicemember about the importance of documenting or maintaining evidence related to MST while on active duty for later benefits purposes, in addition to other useful information. In addition to giving the MST handout, you'll give handouts about the Veterans Crisis Line and VHA services. It is important that all Servicemembers are aware of the Veterans Crisis Line

as a free, easily accessible resource if they are struggling and of VHA services in case they ever need them. While you do not need to give detailed information to the Servicemember about what is in the MST handout, you should know that it provides guidance about:

- Benefits and documentation related to MST, such as the importance of collecting and retaining any evidence.
- MST and the benefits process, such as how to file a claim for a condition related to MST.
- The different types of evidence needed for a claim, and how to collect evidence.
- The fact that healthcare for MST-related conditions is free and separate from the benefits process.

Despite the cautions in the handout and the cautions you may provide verbally, some Servicemembers may still choose to disclose MST at the SHA. If appropriate, gently pause and remind the Servicemember that it is his or her choice, but that disclosing during the SHA may risk his or her confidentiality. Take a few moments to explain to the Servicemember the benefits of calling the Safe Helpline or reviewing the handout before they decide.

If the Servicemember indicates that he or she does not want to call the Safe Helpline, or still wants to speak to your or to someone from the VA, tell them you are glad they feel safe and ready, and offer to schedule an appointment with a disability examiner who is specifically trained to address MST. Explain that the specially trained examiner can provide the evaluation that the Servicemember deserves.

d. How to Respond if a Servicemember Discloses MST

If a Servicemember does disclose, respond in a way that conveys empathy while at the same time placing limits on time and depth of disclosure. Assure the Servicemember that you will refer him or her to someone who can provide support, if desired. If a Servicemember begins to disclose a detailed account of the MST, or if the Servicemember appears distressed, it is helpful to gently limit the disclosure process. Remind the Servicemember that this is to maximize his or her claims opportunity while at the same time maximize his or her comfort and privacy.

e. Documenting MST

If a Servicemember discloses MST, follow these suggestions for documenting an MST incident on the SHA documentation protocol. A legible, clear, objective medical record will facilitate the Servicemember's application for compensation.

- Document the report in the Remarks section of the SHA DBQ, not the mental health section. For example, "Assault happened on (date), no physical residuals." If there are physical residuals, please document those in the appropriate section of the DBQ and include a statement that reflects how the residuals may be related to the MST experience.
- If the Servicemember discloses and/or has not yet filed a report, it is important to be careful in how you document this. You should attempt to document in a

manner that still protects the Servicemember's privacy. For example, it may be better to document that the Servicemember experienced a sexual assault while stationed at Ft. Bragg than stating that the service member was sexually assaulted on May 8, 2011, by her commanding officer.
- Documentation should include direct quotations from the Servicemember, where possible.
- You should avoid using judgmental terms. Avoid blaming the Servicemember for behaviors at the time of the assault such as alcohol consumption, and don't point out other behaviors proximal to the assault that did not contribute to the assault.
- Avoid judgmental statements such as, "The Servicemember did not fight off the perpetrator."
- Avoid suggesting that the Servicemember may have encouraged the perpetrator(s) in some way by his or her behavior.

14.3 POST-TRAUMATIC STRESS DISORDER (PTSD)

a. What is PTSD?

PTSD is a mental disorder that is a specific type of anxiety disorder that may result from a traumatic event such as combat, rape or other personal assault, natural disaster, accident, or other traumatic experience.
DSM-III established the diagnosis of PTSD and set forth clear diagnostic criteria, DSM-IV provided revised diagnostic criteria, and DSM-5 is the most current version. For more comprehensive information the assessment of PTSD, see the booklet: **"VA Practice Guideline for Post-Traumatic Stress Disorder Compensation and Pension Examinations."**

b. Standardized Psychometric Tests Useful in PTSD?

Psychometric assessment of PTSD provides quantitative assessment of degree of PTSD symptom severity. Judgments about symptom severity can be made by comparing an individual's scores against norms established on reference samples of individuals who are known to have or not have PTSD. Cutting scores have been established for the psychometric measures of PTSD recommended here, based on their high sensitivity and specificity in discriminating individuals with PTSD from those without PTSD. Data from psychometric tests never serve as a "stand alone" means for diagnosing PTSD. Rather, the psychometric measures recommended here should be used to supplement and substantiate findings gleaned from interview assessment and other sources of data. The following psychometric instruments are recommended for inclusion in disability evaluations for PTSD:
1. Mississippi Scale for Combat-Related PTSD - for combat-exposed populations
2. PTSD Checklist - for individuals exposed to combat and non-combat trauma Alternatives include:
- MMPI PTSD subscales

- Impact of Event Scale—Revised
- Penn Inventory
- PTSD Stress Diagnostic Scale
- Trauma Symptom Inventory.

