Slide 1 - Gulf War General Medical Examination Course



Lesson Time: 1.5 hours

Core Content: Course

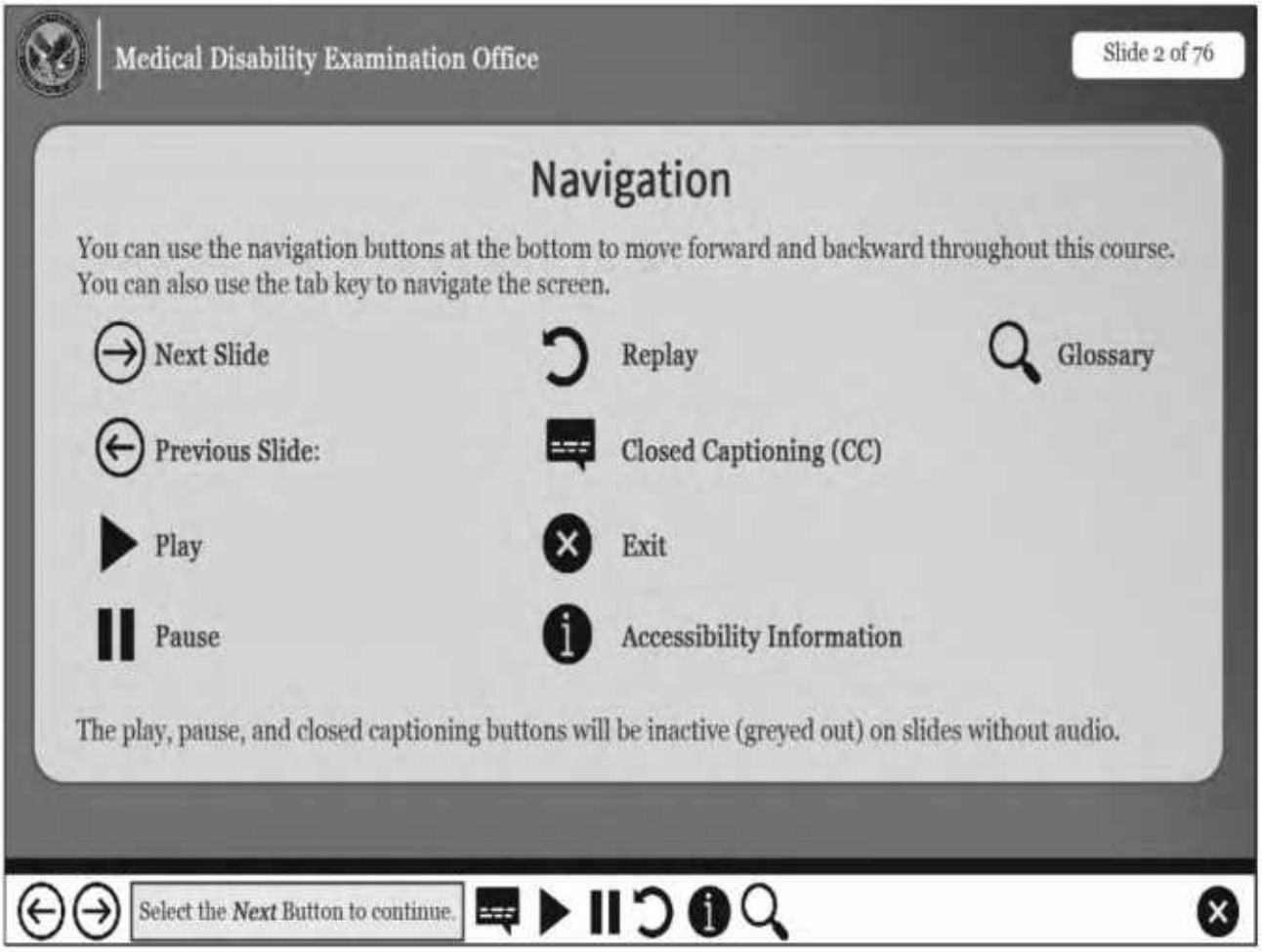
Final Assessment: Yes 80%

Module Objective: After completion of this course, examiners will be able to conduct and accurately complete the Gulf War General Medical Examination.

Lesson Objectives:

1) Understand the history and scope of the Gulf War General Medical Examination, to include recognizing when PACT Act and TERA medical opinion procedures are required.
2) Conduct, and accurately document exam findings on Gulf War claim related examinations.
3) Define the four Gulf War disability patterns, apply the correct opinion type to each Gulf War claim based on the disability pattern chosen, and accurately complete the medical opinion DBQ.

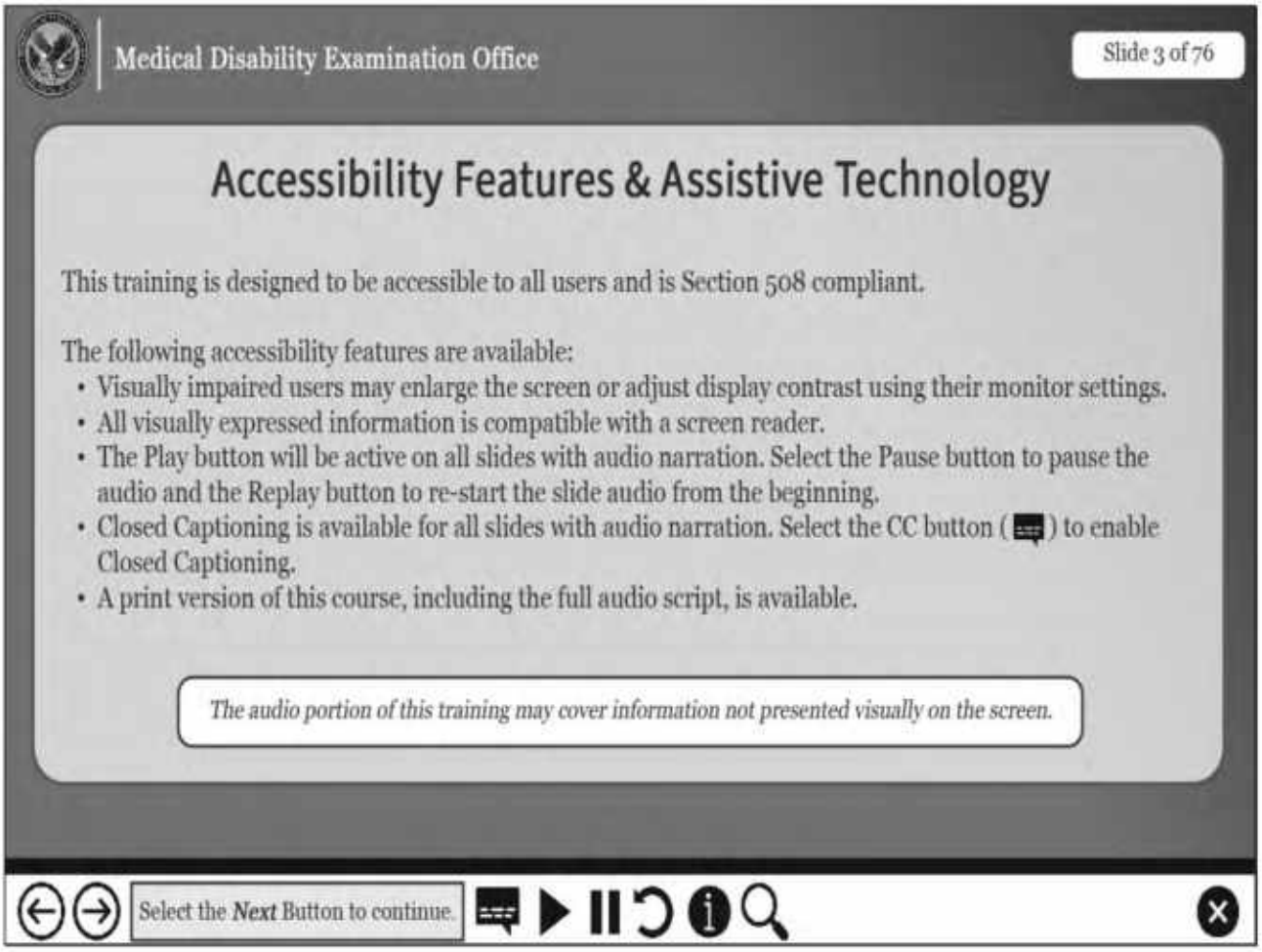
Slide 2 - Navigation



Transcript

Take a moment to review the navigation options for this course. Closed captioned text is available by selecting the closed captioning button located in the bottom middle of the screen. The audio may be paused or replayed at any time.

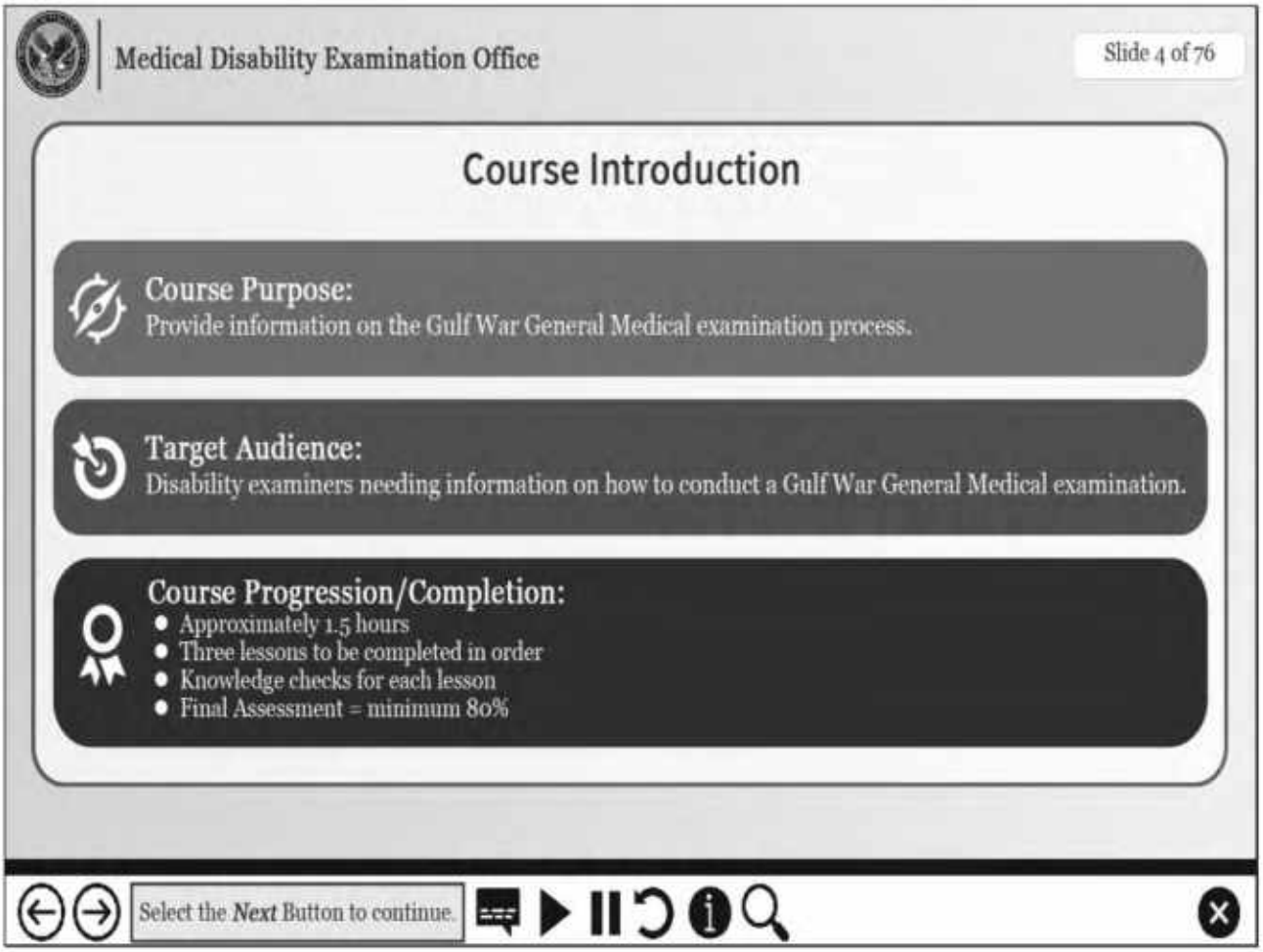
Slide 3 - Accessibility Features & Assistive Technology



Transcript

This presentation is designed to meet specific needs. The screen can be enlarged, and all materials support the use of a screen reader. Closed captioning is available for all audio. The audio in the training may cover information that is not presented visually on the screen. A print version of this training is available, including the full audio script. Please select the next button on the bottom left of each screen to progress through the presentation or use the tab key to navigate the screen.

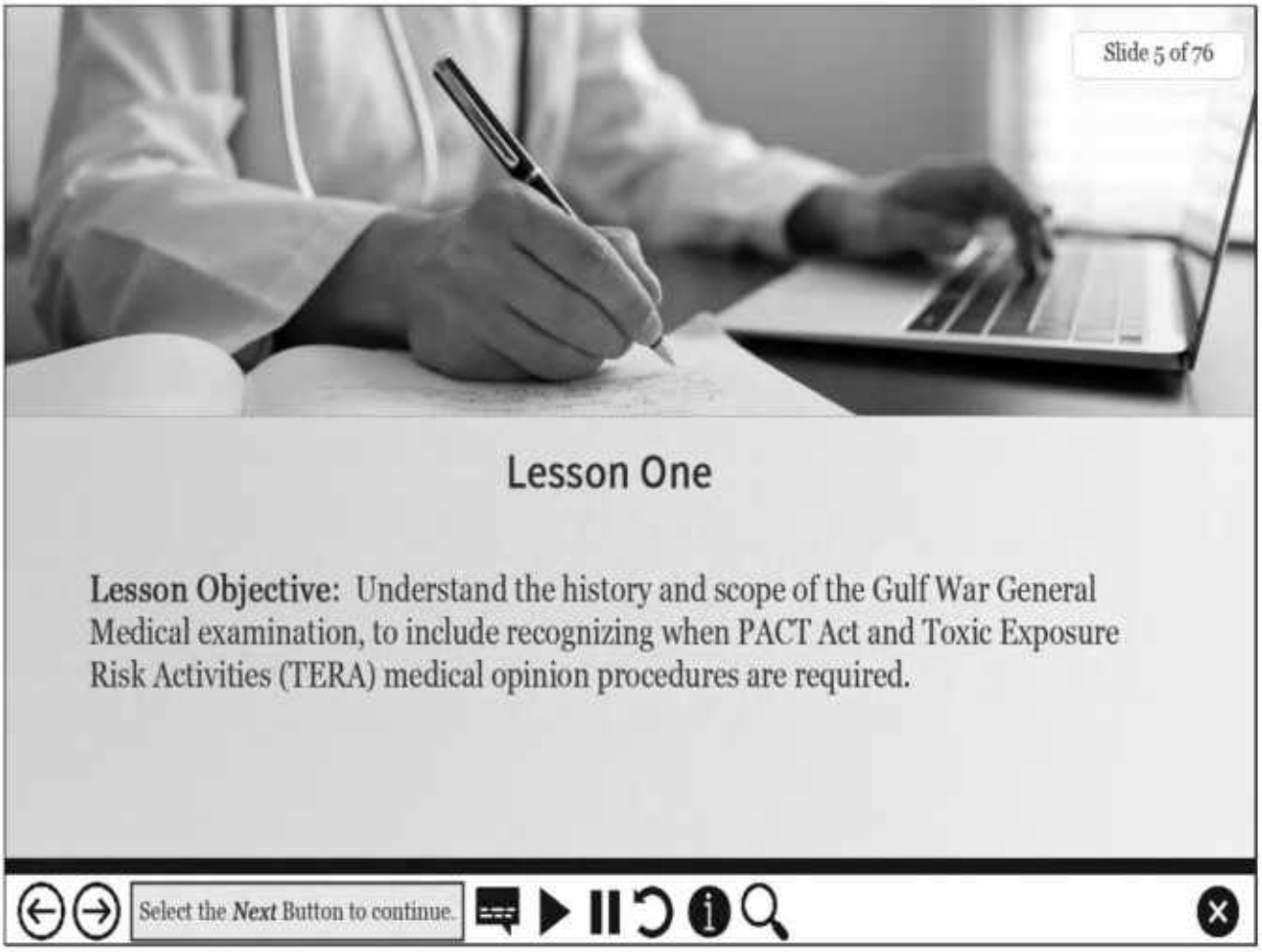
Slide 4 - Course Introduction



Transcript

The purpose of this course is to help you understand the Gulf War General Medical examination process. This course is required for all new examiners as part of the general certification. This course will take approximately an hour and a half to complete. This course is comprised of three lessons. Please view the lessons in the order presented so you can build on knowledge gained from one lesson to the next. You must view every page and achieve a score of at least 80 percent on the end-of-lesson assessment for course completion.

Slide 5 - Lesson One Objective



Transcript

Lesson One will enable you to understand the history and scope of the Gulf War General Medical examination, to include recognizing when PACT Act and TERA medical opinion procedures are required. The PACT Act also known as The Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics Act is a new law enacted in 2022 to address Toxic Exposure Risk Activities that Veterans may have been exposed to during their service.

Please select the next button to begin.

Slide 6 - History of the Gulf War General Medical Examination

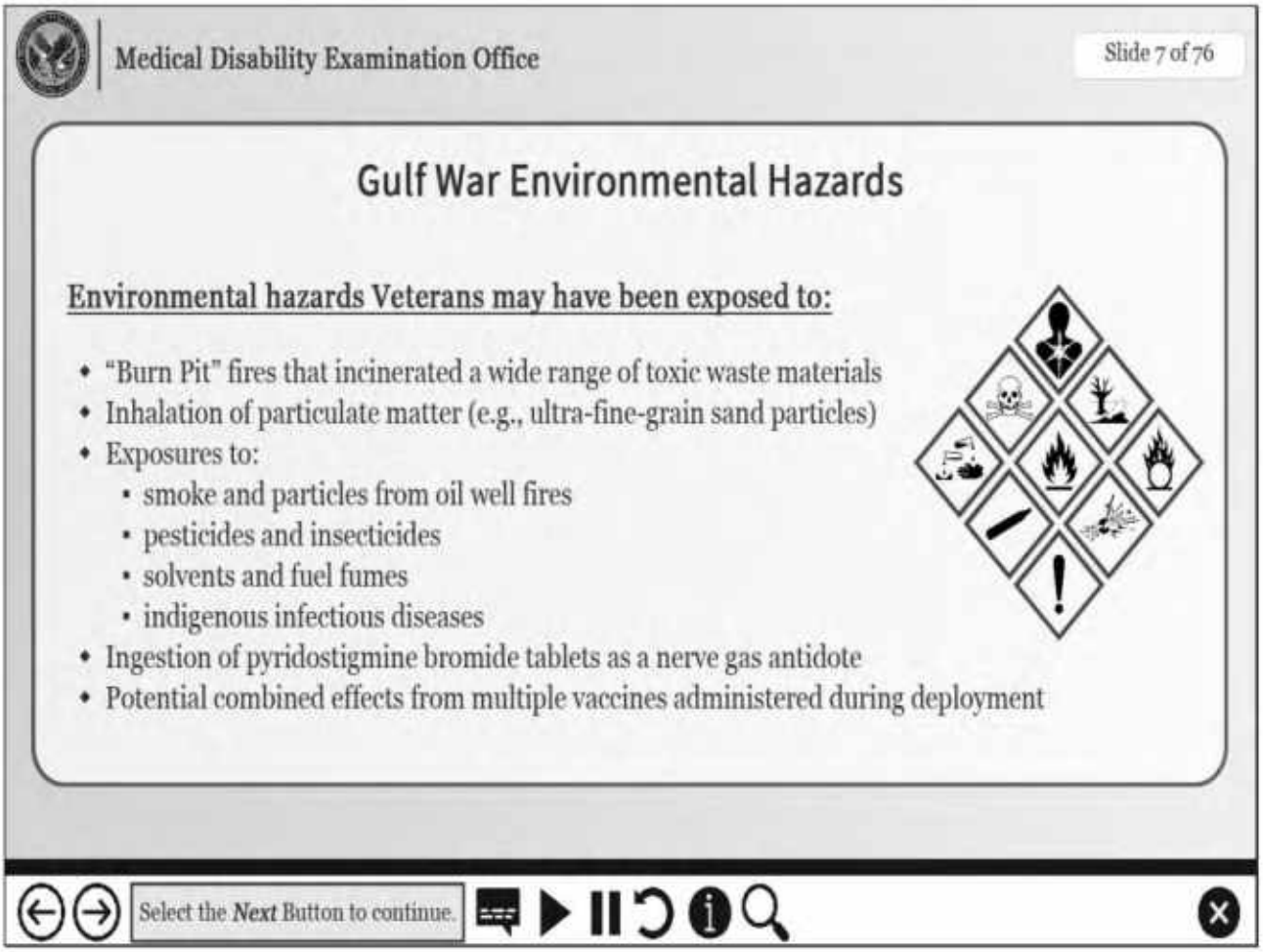


Transcript

In this lesson, we will begin by providing a brief history of the Gulf War and the medical impact it had on returning Service members, which prompted the development of the Gulf War General Medical examination. The Gulf War (also known as Desert Shield/Desert Storm), first began on August 2, 1990, in response to Iraq's invasion of Kuwait. Although the first Gulf War officially came to an end on February 28, 1991, ongoing operations in Southwest Asia led to a military presence in areas that potentially exposed Service members to a variety of different environmental hazards. Per VA regulations, this Gulf War era continues through a date yet to be determined by Presidential proclamation or law.

Select the button **Environmental Hazards** to learn more about those exposures.

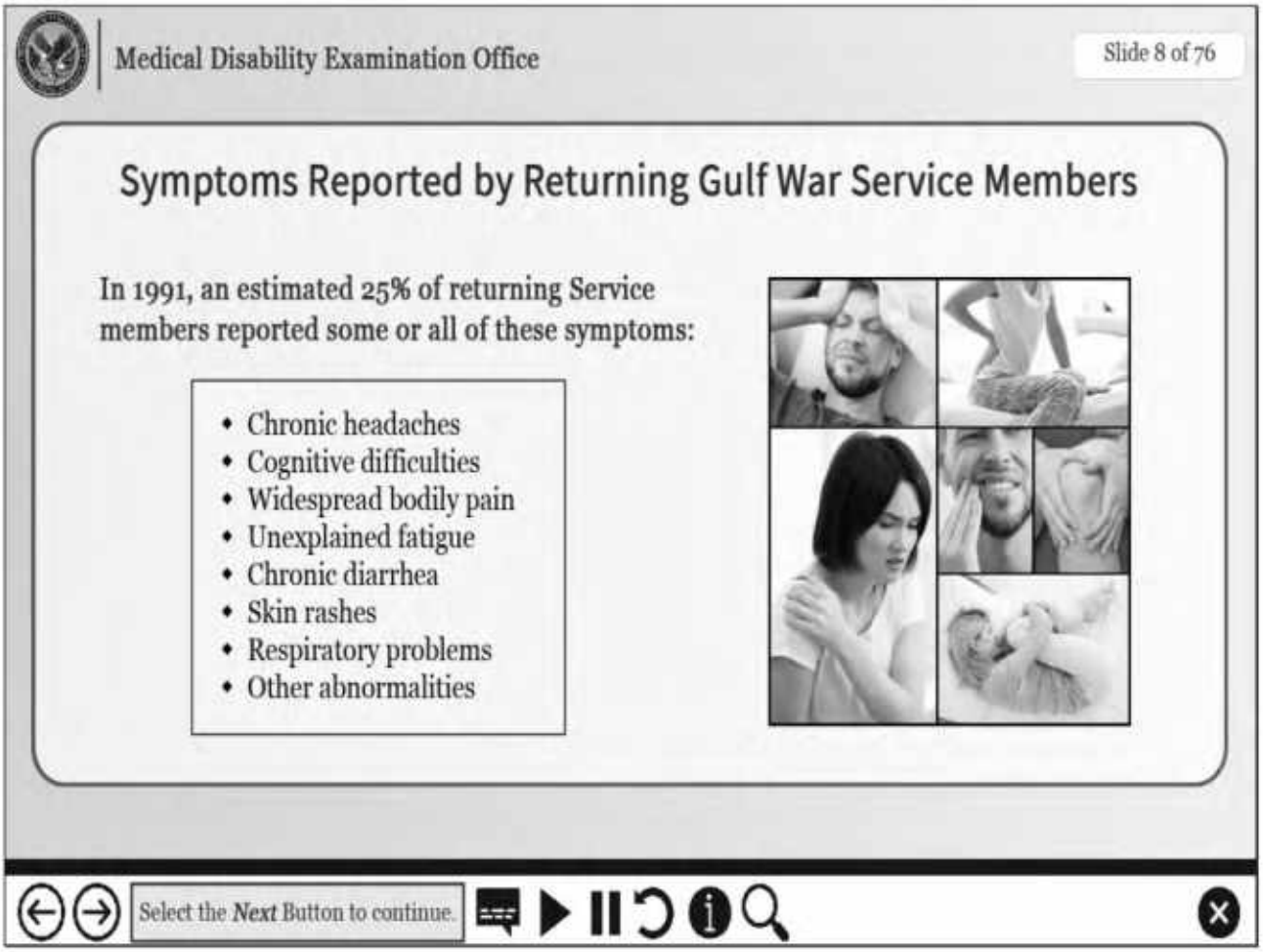
Slide 7 - Environmental Hazards



Transcript

These environmental hazards may have included, but were not limited to, the following listed on screen.

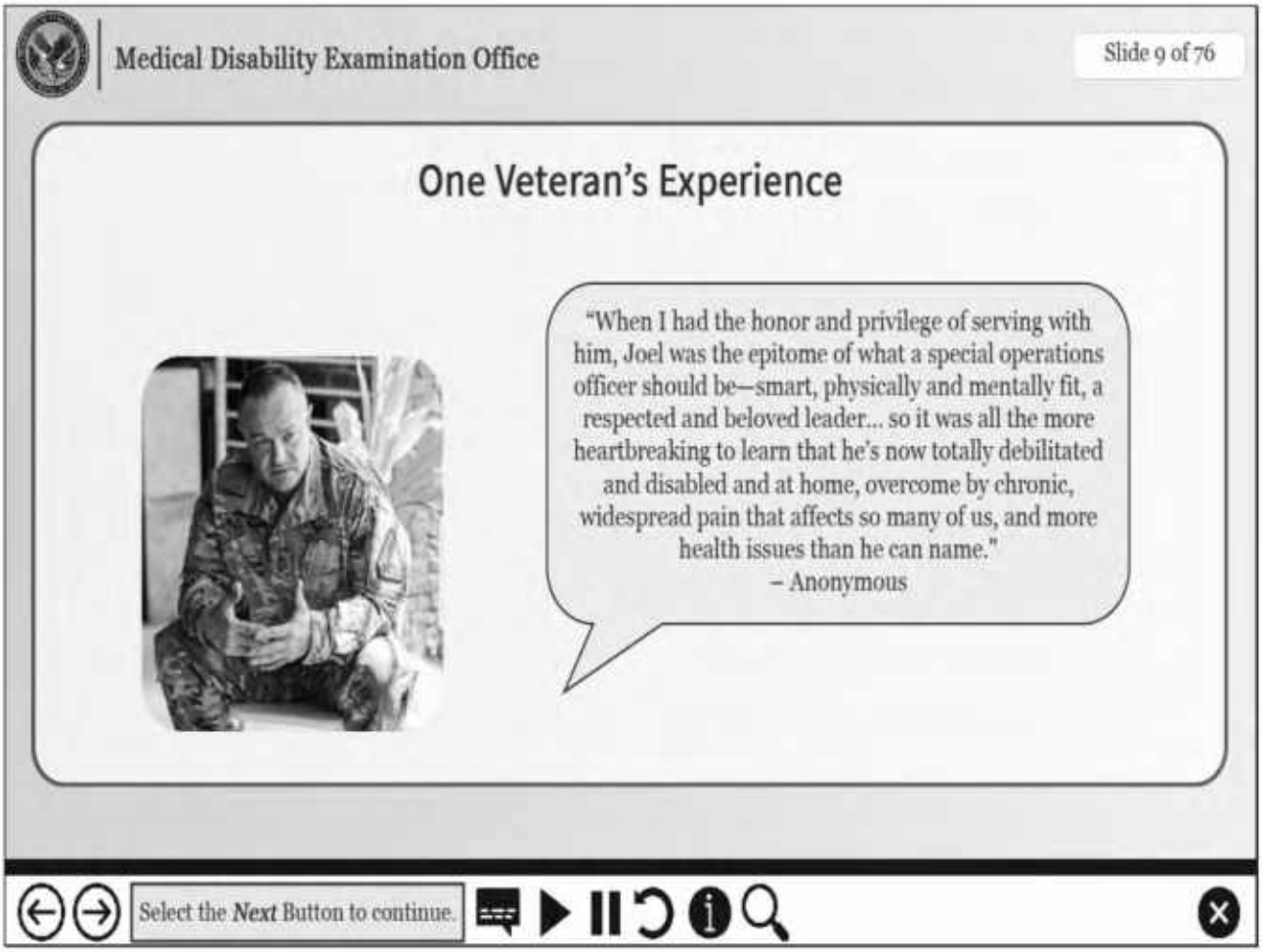
Slide 8 - Symptoms Reported by Returning Gulf War Service Members



Transcript

In 1991, an estimated 25 percent of Service members returning from the Southwest Asia theater of operations began to report patterns of chronic, debilitating medical symptoms that typically included some combination of chronic headaches, cognitive difficulties, widespread bodily pain, unexplained fatigue, chronic diarrhea, skin rashes, respiratory problems, and other abnormalities. These symptoms did not correspond easily to recognized categories of diseases and presented a problem for health care diagnoses and treatment.

Slide 9 - One Veteran's Experience



Transcript

This anonymous quote represents the health struggles that many Veterans endured when returning home from their Gulf War service.

Slide 10 - Establishment of Federal Regulations for Compensation



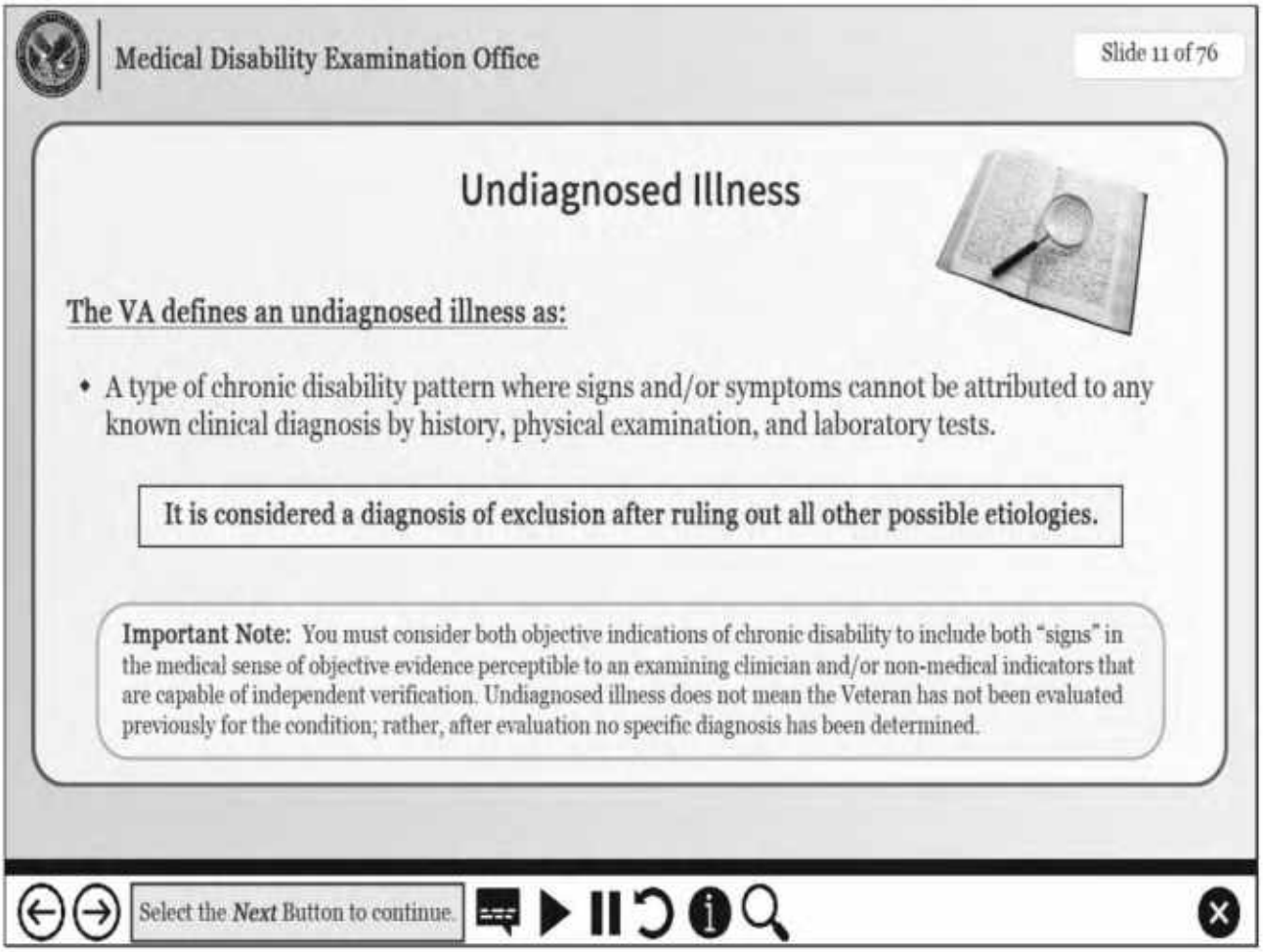
Transcript

These chronic, often debilitating medical symptoms needed to be addressed by Veterans Benefits Administration personnel attempting to adjudicate claims for disability compensation. As a result, Veteran Affairs statutes and regulations were enacted to provide service connection for certain chronic disability patterns based on exposure to environmental hazards experienced during military service in Southwest Asia. This led to the establishment of four disability patterns that would allow for classification of the claimed diagnoses or symptoms. Lesson three will provide more detail on how to report on these disability patterns.

The Code of Federal Regulations, or CFR, describes parameters for compensation evaluation and establishment related to service in the Southwest Asia theater of operations. The regulations that established compensation for these Veterans also coined the terms **undiagnosed illness** and **diagnosable but medically unexplained chronic multisymptom illness also known as MUCMI of unknown etiology** categories to place these medical symptoms for rating purposes.

Select the buttons on screen to learn more about how VA defines the undiagnosed illness and MUCMI categories.

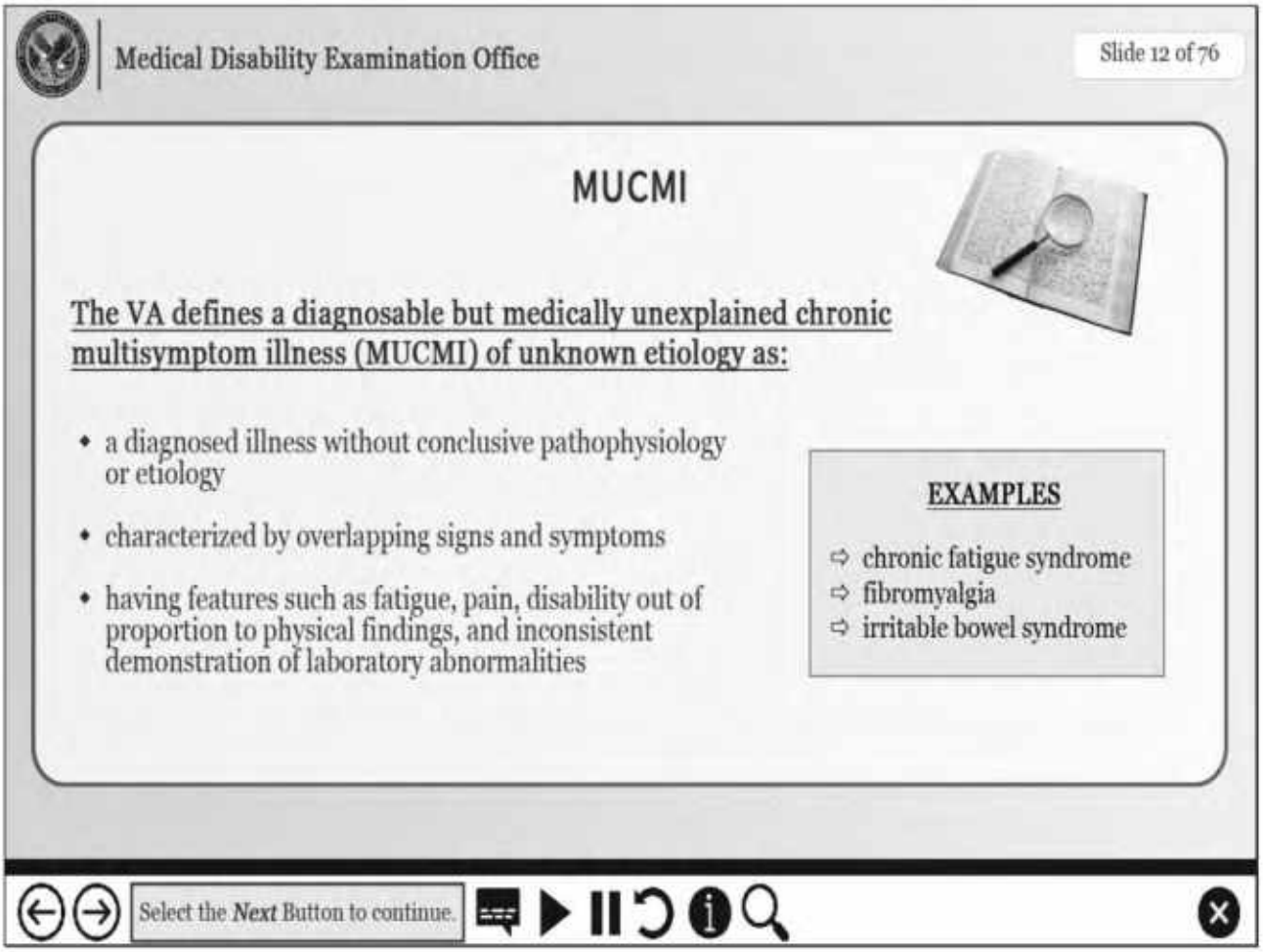
Slide 11 - Undiagnosed Illness



Transcript

The VA defines **undiagnosed illness** as a type of chronic disability where signs and/or symptoms cannot be attributed to any known clinical diagnosis by history, physical examination, and laboratory tests.

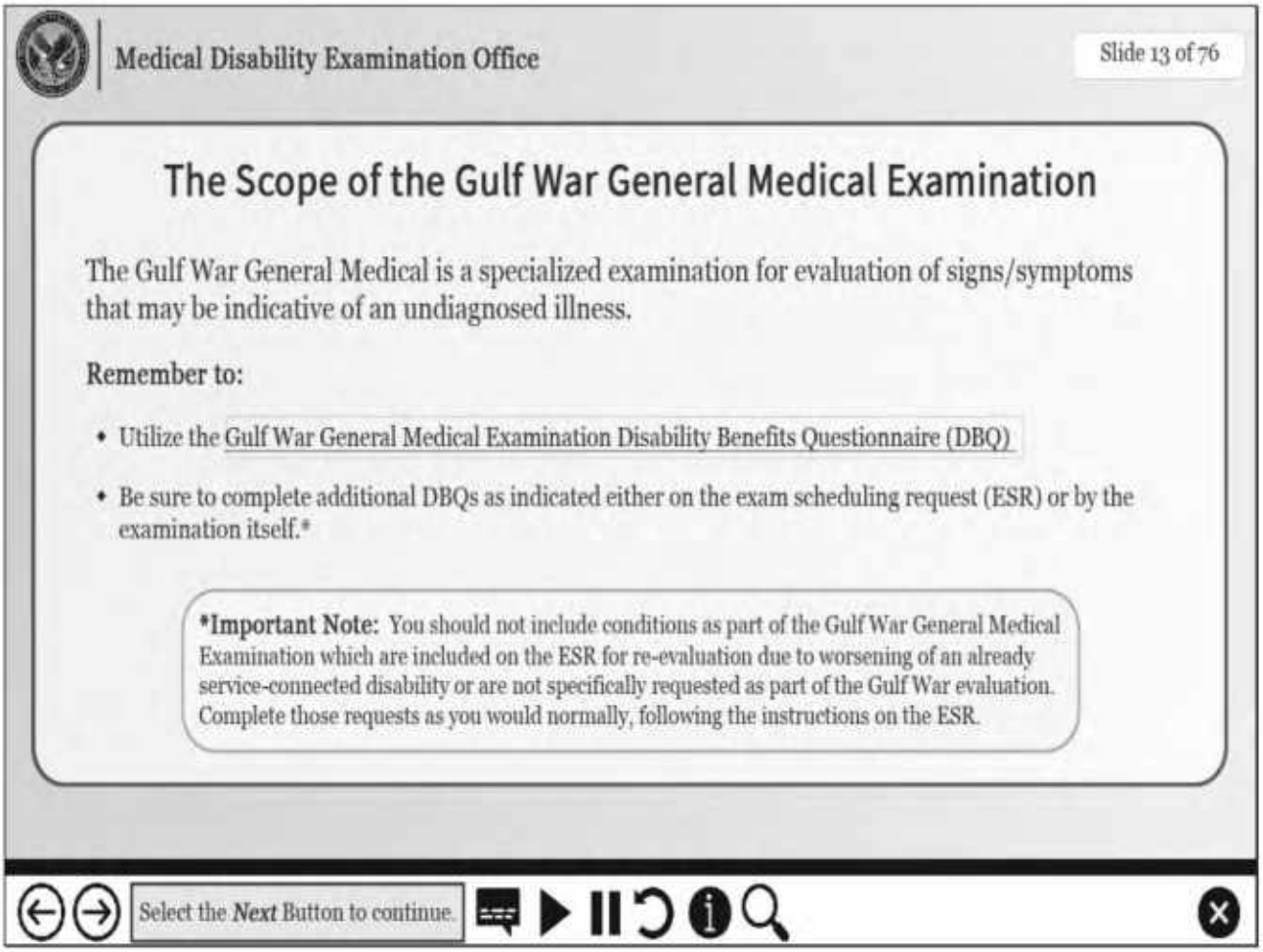
Slide 12 - MUCMI



Transcript

The VA defines a **diagnosable but medically unexplained chronic multisymptom illness or MUCMI of unknown etiology** as a diagnosed illness **without** conclusive pathophysiology **or** etiology. It is characterized by overlapping signs and symptoms and has features such as fatigue, pain, disability out of proportion to physical findings, and inconsistent demonstration of laboratory abnormalities.

Slide 13 - The Scope of the Gulf War General Medical Examination



Transcript

VBA has a duty to assist Veterans with their claims. While Veterans may not explicitly express their claims are due to Gulf War service, VBA will still consider claims are for service connection based on the Veterans' service in the Southwest Asia theater of operations, if applicable, and may request Gulf War General Medical examinations, even if Veterans have previously had one completed.

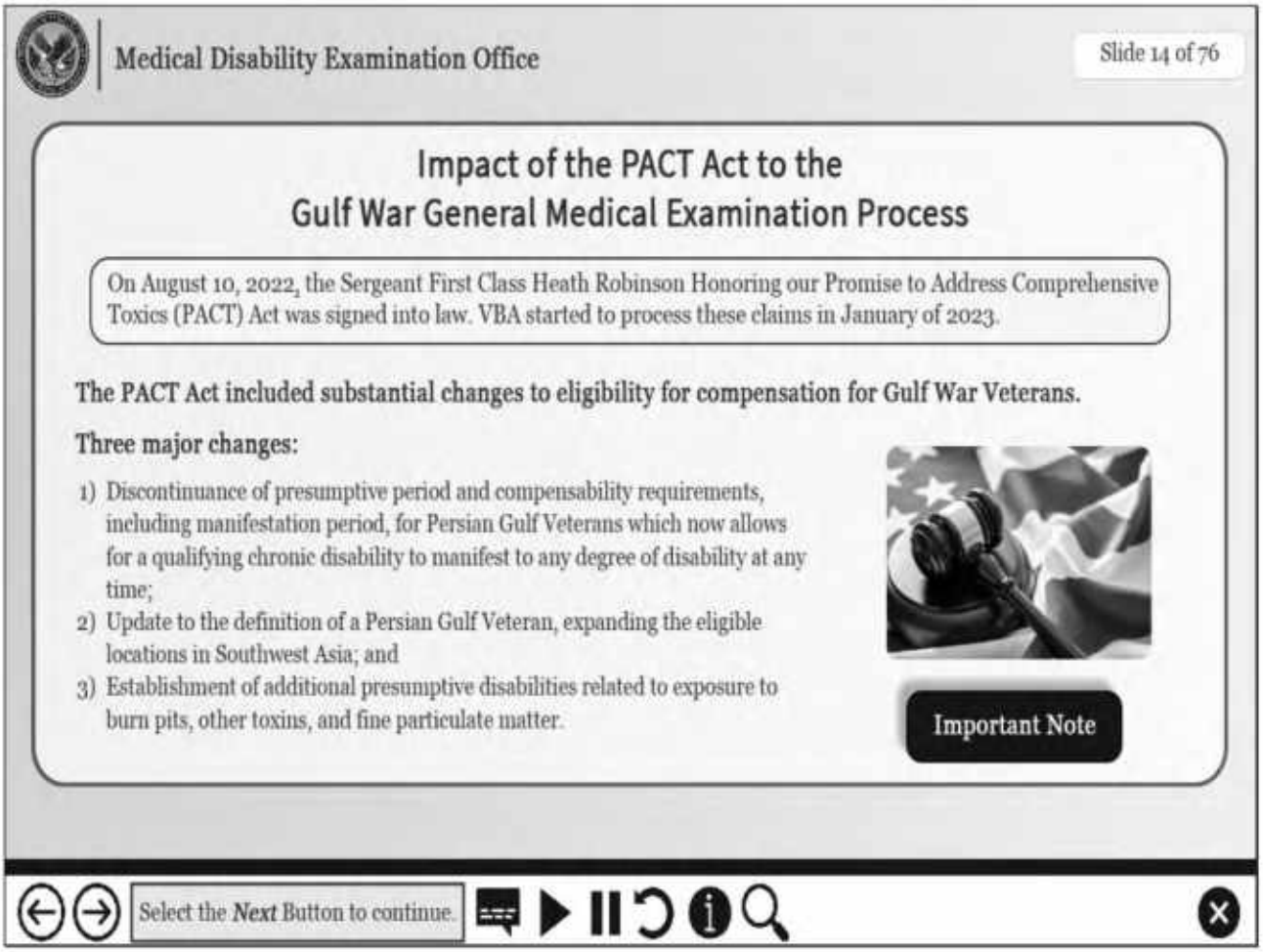
The Gulf War General Medical Examination protocol is a specialized examination that enables evaluation of a Veterans' claimed symptoms and consideration of potential relationship to their service in the Gulf region, including if they may be due to an undiagnosed illness. Reviewing the exam scheduling request, or ESR, along with the pertinent records before the examination will help prepare you for the types of conditions, signs, and symptoms you will be evaluating and documenting.

All claimed symptoms or conditions that are related to Gulf War service should be indicated and accounted for on the Gulf War General Medical DBQ, including completion of any associated DBQs as indicated either on the ESR or by the examination itself.

Select the highlighted link to open a PDF of the Gulf War General Medical DBQ to keep for future reference.

It is important to note that if there are additional non-Gulf War claimed conditions included on the ESR, such as for an increase in an already service-connected condition, do not indicate and address those on the Gulf War General Medical DBQ. You will complete those requests as you would normally, following the instructions on the ESR.

Slide 14 - Impact of the PACT Act to the Gulf War General Medical Examination Process



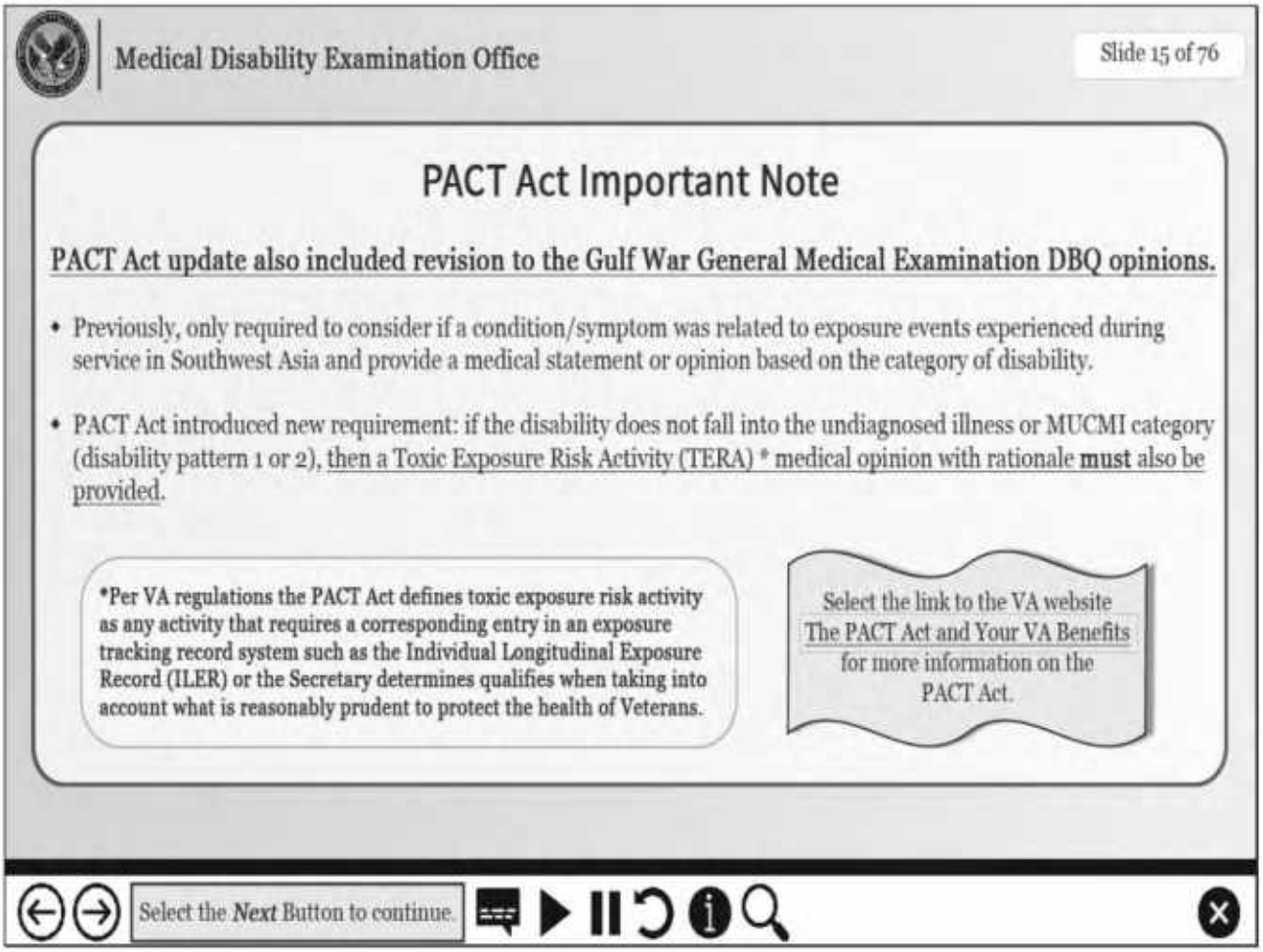
Transcript

On August 10, 2022, the President signed the PACT Act into law and the Veterans Benefits Administration started to process these claims in January of 2023. The implementation of the PACT Act significantly changed how Gulf War conditions are evaluated.

Three major changes impacting Gulf War Veterans included: removing the requirement that the disease must manifest to a certain degree within 10 years of separation from service, thereby allowing for a qualifying disability to manifest to any degree at any time; updating the definition of a Persian Gulf Veteran by expanding eligible locations; and establishing additional presumptive conditions related to burn pits, certain other toxins and fine particulate matter exposures.

Select the **Important Note** button to be provided with some additional PACT Act information.

Slide 15 - PACT Act Important Note

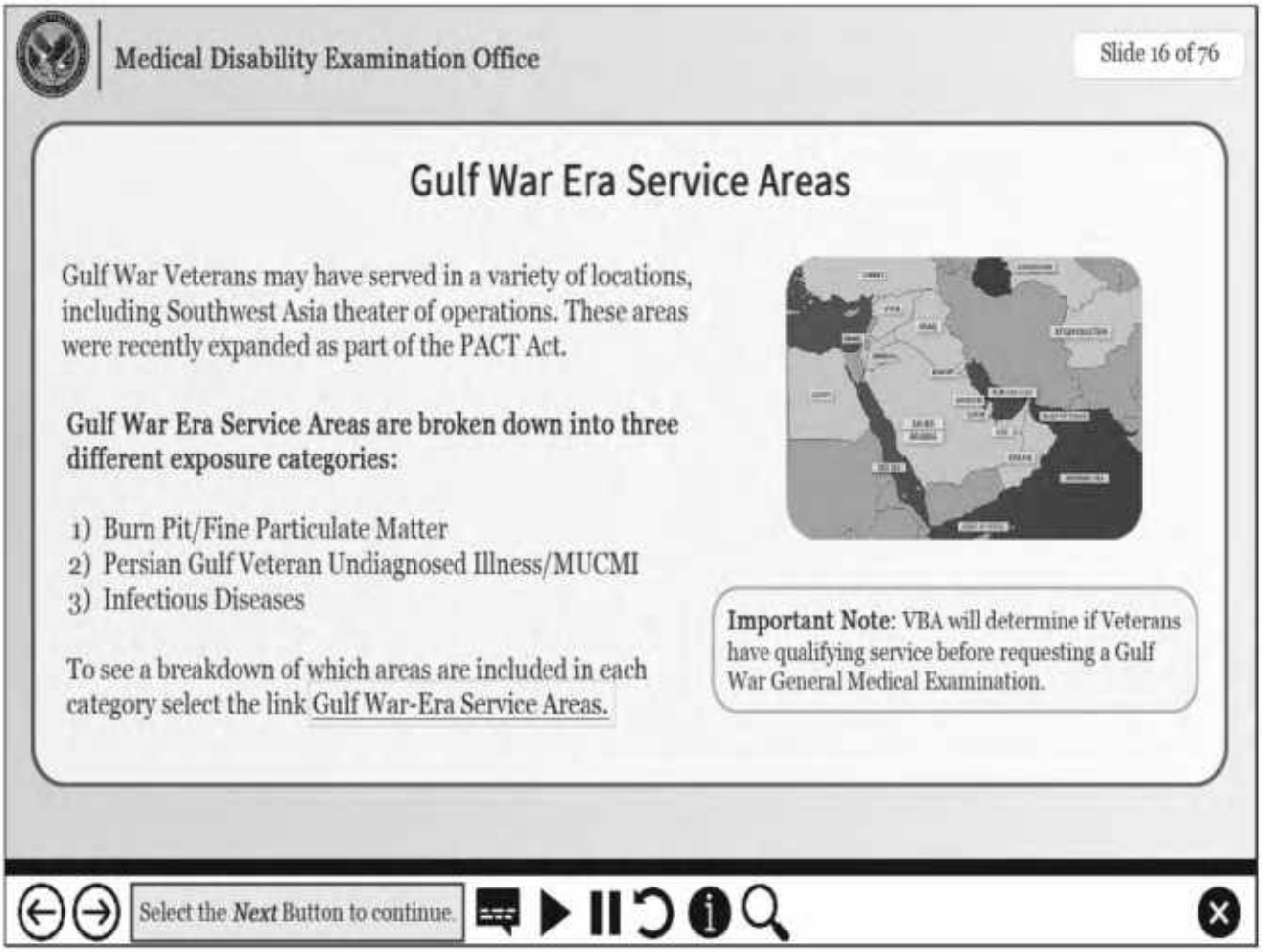


Transcript

Previously, the historical Gulf War General Medical Examination DBQ asked the examiner if the Veteran's disability was at least likely as not (likelihood is at least approximately balanced or nearly equal, if not higher) related to exposure events experienced by the Veteran during service in Southwest Asia.

With the PACT Act, if a disability does not fall into the undiagnosed illness or MUCMI category, then the examiner must now also provide a TERA medical opinion. Per VA regulations the PACT Act defines toxic exposure risk activity as any activity that requires a corresponding entry in an exposure tracking record system such as the Individual Longitudinal Exposure Record (ILER) or the Secretary determines qualifies when taking into account what is reasonably prudent to protect the health of Veterans.

Slide 16 - Gulf War Era Service Areas

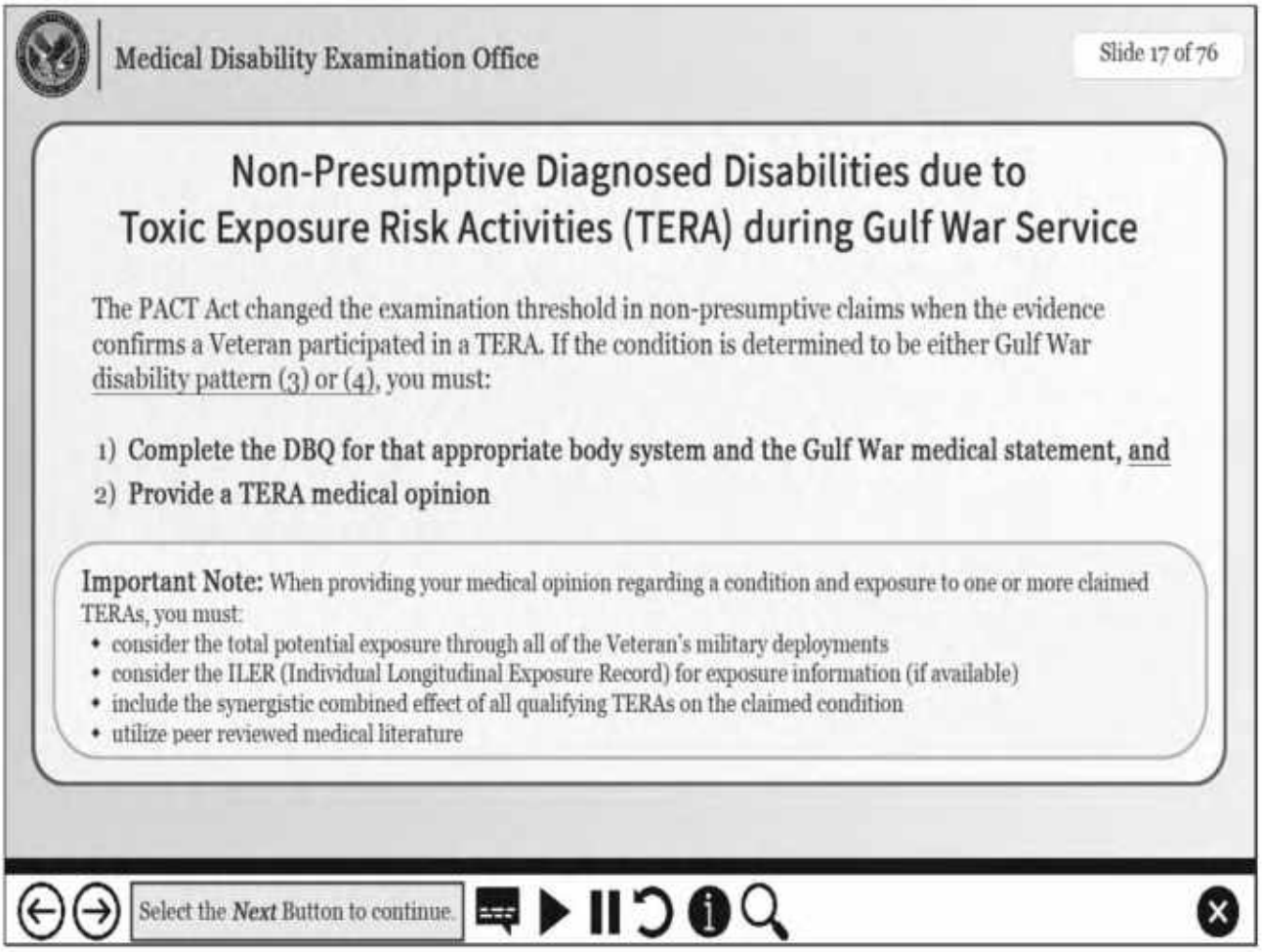


Transcript

Persian Gulf Veterans may have served in a variety of locations, including the Southwest Asia theater of operations depicted in the map shown here on screen. These areas were recently expanded as part of the PACT Act. The Gulf War Era Service Areas are broken down into three different exposure categories that are shown on the screen.

To see a breakdown of these areas, select the link shown on screen, which will bring you to a document that you can save for future reference. This document shows a table that represents the locations of qualifying service, dates of qualification, and applicable authority (regulation vs PACT Act) for various populations of Veterans who served during the Gulf War era. However, it is important to note that VBA will make the determination as to whether Veterans qualify as having Gulf War service before requesting a Gulf War General Medical Examination, therefore there is no need for you, as the examiner, to verify their locations.

Slide 17 - Non-Presumptive Diagnosed Disabilities due to TERA during Gulf War Service

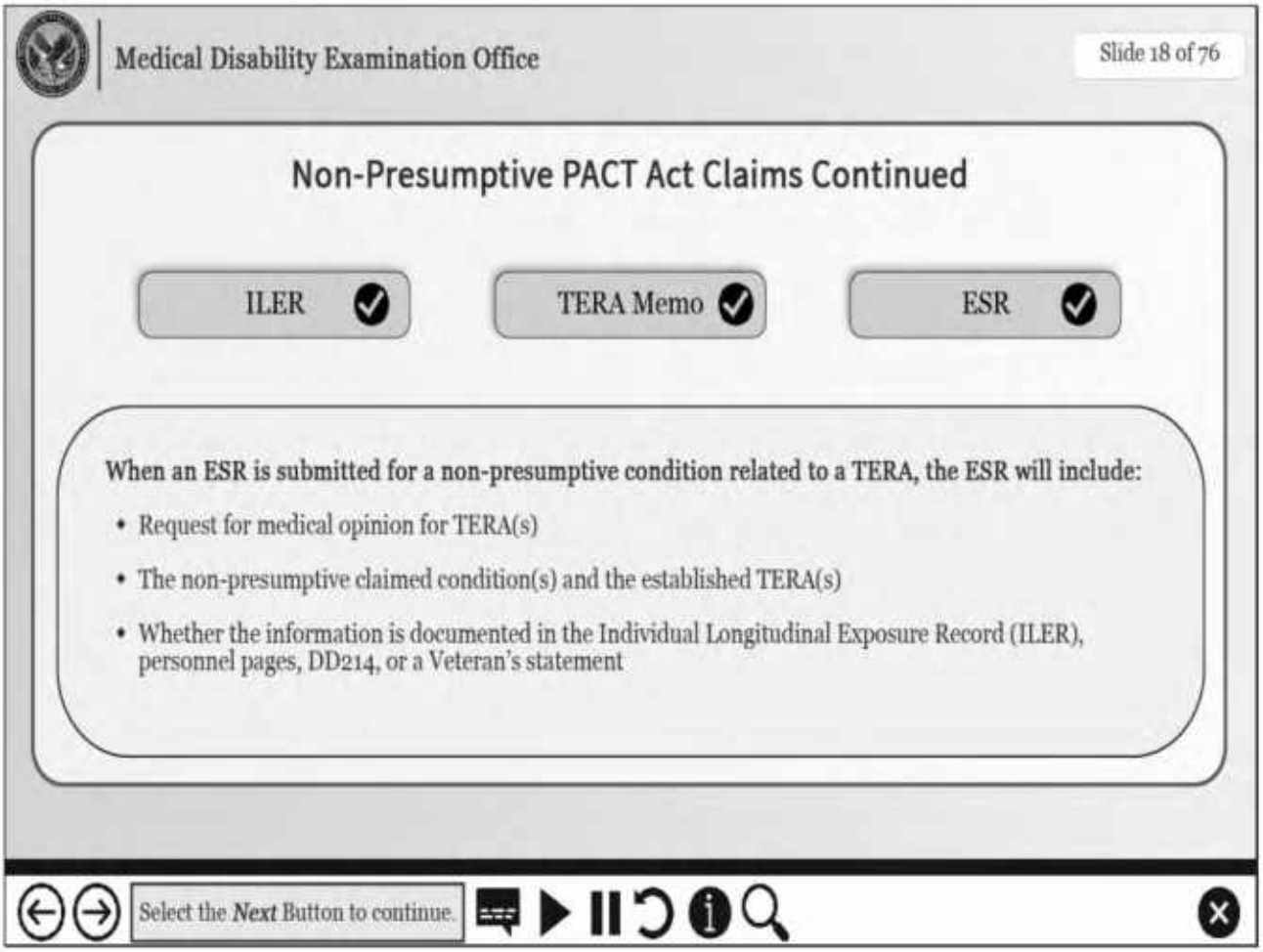


Transcript

The PACT Act changed the examination threshold in non-presumptive claims when the evidence confirms a Veteran participated in a TERA. If the condition is determined to fall into the Gulf War disability pattern (3), a diagnosable chronic multisymptom illness with a partially explained etiology, or disability pattern (4) a disease with a clear and specific etiology, then the DBQ for that appropriate body system should be conducted and both the Gulf War medical statement and a TERA medical opinion completed.

When evaluating a condition based on one or more claimed TERAs, you are to consider the total potential exposure through all of the Veteran's military deployments to include the synergistic combined effect of all qualifying toxic exposure risk activities on the claimed condition when formulating your medical opinion. The ILER summary will be very helpful for determining exposures as well as your discussion during your evaluation of the Veteran and review of the eFolder.

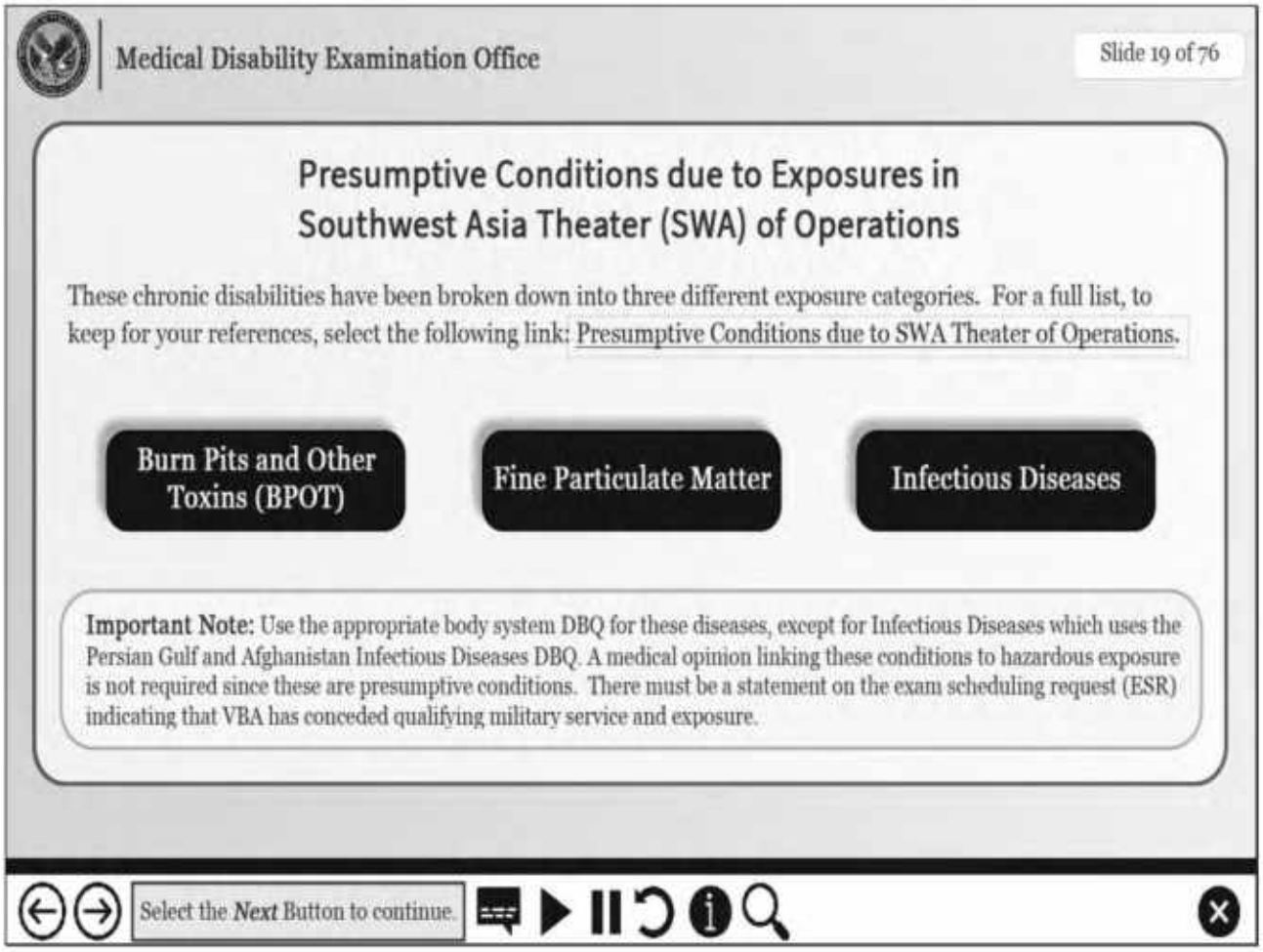
Slide 18 - Non-Presumptive PACT Act Claims Continued



Transcript

Select the buttons to learn more about the **Individual Longitudinal Exposure Record** or **ILER**, the **Toxic Exposure Risk Activities Memorandum** or **TERA Memo,** and the **exam scheduling request** or **ESR.**

Slide 19 - Presumptive Conditions due to Exposures in Southwest Asia Theater of Operations

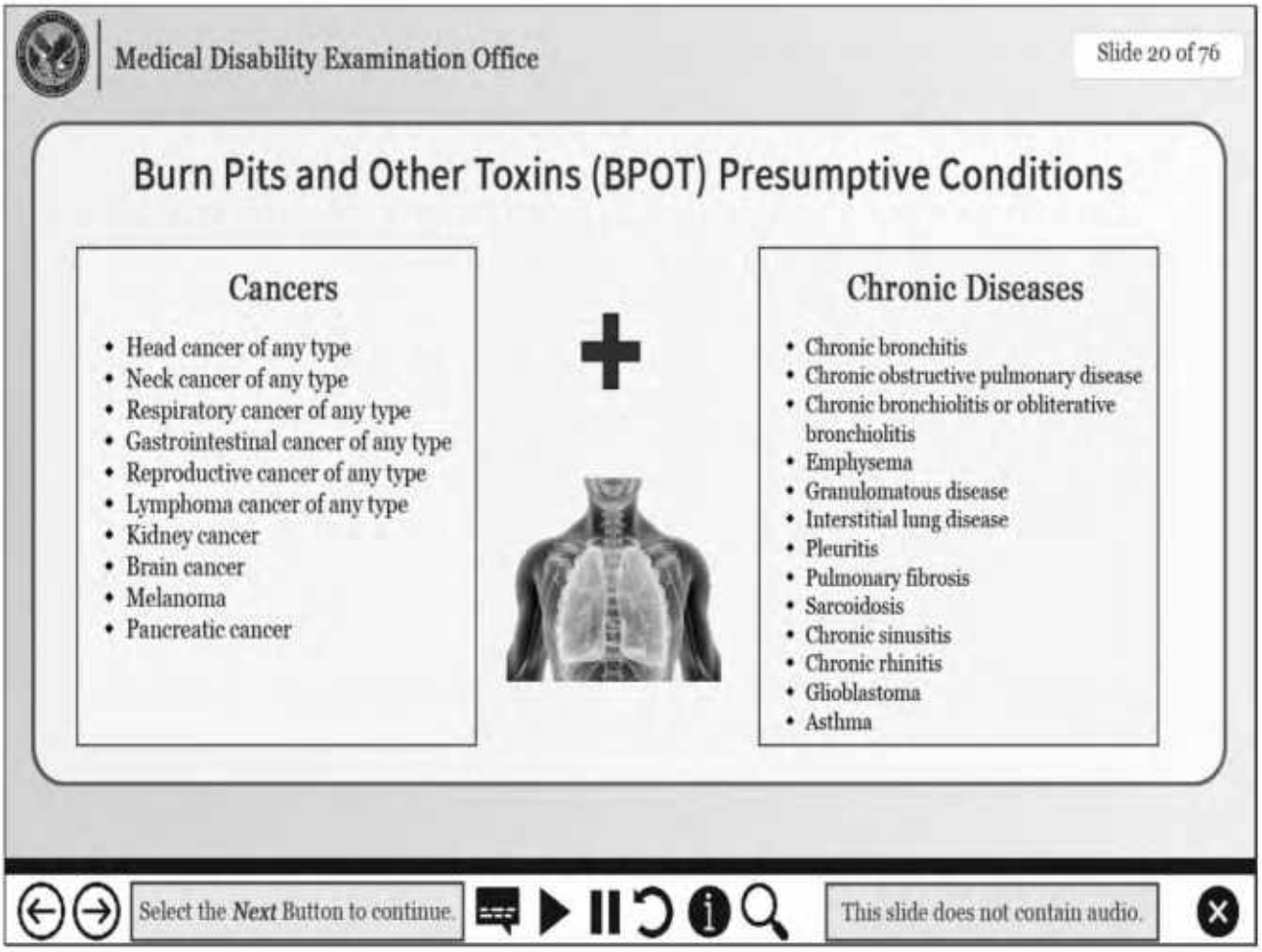


Transcript

Certain disabilities have been identified as presumptively connected to the environmental hazards Veterans were exposed to for each of the regions outlined in the Gulf War-era service areas previously discussed. It is important to note that you will need to use the appropriate body system DBQ for these diseases, except for Infectious Diseases which requires the Persian Gulf and Afghanistan Infectious Diseases DBQ. A medical opinion linking these conditions to hazardous exposure would not be required since they are presumptive conditions. There must be a statement on the exam scheduling request (ESR) indicating that VBA has conceded qualifying military service and exposure.

Select each category shown on the screen to see what disabilities are listed as presumptive conditions for that type of exposure. Additionally, a PDF list of these presumptive conditions is provided in the link shown on the screen, to download and maintain for your records.

Slide 20 - BPOT Presumptive Conditions



Slide 21 - Fine Particulate Matter Presumptive Conditions

Medical Disability Examination Office

Slide 21 of 76

Fine Particulate Matter Presumptive Conditions

Rare Respiratory Cancers

- Squamous cell carcinoma (SCC) of the larynx
- SCC of the trachea
- Adenocarcinoma of the trachea
- Salivary gland-type tumors of the trachea
- Adenosquamous carcinoma of the lung
- Large cell carcinoma of the lung
- Salivary gland-type tumors of the lung
- Sarcomatoid carcinoma of the lung
- Typical and atypical carcinoid of the lung

Other Cancers

- Bladder, ureter, and related genitourinary cancers
- Leukemias
- Multiple myelomas
- Myelodysplastic syndromes
- Myelofibrosis

Chronic Diseases

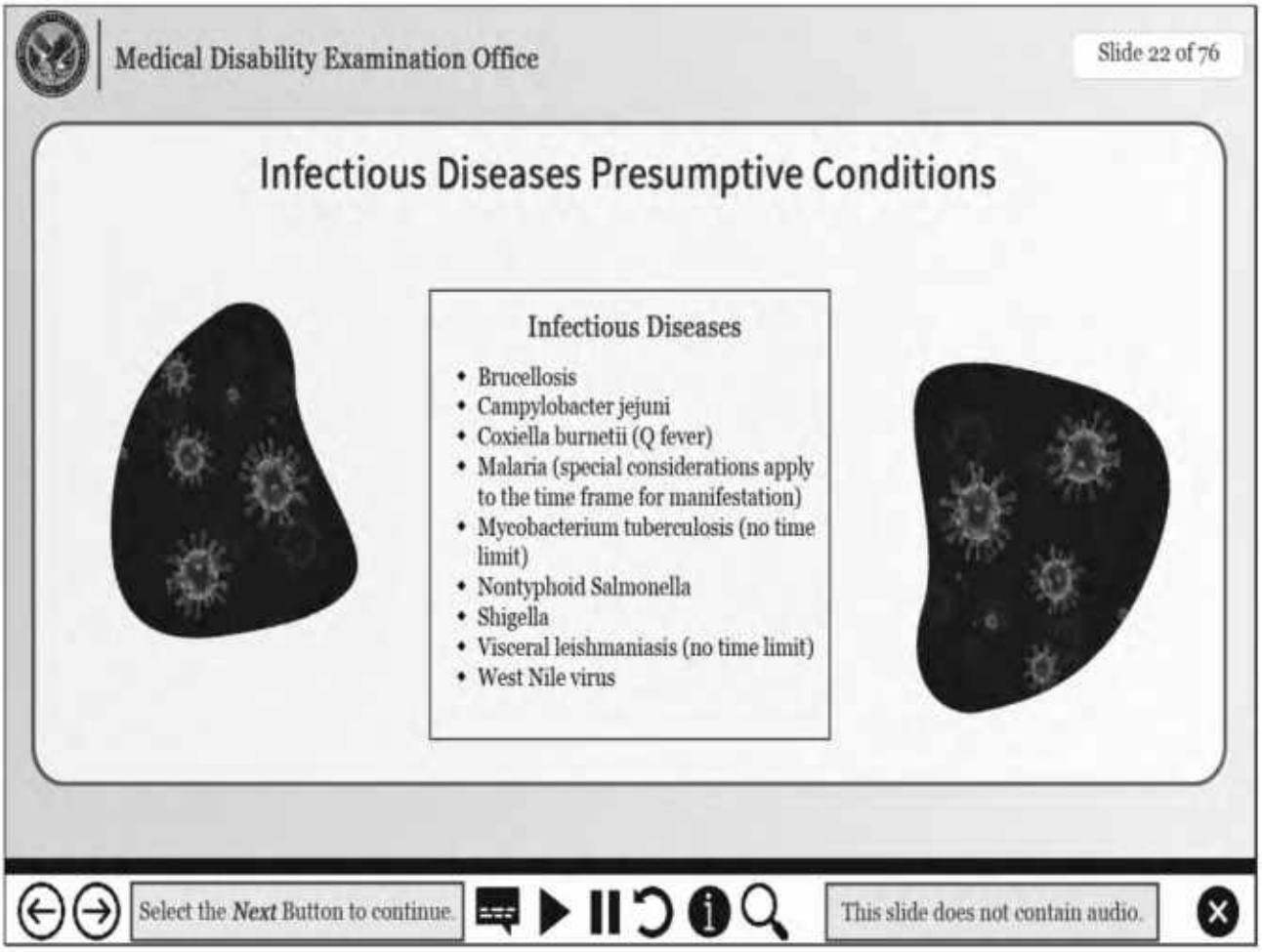
- Asthma
- Rhinitis
- Sinusitis, to include rhinosinusitis



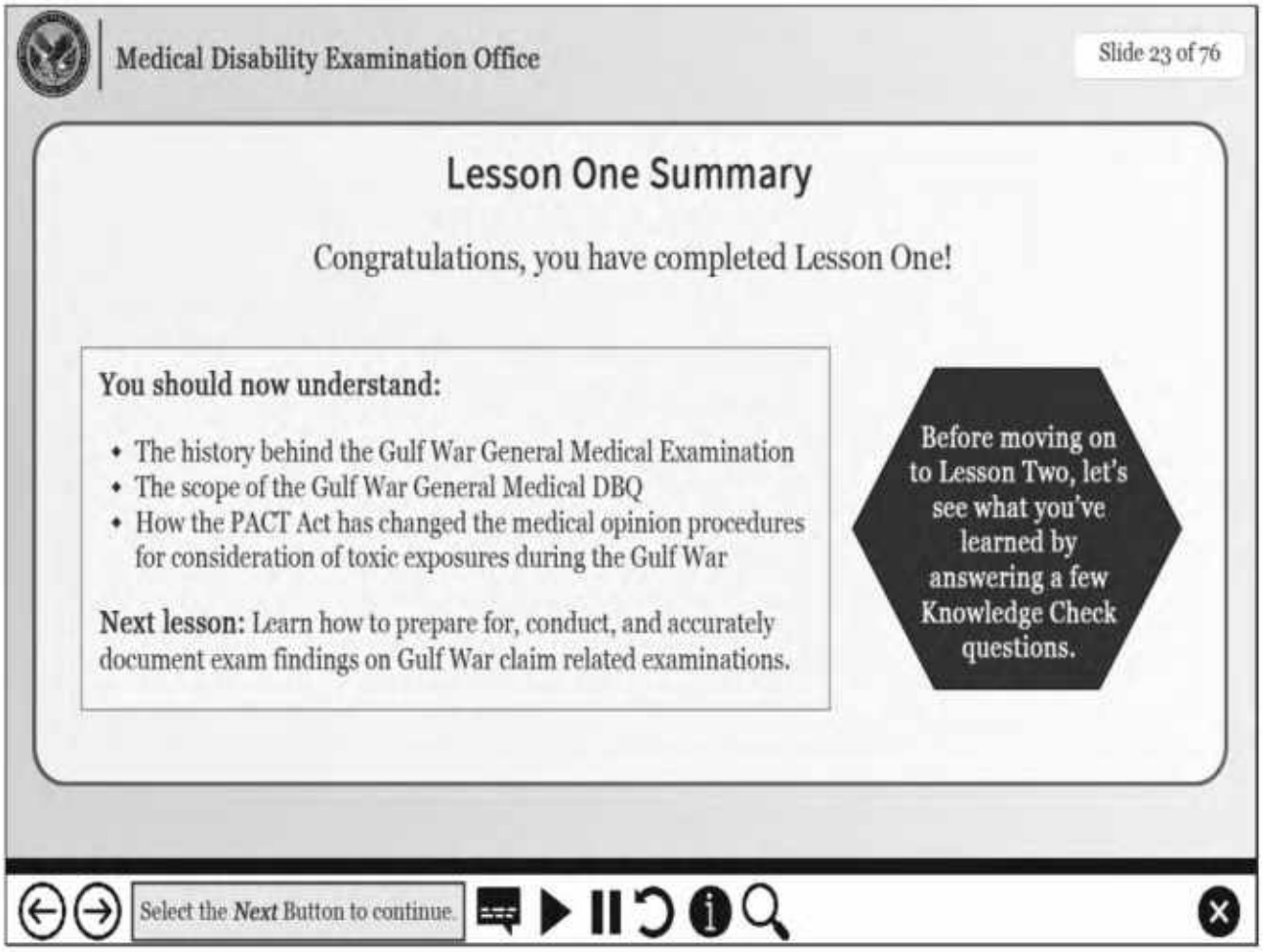
Select the *Next* Button to continue.