Additionally, many instruments (e.g., MMPI) exist for quantifying extent of symptoms of other disorders that often co-occur with PTSD and should be considered for use as resources permit. The MMPI and MMPI-2 include scales known as "validity scales" that are elevated in people who are trying to exaggerate their symptoms. Use of the MMPI and MMPI-2 may help the evaluator determine test-taking style of the Veteran (i.e., defensive, over endorsing, under endorsing). Cutoff scores for utilizing the MMPI-2 to assess validity of PTSD diagnosis have been reported in several research studies. In addition, MMPI-2 cutoff scores for specific PTSD scales (i.e., PK, PS) have been shown to be effective at assessing PTSD.

CHAPTER 15 INFECTIOUS DISEASES AND RHEUMATOLOGICAL DISORDERS

15.1 General

This chapter supplements the appropriate DBQ(s).

15.2 Characteristics of Malaria

Care must be used to evaluate this condition in a Veteran who was in an endemic area and left service during recent months. The disease is often not diagnosed while in service or in endemic areas because of suppressive control measures but later becomes evident after return to civilian life. Rarely, a period of years may occur between the time malaria is acquired and the time it is recognized clinically. Diagnoses of acute or relapsing malaria are based on identification of malarial parasites in blood smears.

15.3 Characteristics of Myalgic Encephalomyelitis/Chronic Fatigue Syndrome

Myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS) is an illness characterized by extreme fatigue that lasts for at least six months and that can't be fully explained by an underlying medical condition. Symptoms of chronic fatigue syndrome can vary from person to person, and the severity of symptoms can fluctuate from day to day. Diagnosing the disease remains a challenge. It is common for people who have chronic fatigue syndrome to also have other health problems at the same time, such as sleep disorders, irritable bowel syndrome, fibromyalgia, depression or anxiety. The 2015 Institute of Medicine (IOM) criteria provide guidance on the diagnostic criteria.

CHAPTER 16 ENDOCRINE CONDITIONS

16.1 General

This chapter supplements the DBQ(s) for the conditions and C&P Examination Training modules VA 15852 DMA Diabetes Mellitus Examination and VA 15956 DMA Neurology Including Peripheral Nerves Examination.

16.2 Diabetes Examination

10-gram (Semmes-Weinstein) monofilament; 128-Hz tuning fork

16.3 Diagnosis of Diabetes Mellitus?

For VA purposes, the diagnosis of adult onset diabetes (DMII) is satisfied if:

a. Fasting plasma glucose test (FPG) of _>126 MG/DL on 2 or more occasions
b. A1C of 6.5% of greater on 2 or more occasions
c. 2-HR plasma glucose of _> 200 MG/DL on glucose tolerance test
d. Random plasma glucose of _> 200 MG/DL with classic symptoms of hyperglycemia

16.4 Latent Autoimmune Diabetes in Adults (LADA)

These adults do not require insulin at diagnosis but progress rapidly to insulin dependence after several months to years. LADA can be distinguished from type 2 diabetes by the presence of pancreatic autoantibodies, such as glutamic acid decarboxylase antibodies. These individuals are likely to respond poorly to oral hypoglycemic drug therapy, and the use of sulfonylureas as initial therapy may cause earlier insulin dependence. The presence and titers of anti-GAD antibodies (or ICA) can help to identify patients initially thought to have type 2 diabetes.

CHAPTER 17 NEOPLASMS

17.1 General

This chapter supplements the oncology DBQ(s).