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Slide 22 - Infectious Diseases Presumptive Conditions



Slide 23 - Lesson One Summary



Transcript

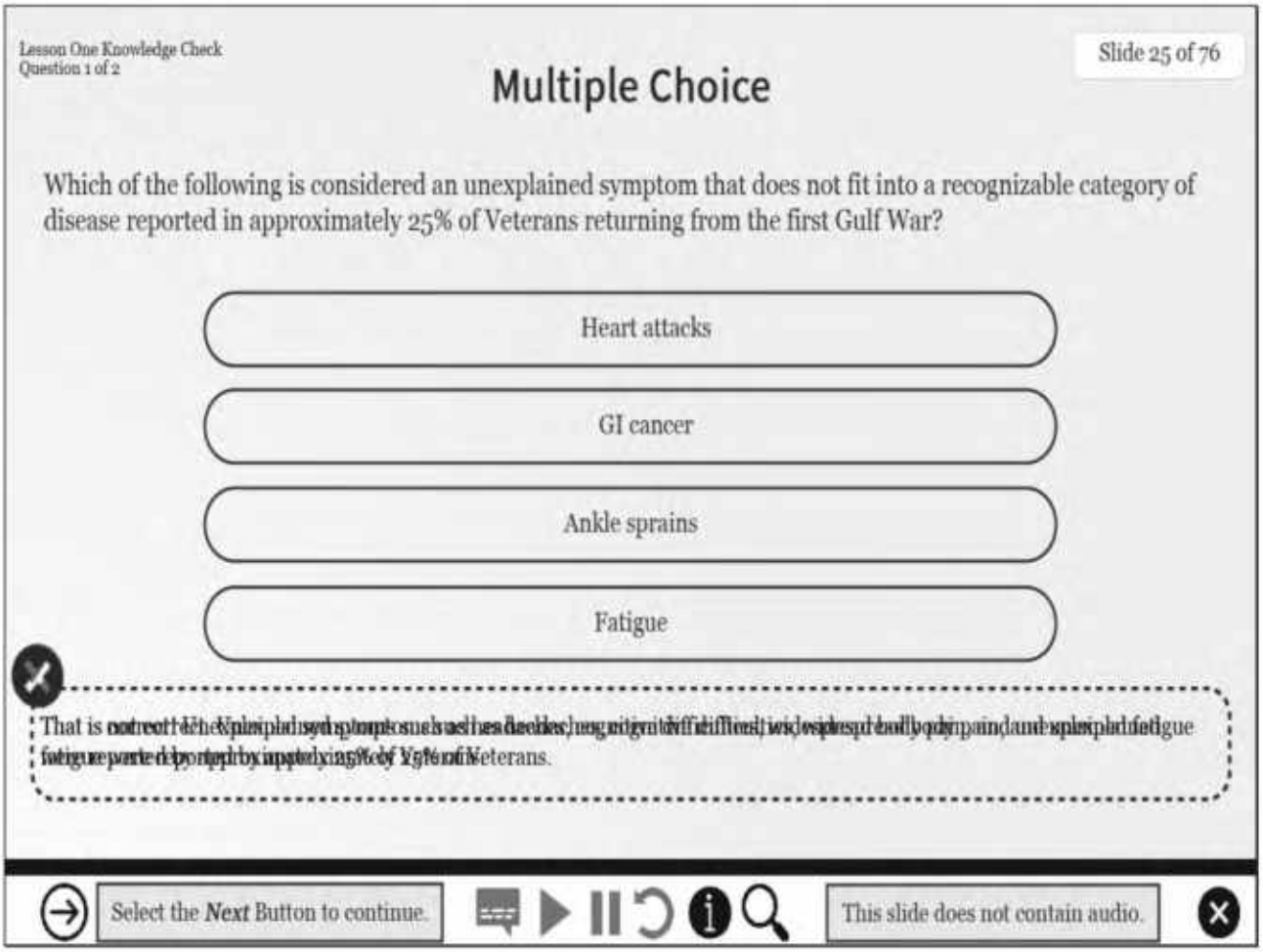
You've completed Lesson one, which has provided an overview of the Gulf War General Medical Examination. The content presented was designed to help you understand the history behind the Gulf War General Medical Examination, the scope of the accompanying DBQ, and how the PACT Act has changed the medical opinion procedures and information that examiners need to consider for toxic exposures during the Gulf War.

The next lesson will explain how to prepare for, conduct, and accurately document exam findings on Gulf War claim related examinations. However, before we move on to Lesson Two, please answer a few Knowledge check questions.

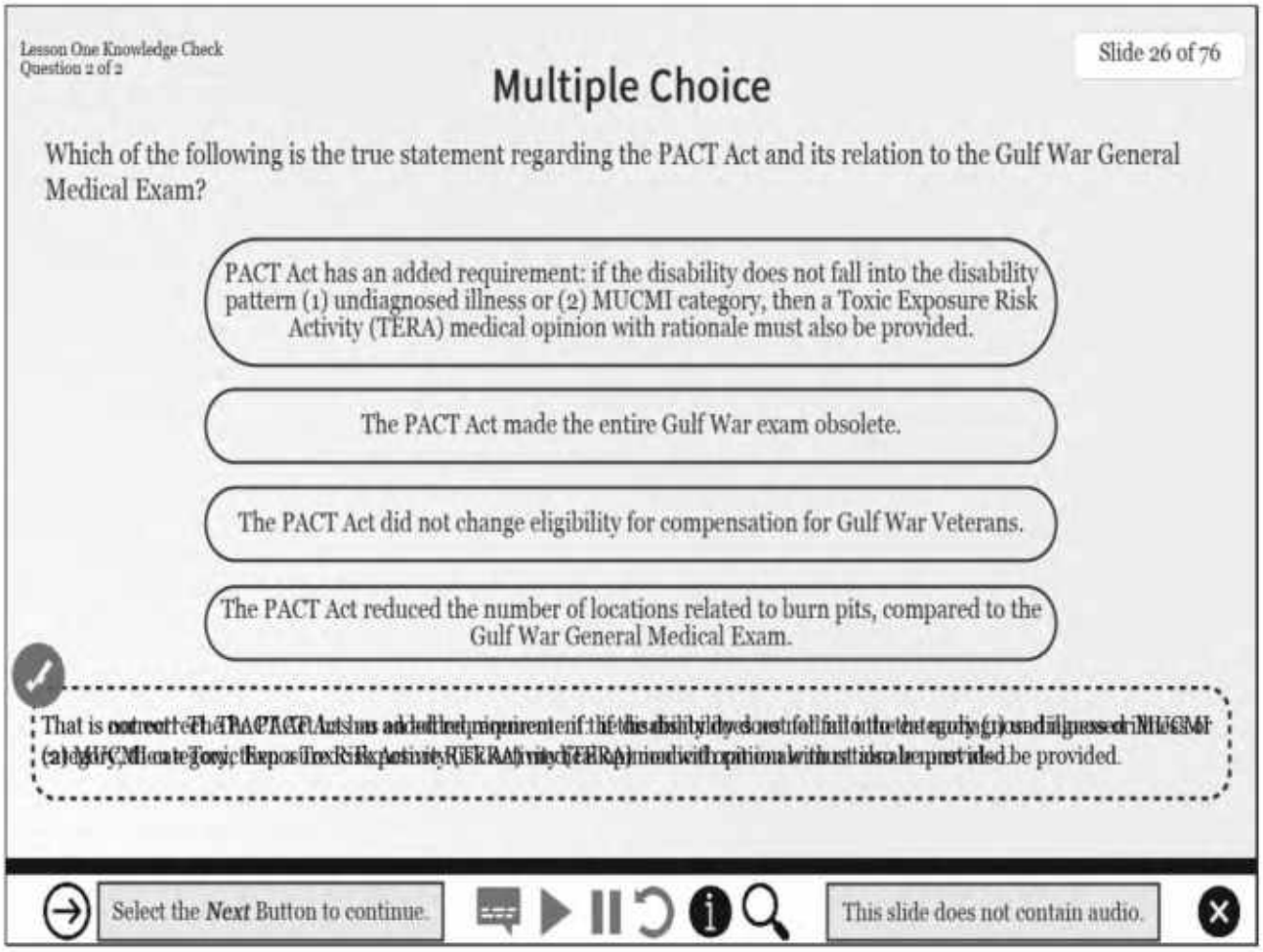
Slide 24 - Knowledge Check Introduction



Slide 25 - Lesson One Knowledge Check Question One



Slide 26 - Lesson One Knowledge Check Question Two



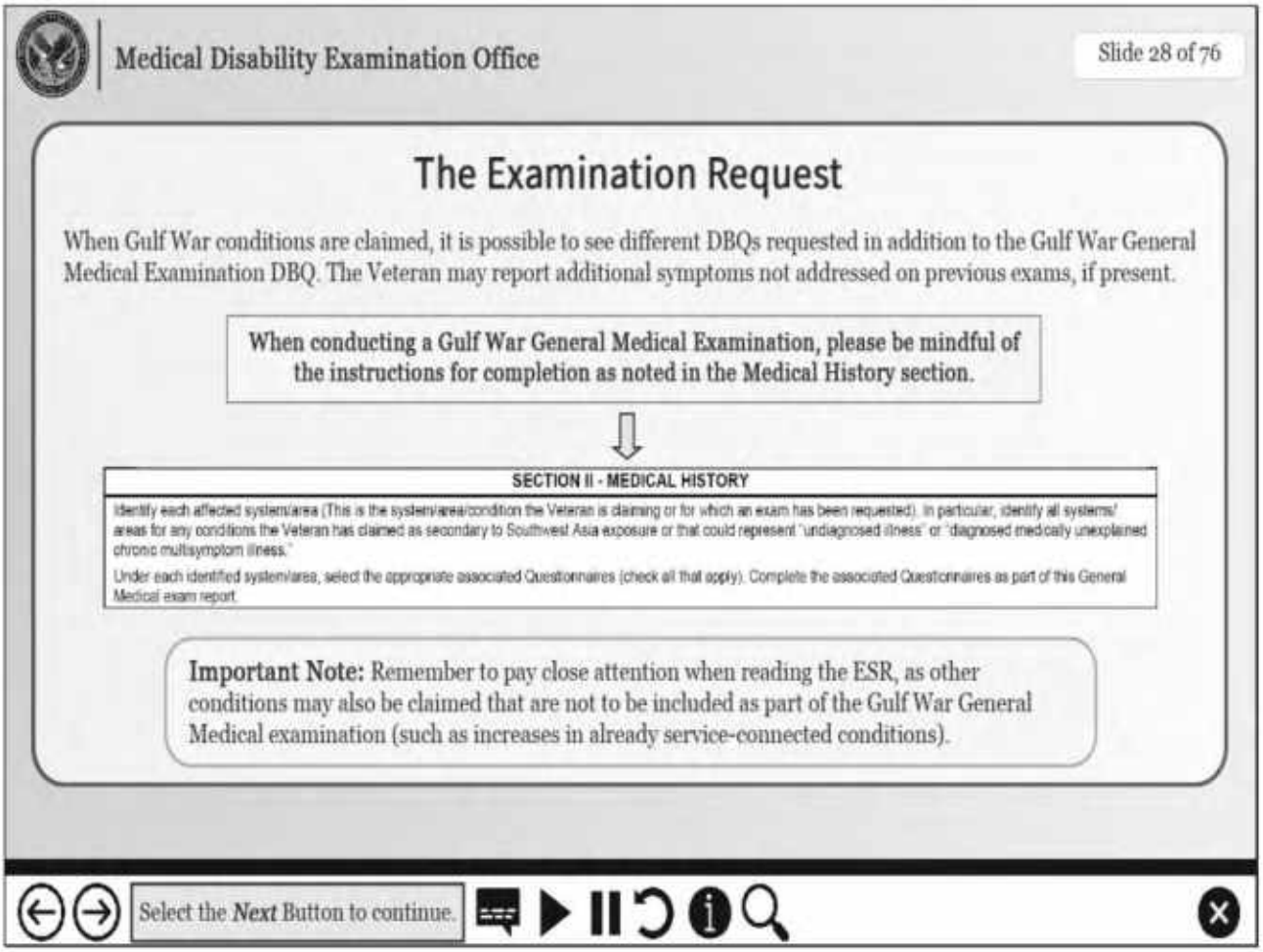
Slide 27 - Lesson Two Objective



Transcript

In Lesson Two you will learn how to prepare for, conduct, and accurately document exam findings on Gulf War claim related examinations.

Slide 28 - The Examination Request

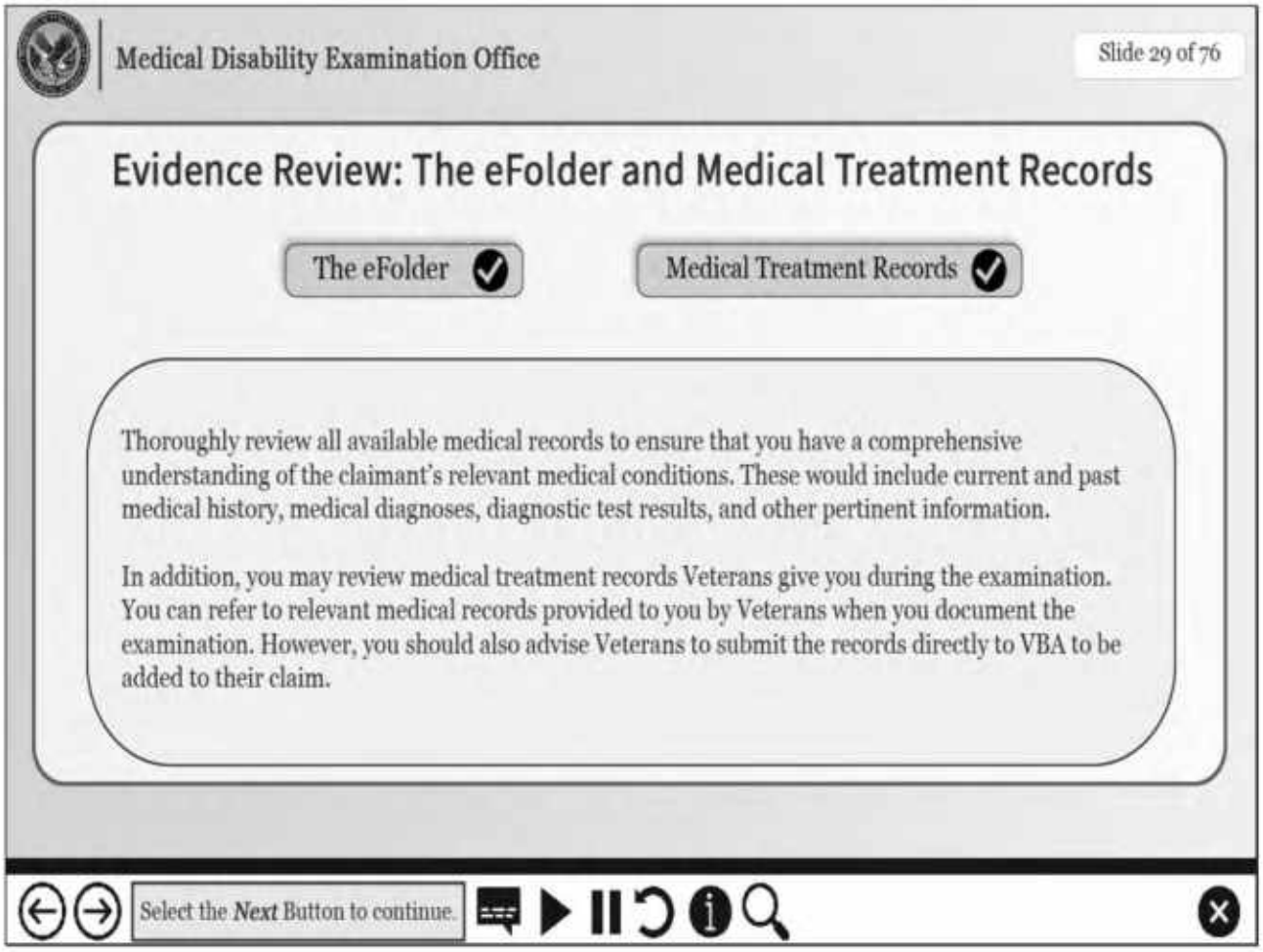


Transcript

An important part of performing the disability examination is understanding what is being requested on the examination scheduling request also known as the ESR. The VBA claims processor may request multiple DBQs with conditions claimed as related to Gulf War service. The Veteran may report symptoms that have not been addressed on previously completed DBQs. If the Veteran claims symptoms due to any potential Gulf War exposure, you, as the examiner, may document the symptoms on the Gulf War General Medical DBQ and choose to add any relevant DBQs to cover those additional symptoms.

Please be mindful of the instructions for completion as noted in the medical history section as well as the ESR.

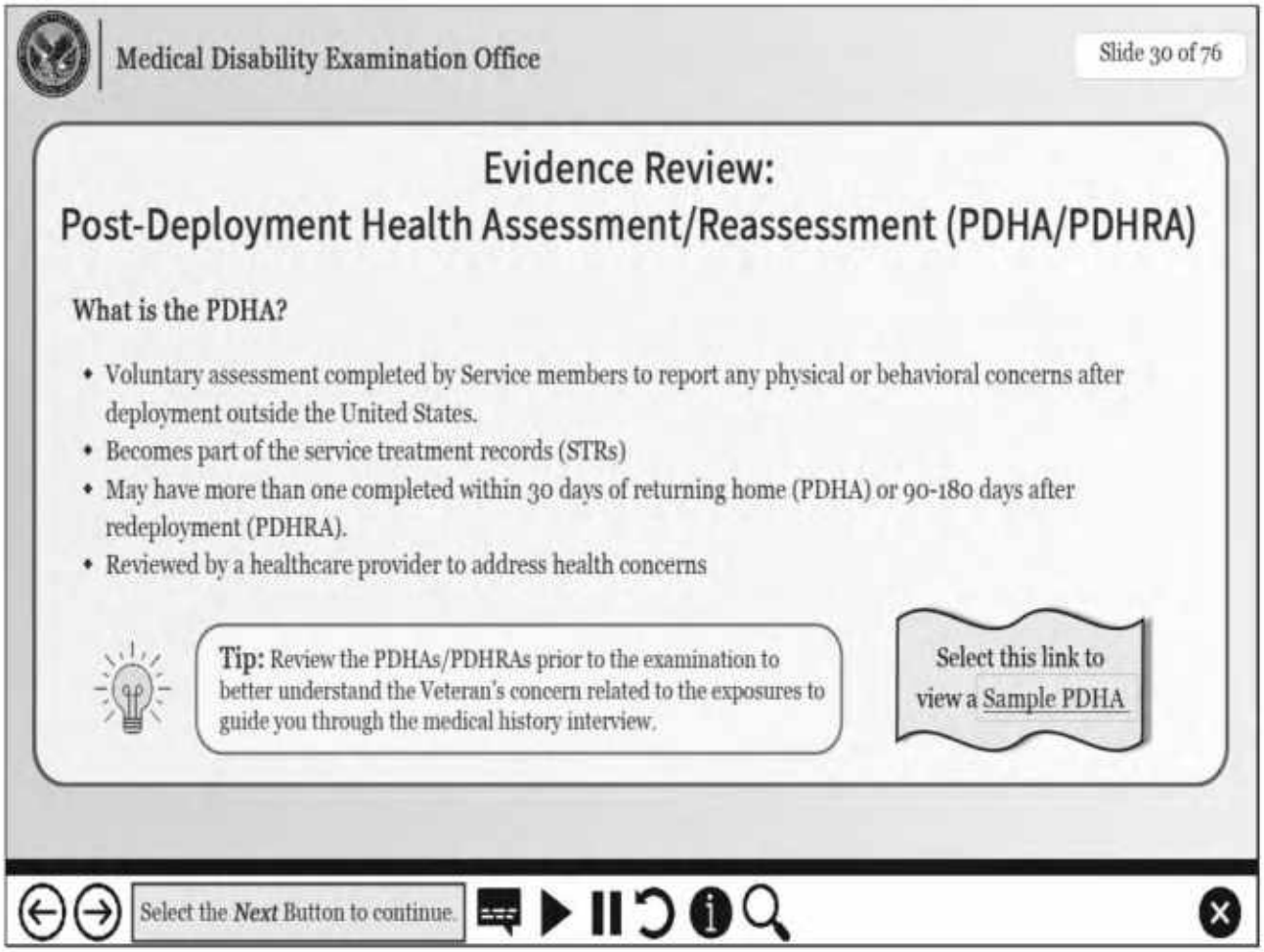
Slide 29 - Evidence Review



Transcript

Your review of evidence for the Gulf War General Medical examination will include a thorough review of the eFolder and available medical treatment records. Select each topic for details about the kinds of information you may review.

Slide 30 - Evidence Review: PDHA/PDHRA



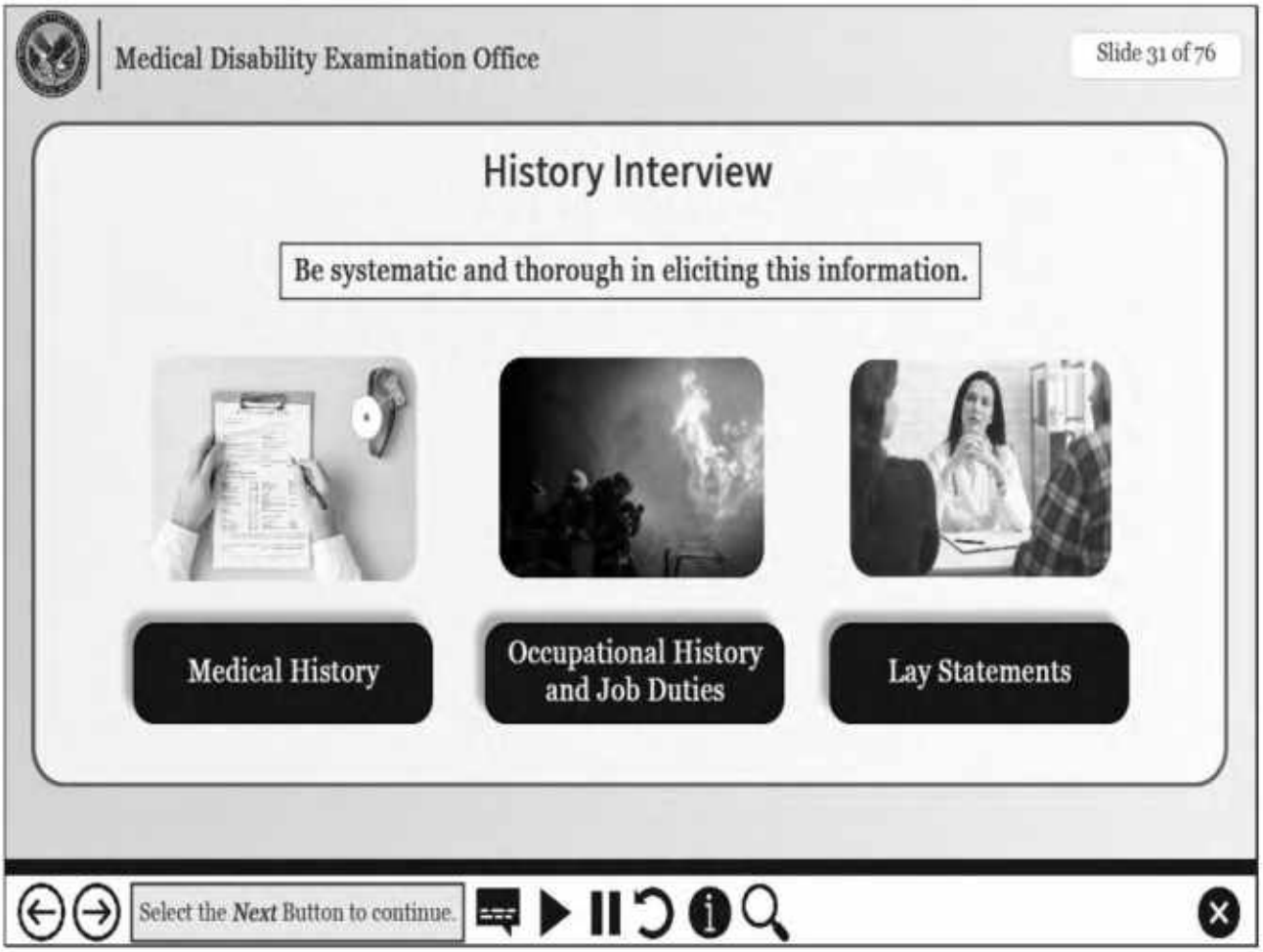
Transcript

The Post-Deployment Health Assessment, or PDHA DoD Form DD 2796, is a voluntary self-reporting form completed by Service members to report any physical or behavioral concerns they may have experienced while being deployed outside of the United States. The PDHA becomes part of their service treatment records also known as STRs, so there may be more than one in an eFolder. The PDHA is completed within 30 days after returning home or to a processing station and is then reviewed with a healthcare provider to address any areas of concern that may need referrals for further evaluation.

Reviewing these available post-deployment assessments will help you prepare for the examination, especially the medical history interview. Keep in mind that Veterans may not have full or accurate knowledge of all the environmental hazards that were present during their deployments. It may also be helpful to assess for other environmental or occupational exposures. Ask Veterans about pre- or post-service employment, any hobbies, and if they have ever been exposed to environmental hazards such as dust and/or sand, fumes from exhaust, smoke, oil fires, chemicals, noise, etc.

Select the PDF **Sample PDHA** to view what the form looks like.

Slide 31 - History Interview

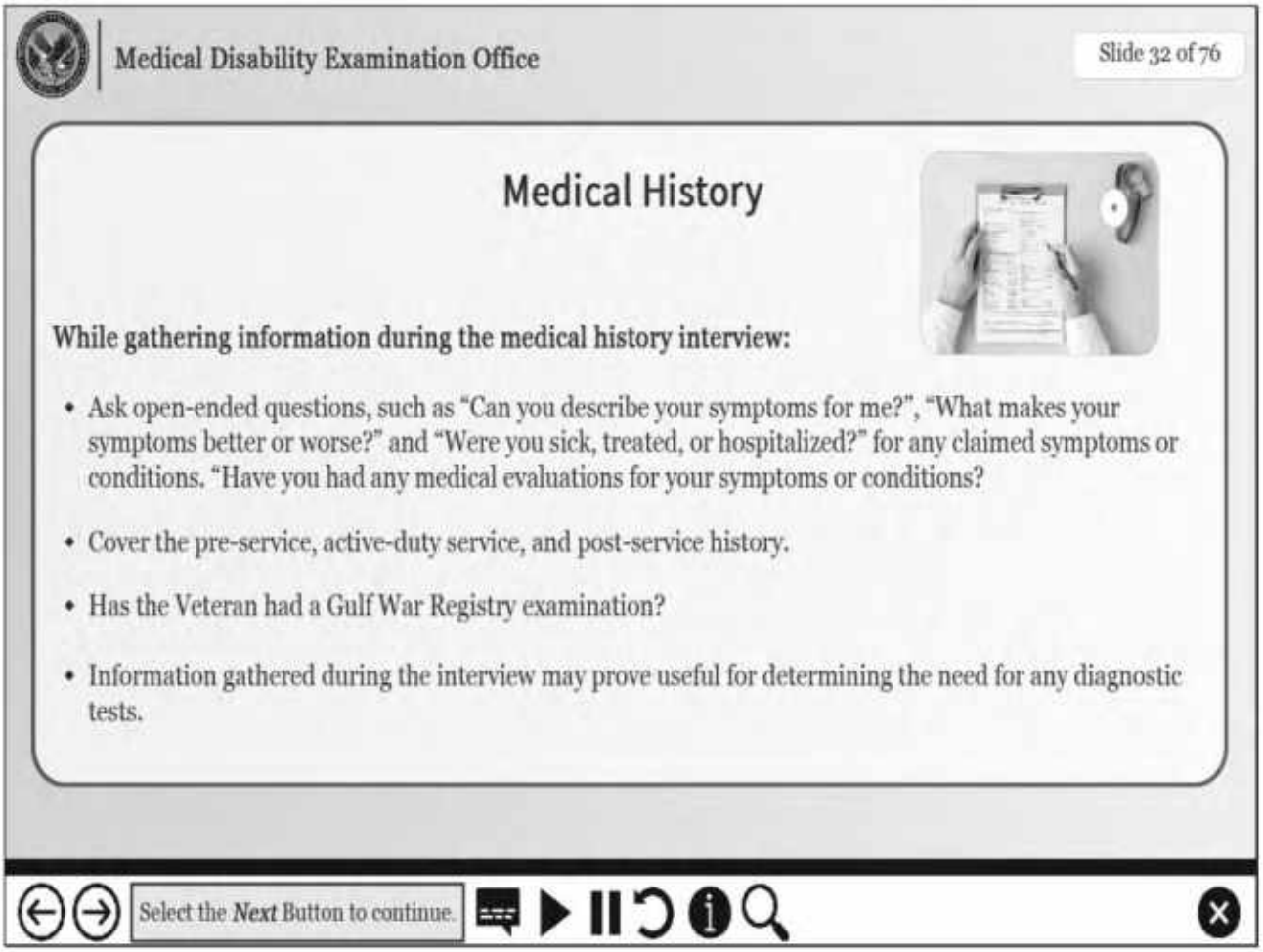


Transcript

A major part of the examination is obtaining Veterans' histories. This includes their medical histories, gathering information on their occupational and job duties both during military service and after, and reviewing all lay statements. Remember to be systematic and thorough in eliciting this information.

Select each button on the screen to learn more about each part of the history interview.

Slide 32 - Medical History

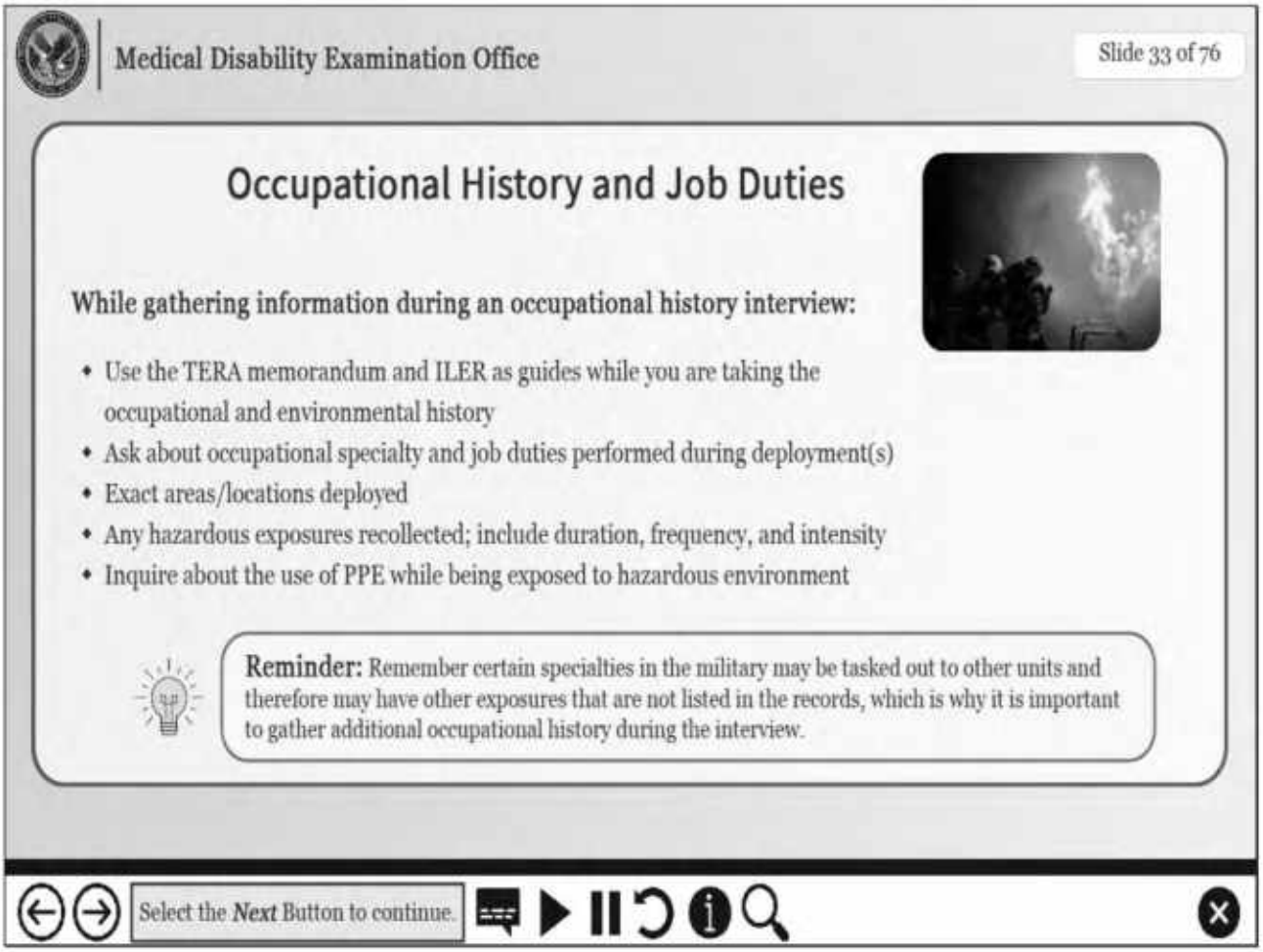


Transcript

The medical history interview for this examination can be extensive. Use the information in the examination request as a guide when taking the Veteran's history. It is important to explain to the Veteran the purpose and process for taking this history. It may be helpful to set parameters for taking the history. For example, start by talking about the context of the interview and explain that you will be following the DBQ. Point out that you will go on to another question once you have sufficient information.

While gathering information during interviews, ask open-ended questions to get more information on the onset, course, and any possible prior evaluations or treatments for their symptoms. Cover Veterans' pre-service, active duty, and post-service histories. Ask if they had a Gulf War Registry examination, as this might lead to additional useful medical information. Keep in mind that the information you gather may assist with determining if there is a need for additional diagnostic testing.

Slide 33 - Occupational History and Job Duties

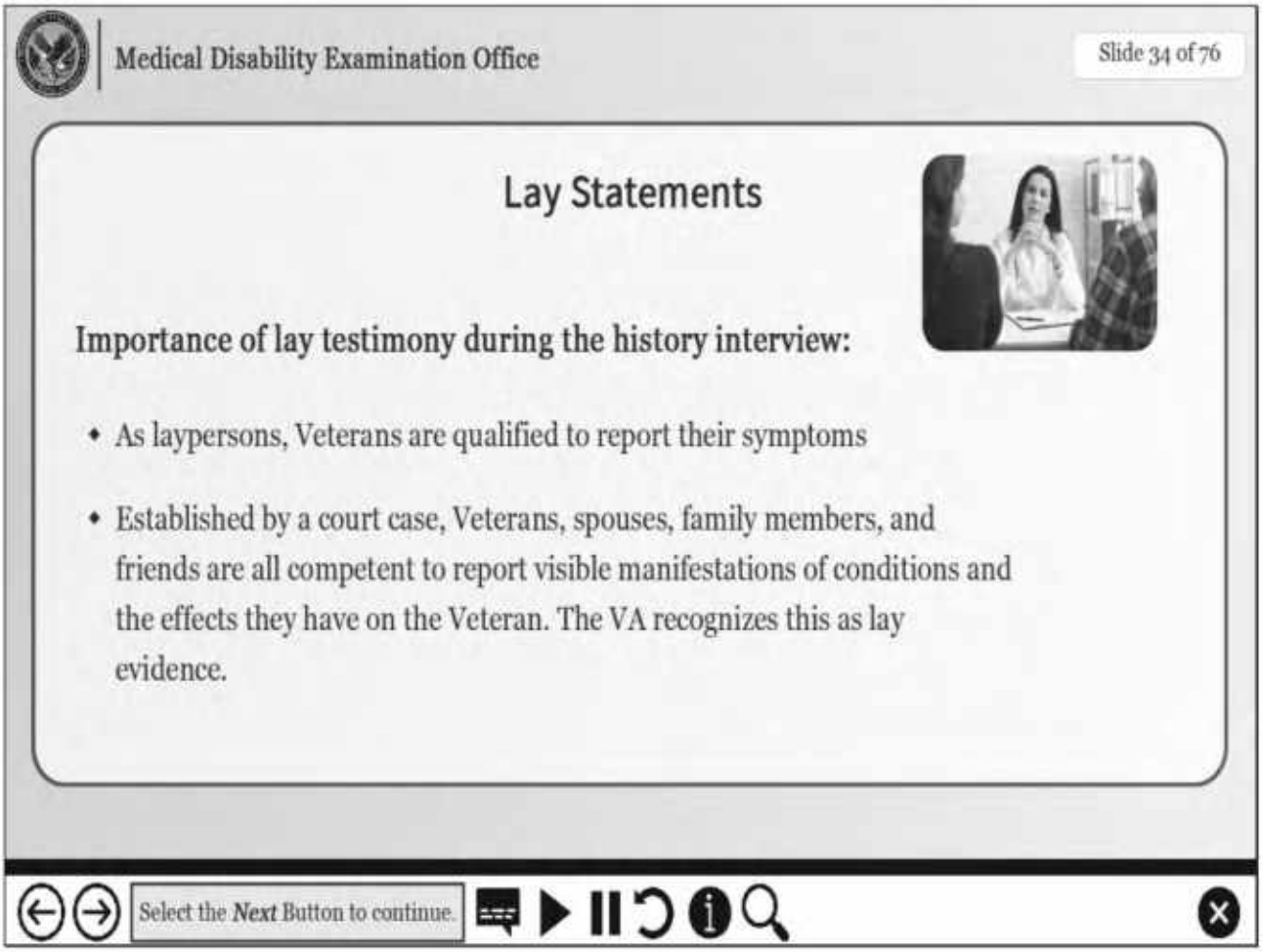


Transcript

Occupational history assessments should also be obtained. You should ask Veterans for information about any occupational specialty they performed while deployed, as there may have been additional exposure risks related to their jobs. You may have seen an occupational specialty listed in the service personnel records you reviewed for these examinations. For example, the Army and Marines use the Military Occupational Specialty Code (MOS), the Air Force uses the Air Force Specialty Code (AFSC), and the Navy uses the Navy Enlisted Classification (NEC). The DoD issues all Service members a DD Form 214, Certificate of Release or Discharge from Active Duty, that refers to their occupational specialty performed for one or more years during the period of military service. Remember to review all DD Form 214's in the eFolder as Veterans might have had several occupational specialties and/or periods of activation/deployments throughout their time in service.

When inquiring about hazardous exposures, it is also important to ask Veterans about the duration and intensity of any exposures and what their duties were in service since they may have performed other functions in addition to their listed occupational specialties, especially while deployed. For example, "What were your daily activities during deployment?" Questions you ask about occupational specialty and job duties may help you learn of other potential hazardous exposures.

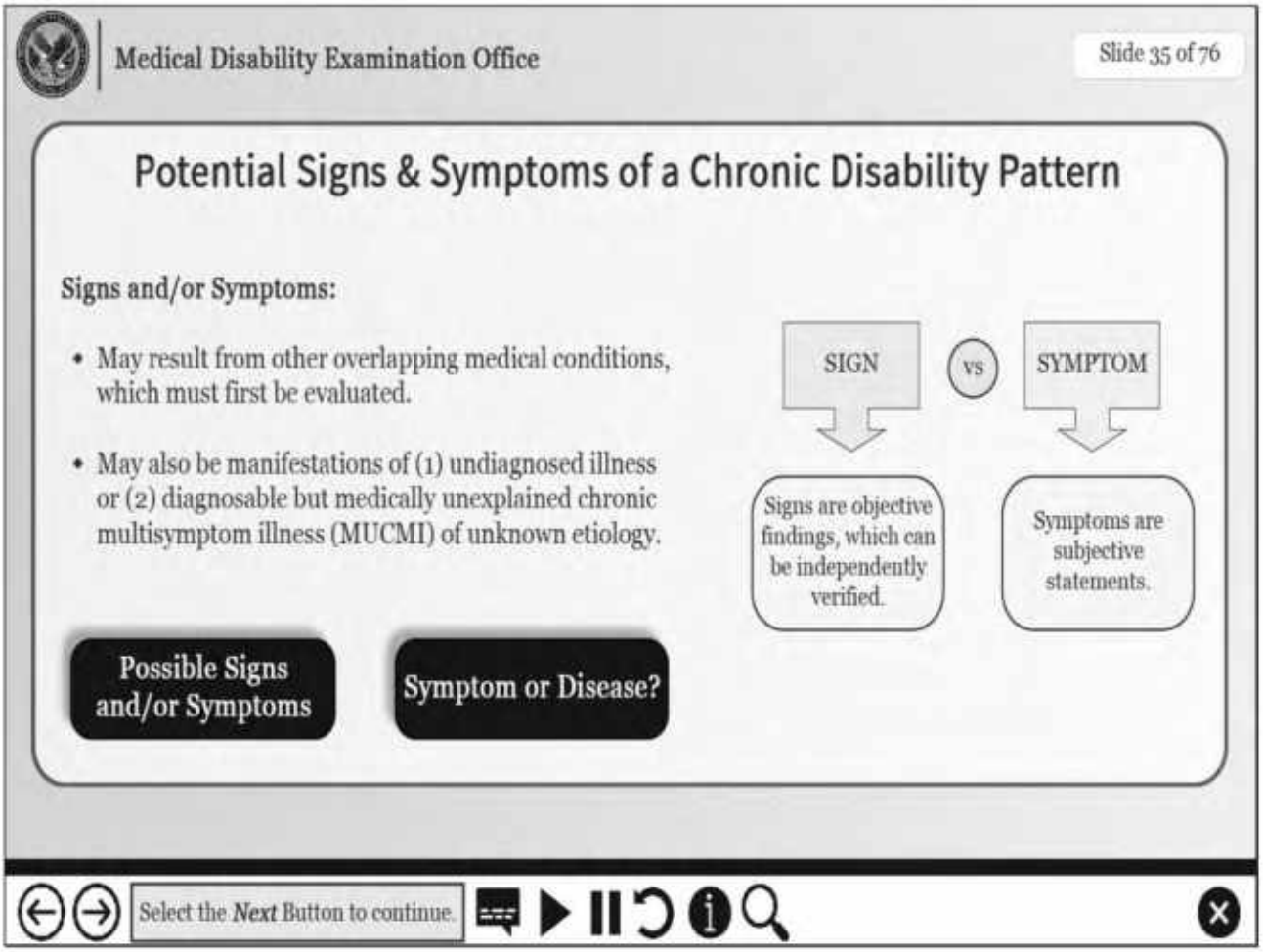
Slide 34 - Lay Statements



Transcript

While conducting the history interview, as well as reviewing the medical evidence, remember that as laypersons, Veterans are qualified to report their symptoms. A court case established that Veterans, spouses, family members, and friends are all competent to report visible manifestations of conditions and the effects of symptoms such as joint pain and fatigue that are capable of a layperson's observation. This, however, does not mean that they have the ability to relate or make a diagnosis without objective verification in a medical record.

Slide 35 - Potential Signs & Symptoms of a Chronic Disability Pattern

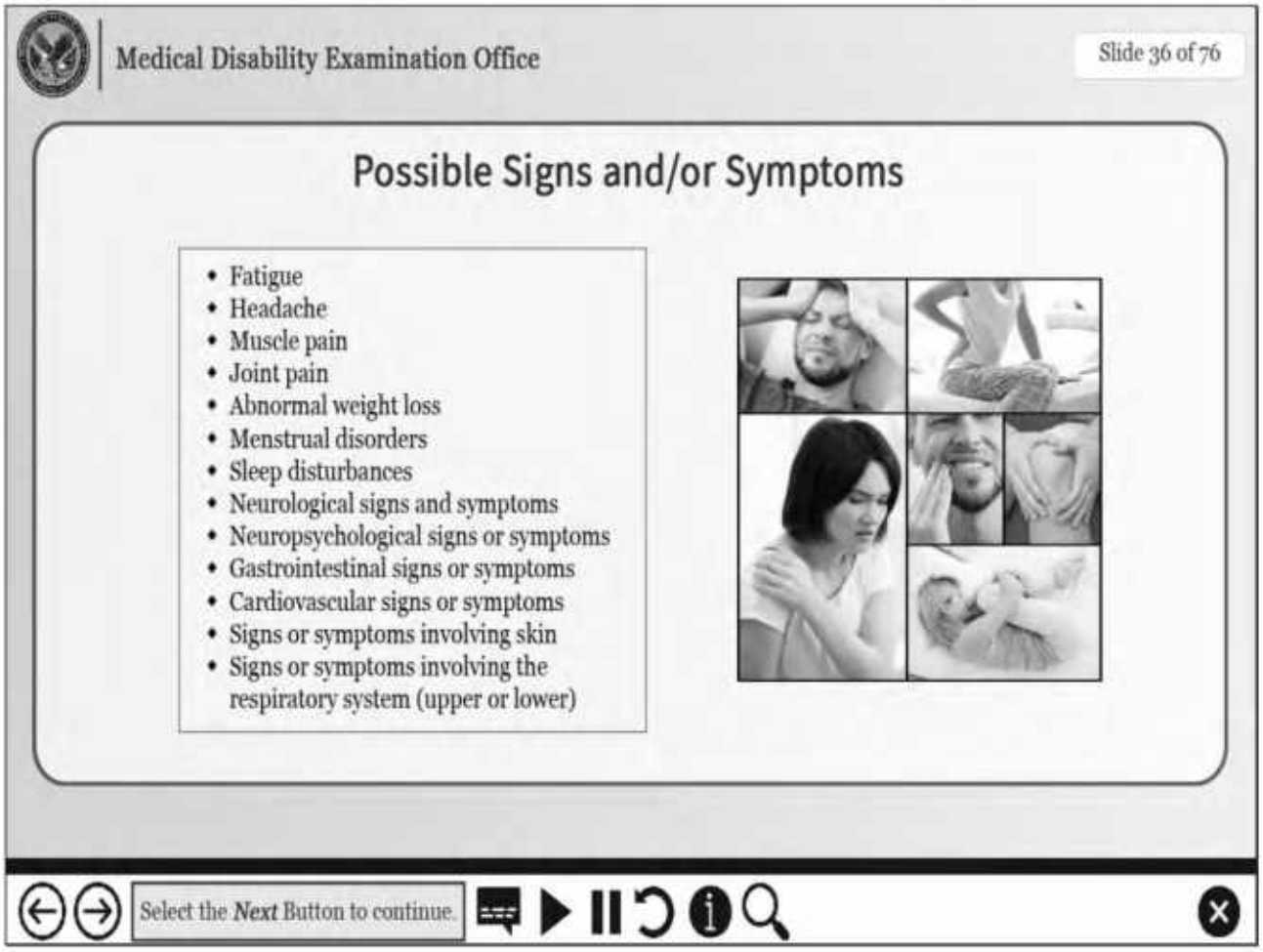


Transcript

There are several signs and symptoms that may be among the claimed conditions you evaluate a Veteran for during a Gulf War General Medical examination. These are established by VA regulation and may be found on the Gulf War DBQ as well as listed on the ESR. Signs are considered objective findings perceptible to the examiner, which can be independently verified, while symptoms are subjective statements by the Veteran. Either may occur due to another medical condition, therefore you must conduct an appropriate assessment and evaluation. It is important to keep in mind the purpose of the Gulf War General Medical examination is to determine if there is a chronic disability resulting from a category (1) undiagnosed illness or category (2) diagnosable but medically unexplained chronic multisymptom illness of unknown etiology disability pattern.

Select the button ***Possible Signs and Symptoms,*** to view what may represent disability patterns (1) or (2), after these have been determined **NOT** to be attributable to another diagnosable condition. Then, select the button ***Symptom or Disease?*** for information on how to differentiate between the two.

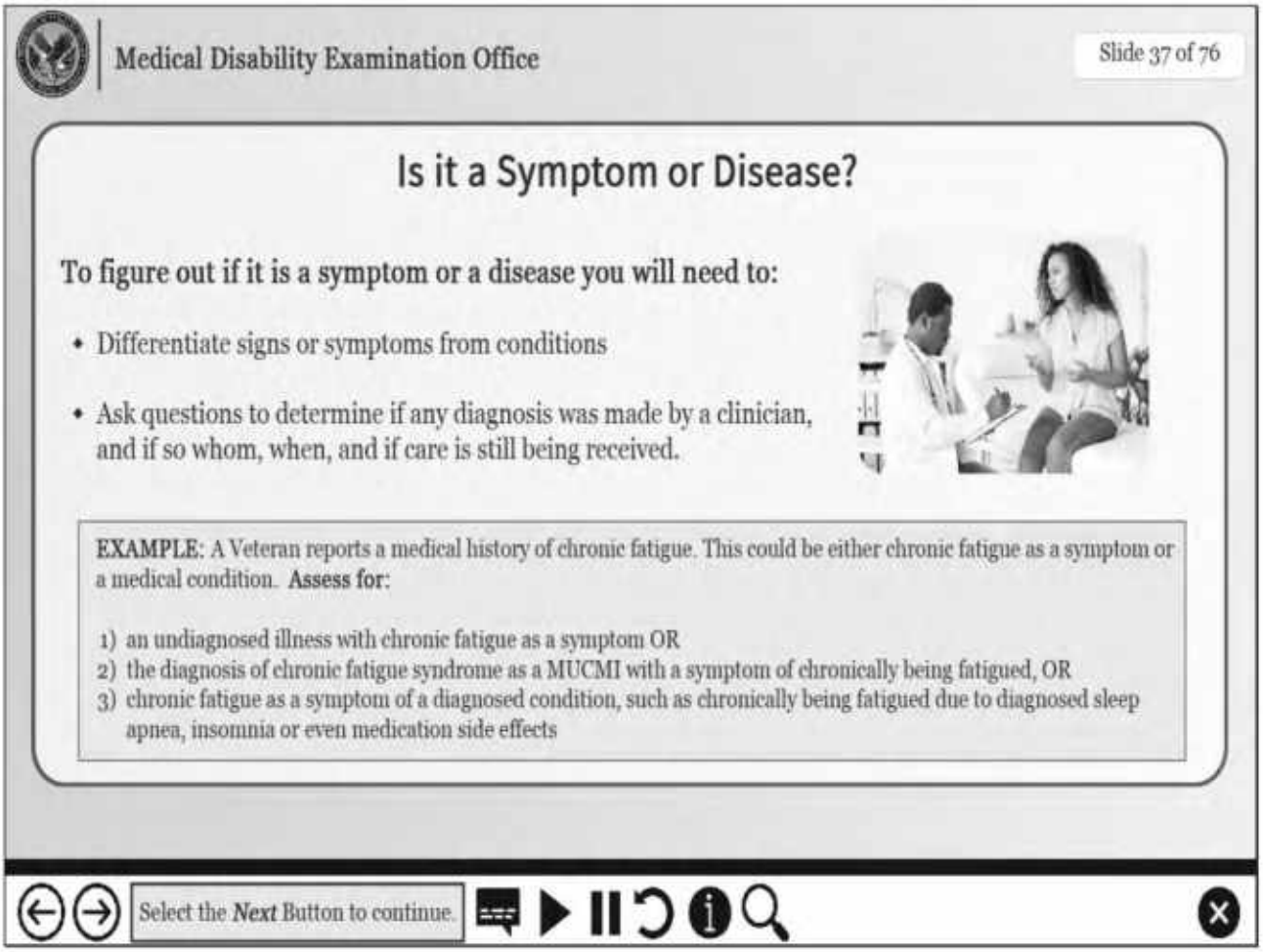
Slide 36 - Potential Signs & Symptoms of a Chronic Disability Pattern



Transcript

VA considers that any one of these may represent an undiagnosed illness or diagnosed medically unexplained chronic multisymptom illness for which the Veteran may be service connected; or you may determine that the symptom or symptoms is better explained by a diagnosis of a known condition. These symptoms could also result from other overlapping medical conditions, which must first be ruled out.

Slide 37 - Is it a Symptom or Disease?

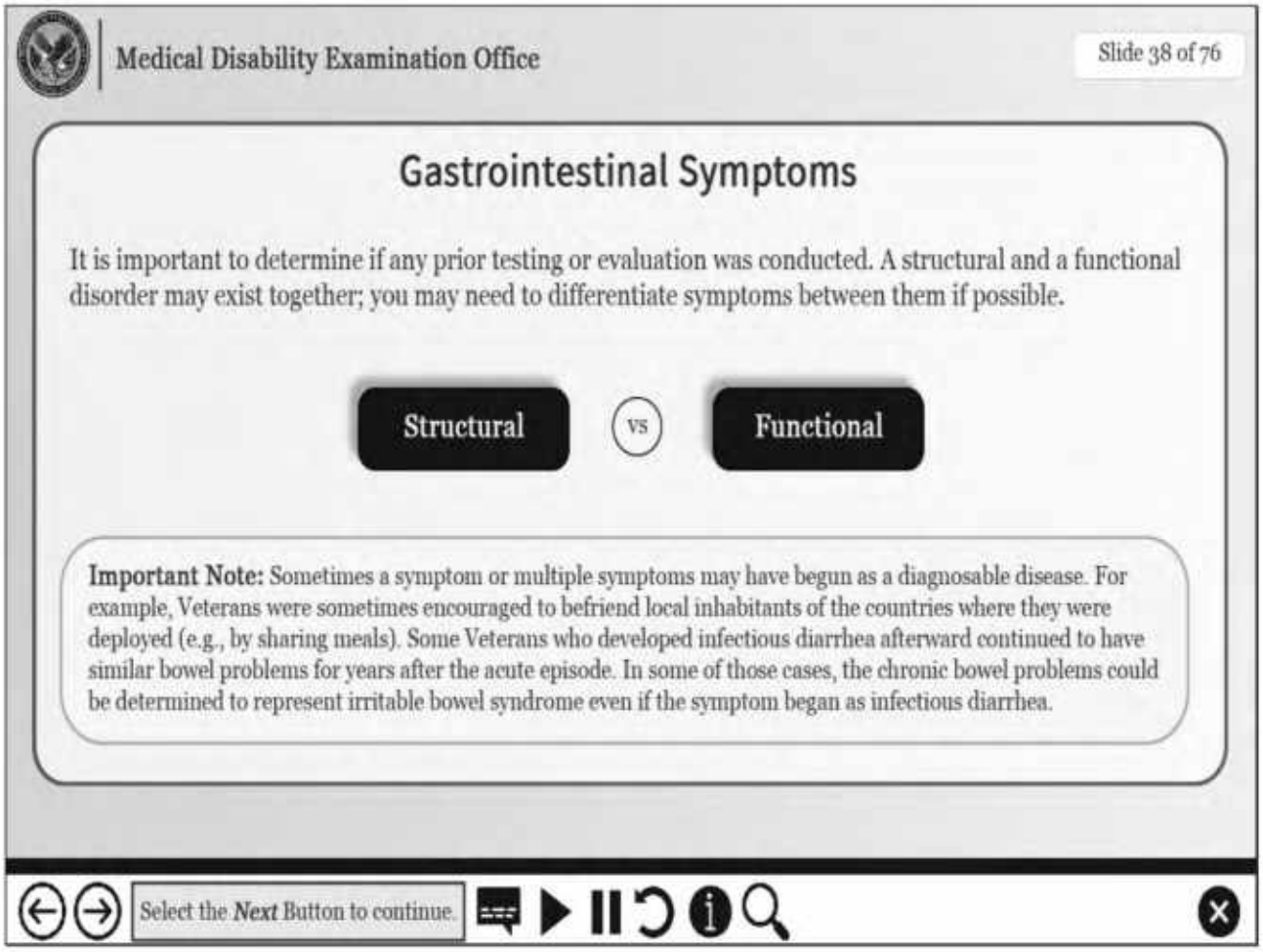


Transcript

Concentrate on symptoms during the medical history interview because you will need to differentiate signs or symptoms from conditions for this examination. For example, when a Veteran reports chronic fatigue, this could mean chronic fatigue as a symptom or a medical condition. Chronic fatigue can be a symptom of an undiagnosed illness but **chronic fatigue syndrome** is a chronic multisymptom illness with specific guidelines for diagnosis.

When Veterans tell you they have diagnoses that are potential MUCMIs (e.g., chronic fatigue syndrome, irritable bowel syndrome, or a functional GI disorder), ask questions to determine if the diagnosis was made by a clinician, and if so whom, when, and if care is still being received. This is important information to document in your examination report so it can be verified by your review of the medical records available in the eFolder.

Slide 38 - Gastrointestinal Symptoms

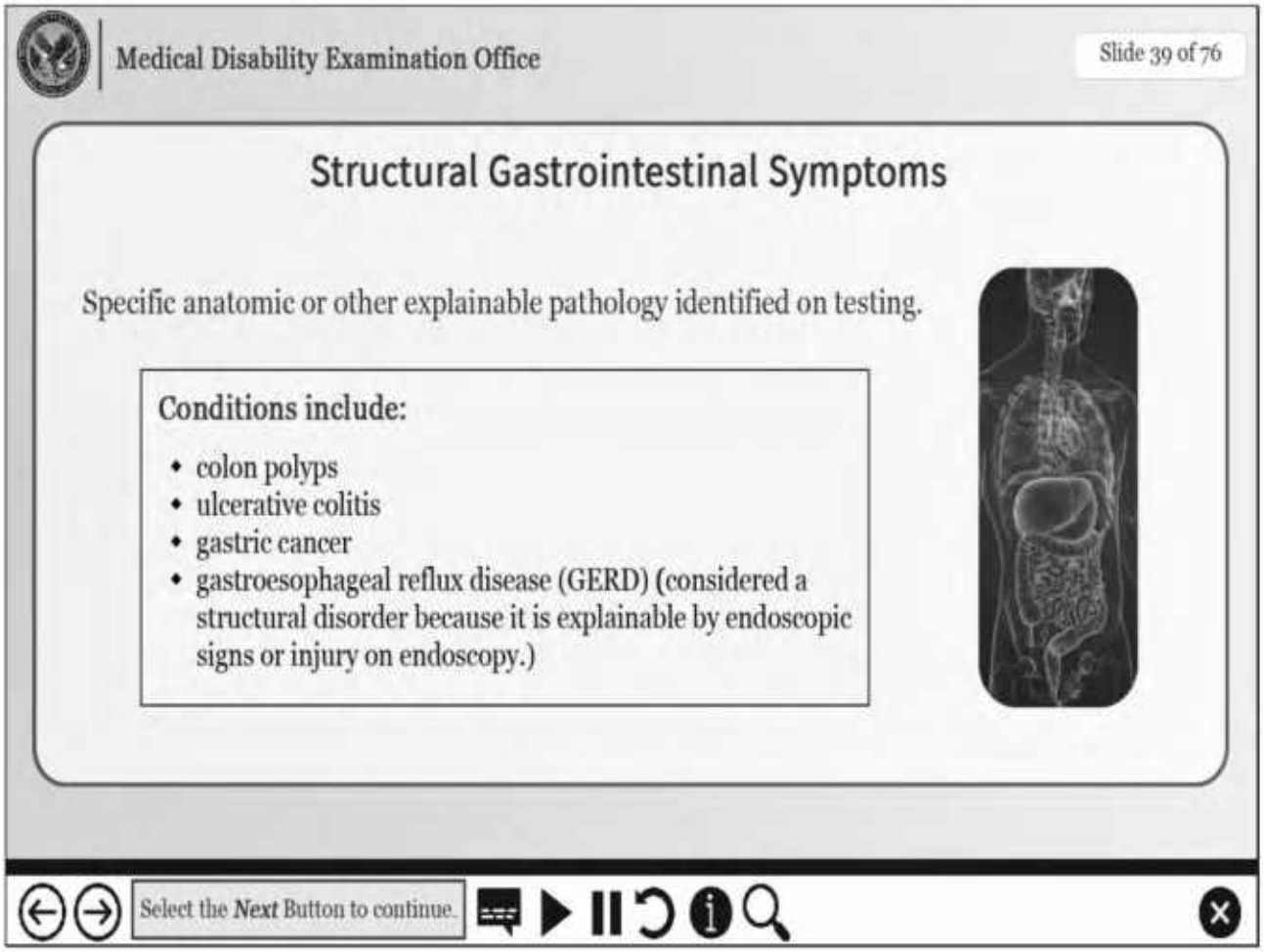


Transcript

If you will be evaluating Veterans who have gastrointestinal or GI complaints, you will need to determine if there has ever been any prior evaluation to investigate if they have structural GI conditions. If specific tests, for example, a colonoscopy or an esophagogastroduodenoscopy (EGD) were performed, include the results of these in the examination report.

Select the button for **Structural and Functional** to review the criteria for each gastrointestinal disorder.

Slide 39 - Structural GI Symptoms

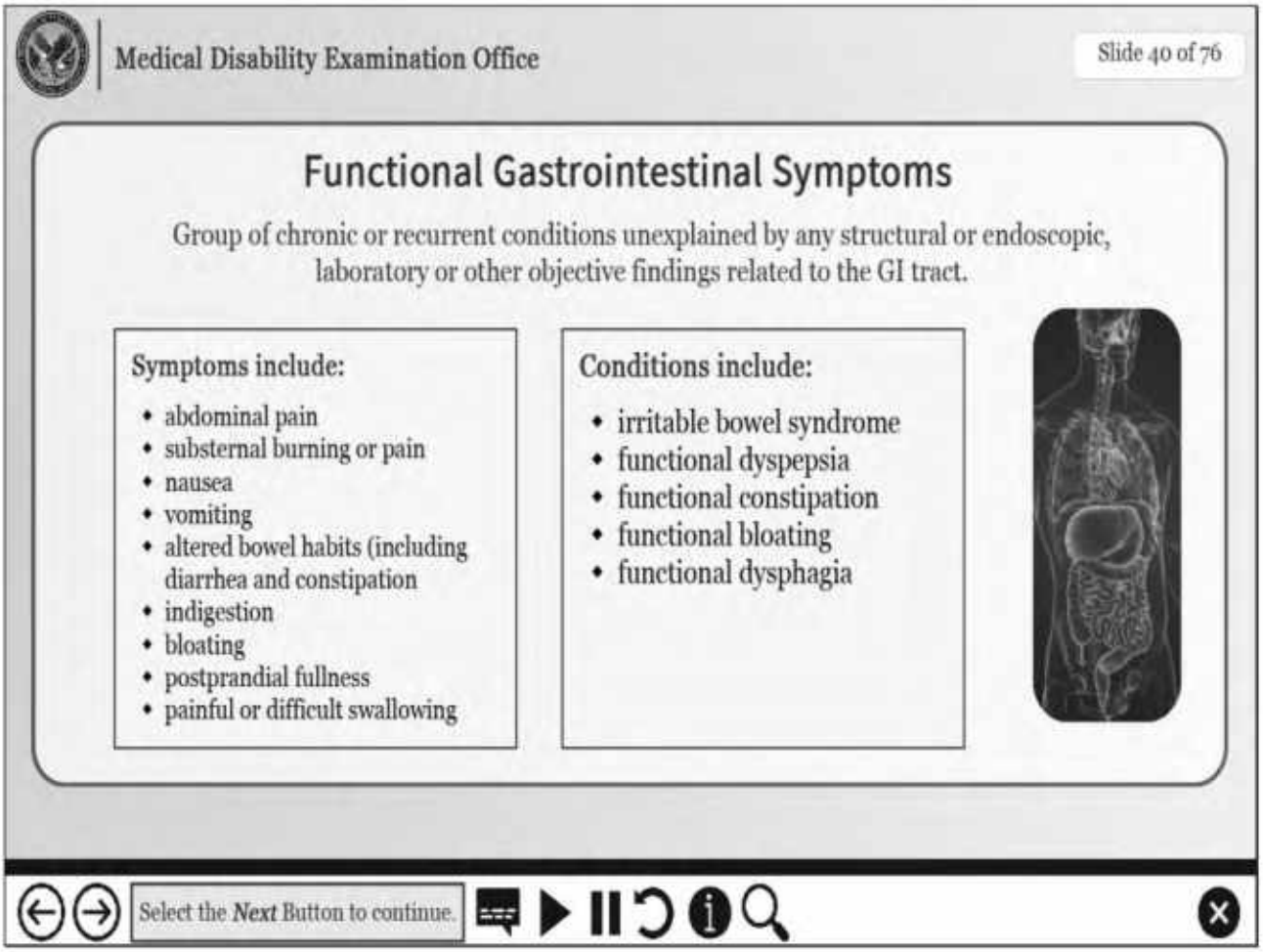


Transcript

The diagnosis is considered a structural condition if a specific anatomic or other explainable pathology is identified. These types of conditions include such things as colon polyps, ulcerative colitis, gastric cancer, and gastroesophageal reflux disease (GERD). Symptoms related to these conditions are not to be attributed to a functional bowel disorder. GERD is specifically not considered a category (2) disability pattern because it can be diagnosed by endoscopic signs or pH probe and therefore has a partially known etiology.

Recall that category 2 conditions have an unexplained etiology. This is why the VA only considers functional GI disorders as a category (2) disability pattern.

Slide 40 - Functional GI Symptoms

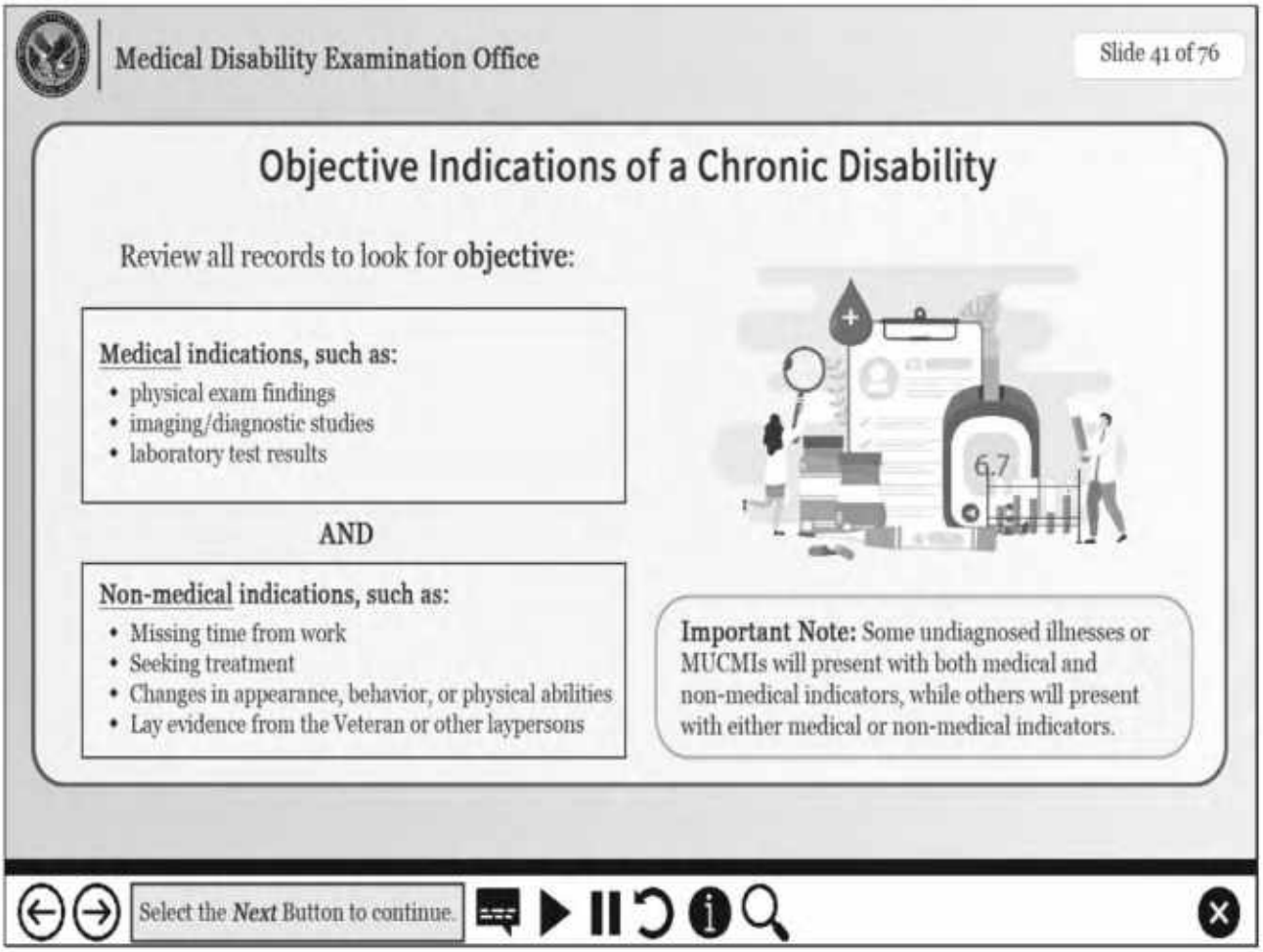


Transcript

A functional GI disorder is generally regarded as a diagnosis of exclusion. It is characterized by chronic or recurrent symptoms that are not explained by structural, endoscopic, laboratory, or other objective signs of injury or disease and may be related to any part of the GI tract. There are several symptoms that can occur, some vague or occurring in other conditions such as substernal burning or pain nausea, indigestion, altered bowel habits, and bloating Functional GI disorders include conditions such as irritable bowel syndrome but **do not** include structural GI diseases such as GERD.

When diagnosing a GI disorder, keep in mind that there is a specific question on the Gulf War medical statement that will ask if the condition is a functional or structural disorder. You will need to explain your answer with supporting evidence and rationale.

Slide 41 - Objective Indications of a Chronic Disability



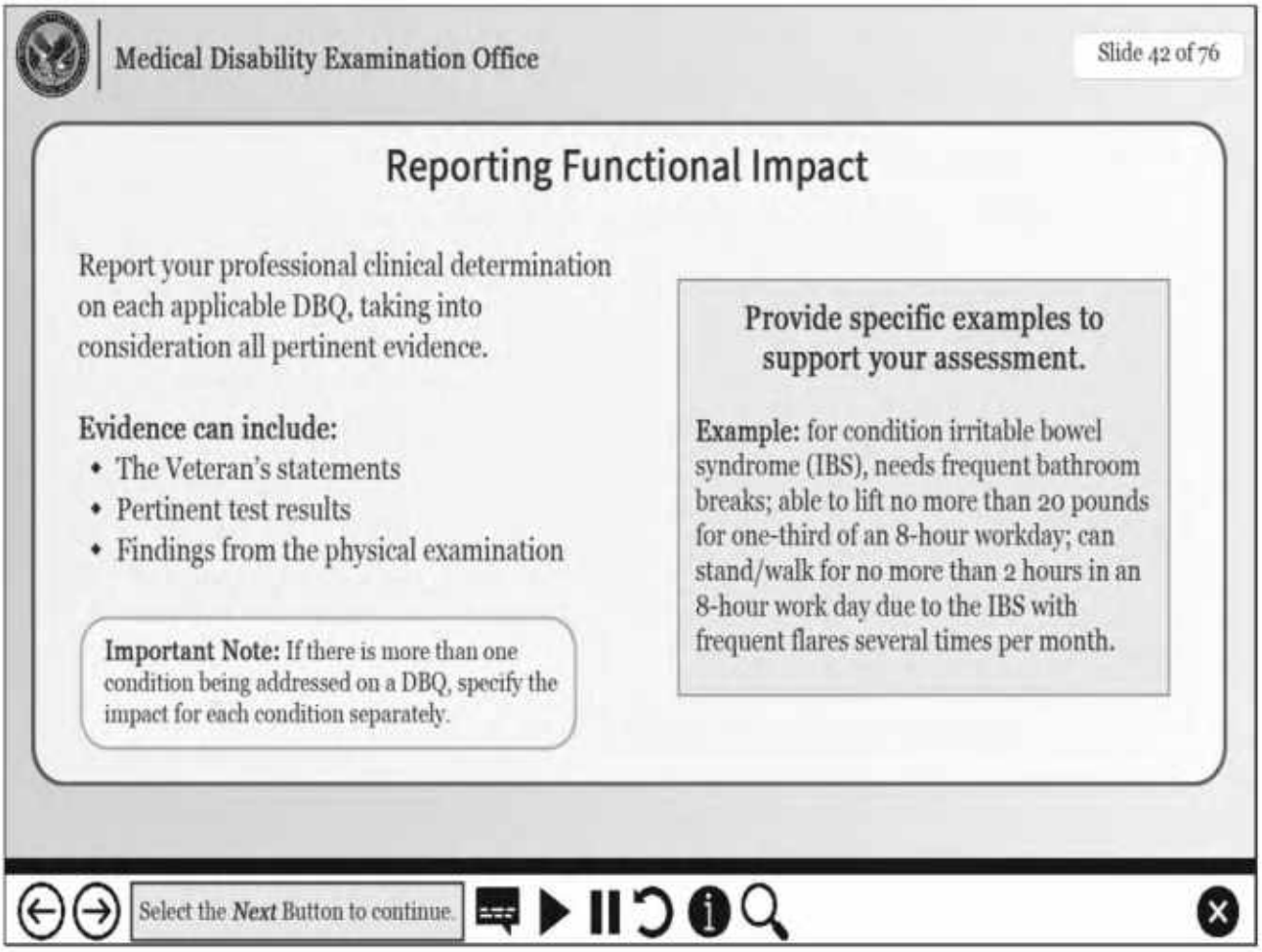
Transcript

For purposes of this section, the VA recognizes the phrase "objective indications of a chronic disability" to include both medical findings as well as written nonmedical evidence in the claims eFolder. These would include items such as vital signs measurements for the medical evidence, and documentation such as time lost from work as nonmedical evidence capable of independent verification.

You should review all records to look for objective medical indications of a chronic disability, such as physical exam findings, imaging studies, and laboratory tests. You should also be looking for nonmedical indicators such as missed time from work, seeking treatment, changes in appearance, behavior, or physical abilities, and lay evidence from the Veteran or other laypersons.

It is important to remember that some undiagnosed illnesses or MUCMIs will present with **both** medical and nonmedical indicators, while others will present with **either** medical or nonmedical indicators.

Slide 42 - Reporting Functional Impact

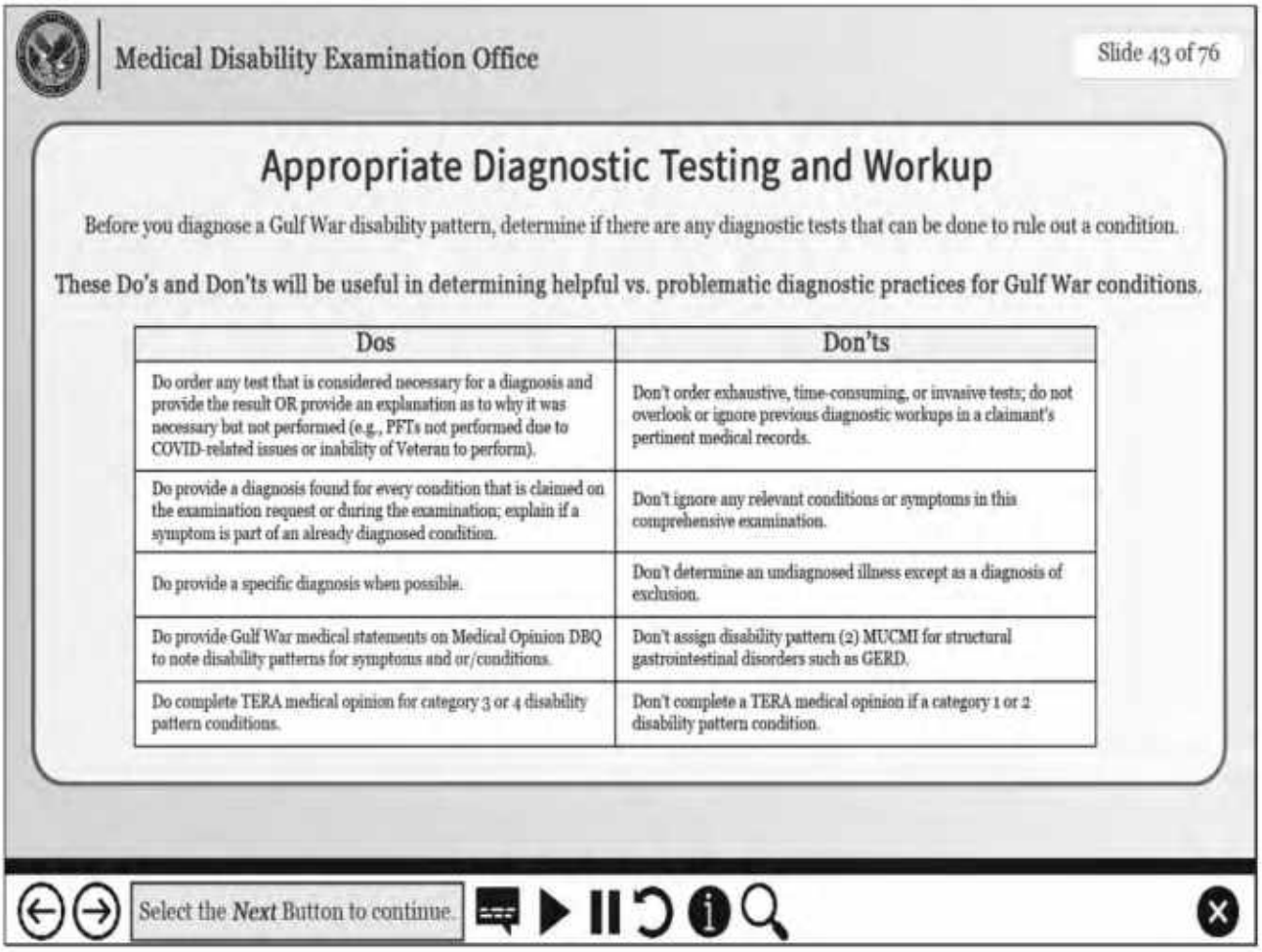


Transcript

Every disability examination requires you to describe the impact of a Veterans' conditions or disabilities on their occupational activities. The Gulf War General Medical examination is no exception. Most DBQs used for a Gulf War General Medical examination will prompt you for information about the functional impact of the condition assessed. Provide as much information as possible on the effects of a condition on Veterans' daily activities in relation to work and their ability to function in physical as well as sedentary occupational settings, regardless of whether they are currently employed.

Consider only the impact of the claimed condition with an emphasis on the occupational limitation of activity it imposes. Document the limitation and provide specific examples as needed, such as "needs the ability to take frequent bathroom breaks; able to perform lifting of no more than 20 pounds for one-third of an 8 hour workday; can stand/walk for approximately 2 hours total in an 8-hour work day due to irritable bowel syndrome with frequent flares several times per month."

Slide 43 - Appropriate Diagnostic Testing and Workup

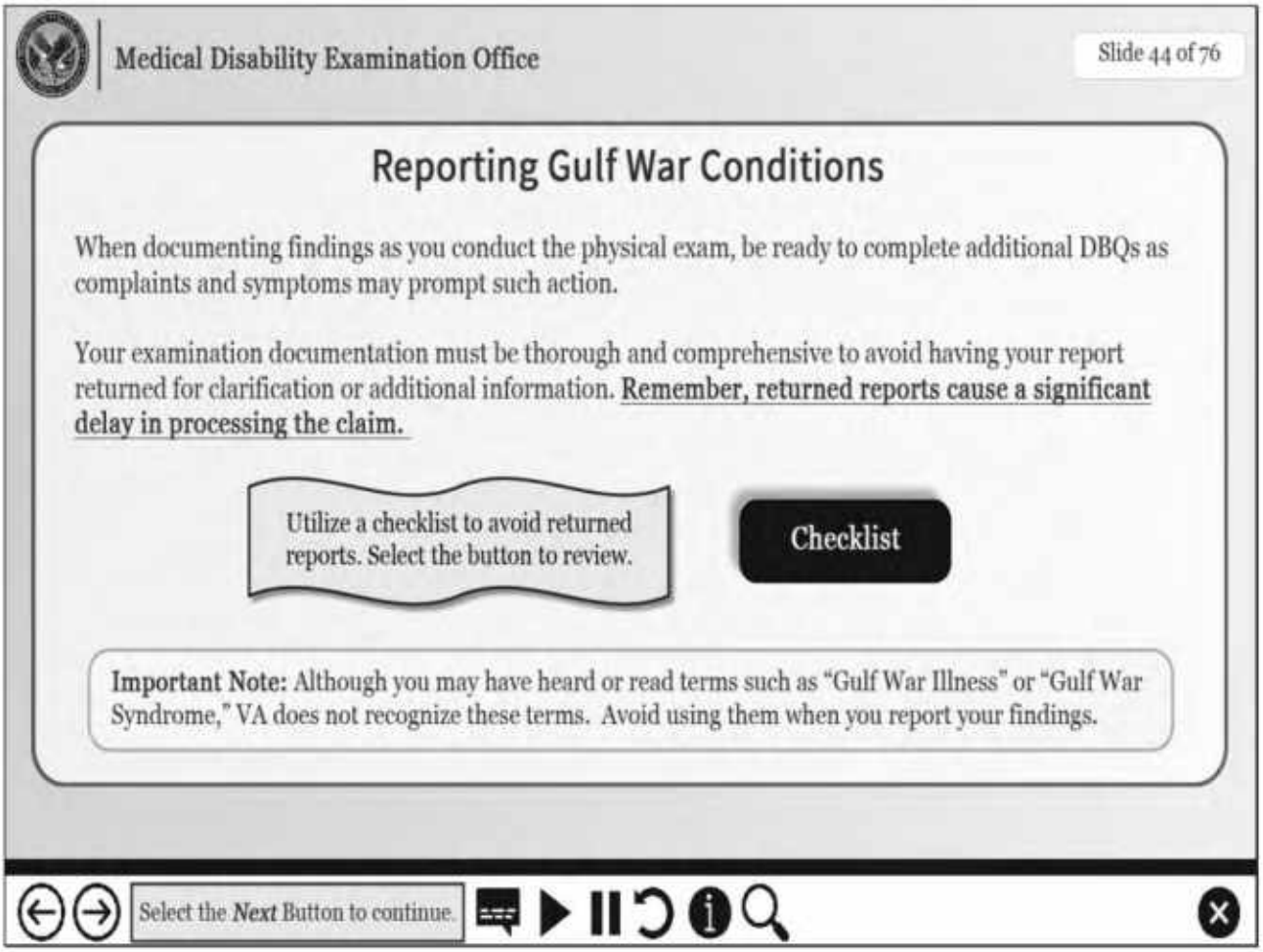


Transcript

Before you diagnose a disability pattern of either (1) an undiagnosed illness or (2) a MUCMI, determine if there is any non-invasive testing needed based on the Veteran's specific signs and symptoms to exclude other diagnosable conditions. It is not necessary to request or conduct a vast array of tests. Only limited or specific diagnostic workups should be ordered. Carefully review all the available medical records. In general, invasive procedures such as (but not limited to) a stress test, angiogram or biopsy are not conducted for compensation evaluations. Simple tests that are easily conducted and do not pose a risk to the Veteran are appropriate. Also, make sure that you've looked in the eFolder at all available medical records for any previous testing and results. All test results obtained as part of an examination (normal or abnormal) should be included in the appropriate examination report.

This list shown on screen shows some Dos and Don'ts for the diagnostic workup and will be useful in determining helpful versus problematic diagnostic practices for Gulf War conditions.

Slide 44 - Reporting Gulf War Conditions



Transcript

Use the Gulf War General Medical and other DBQs requested by VBA on the ESR as you conduct the physical examination. During the physical examination it is important to document your findings as you conduct the exam to make sure everything is accurately captured. Keep in mind that the Veteran's complaints and symptoms may prompt additional DBQs to be completed.

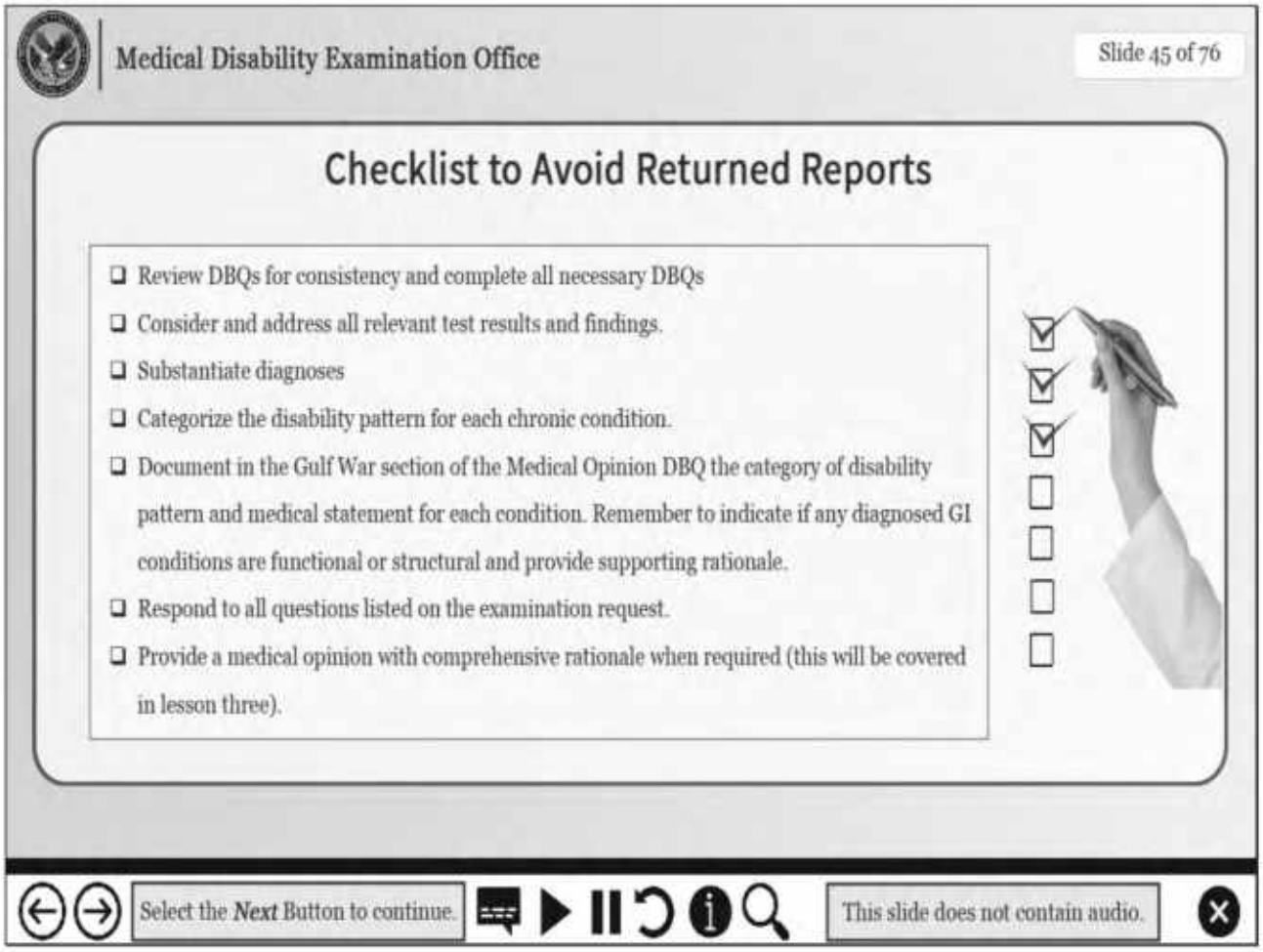
Finalize your documentation of the Gulf War General Medical examination as soon as possible after examining the Veteran to ensure your report is accurate. Your reporting is not complete until you address all claimed conditions by providing the applicable history (including any treatment and side effects), your examination findings, and pertinent test results (if already of record or performed as part of the exam) for the interval required by the examination request.

If you confirm a disability pattern according to VA criteria, describe current symptoms and physical findings. It's also important to include functional limitations or impairments resulting from all assessed conditions. Additionally, it is important to avoid the use of "Gulf War Illness" and "Gulf War Syndrome," which are not recognized terms used by the VA.

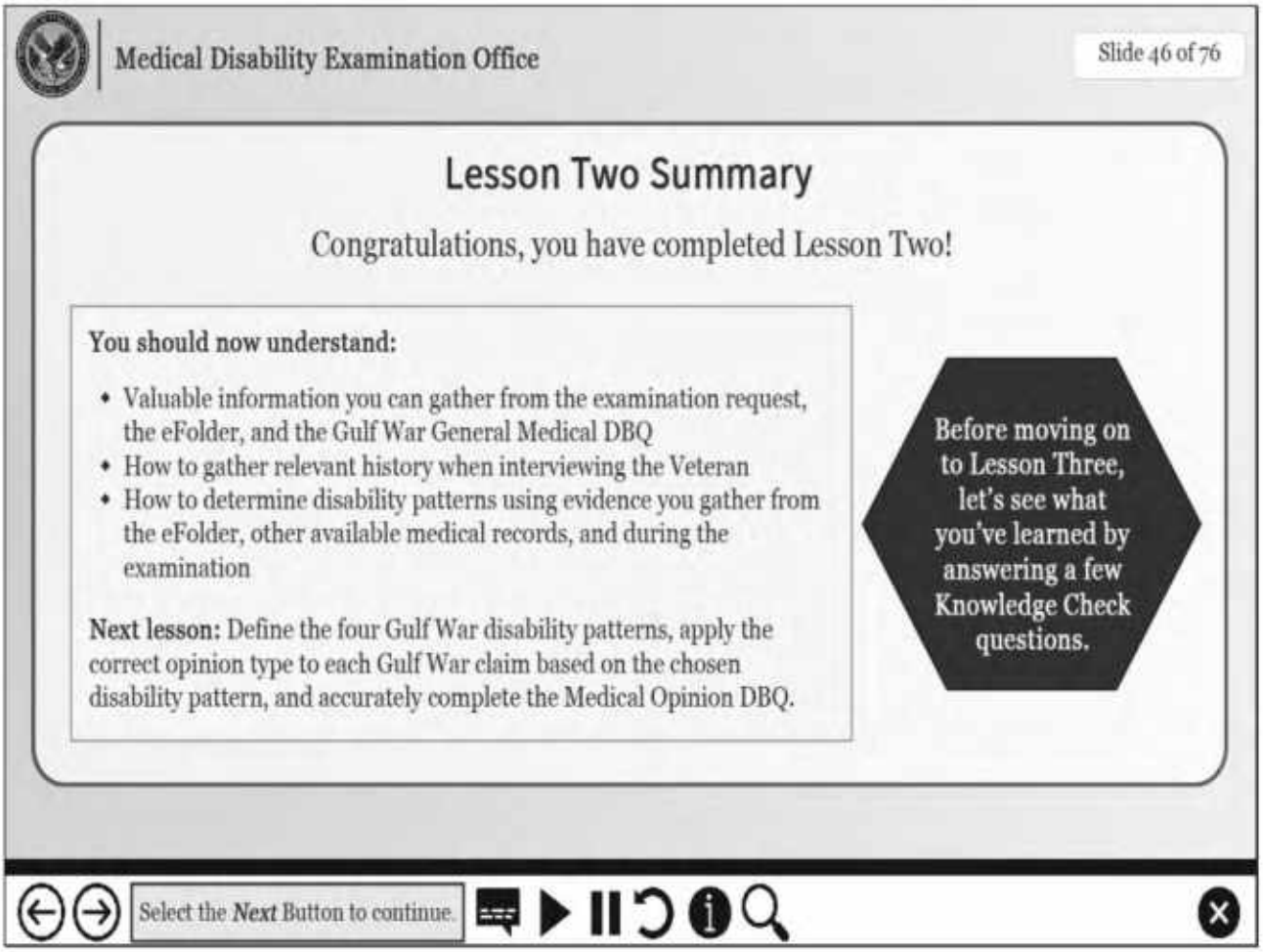
Utilize a checklist to avoid returned examinations from the VA.

Select the button to review that checklist.

Slide 45 - Checklist to Avoid Returned Reports



Slide 46 - Lesson Two Summary



Transcript

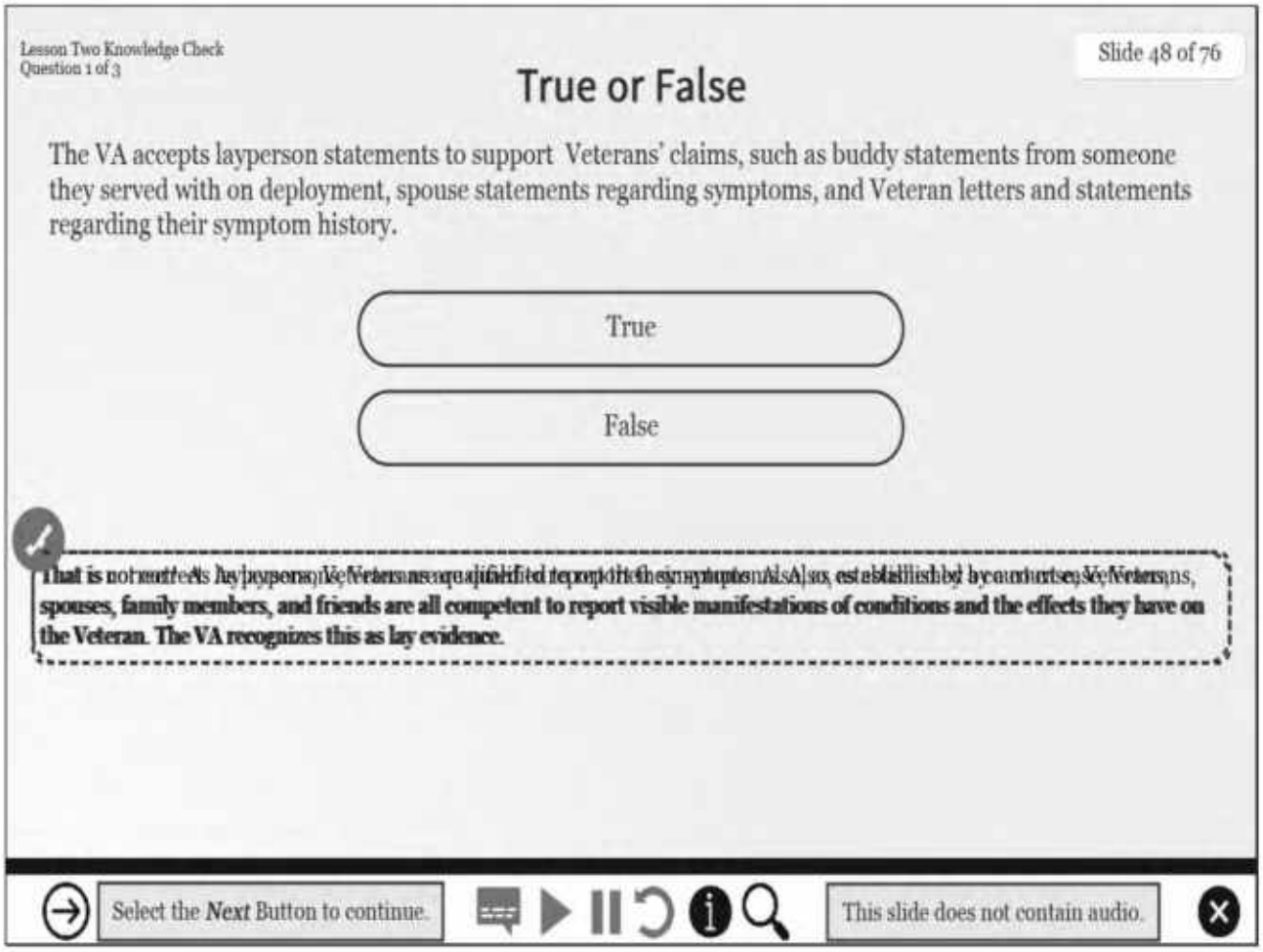
You have completed Lesson 2, on preparing for and conducting a C&P Gulf War General Medical examination. This lesson aimed to help you understand the various types of valuable information you can gather from the examination request, the eFolder, and the Gulf War General Medical DBQ. When conducting the examination, you now know the guidelines for gathering relevant history as you interview the Veteran. You also gained guidance on determining disability patterns using the evidence you gathered from the eFolder, other available medical records, and during the examination.

The next lesson will guide you in recognizing the four Gulf War disability patterns, applying the correct opinion type to each Gulf War claim, and accurately completing the medical opinion DBQ. However, before you move on to Lesson Three please answer the following Knowledge Check Questions.

Slide 47 - Knowledge Check Introduction



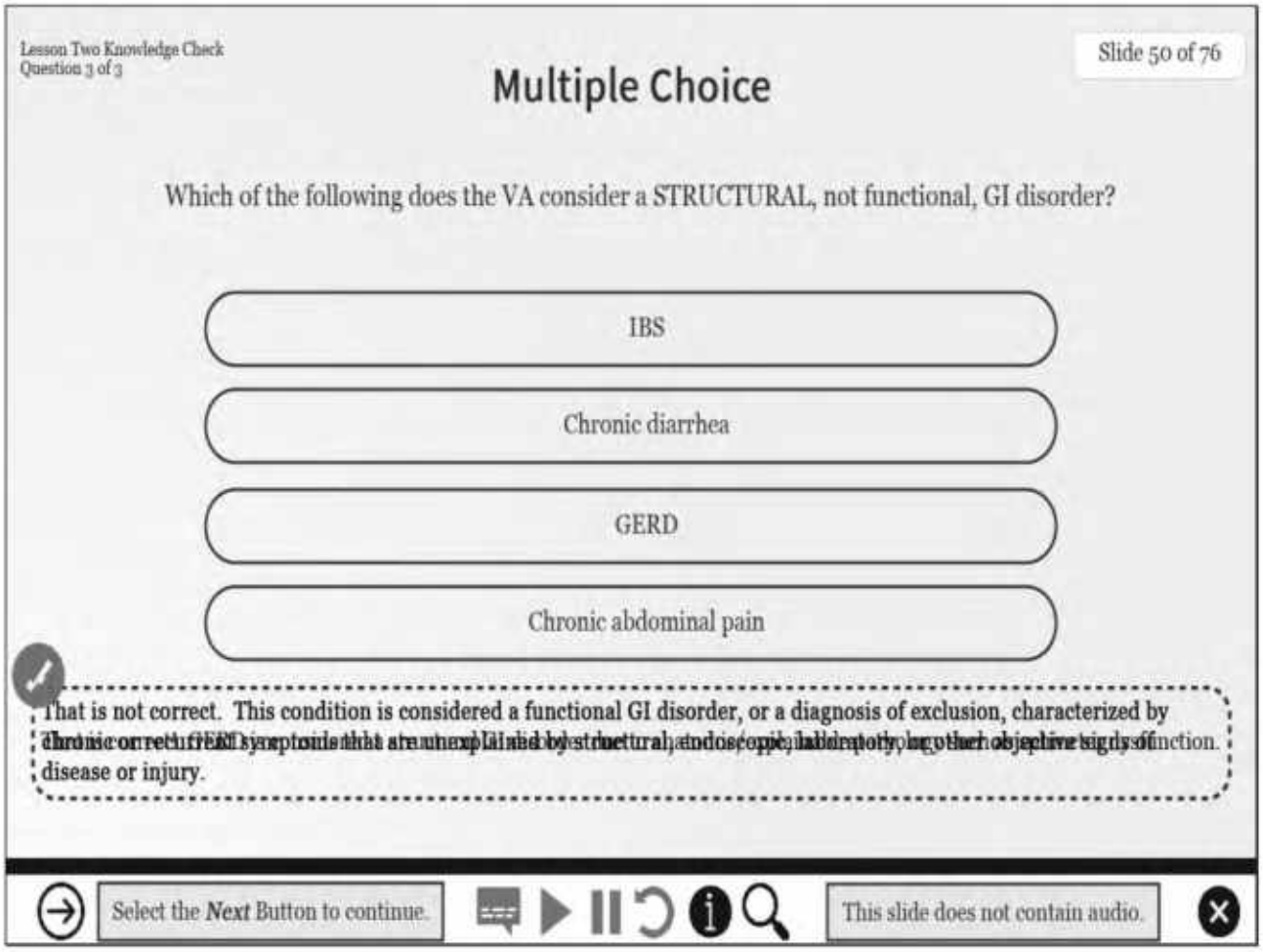
Slide 48 - Lesson Two Knowledge Check Question One



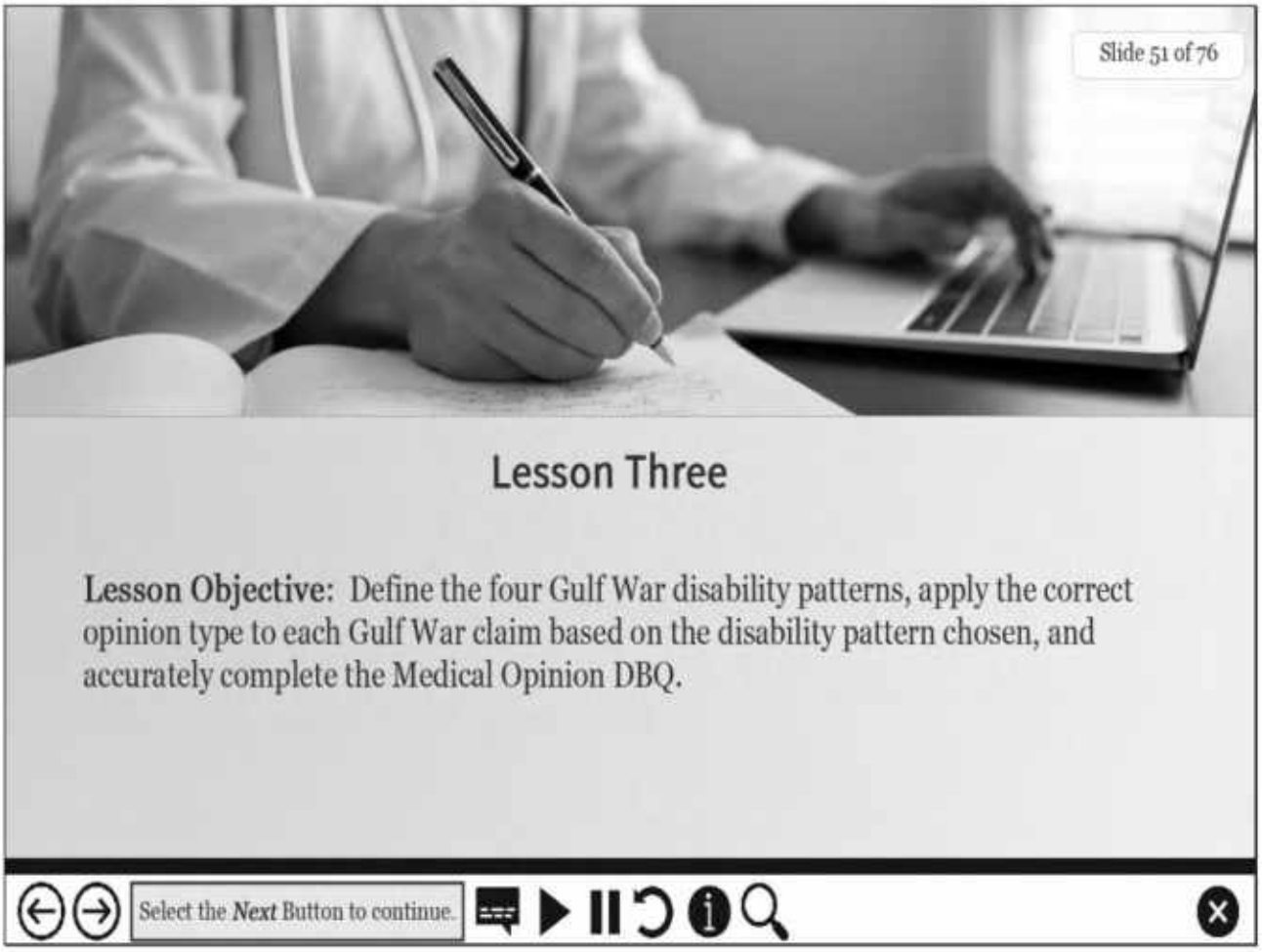
Slide 49 - Lesson Two Knowledge Check Question 2



Slide 50 - Lesson Two Knowledge Check Question Three



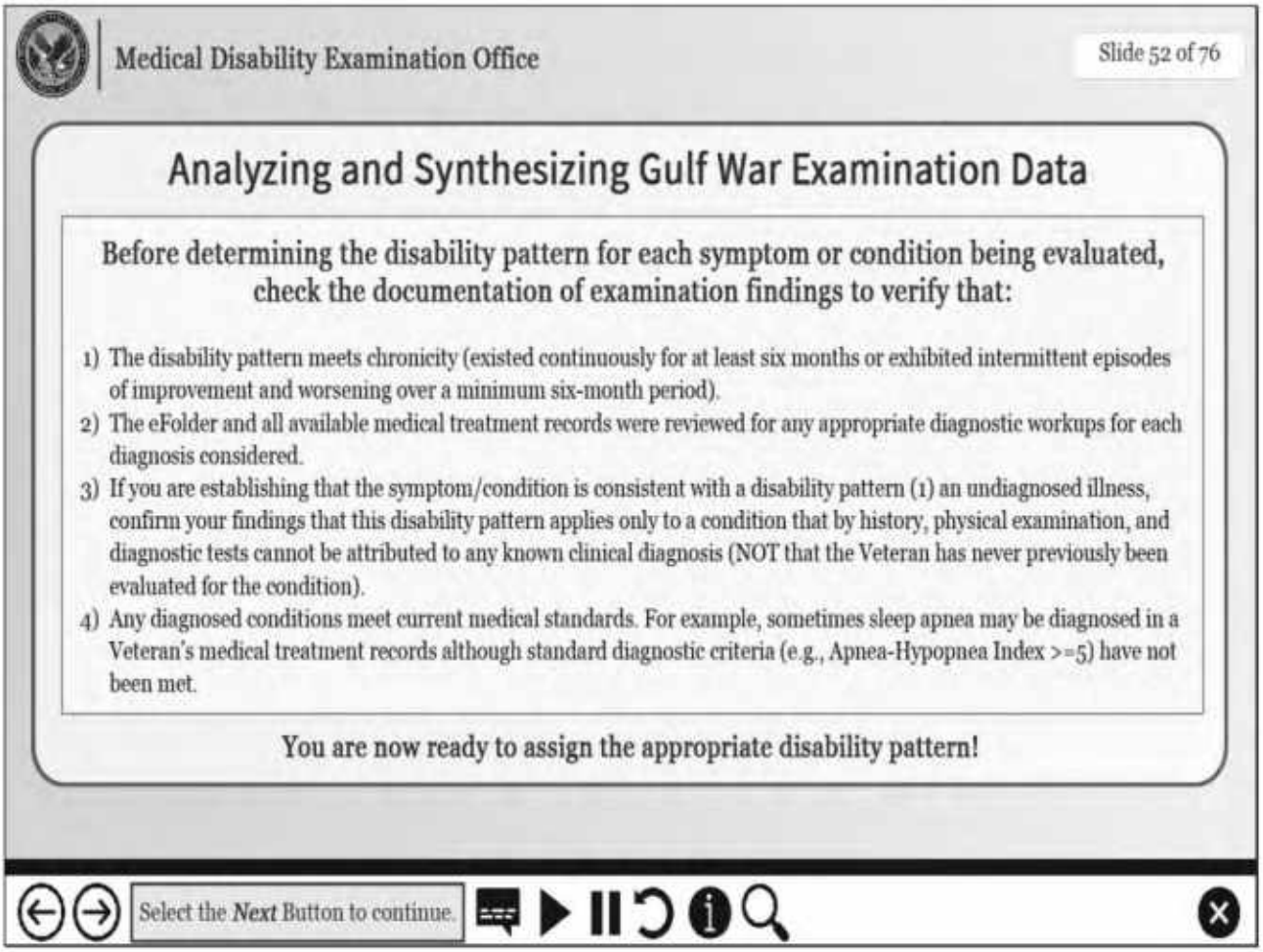
Slide 51 - Lesson Three Objective



Transcript

In Lesson Three you will learn how to define the four Gulf War disability patterns, apply the correct opinion type to each Gulf War claim based on the disability pattern chosen, and accurately complete the medical opinion.

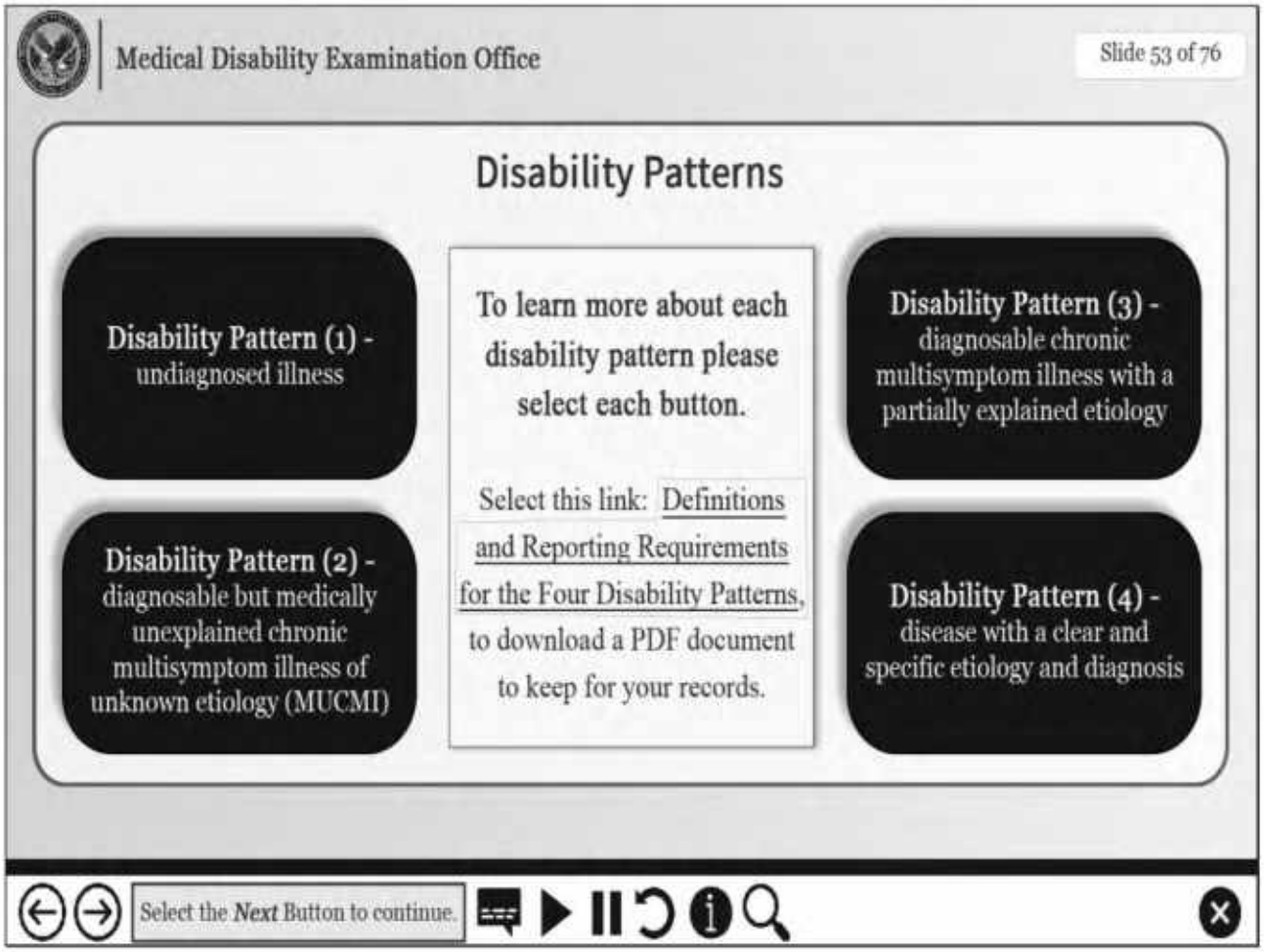
Slide 52 - Analyzing and Synthesizing Gulf War Examination Data



Transcript

In Lesson Two, you learned the information and evidence needed to be able to properly classify the disability pattern each symptom or diagnosis falls under. On screen, you are provided with reminders of what is needed to analyze and synthesize the data that was collected from the physical exam and/or any other evidence in the eFolder. Once your review is complete, then you are ready to assign a disability pattern and provide your medical statement and opinion if required.

Slide 53 - Disability Patterns



Transcript

Select each disability pattern to be provided with the definition, special requirements, and reporting requirements of each category.

Additionally, a downloadable PDF is available that provides a summary of the definitions and reporting requirements for all the disability patterns. Select the link on the screen to open that document and save for future reference.

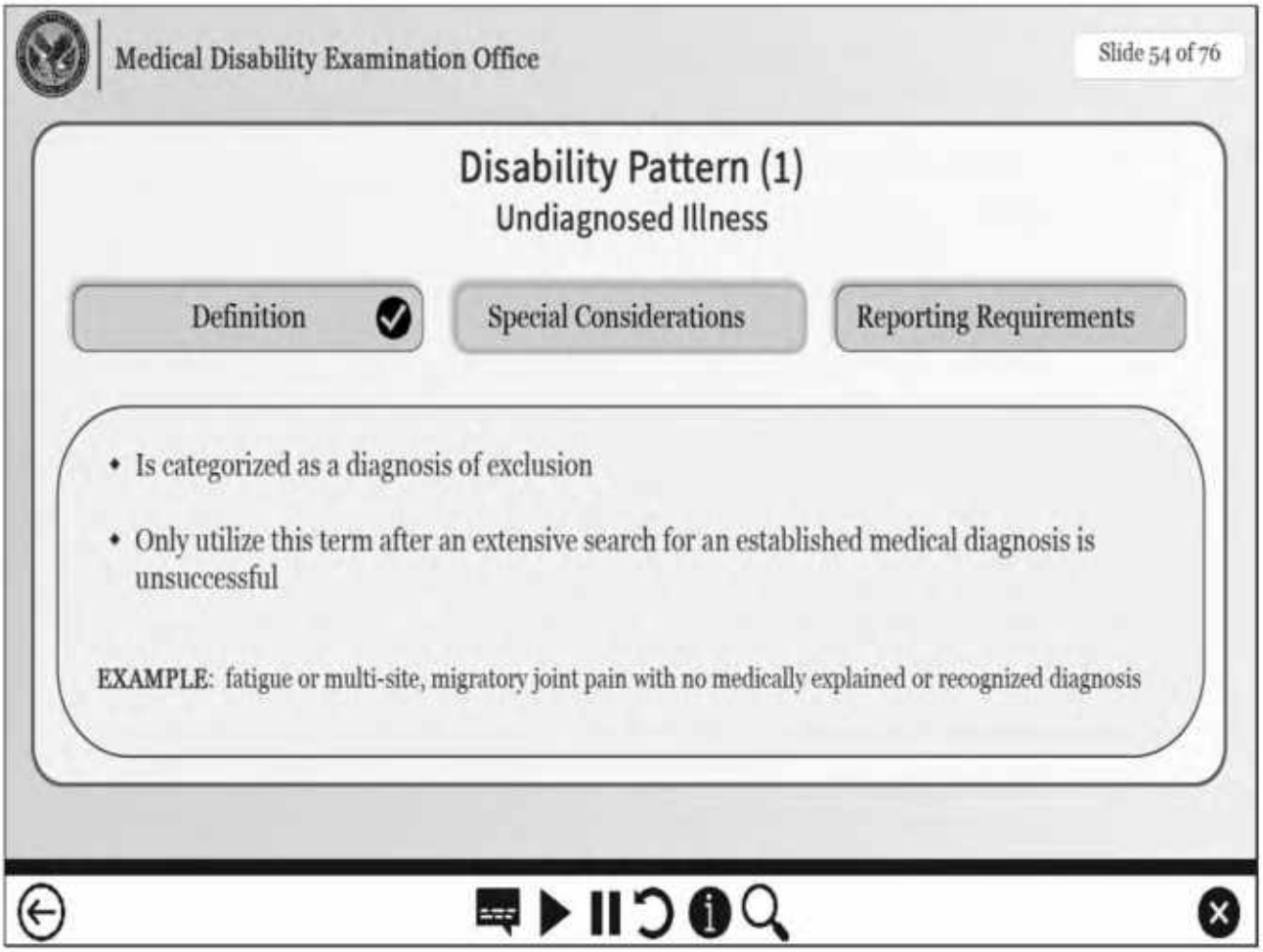
Slide 54 - Disability Pattern (1)



Transcript

Select each button to learn more about disability pattern 1, **undiagnosed illness**.

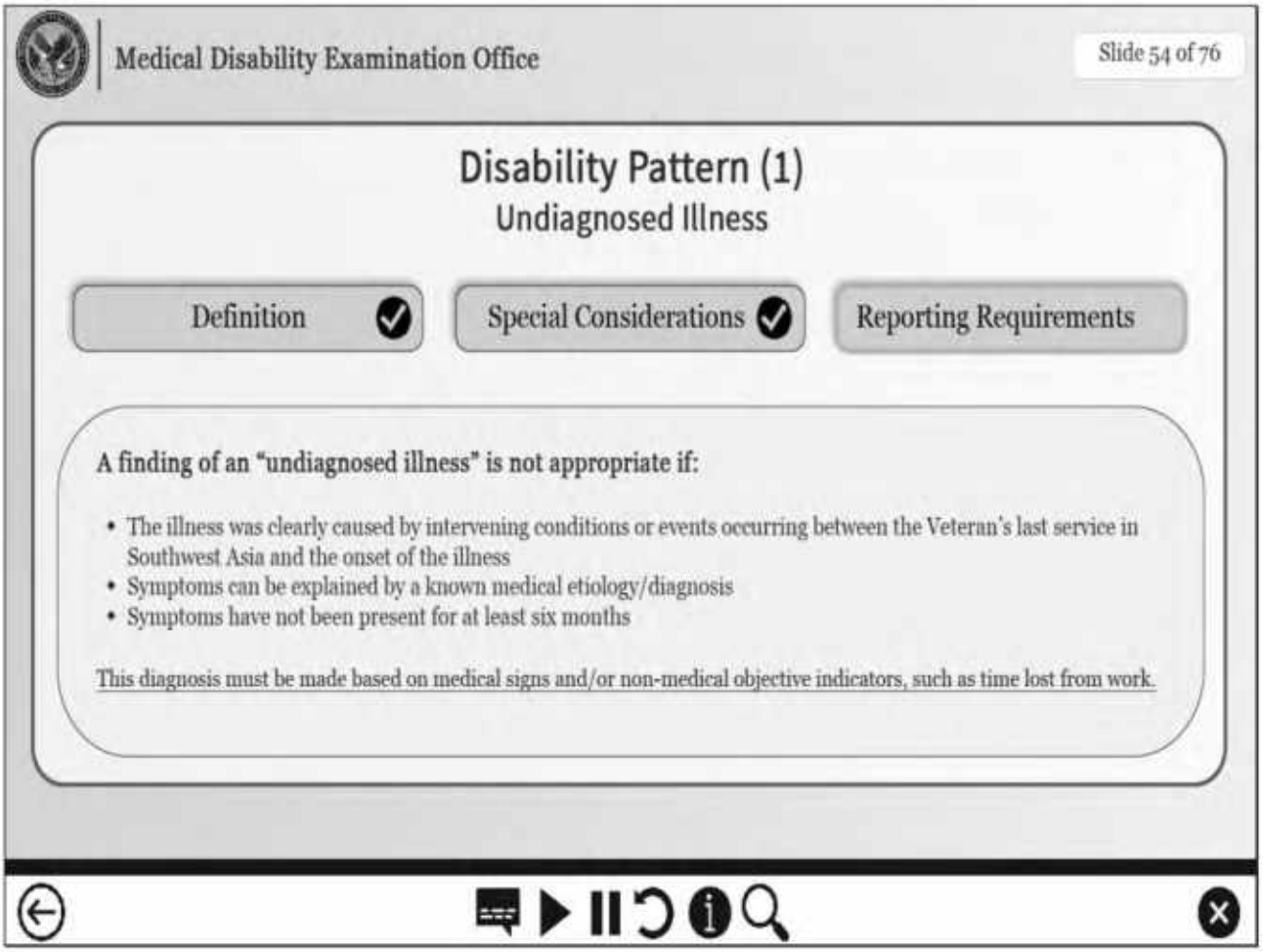
Slide 55 - Disability Pattern (1)



Transcript

The VA defines an undiagnosed illness as a diagnosis of exclusion. You will recall a symptom or condition should only be placed in this category after a search for an established medical diagnosis is unsuccessful. Review the medical records to ensure that other providers have ruled out possible causes of the claimed symptoms, or that a condition is not better accounted for by another diagnosed condition. This practice will avoid overlooking any diagnosable illness for which a Veteran can seek treatment. For example, fatigue can be a symptom of obstructive sleep apnea, which is a diagnosable condition, but if other conditions have been ruled out, it may be a category (1) undiagnosed illness.

Slide 56 - Disability Pattern (1)



Transcript

A finding of undiagnosed illness is not supported if the illness was clearly caused by intervening conditions or events occurring between the Veteran's last service in Southwest Asia and the onset of the illness; if symptoms can be explained by a known diagnosis; or if symptoms have not been present for at least six months. This determination also requires replicable objective findings (capable of independent verification) that are not accounted for by another clinical condition. In other words, this diagnosis must be made based on medical signs and/or nonmedical objective indicators, such as time lost from work.

An undiagnosed illness must be considered chronic and must have existed for six months or more **or** exhibit intermittent episodes of improvement or worsening over a six-month period.

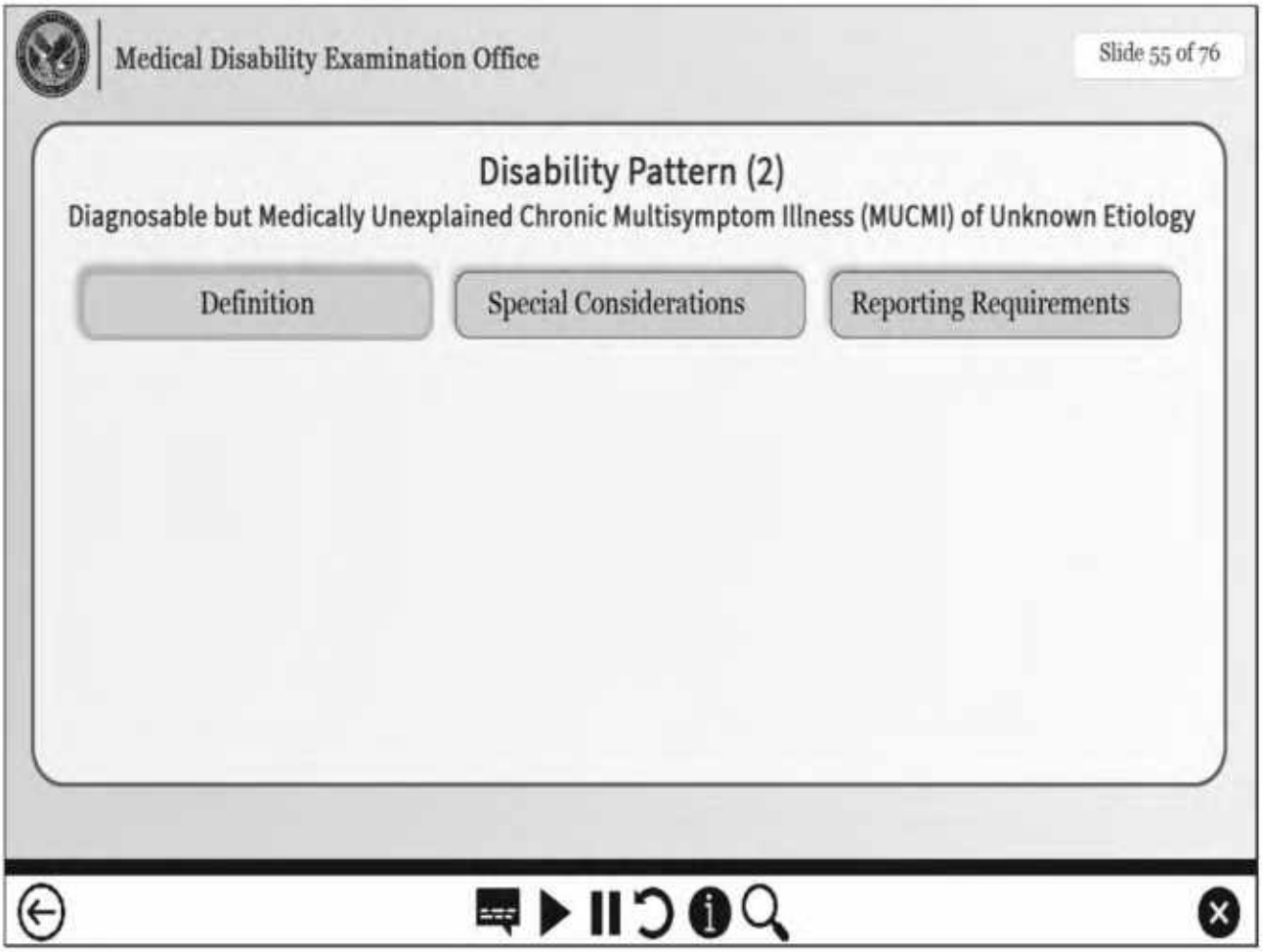
Slide 57 - Disability Pattern (1)



Transcript

If, at the end of your evaluation, you determine the disability pattern to be an undiagnosed illness then you will need to provide a medical statement with supporting rationale in the Gulf War section of the Medical Opinion DBQ.

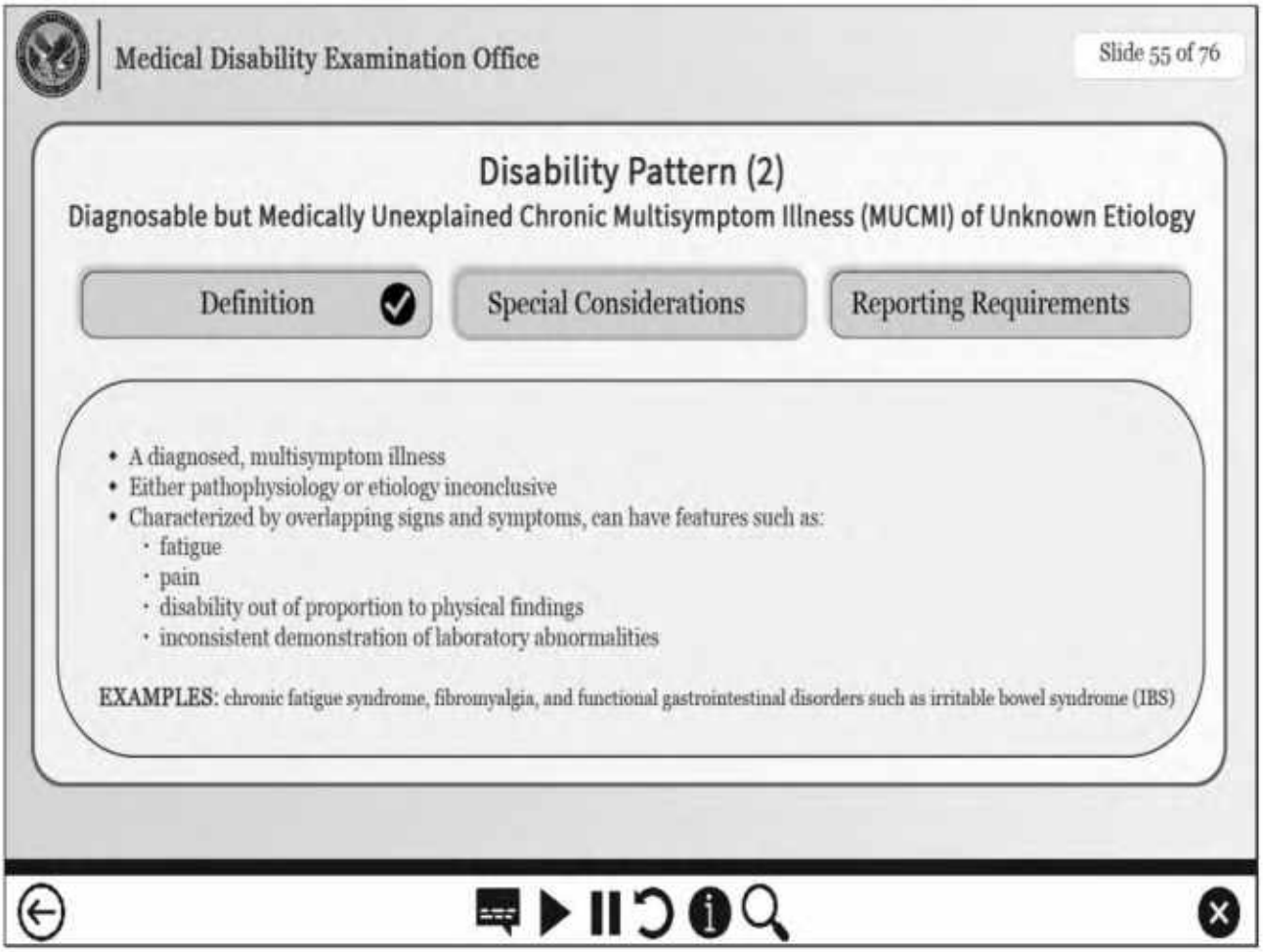
Slide 58 - Disability Pattern (2)



Transcript

Select each button to learn more about disability pattern 2, **diagnosable but medically unexplained chronic multisymptom illness (MUCMI) of unknown etiology**.

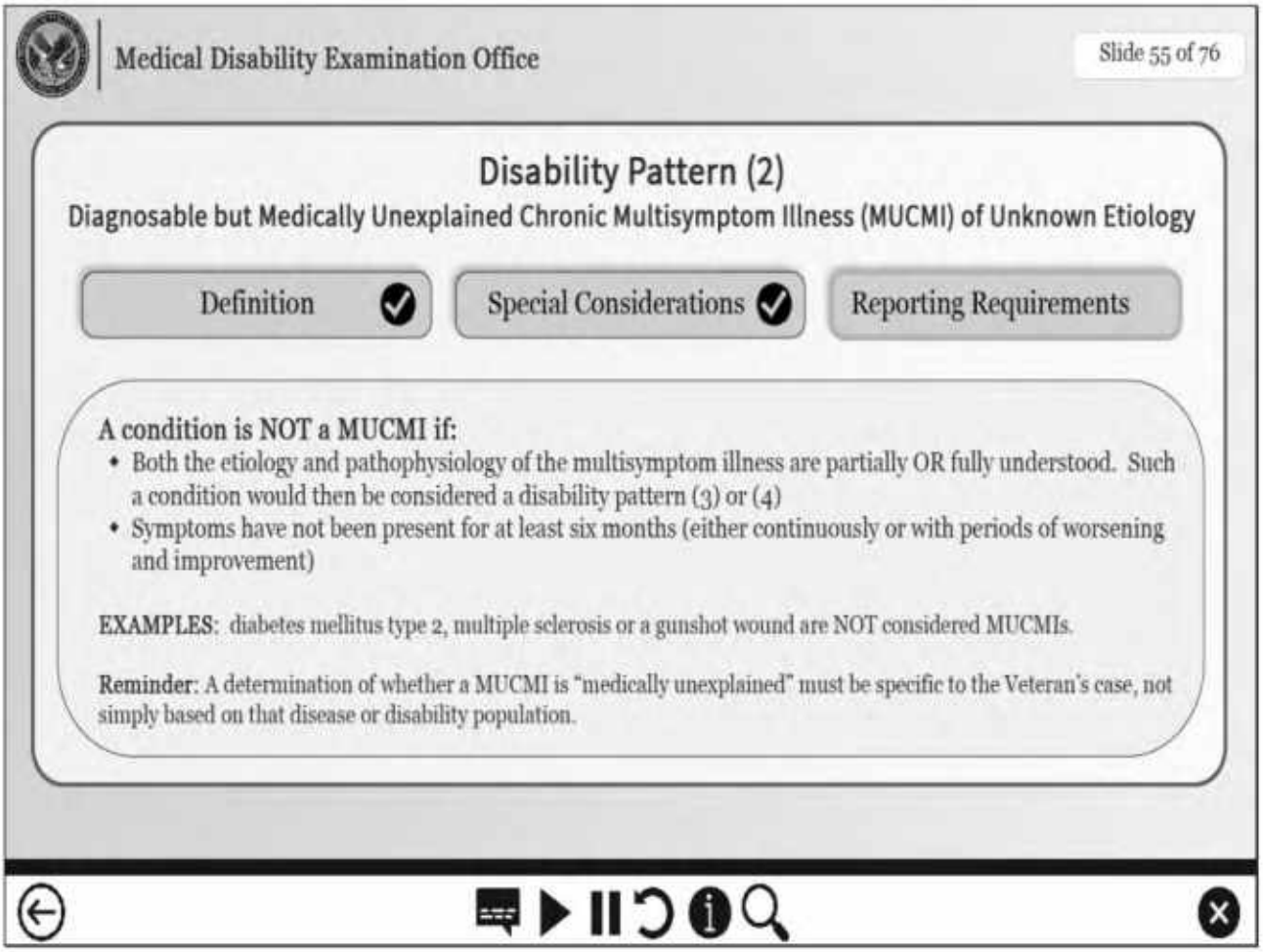
Slide 59 - Disability Pattern (2)



Transcript

A multisymptom illness is a MUCMI when either the etiology **or** pathophysiology of the illness is inconclusive. In other words, are they both inconclusive **or** is at least one of them inconclusive? It is characterized by overlapping signs and symptoms and has features such as fatigue, pain, or disability out of proportion to physical findings, and inconsistent demonstration of laboratory abnormalities. Some common examples of a MUCMI include: chronic fatigue syndrome characterized by long-term and severe fatigue that is not relieved by rest and is not directly caused by other conditions; fibromyalgia characterized by widespread muscle pain (other symptoms may include insomnia, morning stiffness, headache, and memory problems); and functional gastrointestinal disorders such as irritable bowel syndrome (IBS).

Slide 60 - Disability Pattern (2)

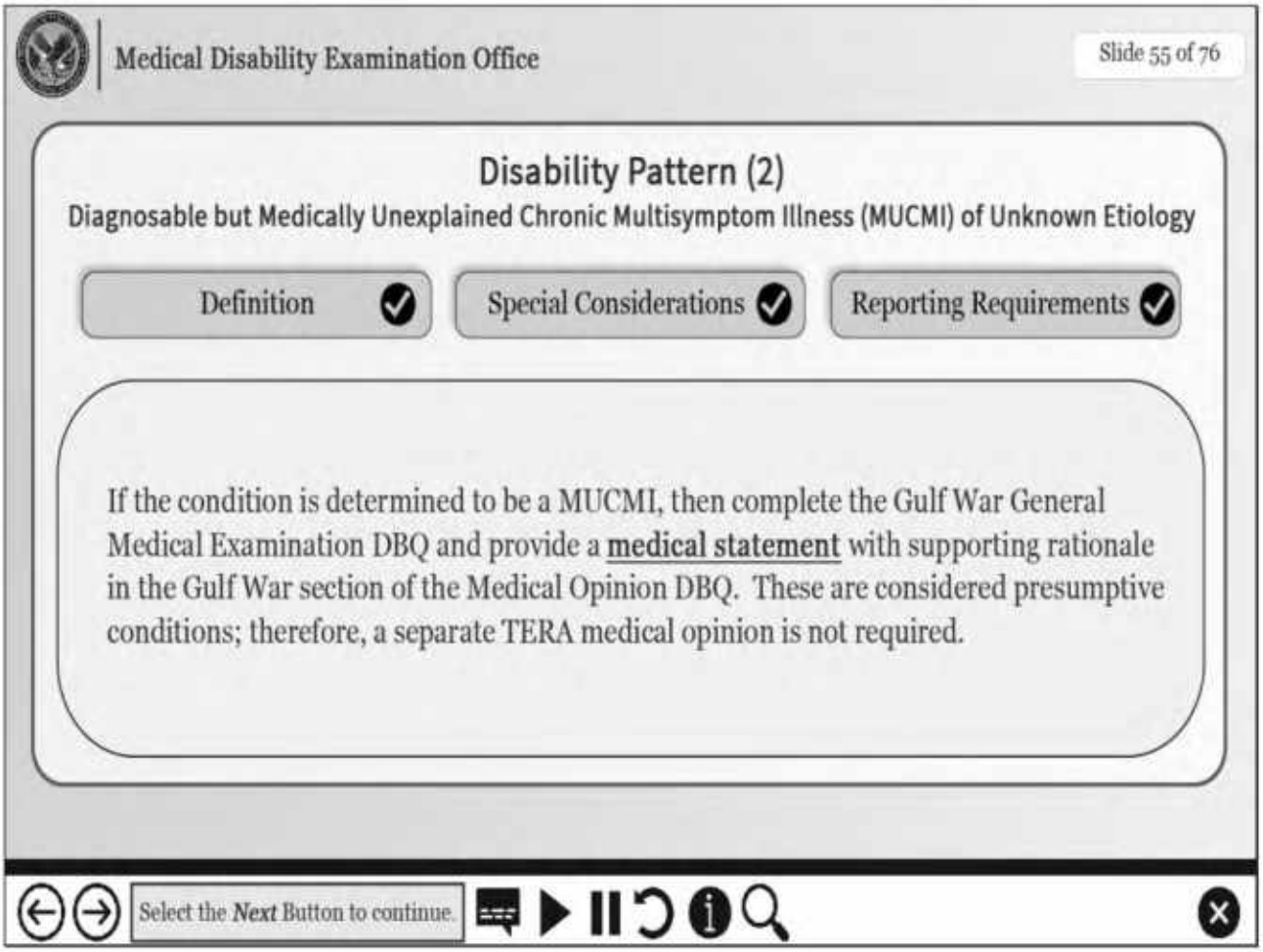


Transcript

If **both** the etiology **and** pathophysiology of the multisymptom illness are partially or fully understood, then the illness is not a MUCMI. Such a multisymptom illness would be classified under category (3) a multisymptom illness with a partially explained etiology (for example diabetes mellitus) or (4) a disease with a clear and specific etiology (for example a gunshot wound), rather than as a category (2) disability pattern, which is for a MUCMI of unknown etiology.

A MUCMI must also meet the six-month criteria for chronicity. Furthermore, the determination of whether a MUCMI is "medically unexplained" (meaning the etiology **and** pathophysiology of the multisymptom illness are unknown) must be specific to the Veteran's case and not simply based on the disease or disability population as a whole. This means that any medical statement you provide for a MUCMI must be based on the evidence and examination findings of the Veteran to whom it applies. When citing risk factors, for example, they should be pertinent to the Veteran you are discussing.

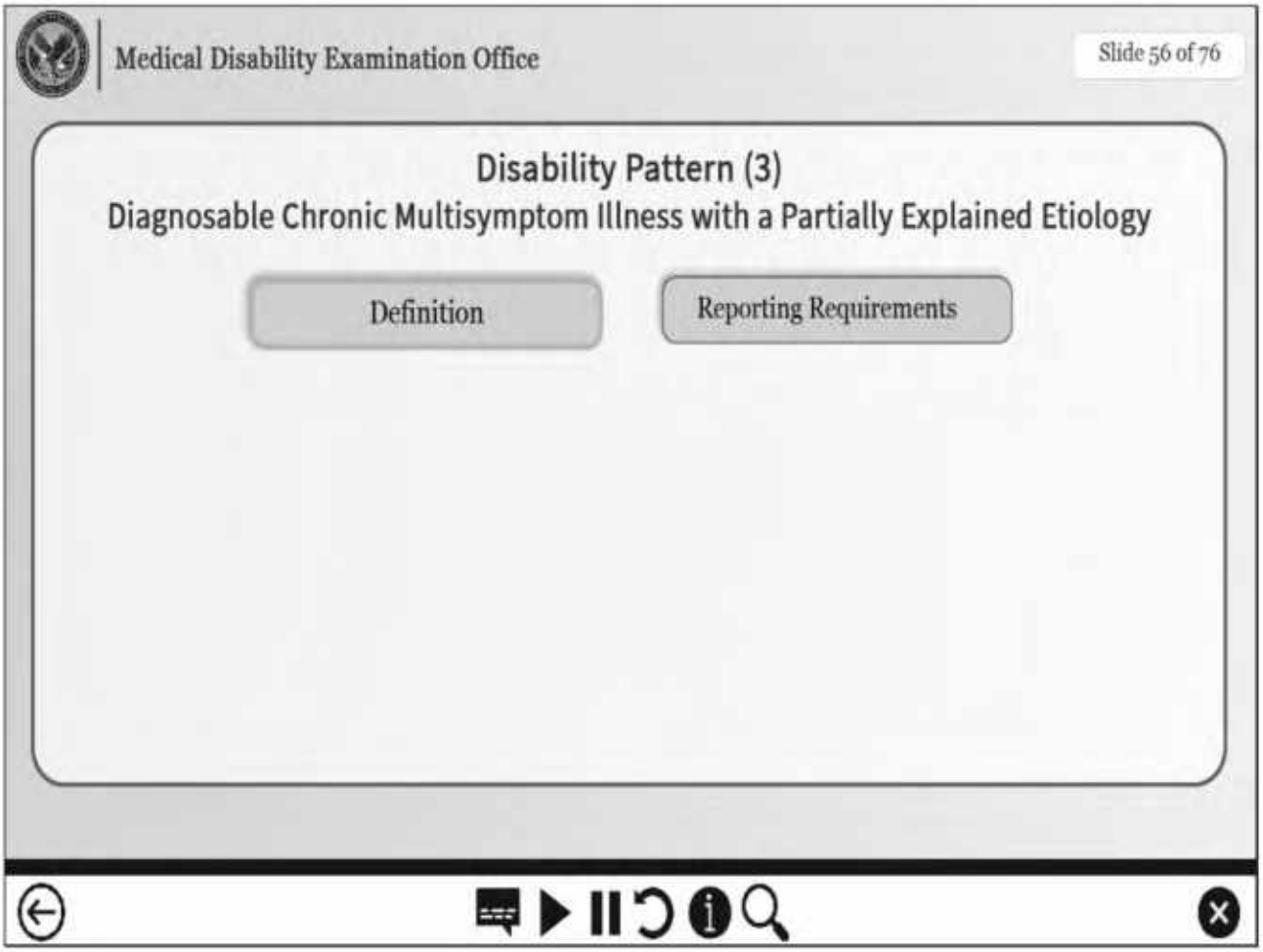
Slide 61 - Disability Pattern (2)



Transcript

If at the end of your evaluation, you determine the disability pattern to be a MUCMI, then you will provide a medical statement with supporting rationale in the Gulf War section of the Medical Opinion DBQ.

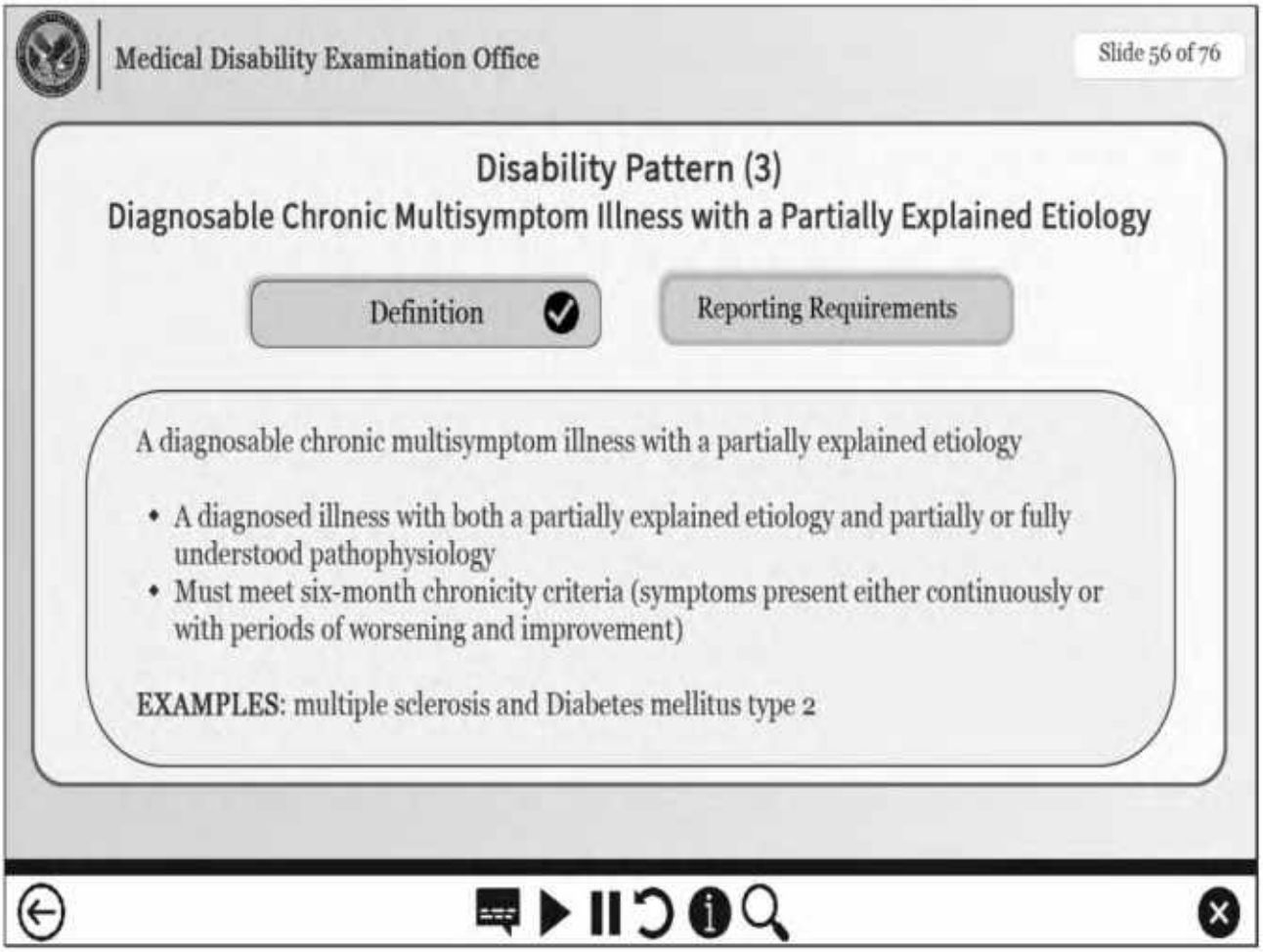
Slide 62 - Disability Pattern (3)



Transcript

Select each button to learn more about disability pattern 3, **diagnosable chronic multisymptom illness with a partially explained etiology**

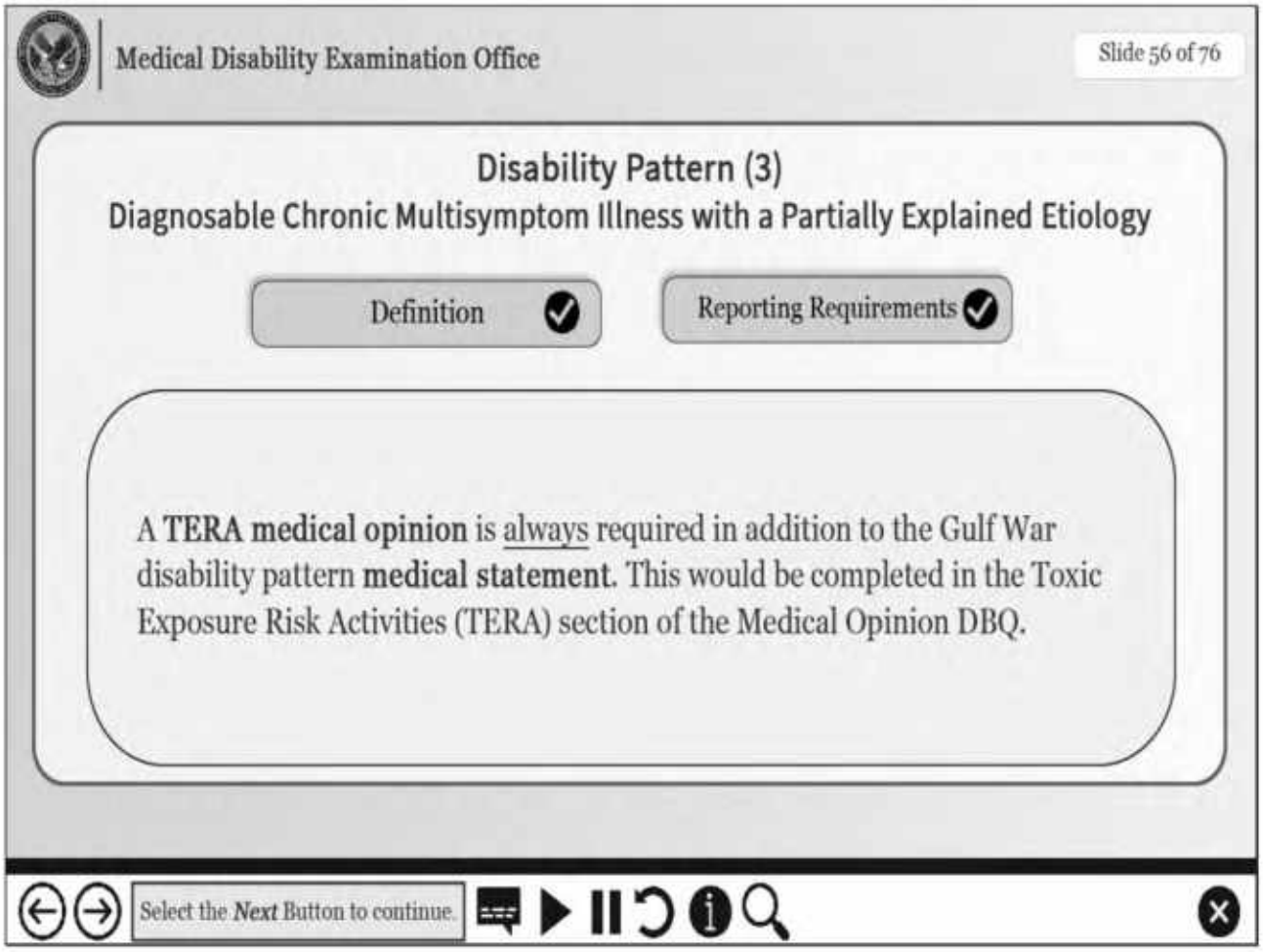
Slide 63 - Disability Pattern (3)



Transcript

Disability pattern (3) is a diagnosable illness with both a partially explained etiology and partially or fully understood pathophysiology. Some examples include multiple sclerosis and diabetes mellitus type 2. You will need to address both the etiology and pathophysiology of the condition taking into account the specifics of the Veteran. The condition must also meet the six-month chronicity criteria.

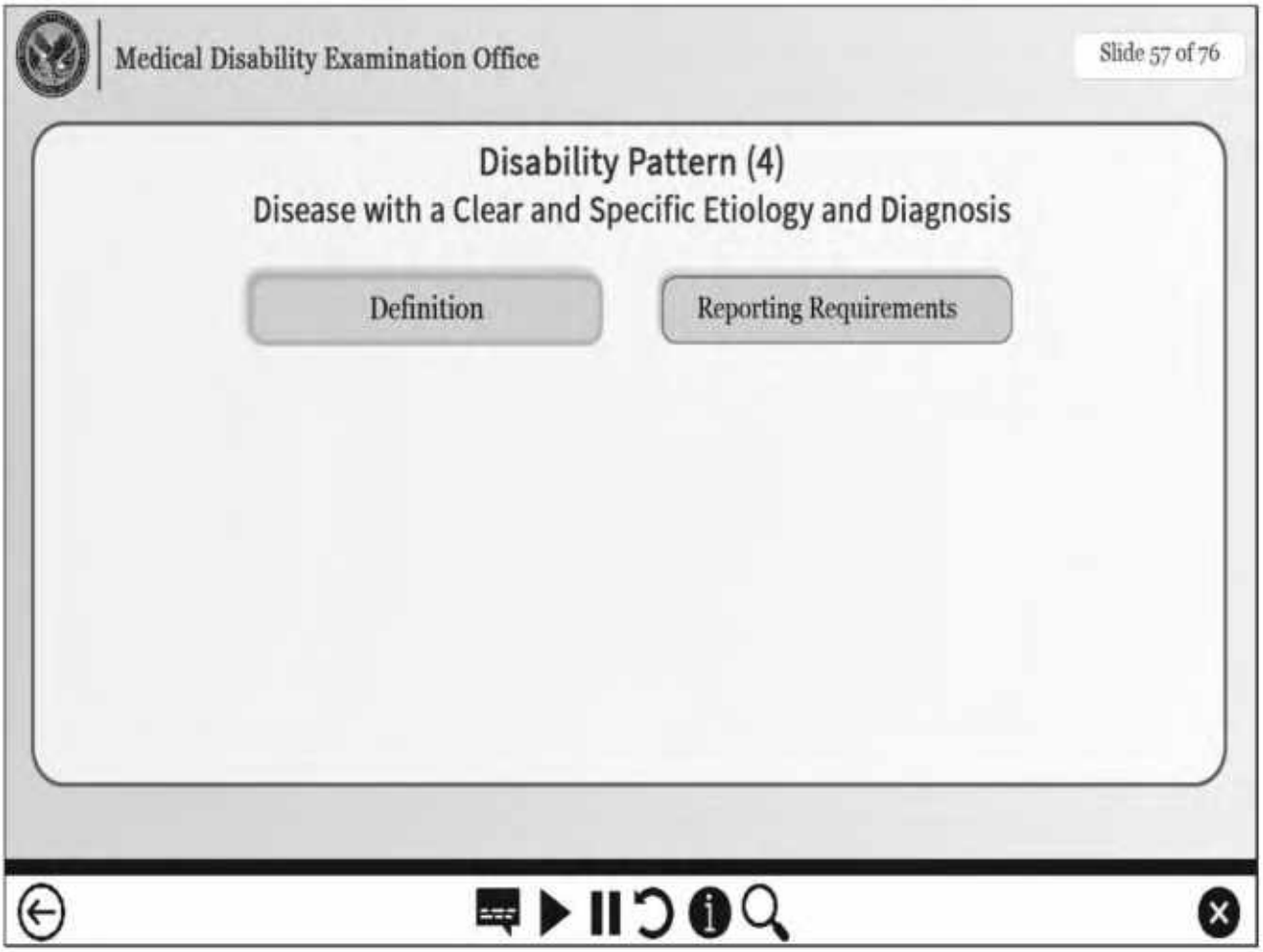
Slide 64 - Disability Pattern (3)



Transcript

A TERA medical opinion is always required in addition to the Gulf War medical statement. This would be completed in the Toxic Exposure Risk Activities (TERA) section of the Medical Opinion DBQ.