17.2 Malignancy Confirmation

a. There are certain conditions, such as cancer, which require evidence of a diagnosis. The diagnosis must be supported by primary source tissue biopsy which should be classified as to pathologic type. Veterans' reporting a "history of" or medical records which simply echo a reported history should be assigned limited, if any probative

value given the perceived commonality of many of the hematological and solid malignancies (leukemias vs.
lymphomas, myeloma vs melanoma, etc.).

b. Common oncological definitions:

- **Benign** – not malignant, noncancerous
- **Malignant** - cancerous
- **Neoplasm** - a new and abnormal growth of tissue in some part of the body which may be benign or malignant.
- **Watchful waiting** - Closely observing a condition but not giving or having provided treatment. Used in conditions that progress slowly or when the risks of treatment are greater than the possible benefits. DBQs which ask, "Treatment completed; currently in watchful waiting status" should be interpreted as meaning- treatment completed and in remission as stated in updated DBQs.
- **Remission** - A decrease in or disappearance of signs and symptoms of cancer for at least one month. In partial remission, some, but not all, signs and symptoms of cancer have disappeared. In complete remission, all signs and symptoms of cancer have disappeared.
- **Cure** - Complete remission for 5 years or more for many types of cancers but not all. Malignancies often don't present for years or decades after service and without an apparent "illness or injury" during service being evident. Post-service occupational, environmental and recreational exposure to radiation or toxic agents (benzene, asbestos, second-hand-smoke, etc.); history of prior malignancy and method of treatment (chemotherapy, XRT, etc.); social, familial, and past medical history are required in determining potential causation(s) leading up to cancer diagnosis unless a presumptive condition (see following Chapters).

CHAPTER 18 RADIATION EXPOSURE

18.1 General

There are no unique requirements for a disability examination for radiation-related conditions because a disease process resulting from radiation exposure is indistinguishable from the same disease process arising from another etiology. However, a careful history which includes family, occupational, social history, and information about other possible risk factors for the condition being examined is particularly important. Depending on the body system involved, the appropriate DBQ(s) for the condition(s) should be followed.

There are two different complex regulations that govern the adjudication of radiation-related disabilities. The regulation which applies depends on the particular circumstances of the Veteran during service and the condition claimed. The type of

examination to be conducted does not differ depending under which regulation the conditions falls. The lists of conditions are subject to change with new regulations.

a. Regulation One

38 CFR 3.309 (d) for presumptive service connection for radiation-related conditions.

1. This regulation provides a list of malignancies that shall be service-connected if they develop in a radiation-exposed Veteran (as defined in this regulation).
2. A radiation-exposed Veteran means a Veteran who participated in a radiation risk activity, which is defined as onsite participation in a test involving the detonation of a nuclear device, the occupation of Hiroshima or Nagasaki during the period August 6, 1945 to July 1, 1946, or internment as a POW in Japan during WWII or active duty in Japan immediately following such internment.
3. These conditions will be service-connected if an intercurrent cause is not established.
4. No radiation dosage estimate is required.
5. Conditions that fall under this regulation are:
   - Leukemia, (other than chronic lymphocytic leukemia)
   - Cancers of the thyroid; breast; pharynx; esophagus; stomach; small intestine; pancreas; bile ducts; gall bladder; salivary gland; urinary tract,
   - Multiple myeloma,
   - Lymphomas (except Hodgkin's disease),
   - Primary liver cancer (except if cirrhosis or hepatitis B is indicated) Bronchioalveolar carcinoma.

b. Regulation Two

38 CFR 3.311 for other claims based on exposure to radiation.

1. This regulation allows service connection for a different list of conditions and for any condition claimed to be due to any type of in-service radiation exposure, if the requirements of the regulation are met. Any other potential in-service exposure that is not named under the first regulation, falls under this regulation. For example, Veterans who had nasopharyngeal radium irradiation therapy (NRI) are adjudicated under this regulation, as are Veterans who were exposed to ionizing radiation during the performance of their normal military duties as radiologists, x-ray technicians, etc.
2. There must be competent scientific or medical evidence that the claimed condition is a radiogenic disease, if the condition is not on the list.
3. There must be a radiation dose estimate, an advisory opinion from the Under Secretary for Health about the relationship of the claimed condition to radiation exposure in view of the reported radiation dose, and a determination by the Under Secretary for Benefits as to whether it is at least as likely as not that the Veteran's claimed condition resulted from exposure to radiation in service.
4. There are also time limitations for certain conditions under this regulation: bone cancer must become manifest within 30 years after exposure, leukemia may become manifest at any time after exposure, posterior subcapsular cataracts must

become manifest 6 months or more after exposure, and all other specified diseases must become manifest 5 years or more after exposure.