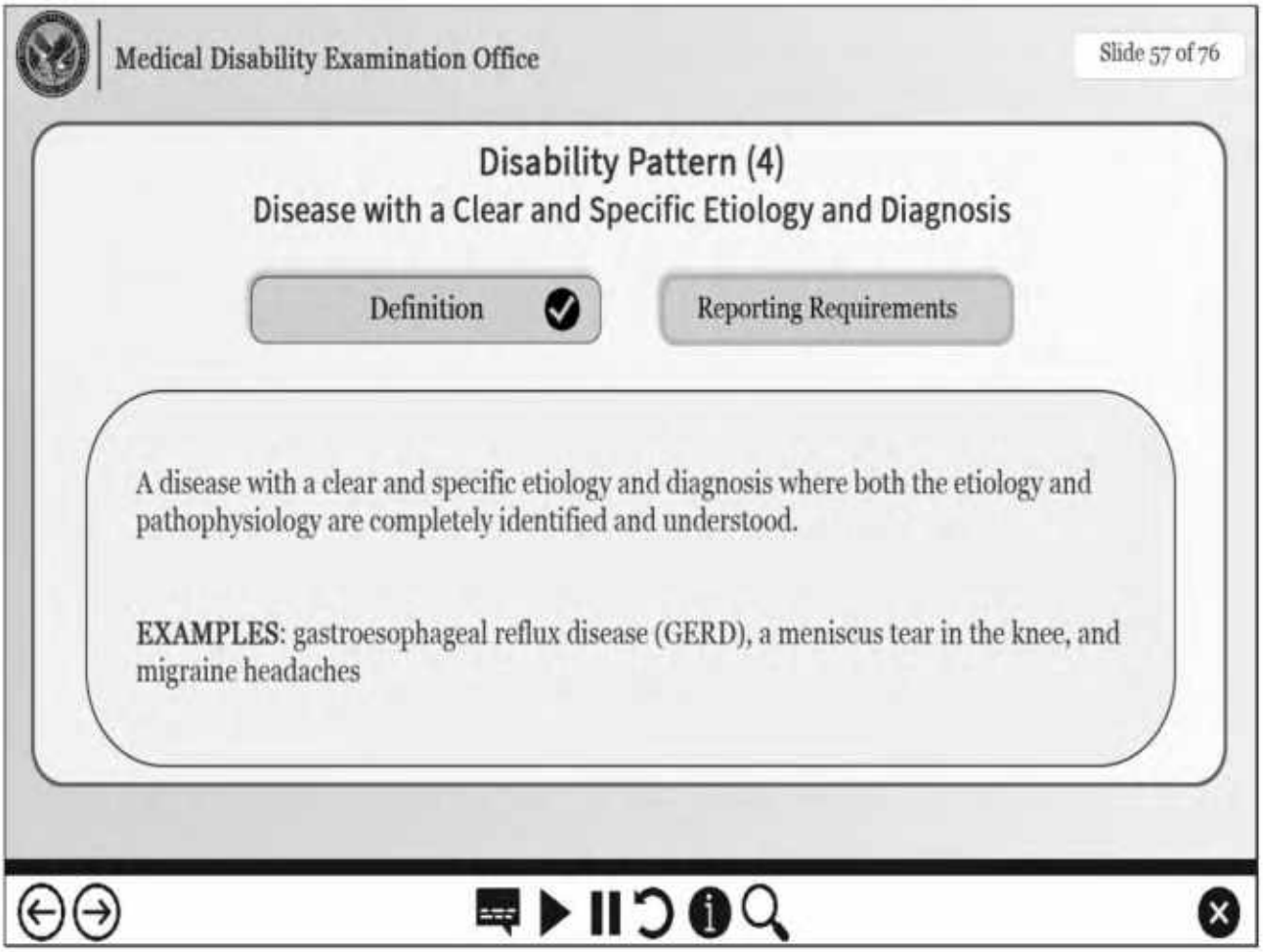
Slide 65 - Disability Pattern (4)



Transcript

Select each button to learn more about disability pattern 4, **disease with a clear and specific etiology and diagnosis.**

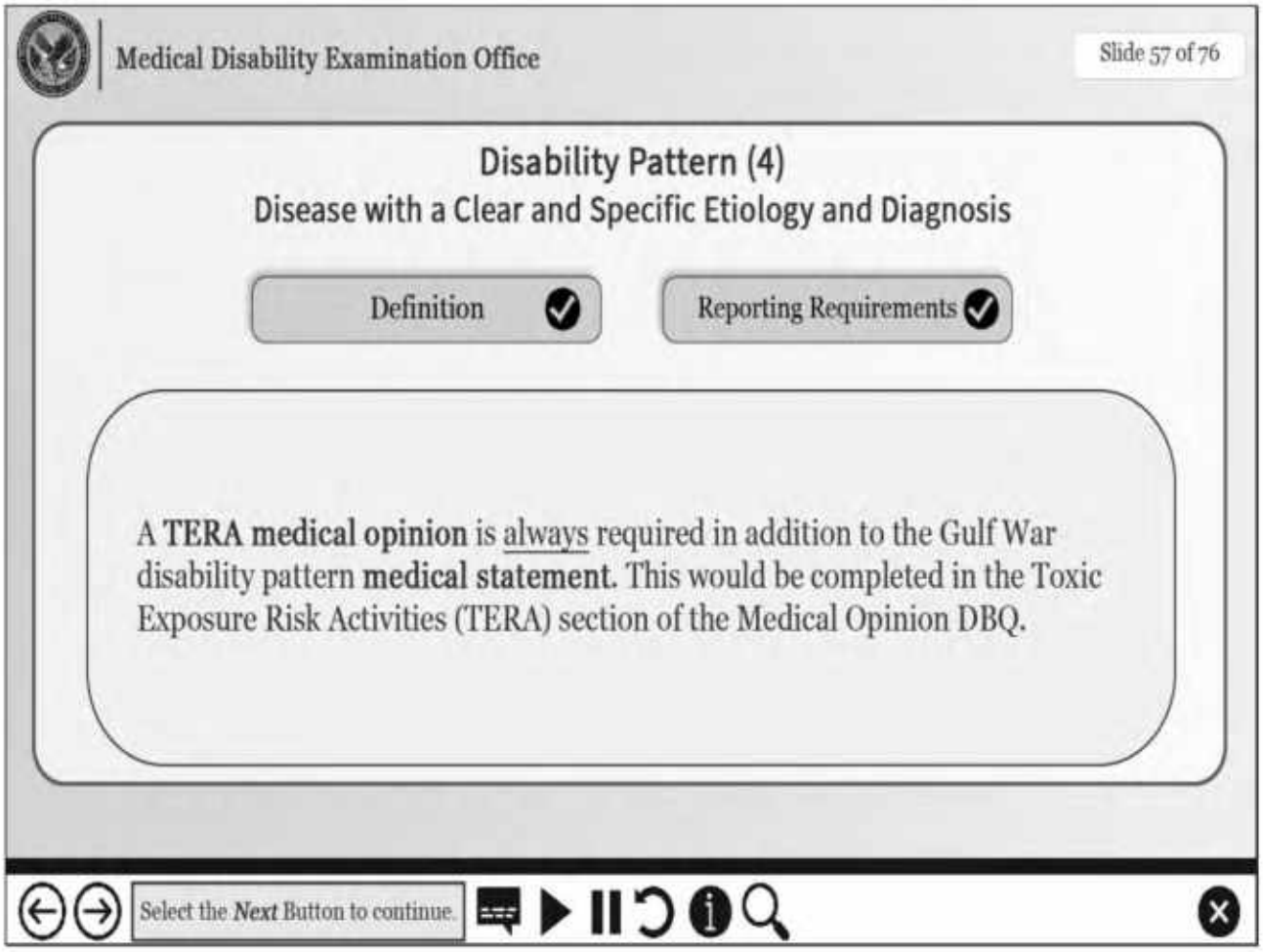
Slide 66 - Disability Pattern (4)



Transcript

Disability pattern (4) is a disease with a clear and specific etiology. Some examples include gastroesophageal reflux disease (GERD), joint issues such as a knee meniscal tear, and migraine headaches. Both the etiology and pathophysiology of the condition need to be completely identified and understood.

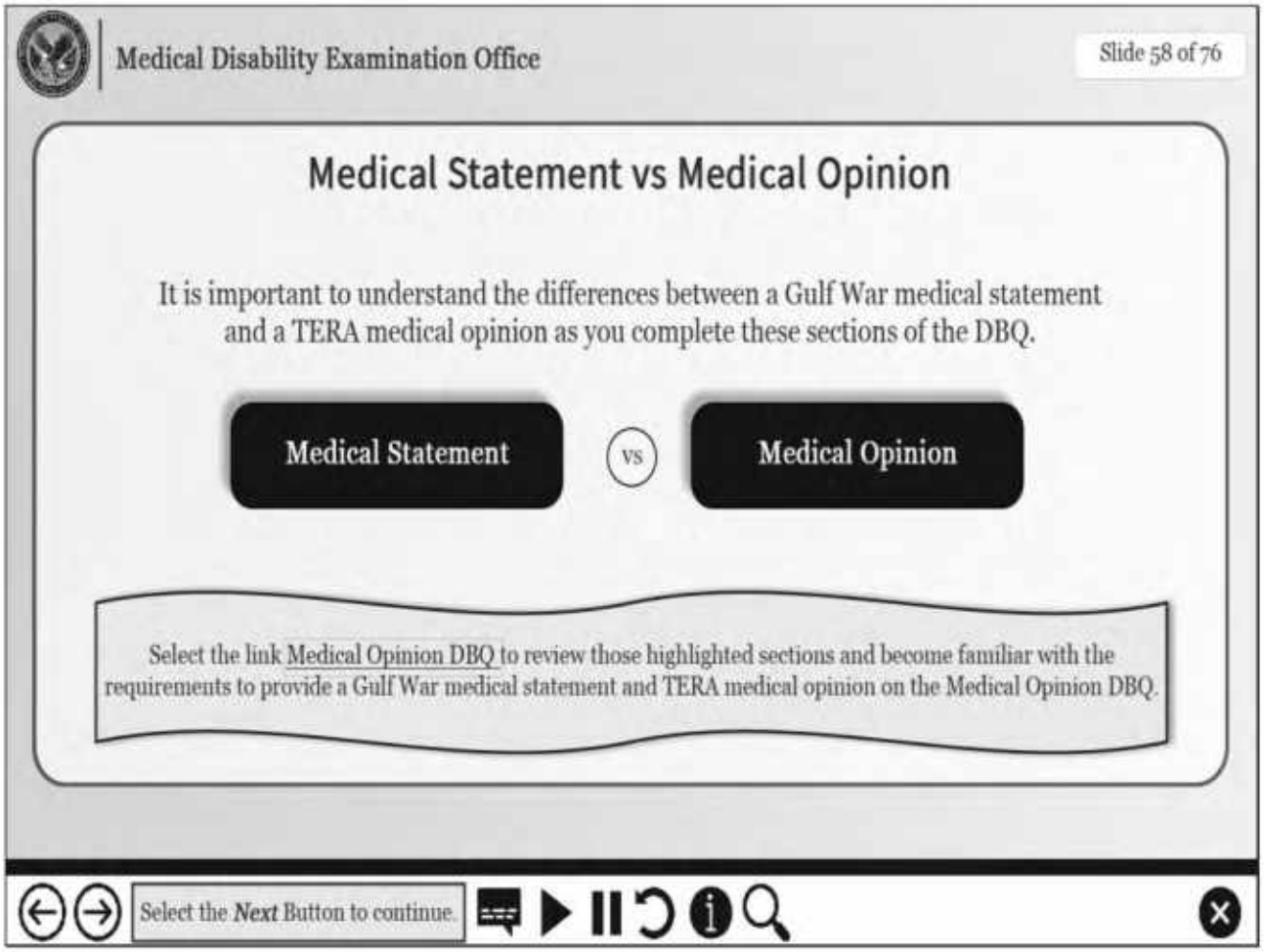
Slide 67 - Disability Pattern (4)



Transcript

A TERA medical opinion is always required in addition to the Gulf War medical statement. This would be completed in the Toxic Exposure Risk Activities (TERA) section of the Medical Opinion DBQ.

Slide 68 - Medical Statement vs Medical Opinion

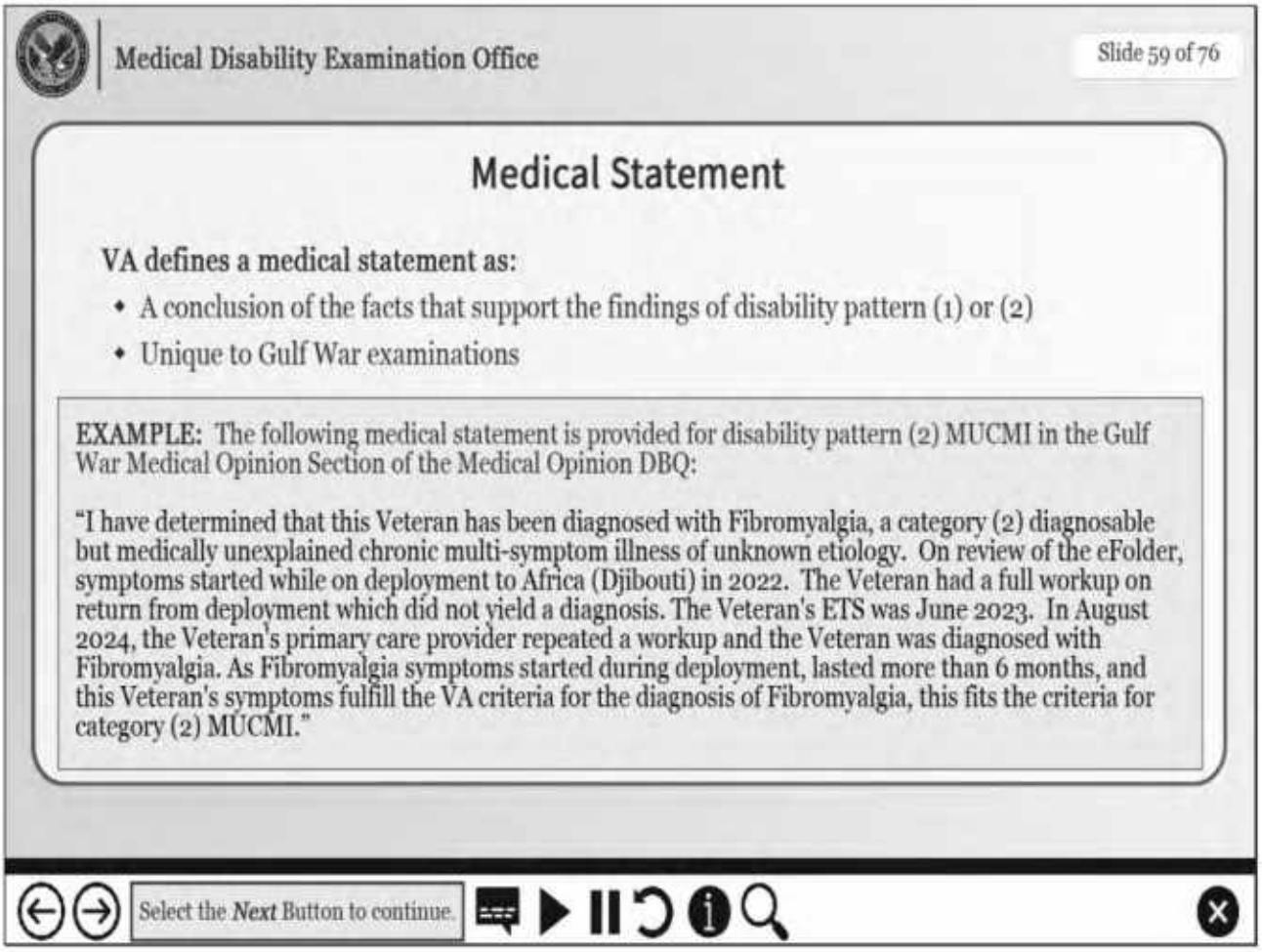


Transcript

It is important to understand the differences between a Gulf War medical statement and a TERA medical opinion as you complete these sections of the DBQ. As we discussed at the beginning of this training, the Gulf War examination is uniquely designed to evaluate conditions, signs, and symptoms that may be due to undiagnosed illness or a MUCMI. The Gulf War DBQ is used to document that information, but it also requires sections of the Medical Opinion DBQ to be completed to explain the findings. This is where your expertise as the clinician summarizes each symptom or condition evaluated, what disability pattern you determined appropriate, and why it will be recorded as the medical statement with rationale.

Select each button to learn more about how the VA defines a **Medical Statement** versus a **Medical Opinion.**

Slide 69 - Medical Statement

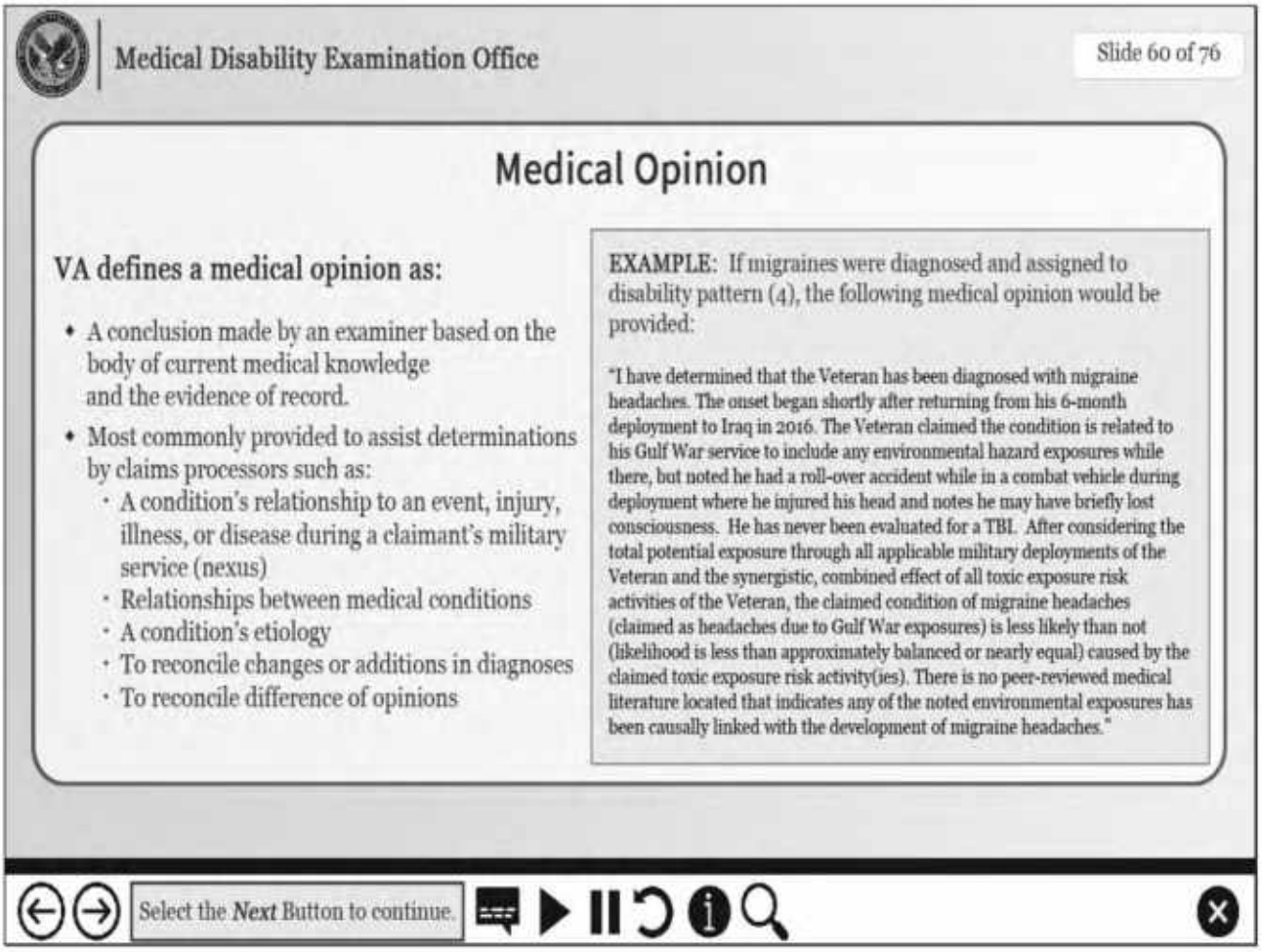


Transcript

The VA defines a medical statement as a conclusion of the facts regarding the disability pattern and does not require causality or an opinion using VA legal language, just a rationale to support the findings. This is unique to Gulf War examinations and can be found on the Medical Opinion DBQ under the **Gulf War Opinion** section.

For example, the following medical statement is provided for disability pattern (2) MUCMI: "I have determined that this Veteran has been diagnosed with Fibromyalgia, a category (2) diagnosable but medically unexplained chronic multi-symptom illness of unknown etiology. On review of the eFolder, symptoms started while on deployment to Africa (Djibouti) in 2022. The Veteran had a full workup on return from deployment which did not yield a diagnosis. The Veteran's ETS was June 2023. In August 2024, the Veteran's primary care provider repeated a workup and the Veteran was diagnosed with Fibromyalgia. As Fibromyalgia symptoms started during deployment, lasted more than 6 months, and this Veteran's symptoms fulfill the VA criteria or the diagnosis of Fibromyalgia, this fits the criteria for category (2) MUCMI."

Slide 70 - Medical Opinion



Transcript

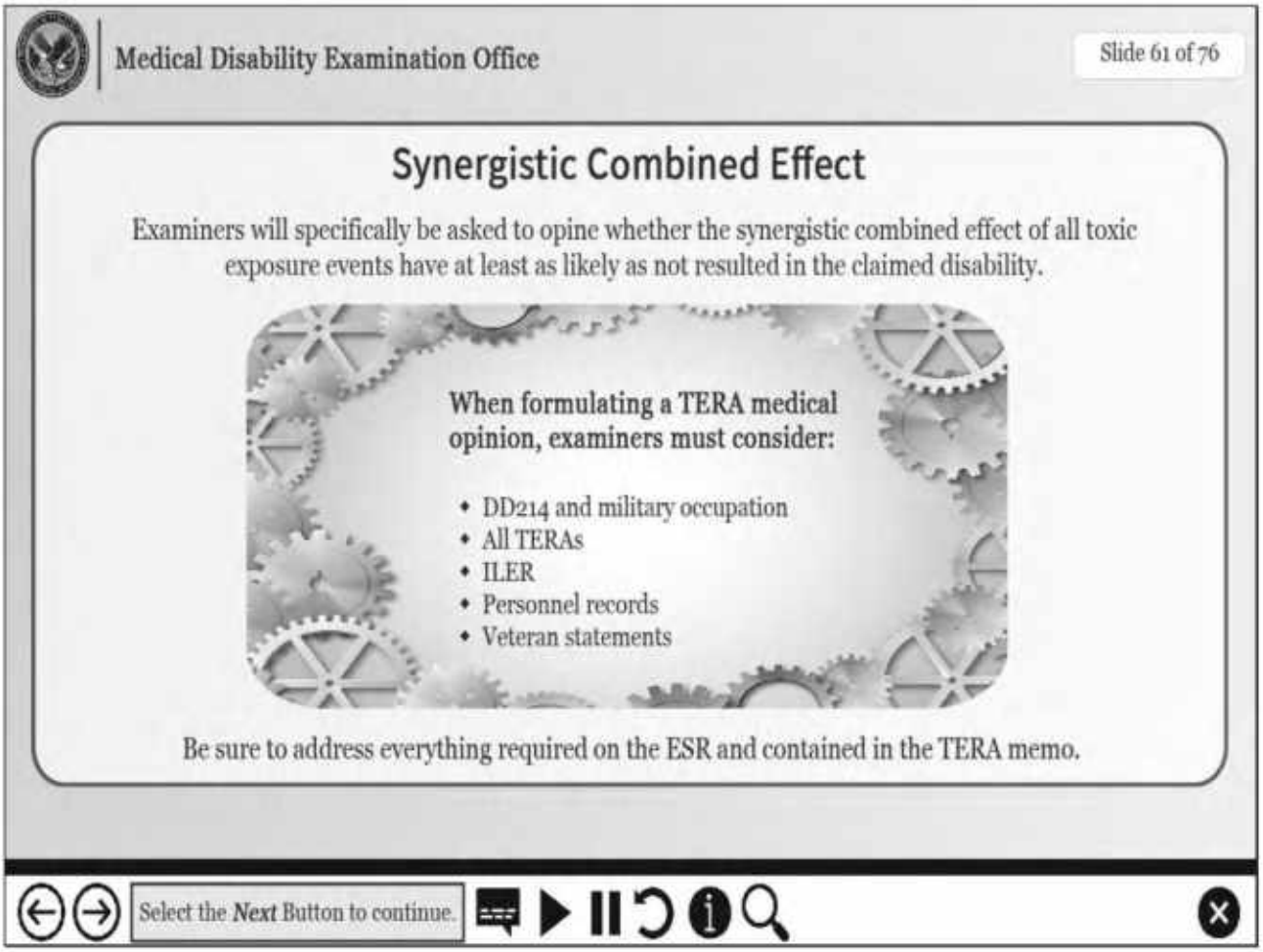
The VA defines a medical opinion as a conclusion made by an examiner based on the body of current medical knowledge and the evidence of record. An examiner may be asked to provide a medical opinion to determine a condition's relationship to an event, injury, illness, or disease during a claimant's military service (what is referred to as a nexus statement or opinion). Examiners must also provide information on the relationship between medical conditions, determine a condition's etiology, explain and reconcile changes or additions to diagnoses, and reconcile any differences of opinions.

If a diagnosable condition falling into disability pattern 3 or 4 has been identified, two sections in the Medical Opinion DBQ must be completed. Examiners must provide the required rationale addressing the etiology and pathophysiology requirement within the Gulf War Opinion medical statement plus complete the TERA medical opinion.

For example, the following medical opinion is provided for disability pattern (4): "I have determined that the Veteran has been diagnosed with migraine headaches. The onset began shortly after returning from his 6-month deployment to Iraq in 2016. The Veteran claimed the condition is related to his Gulf War service to include any

environmental hazard exposures while there, but noted he had a roll-over accident while in a combat vehicle during deployment where he injured his head and notes he may have briefly lost consciousness. He has never been evaluated for a TBI. After considering the total potential exposure through all applicable military deployments of the Veteran and the synergistic, combined effect of all toxic exposure risk activities of the Veteran, the claimed condition of migraine headaches (claimed as headaches due to Gulf War exposures) is less likely than not (likelihood is less than approximately balanced or nearly equal) caused by the claimed toxic exposure risk activity or activities. There is no peer-reviewed medical literature located that indicates any of the noted environmental exposures has been causally linked with the development of migraine headaches."

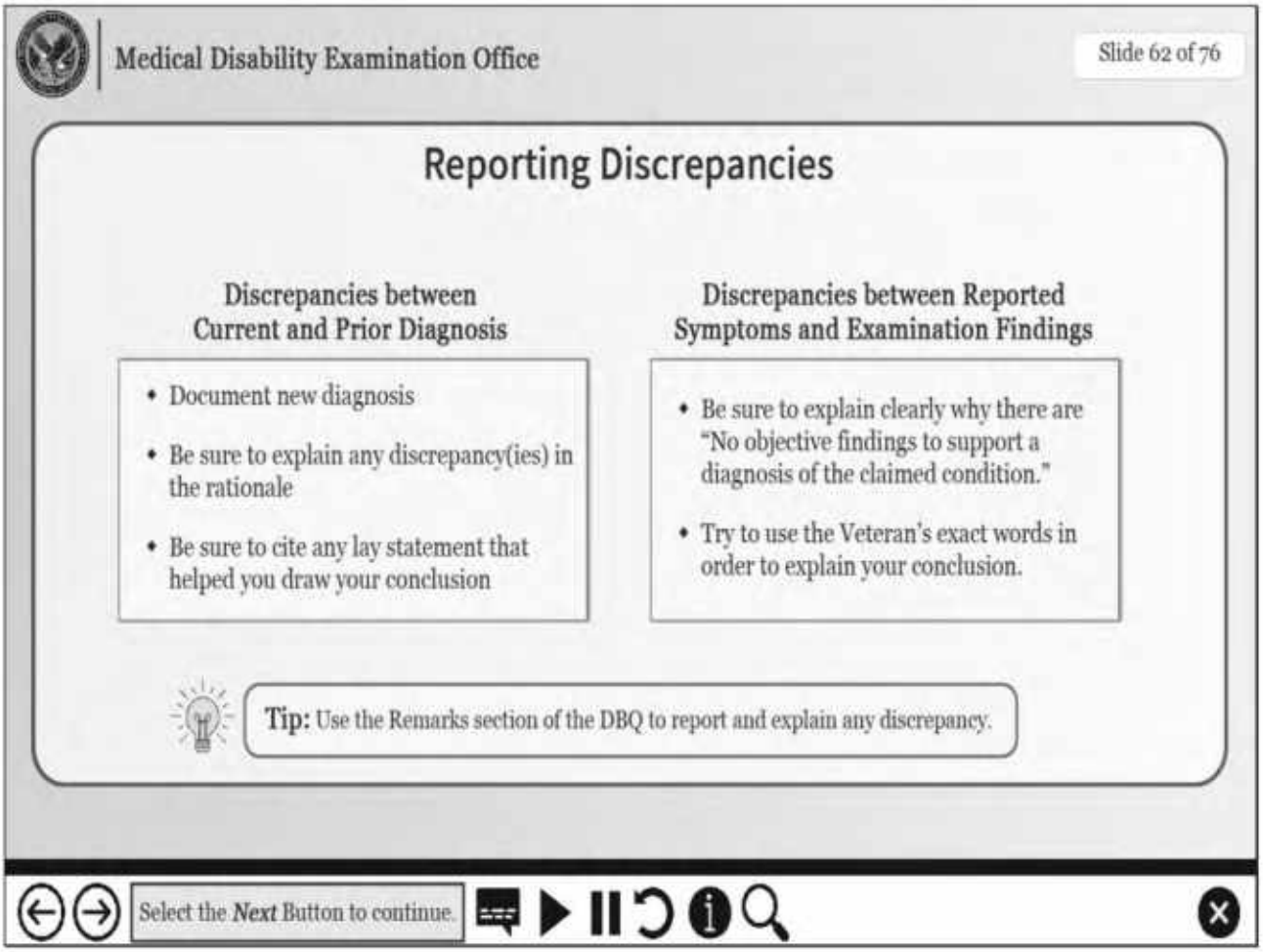
Slide 71 - Synergistic Combined Effect



Transcript

The PACT Act also requires examiners to consider the synergistic combined effect of all exposures during deployments. This includes, for example, particulate matter, burn pit exposures, as well as fumes and local pollution such as oil well fires. You will specifically be asked to opine whether the synergistic combined effect of all toxic exposure events have at least as likely as not resulted in the claimed disability. Consider all TERAs, ILER, personnel records, DD214, and Veteran statements, when opining about the relationship between the claimed disability and the in-service events. Be sure to address everything required on the ESR and contained in the TERA memo.

Slide 72 - Reporting discrepancies

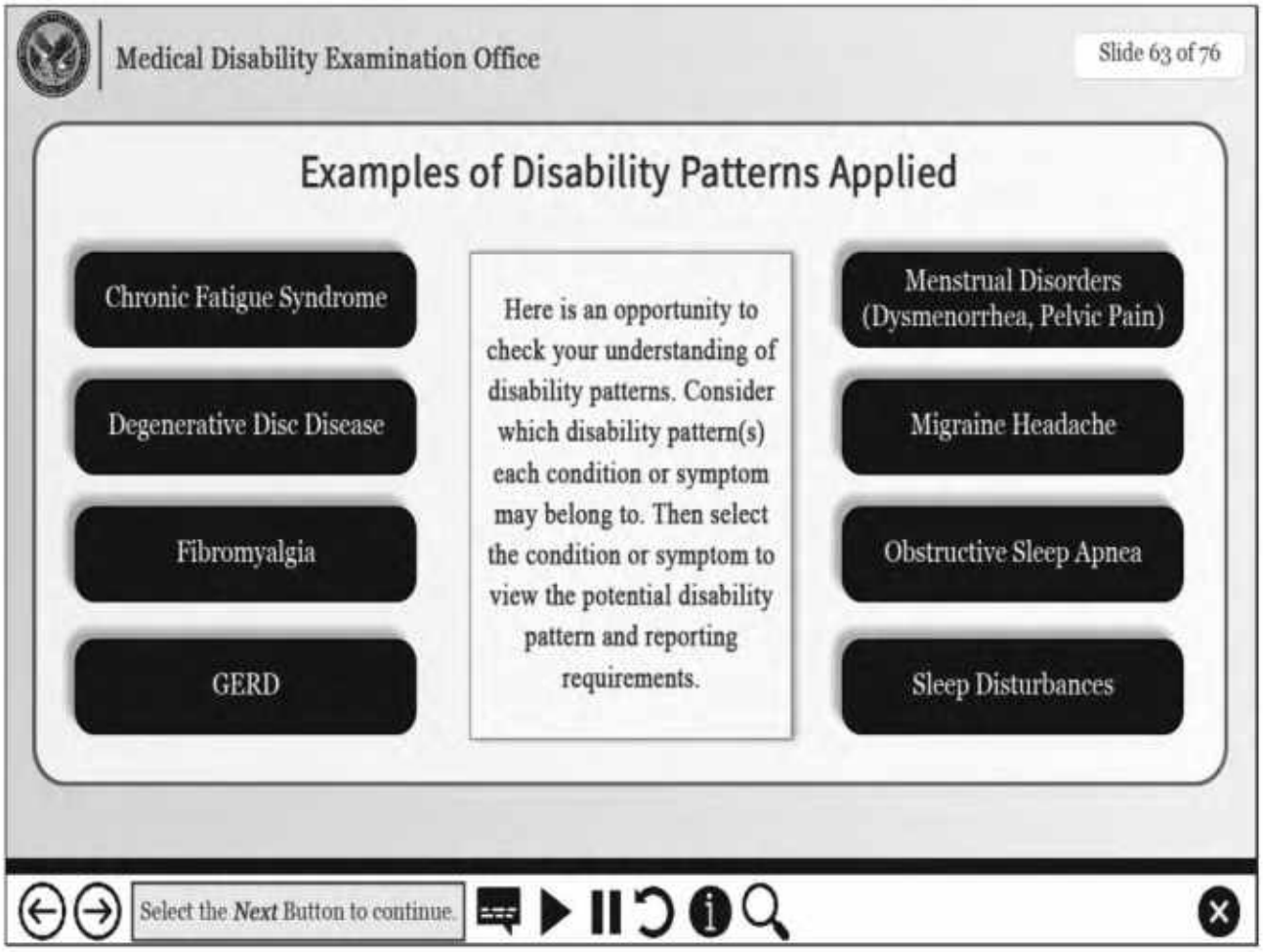


Transcript

You may need to address discrepant findings between your C&P examination and previous reports. There may also be discrepancies between a Veteran's reported symptoms and objective examination findings. Here are suggestions for addressing these problems.

If you find that the diagnosis for a condition differs from or contradicts a previous diagnosis in a Veteran's records, document the new diagnosis and provide a well-reasoned rationale for the difference. Include pertinent examination or test results. It may prove helpful to use statements from the Veteran to ensure the condition is accurately documented. As discussed earlier in this course, Veterans are generally competent to describe their conditions because they are able to see and feel their symptoms. This lay evidence must be addressed in your documentation for a C&P examination. However, if you feel that reported symptoms are not supported by the physical examination, test results, or observations, you may consider including a statement similar to this one in your examination report: "No objective findings to support a diagnosis of the claimed condition." You may also use similar language if examination findings do not support the level of severity suggested by the complaints. Also, explain in detail if you cannot establish a diagnosis or a disability pattern for a claimed symptom or condition. In your explanation, use the Veteran's own unprompted language and be clear when statements are the Veteran's (and not yours.)

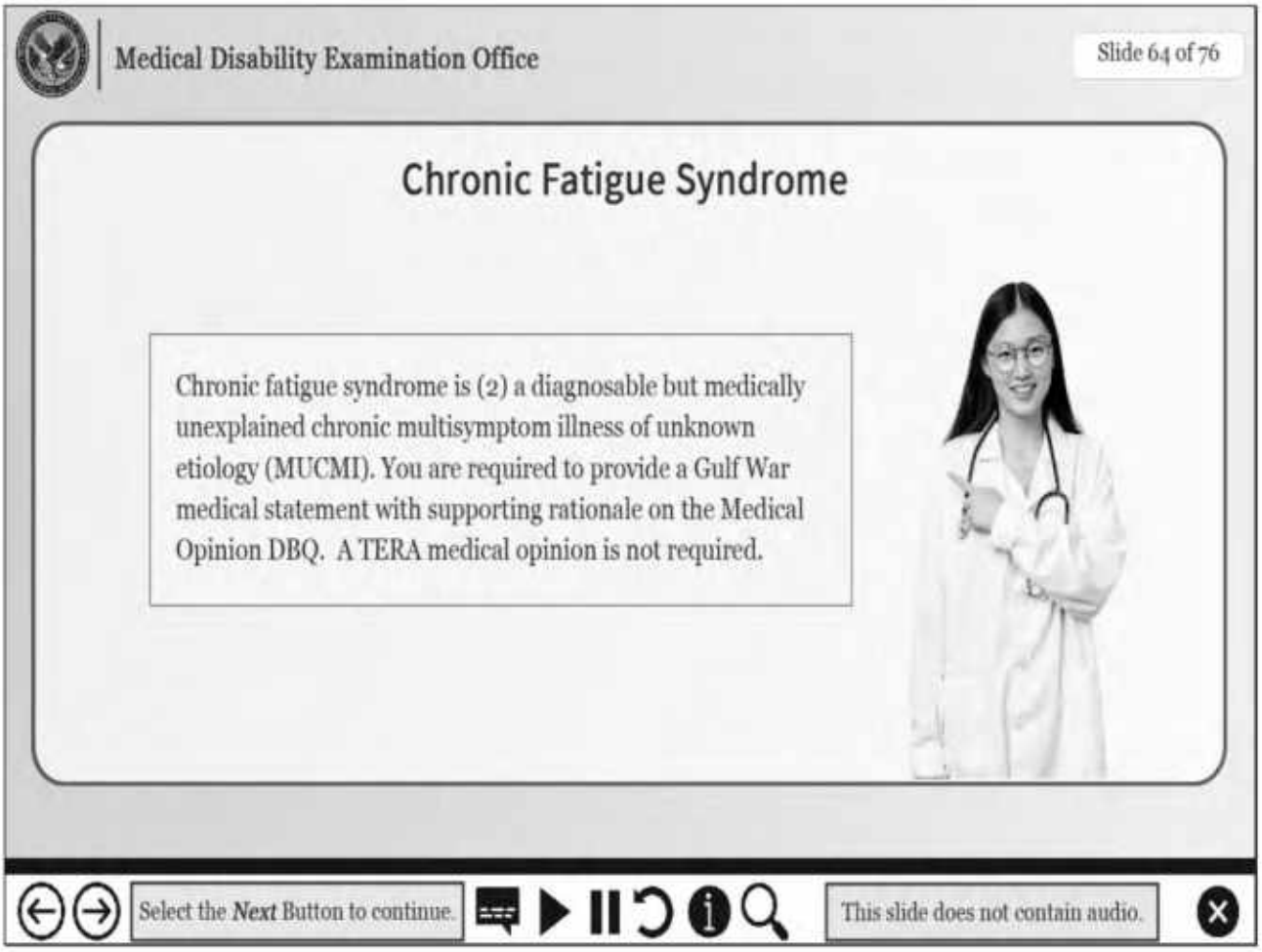
Slide 73 - Examples of Disability Patterns Applied



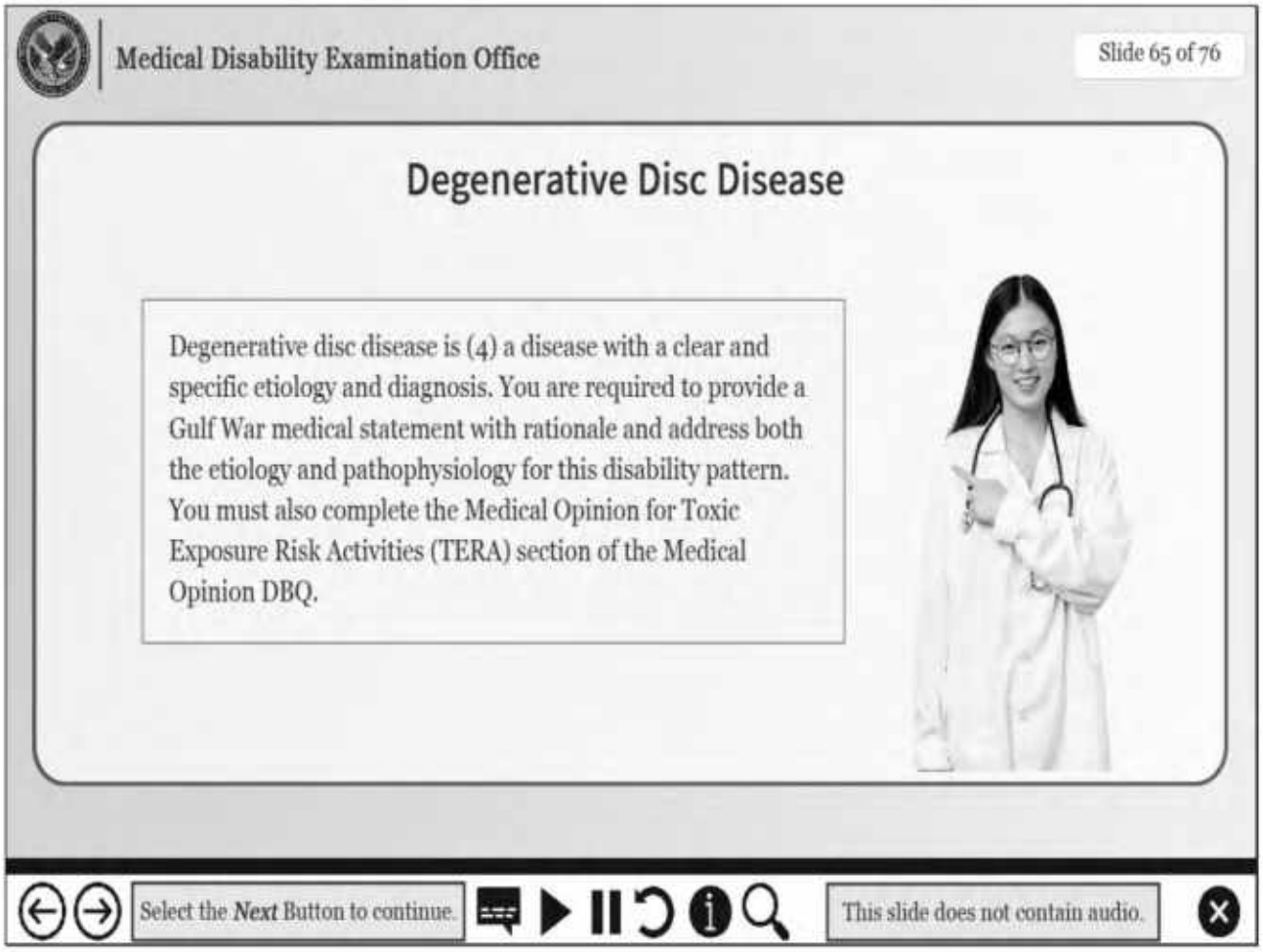
Transcript

Here is an opportunity to check your understanding of disability patterns. Consider which disability pattern or patterns each condition or symptom may belong to. Then select the condition or symptom to view the potential disability pattern and reporting requirements.

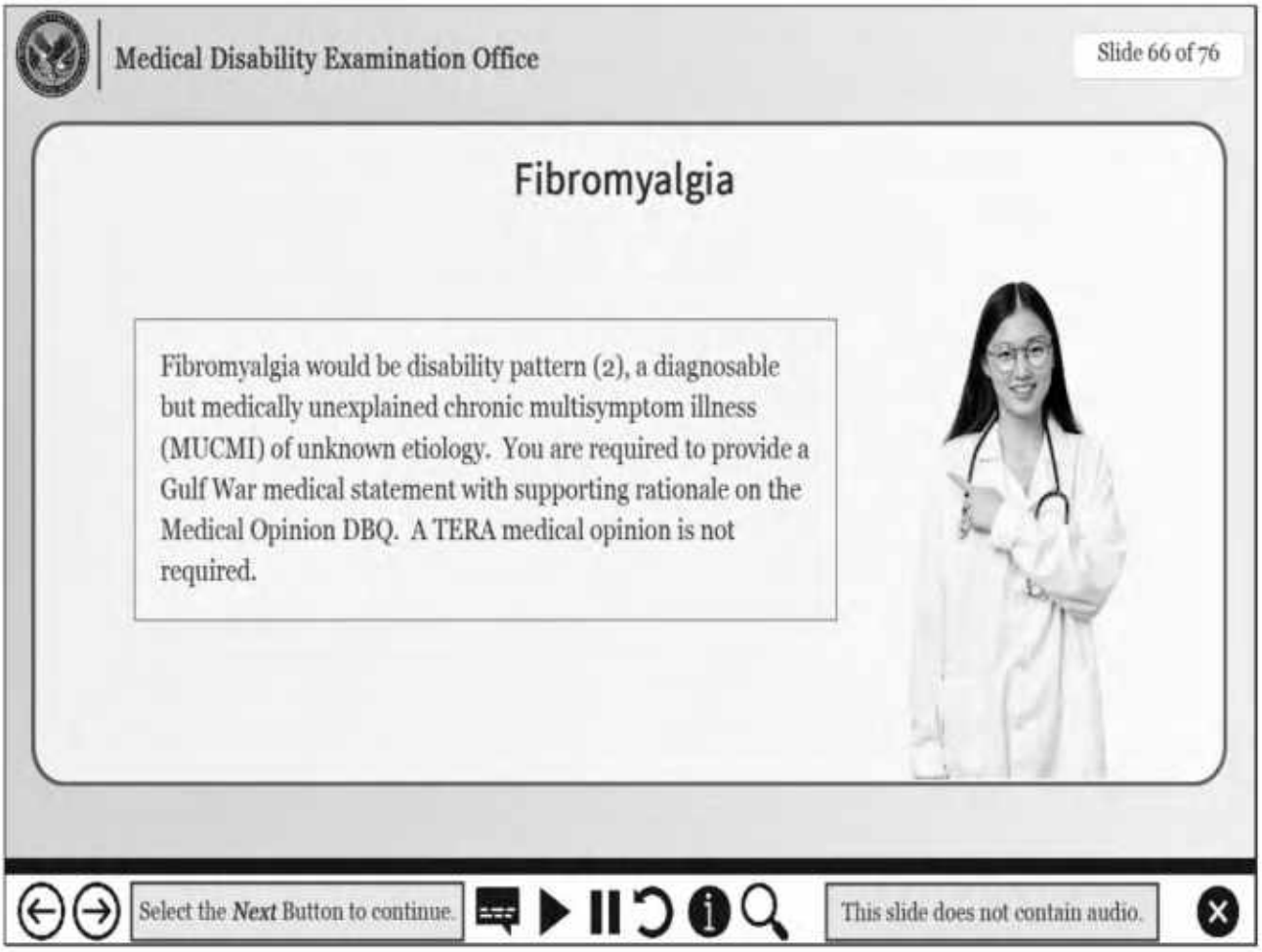
Slide 74 - Example 1 Chronic Fatigue Syndrome



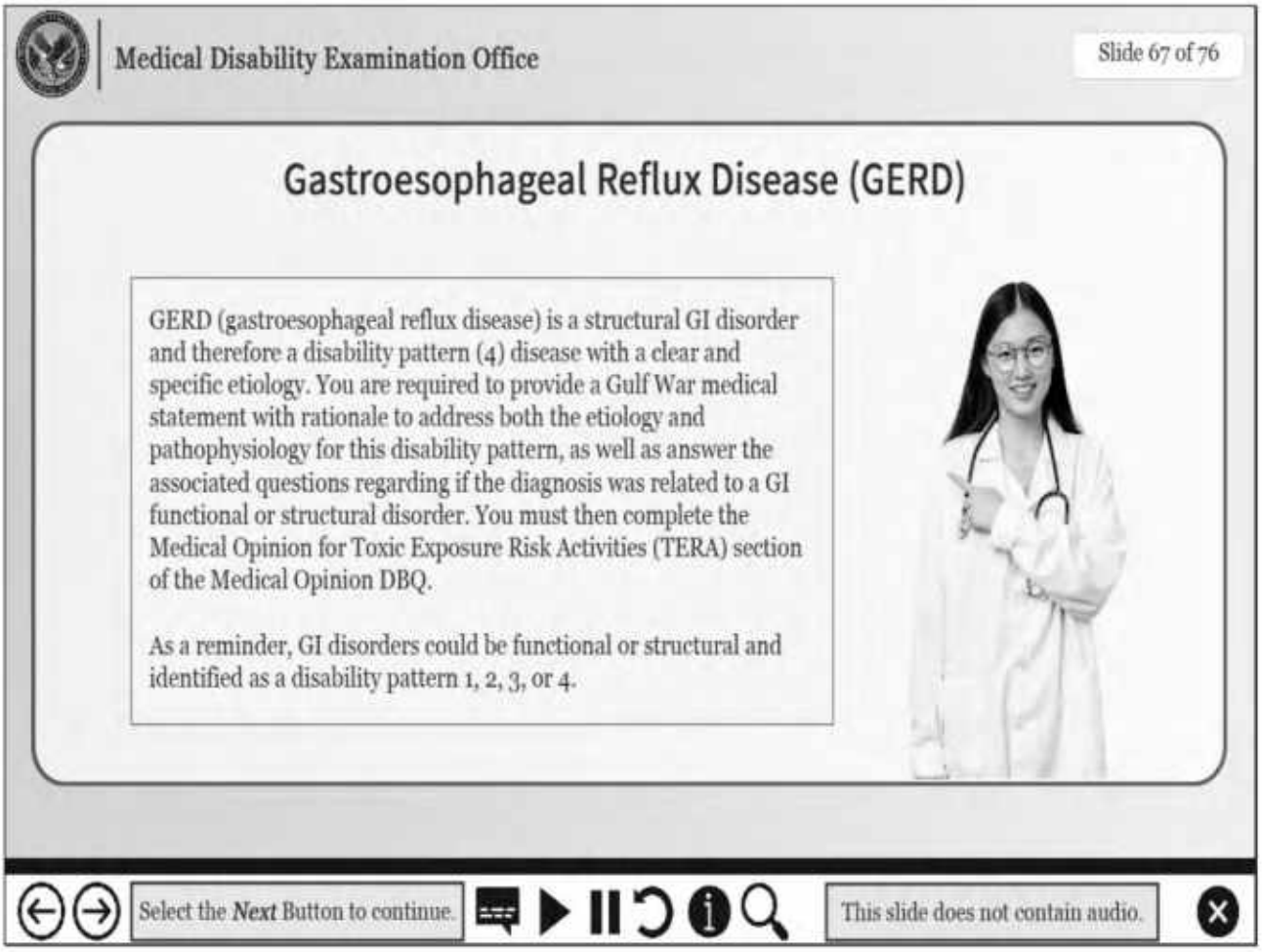
Slide 75 - Example 2 Degenerative Disc Disease



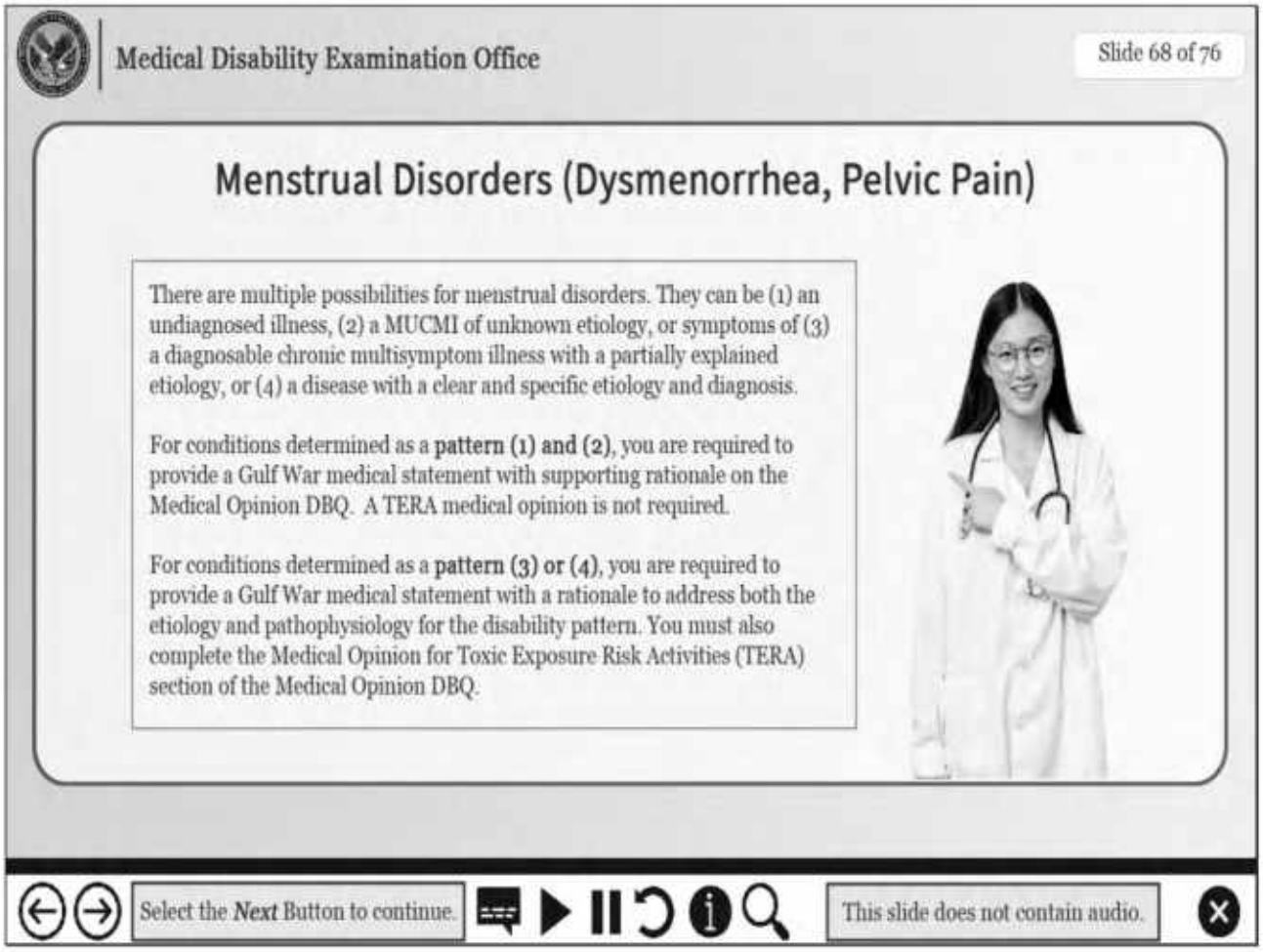
Slide 76 - Example 3 Fibromyalgia



Slide 77 - Example 4 GERD



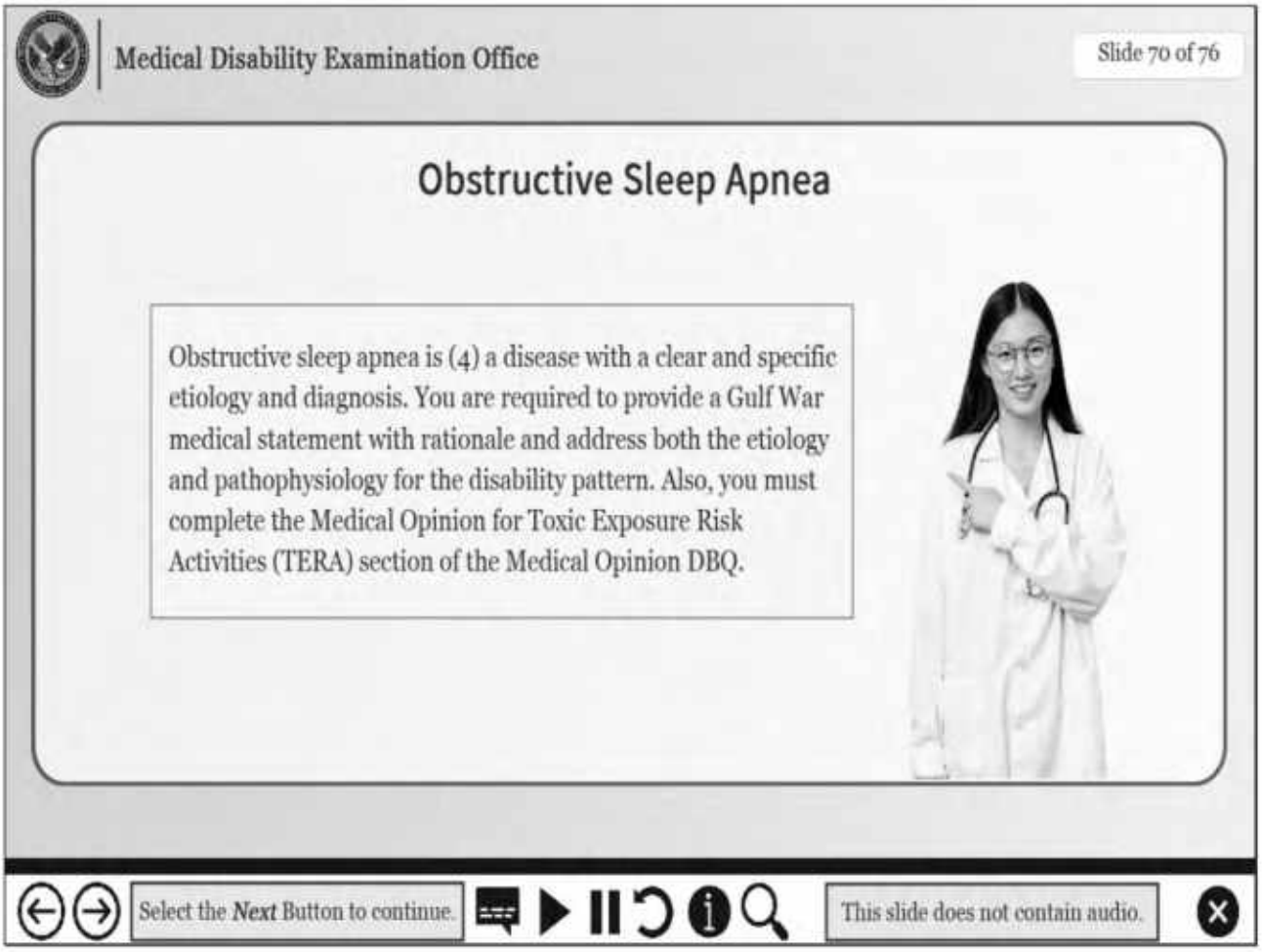
Slide 78 - Example 5 Menstrual Disorders



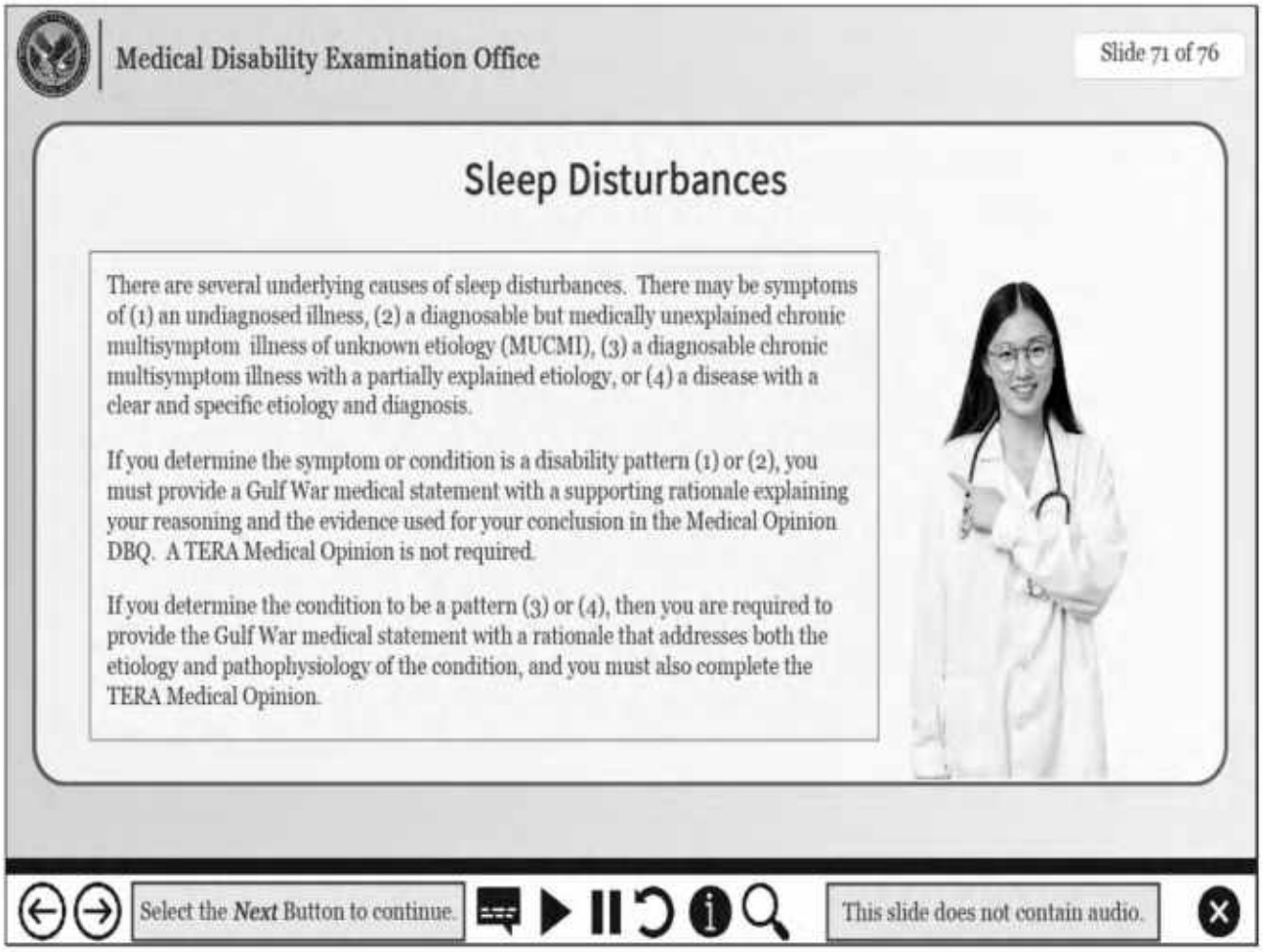
Slide 79 - Example 6 Migraine Headache



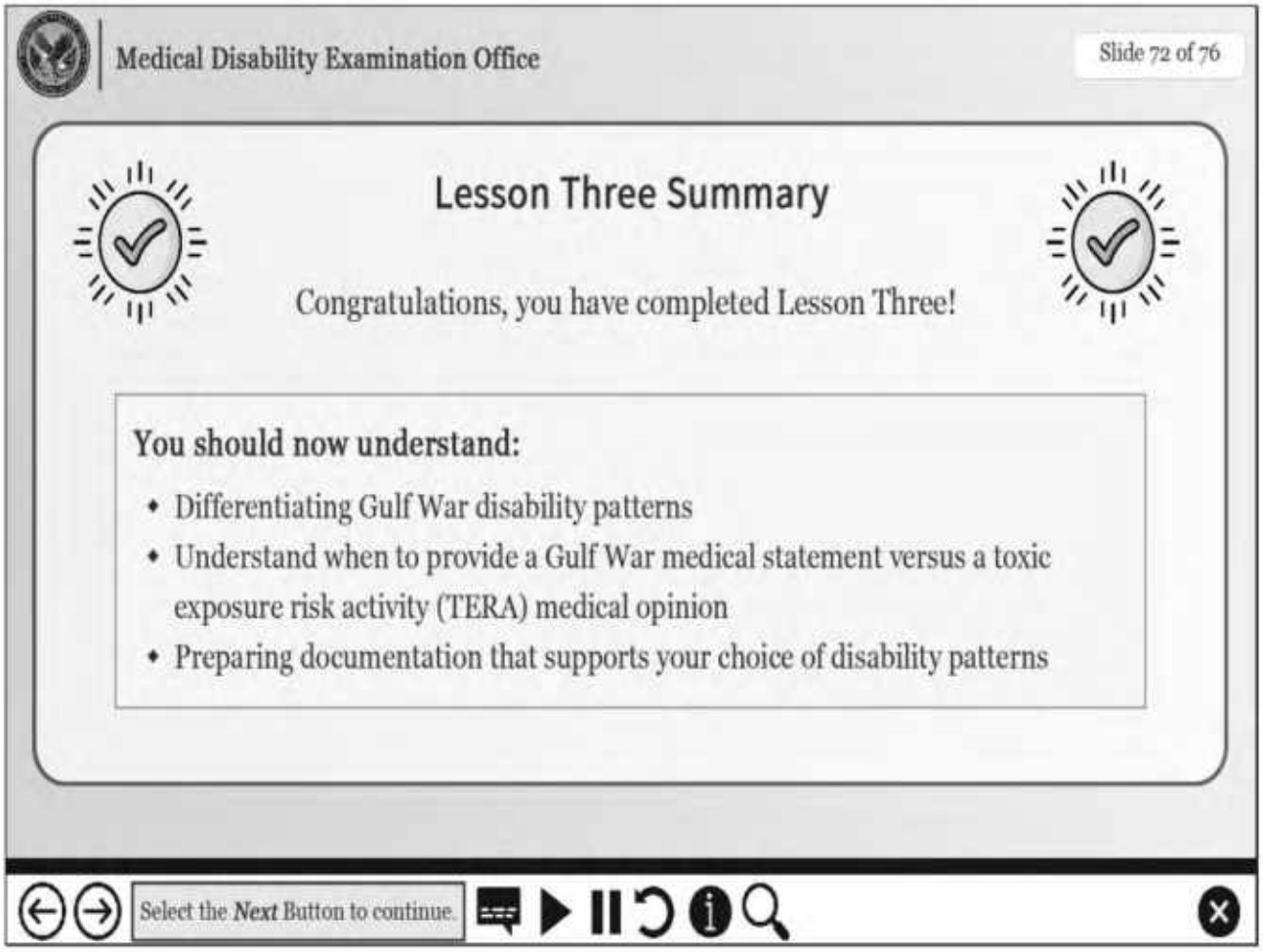
Slide 80 - Example 7 Obstructive Sleep Apnea



Slide 81 - Example 8 Sleep Disturbances



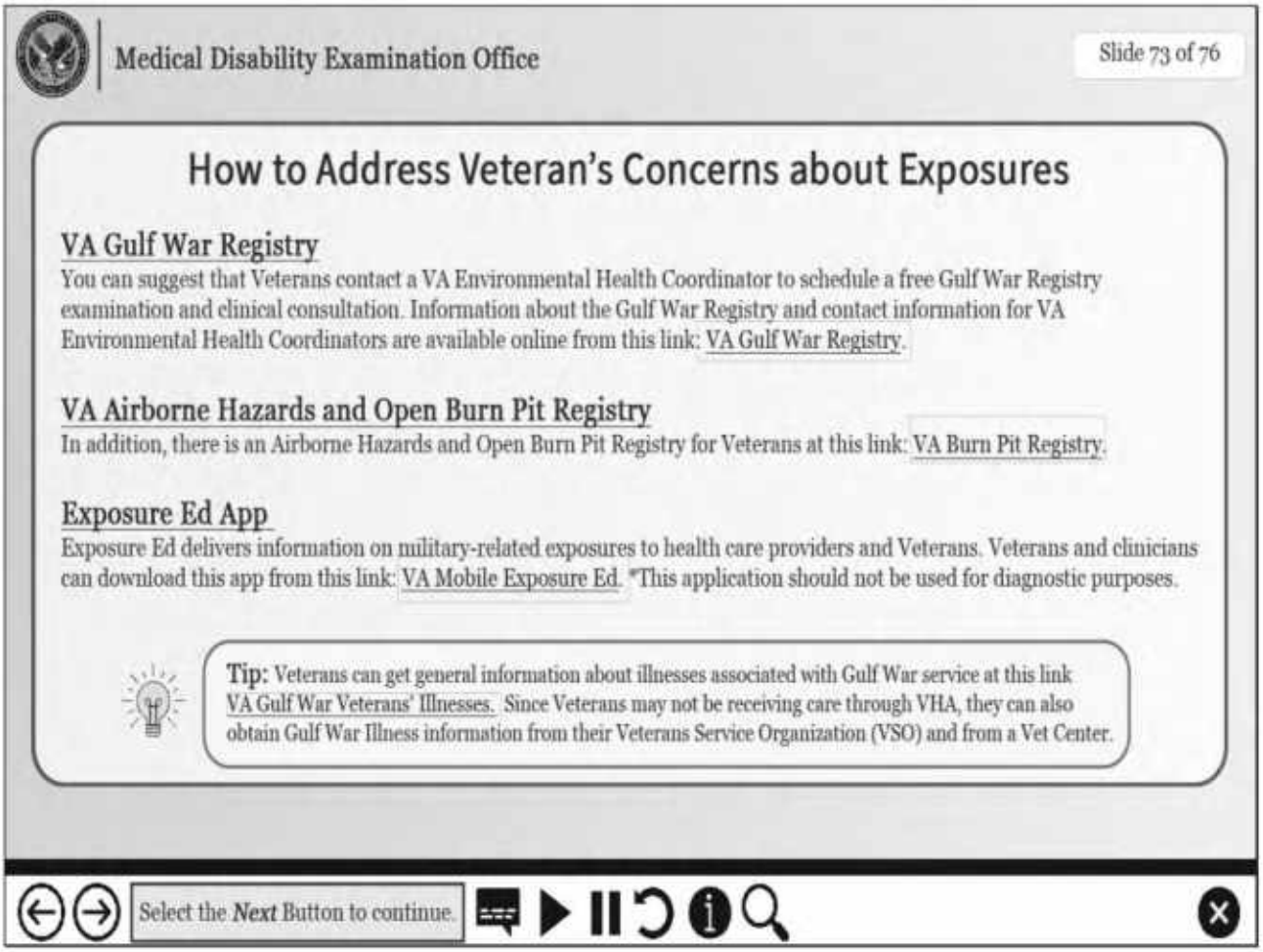
Slide 82 - Lesson Three Summary



Transcript

You have finished lesson 3! You have learned about differentiating between the Gulf War disability patterns, including when to consider utilizing disability patterns (1) and (2). You should be able to provide Gulf War medical statements and toxic exposure risk activity (TERA) medical opinions as well as understand the reporting requirements for each. Lastly, you should now be able to provide documentation, including evidence from the eFolder, that supports your choice of disability patterns, and understand when a TERA is required.

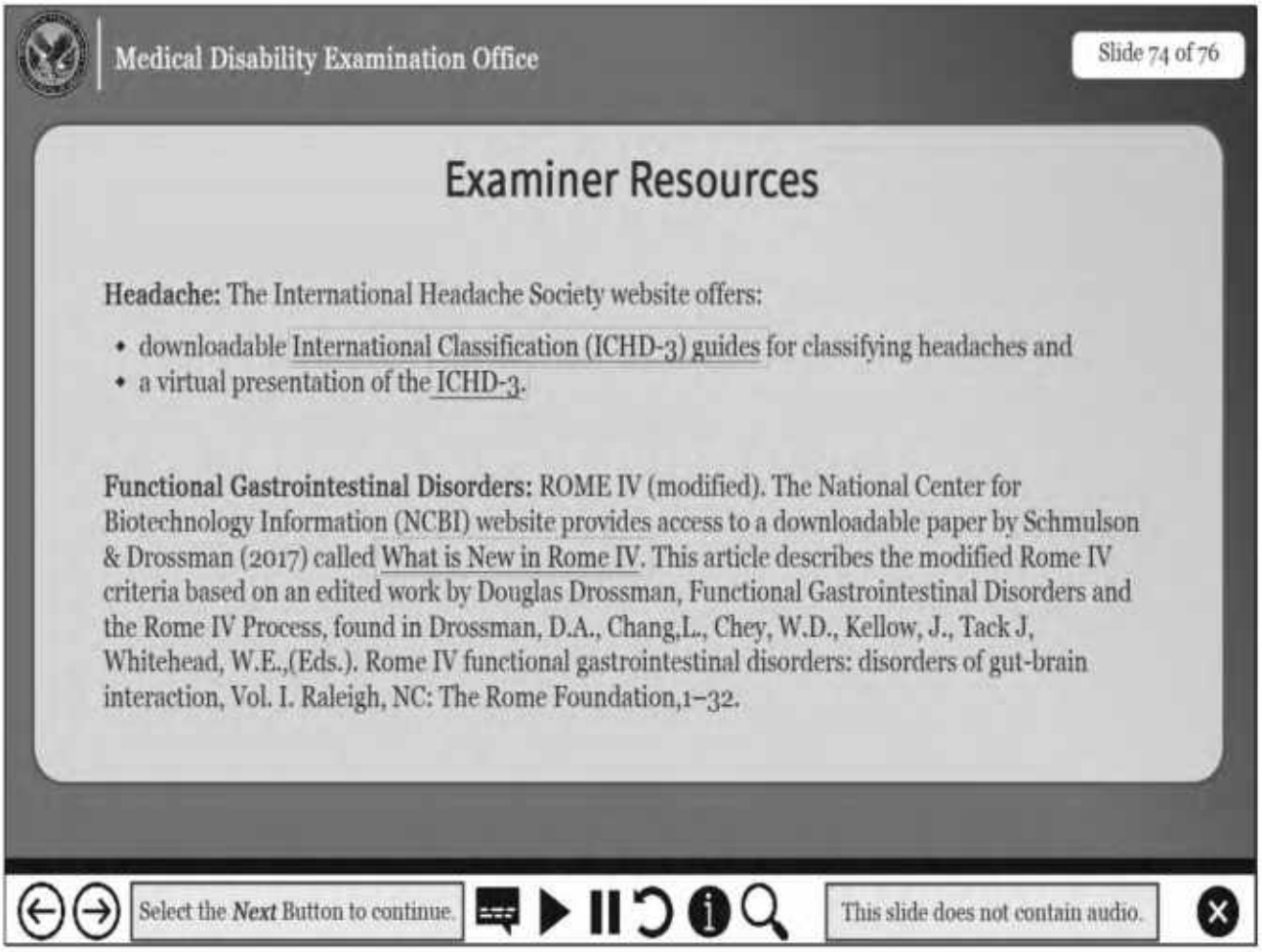
Slide 83 - How to Address Veteran's Concerns about Exposure



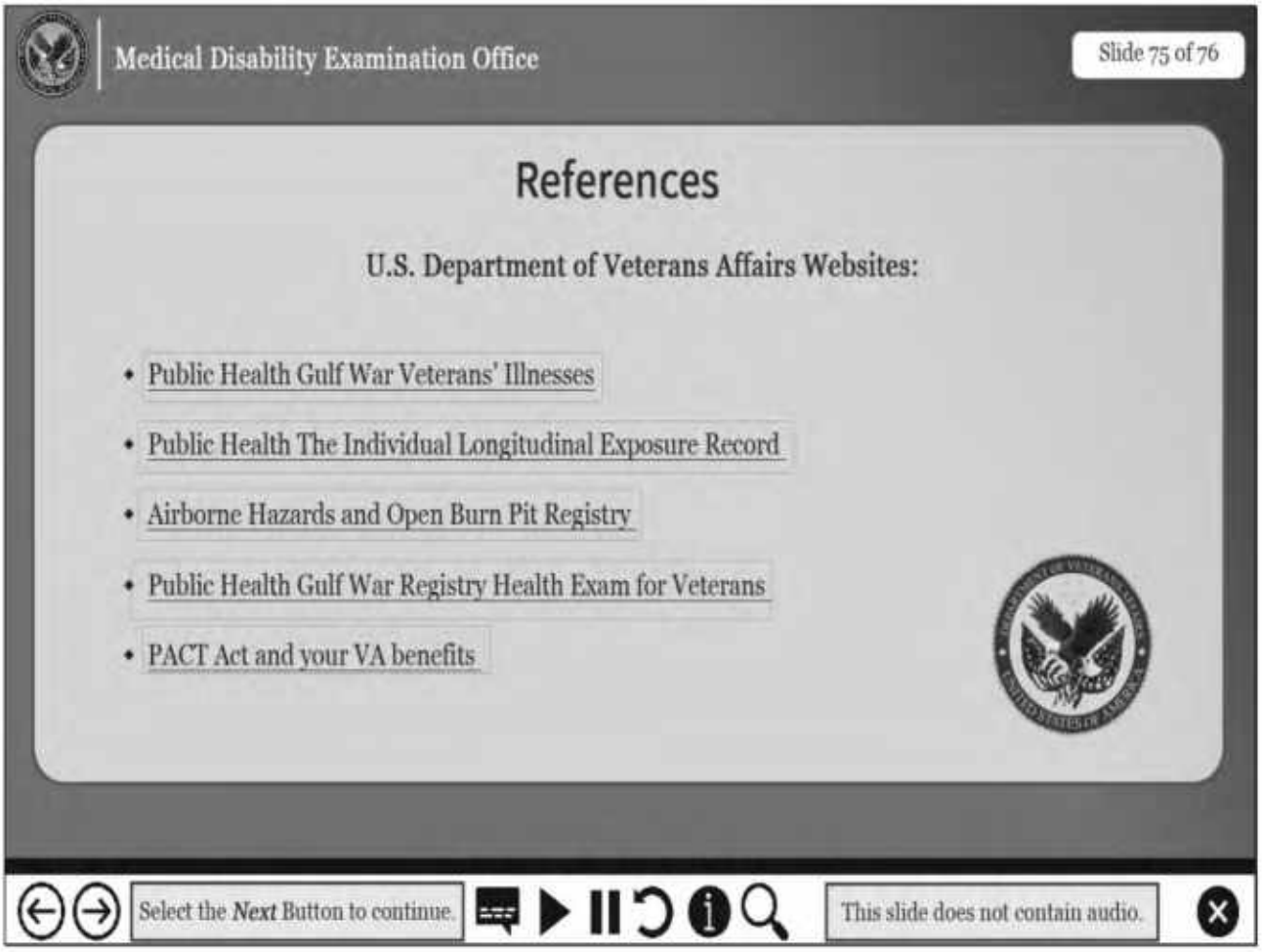
Transcript

Addressing exposure concerns of Gulf War Veterans during a C&P examination is very important. There is a very high level of concern among Veterans about potential exposures encountered Here are some references that you can provide to the Veteran for further resources.

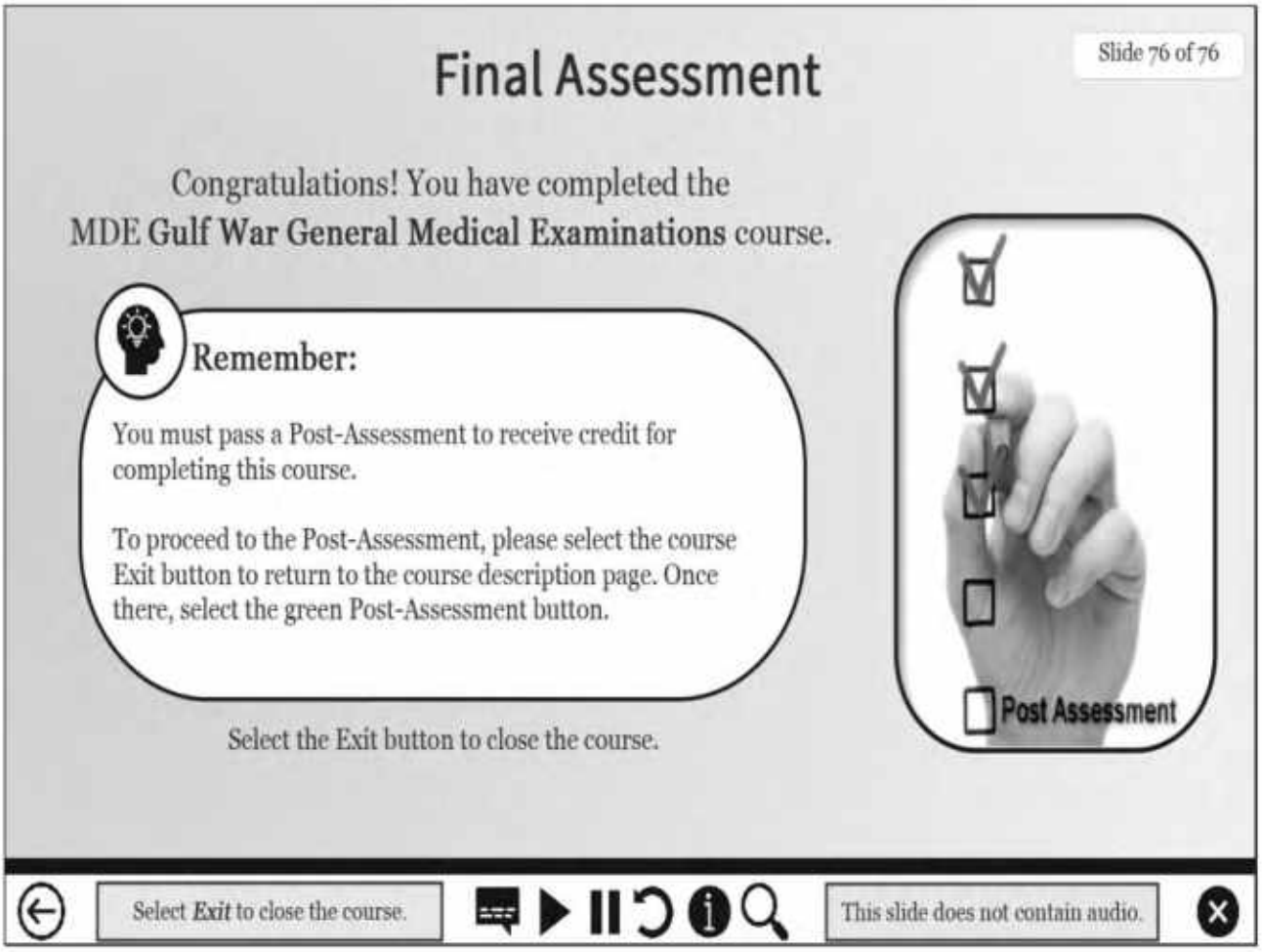
Slide 84 - Examiner Resources



Slide 85 - References



Slide 86 - Closing Slide



MEDICAL DISABILITY EXAMINATION OFFICE
VETERANS BENEFITS ADMINISTRATION

Definition and Reporting Requirements for the Four Disability Patterns

This guide is being provided to the vendor examiners to keep as a quick resource to reference back to as needed. It will define and distinguish the differences between a medical statement and medical opinion, as well as define and provide the reporting requirements for all four Gulf War disability patterns.

Medical Opinion vs Medical Statement

For VA purposes, a **medical statement** is:

- Unique to Gulf War examinations
- Part of the requirements when discussing whether a disability pattern falls under an undiagnosed illness (1) or a MUCMI (2)
- A conclusion of the facts that support the findings of disability pattern (1) or (2)

For VA purposes, a **medical opinion** is:

- A conclusion made by an examiner based on the body of current medical knowledge and the evidence of record
- Most commonly, you will be asked to provide a medical opinion to help with several different determinations by adjudicators such as:
  - A condition's relationship to an event, injury, illness, or disease during a claimant's military service
  - Relationships between medical conditions
  - A condition's etiology
  - Reconcile changes or additions in diagnoses
  - Reconcile difference of opinions

Disability Patterns (1)

The VA defines **undiagnosed illness** as a type of chronic qualifying disability where qualifying signs and/or symptoms **can*not*** be attributed to any known clinical diagnosis by history, physical examination, and laboratory tests. It is a ***diagnosis of exclusion***. It should only be determined after a search for an established medical diagnosis is unsuccessful.

- It is important to rule out diagnosable conditions before determining that symptoms belong to an undiagnosed illness. This practice will avoid overlooking any diagnosable illness for which a Veteran can seek treatment.

- Furthermore, a finding of undiagnosed illness is ***not*** supported if:
  - The illness was clearly caused by intervening conditions or events occurring between the Veteran's last service in Southwest Asia and the onset of the illness
  - Symptoms can be explained by a known diagnosis
  - Symptoms have been present for less than six months

- This diagnosis must be made based on medical signs and/or nonmedical objective indicators, such as time lost from work.

Examples: fatigue or multisite, migratory joint pain with no medically explained diagnosis

Reporting Requirements: If you categorize as a disability pattern (1), an undiagnosed illness, then complete the Gulf War General Medical Examination DBQ and provide a medical statement with supporting rationale explaining why in the Gulf War Medical Opinion DBQ. This is considered a presumptive condition; therefore a separate TERA medical opinion is not required.

Disability Pattern (2)

The VA defines **a diagnosable but medically unexplained chronic multisymptom illness (MUCMI) of unknown etiology** as a diagnosed illness without conclusive pathophysiology or etiology, that is characterized by overlapping symptoms and signs and has features such as fatigue, pain, disability out of proportion to physical findings, and inconsistent demonstration of laboratory abnormalities. A

multisymptom illness is a MUCMI when **either** the etiology or pathophysiology of the illness is inconclusive.

- A finding of a MUCMI is ***not*** supported if both the etiology and pathophysiology of the multi symptom illness are partially understood or fully understood; such conditions would be classified under disability pattens (3) and (4).
- A determination of whether a MUCMI is "medically unexplained" must be specific to the Veteran's case, not simply based on that disease or disability population.
- Again, chronic fatigue syndrome, fibromyalgia, as well as irritable bowel syndrome (IBS) are examples of MUCMIs.

Examples:

- Chronic fatigue syndrome (long-term and severe fatigue that is not relieved by rest and is not directly caused by other conditions). *Note: Chronic fatigue syndrome may be referred to as systemic exertion intolerance disease (SEID) in a claimant's records.*
- Fibromyalgia (characterized by widespread muscle pain; other symptoms may include insomnia, morning stiffness, headache, and memory problems)

- Functional gastrointestinal disorders

Reporting Requirements: If the condition is determined to be a MUCMI, then complete the Gulf War General Medical Examination DBQ and provide a medical statement with supporting rationale in the Gulf War Medical Opinion DBQ. This is considered a presumptive condition; therefore, a separate TERA medical opinion is not required.

Disability Pattern (3)

A diagnosable chronic multisymptom illness with a partially explained etiology:

- A diagnosed illness with both a partially explained etiology and partially or fully understood pathophysiology
- Must meet six-month chronicity criteria (symptoms present either continuously or with periods of worsening and improvement)

Examples: multiple sclerosis and diabetes mellitus type 2

Reporting Requirements: A medical opinion is always required in addition to the medical statement. This would be completed on the Medical Opinion for Toxic Exposure Risk Activities (TERA) section of the Medical Opinion DBQ.

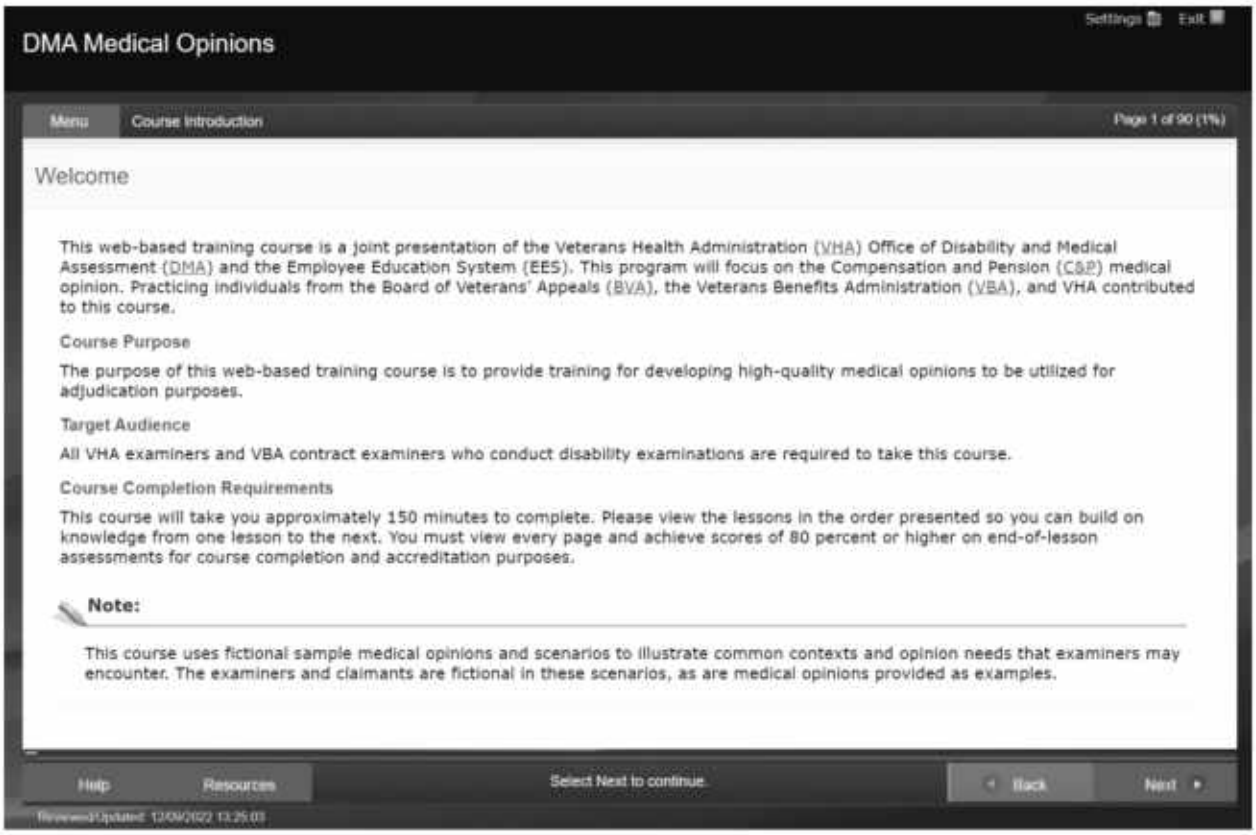
Disability Pattern (4)

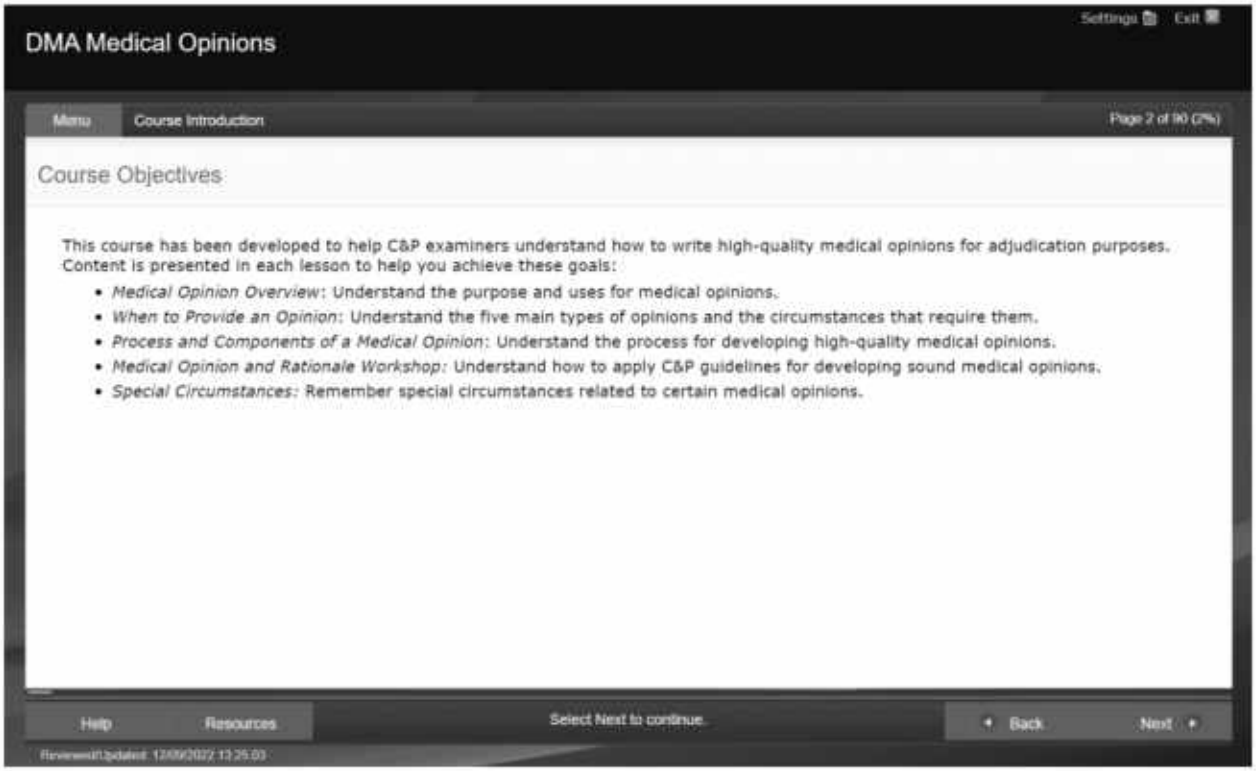
A disease with a clear and specific etiology and diagnosis: Both etiology and pathophysiology completely identified/understood.

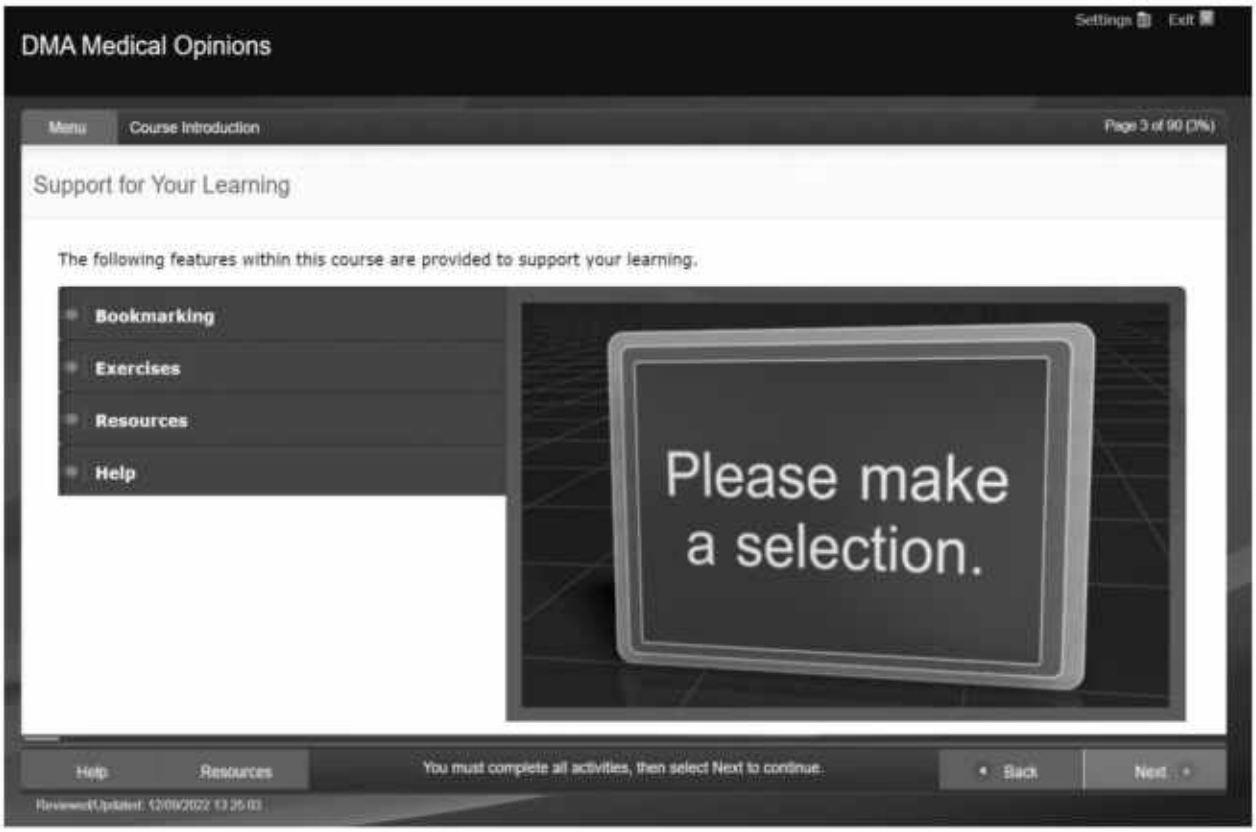
Examples: gastroesophageal reflux disease (GERD), a meniscus tear in the knee, and migraine headaches

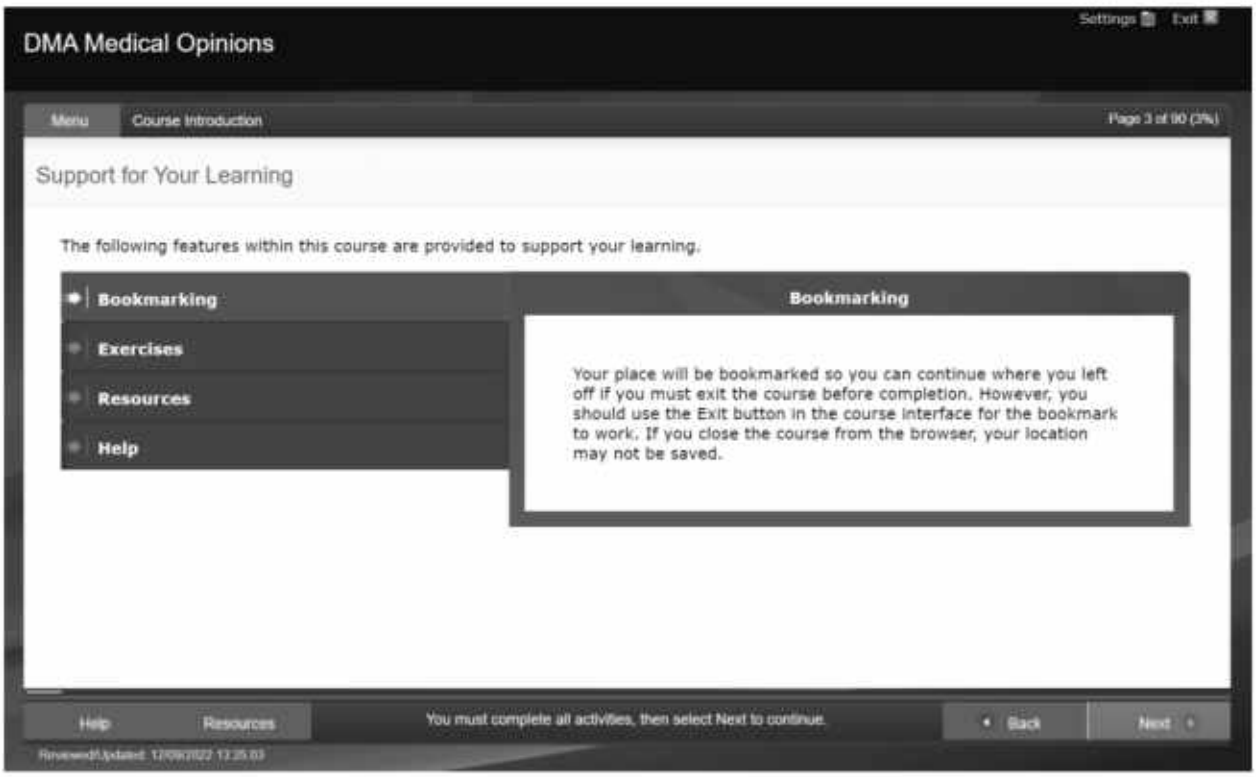
- **GERD**: For the claimed conditions of burping, heartburn, nausea the diagnosis is GERD. Since GERD is a category (4) condition, you will need to provide a rationale which explains both the etiology **and** pathophysiology. You should also include any pertinent evidence you considered from review of the eFolder. Ensure you answer Question 7C which asks if there is any diagnosed gastrointestinal disorder, and if so is it structural or functional. In this example, since GERD has been identified as a disability pattern(4), the answer to Question 7C would be yes, and that it is structural. Lastly, proceed to Section VIII to complete the Medical Opinion for Toxic Exposure Risk Activities (TERA). The TERA Memorandum should be of record and ILER reviewed for exposure information.

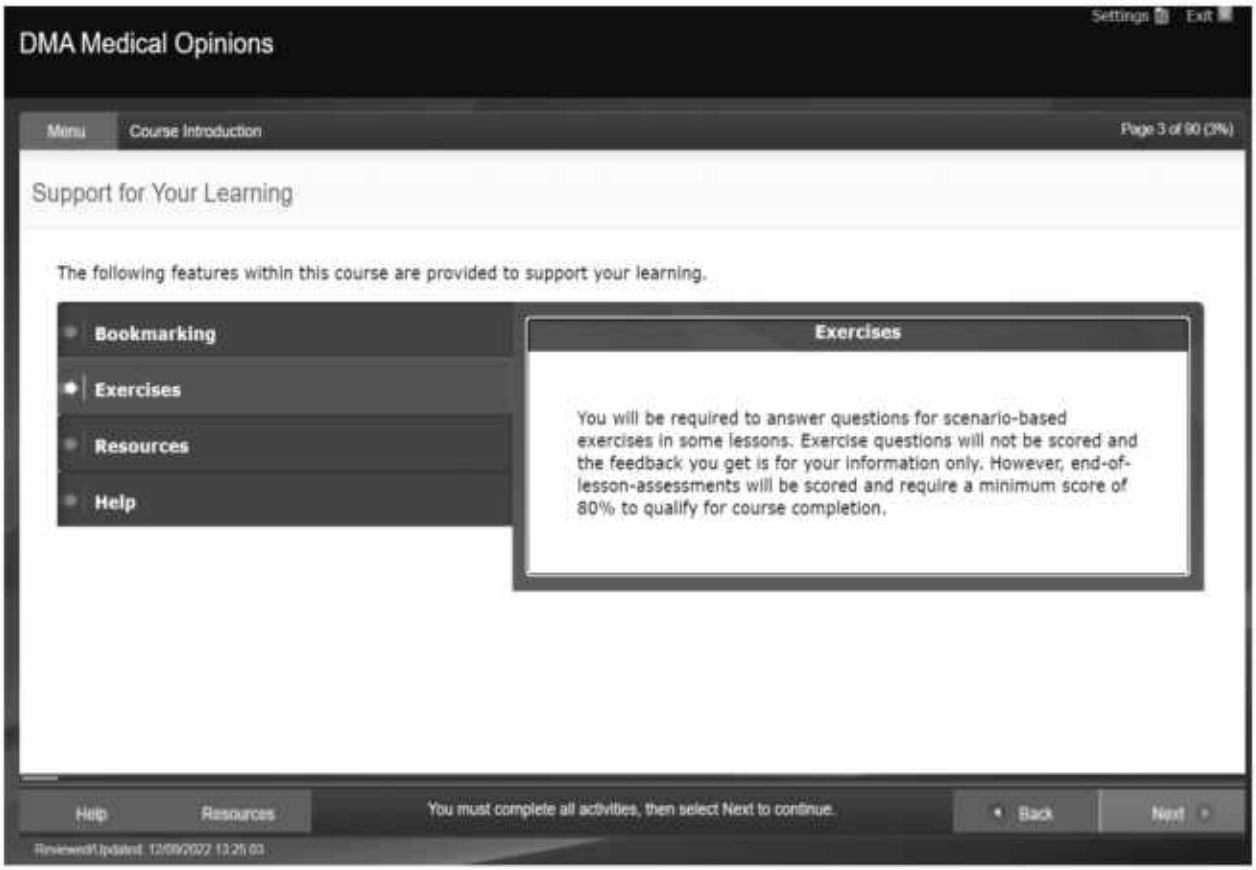
Reporting Requirements: A medical opinion is always required in addition to the medical statement. This would be completed on the Medical Opinion for Toxic Exposure Risk Activities (TERA) section of the Medical Opinion DBQ.

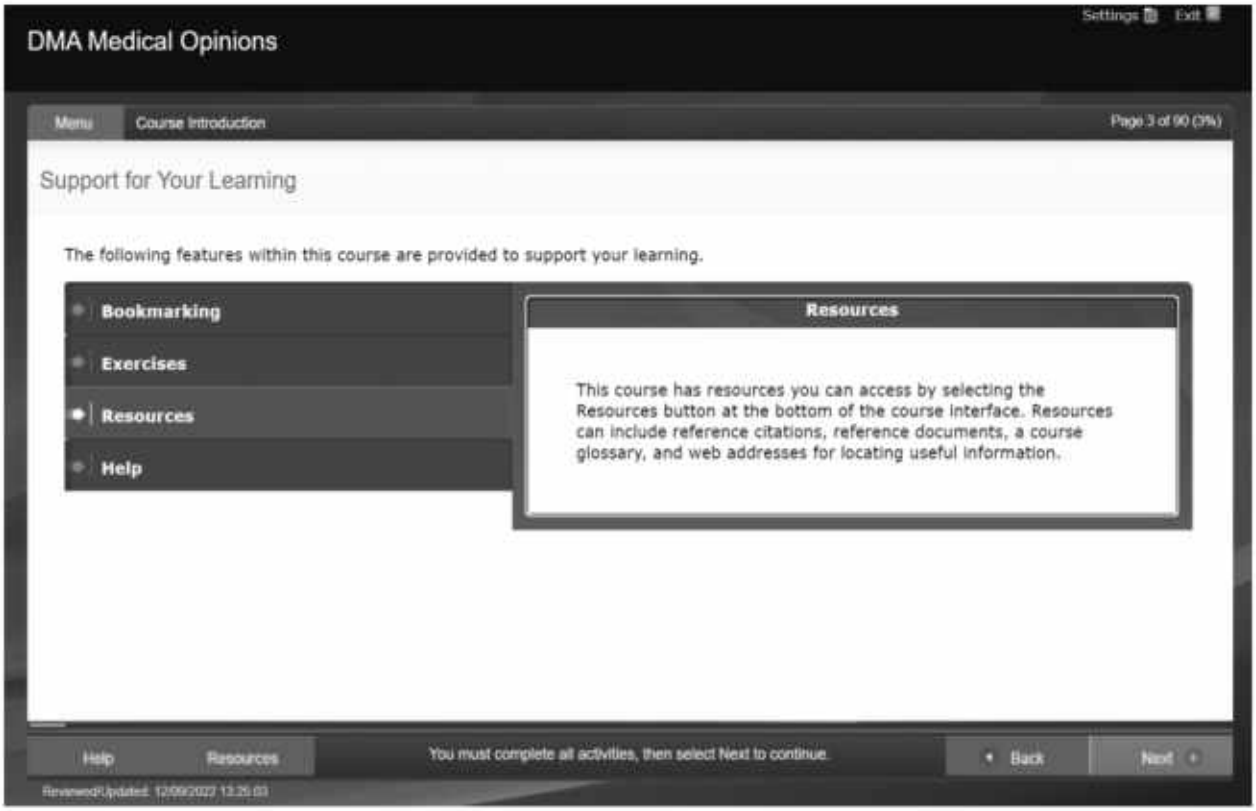

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Course Introduction
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Welcome
This web-based training course is a joint presentation of the Veterans Health Administration (VHA) Office of Disability and Medical Assessment (DMA) and the Employee Education System (EES). This program will focus on the Compensation and Pension (C&P) medical opinion. Practicing individuals from the Board of Veterans' Appeals (BVA), the Veterans Benefits Administration (VBA), and VHA contributed to this course.
Course Purpose
The purpose of this web-based training course is to provide training for developing high-quality medical opinions to be utilized for adjudication purposes.
Target Audience
All VHA examiners and VBA contract examiners who conduct disability examinations are required to take this course.
Course Completion Requirements
This course will take you approximately 150 minutes to complete. Please view the lessons in the order presented so you can build on knowledge from one lesson to the next. You must view every page and achieve scores of 80 percent or higher on end-of-lesson assessments for course completion and accreditation purposes.
Note:
This course uses fictional sample medical opinions and scenarios to illustrate common contexts and opinion needs that examiners may encounter. The examiners and claimants are fictional in these scenarios, as are medical opinions provided as examples.
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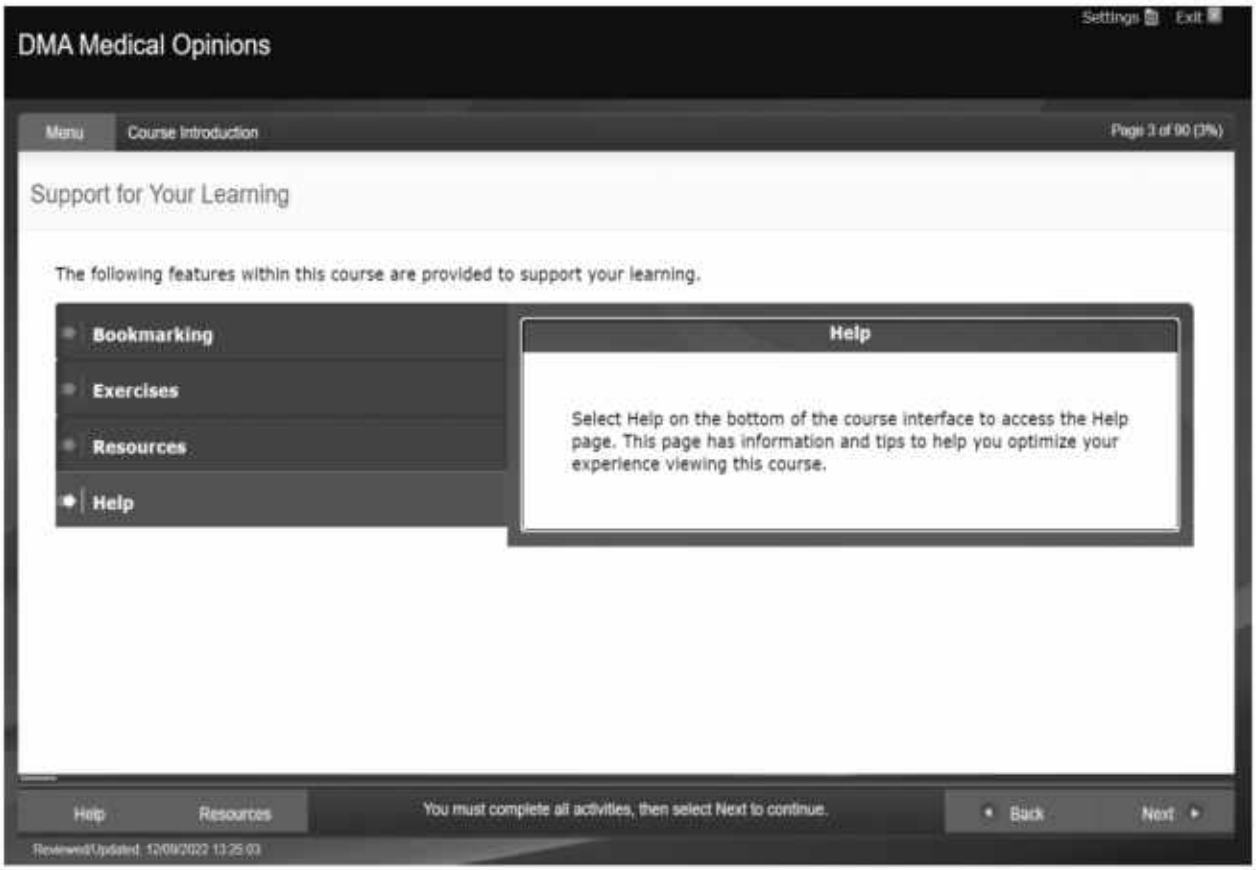

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Course Objectives
This course has been developed to help C&P examiners understand how to write high-quality medical opinions for adjudication purposes. Content is presented in each lesson to help you achieve these goals:
Medical Opinion Overview: Understand the purpose and uses for medical opinions.
When to Provide an Opinion: Understand the five main types of opinions and the circumstances that require them.
Process and Components of a Medical Opinion: Understand the process for developing high-quality medical opinions.
Medical Opinion and Rationale Workshop: Understand how to apply C&P guidelines for developing sound medical opinions.
Special Circumstances: Remember special circumstances related to certain medical opinions.
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The following features within this course are provided to support your learning.
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Please make a selection.
Help
Resources
You must complete all activities, then select Next to continue.
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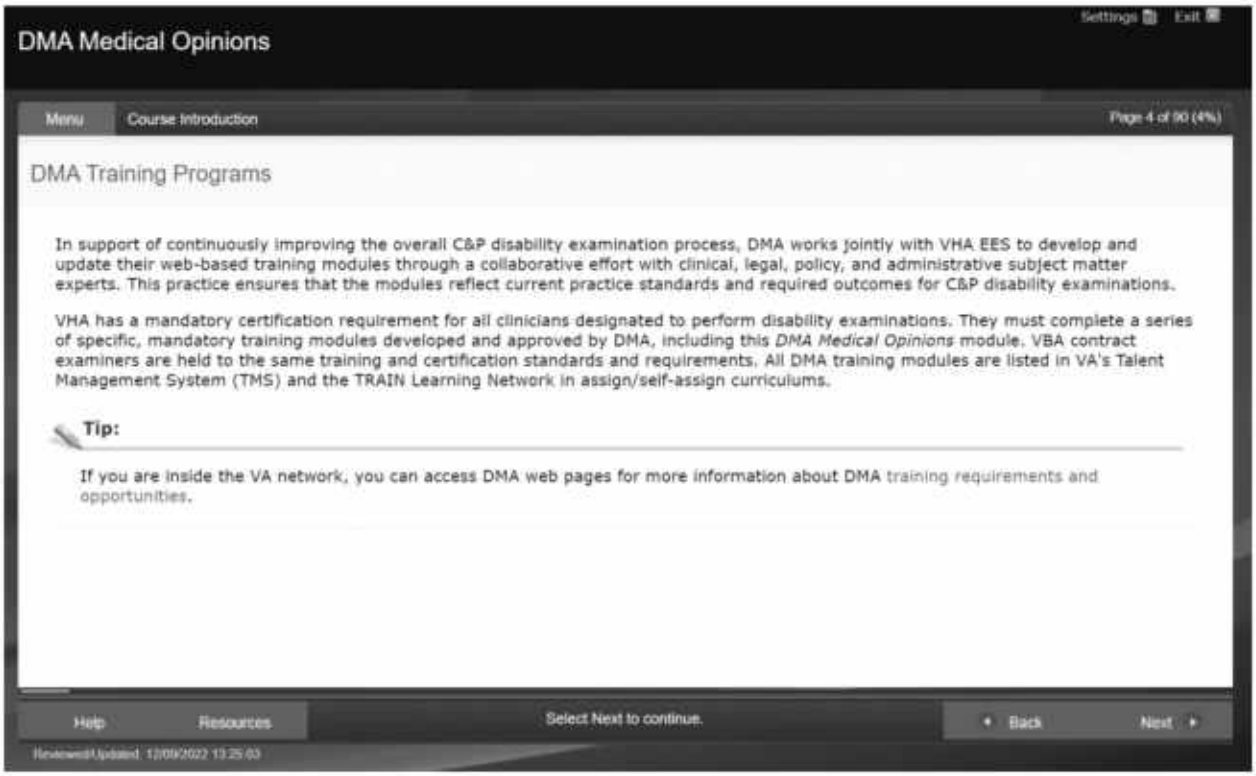

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Your place will be bookmarked so you can continue where you left off if you must exit the course before completion. However, you should use the Exit button in the course interface for the bookmark to work. If you close the course from the browser, your location may not be saved.
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Support for Your Learning
The following features within this course are provided to support your learning.
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Exercises
You will be required to answer questions for scenario-based exercises in some lessons. Exercise questions will not be scored and the feedback you get is for your information only. However, end-of-lesson-assessments will be scored and require a minimum score of 80% to qualify for course completion.
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Support for Your Learning
The following features within this course are provided to support your learning.
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Exercises
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Resources
This course has resources you can access by selecting the Resources button at the bottom of the course interface. Resources can include reference citations, reference documents, a course glossary, and web addresses for locating useful information.
Help
Resources
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Tip: Training Resources (va.gov)



DMA Medical Opinions

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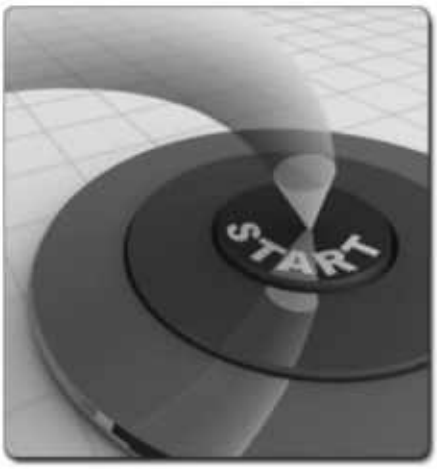
Menu | Medical Opinion Overview | Page 5 of 90 (6%)

Lesson 1 Introduction

This lesson will present content to help you understand the purpose and uses for medical opinions. It will start by defining the term, medical opinion, and then will explain why medical opinions are needed for C&P claims, the purposes for medical opinions, and the audience for them.

In addition, you will also need to be aware of VA policies and standards that will affect your approach when writing opinions:

- Presumption of soundness,
- Benefit of the doubt, and
- An unbiased approach.



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A C&P Medical Opinion Defined

For C&P purposes, a medical opinion is a conclusion expressed by an examiner in legally required language (explained later in this course) and based on current medical knowledge and available evidence for a Veteran's or Service member's disability claim.

All medical opinions must be accompanied by a well-supported rationale that is both consistent with the evidence of record for a Veteran's or Service member's claim and consistent with widely accepted standards and knowledge of the medical community at large. You can think of a medical opinion as having two parts: the opinion and a rationale that explains and supports it.

You may recall from the *DMA General Certification Overview* course that examiners should also keep in mind that VBA considers multiple factors in deciding a Veteran's or Service member's claim. A medical opinion is a critical part of the overall claims process, but not the sole factor for determining their entitlement to benefits.

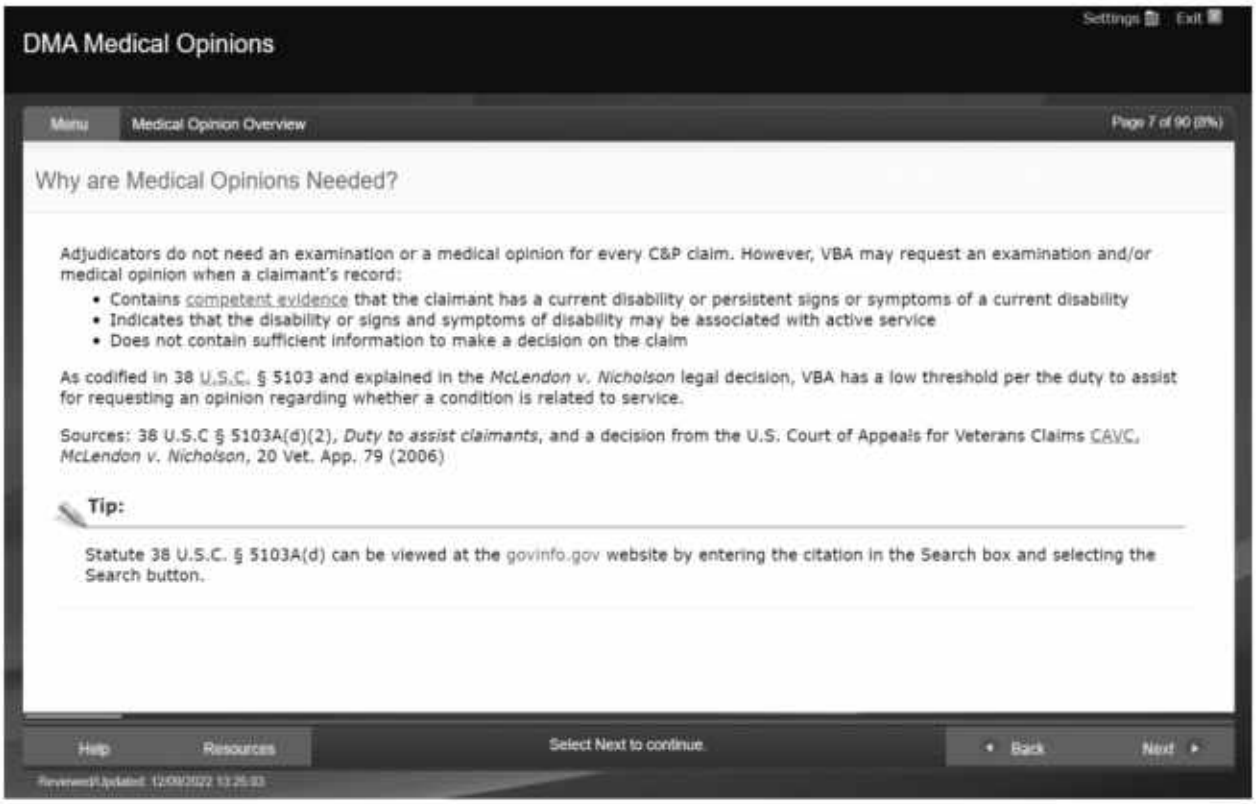
Note:

Because C&P clinicians apply their individual judgment, experience, and medical knowledge when assessing the pertinent facts of a case, it is possible that different medical opinions could be formed based on a review of the same evidence.



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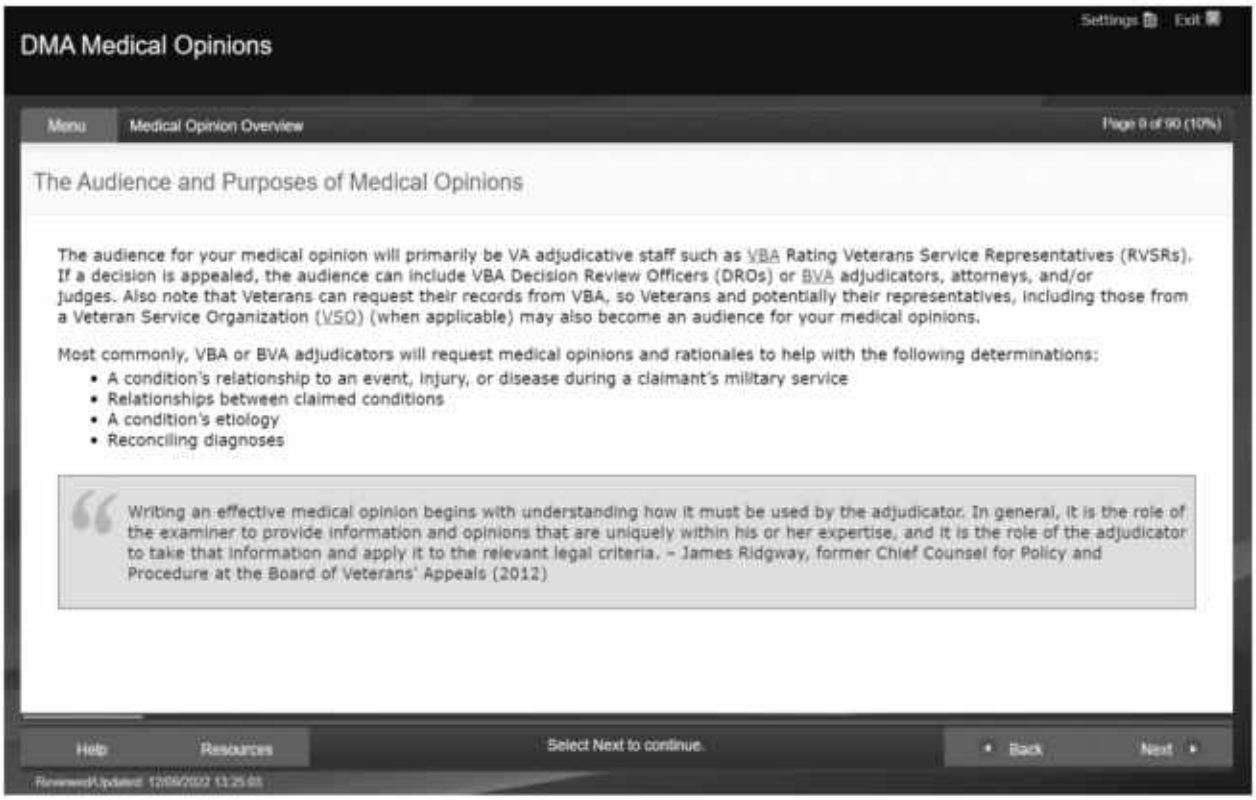

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Medical Opinion Overview
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Why are Medical Opinions Needed?
Adjudicators do not need an examination or a medical opinion for every C&P claim. However, VBA may request an examination and/or medical opinion when a claimant's record:
• Contains competent evidence that the claimant has a current disability or persistent signs or symptoms of a current disability
• Indicates that the disability or signs and symptoms of disability may be associated with active service
• Does not contain sufficient information to make a decision on the claim
As codified in 38 U.S.C. § 5103 and explained in the McLendon v. Nicholson legal decision, VBA has a low threshold per the duty to assist for requesting an opinion regarding whether a condition is related to service.
Sources: 38 U.S.C § 5103A(d)(2), Duty to assist claimants, and a decision from the U.S. Court of Appeals for Veterans Claims CAVC, McLendon v. Nicholson, 20 Vet. App. 79 (2006)
Tip:
Statute 38 U.S.C. § 5103A(d) can be viewed at the govinfo.gov website by entering the citation in the Search box and selecting the Search button.
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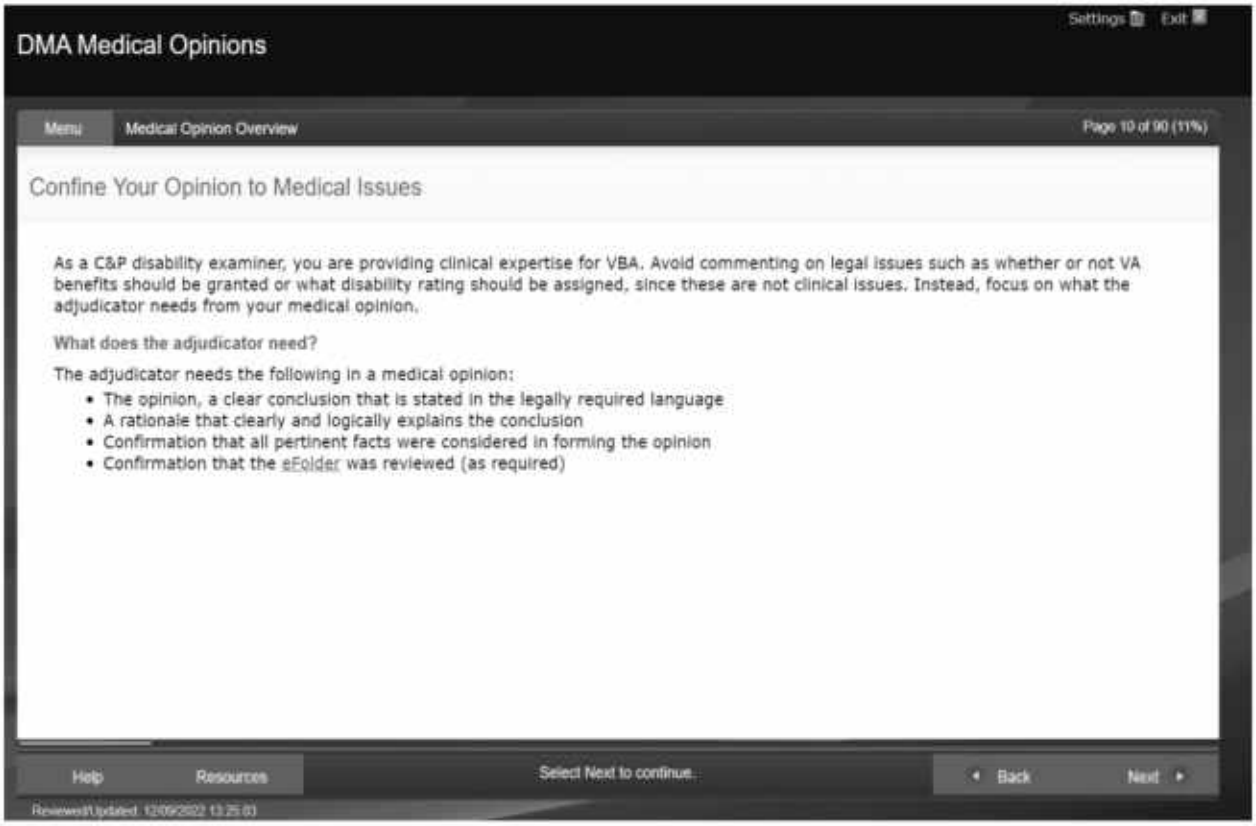

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Additional Case Law about Opinion Needs
Additional legal cases have impacted when a medical opinion is necessary. Select each case for a summary.
Colvin v. Derwinski (1991)
Charles v. Principi (2002)
Please make a selection.
Tip:
The full text of these decisions, as well as the McLendon v. Nicholson decision on the previous page, can be accessed under the year they were decided on the U.S. Court of Appeals for Veterans Claims website, on the Orders and Opinions tab. For decisions prior to 2000, follow directions at the bottom of the Orders and Opinions tab to link to archived cases. On the Archived Cases tab, look for the correct year under Panel Decisions. When you select the linked year, you will download a zipped file of all Panel Decisions for that year.
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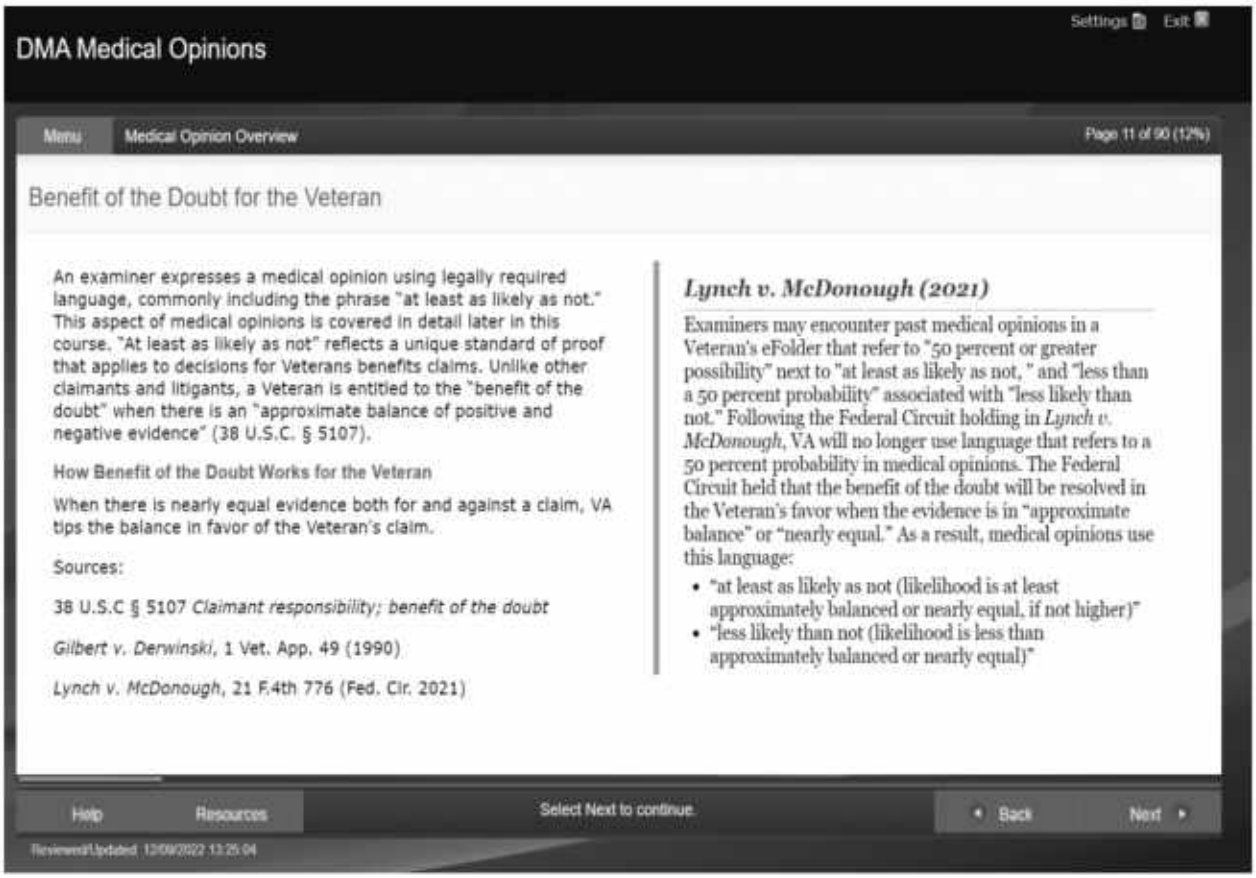


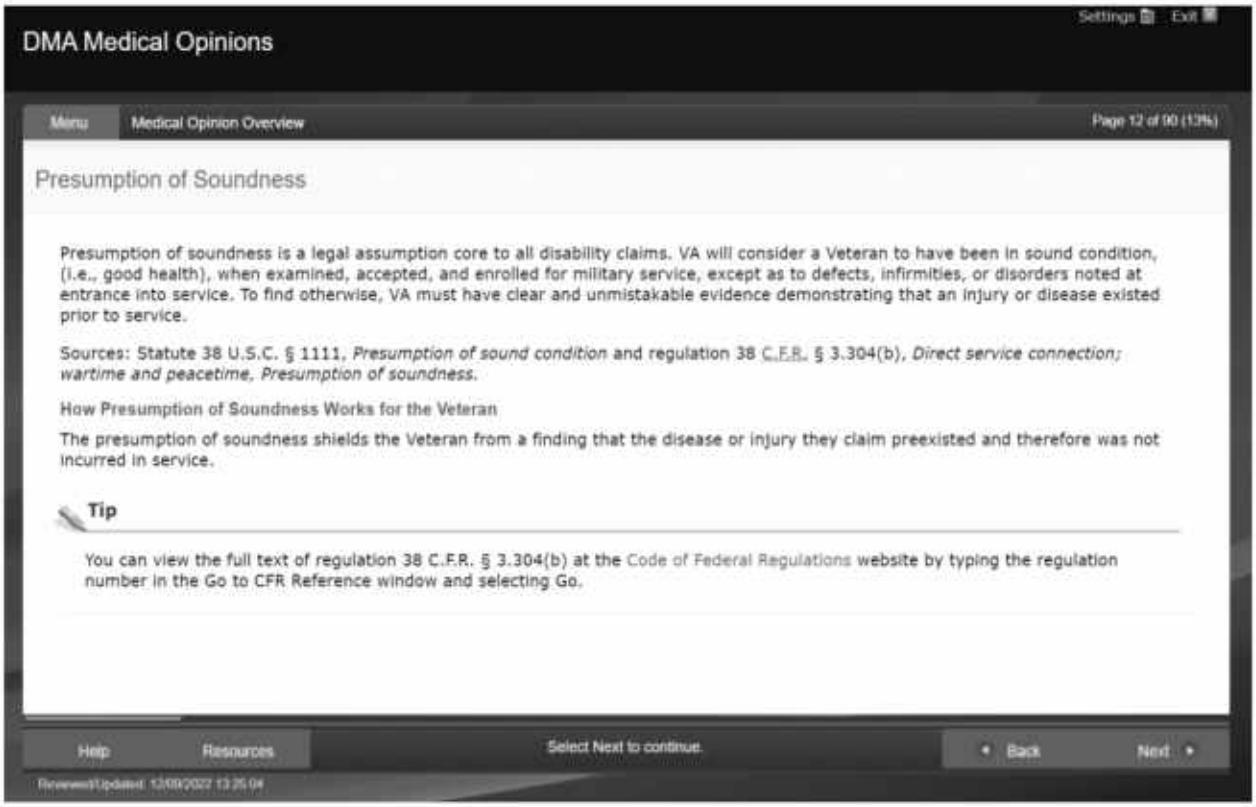


U.S. Court of Appeals for Veterans Claims Website: US Court of Appeals for Veterans Claims - Opinions (cavc.gov)


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The Audience and Purposes of Medical Opinions
The audience for your medical opinion will primarily be VA adjudicative staff such as VBA Rating Veterans Service Representatives (RVSRs). If a decision is appealed, the audience can include VBA Decision Review Officers (DROs) or BVA adjudicators, attorneys, and/or judges. Also note that Veterans can request their records from VBA, so Veterans and potentially their representatives, including those from a Veteran Service Organization (VSO) (when applicable) may also become an audience for your medical opinions.
Most commonly, VBA or BVA adjudicators will request medical opinions and rationales to help with the following determinations:
A condition's relationship to an event, injury, or disease during a claimant's military service
Relationships between claimed conditions
A condition's etiology
Reconciling diagnoses
Writing an effective medical opinion begins with understanding how it must be used by the adjudicator. In general, it is the role of the examiner to provide information and opinions that are uniquely within his or her expertise, and it is the role of the adjudicator to take that information and apply it to the relevant legal criteria. – James Ridgway, former Chief Counsel for Policy and Procedure at the Board of Veterans' Appeals (2012)
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Confine Your Opinion to Medical Issues
As a C&P disability examiner, you are providing clinical expertise for VBA. Avoid commenting on legal issues such as whether or not VA benefits should be granted or what disability rating should be assigned, since these are not clinical issues. Instead, focus on what the adjudicator needs from your medical opinion.
What does the adjudicator need?
The adjudicator needs the following in a medical opinion:
The opinion, a clear conclusion that is stated in the legally required language
A rationale that clearly and logically explains the conclusion
Confirmation that all pertinent facts were considered in forming the opinion
Confirmation that the eFolder was reviewed (as required)
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Benefit of the Doubt for the Veteran
An examiner expresses a medical opinion using legally required language, commonly including the phrase "at least as likely as not." This aspect of medical opinions is covered in detail later in this course. "At least as likely as not" reflects a unique standard of proof that applies to decisions for Veterans benefits claims. Unlike other claimants and litigants, a Veteran is entitled to the "benefit of the doubt" when there is an "approximate balance of positive and negative evidence" (38 U.S.C. § 5107).
How Benefit of the Doubt Works for the Veteran
When there is nearly equal evidence both for and against a claim, VA tips the balance in favor of the Veteran's claim.
Sources:
38 U.S.C § 5107 Claimant responsibility; benefit of the doubt
Gilbert v. Derwinski, 1 Vet. App. 49 (1990)
Lynch v. McDonough, 21 F.4th 776 (Fed. Cir. 2021)
Lynch v. McDonough (2021)
Examiners may encounter past medical opinions in a Veteran's eFolder that refer to "50 percent or greater possibility" next to "at least as likely as not," and "less than a 50 percent probability" associated with "less likely than not." Following the Federal Circuit holding in Lynch v. McDonough, VA will no longer use language that refers to a 50 percent probability in medical opinions. The Federal Circuit held that the benefit of the doubt will be resolved in the Veteran's favor when the evidence is in "approximate balance" or "nearly equal." As a result, medical opinions use this language:
• "at least as likely as not (likelihood is at least approximately balanced or nearly equal, if not higher)"
• "less likely than not (likelihood is less than approximately balanced or nearly equal)"
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Presumption of Soundness
Presumption of soundness is a legal assumption core to all disability claims. VA will consider a Veteran to have been in sound condition, (i.e., good health), when examined, accepted, and enrolled for military service, except as to defects, infirmities, or disorders noted at entrance into service. To find otherwise, VA must have clear and unmistakable evidence demonstrating that an injury or disease existed prior to service.
Sources: Statute 38 U.S.C. § 1111, Presumption of sound condition and regulation 38 C.F.R. § 3.304(b), Direct service connection; wartime and peacetime, Presumption of soundness.
How Presumption of Soundness Works for the Veteran
The presumption of soundness shields the Veteran from a finding that the disease or injury they claim preexisted and therefore was not incurred in service.
Tip
You can view the full text of regulation 38 C.F.R. § 3.304(b) at the Code of Federal Regulations website by typing the regulation number in the Go to CFR Reference window and selecting Go.
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An Unbiased Approach

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

Address all pertinent evidence, not just evidence that supports the opinion.

You will notice that VA is careful to use unbiased language for an examination request. As the examiner, you must also be unbiased in your approach. You are expected to review and weigh all available evidence for and against a claim and use your clinical expertise and pertinent, widely accepted medical knowledge, including peer-reviewed medical literature as needed, to formulate and substantiate a medical opinion.

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

A medical opinion may not be "correct" or "incorrect" per se, but it can be determined to be insufficient when it lacks a rationale, is poorly reasoned, or is based on inaccurate or incomplete evidence.

How a Veteran Benefits from an Unbiased Approach

A Veteran's claim can be determined objectively when a medical opinion with rationale is written using unbiased language and explains how all available evidence was considered.

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Video: VA Policies That Affect Medical Opinions

Meet the panel of subject matter experts from VHA, VBA, and the Board (BVA):

Bio: Dr. Gavino Oliva Bio: Dr. Courtney Pederzani

Bio: Ms. Tina Skelly Bio: Ms. Annette Griffin

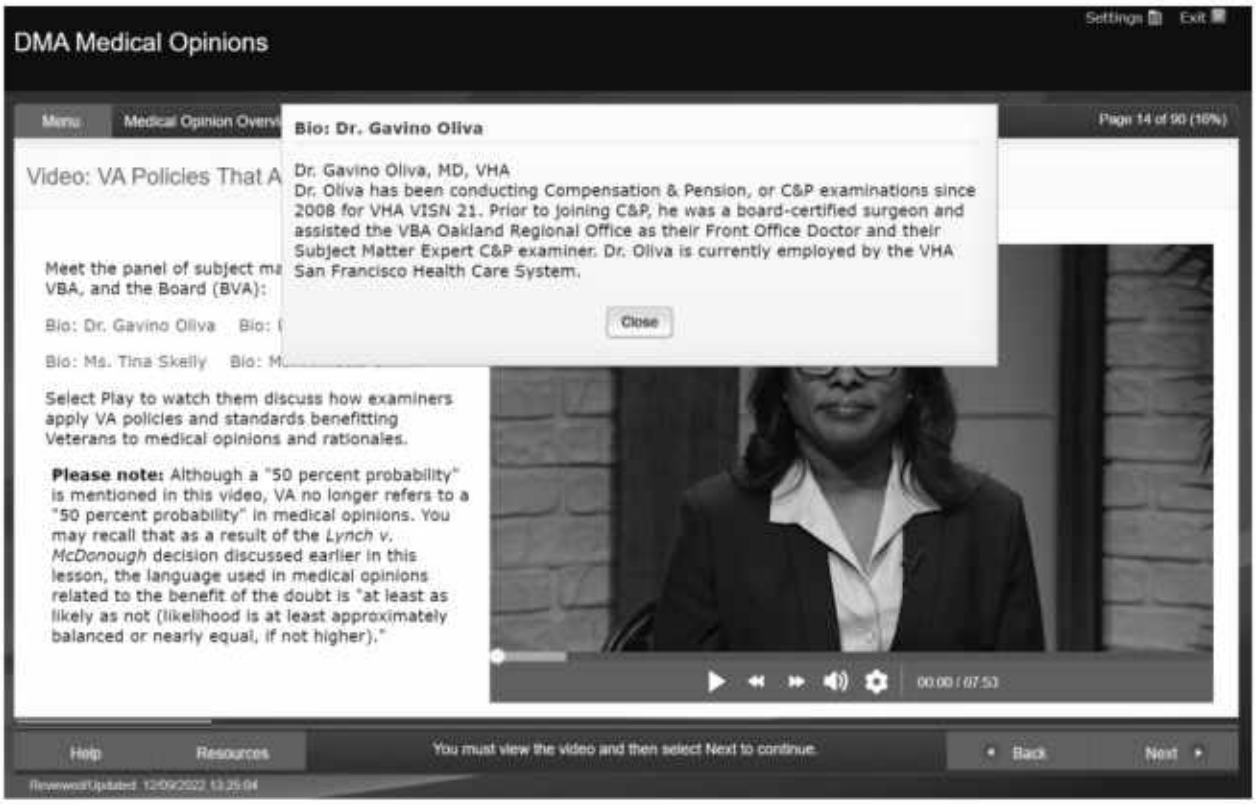
Select Play to watch them discuss how examiners apply VA policies and standards benefitting Veterans to medical opinions and rationales.

Please note: Although a "50 percent probability" is mentioned in this video, VA no longer refers to a "50 percent probability" in medical opinions. You may recall that as a result of the *Lynch v. McDonough* decision discussed earlier in this lesson, the language used in medical opinions related to the benefit of the doubt is "at least as likely as not (likelihood is at least approximately balanced or nearly equal, if not higher)."



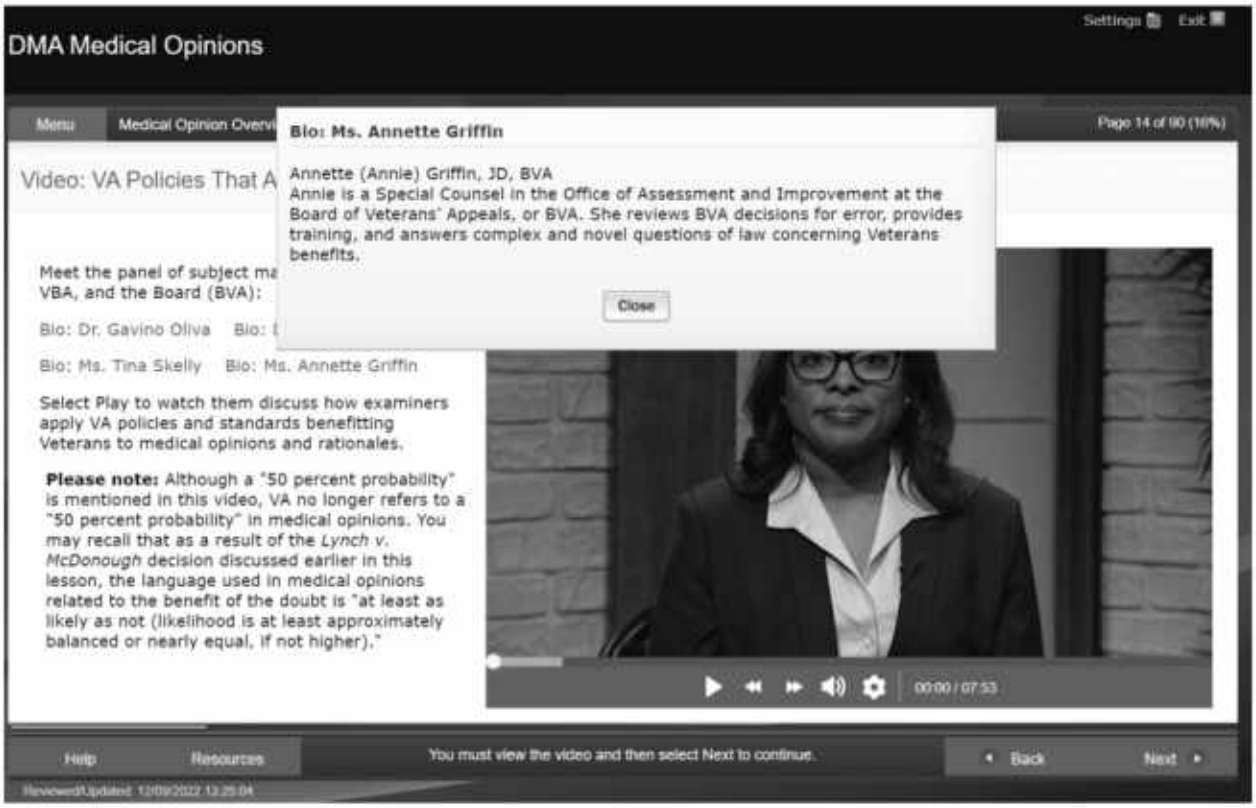
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Bio: Dr. Gavino Oliva
Dr. Gavino Oliva, MD, VHA
Dr. Oliva has been conducting Compensation & Pension, or C&P examinations since 2008 for VHA VISN 21. Prior to joining C&P, he was a board-certified surgeon and assisted the VBA Oakland Regional Office as their Front Office Doctor and their Subject Matter Expert C&P examiner. Dr. Oliva is currently employed by the VHA San Francisco Health Care System.
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Bio: Dr. Courtney Pederzani
Dr. Courtney Pederzani, PsyD, VBA
Dr. Pederzani is a licensed Clinical Psychologist. She is a former VHA compensation & pension examiner, supervisor, and program manager. She also served as an in-house clinician providing complex medical opinions to the Philadelphia Regional Office, and has been a subject matter expert for several DMA trainings and initiatives. After 10 years with VHA, she is now a Senior Mental Health Officer in the VBA Medical Disability Examination Office.
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Welcome to this discussion about VA policies that affect medical opinions. I'm Matuschka Lindo, and I will moderate the panel discussions for this DMA Medical Opinions Course. I am joined by four panelists

Tina Skelly from VBA. Tina is a lead management and program analyst with the Medical Disability Examination Policy and Program Management Office. Tina has been a subject matter expert on numerous DMA training courses related to C&P. Dr. Gavino Oliva, a VHA physician from the San Francisco VA Medical Center. Dr. Oliva has been conducting compensation and pension, or C&P examination, since 2008.He also served as a subject matter expert for multiple DMA training courses. Annette Griffin, from the Board of Veterans' Appeals or BVA. Annette is a special counsel in the Office of Assessment and Improvement at BVA. Dr. Courtney Pederzani, a licensed clinical psychologist who serves as a senior mental health officer in the VBA Medical Disability Examination Office. Dr. Pederzani is a former C&P examiner, supervisor, and program manager at VHA, and she has been a subject matter expert for several DMA trainings and initiatives. Let's start with the benefit of the doubt. Giving a Veteran the benefit of the doubt is a central concept in adjudicating compensation and pension claims. Ms. Skelly, could you tell us more about how this approach is applied by VBA? Sure, benefit of the doubt is also called the reasonable doubt rule. It's based on regulation 38 CFR 3.102.The reasonable doubt rule means that the evidence provided by the claimant or obtained on their behalf must only persuade the adjudicator that each factual matter is as likely as not. It is a concept that VA consistently applies to administer the law under a broad interpretation, but still consistent with the fact shown in each individual case. After an adjudicator gives careful consideration of all procurable and assembled data for a claim, if a reasonable doubt arises about service origin, the degree of disability, or any other point, the doubt will be resolved in favor of the claimant. Thank you, Ms. Skelly. Doctors Pederzani and Oliva, how does this policy affect examiners? Well, examiners are aware by now that the disability examinations they complete for VA are medical legal exams. They are medical evaluations that are used within a legal decision-making process. And that larger legal context sometimes defines terms or standards in ways that affect the language examiners are expected to use, or the standards they are asked to apply when forming opinions. So, for example, one way that this concept of benefit of the doubt shows up is in the language required for stating medical opinions, such as "at least as likely as not. "When you think about what those words mean, that is giving someone the benefit of the doubt, it's built into the language. It means if it is just as likely as not likely, hitting 50% certainty in your professional opinion, then the benefit of the doubt is extended to the Veteran's contention. So, getting into this way of approaching examinations is often a real shift for examiners, shifting from their usual medical provider mindset away from the priorities of a treatment appointment to a medical-legal mindset, and learning what the legal terms and concepts mean. We, healthcare providers, are accustomed during our medical training to assessing any medical condition from subjective and objective findings. This rigorous thought process may rule in and rule out any other potential medical conditions which then lead us to assess a specific diagnosis in a planned medical course to include a treatment protocol. The certainty to reach a diagnosis is most often a precise one. Terms such as "at least as likely as not "or "less likely than not" for medical opinions are not medically customary terms, but instead these are medical-legal terms that are used to help guide a C&P evaluator's threshold, which is 50% or greater probability to form an opinion based on medical evidence and construct a cogent rationale. So benefit of the doubt for Veteran's claim is applied after an examiner thoroughly looks at all evidence that may be equally for or against a claim. It eases the evidentiary burden an examiner would have in a treatment setting compared to a C&P setting. When evidence is in relative equal poise, benefit of the doubt enables the examiner to write an opinion that is favorable for the Veteran's claim. Thank you panelists. Another key concept for writing medical opinions is having a fair and objective approach. Dr. Pederzani, what does being fair and objective mean for the clinician who is writing an opinion? Well, as much as it is important to extend the benefit of the doubt

when it applies, medical opinions must be data driven. The Veteran's perspective will give you certain data points, but then you need to look for all of the other data points that are also relevant, and then use your clinical expertise to reconcile all of the evidence into a fair and objective opinion. So the balance for examiners is to be both Veteran-centric by respecting Veterans' perspectives and giving fair consideration to their claims, while also being analytical, objective, and accounting for the data. There's a kind of generosity built into the regulations by extending the benefit of the doubt, but ultimately we are part of the process because of our expertise and ability to consolidate data in to a clinical finding. Dr. Oliva, Dr. Pederzani talked about the need to reconcile the information you, as an examiner, are getting from the Veteran with other data points you've seen in the eFolder or in findings from the C&P examination. How do you explain this need for reconciliation to a new examiner? As an examiner, I have to ensure I reviewed all pertinent information that is asked of me by our VBA partners, and information that I may have discovered independently as pertinent evidence. It is paramount that new examiners are diligent in annotating new findings and reviewing such information as evidence. This evidence then becomes part of a C&P examiner's building blocks when forming eventually a cogent rationale and opinion. Adding to what Dr. Oliva is saying, providing a medical opinion is like giving expert testimony. And the courts have made the same comparison before in cases like Nieves-Rodriguez versus Peake. Adjudicators themselves are not competent to opine or reach medical conclusions. Examiner medical opinions are our eyes and ears into that perspective of a claim. These opinions help us confirm connections, fill in the gaps, or address inconsistencies. And so, it's those opinions, and more importantly, explanations for how they were reached, that really illustrate the disability picture from a medical perspective and bring the case to life for the adjudicator. Thank you all for clarifying what a fair and objective approach to medical opinions means for new examiners. Another policy that impacts how opinions and rationales are developed is the presumption of soundness, VA's policy that a Veteran who enters service is presumed to be of sound health unless otherwise noted by a clinician in their service entrance examination. We'll go more into presumption of soundness and how it applies to medical opinions later in this course.



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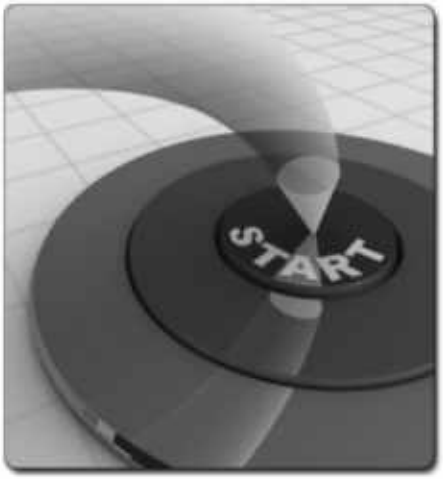
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Lesson 2 Introduction

This lesson will present content to help you understand common types of opinions and when to provide them. It will describe the most common types of medical opinions you will use to explain the relationship of a Veteran's or Service member's condition(s) and their military service. This lesson also indicates federal regulations and legal decisions that set forth requirements for each type of service connection.

Knowing when to provide an opinion is important, so this lesson will cover circumstances that require medical opinions. Equally important, it will clarify when you should not provide one.