5. Conditions that fall under this regulation are:
   - All forms of leukemia except chronic lymphatic (lymphocytic) leukemia Thyroid cancer
   - Breast cancer
   - Lung cancer
   - Bone cancer
   - Liver cancer
   - Skin cancer
   - Esophageal cancer
   - Stomach cancer
   - Colon cancer
   - Pancreatic cancer
   - Kidney cancer
   - Urinary bladder cancer
   - Salivary gland cancer
   - Multiple myeloma
   - Posterior subcapsular cataracts
   - Non-malignant thyroid nodular disease
   - Ovarian cancer
   - Parathyroid adenoma
   - Tumors of the brain and central nervous system
   - Cancer of the rectum
   - Lymphomas other than Hodgkin's disease
   - Prostate cancer
   - Any other cancer

CHAPTER 19 FORMER PRISONERS OF WAR (FPOWs) AND COLD INJURY

19.1 General

This chapter supplements the DBQ(s) and C&P Examination Training modules VA 6554 DMA Former Prisoner of War (FPOW) Examination and VA 6527 DMA Cold Injury Residuals Examination

19.2 Unique Problems in Former POWs

There is a need for examiners to have compassion for former POWs and sensitivity to the POW experience from World War I, World War II, the Korean Conflict, and Vietnam Era. Studies in this country and abroad have shown that the physical deprivation and psychological stress endured as a captive have lifelong effects on subsequent health, as well as on social and vocational adjustment. Former POWs have a significantly higher incidence for illnesses in many body systems, longer hospital stays and vulnerability to psychological stress are also markedly increased.

19.3 FPOW Concerns

Clinicians should thoroughly review all POW experiences with the Veteran, including all claimed and potential injuries and diseases which may be associated with confinement, deprivation, malnutrition, avitaminosis, cold or wet exposure, and physical and mental abuse. Include a review of VA Form 10-0048, Former POW Medical History, which the Veteran should have completed, prior to conducting the examination.

19.4 FPOW Presumptives

These conditions will be service-connected even though there is no record of them during service because they are presumed to be related to the POW experience (unless there is an intervening cause for the condition or other reason to rebut the presumption).

- Avitaminosis
- Beriberi (including beriberi heart disease, which includes ischemic heart disease in a former prisoner of war who had experienced localized edema during captivity)
- Chronic dysentery
- Helminthiasis
- Malnutrition (including optic atrophy associated with malnutrition)
- Pellagra
- Any other nutritional deficiency
- Psychosis
- Any of the anxiety states
- Dysthymic disorder (or depressive neurosis)
- Organic residuals of frostbite, if it is determined that the Veteran was interned in climatic conditions consistent with the occurrence of frostbite
- Post-traumatic osteoarthritis
- Irritable bowel syndrome
- Peptic ulcer disease
- Peripheral neuropathy except where directly related to infectious causes

19.5 FPOW Examination

As per VHA Directive 2011-018 each VA Medical Center must have a Care and Benefits Team (CBT) to evaluate and treat Former POWs. Each CBT must be comprised of two

clinicians, one providing treatment and one certified to conduct C&P evaluations and be an FPOW advocate. Each CBT member must complete the appropriate FPOW training coursework. Once only a mandatory face-to-face course, it is now available online through TMS.

VA has developed a special FPOW Medical History Questionnaire and a Physical Examination Package (See DBQ Former FPOW Protocol), which is to be used by all VA health care facilities. This evaluation is conducted only once in a Veteran's life to determine the baseline medical condition of the Veteran from his/her incarceration. It is also used as a comprehensive examination for disability compensation purposes.

a. The former POW fills out the first portion of the history and then presents it to the examining physician, who checks its contents for completeness and any required clarification.
b. The examining physician completes the second part of the history, the physical and the summary forms.
c. A copy of the entire packet is sent to Washington, D.C. for future reference.

References: VHA Directive 2011-018, Certification of Special Care and Benefits Teams (CBTs) Evaluating or Treating Former Prisoners of War (FPOW), March 31, 2011
DMA Fact Sheet 12-001, Certification of Special Care and Benefits Teams (CBTs) Evaluating or Treating Former Prisoners of War (FPOW), January 12, 2012

19.6 Residuals of Cold Injury

Follow the DBQ COLD INJURY Residuals for a detailed examination protocol. Additional detailed clinical information about the late effects of cold injury is available on the VA Public Health cold injury website at https://www.publichealth.va.gov/exposures/cold-injuries/index.asp

For more information on FPOW Social Surveys, see VBA Procedure Manual M21-1, Part III, Subpart iv, Chapter 3, section A (http://www.knowva.ebenefits.va.gov).