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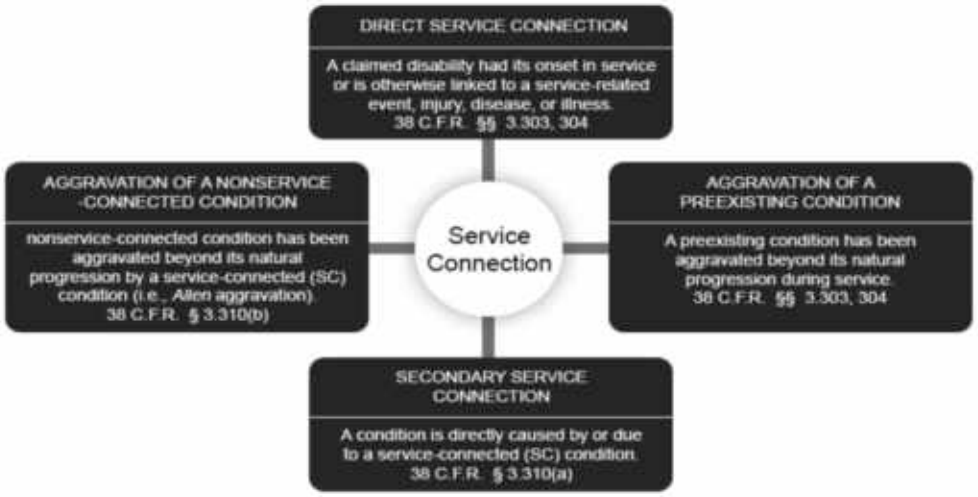
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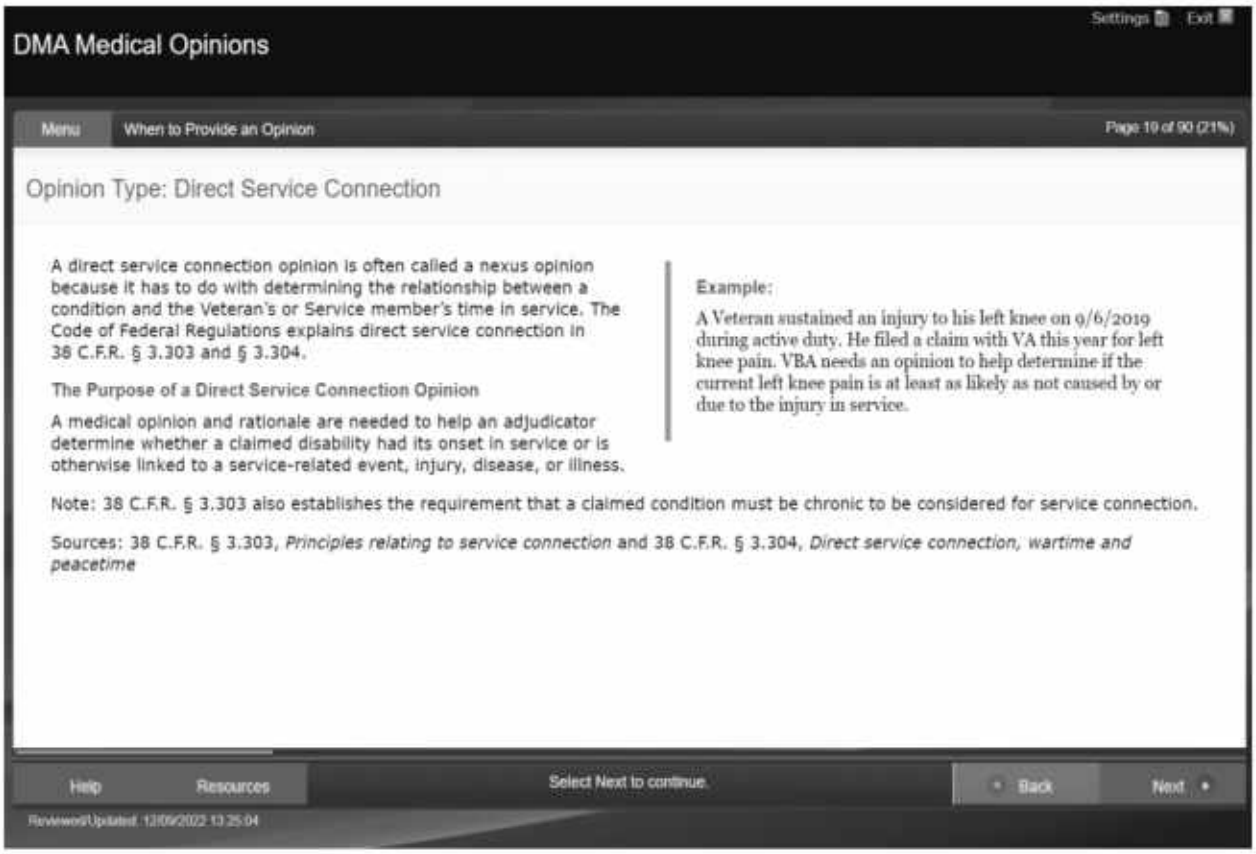
Types of Medical Opinions

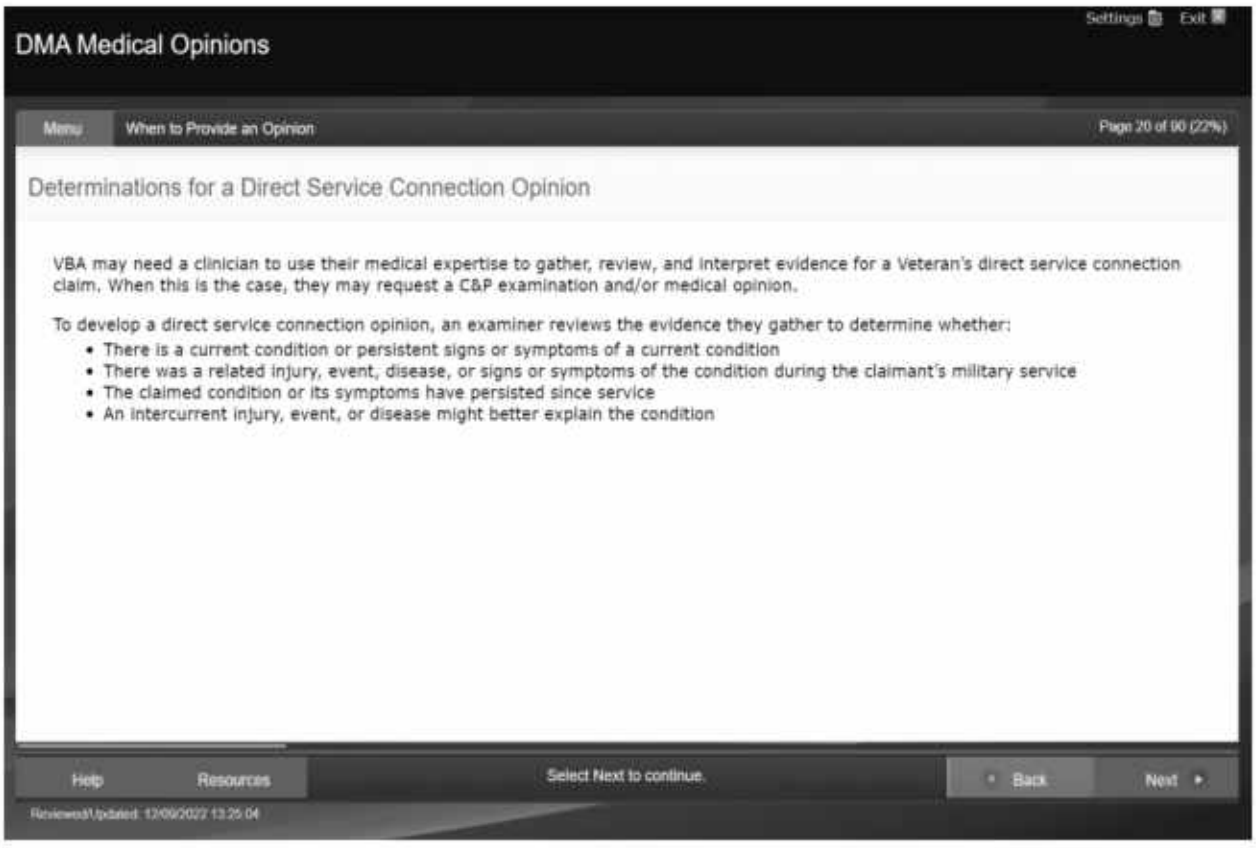
Medical opinions are used to explain the potential relationships of Veterans' or Service members' claimed disabilities and their military service. There are four kinds of opinions for service connection shown here. Select each section of the graphic to learn more:

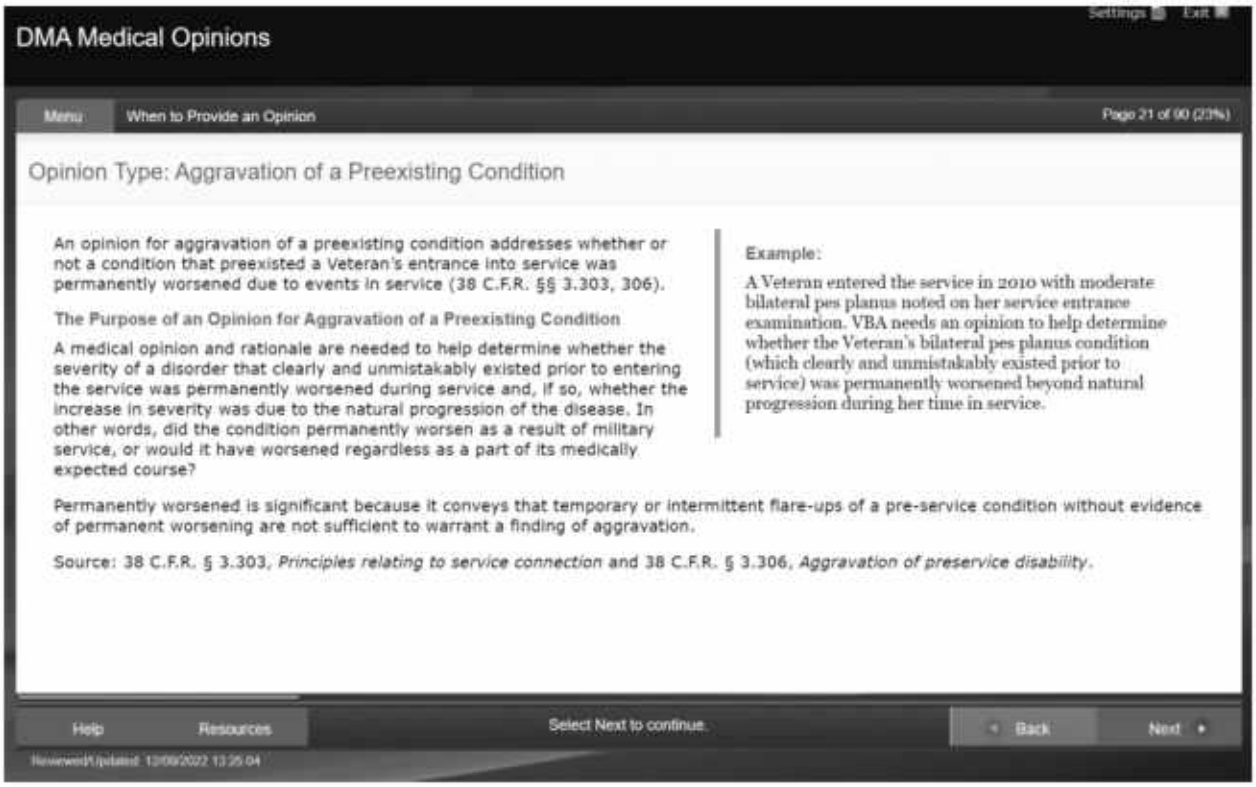


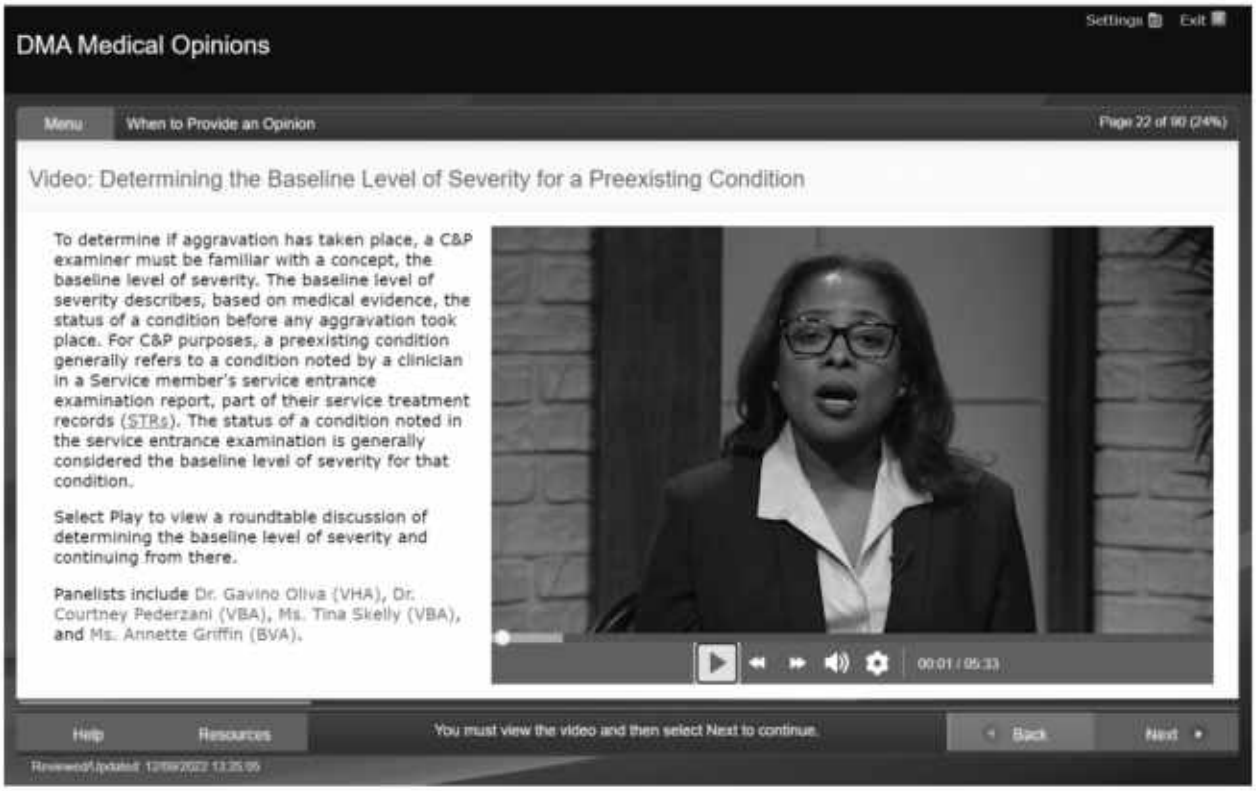
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Opinion Type: Direct Service Connection
A direct service connection opinion is often called a nexus opinion because it has to do with determining the relationship between a condition and the Veteran's or Service member's time in service. The Code of Federal Regulations explains direct service connection in 38 C.F.R. § 3.303 and § 3.304.
The Purpose of a Direct Service Connection Opinion
A medical opinion and rationale are needed to help an adjudicator determine whether a claimed disability had its onset in service or is otherwise linked to a service-related event, injury, disease, or illness.
Example:
A Veteran sustained an injury to his left knee on 9/6/2019 during active duty. He filed a claim with VA this year for left knee pain. VBA needs an opinion to help determine if the current left knee pain is at least as likely as not caused by or due to the injury in service.
Note: 38 C.F.R. § 3.303 also establishes the requirement that a claimed condition must be chronic to be considered for service connection.
Sources: 38 C.F.R. § 3.303, Principles relating to service connection and 38 C.F.R. § 3.304, Direct service connection, wartime and peacetime
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Determinations for a Direct Service Connection Opinion
VBA may need a clinician to use their medical expertise to gather, review, and interpret evidence for a Veteran's direct service connection claim. When this is the case, they may request a C&P examination and/or medical opinion.
To develop a direct service connection opinion, an examiner reviews the evidence they gather to determine whether:
• There is a current condition or persistent signs or symptoms of a current condition
• There was a related injury, event, disease, or signs or symptoms of the condition during the claimant's military service
• The claimed condition or its symptoms have persisted since service
• An intercurrent injury, event, or disease might better explain the condition
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Opinion Type: Aggravation of a Preexisting Condition
An opinion for aggravation of a preexisting condition addresses whether or not a condition that preexisted a Veteran's entrance into service was permanently worsened due to events in service (38 C.F.R. §§ 3.303, 306).
The Purpose of an Opinion for Aggravation of a Preexisting Condition
A medical opinion and rationale are needed to help determine whether the severity of a disorder that clearly and unmistakably existed prior to entering the service was permanently worsened during service and, if so, whether the increase in severity was due to the natural progression of the disease. In other words, did the condition permanently worsen as a result of military service, or would it have worsened regardless as a part of its medically expected course?
Example:
A Veteran entered the service in 2010 with moderate bilateral pes planus noted on her service entrance examination. VBA needs an opinion to help determine whether the Veteran's bilateral pes planus condition (which clearly and unmistakably existed prior to service) was permanently worsened beyond natural progression during her time in service.
Permanently worsened is significant because it conveys that temporary or intermittent flare-ups of a pre-service condition without evidence of permanent worsening are not sufficient to warrant a finding of aggravation.
Source: 38 C.F.R. § 3.303, Principles relating to service connection and 38 C.F.R. § 3.306, Aggravation of preservice disability.
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Video: Determining the Baseline Level of Severity for a Preexisting Condition
To determine if aggravation has taken place, a C&P examiner must be familiar with a concept, the baseline level of severity. The baseline level of severity describes, based on medical evidence, the status of a condition before any aggravation took place. For C&P purposes, a preexisting condition generally refers to a condition noted by a clinician in a Service member's service entrance examination report, part of their service treatment records (STRs). The status of a condition noted in the service entrance examination is generally considered the baseline level of severity for that condition.
Select Play to view a roundtable discussion of determining the baseline level of severity and continuing from there.
Panelists include Dr. Gavino Oliva (VHA), Dr. Courtney Pederzani (VBA), Ms. Tina Skelly (VBA), and Ms. Annette Griffin (BVA).
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The topic for this video is determining the baseline level of severity for a condition. This is a concept that examiners use when they develop medical opinions for aggravation. With me are Dr. Oliva, Ms. Skelly and Dr. Pederzani, who will explain this concept and how it fits into developing an opinion about whether a claimed condition was aggravated. As I understand it, determining the extent, if any, that a preexisting condition was aggravated during service starts with determining a baseline status of severity for the condition before it worsened. Dr. Oliva, where would you look first? I would look at available medical records during or prior to a Veteran's service entrance examination to see what a clinician noted at the time of pertaining to the claimed medical condition, including a review of anybody's statements from a Veteran's family or friends that have creditable knowledge of his or her medical condition prior to service. That makes sense, but what if there isn't a write up in the service entrance examination? Ms. Skelly, is this something that VBA would work on before requesting a medical opinion? Yes, it is. For purposes of aggravation, if a claimed condition was not noted on the examination request so that the presumption of soundness applies, VBA can use other evidence provided it shows the claim disorder existed clearly and unmistakably prior to enlistment to establish that the claim condition existed before enlistment. We carefully evaluate medical records from before, during or after service, as well as lay evidence such as history provided by the claimant. The exam request should identify whether the condition was shown on entrance examination or not. If it wasn't noted on the service entrance exam, the exam request will identify related evidence for the examiner to review. Thank you panelists. Once an examiner determines the baseline level of severity, what are the next steps? Once they have a baseline, examiners will also need to look for information about level of functioning, level of impairment, treatments and treatment outcomes, chronicity of symptoms over time, and other similar information that is clinically relevant. And this might depend on what the condition is that's being assessed. An examiner needs to find data points that tell them about any progression of the condition. You might think of it as sort of mining for data. The information can come from several sources, and essentially, the examiner is trying to use this information to map out when and how did this condition start? What is the status now, and what happened in between? I agree with Dr. Pederzani. The examiner reviews records in the eFolder looking for data points about when a condition began, like general practitioner notes about the status of a condition from an office visit before service, intake notes for VA care, et cetera. The process sounds like putting together pieces of a puzzle. Ms. Skelly, many conditions can worsen, that is get worse due to their natural progression over time. Do examiners need to account for that? Yes, they do. VBA actually needs to know if a condition was aggravated beyond its natural progression as stipulated in federal regulations. It's also important to emphasize that examiners need to synthesize the information that they gathered and explain their positive or negative opinion as to whether the aggravation took place. A list of evidence without clinical analysis doesn't meet the need for a clinical rationale. Anyone could make a list, but a clinician is needed because they have the expertise to make sense of the data and to use it in crafting an informed decision. A clinical synthesis or analysis needs to be provided to explain this process. What was the clinical relevance of the available data, and how did it get the examiner from VBA's question to the clinician's answer? Sometimes VBA will ask if the examiner can determine the extent that a condition worsened due to natural progression versus aggravation, that is beyond natural progression. An examiner may not know the natural progression of a claimed condition, and thus may not have the answer without resorting to mere speculation. This may be the case when there are no valid studies of historical importance for a given condition from which natural progression can be derived. As an examiner, you have diligently looked at everything, but found nothing that weighs more favorably in one direction or the other When that happens, VBA needs the examiner to explain how the lack of knowledge in the medical community at large is the problem. In the past, we were getting canned language and exam reports that contained the whole phrase, cannot resort to mere speculation or it's mere speculation for us to comment. An examiner can still have this kind of conclusion, but it really needs to be backed up and not used with canned text as a substitute. Thank you panelists, for explaining some key points for new examiners. In summary, the examiner finds and uses data points for claimed aggravation to determine the baseline level of severity and any worsening of a condition beyond its natural course.

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Scope of Evidence for Aggravation of a Preexisting Condition

Once the existence of a preexisting condition has been established, the C&P disability examiner's search for evidence is not restricted to a Veteran's or Service member's time in service. You should also consider evidence of record after service as well as during service to determine if a condition was aggravated.

This requirement comes from the *Maxon v. Gober* (2000) court opinion. The Court found that evidence of a prolonged period without medical complaint following service can be considered as evidence of whether a pre-existing condition was aggravated by military service, along with other factors concerning a Veteran's health and medical treatment during and after military service.

This legal opinion referred to 38 C.F.R. § 3.306(b), which states, "Aggravation may not be conceded where the disability underwent no increase in severity on the basis of all the evidence of record pertaining to the manifestations of the disability prior to, during and subsequent to service."

Sources:
Maxon v. Gober, 230 F.3d 1330 (Fed. Cir. 2000)
38 C.F.R. § 3.306, *Aggravation of preservice disability, (b) Wartime service; peacetime service after December 31, 1946.*

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Video: Baseline Level of Severity and Presumption of Soundness

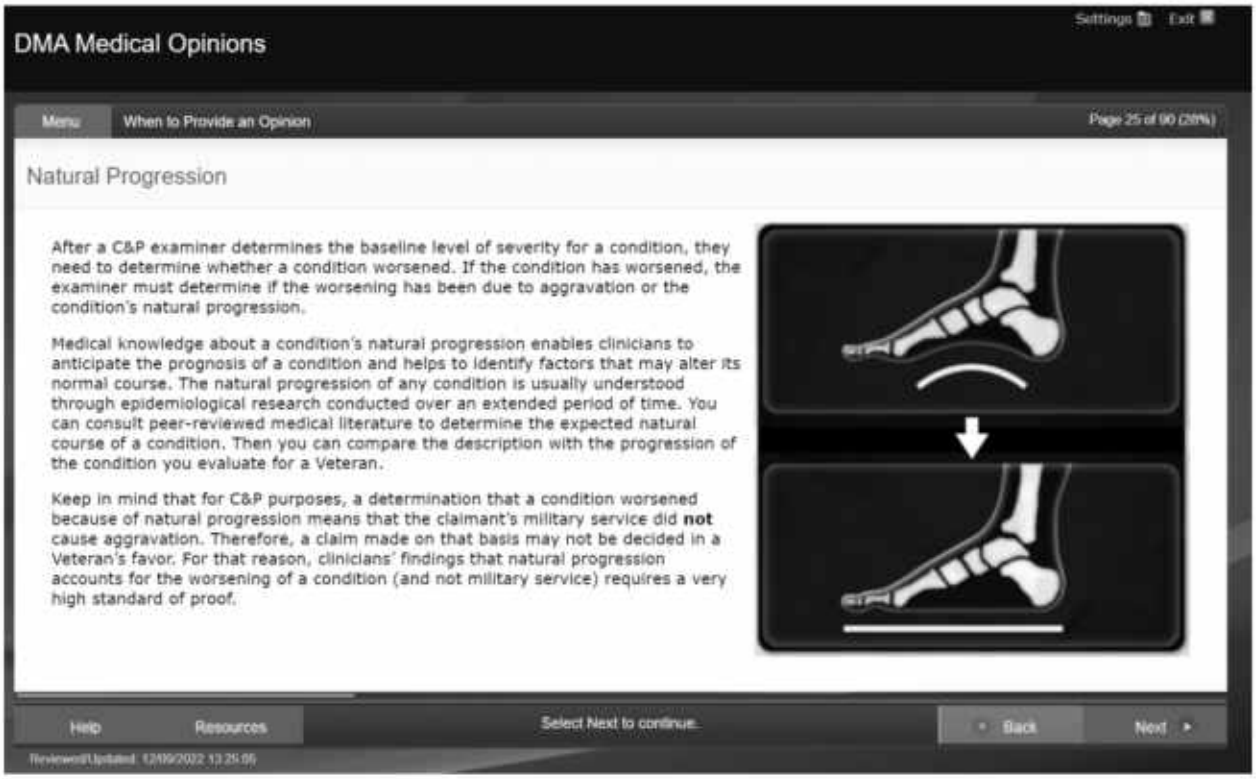
For a preexisting condition, the presumption of soundness can be tied to establishing a baseline level of severity for purposes of developing an opinion. Select Play to learn more.

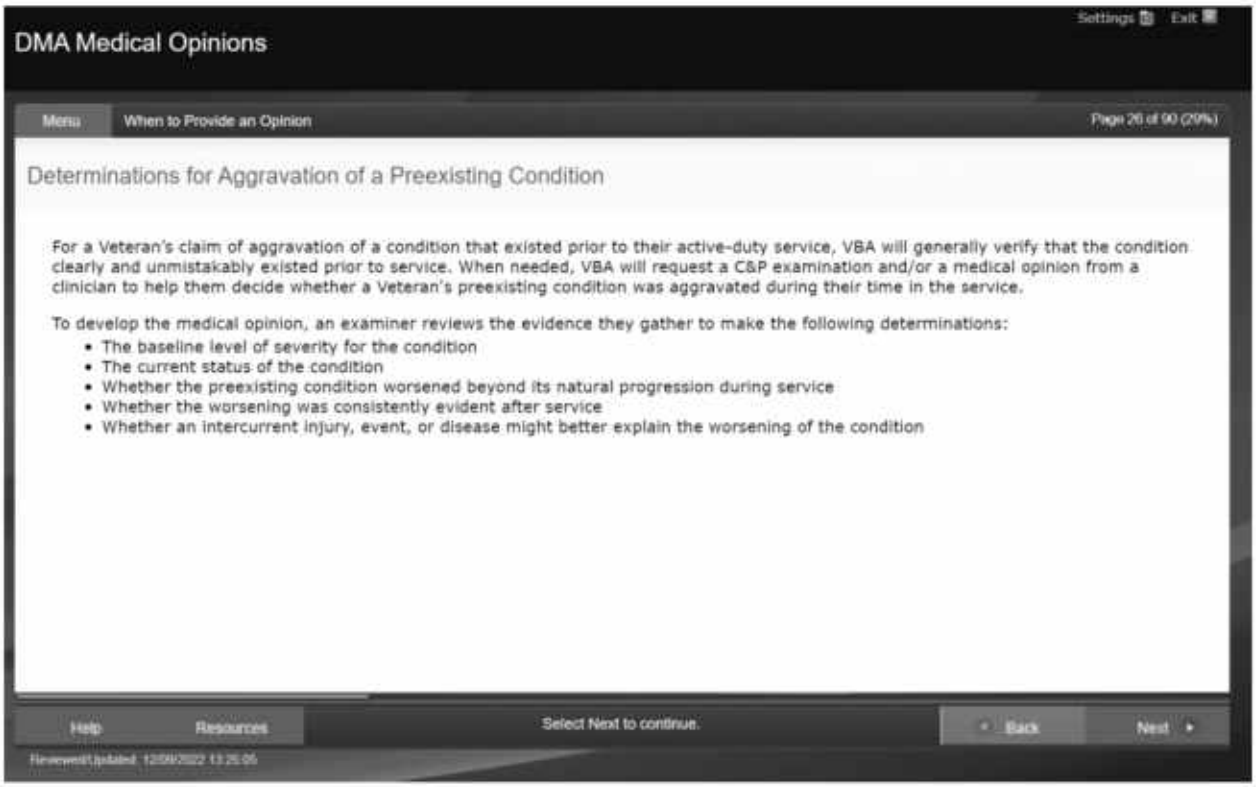


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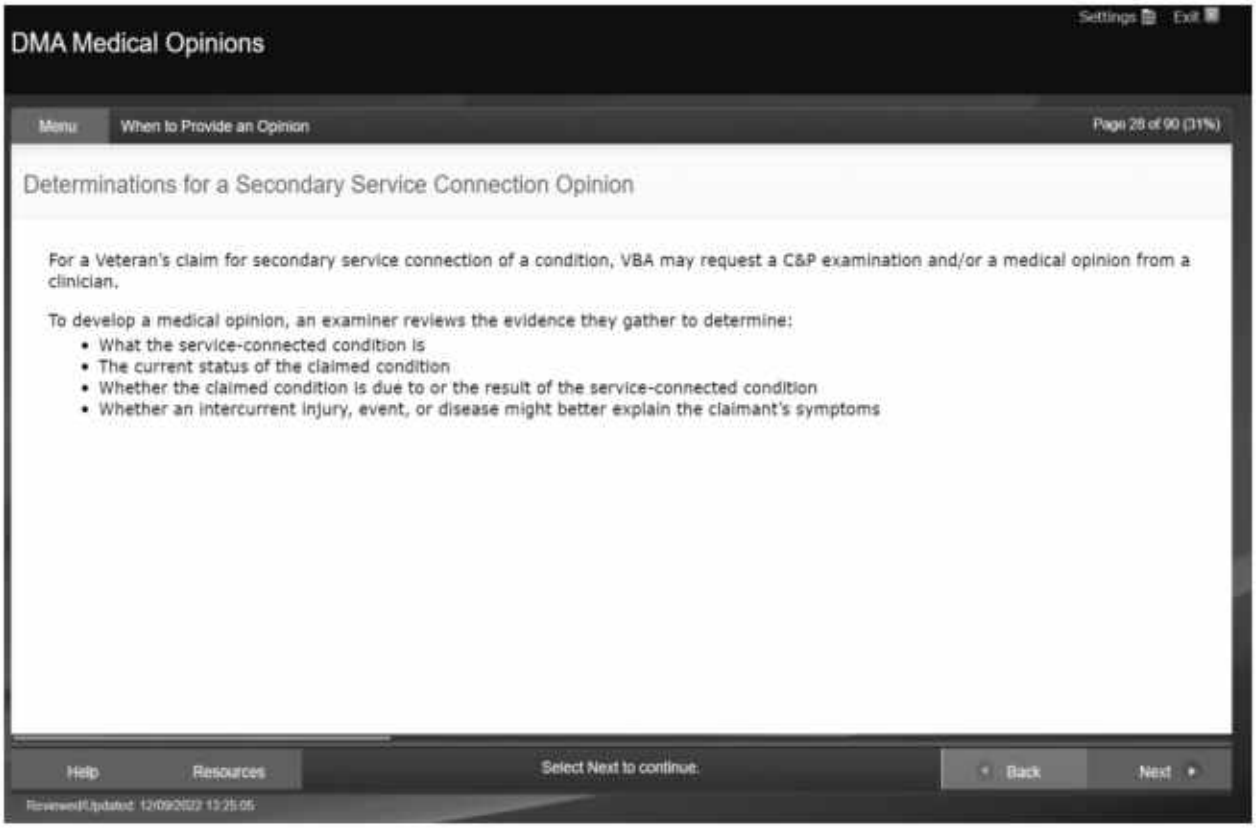
Presumption of soundness is a concept explained earlier in this course. You may recall that presumption of soundness means that VA will consider a Veteran to have been in sound condition, that is good health, when they were examined and accepted for service, unless there were any conditions noted in the service entrance examination report. To find otherwise, VA must have clear and unmistakable evidence demonstrating that a condition preexisted service and was not aggravated during service. Veterans who file a claim for a condition are thus shielded by the presumption of soundness from having to prove that the condition was not present before they entered service. Sometimes the presumption of soundness can help with establishing the baseline severity of a condition for aggravation opinions. I am joined by Dr. Oliva and Dr. Pederzani to talk about how this might work. Dr. Pederzani, can you provide an example for mental health examiners watching this video? Of course. A common scenario mental health examiners may encounter is when a Veteran makes mention of mental health symptoms prior to military service. And what I mean by this is that there are no confirmed pre-military diagnoses, but a Veteran might say during the exam or to a provider who documented it in a note in the records ,"Oh, well, I had some anxiety when I was a teenager in high school and I saw the guidance counselor a few times. "So this should raise a question for the examiner. Did this Veteran have a preexisting mental health condition? This history is now a data point that the examiner needs to account for. So then the examiner should go look for additional data in the records to answer this question. One of the first places to look is the entrance paperwork. At the time the Veteran was accepted into service, were there any mental health symptoms present or was a history of mental health conditions disclosed? And I've seen both scenarios. In cases where a person who is trying to enlist discloses a mental health history, there's likely to also be documentation of a waiver, essentially a confirmation from a pre-military treatment provider that the condition is fully resolved, or the individual is asymptomatic. And this gives the examiner the baseline that they need. There's a confirmed history from a clinical provider and documentation that symptoms were fully resolved, meaning there was no clinically significant distress or impairment at the time of entry into service. So the baseline is essentially zero impairment at the time of enlistment. In other cases where no mental health history was disclosed or later there is this mention of seeing a guidance counselor or something similar, mental health examiners need to exercise caution in how heavy that data point is. You don't have a confirmed diagnosis. You don't have documentation of clinically significant symptoms that may or may not have been experienced. What you do have is the enlistment paperwork where the military confirmed that the person was sound at the time of entry into service. And that's where the presumption of soundness comes into play. If the Veteran was accepted into service, unless there has been a later determination by the military that they fraudulently enlisted or there is clear and unmistakable evidence to the contrary, the examiner would be justified in presuming that any preexisting mental health symptoms had resolved to the satisfaction of the military. Otherwise the individual would not have been accepted into service. So you can see from these two example show the concepts of baseline and presumption of soundness function similarly, depending on the details of a given case. And I would make note that these are just scenarios that are examples to demonstrate thinking through these concepts and what they might look like in practice. When questions of aggravation are at play, cases can be either simpler or more complex than this. Thank you, Dr. Pederzani. That was a good example of how a clinician uses their training and experience to analyze the information they receive and make a determination. Dr. Oliva, would you provide a similar example for a physical condition? Yes. You might consider a case where a Veteran clearly and unmistakably had a high school football injury. For example, a left knee injury. Prior to entering the military, the injury was treated and physical therapy was provided. The Veteran was then found to have full range of motion and recovered post injury. Later during the induction exam for the entry into service, both knees were identified to have a full range of motion with no symptoms. Thus, both knees were found to be normal during this induction or enlistment examination. Then during their basic training, the Service member reported pain in the same leg that he had that high school knee injury. He sought active treatment during his service period and was diagnosed with left knee strain. The C&P examiner must take into account presumption of soundness when VBA asked whether the knee condition was aggravated during service. The mere fact that the Veteran's knees were found to be normal during the enlistment examination does not necessarily preclude a medical examiner from finding that the knee condition preexisted service and increased in severity during service. This helps the C&P examiner's

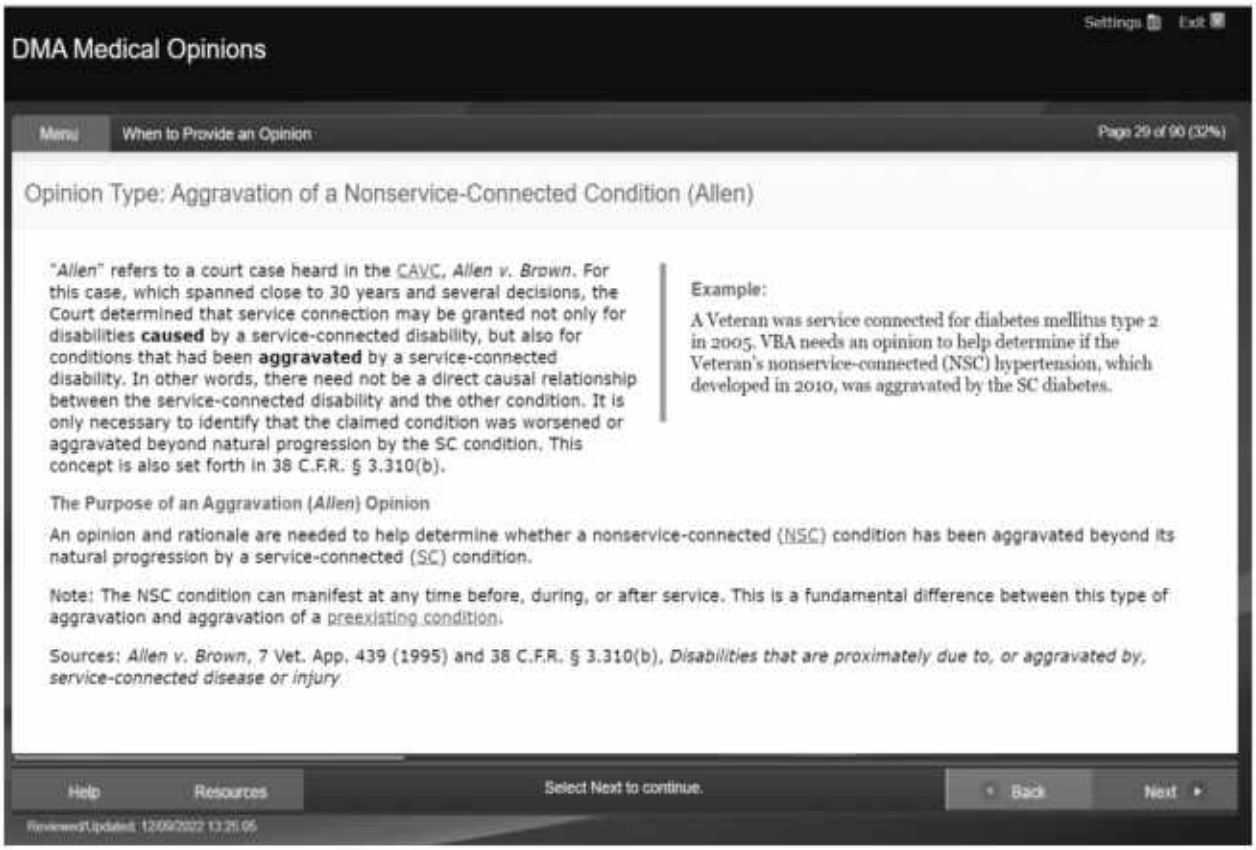
mindset with aggravation cases. Thank you, Dr. Oliva and Dr. Pederzani for those insights into how presumption of soundness can impact determining the baseline level of severity for an aggravation opinion, and sometimes determining whether a condition preexisted service.

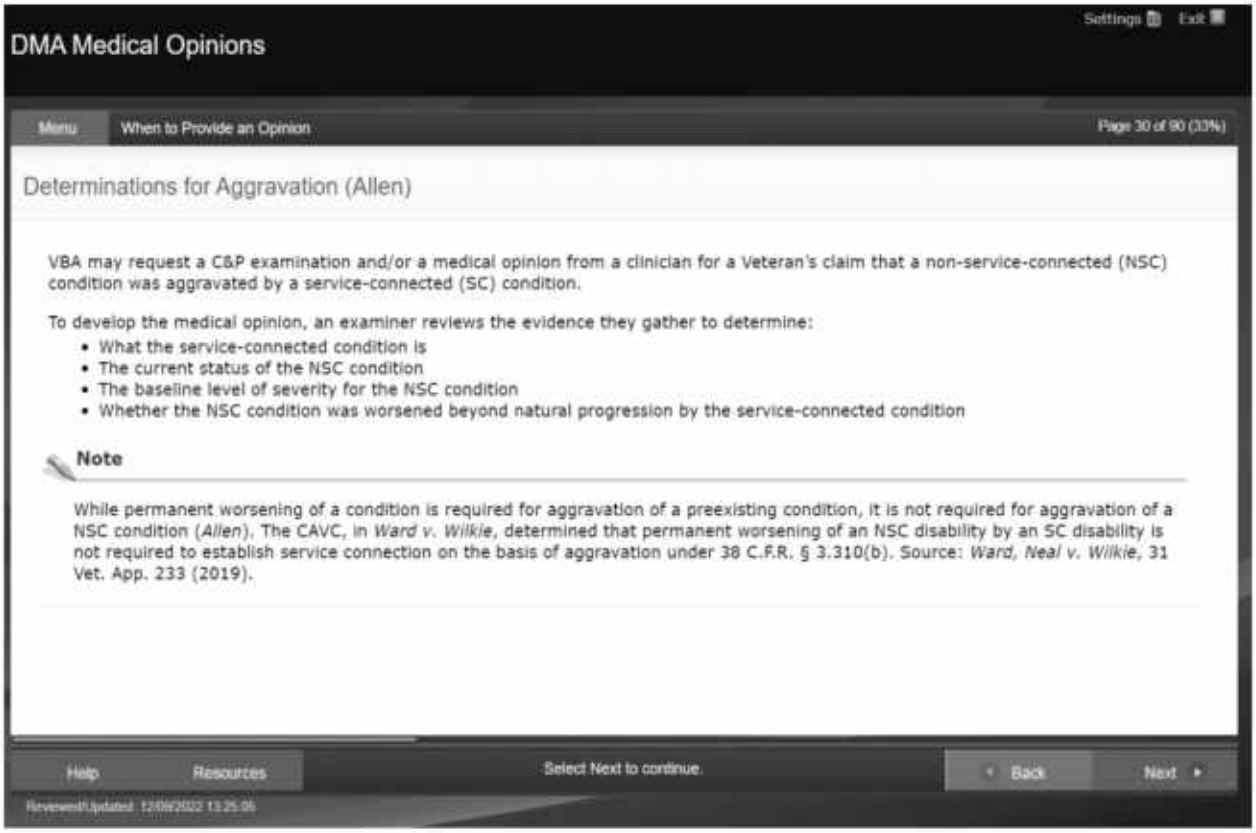


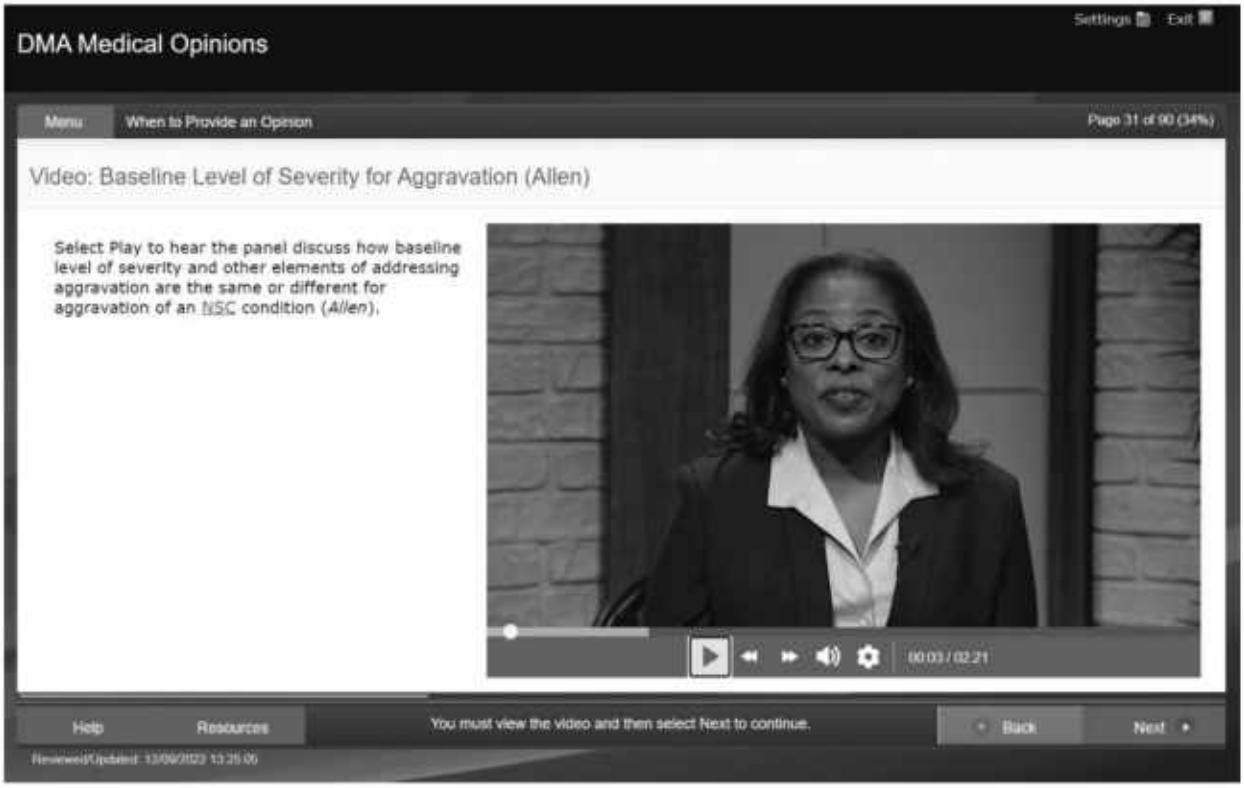



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Opinion Type: Secondary Service Connection
A secondary service connection opinion concerns a disability that is proximately due to or the result of a previously service-connected (SC) condition (38 C.F.R. § 3.310(a)).
The Purpose of a Secondary Service Connection Opinion
An opinion and rationale are needed to help determine whether a condition is due to, caused by, or a result of an SC condition.
Source:
Regulation 38 C.F.R. § 3.310, Disabilities that are proximately due to, or aggravated by, service-connected disease or injury
Example:
A Veteran is claiming service connection for headaches secondary to service-connected cervical neck strain. VBA needs an opinion to help determine whether it is at least as likely as not that the current headaches are proximately due to, or caused by, the service-connected cervical strain.
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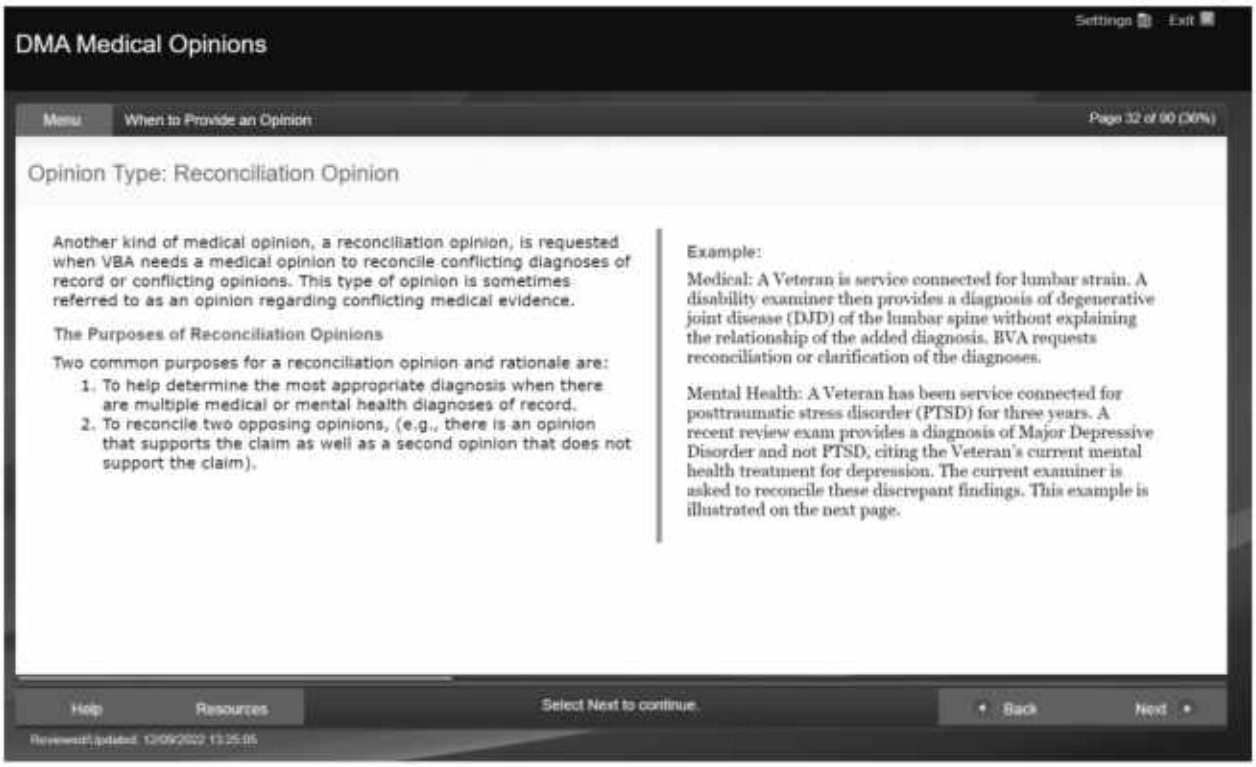

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Determinations for a Secondary Service Connection Opinion
For a Veteran's claim for secondary service connection of a condition, VBA may request a C&P examination and/or a medical opinion from a clinician.
To develop a medical opinion, an examiner reviews the evidence they gather to determine:
• What the service-connected condition is
• The current status of the claimed condition
• Whether the claimed condition is due to or the result of the service-connected condition
• Whether an intercurrent injury, event, or disease might better explain the claimant's symptoms
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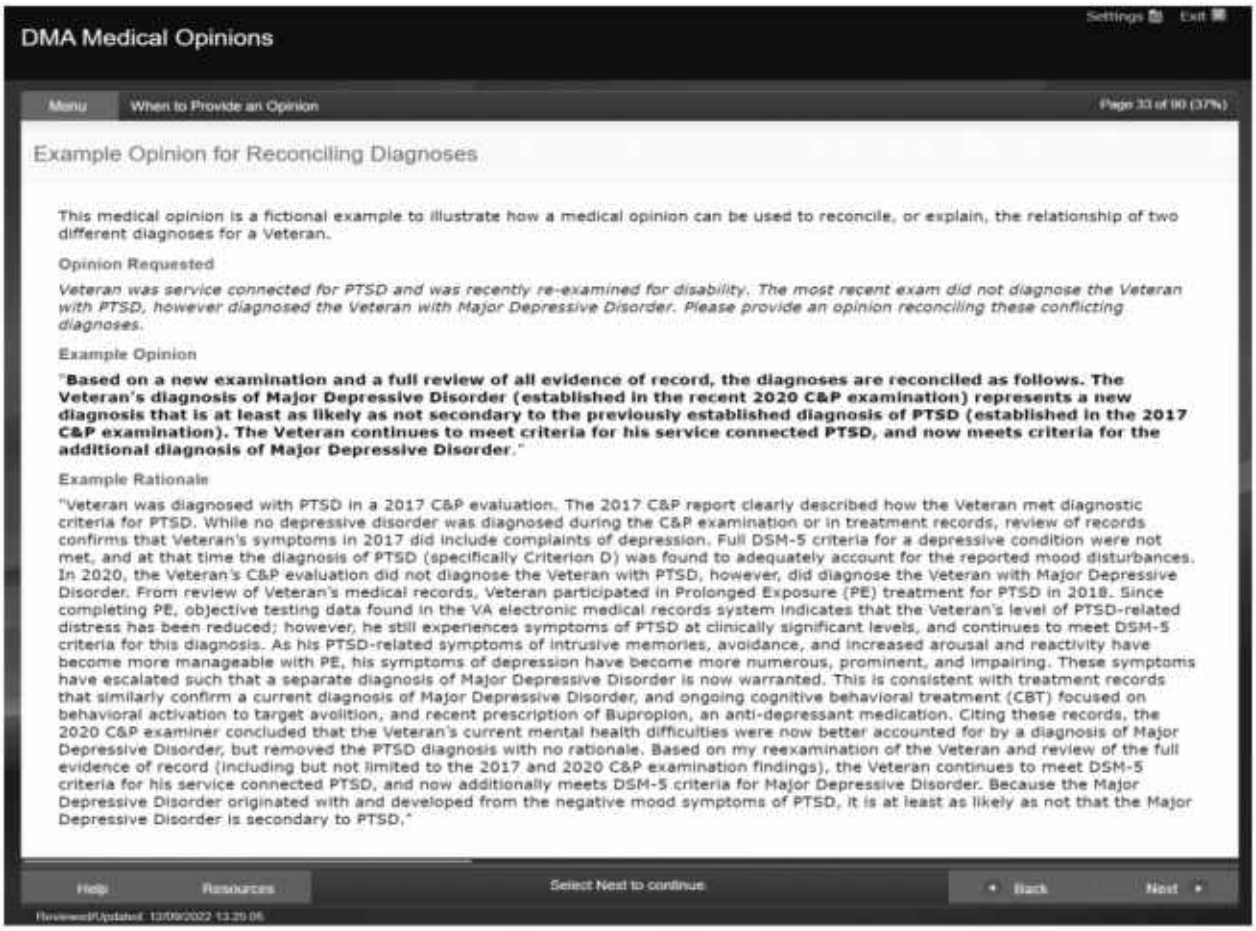

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Opinion Type: Aggravation of a Nonservice-Connected Condition (Allen)
"Allen" refers to a court case heard in the CAVC, Allen v. Brown. For this case, which spanned close to 30 years and several decisions, the Court determined that service connection may be granted not only for disabilities caused by a service-connected disability, but also for conditions that had been aggravated by a service-connected disability. In other words, there need not be a direct causal relationship between the service-connected disability and the other condition. It is only necessary to identify that the claimed condition was worsened or aggravated beyond natural progression by the SC condition. This concept is also set forth in 38 C.F.R. § 3.310(b).
Example:
A Veteran was service connected for diabetes mellitus type 2 in 2005. VBA needs an opinion to help determine if the Veteran's nonservice-connected (NSC) hypertension, which developed in 2010, was aggravated by the SC diabetes.
The Purpose of an Aggravation (Allen) Opinion
An opinion and rationale are needed to help determine whether a nonservice-connected (NSC) condition has been aggravated beyond its natural progression by a service-connected (SC) condition.
Note: The NSC condition can manifest at any time before, during, or after service. This is a fundamental difference between this type of aggravation and aggravation of a preexisting condition.
Sources: Allen v. Brown, 7 Vet. App. 439 (1995) and 38 C.F.R. § 3.310(b), Disabilities that are proximately due to, or aggravated by, service-connected disease or injury
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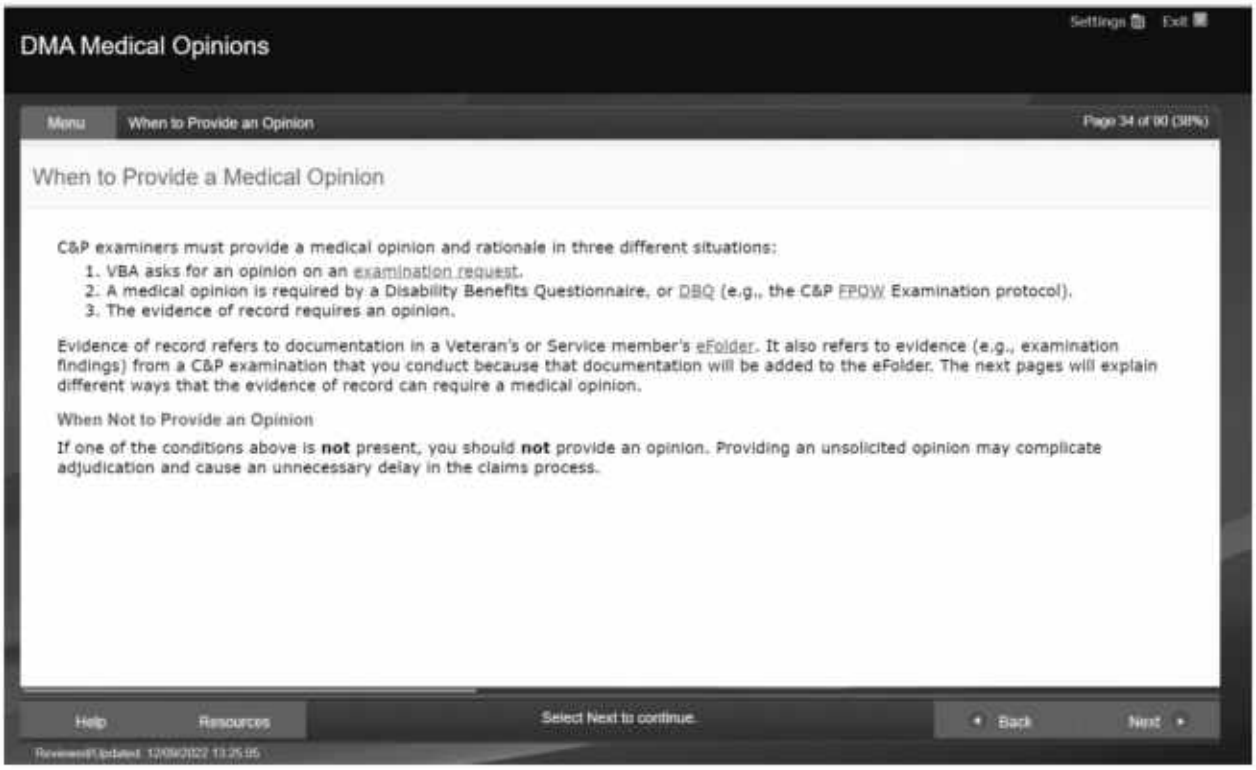

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Determinations for Aggravation (Allen)
VBA may request a C&P examination and/or a medical opinion from a clinician for a Veteran's claim that a non-service-connected (NSC) condition was aggravated by a service-connected (SC) condition.
To develop the medical opinion, an examiner reviews the evidence they gather to determine:
• What the service-connected condition is
• The current status of the NSC condition
• The baseline level of severity for the NSC condition
• Whether the NSC condition was worsened beyond natural progression by the service-connected condition
Note
While permanent worsening of a condition is required for aggravation of a preexisting condition, it is not required for aggravation of a NSC condition (Allen). The CAVC, in Ward v. Wilkie, determined that permanent worsening of an NSC disability by an SC disability is not required to establish service connection on the basis of aggravation under 38 C.F.R. § 3.310(b). Source: Ward, Neal v. Wilkie, 31 Vet. App. 233 (2019).
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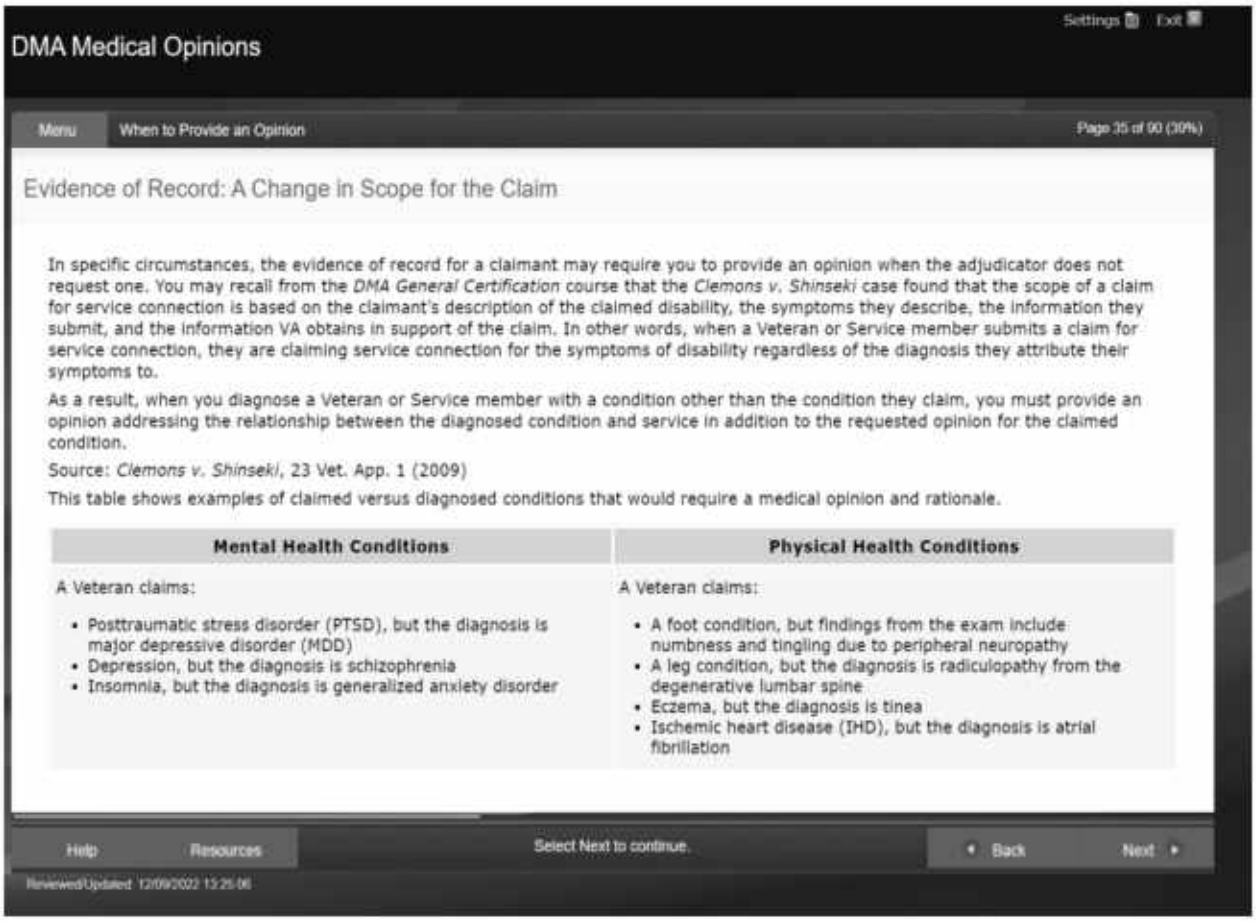


We've talked about the baseline level of severity for aggravation of a preexisting condition. Is there any difference in what an examiner does to determine the baseline level of severity for the other kind of aggravation, aggravation of a nonservice-connected condition? Ms. Skelly, Dr. Oliva and Dr. Pederzani are here with me to talk about this. One of the main differences between aggravation of a preexisting condition and aggravation of a nonservice-connected condition, also called Allen aggravation ,is that a nonservice-connected or NSC condition can occur at any time, not just before service. Ms. Skelly, would you agree? That's right. A nonservice-connected condition can occur at any time before, during, or after service. For Allen aggravation, an adjudicator still needs to know the level of severity of the NSC condition before it was aggravated by the service-connected condition or as soon as possible after it was aggravated. It is the claimant's responsibility to submit evidence to establish the baseline level of severity for Allen aggravation. Thus, the adjudicator has the evidence submitted by the claimant before they ask for a medical opinion. The examiner's role is to provide to the extent possible a description of the baseline level of severity as shown in the medical evidence. Dr. Oliva, can you tell us what this means for the examiner? Yes. The examiner reviews available medical records as far back as they can go, looking for documentation that may indicate any relationship between when the symptoms or diagnoses of the NSC condition were first recorded versus the service-connected condition. In terms of data collection, the process will essentially be the same for any question involving aggravation, including Allen aggravation. Examiners will want to find out all of the data points that are relevant to determining the onset and baseline for the condition, and then identifying the course, severity, and contributing factors over time. Thank you, panelists, for explaining for new examiner show the baseline level of severity is determined and used for an opinion regarding Allen aggravation.

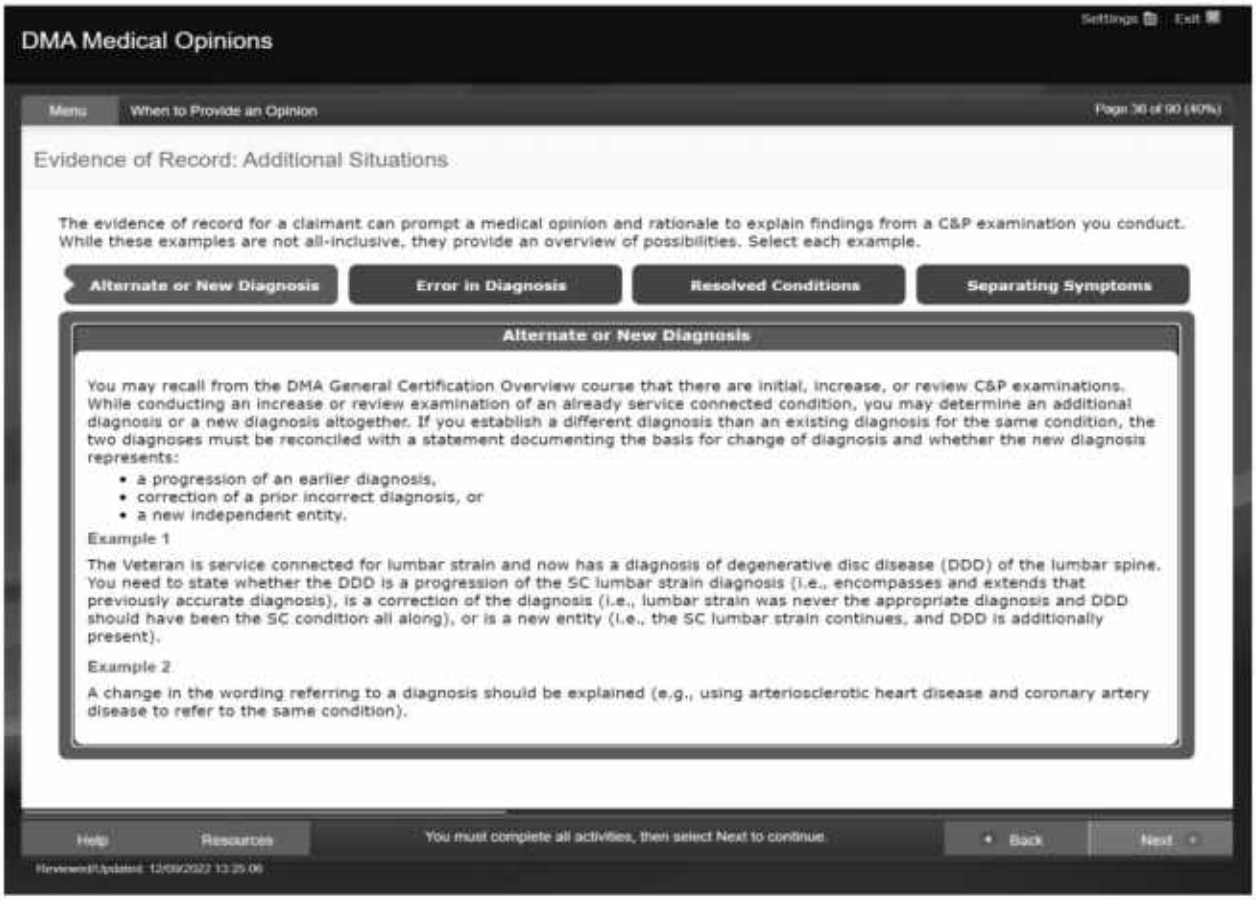

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Opinion Type: Reconciliation Opinion
Another kind of medical opinion, a reconciliation opinion, is requested when VBA needs a medical opinion to reconcile conflicting diagnoses of record or conflicting opinions. This type of opinion is sometimes referred to as an opinion regarding conflicting medical evidence.
The Purposes of Reconciliation Opinions
Two common purposes for a reconciliation opinion and rationale are:
1. To help determine the most appropriate diagnosis when there are multiple medical or mental health diagnoses of record.
2. To reconcile two opposing opinions, (e.g., there is an opinion that supports the claim as well as a second opinion that does not support the claim).
Example:
Medical: A Veteran is service connected for lumbar strain. A disability examiner then provides a diagnosis of degenerative joint disease (DJD) of the lumbar spine without explaining the relationship of the added diagnosis. BVA requests reconciliation or clarification of the diagnoses.
Mental Health: A Veteran has been service connected for posttraumatic stress disorder (PTSD) for three years. A recent review exam provides a diagnosis of Major Depressive Disorder and not PTSD, citing the Veteran's current mental health treatment for depression. The current examiner is asked to reconcile these discrepant findings. This example is illustrated on the next page.
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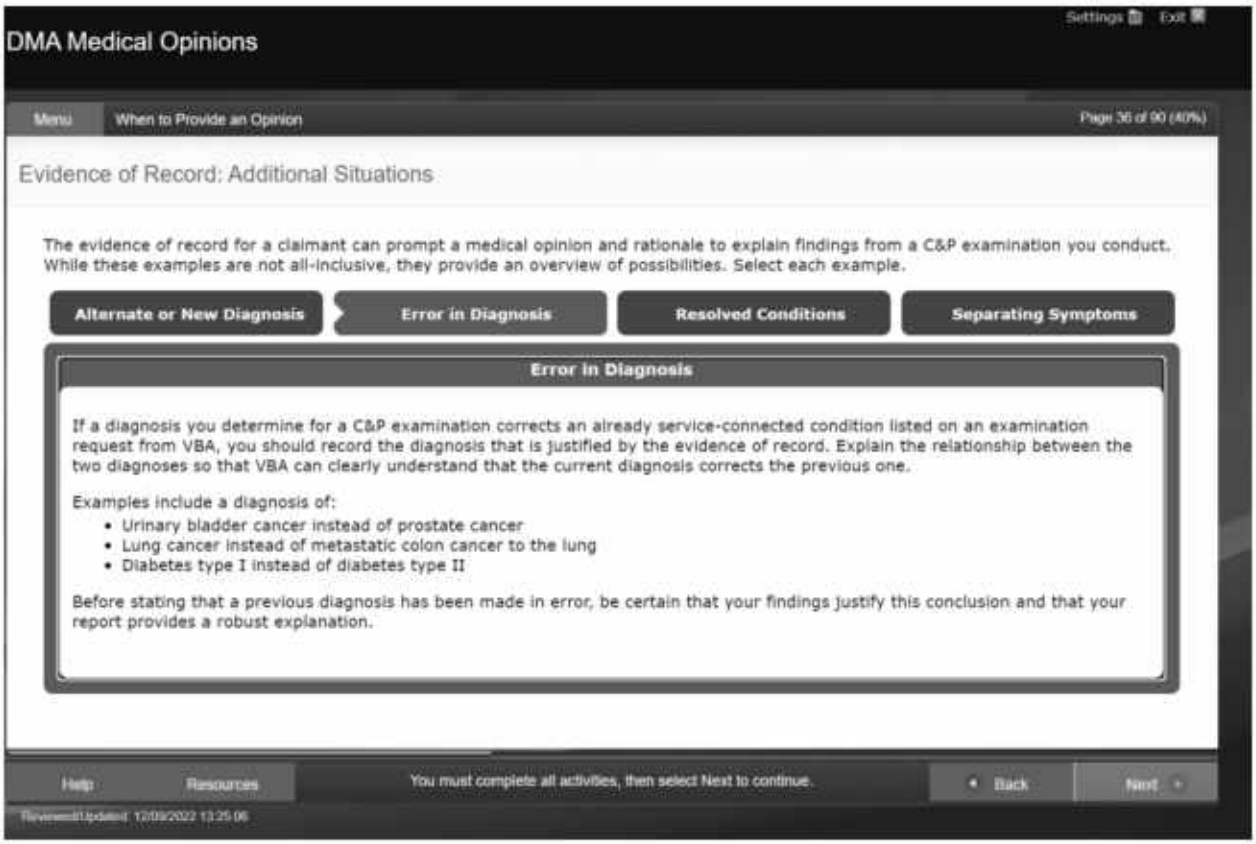

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Example Opinion for Reconciling Diagnoses
This medical opinion is a fictional example to illustrate how a medical opinion can be used to reconcile, or explain, the relationship of two different diagnoses for a Veteran.
Opinion Requested
Veteran was service connected for PTSD and was recently re-examined for disability. The most recent exam did not diagnose the Veteran with PTSD, however diagnosed the Veteran with Major Depressive Disorder. Please provide an opinion reconciling these conflicting diagnoses.
Example Opinion
"Based on a new examination and a full review of all evidence of record, the diagnoses are reconciled as follows. The Veteran's diagnosis of Major Depressive Disorder (established in the recent 2020 C&P examination) represents a new diagnosis that is at least as likely as not secondary to the previously established diagnosis of PTSD (established in the 2017 C&P examination). The Veteran continues to meet criteria for his service connected PTSD, and now meets criteria for the additional diagnosis of Major Depressive Disorder."
Example Rationale
"Veteran was diagnosed with PTSD in a 2017 C&P evaluation. The 2017 C&P report clearly described how the Veteran met diagnostic criteria for PTSD. While no depressive disorder was diagnosed during the C&P examination or in treatment records, review of records confirms that Veteran's symptoms in 2017 did include complaints of depression. Full DSM-5 criteria for a depressive condition were not met, and at that time the diagnosis of PTSD (specifically Criterion D) was found to adequately account for the reported mood disturbances. In 2020, the Veteran's C&P evaluation did not diagnose the Veteran with PTSD, however, did diagnose the Veteran with Major Depressive Disorder. From review of Veteran's medical records, Veteran participated in Prolonged Exposure (PE) treatment for PTSD in 2018. Since completing PE, objective testing data found in the VA electronic medical records system indicates that the Veteran's level of PTSD-related distress has been reduced; however, he still experiences symptoms of PTSD at clinically significant levels, and continues to meet DSM-5 criteria for this diagnosis. As his PTSD-related symptoms of intrusive memories, avoidance, and increased arousal and reactivity have become more manageable with PE, his symptoms of depression have become more numerous, prominent, and impairing. These symptoms have escalated such that a separate diagnosis of Major Depressive Disorder is now warranted. This is consistent with treatment records that similarly confirm a current diagnosis of Major Depressive Disorder, and ongoing cognitive behavioral treatment (CBT) focused on behavioral activation to target avolition, and recent prescription of Bupropion, an anti-depressant medication. Citing these records, the 2020 C&P examiner concluded that the Veteran's current mental health difficulties were now better accounted for by a diagnosis of Major Depressive Disorder, but removed the PTSD diagnosis with no rationale. Based on my reexamination of the Veteran and review of the full evidence of record (including but not limited to the 2017 and 2020 C&P examination findings), the Veteran continues to meet DSM-5 criteria for his service connected PTSD, and now additionally meets DSM-5 criteria for Major Depressive Disorder. Because the Major Depressive Disorder originated with and developed from the negative mood symptoms of PTSD, it is at least as likely as not that the Major Depressive Disorder is secondary to PTSD."
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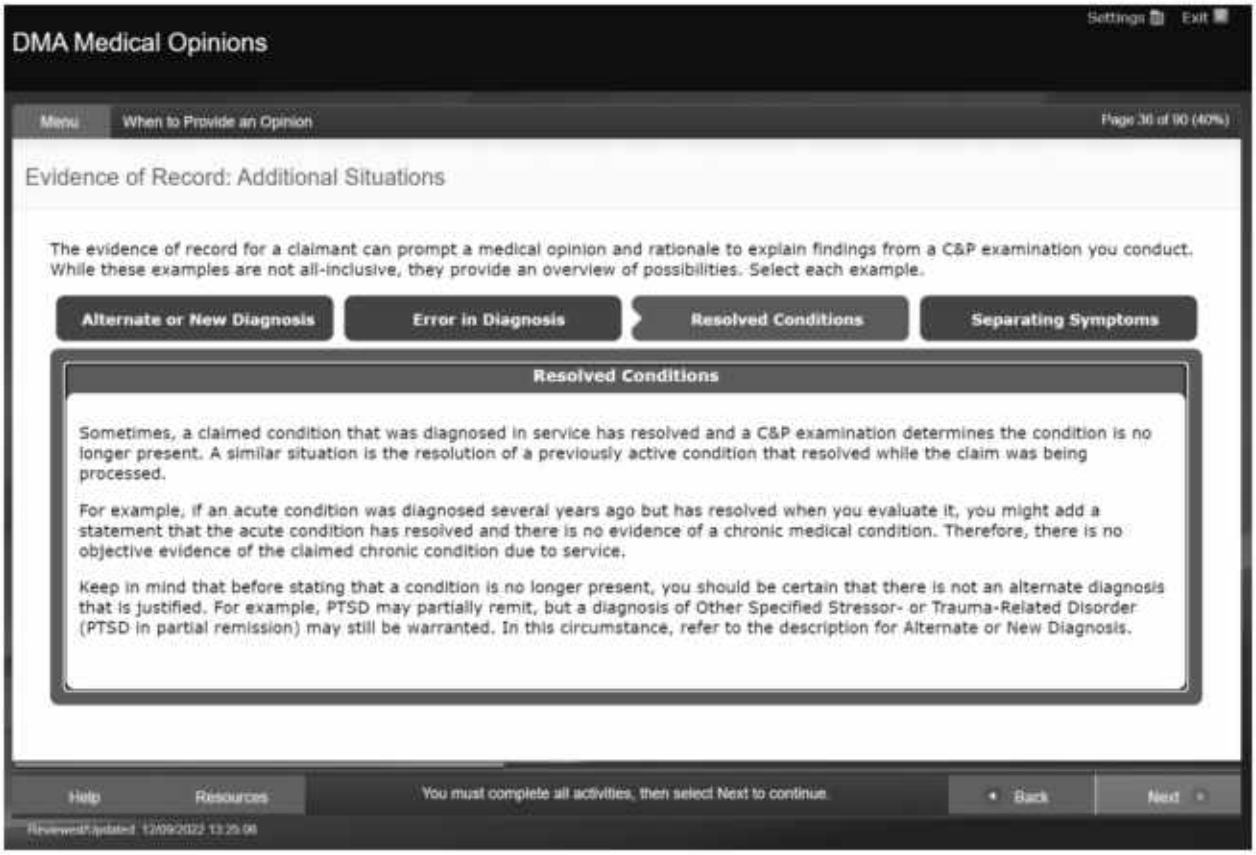

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When to Provide a Medical Opinion
C&P examiners must provide a medical opinion and rationale in three different situations:
1. VBA asks for an opinion on an examination request.
2. A medical opinion is required by a Disability Benefits Questionnaire, or DBQ (e.g., the C&P FPOW Examination protocol).
3. The evidence of record requires an opinion.
Evidence of record refers to documentation in a Veteran's or Service member's eFolder. It also refers to evidence (e.g., examination findings) from a C&P examination that you conduct because that documentation will be added to the eFolder. The next pages will explain different ways that the evidence of record can require a medical opinion.
When Not to Provide an Opinion
If one of the conditions above is not present, you should not provide an opinion. Providing an unsolicited opinion may complicate adjudication and cause an unnecessary delay in the claims process.
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Evidence of Record: A Change in Scope for the Claim
In specific circumstances, the evidence of record for a claimant may require you to provide an opinion when the adjudicator does not request one. You may recall from the DMA General Certification course that the Clemons v. Shinseki case found that the scope of a claim for service connection is based on the claimant's description of the claimed disability, the symptoms they describe, the information they submit, and the information VA obtains in support of the claim. In other words, when a Veteran or Service member submits a claim for service connection, they are claiming service connection for the symptoms of disability regardless of the diagnosis they attribute their symptoms to.
As a result, when you diagnose a Veteran or Service member with a condition other than the condition they claim, you must provide an opinion addressing the relationship between the diagnosed condition and service in addition to the requested opinion for the claimed condition.
Source: Clemons v. Shinseki, 23 Vet. App. 1 (2009)
This table shows examples of claimed versus diagnosed conditions that would require a medical opinion and rationale.
Mental Health Conditions
Physical Health Conditions
A Veteran claims:
Posttraumatic stress disorder (PTSD), but the diagnosis is major depressive disorder (MDD)
Depression, but the diagnosis is schizophrenia
Insomnia, but the diagnosis is generalized anxiety disorder
A Veteran claims:
A foot condition, but findings from the exam include numbness and tingling due to peripheral neuropathy
A leg condition, but the diagnosis is radiculopathy from the degenerative lumbar spine
Eczema, but the diagnosis is tinea
Ischemic heart disease (IHD), but the diagnosis is atrial fibrillation
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Evidence of Record: Additional Situations
The evidence of record for a claimant can prompt a medical opinion and rationale to explain findings from a C&P examination you conduct. While these examples are not all-inclusive, they provide an overview of possibilities. Select each example.
Alternate or New Diagnosis
Error in Diagnosis
Resolved Conditions
Separating Symptoms
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Evidence of Record: Additional Situations
The evidence of record for a claimant can prompt a medical opinion and rationale to explain findings from a C&P examination you conduct. While these examples are not all-inclusive, they provide an overview of possibilities. Select each example.
Alternate or New Diagnosis
Error in Diagnosis
Resolved Conditions
Separating Symptoms
Alternate or New Diagnosis
You may recall from the DMA General Certification Overview course that there are initial, increase, or review C&P examinations. While conducting an increase or review examination of an already service connected condition, you may determine an additional diagnosis or a new diagnosis altogether. If you establish a different diagnosis than an existing diagnosis for the same condition, the two diagnoses must be reconciled with a statement documenting the basis for change of diagnosis and whether the new diagnosis represents:
• a progression of an earlier diagnosis,
• correction of a prior incorrect diagnosis, or
• a new independent entity.
Example 1
The Veteran is service connected for lumbar strain and now has a diagnosis of degenerative disc disease (DDD) of the lumbar spine. You need to state whether the DDD is a progression of the SC lumbar strain diagnosis (i.e., encompasses and extends that previously accurate diagnosis), is a correction of the diagnosis (i.e., lumbar strain was never the appropriate diagnosis and DDD should have been the SC condition all along), or is a new entity (i.e., the SC lumbar strain continues, and DDD is additionally present).
Example 2
A change in the wording referring to a diagnosis should be explained (e.g., using arteriosclerotic heart disease and coronary artery disease to refer to the same condition).
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Evidence of Record: Additional Situations
The evidence of record for a claimant can prompt a medical opinion and rationale to explain findings from a C&P examination you conduct. While these examples are not all-inclusive, they provide an overview of possibilities. Select each example.
Alternate or New Diagnosis
Error in Diagnosis
Resolved Conditions
Separating Symptoms
Error in Diagnosis
If a diagnosis you determine for a C&P examination corrects an already service-connected condition listed on an examination request from VBA, you should record the diagnosis that is justified by the evidence of record. Explain the relationship between the two diagnoses so that VBA can clearly understand that the current diagnosis corrects the previous one.
Examples include a diagnosis of:
• Urinary bladder cancer instead of prostate cancer
• Lung cancer instead of metastatic colon cancer to the lung
• Diabetes type I instead of diabetes type II
Before stating that a previous diagnosis has been made in error, be certain that your findings justify this conclusion and that your report provides a robust explanation.
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Evidence of Record: Additional Situations
The evidence of record for a claimant can prompt a medical opinion and rationale to explain findings from a C&P examination you conduct. While these examples are not all-inclusive, they provide an overview of possibilities. Select each example.
Alternate or New Diagnosis
Error in Diagnosis
Resolved Conditions
Separating Symptoms
Resolved Conditions
Sometimes, a claimed condition that was diagnosed in service has resolved and a C&P examination determines the condition is no longer present. A similar situation is the resolution of a previously active condition that resolved while the claim was being processed.
For example, if an acute condition was diagnosed several years ago but has resolved when you evaluate it, you might add a statement that the acute condition has resolved and there is no evidence of a chronic medical condition. Therefore, there is no objective evidence of the claimed chronic condition due to service.
Keep in mind that before stating that a condition is no longer present, you should be certain that there is not an alternate diagnosis that is justified. For example, PTSD may partially remit, but a diagnosis of Other Specified Stressor- or Trauma-Related Disorder (PTSD in partial remission) may still be warranted. In this circumstance, refer to the description for Alternate or New Diagnosis.
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Evidence of Record: Additional Situations

The evidence of record for a claimant can prompt a medical opinion and rationale to explain findings from a C&P examination you conduct. While these examples are not all-inclusive, they provide an overview of possibilities. Select each example.