CHAPTER 20 GULF WAR

20.1 General

This chapter supplements the Gulf War DBQ and C&P Examination Training module VA 24549 DMA Gulf War General Medical Examination

20.2 Gulf War Exposures

According to the Department of Defense (DoD) the approximately 690,000 American servicemen and women who served in the Gulf War may have been exposed to many hazards such as:

- oil and other petrochemical agents
- smoke from the sabotage of Kuwaiti oil wells by retreating Iraqi forces
- Leishmaniasis (Sand flies)
- pyridostigmine bromide, malaria prophylaxis, and other prophylactic drug treatments
- depleted Uranium (DU)
- inoculations (Anthrax, botulism, etc.)
- pesticides
- diesel and jet fuels and other petrochemicals and solvents
- Chemical Agent Resistant Compound (CARC) paint
- chemical and/or biological warfare agents
- contaminated food and water obtained in the Persian Gulf
- air pollutants (carbon monoxide, sulfur oxide, hydrocarbons, particulate matter, and nitrogen oxide)
- psychological stressors

20.3 The Southwest Asia Theater of Operations

Defined in 38 CFR 3.317(e)(2), includes the following locations and the airspace above them: Iraq, Kuwait, Saudi Arabia., the neutral zone between Iraq and Saudi Arabia, United Arab Emirates, Bahrain, Qatar, Oman, the Gulf of Aden, the Gulf of Oman, the Persian Gulf, the Arabian Sea, and the Red Sea.

20.4 Unique Aspects

What is unique about Gulf War Veterans is that some will need a comprehensive examination that will allow the examiner to distinguish between a clearly diagnosable condition (like asthma) and an "undiagnosed illness" (like a chronic cough that cannot be attributed to a specific diagnosis). An undiagnosed illness is established when findings are present that cannot be attributed to a known, clearly defined etiology, after all likely diagnostic possibilities for such abnormalities have been ruled out. Examples of medically unexplained chronic multi-symptom illnesses include, but are not limited to:

- chronic fatigue syndrome,
- fibromyalgia, and
- irritable bowel syndrome.

Examiners should follow the worksheet titled DBQ Gulf War General Medical which provides detailed guidance.

20.5 Manifestations of Undiagnosed Illnesses in Gulf War Veterans

a. Undiagnosed illnesses

An illness to which the examiner is unable to provide a diagnosis or label. Most commonly it is a symptom that is clearly present but has no clear pathology that would allow the examiner to give it a diagnosis. For example, joint pain with no history of trauma and normal x-rays and normal labs would be reasonable to call joint pain of unknown diagnosis. On the other hand, if an x-ray showed arthritis, this would be diagnosed as arthritis. The ability, or not, to identify an etiology is not by itself a factor of undiagnosed illness. Exemplary of this would be the diagnosis of malignancies. For most cancers, there is no known etiology, but it clearly can be diagnosed and thus not an undiagnosed illness. Common complaints include:

- fatigue
- signs or symptoms involving the skin
- headache
- muscle pain
- joint pain
- neurologic signs and symptoms
- neuropsychological signs and symptoms
- signs or symptoms involving the respiratory system (upper or lower)
- sleep disturbances
- gastrointestinal signs or symptoms
- cardiovascular signs or symptoms
- abnormal weight loss
- menstrual disorders

b. Chronic Multi-Symptom Illnesses

A collection of multiple un-diagnosed illnesses or symptoms that happen to occur together in varying patterns. Frequently they are a diagnosis of exclusion. There is no single test that can rule this condition in or out, commonly syndromic in nature noting "if you have x out of y symptoms." Examples are fibromyalgia and chronic fatigue syndrome. Both are defined as having a constellation of symptoms or findings from an extensive list of symptoms and findings that have been noted to occur together. No single symptom, finding or diagnostic study can be clearly used singly to say the condition exists or doesn't. In fact, as with irritable bowel syndrome, these are a group of un-diagnosed illnesses or symptoms that happen to occur together, and each symptom has no clear diagnosis to which it can be attributed.

CHAPTER 21 HERBICIDE EXPOSURE

21.1 General

From 1962 to 1971, the military sprayed millions of gallons of herbicides in Vietnam and neighboring countries to destroy crops, protective cover and to clear perimeters around US positions. Agent Orange was a commonly used type of herbicide. Toxic chemicals

in the herbicides included 2, 4-D; 2, 4, 5-T and its contaminant TCDD; cacodylic acid; and picloram. In 1969, a scientific study concluded that 2, 4-5T caused birth defects in animals. Later studies indicated dangers from exposure to dioxins, such as TCDD, found in the herbicides.

21.2. Veterans Presumed to Have Been Exposed

a. Affected Veterans

For the purposes of VA compensation benefits, Veterans who served anywhere in Vietnam between January 9, 1962 and May 7, 1975 are presumed to have been exposed to herbicides, as specified in the Agent Orange Act of 1991 These Veterans do not need to show that they were exposed to Agent Orange or other herbicides in order to get disability compensation for diseases related to Agent Orange exposure. Service in Vietnam means service on land in Vietnam or on the inland waterways of Vietnam. This includes Veterans who set foot in Vietnam or served on a ship while it operated on the inland waterways of Vietnam ("brown water"). This includes brief visits ashore, such as when a ship docked to the shore of Vietnam or when a ship operated in Vietnam's close coastal waters for extended periods and crew members went ashore, or smaller vessels from the ship went ashore with supplies or personnel. The Veteran further must provide a statement of personally going ashore. Blue Water Veterans are not presumed to have been exposed to Agent Orange or other herbicides unless they set foot in Vietnam or served aboard ships that operated on the inland waterways of Vietnam anytime between January 9, 1962 and May 7, 1975. VA has acknowledged exposure to herbicide agents for personnel whose military service involved regular contact with contaminated C-123 aircraft. This includes individuals who performed service in the Air Force or Air Force Reserve who regularly operated, maintained, or served onboard C-123 aircraft known to have been used to spray herbicides during the Vietnam era.

Veterans who served in a unit in or near the Korean demilitarized zone (DMZ) anytime between April 1, 1968, and August 31, 1971, and who have a disease VA recognizes as associated with herbicide agent exposure are presumed to have been exposed. Vietnam-era Veterans whose service involved duty on or near the perimeters of military bases in Thailand anytime between February 28, 1961, and May 7, 1975, may have been exposed to herbicides and may qualify for VA benefits.
Agent Orange and other herbicides used in Vietnam were tested or stored elsewhere, including some military bases in the United States. The Department of Defense gave VA a list of dates and locations of herbicide test and storage locations. This list can be found at:
https://www.publichealth.va.gov/docs/agentorange/dod_herbicides_outside_vietnam.pdf

b. Presumptive Service Connection

Disease will be service-connected even though there is no record of such disease during service, if a Veteran had the requisite service in Vietnam and there is not an intervening cause for the condition or other reason to rebut the presumption.

c. Presumptive Diseases for Service Connection and Examination Needed

These are the diseases that have been recognized by VA as associated with herbicide exposure as of March 2001. The examination to be conducted will depend on the conditions(s) claimed by the Veteran, as indicated by the regional office examination request. The examiner should base the examination on the appropriate DBQ worksheet(s).

1) chloracne, or other acneiform disease consistent with chloracne
2) Hodgkin's disease
3) multiple myeloma
4) non-Hodgkin's lymphoma
5) acute and subacute peripheral neuropathy (transient peripheral neuropathy that appears within weeks or months of exposure to an herbicide agent and resolves within two years of the date of onset)
6) porphyria cutanea tarda
7) diabetes
8) prostate cancer
9) respiratory cancers (cancers of the lung, bronchus, larynx, or trachea)
10) soft-tissue sarcoma (adult fibrosarcoma, dermatofibrosarcoma protuberans, malignant fibrous histiocytoma, liposarcoma; leiomyosarcoma, epithelioid leiomyosarcoma, malignant leiomyoblastoma, rhabdomyosarcoma, ectomesenchymoma, angiosarcoma, hemangiosarcoma, lymphangiosarcoma, proliferating (systemic) angioendotheliomatosis, malignant glomus tumor, malignant hemangiopericytoma, synovial sarcoma (malignant synovioma), malignant giant cell tumor of tendon sheath, malignant schwannoma, malignant schwannoma with rhabdomyoblastic differentiation (malignant Triton tumor), glandular and epithelioid malignant schwannomas, malignant mesenchymoma, malignant granular cell tumor, alveolar soft part sarcoma, epithelioid sarcoma, clear cell sarcoma of tendons and aponeuroses, extra skeletal Ewing's sarcoma, congenital and infantile fibrosarcoma, and malignant ganglioneuroma.
11) Chronic B-cell leukemia
12) Ischemic Heart Disease
13) Parkinson's disease