Alternate or New Diagnosis | Error in Diagnosis | Resolved Conditions | Separating Symptoms

Separating Symptoms

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

Note:

If you cannot separate symptoms without resorting to mere speculation, then you should so state and explain this finding. The term "resorting to mere speculation" will be explained in more detail later in this course.

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Opinions That Involve Specialist Clinicians

You may not be qualified to render certain opinions that require the expertise of a specialist. In general, all vision, hearing, dental, and mental health examinations (including C&P examinations for PTSD, mental disorders, and eating disorders) must be conducted by a specialist who can then provide a requested opinion and rationale.



Tip

If you are a VHA C&P examiner, you'll want to be aware of your facility's resources and procedures for obtaining a specialist opinion. Not all VA medical facilities have the resources to provide an opinion from the requisite specialist.

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Lesson 2 Summary

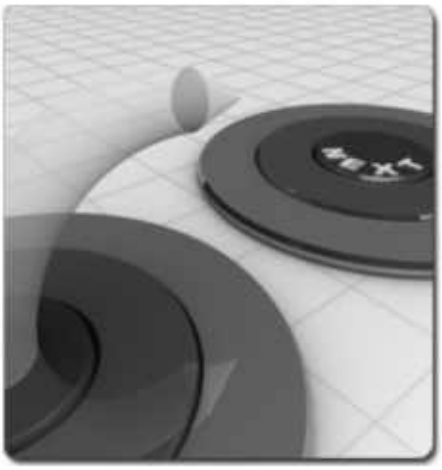
This lesson described common types of opinions requested by adjudicators to help them determine the relationship of a Veteran's or Service member's condition and their military service. It showed you that methods of service connection are based in federal regulations that also set forth requirements for establishing service connection.

This lesson also explained that you must provide a medical opinion when VBA asks for one on an examination request, when a DBQ requires one, or when the evidence of record requires one. You will benefit from being familiar with situations in which the evidence of record may require an opinion because you will encounter them as an examiner. You also learned about the problems caused by providing an unsolicited opinion.

Now that you have completed this When to Provide an Opinion lesson, you are able to:

- Classify common types of medical opinions by purpose.
- Recognize guidelines for determining aggravation of a condition for C&P purposes.
- Recognize circumstances that require a medical opinion

This knowledge will provide context when you review a request from VBA for an opinion and help you determine if the evidence of record requires one.



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Lesson 3 Introduction

This lesson will present content to help you understand the process for developing high-quality medical opinions. It will illustrate the process of developing a medical opinion in five steps. Adjudicators need medical opinions they can use in deciding claims, so this lesson will also describe the qualities of opinions that are useful for adjudication purposes. As well, there are common errors that you should avoid because they can result in opinions being found insufficient, thus delaying the claim process.



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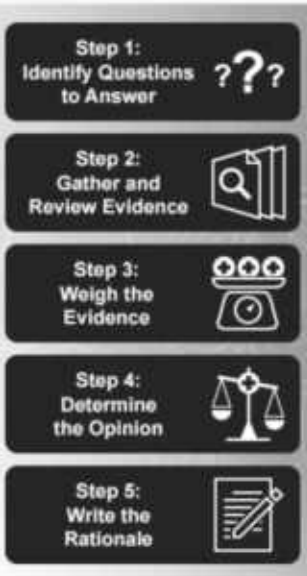
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The Five-Step Process for Writing a Medical Opinion

There are five steps to writing a medical opinion and rationale:

1. Identify questions to answer for VBA and/or BVA.
2. Gather and review evidence.
3. Weigh the evidence.
4. Determine the medical opinion.
5. Write the supporting rationale.

Each step will be explained in the pages that follow.



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Step 1: Identify Questions to Answer for VBA or BVA

As an examiner, you will start by reviewing the instructions and questions posed on the examination request. VBA may ask more than one question. They commonly request a medical opinion in the form of a question related to a pending claim for benefits.

For example, a Veteran sustained a neck injury while riding in a truck during service. An adjudicator is requesting an opinion to determine whether a current disability is related to the injury sustained in service. Here is a sample request for an opinion as it might be seen on an examination request:

The Veteran claims service connection for a cervical spine condition with pain and stiffness. Is the Veteran's current cervical spine condition at least as likely as not (likelihood is at least approximately balanced or nearly equal, if not higher) due to or caused by events during military service?

For this direct service connection example, VBA asks one question that an examiner will answer by providing an opinion. While reviewing the requested opinion, an examiner thinks of other questions to answer, and evidence needed to reach an opinion.

Examiner's Questions:

- Is there objective evidence of symptoms, treatment or diagnosis in service or shortly after service?
- Is there evidence of a chronic neck condition that has persisted since the injury?
- Does the Veteran presently have a diagnosed chronic cervical spine condition?
- Is there any intercurrent (between the service and present time) event, injury, or occurrence that better explains the claimed condition?
- Is it as least as likely as not that the Veteran's claimed condition proximately due to an event, illness, or injury during service?

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Video: Panelists Discuss Reviewing an Examination Request

Examiners start with reviewing the medical opinion requested by VBA to learn which type of opinion is needed. However, panelists in this video will share reasons to refer to the examination request throughout the process of gathering and weighing evidence for the medical opinion. Panelists include Dr. Gavino Oliva (VHA), Dr. Courtney Pederzani (VBA), Ms. Tina Skelly (VBA), and Ms. Annette Griffin (BVA).

Select Play to view this discussion.

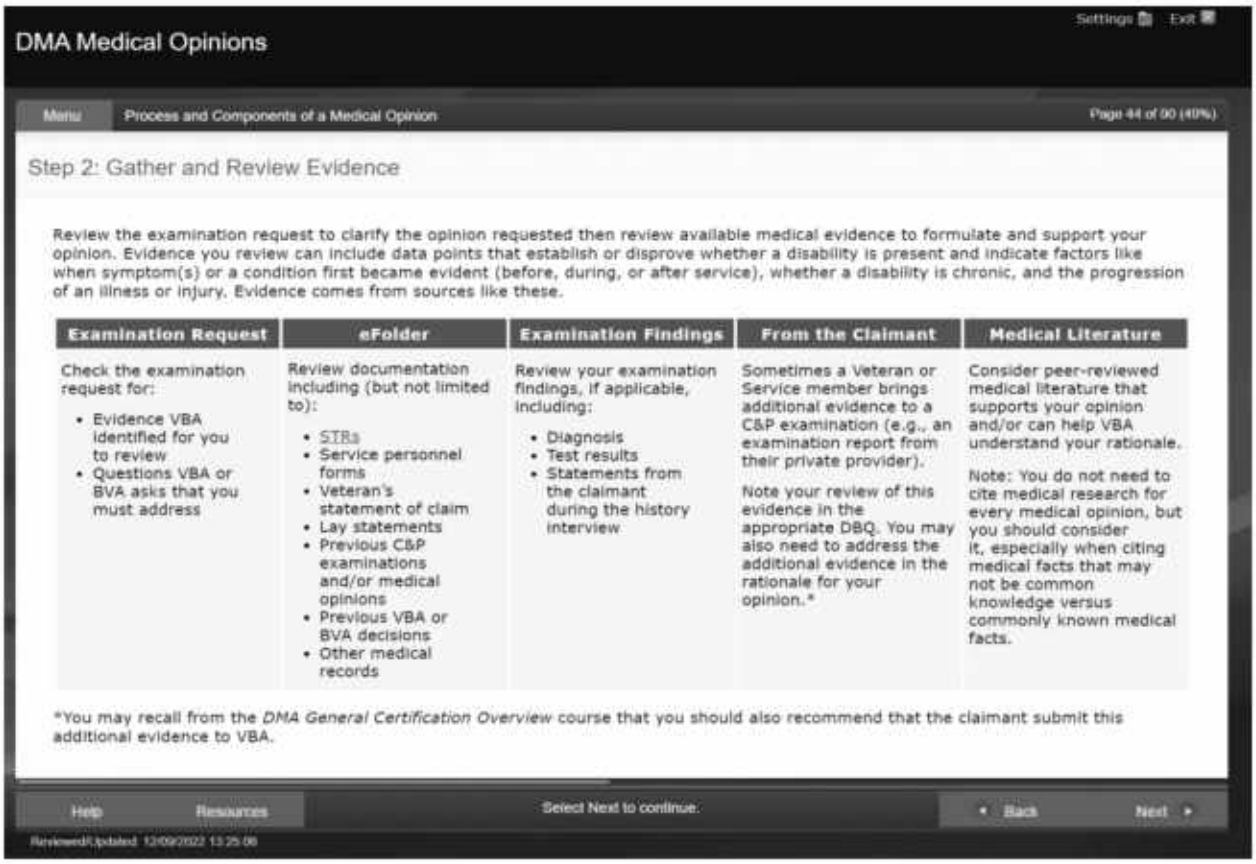


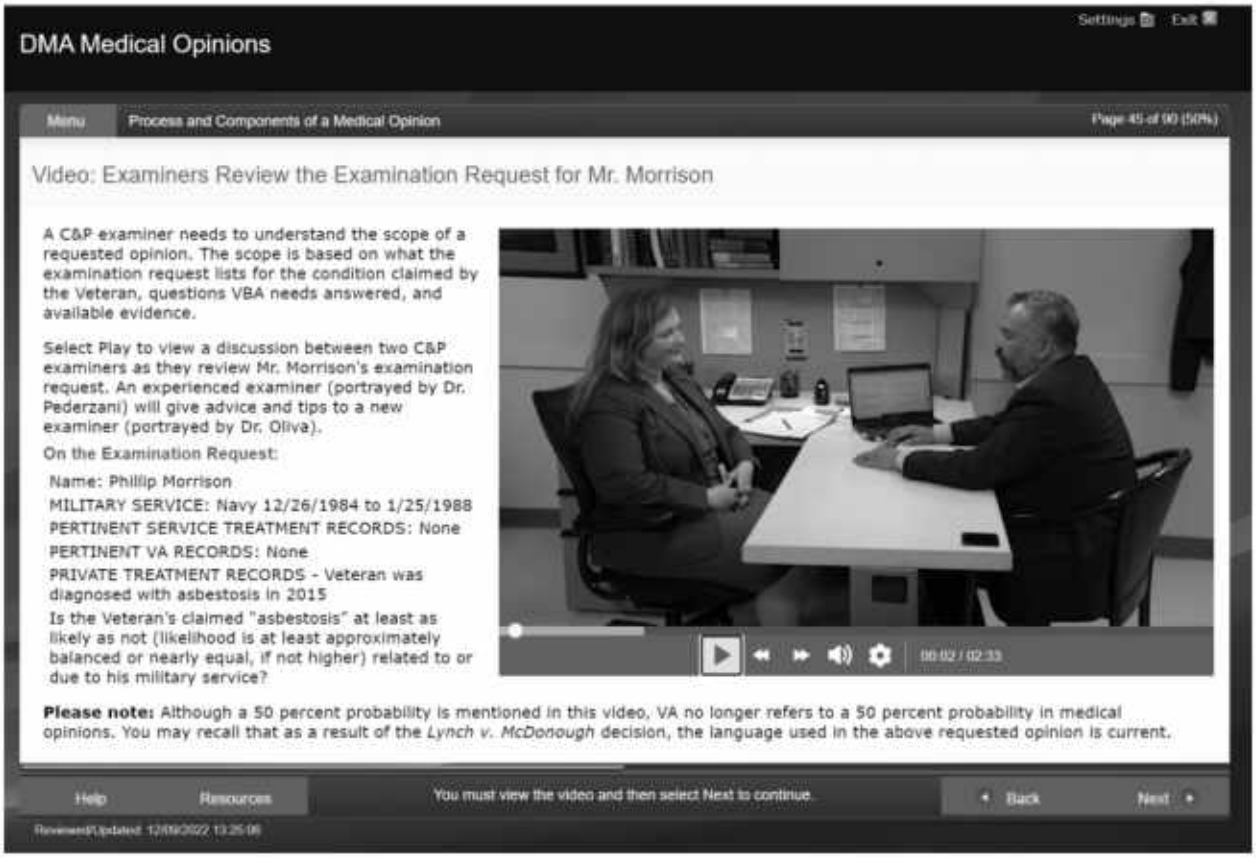
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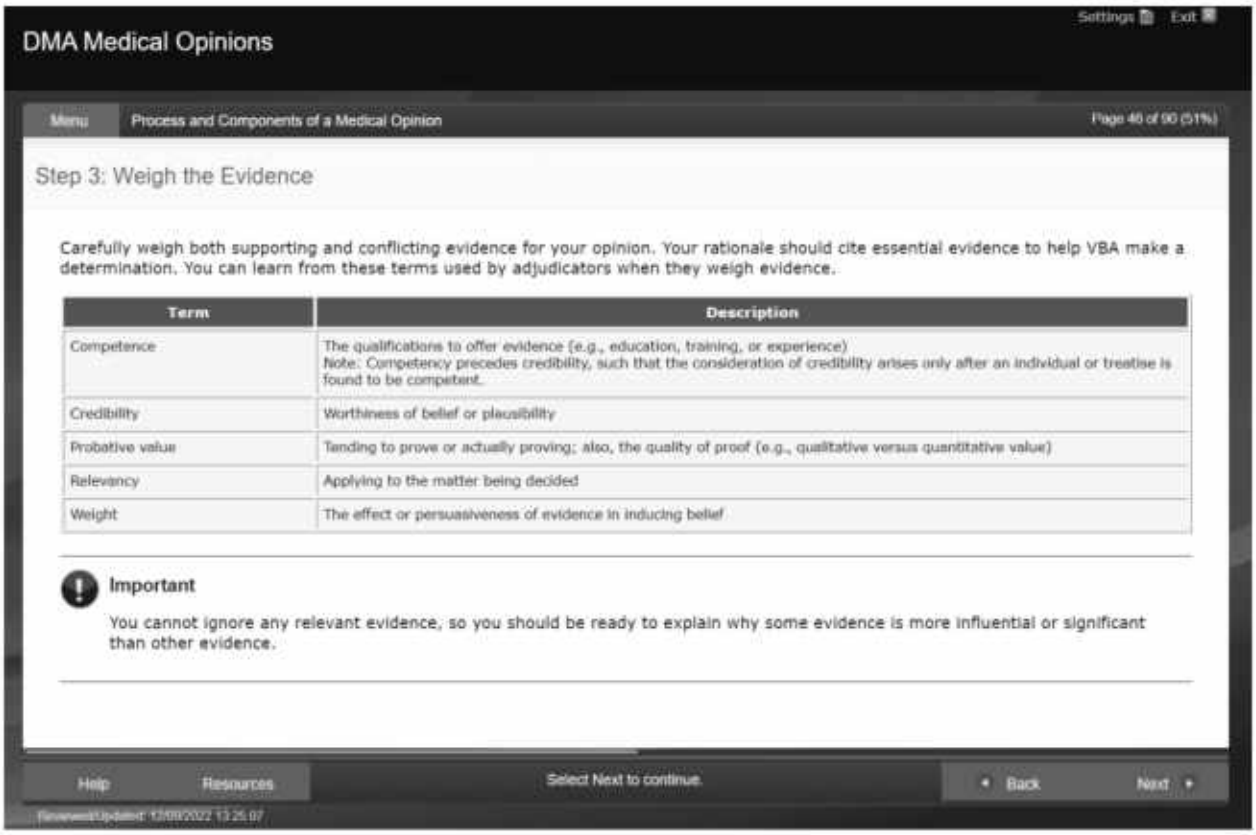
I have been told that not every examination request includes a medical opinion, however, when VBA ask for an opinion, they usually ask for an opinion and a rationale. Furthermore, VBA will sometimes ask specific questions for an examiner to answer. I am here with Dr. Pederzani, Ms. Griffin, Ms. Skelly, and Dr. Oliva, to talk about reviewing the exam request. Dr. Pederzani, how does the examiner's review of an exam request prepare them for writing a medical opinion and rationale? First, examiners should check to see what specific questions VBA needs addressed. The question is usually expressed in the examination request, in the form of VBA asking for an opinion. So that question is going to prompt you to include an opinion. Does VBA ever ask other questions that need to be answered? Yes. For example in a DBQ heart, for a Veteran who had agent orange exposure, a Veteran may have multiple heart conditions, such as hypertension, coronary artery disease, myocardial ischemia status post stent placement, congestive heart failure, mitral valve prolapse, and atrial arrhythmia. VBA may ask which cardiac conditions, as diagnosed are related to ischemic heart disease, as per VBA regulations. I have been told that BVA, that is the Board, sometimes submits a request for a remand, an examination and medical opinion, needed to adjudicate an appeal. The examination request for BVA, often have specific instructions and questions to be answered. Ms. Griffin, would you please describe the kinds of situations that lead to remanded C&P examinations? Sure. Well, sometimes it's as simple as not answering the question that was asked, or answering part of it. More often though, it's that the explanation provided for the opinion is not thorough enough. Remember, we adjudicators are not competent to provide medical opinions. We're not the experts, but we've got to be able to understand the opinion, and see how it all fits together with all of the evidence. So maybe the opinion makes it clear that based on certain evidence, there can be only one conclusion, but we're looking at all the rest of the evidence and saying, "What about these statements the Veteran made? "What about these private or VA records, "that at first glance seem to conflict with the conclusion? "Or, "What about this medical literature "the Veteran highlighted? "So in terms of what can cause a remand, at the end of the day, adjudicators have to be sufficiently informed to make a decision on the claim, and if they are not, then BVA will remand the appeal, seeking out more information. Thank you, Ms. Griffin. Dr. Oliva, what would you tell new examiners about these questions on remands? The questions can be difficult in general. It is very important to understand on what is specifically asked in the remand, and to follow it precisely. As a new examiner, I would solicit guidance from an experienced C&P examiner, to better understand what is asked, and to mitigate any misunderstandings that can lead to insufficiencies. Thank you, Dr. Oliva. That's all helpful information to keep in mind about questions on the exam request from VBA or the Board. Dr. Pederzani, does an examiner look for other information on the exam request when VBA asks for an opinion? When looking at the questions or opinions that VBA needs the examiner to address, the phrasing of that question will tell the examiner what type of opinion is needed. Meaning, is this a contention involving direct service connection, secondary aggravation, and so on. Remands will sometimes ask for multiple opinions, for instance asking for a direct opinion. If that's negative, then how about a secondary condition, and so on. Some cases like MST-related exams, or Gulf War exams, may have specialized opinions, but there are separate DMA training modules to address these types of cases. What's most important for examiners to remember in general terms, is that they need to answer the opinions that are asked of them. Examiners should also take note of the specific phrasing used in an examination request. Sometimes VBA, or BVA for remand cases, will ask for opinions using language that they need the examiner to use precisely. Examiners should mirror the language from the examination request when providing their opinions. As clinicians, sometimes we swap out language that in our minds is equivalent, sometimes without even thinking about it, but what seems like a minor change clinically, can have downstream effects on quality and adjudication. So this is another one of those shifts in mindset that clinicians have to make. You need to be clinically accurate, but you can't ignore the language that was used in the examination request. Thank you, panelists. I understand that sometimes VBA will identify evidence related to the requested opinion on the exam request. What should the examiner do in response? That is correct. In common practice, an examiner must not only annotate that they had reviewed VBA's identified evidence on the exam request, but also on the rationale portion of the medical opinion, include a statement weighing in on the value, if any, of VBA's identified evidence. Dr. Oliva is right, but it's also important to keep in mind that while VBA identifies certain evidence, the examiner still needs to review all of the records. We talked about this in the DMA General

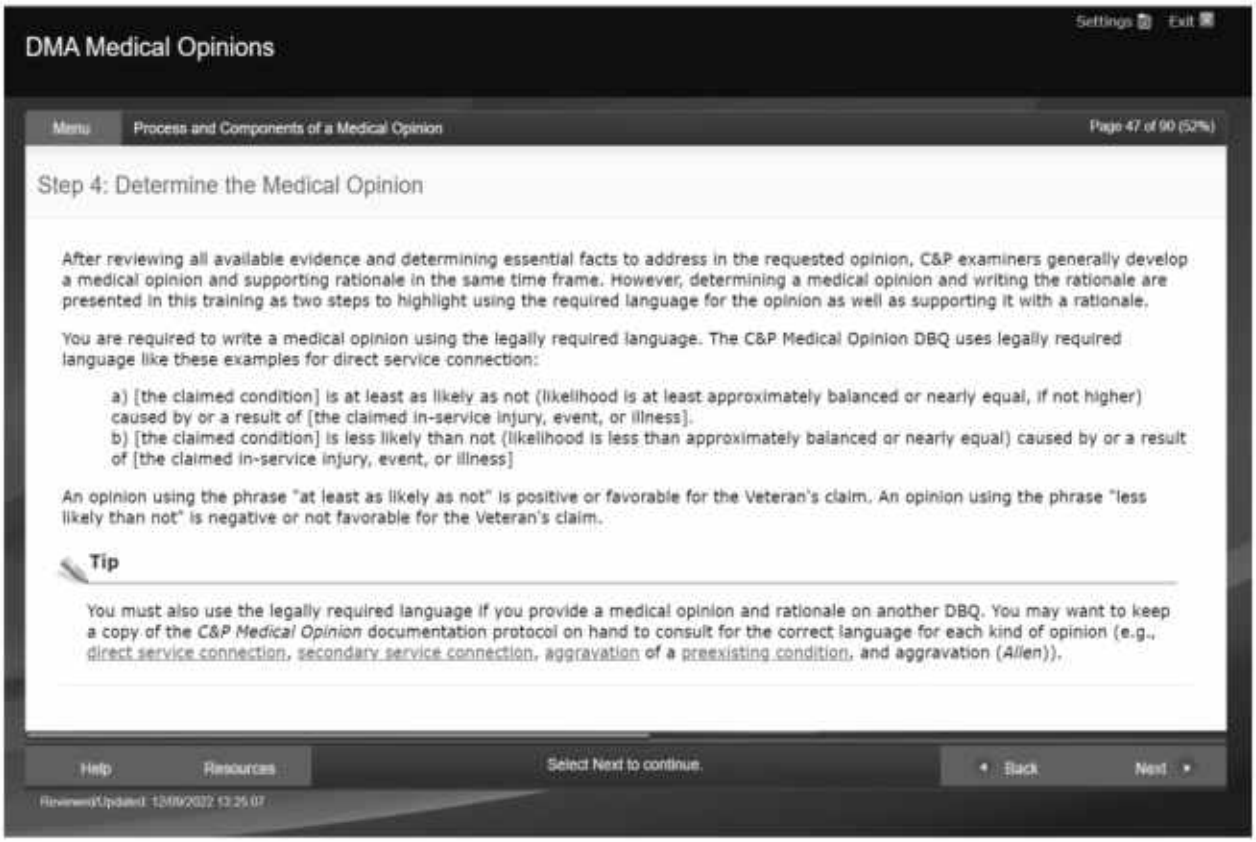
Certification course, but it bears repeating how adjudicators rely on the examiner's clinical expertise to determine which evidence is pertinent to the opinion at hand. The records review sounds like a critical step for writing an opinion and rationale. What kinds of information should the examiner lo ok for? Dr. Oliva, where should examiners start? To review records is a critical step in order to write a cogent opinion and rationale. A C&P examiner should look for all medical records that perform to the claimed condition. We may start with service personnel records, such as DD 214, certificate of release, or discharge from active duty, which is helpful with a Veteran's primary specialty, as it identifies the Veteran's primary job while in service. Similar to a treatment protocol, a C&P examiner also needs to ask the Veteran for any special assignments that may not be mentioned in the DD 214.Accepting additional duties as ordered by one's command is common practice in military service, and these additional duties may not be evident in the DD 214.Furthermore, we look at the STR. This review of treatment records includes, but is not limited to, entrance and exit paperwork, medical records, radiographic studies, laboratory workups, medical referrals, or treatment outcomes from events relating to a claimed condition. Buddy statements from individuals that can speak to the Veteran's claimed condition are also valuable information, and it is a requirement to review lay evidence. Examiners should also review any post-discharge medical treatment notes for documentation of symptoms, diagnosis, or other related residuals the Veteran may have been experiencing. It seems like reviewing the evidence is not a passive activity, and an examiner uses the information they gather in different ways. Once an examiner understands what they need to do from the exam request, and gathers information from reviewing records, are they done with the exam request? Would you agree, Dr. Pederzani? Not quite. It's important for examiners to check the exam request several times while completing DBQs and developing medical opinions. Examiners need to make sure their opinions and rationales answer all of VBA's questions in a logical, easy to understand way. As I mentioned earlier, clinicians do tend to slip back into their routines with language, and forget the audience for these exams and opinions, so referring back to that exam request is critical to staying on task, and meeting the needs of the adjudication process. Examiners are reminded to use the legally required language to render an opinion, but that's not all. It is important to check that the opinion refers to the claimed condition on the exam request, and to provide a cogent rationale , reflective of your rendered opinion. Ms. Skelly, we just saw and heard examples of how examiners might receive an exam request from VBA that needs them to supply an opinion, and address various tasks for determining an opinion, and explaining it to VBA. It seems that the process really starts with, and ends with the adjudicator, and what they need. Yes, it does.

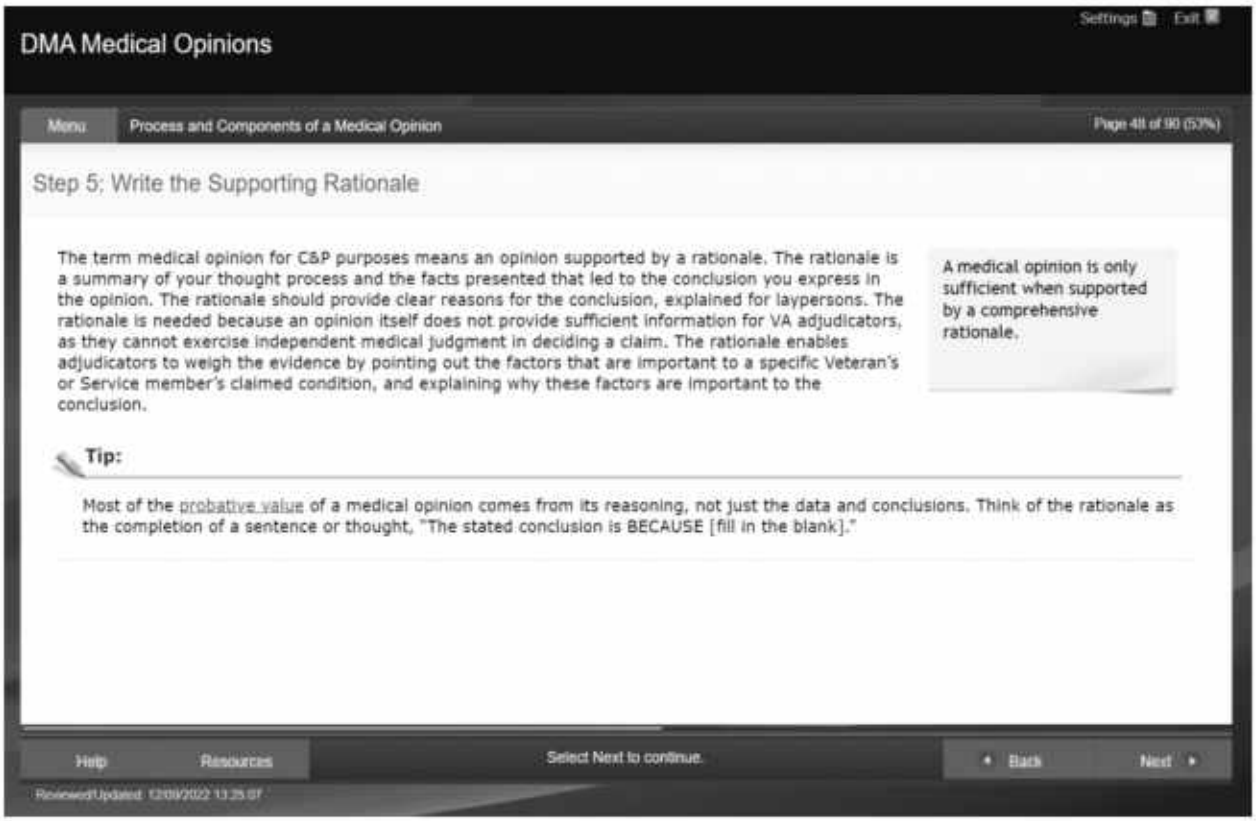

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Step 2: Gather and Review Evidence
Review the examination request to clarify the opinion requested then review available medical evidence to formulate and support your opinion. Evidence you review can include data points that establish or disprove whether a disability is present and indicate factors like when symptom(s) or a condition first became evident (before, during, or after service), whether a disability is chronic, and the progression of an illness or injury. Evidence comes from sources like these.
Examination Request
Check the examination request for:
• Evidence VBA identified for you to review
• Questions VBA or BVA asks that you must address
eFolder
Review documentation including (but not limited to):
• STRs
• Service personnel forms
• Veteran's statement of claim
• Lay statements
• Previous C&P examinations and/or medical opinions
• Previous VBA or BVA decisions
• Other medical records
Examination Findings
Review your examination findings, if applicable, including:
• Diagnosis
• Test results
• Statements from the claimant during the history interview
From the Claimant
Sometimes a Veteran or Service member brings additional evidence to a C&P examination (e.g., an examination report from their private provider).
Note your review of this evidence in the appropriate DBQ. You may also need to address the additional evidence in the rationale for your opinion.*
Medical Literature
Consider peer-reviewed medical literature that supports your opinion and/or can help VBA understand your rationale.
Note: You do not need to cite medical research for every medical opinion, but you should consider it, especially when citing medical facts that may not be common knowledge versus commonly known medical facts.
*You may recall from the DMA General Certification Overview course that you should also recommend that the claimant submit this additional evidence to VBA.
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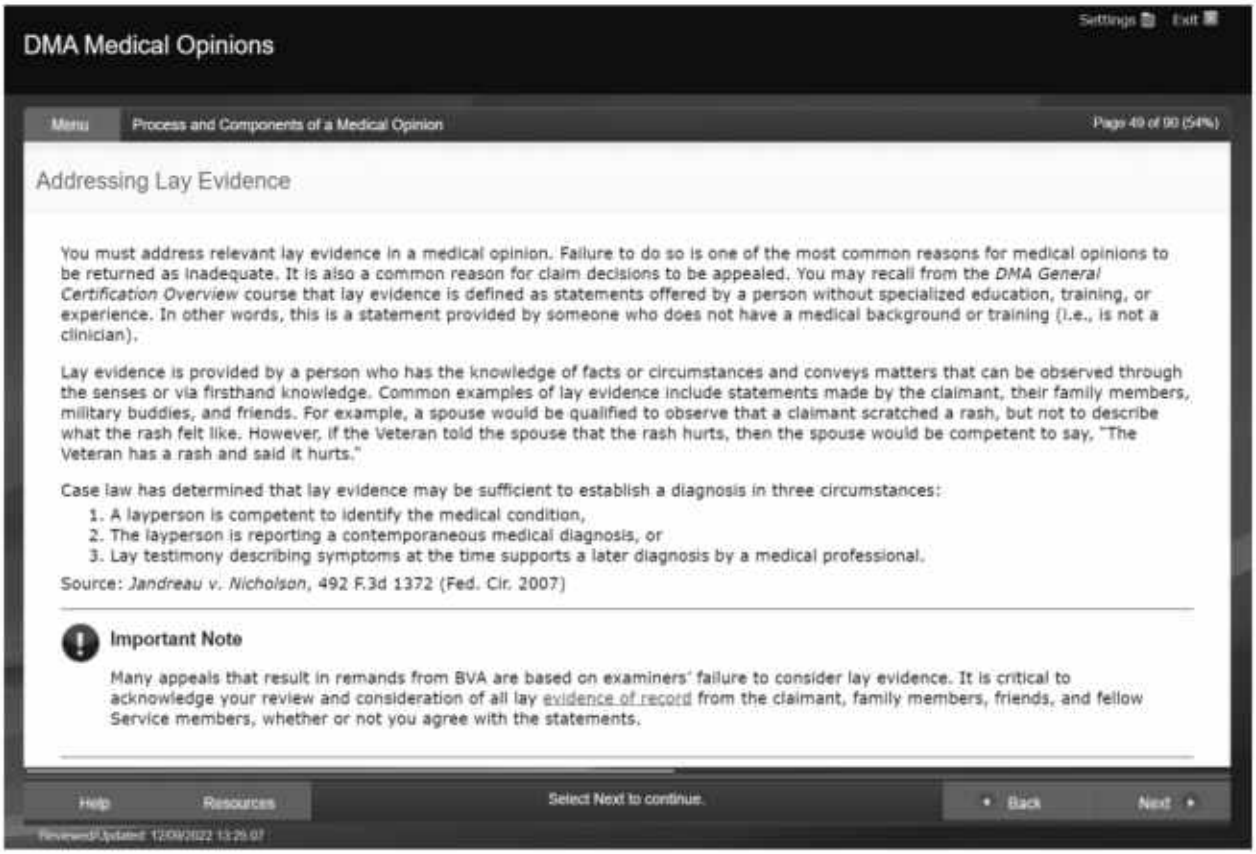


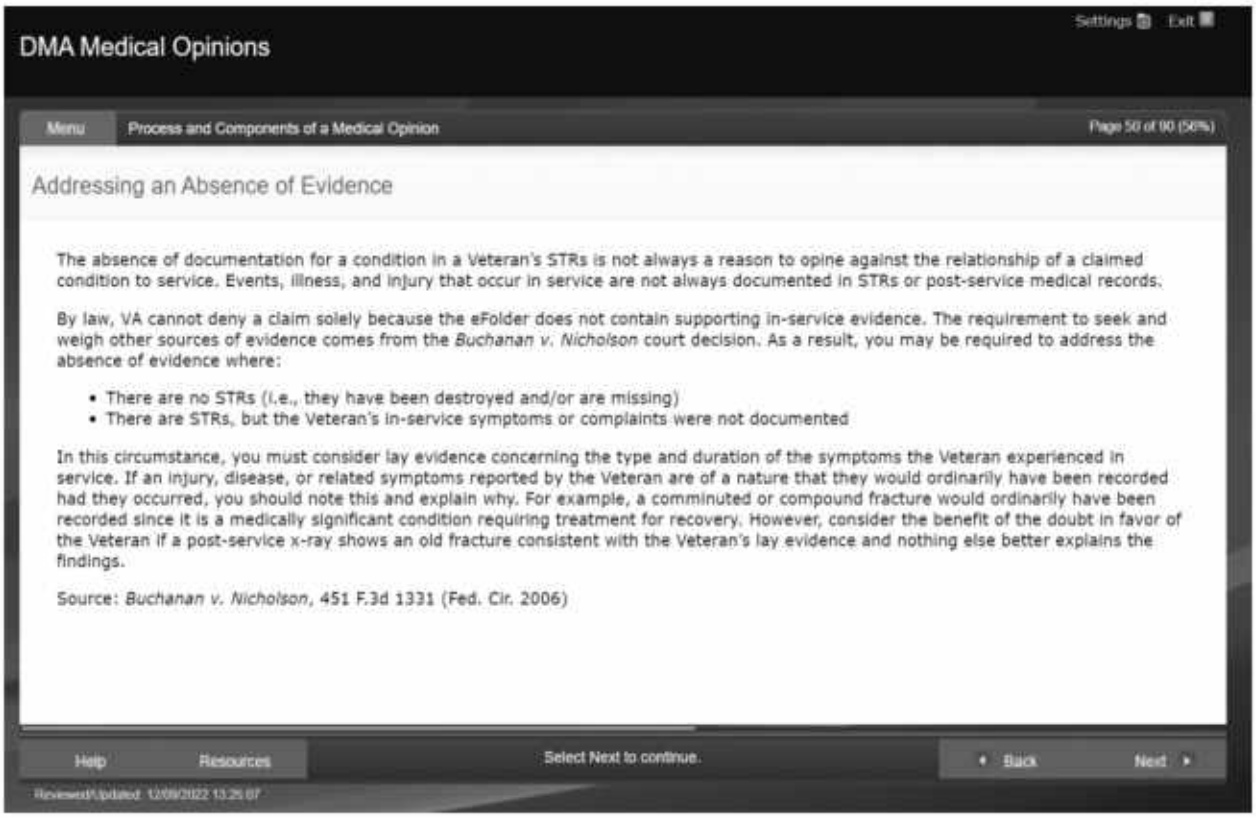
Thank you for finding the time to work with me. I'm still new at C&P examinations and I want to make sure I get what I need from the exam request. Of course, I'm happy to help. Who will you examine and what are they claiming? I'll evaluate a respiratory condition for Mr. Phil Morrison. He's claiming asbestosis related to his service. Let's see. He was in the Navy. Okay, so because asbestosis is a chronic lung disease from hazardous exposure to asbestos, you'll need to look for asbestos exposures as well as medical history pertaining to related chronic lung disease, for example, COPD. Does VBA have any specific questions that they need answered? Yes. Is the Veteran's claim asbestosis at least as likely as not 50% or greater probability related to or due to his military service? I see. So VBA needs you to provide an opinion and rationale that address that opinion. Are there any other questions? No. Okay. And did VBA identify specific evidence for you to review? They did. It says here that private medical records show that the Veteran was diagnosed with asbestosis in 2015.I see. Then, you'll need to specifically address that evidence in the rationale. But you know that you're going to look at all of the evidence to see whether Mr. Morrison has asbestosis and if it was caused by his service. Do you mean all the evidence in the eFolder? Yes, as well as from the physical exam and from talking to Mr. Morrison. As I see it, you'll be looking for the Veteran's current diagnosis from the C&P exam, evidence of exposure to asbestos in service, service treatment records that discuss any related complaints, evidence of asbestos exposure after service, symptoms or diagnoses in his private medical records, and any other available medical records. Basically, you'll be looking for evidence that tells you about Mr. Morrison's current condition or symptoms, evidence for any connection to his service, and then how his condition has progressed since his time in the military. Thanks. I can follow this plan. I recently read some medical literature about asbestosis. Could that help me to explain things to VBA? Yes. That might wind up as important evidence. You might also find it helpful to look at the asbestos fact sheet from the VA's war related illnesses website. I can email you a link. That would be helpful. Thanks again, Dr. Pederzani.

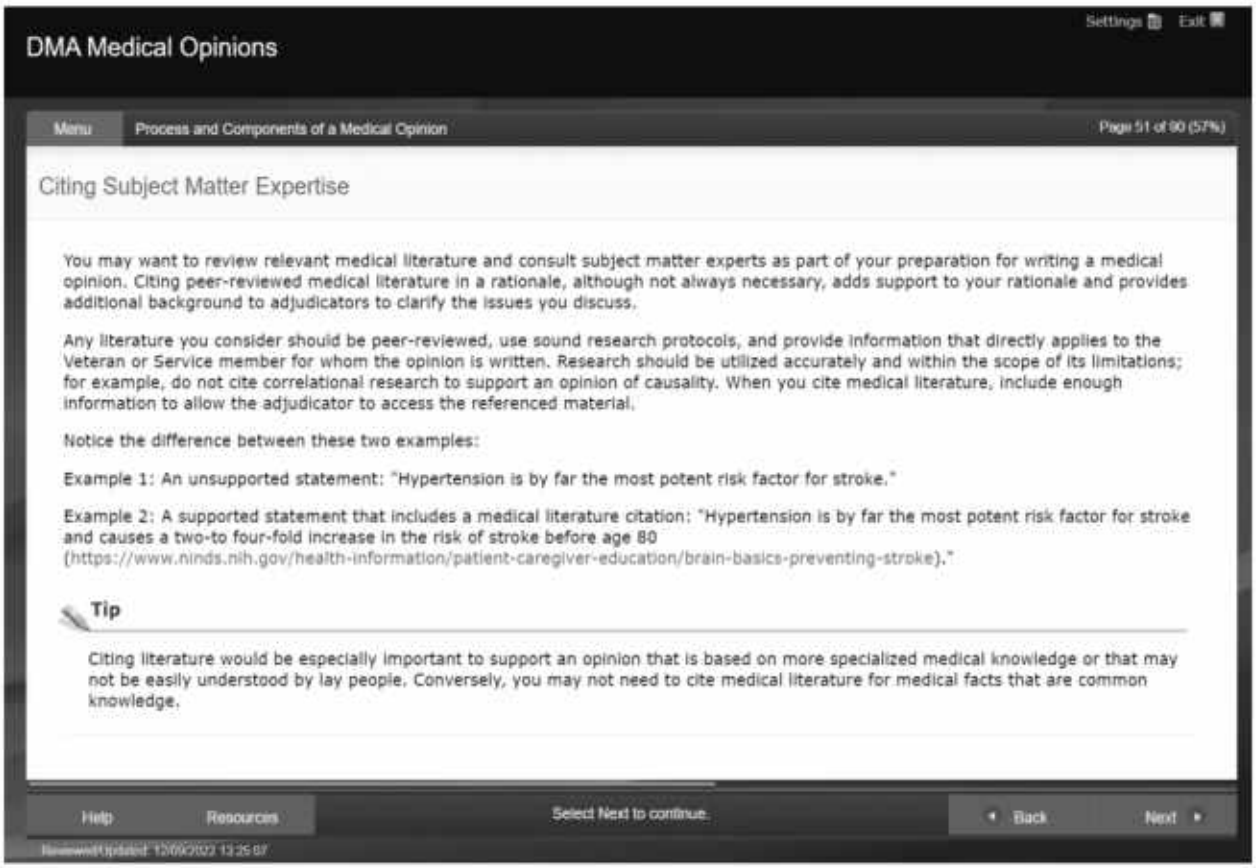

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Step 3: Weigh the Evidence
Carefully weigh both supporting and conflicting evidence for your opinion. Your rationale should cite essential evidence to help VBA make a determination. You can learn from these terms used by adjudicators when they weigh evidence.
Term
Description
Competence
The qualifications to offer evidence (e.g., education, training, or experience)
Note: Competency precedes credibility, such that the consideration of credibility arises only after an individual or treatise is found to be competent.
Credibility
Worthiness of belief or plausibility
Probative value
Tending to prove or actually proving; also, the quality of proof (e.g., qualitative versus quantitative value)
Relevancy
Applying to the matter being decided
Weight
The effect or persuasiveness of evidence in inducing belief
Important
You cannot ignore any relevant evidence, so you should be ready to explain why some evidence is more influential or significant than other evidence.
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Step 4: Determine the Medical Opinion
After reviewing all available evidence and determining essential facts to address in the requested opinion, C&P examiners generally develop a medical opinion and supporting rationale in the same time frame. However, determining a medical opinion and writing the rationale are presented in this training as two steps to highlight using the required language for the opinion as well as supporting it with a rationale.
You are required to write a medical opinion using the legally required language. The C&P Medical Opinion DBQ uses legally required language like these examples for direct service connection:
a) [the claimed condition] is at least as likely as not (likelihood is at least approximately balanced or nearly equal, if not higher) caused by or a result of [the claimed in-service injury, event, or illness].
b) [the claimed condition] is less likely than not (likelihood is less than approximately balanced or nearly equal) caused by or a result of [the claimed in-service injury, event, or illness]
An opinion using the phrase "at least as likely as not" is positive or favorable for the Veteran's claim. An opinion using the phrase "less likely than not" is negative or not favorable for the Veteran's claim.
Tip
You must also use the legally required language if you provide a medical opinion and rationale on another DBQ. You may want to keep a copy of the C&P Medical Opinion documentation protocol on hand to consult for the correct language for each kind of opinion (e.g., direct service connection, secondary service connection, aggravation of a preexisting condition, and aggravation (Allen)).
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Step 5: Write the Supporting Rationale
The term medical opinion for C&P purposes means an opinion supported by a rationale. The rationale is a summary of your thought process and the facts presented that led to the conclusion you express in the opinion. The rationale should provide clear reasons for the conclusion, explained for laypersons. The rationale is needed because an opinion itself does not provide sufficient information for VA adjudicators, as they cannot exercise independent medical judgment in deciding a claim. The rationale enables adjudicators to weigh the evidence by pointing out the factors that are important to a specific Veteran's or Service member's claimed condition, and explaining why these factors are important to the conclusion.
A medical opinion is only sufficient when supported by a comprehensive rationale.
Tip:
Most of the probative value of a medical opinion comes from its reasoning, not just the data and conclusions. Think of the rationale as the completion of a sentence or thought, "The stated conclusion is BECAUSE [fill in the blank]."
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Addressing Lay Evidence
You must address relevant lay evidence in a medical opinion. Failure to do so is one of the most common reasons for medical opinions to be returned as inadequate. It is also a common reason for claim decisions to be appealed. You may recall from the DMA General Certification Overview course that lay evidence is defined as statements offered by a person without specialized education, training, or experience. In other words, this is a statement provided by someone who does not have a medical background or training (i.e., is not a clinician).
Lay evidence is provided by a person who has the knowledge of facts or circumstances and conveys matters that can be observed through the senses or via firsthand knowledge. Common examples of lay evidence include statements made by the claimant, their family members, military buddies, and friends. For example, a spouse would be qualified to observe that a claimant scratched a rash, but not to describe what the rash felt like. However, if the Veteran told the spouse that the rash hurts, then the spouse would be competent to say, "The Veteran has a rash and said it hurts."
Case law has determined that lay evidence may be sufficient to establish a diagnosis in three circumstances:
1. A layperson is competent to identify the medical condition,
2. The layperson is reporting a contemporaneous medical diagnosis, or
3. Lay testimony describing symptoms at the time supports a later diagnosis by a medical professional.
Source: Jandreau v. Nicholson, 492 F.3d 1372 (Fed. Cir. 2007)
Important Note
Many appeals that result in remands from BVA are based on examiners' failure to consider lay evidence. It is critical to acknowledge your review and consideration of all lay evidence of record from the claimant, family members, friends, and fellow Service members, whether or not you agree with the statements.
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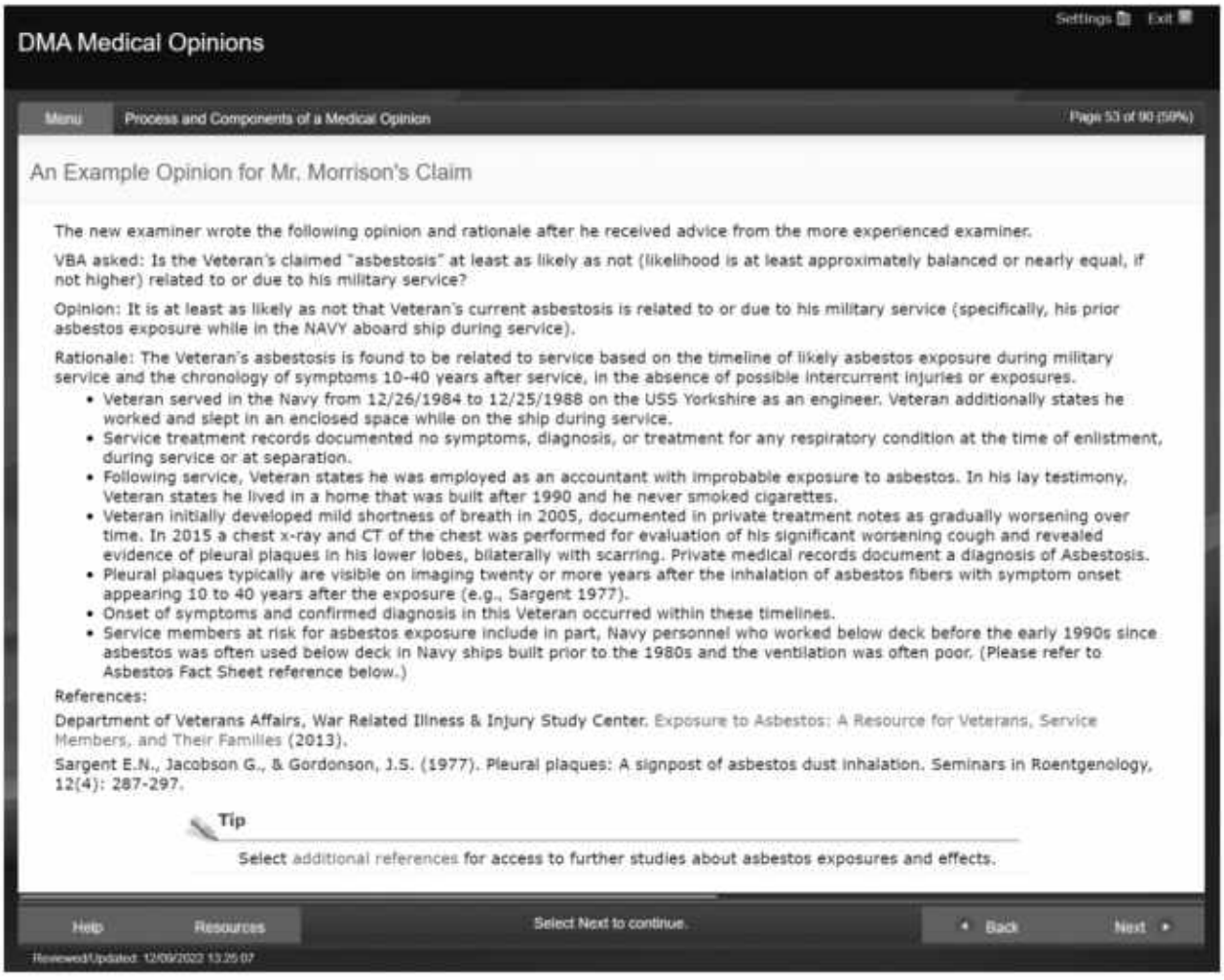

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Addressing an Absence of Evidence
The absence of documentation for a condition in a Veteran's STRs is not always a reason to opine against the relationship of a claimed condition to service. Events, illness, and injury that occur in service are not always documented in STRs or post-service medical records.
By law, VA cannot deny a claim solely because the eFolder does not contain supporting in-service evidence. The requirement to seek and weigh other sources of evidence comes from the Buchanan v. Nicholson court decision. As a result, you may be required to address the absence of evidence where:
There are no STRs (i.e., they have been destroyed and/or are missing)
There are STRs, but the Veteran's in-service symptoms or complaints were not documented
In this circumstance, you must consider lay evidence concerning the type and duration of the symptoms the Veteran experienced in service. If an injury, disease, or related symptoms reported by the Veteran are of a nature that they would ordinarily have been recorded had they occurred, you should note this and explain why. For example, a comminuted or compound fracture would ordinarily have been recorded since it is a medically significant condition requiring treatment for recovery. However, consider the benefit of the doubt in favor of the Veteran if a post-service x-ray shows an old fracture consistent with the Veteran's lay evidence and nothing else better explains the findings.
Source: Buchanan v. Nicholson, 451 F.3d 1331 (Fed. Cir. 2006)
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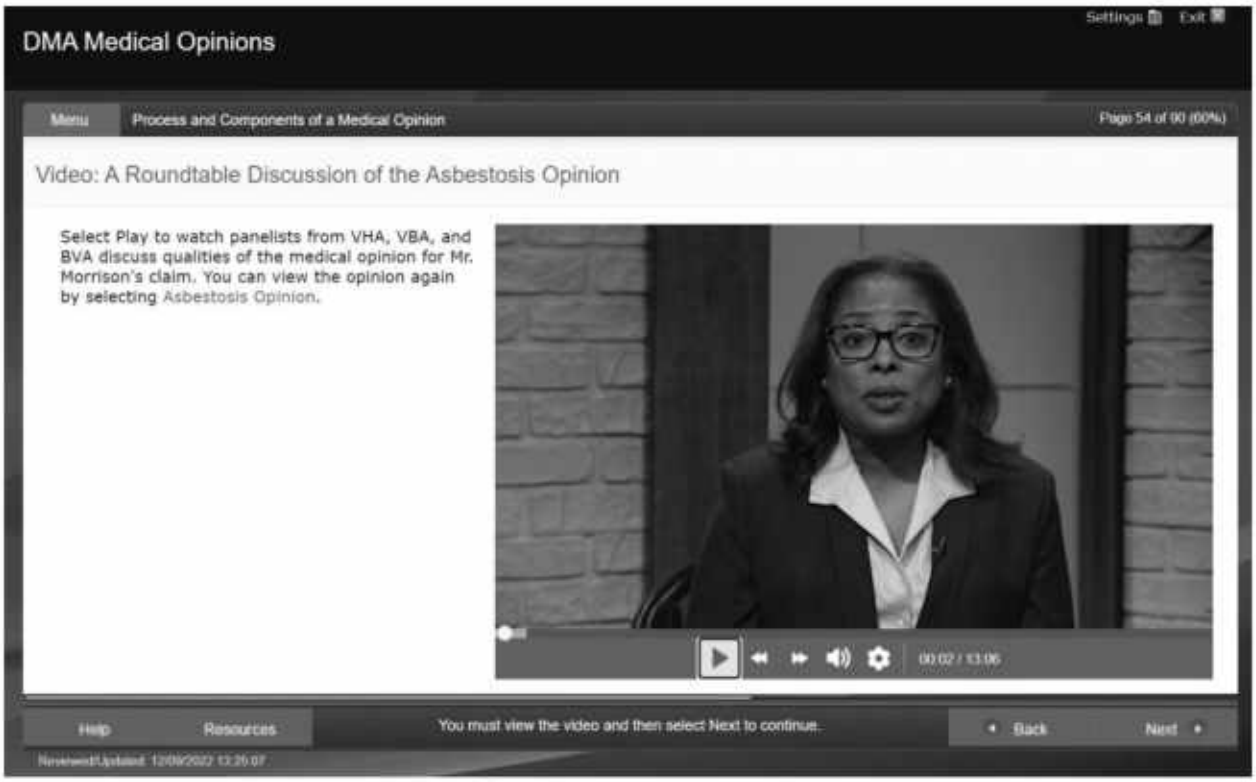

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Citing Subject Matter Expertise
You may want to review relevant medical literature and consult subject matter experts as part of your preparation for writing a medical opinion. Citing peer-reviewed medical literature in a rationale, although not always necessary, adds support to your rationale and provides additional background to adjudicators to clarify the issues you discuss.
Any literature you consider should be peer-reviewed, use sound research protocols, and provide information that directly applies to the Veteran or Service member for whom the opinion is written. Research should be utilized accurately and within the scope of its limitations; for example, do not cite correlational research to support an opinion of causality. When you cite medical literature, include enough information to allow the adjudicator to access the referenced material.
Notice the difference between these two examples:
Example 1: An unsupported statement: "Hypertension is by far the most potent risk factor for stroke."
Example 2: A supported statement that includes a medical literature citation: "Hypertension is by far the most potent risk factor for stroke and causes a two-to four-fold increase in the risk of stroke before age 80 (https://www.ninds.nih.gov/health-information/patient-caregiver-education/brain-basics-preventing-stroke)."
Tip
Citing literature would be especially important to support an opinion that is based on more specialized medical knowledge or that may not be easily understood by lay people. Conversely, you may not need to cite medical literature for medical facts that are common knowledge.
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How did the exam go with Mr. Morrison? Just fine. I evaluated him today and I'm working on medical opinion. He's claiming service connection for asbestosis, right? Yes .I have a lot of data and findings and I could use some advice. I probably don't need all of it and I'm not sure how to organize the rationale. Okay. I see. Here's how I look at the process, generally speaking. First, you have to demonstrate whether the person, Mr. Morrison, has the condition that he's claiming and then since this is about asbestos exposure, you want to include evidence of potential exposure that he had in the military, if there was any, and any other potential asbestos exposures outside of the military. And then you should present medical evidence that is relevant to the development of the asbestosis, if you diagnosed the condition. That makes sense. Thank you, Dr. Pederzani. I'll use this outline. Sure. Basically, give the VBA the medical opinion and evidence that they need for their decision on the claim. This means the essential evidence that backs up your opinion and findings. Let's review the data points that you have. Did you finish the DBQ for evaluating Mr. Morrison's condition? Yes, and I confirmed the diagnosis of asbestosis. Okay. So now what do you have for potential exposure to asbestos in the military? The Veteran's DD214 shows he served on a Naval vessel as an engineer from 1984 to 1988.When I talked to him, Mr. Morrison said that he worked and slept in an enclosed space during service. And how about after service? Did you find out about any exposure then? No. He told me he worked as an accountant in buildings that did not have asbestos problems and his home was built after 1990, when asbestos was not used. Okay. I would include that. When did he start having signs or symptoms? I saw no signs or symptoms in his STRs and Mr. Morrison said he generally felt fine while he was in the service, but then his private medical records from 2005-2015indicate shortness of breath that worsened over time. Okay, good. That evidence will be useful for showing the progression of his condition. He developed a worsening cough, too. A chest x-ray in 2015, followed by a CT scan of the chest, showed the evidence of pleural plaques in his lower lobes with scarring. He was diagnosed with asbestosis at that time. Okay. You have data points that show asbestosis developing over time. I'd include these events on your rationale, but you'll need to explain the significance of the pleural plaques for VBA. Clinicians know what that means, but you're writing the rationale for the adjudicators, so it's similar to how you might explain things to a patient to be sure that they understand. Yes, I'll do that. I also reviewed the asbestos fact sheet that you recommended. I can

use data from it regarding potential asbestos exposure for Mr. Morrison. Great. Then just be sure to include enough details for VBA to access the fact sheet, if they want to. I'll do that. I appreciate your assistance with this Dr. Pederzani. My conclusion is that this Veteran's asbestosis is connected to his time in service. Now, I have a better sense of how to explain what happened to VBA.I agree, but one additional aspect that you need to consider. Did you find any evidence that could better explain Mr. Morrison's asbestosis? Remember, you have to weigh all pertinent evidence in your rationale, not just evidence that supports or contradicts the contention. No, I didn't find anything like that. No evidence that would better explain it. I think we're almost done here then. Just one more thing. Let's look at how you should legally state your opinion. I know what you mean. Here's what I wrote. "It is as likely as not that the Veteran's current asbestosis is the result of prior asbestos exposure while in the Navy aboard a ship during his military service. "Yes. That'll work. I took my cue from the way VBA asked the question on the exam request. Great. And if you did not think that the Veteran's asbestosis was connected to his service, you could use less likely than not. For sure. You've answered all my questions. Thank you for taking the time with me. You're welcome. I'm glad to help. Just let me know if you'd like me to look at your opinion before you submit it to VBA.

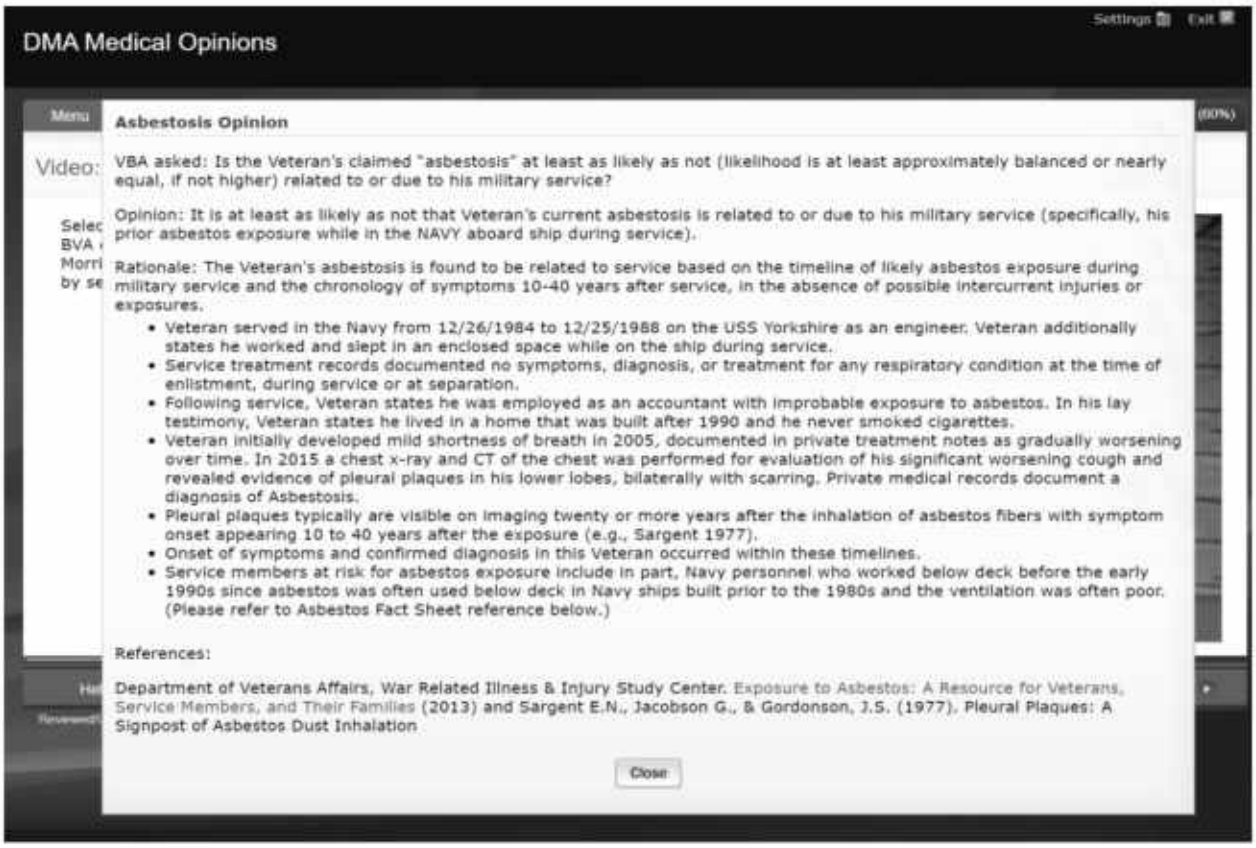




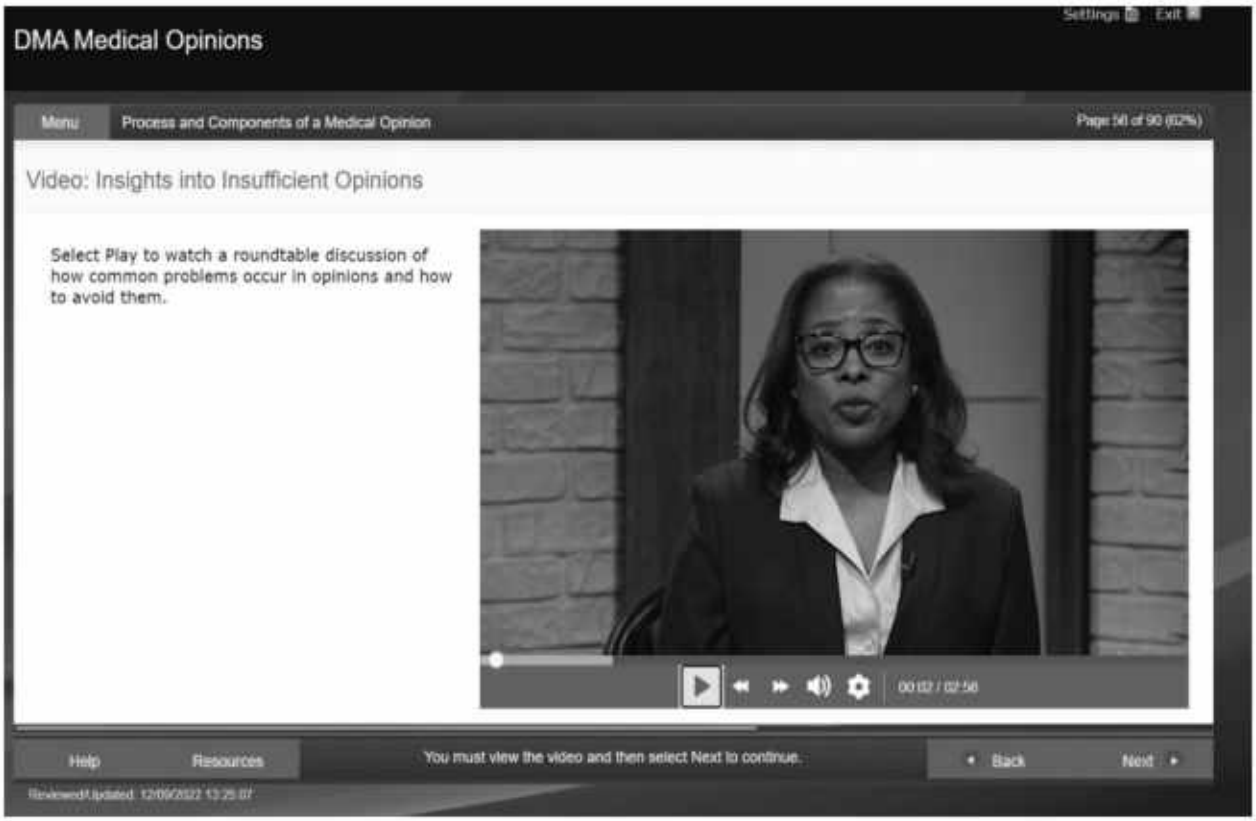
We are here to discuss an example opinion for direct service connection. I am here with Ms. Skelly, Ms. Griffin, Dr. Pederzani, and Dr. Oliva. We will examine specifically how this opinion reflects the five-step process an examiner uses to develop a medical opinion and rationale. Those steps are identify questions to answer for VBA or the Board, gather and review evidence, weigh the evidence, determine the opinion and write the rationale. In this case, the opinion was provided to answer a question from VBA .Dr. Pederzani, does this opinion answer the question VBA asked? Yes. You can see that the examiner very clearly spoke to that opinion request in the report. The examiner also used the legally required phrasing in presenting their opinion, and they mirrored the language used by VBA in this opinion request. I would like to add that answering the question should apply in pretty much every case. This would be no different than if we asked a question in the general remarks on an exam request that would need to be addressed in the examiner's response. Examiners need to address every question that's asked of them. Thank you, panelists. That takes care of step one; Identify questions to answer for VBA or the Board. Is it apparent in this opinion that the examiner followed step two, gather and review evidence? Yes they did. In this case, we see the most relevant evidence summarized in a bulleted list. In general, there is a place on the opinion DBQ, where an examiner acknowledges and documents what they reviewed. Ultimately, this provides clarity to the opinion provided to VBA or BVA of how the examiner led themselves to gather and review evidence. In addition to saying they reviewed the evidence, by just reading the opinion I can see the examiner clearly looked at service treatment records, post-service evidence to include private evidence, and the Veteran's lay statements. This shows that the examiner looked at everything in the file, or at least reviewed the relevant evidence. Thank you, Ms. Griffin. Step three in the process is to weigh the evidence for relevance, probity, and other qualities. How does this opinion show that the examiner weighed the evidence? I personally weigh the evidence with regards to trying to build up a rationale that is cogent. All relevant evidence, whether unannotated or annotated by VBA, has to be addressed. The evidence has to culminate in a medically and logically sound rationale. A legally stated opinion has to be aligned with the same logic as my rationale. I see that kind of process followed in this opinion. It is apparent that the examiner weighed the evidence by considering all sorts of information and objectively assessed this data to determine whether or not it supported the Veteran's contention. It is also apparent that the examiner placed a high value in documentation from medical records, but also did not dismiss the

information provided by the Veteran. Thank you, Dr. Oliva. It sounds like examiners determine the rationale before the opinion, or both at the same time. This example shows the opinion first and then the rationale. Is the opinion usually stated first? The opinion is stated first on the current medical opinion DBQ. So in terms of formatting, examiners will document the opinion first and then the rationale section of the DBQ follows. But this doesn't mean that their clinical process will occur in that order. Many clinicians find that their medical opinions form alongside the evidence review and examination. As new information is obtained, it gets consolidated into a clinician's understanding of the case and ultimately their opinion and rationale. The process can sometimes feel a little flipped. I think when clinicians are making that transition to writing these types of reports, the tendency is to think you're coming to your conclusion at the end, so why don't you state it at the end? And the reason that it's inverted on the current DBQs with the opinion first is because adjudicators need the final opinion in order to decide a claim, but they also need to know the opinion is backed up by a sound rationale. We have already looked at the opinion in terms of whether it answers the question asked on the examination request and shows that the examiner reviewed and weighed the evidence for the claim. For step four, write the opinion, does this opinion reflect legal requirements? It seems to me that the examiner's opinion uses the legally required language, at least as likely as not, and reflects the question VBA asked. Correct. It takes a new and C&P examiner time to get used to the legally required language. We as the medical professionals have been trained rigorously for many years to treat patients during our medical practice, but not to use this type of language. So it is understandable that new examiners might experience initial difficulty, but it gets easier with more practice, patience and time. Thank you, Dr. Oliva. Dr. Pederzani, step five of the process is write the rationale. Does the rationale in this example reflect the kind of guidance you would provide to a new examiner? Yes. Looking at the rationale, I think the fact that it's laid out very clearly and specifically and it also follows a chronology which helps to build towards a logical, well-supported rationale. It starts off with the military service and clarifying when military exposure might have happened, then it kind of walks through the Veteran's history sequentially after the military. I think that's very effective. The rationale also lays out the clinical thought process. You can tell what the examiner considered. For example, one part of the opinion that jumps out to me is where the examiner talks about the Veteran's occupation and any history of smoking. So you can tell that the examiner was making inquiries to consider other possible explanations or contributing factors. The rationale really spells out the clinical thinking behind the conclusion, and it culminates in the opinion but you can see how the examiner worked their way through it to reach the best supported opinion. Rationales always remind me of mathematical proofs. If you're going to arrive at a statement that something is so, you need to lay out all of the steps to build toward that conclusion. I agree with Dr. Pederzani. This is similar to medical training, as basic as SOAP notes, meaning subjective objective assessment and plan. We medical practitioners know SOAP, as all our treatment notes are based on this idea. It is the same manner with an opinion and rationale, but the order is different. The opinion and rationale should correlate with each other. The best-suited medically logical and widely accepted knowledge amongst medical peers is used to come to a cogent rationale in order to support one's opinion. So what Dr. Pederzani was saying, describe building blocks as medically reviewed evidence which is similar to subjective and objective findings. And you come up with a legally stated opinion from those building blocks. Again, this is similar to an assessment and plan with a SOAP note. Ms. Skelly, would an adjudicator need anything more from this opinion and rationale, assuming it addresses all questions asked and instructions on the exam request? For us, it basically is a matter of whether an opinion is usable. I don't see any reason why I would return this one. That's the key. It's usable. I can rate off of it and it is a positive opinion. So unless there's something that's inconsistent within the opinion itself, something doesn't jive with something that was previously said, I'm going to be able to use it. I don't see anything here that is inconsistent with something previously noted or stated. Thank you, Ms. Skelly. And that is a good reminder that consistency is important in the opinion and rationale. Panelists, this opinion cites medical literature. Does this opinion reflect a good use of medical literature? Yes. References are most important when making a medical connection that might not be clear to somebody who's outside of your profession, or you're making an argument for something that isn't all that common. Not every opinion requires research citations and examiners need to be cautious about how medical literature is used. There are some pitfalls clinicians need to avoid. In some cases, clinicians will

cite literature from sources that are not reliable, which is one problem. I agree with Dr. Pederzani. As an examiner, one needs to provide credible references such as widely accepted medical literature. These are not internet blogs, case report studies, or anecdotal experiences. When citing research, clinicians need to consider the source of the data. Some questions an examiner should explore when considering research include does it come from an objective and unbiased source or is there a potential influence on the data by, for example, the funding source or publication outlet? Were the research method and procedure rigorous? What was the sample size? What level of data was collected and was it appropriately analyzed and interpreted? Even in cases where medical literature is from a reputable, peer-reviewed scientific journal, clinicians need to remember that what is presented in such articles is typically group-level data and the findings may not apply to a given individual. So while medical literature can be informative, ultimately the clinician must speak to the specific circumstances of the specific individual they have evaluated. And even when citing a scientifically rigorous source, it's not enough to cite that article in the absence of case-specific details and an explanation of the significance of this research to this unique individual. When opinions come before the Board that cite research that is questionable, these opinions can be rebutted by a VA clinician explaining why the research was not accurately used. For example, this might be on the grounds that the research was not reliable or was not applied appropriately in this specific case. An explanation of this nature can increase the probative value of the VA medical opinion. If clinicians are going to cite literature, this must be a thoughtful process. Clinicians should not cite research they have not personally reviewed and they should not cut and paste identical lists of references for the same types of claims when those references may or may not apply to a specific case. Along with this, examiner's need to bear in mind that old caution we have all heard as clinicians, correlation does not imply causation. Clinicians cannot use correlational data to make a determination of causality. Also consider that asbestosis has been a well-known medical condition for which any examiner with a modicum of knowledge of medicine can easily determine medically accepted facts. Looking at the reference used in this asbestosis opinion and the way those reference were utilized, one reference used here from the VA War Related Illness and Injury Study Center is excellent. It covers a large well-known population, in this case apropos to Veterans in question, and a large population as a study group. This study has been vetted by the medical community and specifically the VA. Thank you, Dr. Oliva. Before we finish, does anything else stand out in this opinion and rationale? It's a very efficient opinion. The examiner had a great deal of information to summarize and to figure out what to highlight. They wound up with something that was succinct, accurate, and fulfilled adjudication needs. An exhaustive accounting of evidence is not necessarily needed. Medical opinions are not a "more is more" situation. Adjudicators really need the information distilled into its most useful components. Thank you, panelists, for sharing your insights into this sample opinion with new examiners in our audience.


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Asbestosis Opinion
Video:
VBA asked: Is the Veteran's claimed "asbestosis" at least as likely as not (likelihood is at least approximately balanced or nearly equal, if not higher) related to or due to his military service?
Opinion: It is at least as likely as not that Veteran's current asbestosis is related to or due to his military service (specifically, his prior asbestos exposure while in the NAVY aboard ship during service).
Rationale: The Veteran's asbestosis is found to be related to service based on the timeline of likely asbestos exposure during military service and the chronology of symptoms 10-40 years after service, in the absence of possible intercurrent injuries or exposures.
• Veteran served in the Navy from 12/26/1984 to 12/25/1988 on the USS Yorkshire as an engineer. Veteran additionally states he worked and slept in an enclosed space while on the ship during service.
• Service treatment records documented no symptoms, diagnosis, or treatment for any respiratory condition at the time of enlistment, during service or at separation.
• Following service, Veteran states he was employed as an accountant with improbable exposure to asbestos. In his lay testimony, Veteran states he lived in a home that was built after 1990 and he never smoked cigarettes.
• Veteran initially developed mild shortness of breath in 2005, documented in private treatment notes as gradually worsening over time. In 2015 a chest x-ray and CT of the chest was performed for evaluation of his significant worsening cough and revealed evidence of pleural plaques in his lower lobes, bilaterally with scarring. Private medical records document a diagnosis of Asbestosis.
• Pleural plaques typically are visible on imaging twenty or more years after the inhalation of asbestos fibers with symptom onset appearing 10 to 40 years after the exposure (e.g., Sargent 1977).
• Onset of symptoms and confirmed diagnosis in this Veteran occurred within these timelines.
• Service members at risk for asbestos exposure include in part, Navy personnel who worked below deck before the early 1990s since asbestos was often used below deck in Navy ships built prior to the 1980s and the ventilation was often poor. (Please refer to Asbestos Fact Sheet reference below.)
References:
Department of Veterans Affairs, War Related Illness & Injury Study Center. Exposure to Asbestos: A Resource for Veterans, Service Members, and Their Families (2013) and Sargent E.N., Jacobson G., & Gordonson, J.S. (1977). Pleural Plaques: A Signpost of Asbestos Dust Inhalation
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Process and Components of a Medical Opinion
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Avoid Insufficient Opinions
A medical opinion and rationale that is missing critical information or is otherwise unusable will be returned as insufficient. At that point, an examiner will be required to revisit the opinion and rectify the insufficiencies. Insufficient opinions slow down the overall claims process by delaying adjudication of a claim and are considered for C&P quality performance measures.
Here are the most common errors that result in insufficient opinions:
• The opinion is not stated in the legally required language.
• Questions on the examination request were not answered clearly, or were not answered at all.
• The rationale is missing, incomplete, and/or inconsistent.
Common Reasons for Insufficient Opinions
The Legally Required Language Is Not Used
VBA's Questions Are Not Answered at All
VBA's Questions Are Not Answered Clearly
The Rationale Is Inconsistent
The Rationale Is Incomplete
The Rationale Is Missing
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Sometimes, medical opinions are found to be insufficient for rating purposes. Our panelists, Dr. Oliva, Ms. Griffin, Dr. Pederzani, and Ms. Skelly have reviewed many medical opinions and rationales over time. What are some of the most common errors that you see in medical opinions? It might be helpful to new examiners to hear about some common errors and how to avoid them. I've reviewed opinions where examiners get into a position where they contradicted themselves. They may be focusing on medical facts, but not taking any VBA regulations into account. Thus, their rationale may be medically sound, but not legally accepted for a claim condition. Dr. Oliva, what advice can you share with new examiners to avoid a common error? One problem is when examiners do not use the legal language, "at least as likely as not. "Examiners need to get used to the legal language. Obviously, medical practitioners are trained in the art of medicine with the purpose to treat. However, C&P is not meant to treat. Thus, C&P examiners may take a while to get accustomed to more legal language than the medical language we are well versed in. Examiners can also avoid an insufficient opinion by making sure that an opinion and rationale are consistent. Opinions that are conflicting or inconsistent are not going to help with adjudication. As a mental health example, citing evidence that a condition had onset in recent years following the death of a spouse, but then providing an opinion that the condition is at least as likely as not due to military service 40 years ago. That is inconsistent and VBA will need to resolve it. And this means a delay for the Veteran's claim. I think examiners can also prevent inconsistencies by focusing on what VBA asks and answering that. It's like giving a deposition. Listen to the questions that VBA or the Board asks and seek clarification if needed .It's also good to confirm that a medical opinion has been requested, as not all exam requests require one. Writing an unsolicited opinion causes problems for a claim as it may delay its progress. You're saying that giving an unsolicited medical opinion causes problems for a Veteran's claim. Ms. Skelly, can you tell us more about the problems that can result? Sure, unsolicited opinions cause significant confusion for raters. They can also cause a conflict that must be resolved to determine a claim. The bottom line is that an unsolicited opinion prolongs the claim. Thank you panelists for your suggestions for preventing a medical opinion and rationale to be insufficient, and for some very good reasons, to not provide an unsolicited opinion.