If a Veteran does not have one of the diseases listed in 20.2d, service connection may, however, be established on a direct, rather than a presumptive basis if the Veteran is found on a factual basis to have had contact with herbicides during military service (for example, in their transport or manufacture), or there is medical (nexus statement), or

scientific evidence provided supporting an etiological relationship between the claimed condition and herbicide exposure.

CHAPTER 22 CAMP LEJEUNE CONTAMINATED WATER

22.1 General

This chapter supplements the CLCW Admin DBQ.

22.2 Veterans Presumed to Have Been Exposed

a. From the 1950s through the 1980s, people living or working at the U.S. Marine Corps Base Camp Lejeune, North Carolina, were potentially exposed to drinking water contaminated with industrial solvents, benzene, and other chemicals. With an effective date of March 14, 2017, VA established a presumptive service connection for Veterans, Reservists, and National Guard members exposed to contaminants in the water supply at Camp Lejeune from August 1, 1953, through December 31, 1987, who later developed one of the following eight diseases:

- Adult leukemia (All types)
- Aplastic anemia and other myelodysplastic syndromes
- Bladder cancer
- Kidney cancer
- Liver cancer
- Multiple myeloma
- Non-Hodgkin's lymphoma
- Parkinson's disease

b. VBA has mandated that claims for presumptive conditions filed prior to March 14, 2017, require a medical opinion regarding the causality of the claimant's disease with respect to Camp Lejeune Contaminated Water exposure, which are to be completed by appropriately designated and trained C&P clinicians.

c. Examination for residuals are appropriate for completion by generalists or other appropriate specialties within C&P following the same guidance as has been used for herbicide exposure claims**.**

d. If a Veteran does not have one of the diseases listed in 22a. service connection may, however, be established on a direct, rather than a presumptive basis if the Veteran is found on a factual basis to have had contact with CLCW during military service, or there is medical (nexus statement), or scientific evidence supporting an etiological relationship between the claimed condition and exposure at Camp Lejeune.

e. Medical opinion regarding the causality of the claimant's disease with respect to Camp Lejeune Contaminated Water exposure are to be completed by appropriately designated and trained C&P clinicians.

22.3 Camp Lejeune Care Act 2012

a. In accordance with the 2012 Camp Lejeune health care law, VA provides cost-free health care for certain conditions to Veterans who served at least 30 days of active duty at Camp Lejeune from January 1, 1957 and December 31, 1987. This benefit is provided regardless of service connection and includes both presumptive conditions (22a) and the non-presumptive conditions identified below. The IOM has provided clinical guidance for VHA clinicians to aid in the evaluation of Veterans seeking health care.

Qualifying non-presumptive health conditions:

- Esophageal cancer
- Breast cancer
- Renal toxicity
- Female infertility
- Scleroderma
- Lung cancer
- Hepatic steatosis
- Miscarriage
- Neurobehavioral effects

b. Family members of Veterans who also resided at Camp Lejeune during the qualifying period are eligible for reimbursement of out-of-pocket medical expenses incurred for any of the following 15 conditions:

- Esophageal cancer
- Breast cancer
- Kidney cancer
- Multiple myeloma
- Renal toxicity
- Female infertility
- Scleroderma
- Non-Hodgkin's lymphoma
- Lung cancer
- Bladder cancer
- Leukemia
- Meylodysplastic syndromes
- Hepatic steatosis
- Miscarriage
- Neurobehavioral effects

23. ADDITIONAL INFORMATION

Medical and legal information undergoes regular revision and modification. For additional or updated information, please refer to DMA Fact Sheets, FAQ documents, the DMA C&P Disability Examinations Procedural Manual and other documents found on the DMA website http://vaww.demo.va.gov/.