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Speculative Opinions

A statement by an examiner that an opinion is not possible without resorting to speculation would likely be returned as insufficient unless further justification is contained in a rationale.

Sometimes, a medical opinion cannot be provided. This can happen in rare circumstances, such as when a condition has multiple possible etiologies, or where limitations of the medical field make it impossible to reach a conclusion. In either of these circumstances, you may find that you cannot provide the requested opinion without resorting to speculation. You should know, however, that there is a high legal threshold for determining whether an opinion truly cannot be provided without resorting to speculation (*Jones v. Shinseki*). The phrase "without resorting to mere speculation" should reflect the limitations of knowledge in the medical community at large, and not those of a particular examiner. You should arrive at this conclusion after all due diligence in seeking relevant medical information that may have a bearing on the requested opinion.

Determining that you are unable to provide an opinion without resorting to speculation is a medical conclusion. Therefore, you must explain the basis for this conclusion, just as you would any opinion. To justify a determination that you cannot provide a requested opinion without resorting to mere speculation, you need to document that you have exhausted your options for obtaining any and all data that would have resolved the findings. It must be clear from the completed DBQ(s) that you considered the full evidence of record available to you; obtained all tests and records that could inform your clinical analysis; and, when applicable, conducted a review of medical literature for pertinent data to resolve insufficient facts or data.

Sources: *Jones v. Shinseki*, 23 Vet. App. 382 (2010). Note: Some of these requirements were also stated in *Sharp v. Shulkin*, 29 Vet. App. 26 (2017).

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Medical Opinion Checklist

The best way to write a medical opinion sufficient for adjudication purposes is to use a checklist like this. It looks like a long list, but with practice, you can move through the three steps quickly.



Medical Opinion Checklist

(1) Ensure you followed general requirements for the opinion:
- __ Document in the DBQ that you reviewed the evidence of record as required
- __ State the opinion using the required legal language
- __ Include a supporting rationale

(2) Compare your opinion and rationale to the examination request to verify that you:
- __ Mirror the language used on the examination request
- __ Specifically address any identified evidence
- __ Answer all questions

(3) Check your rationale to ensure it:
- __ Is complete
- __ Demonstrates a thorough record review
- __ Is consistent within itself and per the evidence of record (reconciling any discrepancies)
- __ Is based on accurate facts and proper associations
- __ Addresses all pertinent facts
- __ Addresses relevant lay statements
- __ Explains points clearly using objective, neutral language

Tip

You can download a copy of this checklist from the Resources for this course.

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Process and Components of a Medical Opinion
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Lesson 3 Summary
This lesson presented the process of writing an opinion in five steps, with details for accomplishing each step. It also described how writing an opinion and writing a rationale are usually done at the same time. In practice, the order of steps is not as important as how thoroughly and precisely you complete them.
This lesson explained qualities of opinions that are sufficient for adjudication purposes and illustrated them in an example opinion for a claim of service connection of asbestosis. This lesson also described common errors that you should avoid as well. One method for avoiding insufficient opinions is to use a Medical Opinions checklist like the one provided in this lesson.
Now that you have completed this Process and Components of a Medical Opinion lesson, you are able to:
• Interpret the five-step process for providing a medical opinion.
• Recognize methods of ensuring that a medical opinion is sufficient.
This knowledge will enable you to be systematic and thorough when you develop medical opinions.
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Scenario 4: Aggravation of a Preexisting Condition



Paul Murphy, Scenario 4



Examiner, Scenario 4

Paul Murphy is a 40-year old U.S. Army Veteran who entered the service with mild pes planus in both feet. He filed a claim with VBA for worsening of his flat foot condition during service. Select each step in order to see how the C&P examiner developed the requested opinion.

- Step 1: Identify Questions to Answer
- Step 2: Gather and Review Evidence
- Step 3: Weigh the Evidence
- Step 4: Determine the Opinion
- Step 5: Write the Rationale

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Step 1: Identify Questions to Answer

The examination request presents this information for the examiner. She reviews it carefully to identify questions for Mr. Murphy's claim.

Service-connected disabilities: None
Claimed disabilities: Flat feet
Examination requested: Foot Conditions Including Flatfoot (Pes Planus) DBQ, Medical Opinions DBQ
The Veteran claims service connection for worsening of his flat feet during service. Was Veteran's bilateral pes planus permanently aggravated beyond the natural progression by his active military service?



Paul Murphy, Scenario 4

The examiner must provide a medical opinion and rationale to answer this question.

Additional Examiner Considerations

Which questions do you think the examiner must answer to determine her opinion? The examiner can think of of seven questions. Enter your questions and then select "Compare" to see the examiner's list.

Type your questions here, then click Compare.

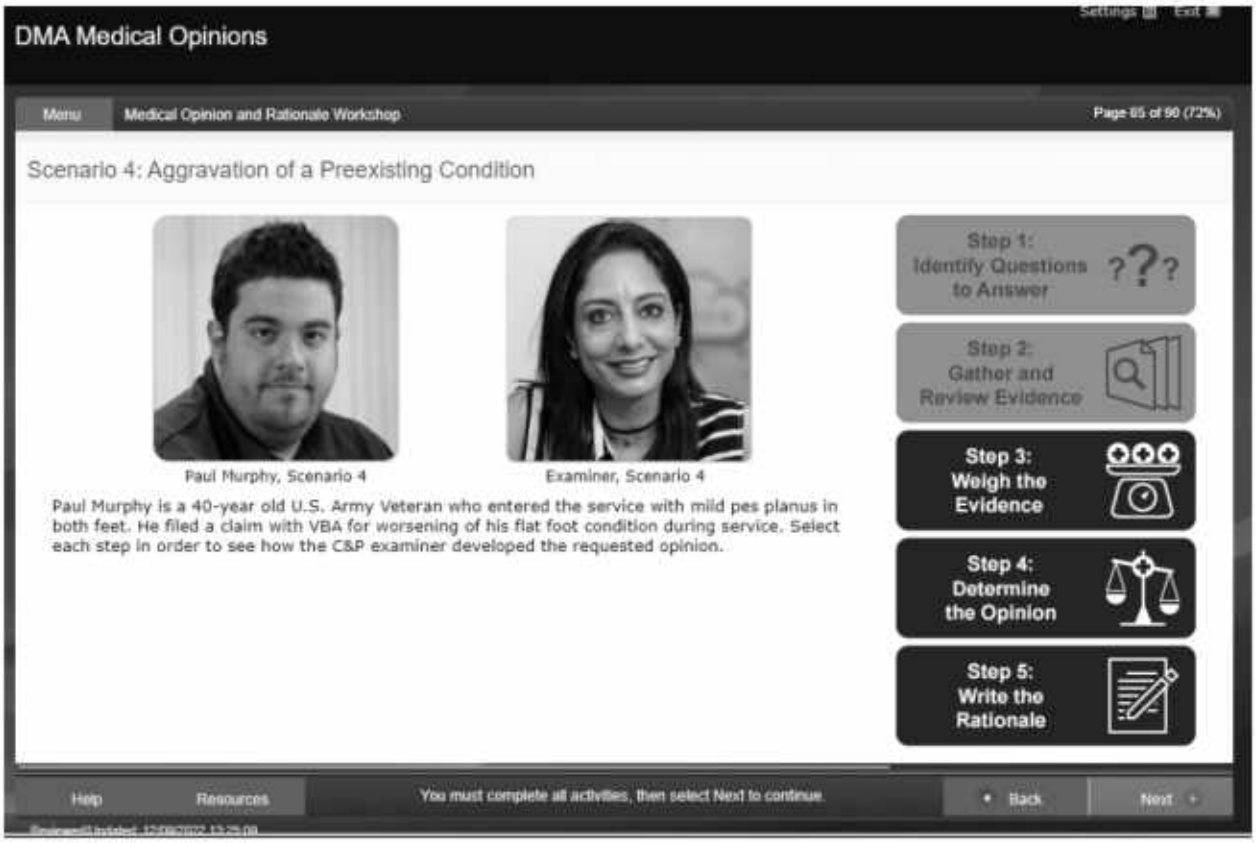
Compare

Examiner's Questions:

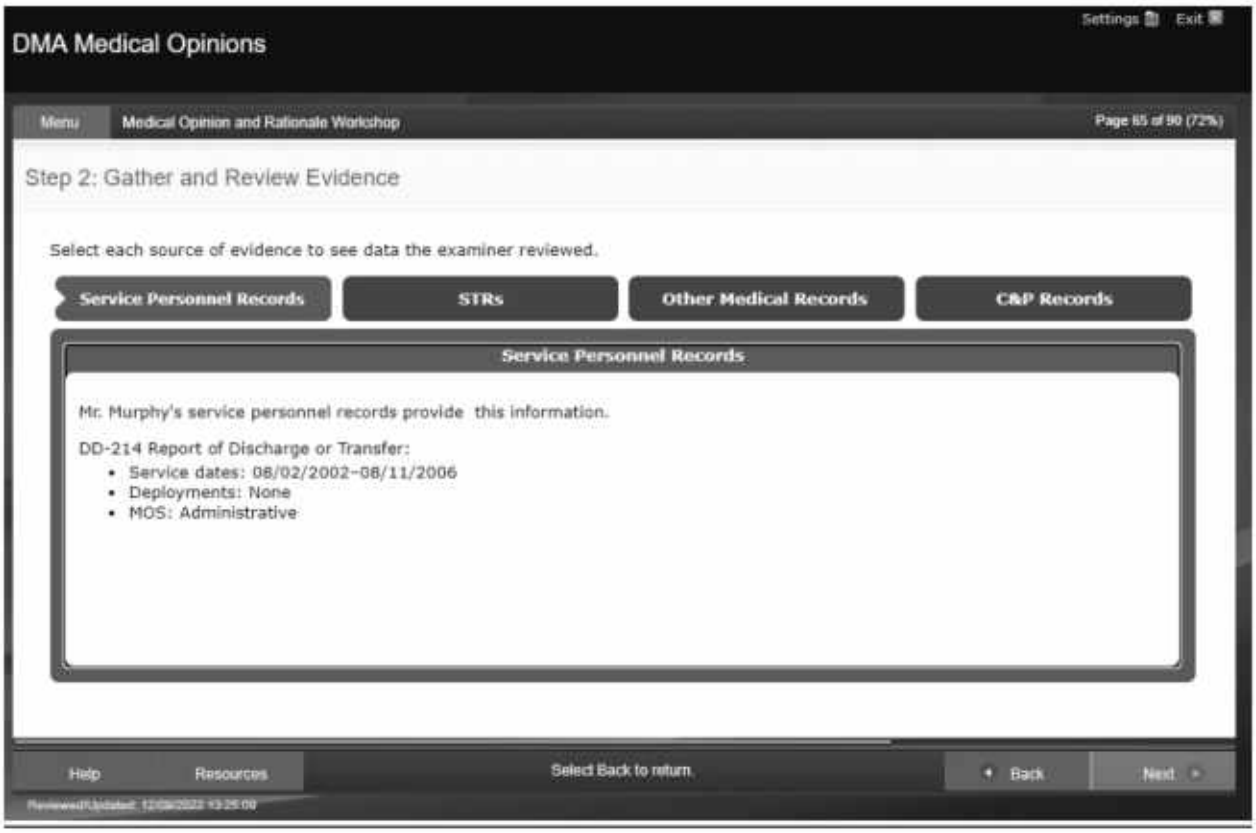
1. Did the Service Entrance Examination note preexisting pes planus?
2. What is the baseline level of severity for the Veteran's bilateral pes planus?
3. Is there medical evidence in the STRs that it worsened during service?
4. Did the Service Separation Examination note any worsening of the pes planus?
5. If it worsened, how did the extent of worsening compare to natural progression?
6. Did symptoms continue after service (i.e., evidence of permanent worsening)?
7. Is there any event or injury after service that would better explain the worsening of this Veteran's condition?

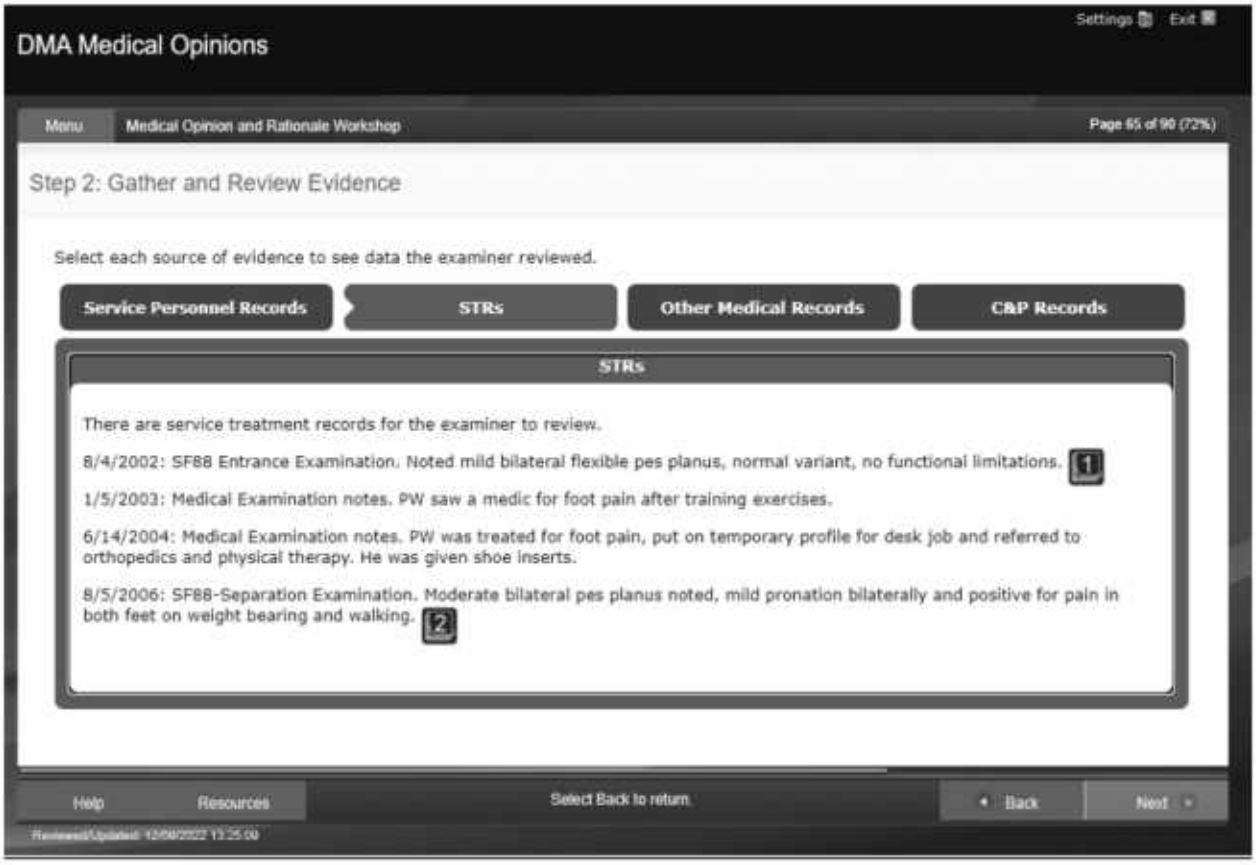
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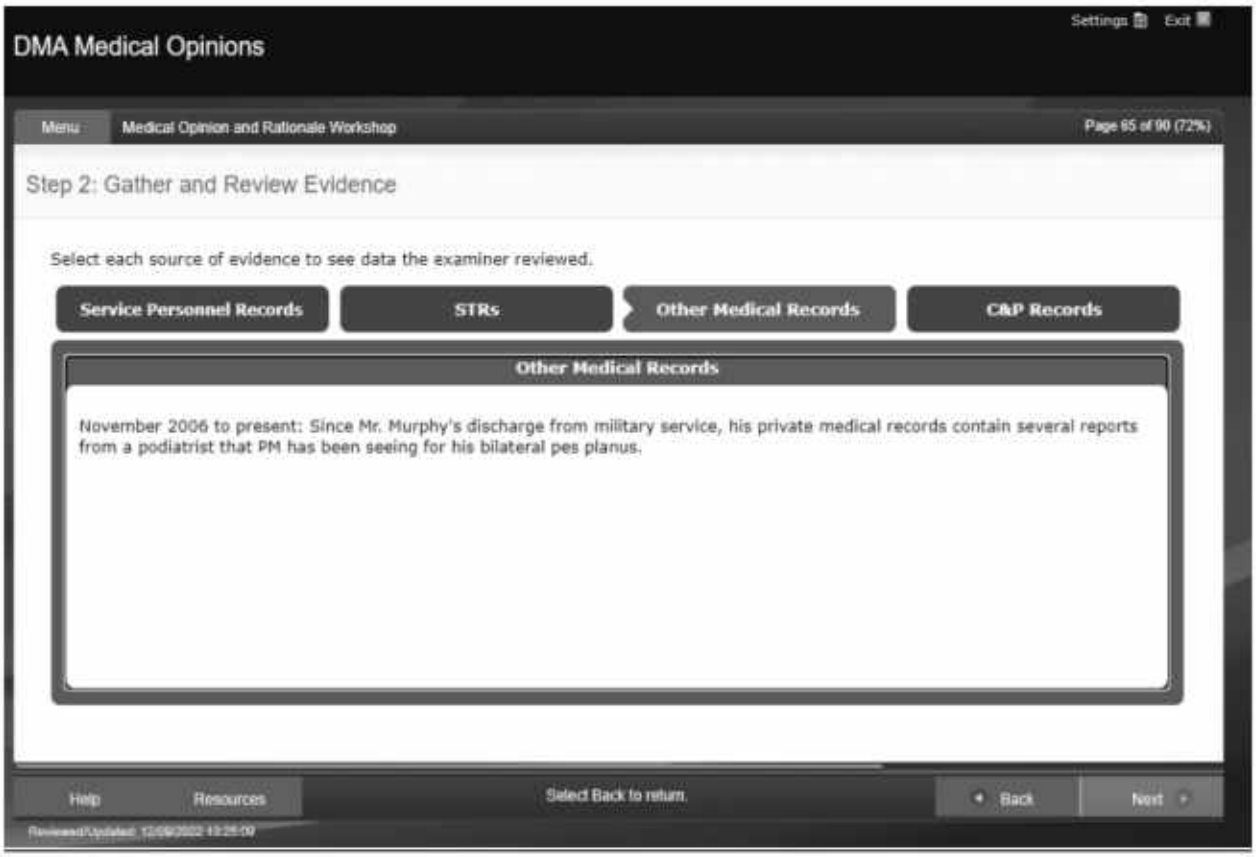
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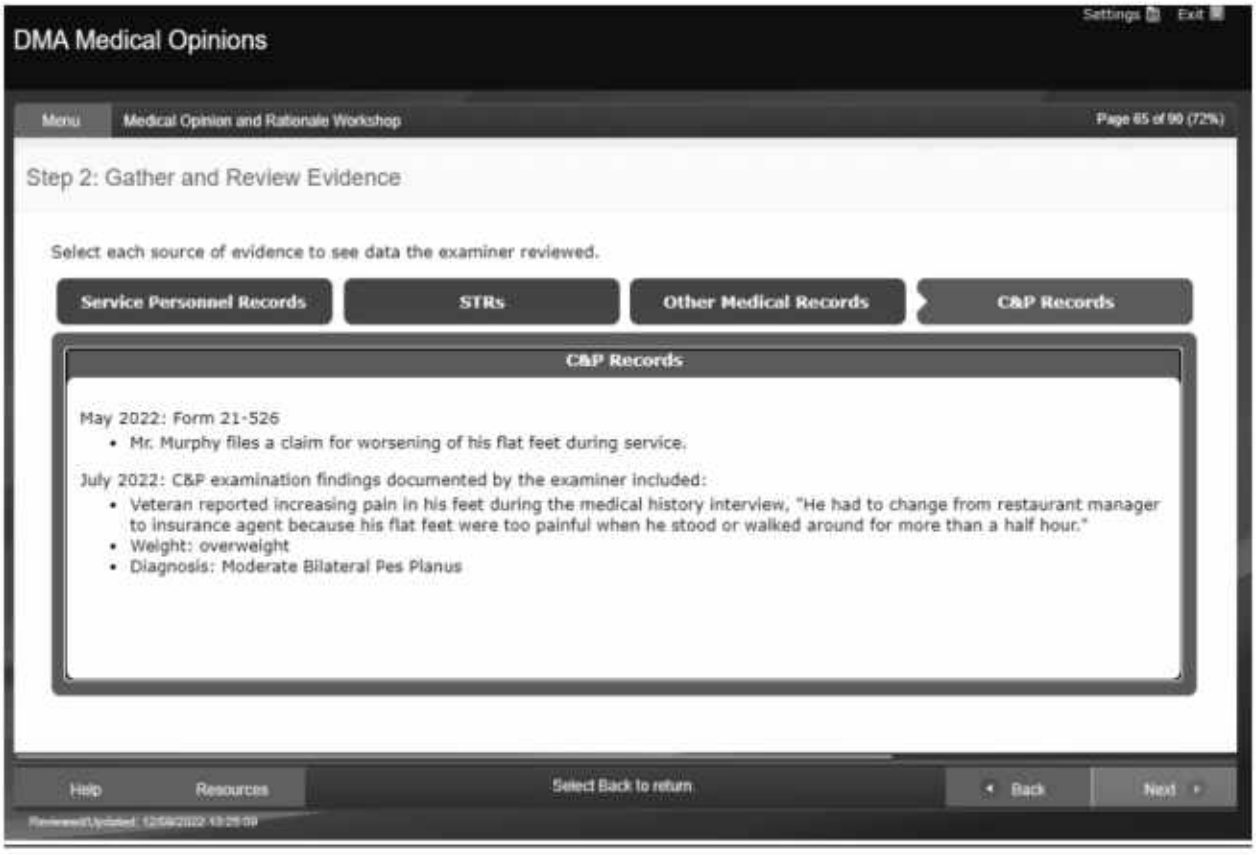

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Scenario 4: Aggravation of a Preexisting Condition
Paul Murphy, Scenario 4
Examiner, Scenario 4
Paul Murphy is a 40-year old U.S. Army Veteran who entered the service with mild pes planus in both feet. He filed a claim with VBA for worsening of his flat foot condition during service. Select each step in order to see how the C&P examiner developed the requested opinion.
Step 1: Identify Questions to Answer
Step 2: Gather and Review Evidence
Step 3: Weigh the Evidence
Step 4: Determine the Opinion
Step 5: Write the Rationale
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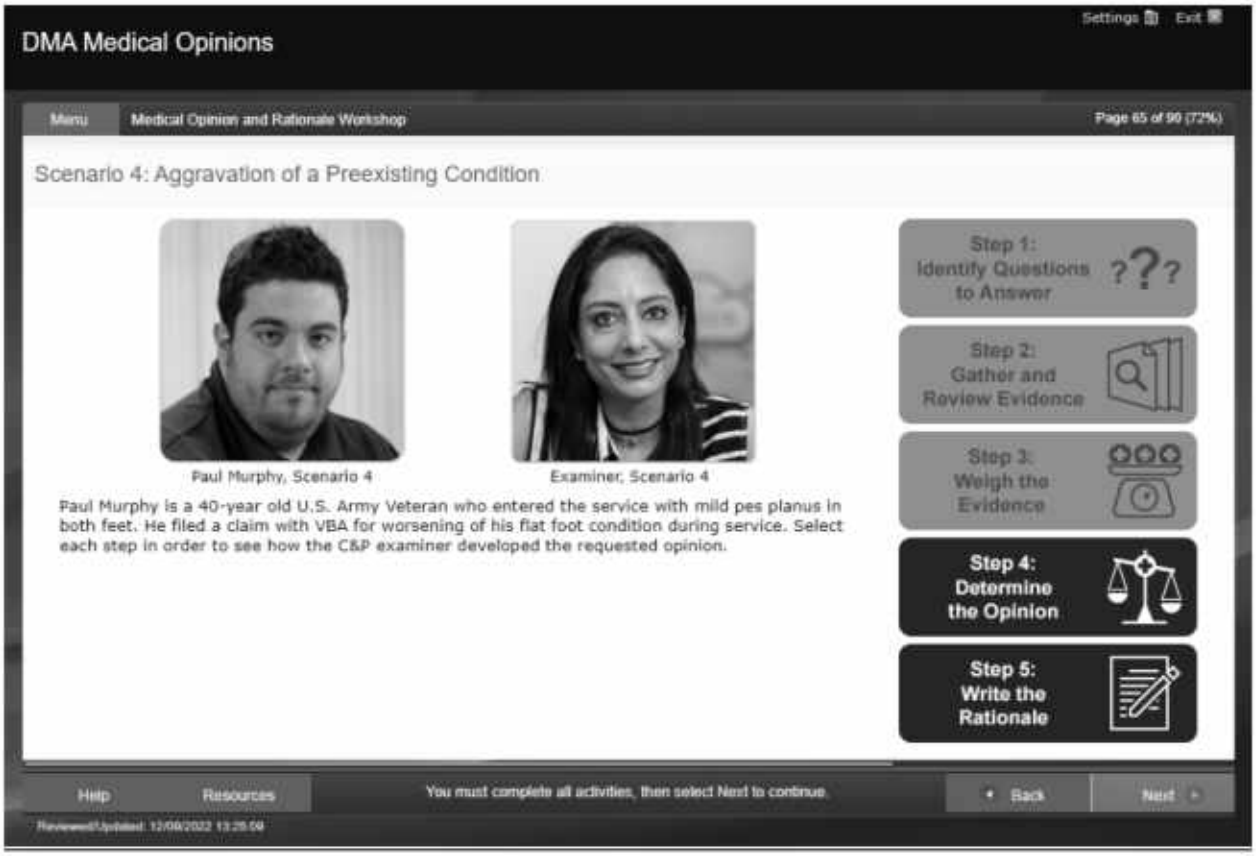

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Step 2: Gather and Review Evidence
Select each source of evidence to see data the examiner reviewed.
Service Personnel Records
STRs
Other Medical Records
C&P Records
Please make a selection
Paul Murphy, Scenario 4
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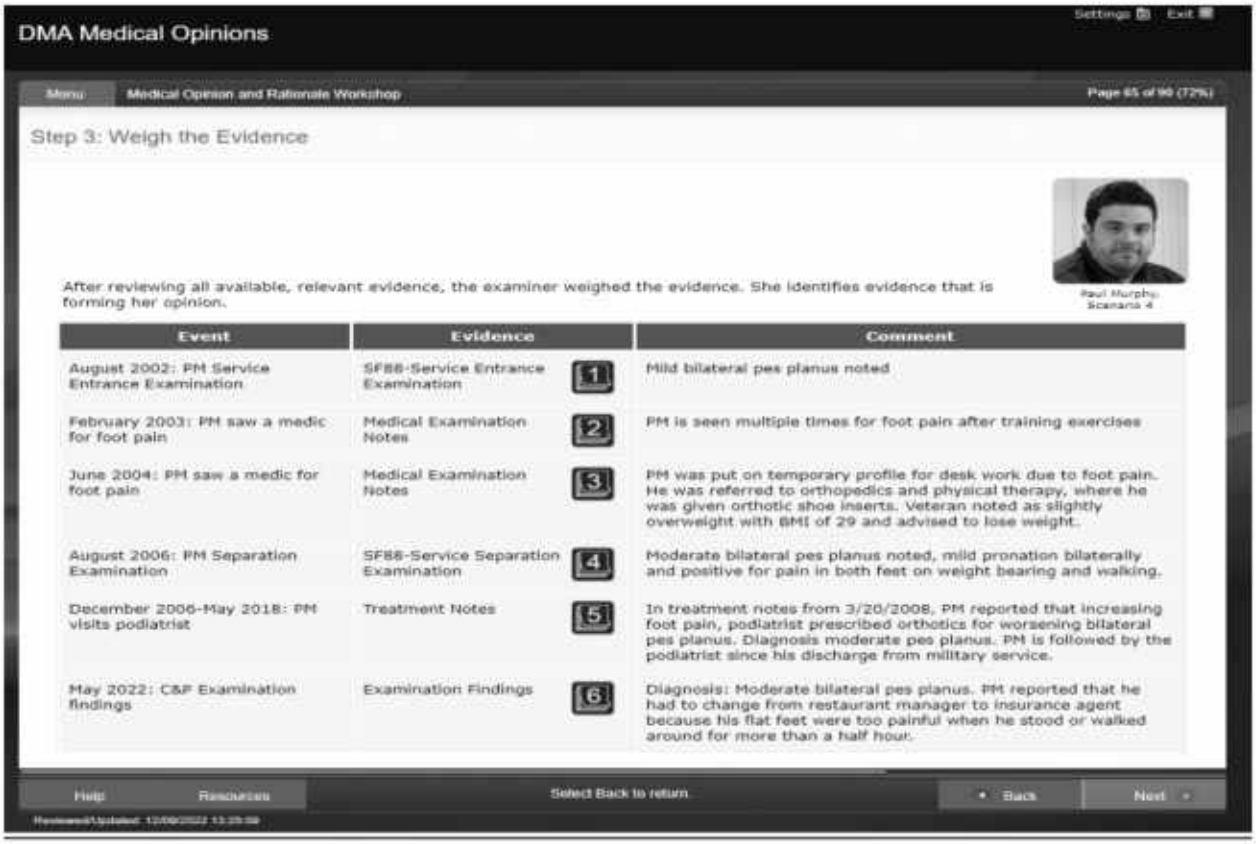

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Step 2: Gather and Review Evidence
Select each source of evidence to see data the examiner reviewed.
Service Personnel Records
STRs
Other Medical Records
C&P Records
Service Personnel Records
Mr. Murphy's service personnel records provide this information.
DD-214 Report of Discharge or Transfer:
Service dates: 08/02/2002–08/11/2006
Deployments: None
MOS: Administrative
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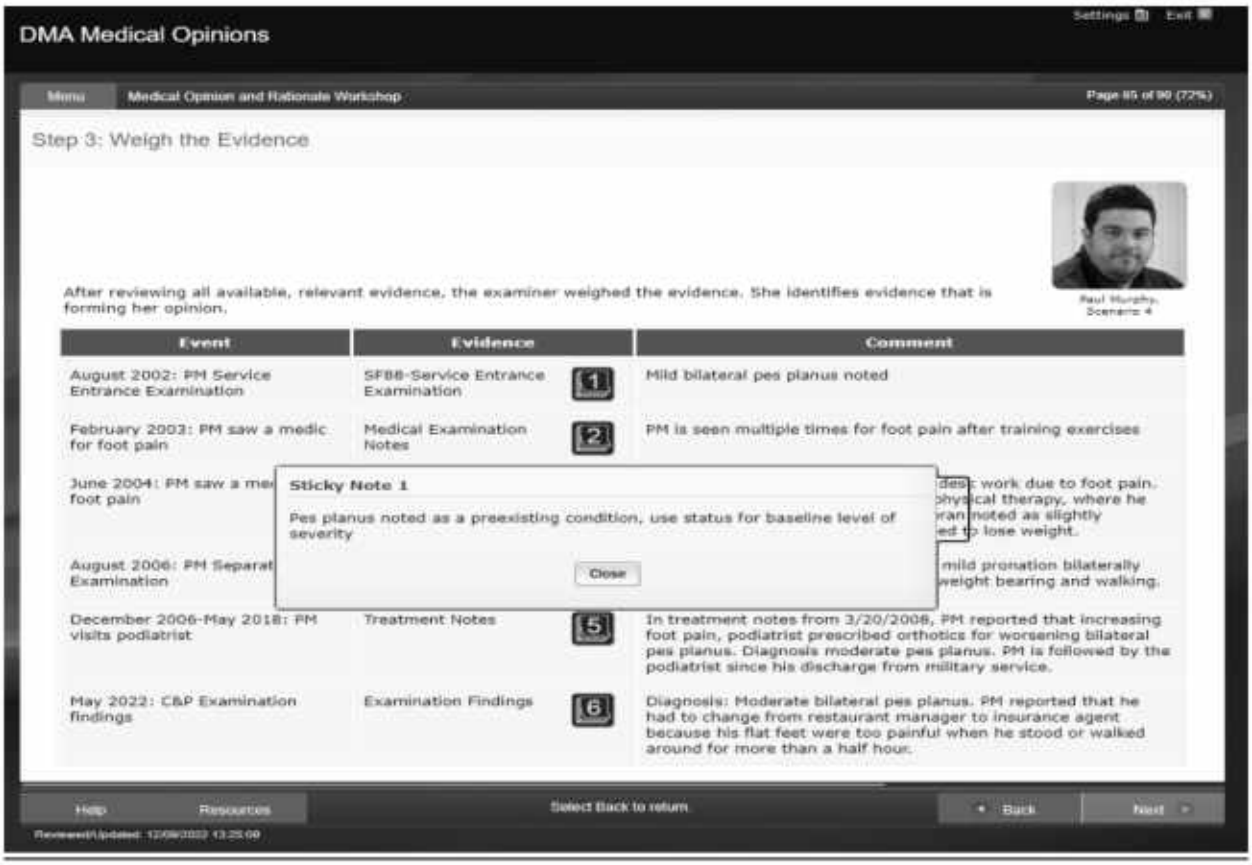

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Step 2: Gather and Review Evidence
Select each source of evidence to see data the examiner reviewed.
Service Personnel Records
STRs
Other Medical Records
C&P Records
STRs
There are service treatment records for the examiner to review.
8/4/2002: SF88 Entrance Examination. Noted mild bilateral flexible pes planus, normal variant, no functional limitations.
1/5/2003: Medical Examination notes. PW saw a medic for foot pain after training exercises.
6/14/2004: Medical Examination notes. PW was treated for foot pain, put on temporary profile for desk job and referred to orthopedics and physical therapy. He was given shoe inserts.
8/5/2006: SF88-Separation Examination. Moderate bilateral pes planus noted, mild pronation bilaterally and positive for pain in both feet on weight bearing and walking.
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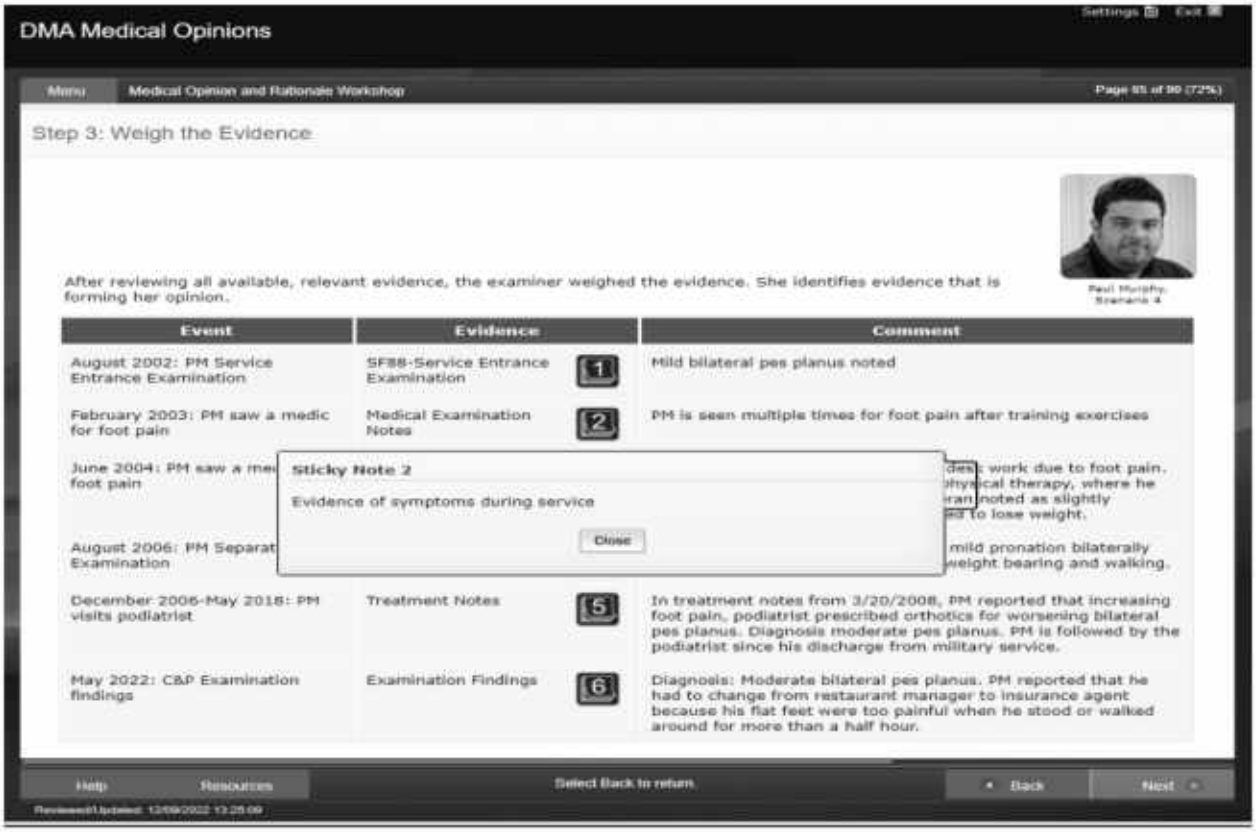

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Step 2: Gather and Review Evidence
Select each source of evidence to see data the examiner reviewed.
Service Personnel Records
STRs
Other Medical Records
C&P Records
Other Medical Records
November 2006 to present: Since Mr. Murphy's discharge from military service, his private medical records contain several reports from a podiatrist that PM has been seeing for his bilateral pes planus.
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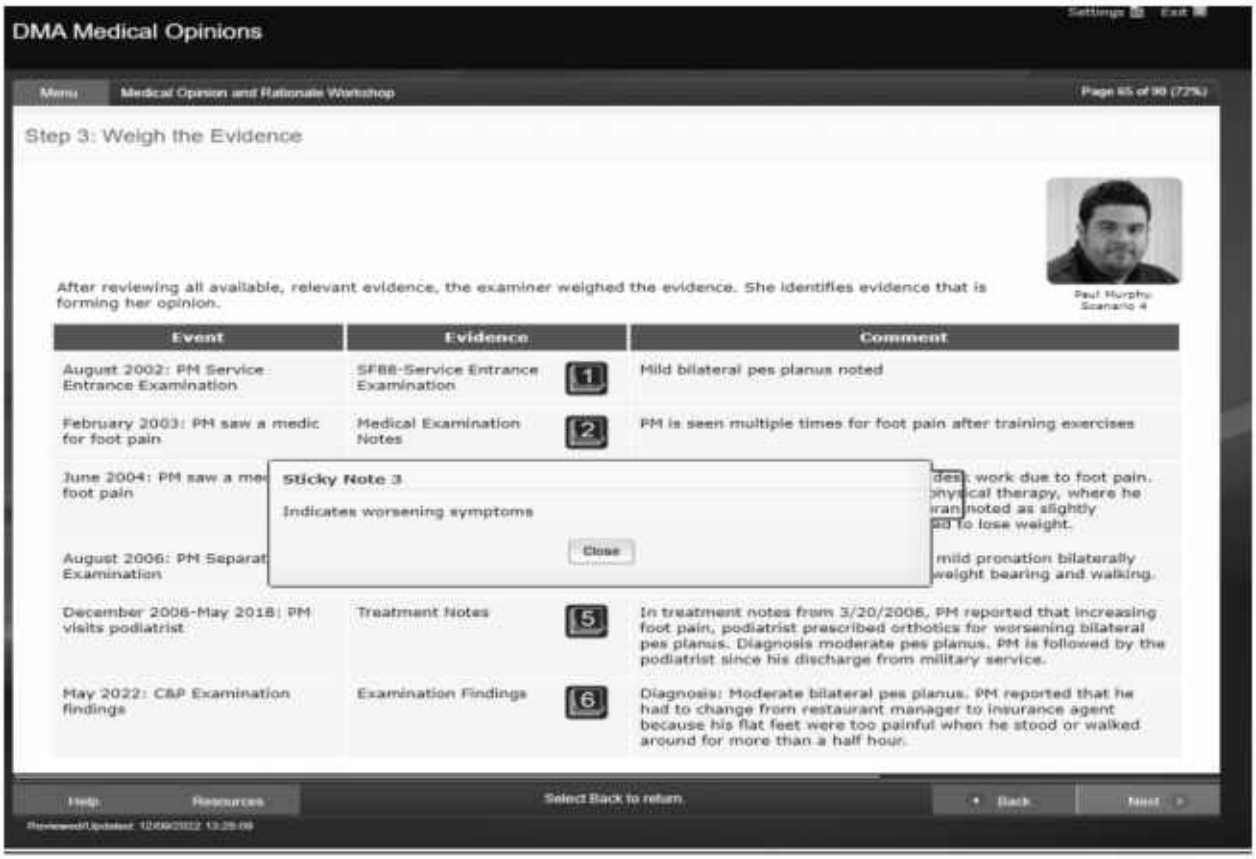

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Step 2: Gather and Review Evidence
Select each source of evidence to see data the examiner reviewed.
Service Personnel Records
STRs
Other Medical Records
C&P Records
C&P Records
May 2022: Form 21-526
• Mr. Murphy files a claim for worsening of his flat feet during service.
July 2022: C&P examination findings documented by the examiner included:
• Veteran reported increasing pain in his feet during the medical history interview, "He had to change from restaurant manager to insurance agent because his flat feet were too painful when he stood or walked around for more than a half hour."
• Weight: overweight
• Diagnosis: Moderate Bilateral Pes Planus
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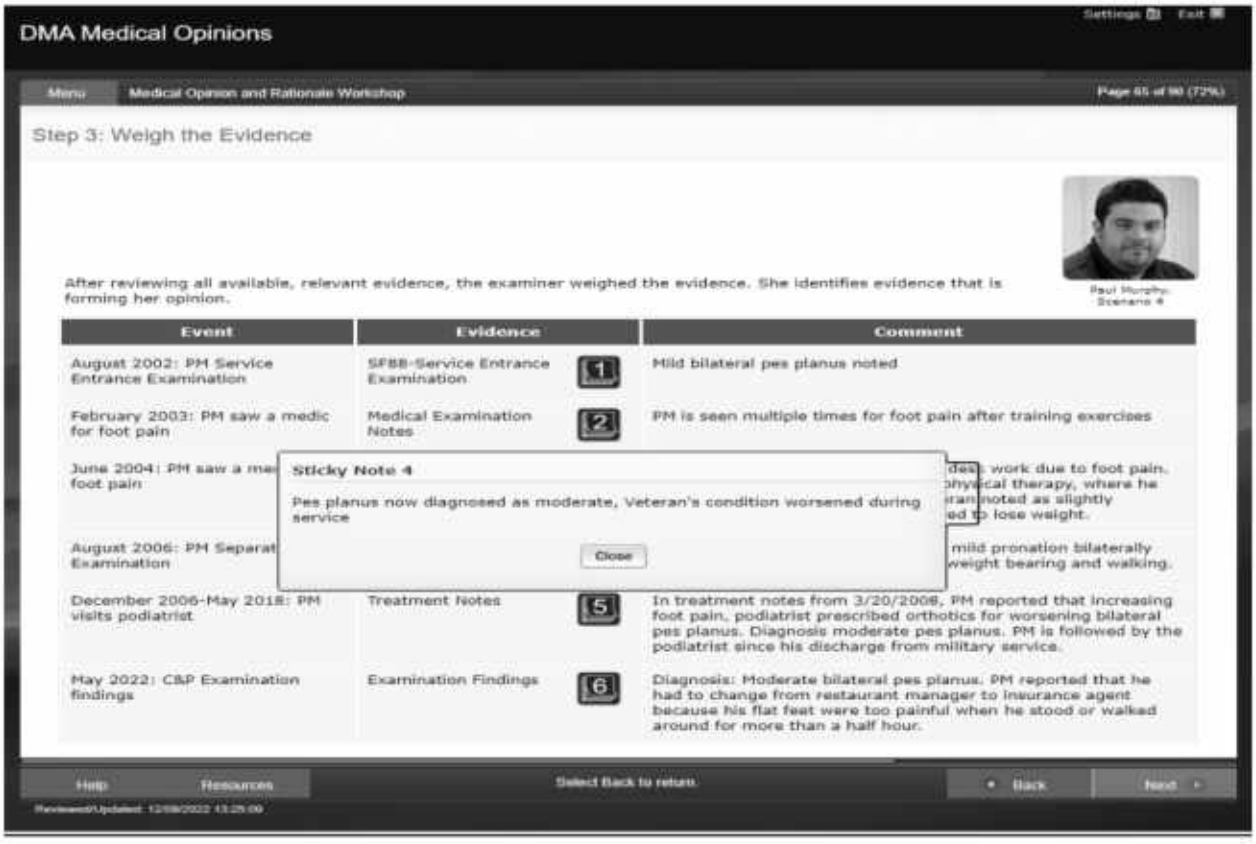

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Scenario 4: Aggravation of a Preexisting Condition
Paul Murphy, Scenario 4
Examiner, Scenario 4
Paul Murphy is a 40-year old U.S. Army Veteran who entered the service with mild pes planus in both feet. He filed a claim with VBA for worsening of his flat foot condition during service. Select each step in order to see how the C&P examiner developed the requested opinion.
Step 1: Identify Questions to Answer
Step 2: Gather and Review Evidence
Step 3: Weigh the Evidence
Step 4: Determine the Opinion
Step 5: Write the Rationale
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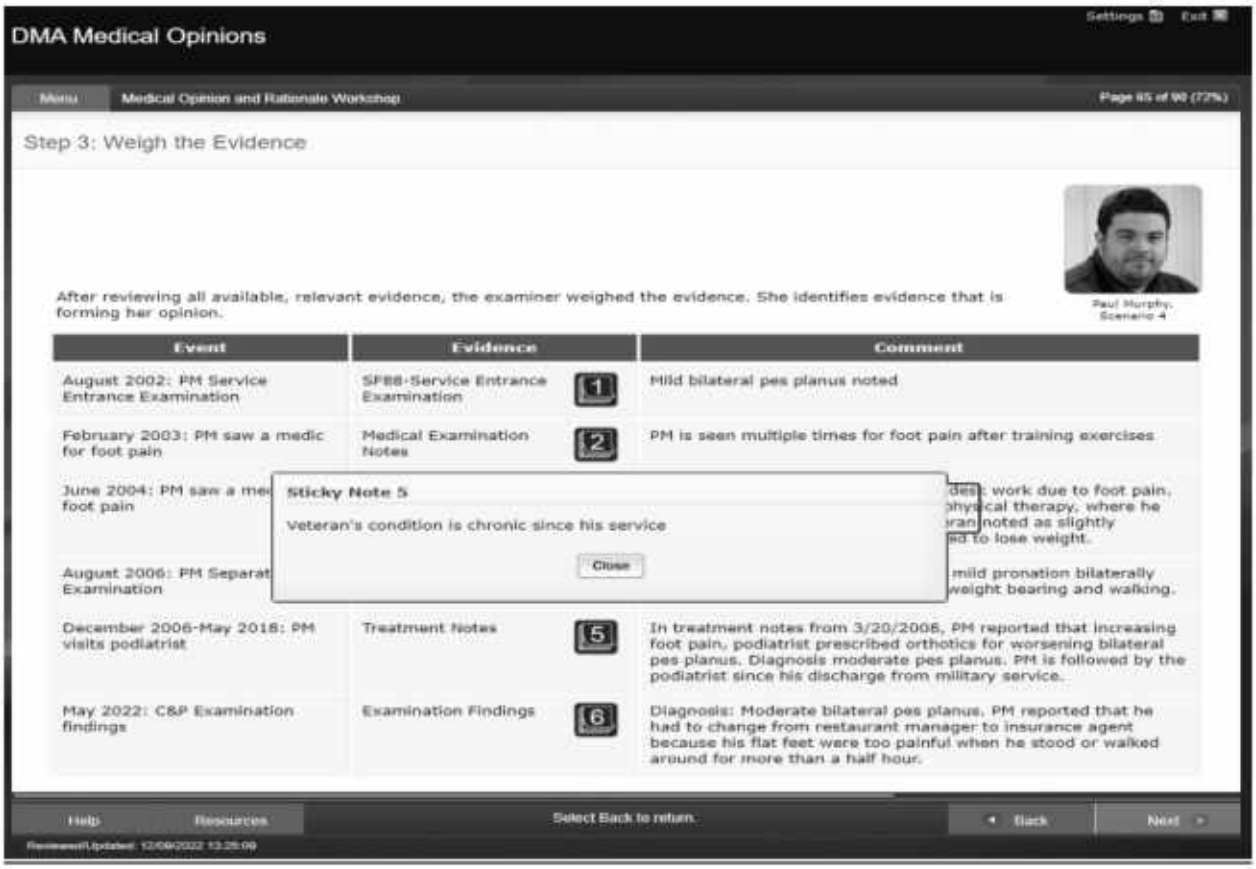

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Step 3: Weigh the Evidence
Paul Murphy, Scenario 4
After reviewing all available, relevant evidence, the examiner weighed the evidence. She identifies evidence that is forming her opinion.
Event
Evidence
Comment
August 2002: PM Service Entrance Examination
SF88-Service Entrance Examination
1
Mild bilateral pes planus noted
February 2003: PM saw a medic for foot pain
Medical Examination Notes
2
PM is seen multiple times for foot pain after training exercises
June 2004: PM saw a medic for foot pain
Medical Examination Notes
3
PM was put on temporary profile for desk work due to foot pain. He was referred to orthopedics and physical therapy, where he was given orthotic shoe inserts. Veteran noted as slightly overweight with BMI of 29 and advised to lose weight.
August 2006: PM Separation Examination
SF88-Service Separation Examination
4
Moderate bilateral pes planus noted, mild pronation bilaterally and positive for pain in both feet on weight bearing and walking.
December 2006-May 2018: PM visits podiatrist
Treatment Notes
5
In treatment notes from 3/20/2008, PM reported that increasing foot pain, podiatrist prescribed orthotics for worsening bilateral pes planus. Diagnosis moderate pes planus. PM is followed by the podiatrist since his discharge from military service.
May 2022: C&P Examination findings
Examination Findings
6
Diagnosis: Moderate bilateral pes planus. PM reported that he had to change from restaurant manager to insurance agent because his flat feet were too painful when he stood or walked around for more than a half hour.
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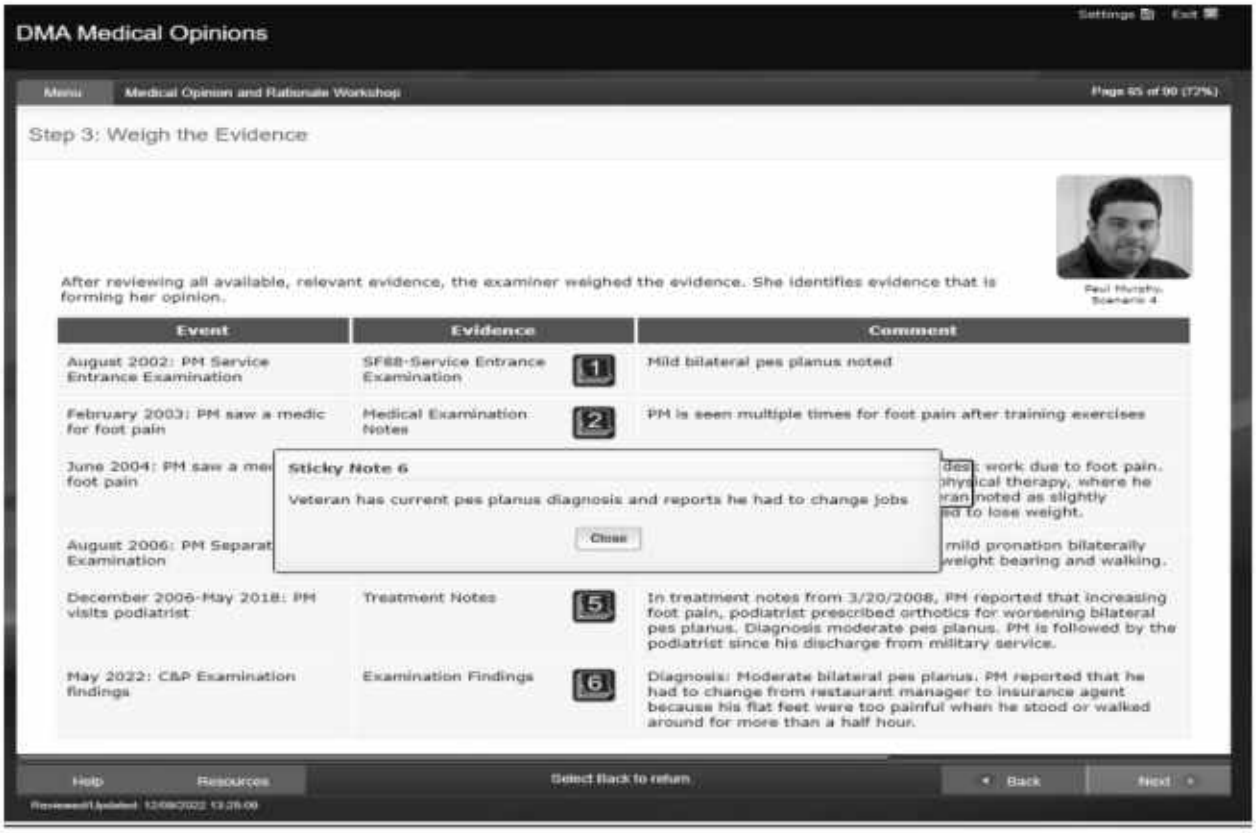

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Step 3: Weigh the Evidence
Paul Murphy, Scenario 4
After reviewing all available, relevant evidence, the examiner weighed the evidence. She identifies evidence that is forming her opinion.
Event
Evidence
Comment
August 2002: PM Service Entrance Examination
SF88-Service Entrance Examination
1
Mild bilateral pes planus noted
February 2003: PM saw a medic for foot pain
Medical Examination Notes
2
PM is seen multiple times for foot pain after training exercises
June 2004: PM saw a me
foot pain
Sticky Note 1
Pes planus noted as a preexisting condition, use status for baseline level of severity
Close
work due to foot pain.
physical therapy, where he
ran noted as slightly
ed to lose weight.
August 2006: PM Separat
Examination
mild pronation bilaterally
weight bearing and walking.
December 2006-May 2018: PM visits podiatrist
Treatment Notes
5
In treatment notes from 3/20/2008, PM reported that increasing foot pain, podiatrist prescribed orthotics for worsening bilateral pes planus. Diagnosis moderate pes planus. PM is followed by the podiatrist since his discharge from military service.
May 2022: C&P Examination findings
Examination Findings
6
Diagnosis: Moderate bilateral pes planus. PM reported that he had to change from restaurant manager to insurance agent because his flat feet were too painful when he stood or walked around for more than a half hour.
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Step 3: Weigh the Evidence
Paul Murphy, Scenario 4
After reviewing all available, relevant evidence, the examiner weighed the evidence. She identifies evidence that is forming her opinion.
Event
Evidence
Comment
August 2002: PM Service Entrance Examination
SF88-Service Entrance Examination
1
Mild bilateral pes planus noted
February 2003: PM saw a medic for foot pain
Medical Examination Notes
2
PM is seen multiple times for foot pain after training exercises
June 2004: PM saw a me
foot pain
Sticky Note 2
Evidence of symptoms during service
Close
work due to foot pain.
physical therapy, where he
ran noted as slightly
ed to lose weight.
August 2006: PM Separat
Examination
mild pronation bilaterally
weight bearing and walking.
December 2006-May 2018: PM visits podiatrist
Treatment Notes
5
In treatment notes from 3/20/2008, PM reported that increasing foot pain, podiatrist prescribed orthotics for worsening bilateral pes planus. Diagnosis moderate pes planus. PM is followed by the podiatrist since his discharge from military service.
May 2022: C&P Examination findings
Examination Findings
6
Diagnosis: Moderate bilateral pes planus. PM reported that he had to change from restaurant manager to insurance agent because his flat feet were too painful when he stood or walked around for more than a half hour.
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Step 3: Weigh the Evidence
Paul Murphy
Scenario 4
After reviewing all available, relevant evidence, the examiner weighed the evidence. She identifies evidence that is forming her opinion.
Event
Evidence
Comment
August 2002: PM Service Entrance Examination
SF88-Service Entrance Examination
1
Mild bilateral pes planus noted
February 2003: PM saw a medic for foot pain
Medical Examination Notes
2
PM is seen multiple times for foot pain after training exercises
June 2004: PM saw a me
foot pain
Sticky Note 3
Indicates worsening symptoms
Close
work due to foot pain.
ysical therapy, where he
noted as slightly
to lose weight.
August 2006: PM Separat
Examination
mild pronation bilaterally
weight bearing and walking.
December 2006-May 2018: PM visits podiatrist
Treatment Notes
5
In treatment notes from 3/20/2006, PM reported that increasing foot pain, podiatrist prescribed orthotics for worsening bilateral pes planus. Diagnosis moderate pes planus. PM is followed by the podiatrist since his discharge from military service.
May 2022: C&P Examination findings
Examination Findings
6
Diagnosis: Moderate bilateral pes planus. PM reported that he had to change from restaurant manager to insurance agent because his flat feet were too painful when he stood or walked around for more than a half hour.
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Step 3: Weigh the Evidence
Paul Murphy
Scenario 4
After reviewing all available, relevant evidence, the examiner weighed the evidence. She identifies evidence that is forming her opinion.
Event
Evidence
Comment
August 2002: PM Service Entrance Examination
SF88-Service Entrance Examination
1
Mild bilateral pes planus noted
February 2003: PM saw a medic for foot pain
Medical Examination Notes
2
PM is seen multiple times for foot pain after training exercises
June 2004: PM saw a me
foot pain
Sticky Note 4
Pes planus now diagnosed as moderate, Veteran's condition worsened during service
Close
work due to foot pain.
ysical therapy, where he
noted as slightly
to lose weight.
August 2006: PM Separat
Examination
mild pronation bilaterally
weight bearing and walking.
December 2006-May 2018: PM visits podiatrist
Treatment Notes
5
In treatment notes from 3/20/2006, PM reported that increasing foot pain, podiatrist prescribed orthotics for worsening bilateral pes planus. Diagnosis moderate pes planus. PM is followed by the podiatrist since his discharge from military service.
May 2022: C&P Examination findings
Examination Findings
6
Diagnosis: Moderate bilateral pes planus. PM reported that he had to change from restaurant manager to insurance agent because his flat feet were too painful when he stood or walked around for more than a half hour.
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Step 3: Weigh the Evidence
Paul Murphy, Scenario 4
After reviewing all available, relevant evidence, the examiner weighed the evidence. She identifies evidence that is forming her opinion.
Event
Evidence
Comment
August 2002: PM Service Entrance Examination
SF88-Service Entrance Examination
1
Mild bilateral pes planus noted
February 2003: PM saw a medic for foot pain
Medical Examination Notes
2
PM is seen multiple times for foot pain after training exercises
June 2004: PM saw a me
foot pain
Sticky Note 5
Veteran's condition is chronic since his service
Close
work due to foot pain.
hysical therapy, where he
ran noted as slightly
ed to lose weight.
August 2006: PM Separat
Examination
mild pronation bilaterally
weight bearing and walking.
December 2006-May 2018: PM visits podiatrist
Treatment Notes
5
In treatment notes from 3/20/2008, PM reported that increasing foot pain, podiatrist prescribed orthotics for worsening bilateral pes planus. Diagnosis moderate pes planus. PM is followed by the podiatrist since his discharge from military service.
May 2022: C&P Examination findings
Examination Findings
6
Diagnosis: Moderate bilateral pes planus. PM reported that he had to change from restaurant manager to insurance agent because his flat feet were too painful when he stood or walked around for more than a half hour.
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Step 3: Weigh the Evidence
Paul Murphy, Scenario 4
After reviewing all available, relevant evidence, the examiner weighed the evidence. She identifies evidence that is forming her opinion.
Event
Evidence
Comment
August 2002: PM Service Entrance Examination
SF88-Service Entrance Examination
1
Mild bilateral pes planus noted
February 2003: PM saw a medic for foot pain
Medical Examination Notes
2
PM is seen multiple times for foot pain after training exercises
June 2004: PM saw a me
foot pain
Sticky Note 6
Veteran has current pes planus diagnosis and reports he had to change jobs
Close
work due to foot pain.
hysical therapy, where he
ran noted as slightly
ed to lose weight.
August 2006: PM Separat
Examination
mild pronation bilaterally
weight bearing and walking.
December 2006-May 2018: PM visits podiatrist
Treatment Notes
5
In treatment notes from 3/20/2008, PM reported that increasing foot pain, podiatrist prescribed orthotics for worsening bilateral pes planus. Diagnosis moderate pes planus. PM is followed by the podiatrist since his discharge from military service.
May 2022: C&P Examination findings
Examination Findings
6
Diagnosis: Moderate bilateral pes planus. PM reported that he had to change from restaurant manager to insurance agent because his flat feet were too painful when he stood or walked around for more than a half hour.
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Scenario 4: Aggravation of a Preexisting Condition



Paul Murphy, Scenario 4



Examiner, Scenario 4

Paul Murphy is a 40-year old U.S. Army Veteran who entered the service with mild pes planus in both feet. He filed a claim with VBA for worsening of his flat foot condition during service. Select each step in order to see how the C&P examiner developed the requested opinion.

- Step 1: Identify Questions to Answer
- Step 2: Gather and Review Evidence
- Step 3: Weigh the Evidence
- Step 4: Determine the Opinion
- **Step 5: Write the Rationale**

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Step 4: Determine the Medical Opinion

Requested opinion:

Was Veteran's bilateral pes planus permanently aggravated beyond the natural progression by his active military service?

The examiner determined that the evidence was positive for aggravation of Mr. Murphy's claimed flat feet. She recorded her opinion on the Medical Opinion DBQ.

> The Veteran's pes planus, which clearly and unmistakably existed prior to service, was as likely as not aggravated beyond its natural progression due to his military service.



Paul Murphy, Scenario 4

The Examiner's Considerations

The answers to questions the examiner asked when she reviewed the examination request served as building blocks for her opinion. You may have been answering similar questions as the examiner did. Select each question to compare your answer to hers.

What is the baseline level of severity for the Veteran's bilateral pes planus?

Is there medical evidence that it worsened during service?

Did the Service Separation Examination note any worsening of the pes planus?

If it worsened, how did the extent of worsening compare to natural progression?

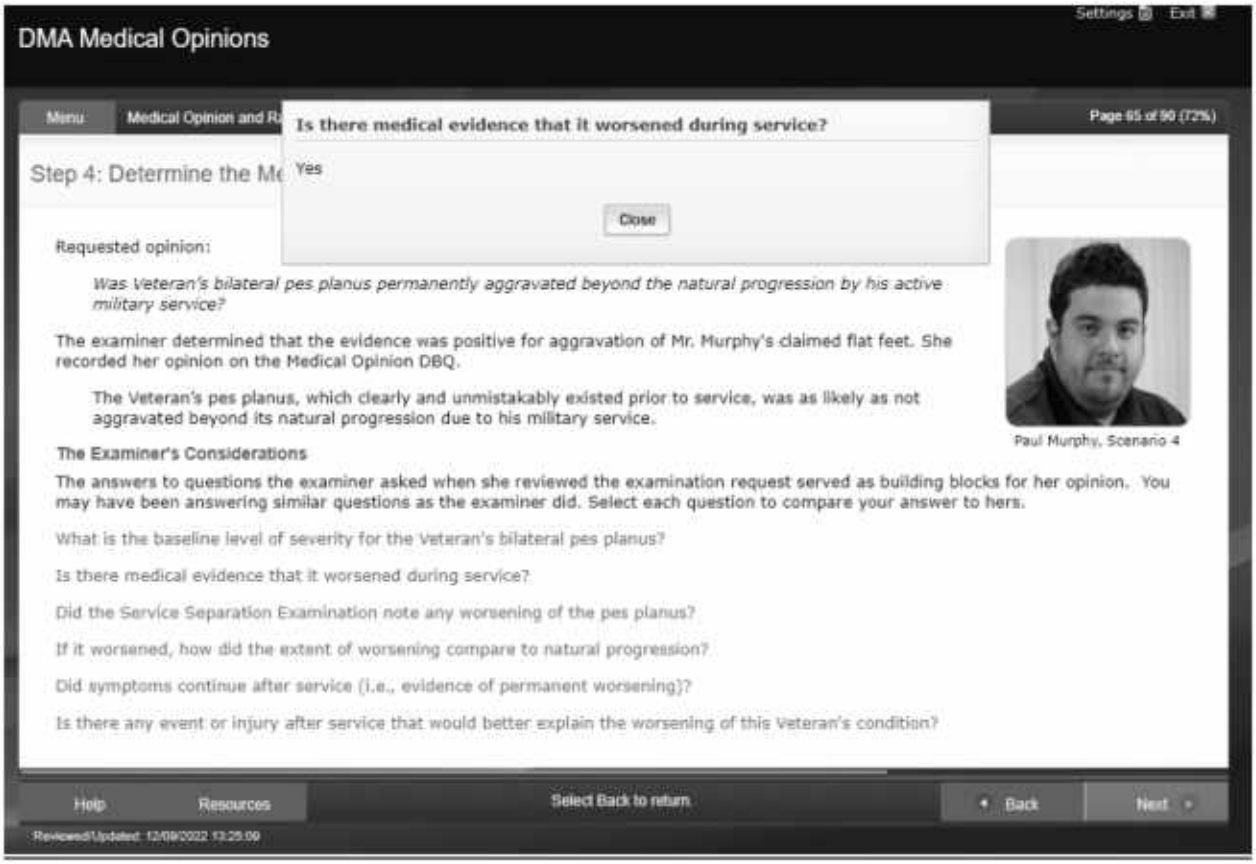
Did symptoms continue after service (i.e., evidence of permanent worsening)?

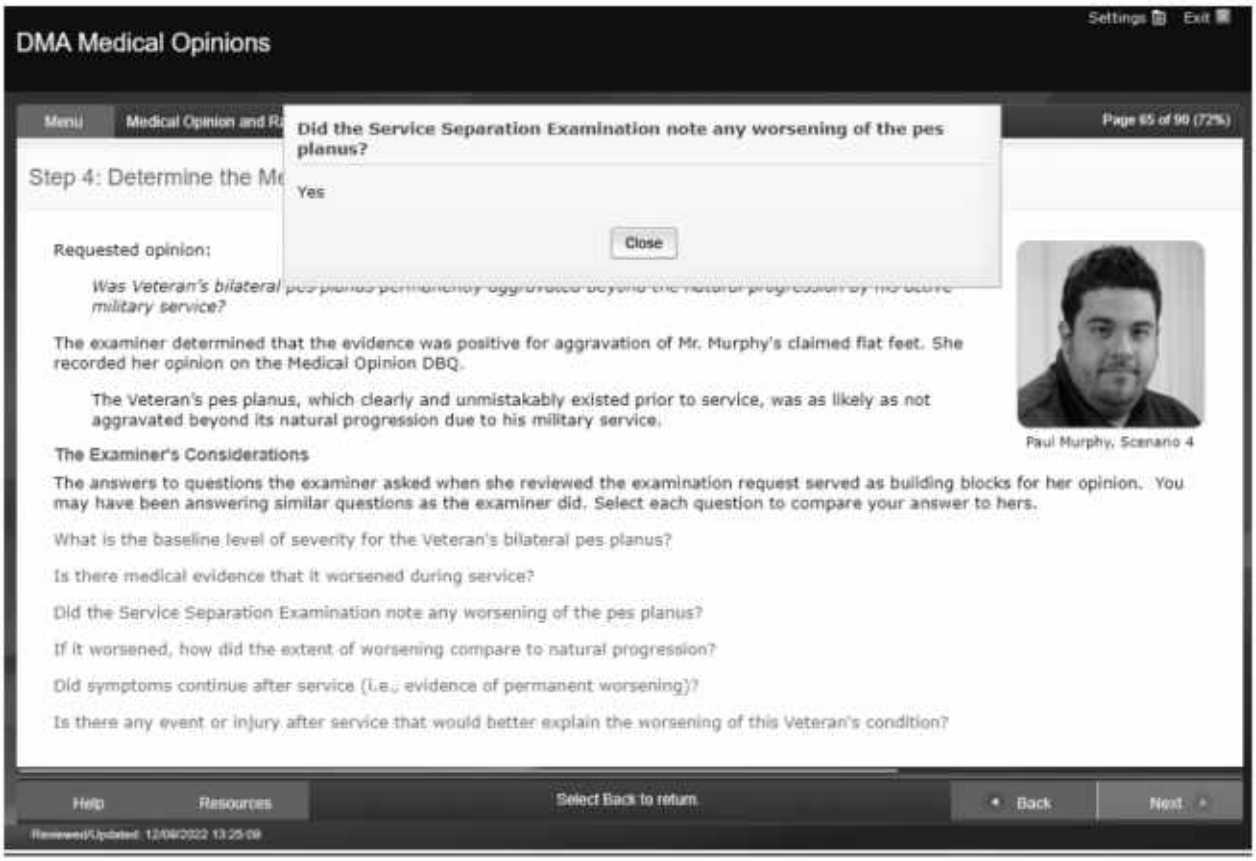
Is there any event or injury after service that would better explain the worsening of this Veteran's condition?

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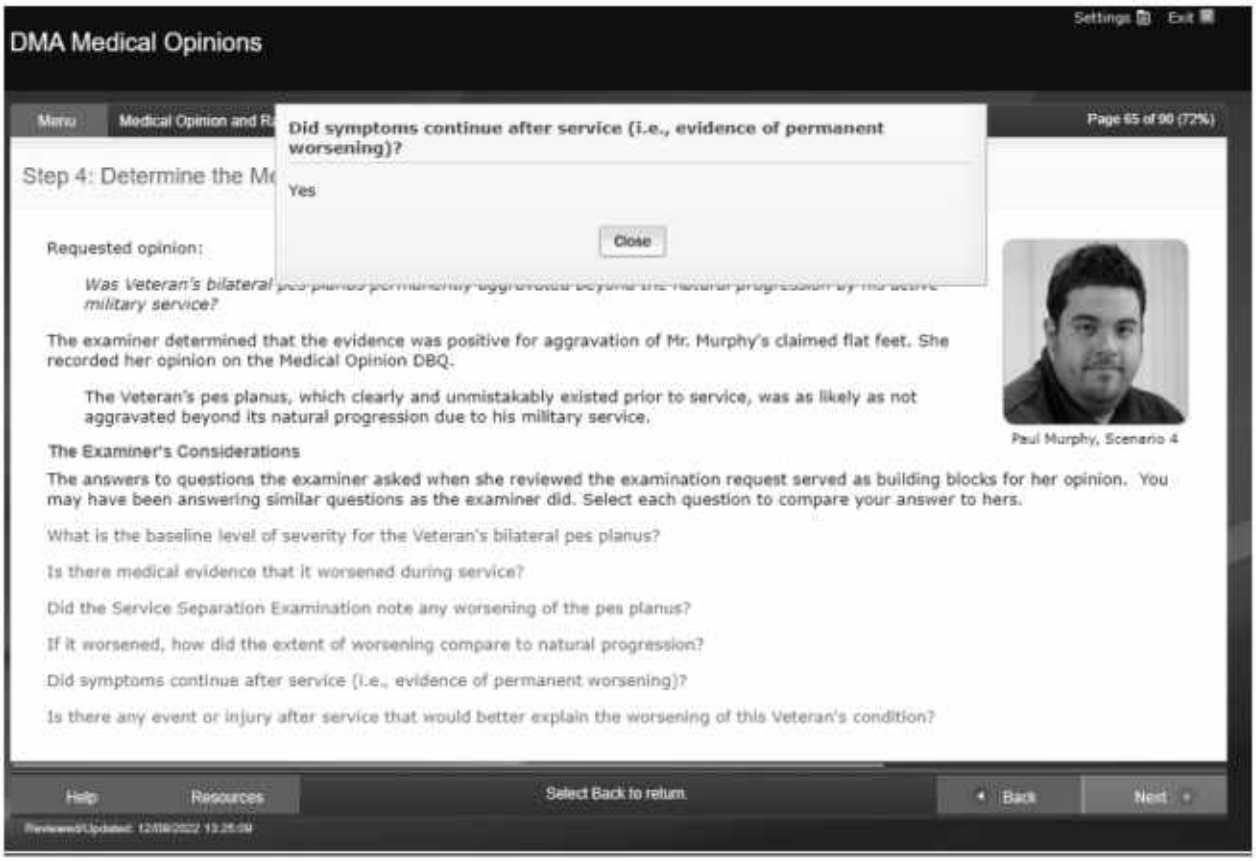
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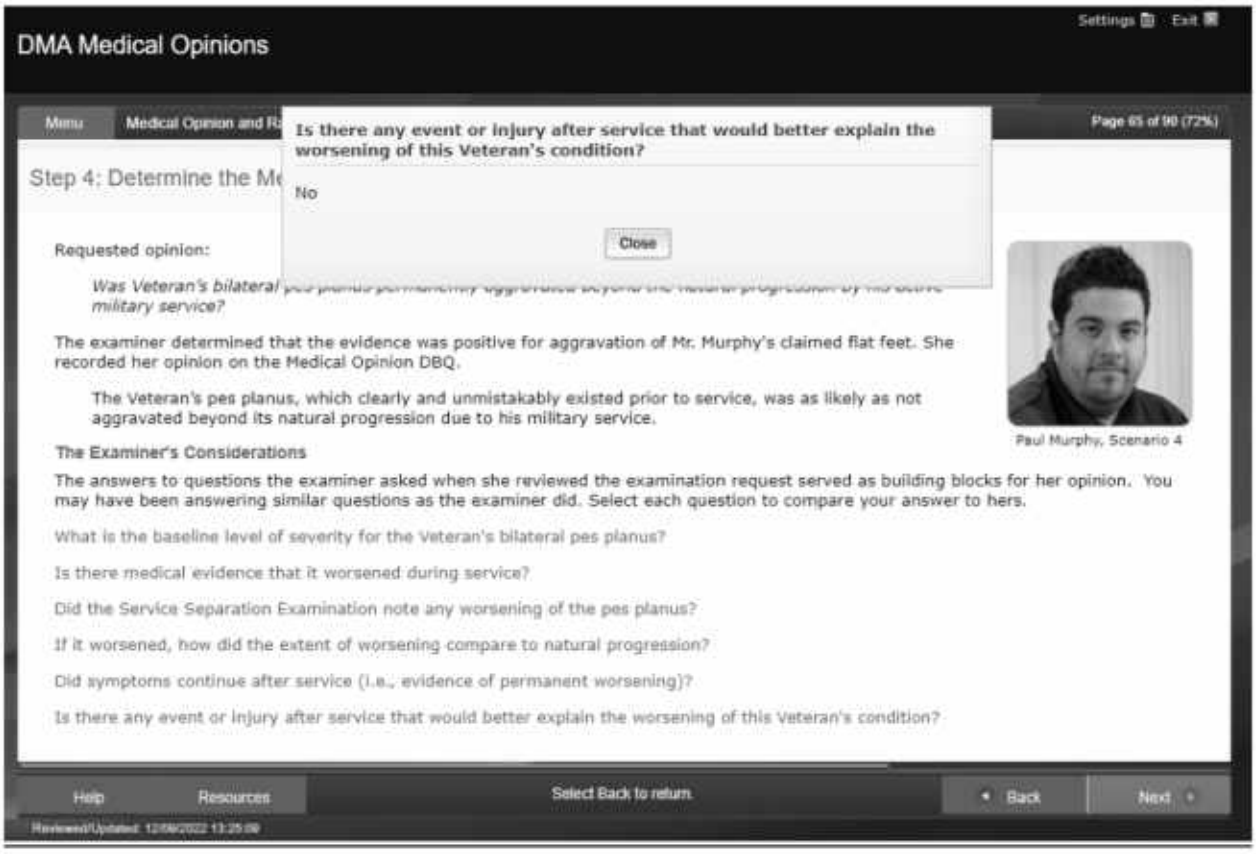

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What is the baseline level of severity for the Veteran's bilateral pes planus?
Mild bilateral flexible pes planus, normal variant, no functional limitations
Close
Step 4: Determine the Me
Requested opinion:
Was Veteran's bilateral pes planus permanently aggravated beyond the natural progression by his active military service?
The examiner determined that the evidence was positive for aggravation of Mr. Murphy's claimed flat feet. She recorded her opinion on the Medical Opinion DBQ.
The Veteran's pes planus, which clearly and unmistakably existed prior to service, was as likely as not aggravated beyond its natural progression due to his military service.
Paul Murphy, Scenario 4
The Examiner's Considerations
The answers to questions the examiner asked when she reviewed the examination request served as building blocks for her opinion. You may have been answering similar questions as the examiner did. Select each question to compare your answer to hers.
What is the baseline level of severity for the Veteran's bilateral pes planus?
Is there medical evidence that it worsened during service?
Did the Service Separation Examination note any worsening of the pes planus?
If it worsened, how did the extent of worsening compare to natural progression?
Did symptoms continue after service (i.e., evidence of permanent worsening)?
Is there any event or injury after service that would better explain the worsening of this Veteran's condition?
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Is there medical evidence that it worsened during service?
Yes
Close
Step 4: Determine the Me
Requested opinion:
Was Veteran's bilateral pes planus permanently aggravated beyond the natural progression by his active military service?
The examiner determined that the evidence was positive for aggravation of Mr. Murphy's claimed flat feet. She recorded her opinion on the Medical Opinion DBQ.
The Veteran's pes planus, which clearly and unmistakably existed prior to service, was as likely as not aggravated beyond its natural progression due to his military service.
Paul Murphy, Scenario 4
The Examiner's Considerations
The answers to questions the examiner asked when she reviewed the examination request served as building blocks for her opinion. You may have been answering similar questions as the examiner did. Select each question to compare your answer to hers.
What is the baseline level of severity for the Veteran's bilateral pes planus?
Is there medical evidence that it worsened during service?
Did the Service Separation Examination note any worsening of the pes planus?
If it worsened, how did the extent of worsening compare to natural progression?
Did symptoms continue after service (i.e., evidence of permanent worsening)?
Is there any event or injury after service that would better explain the worsening of this Veteran's condition?
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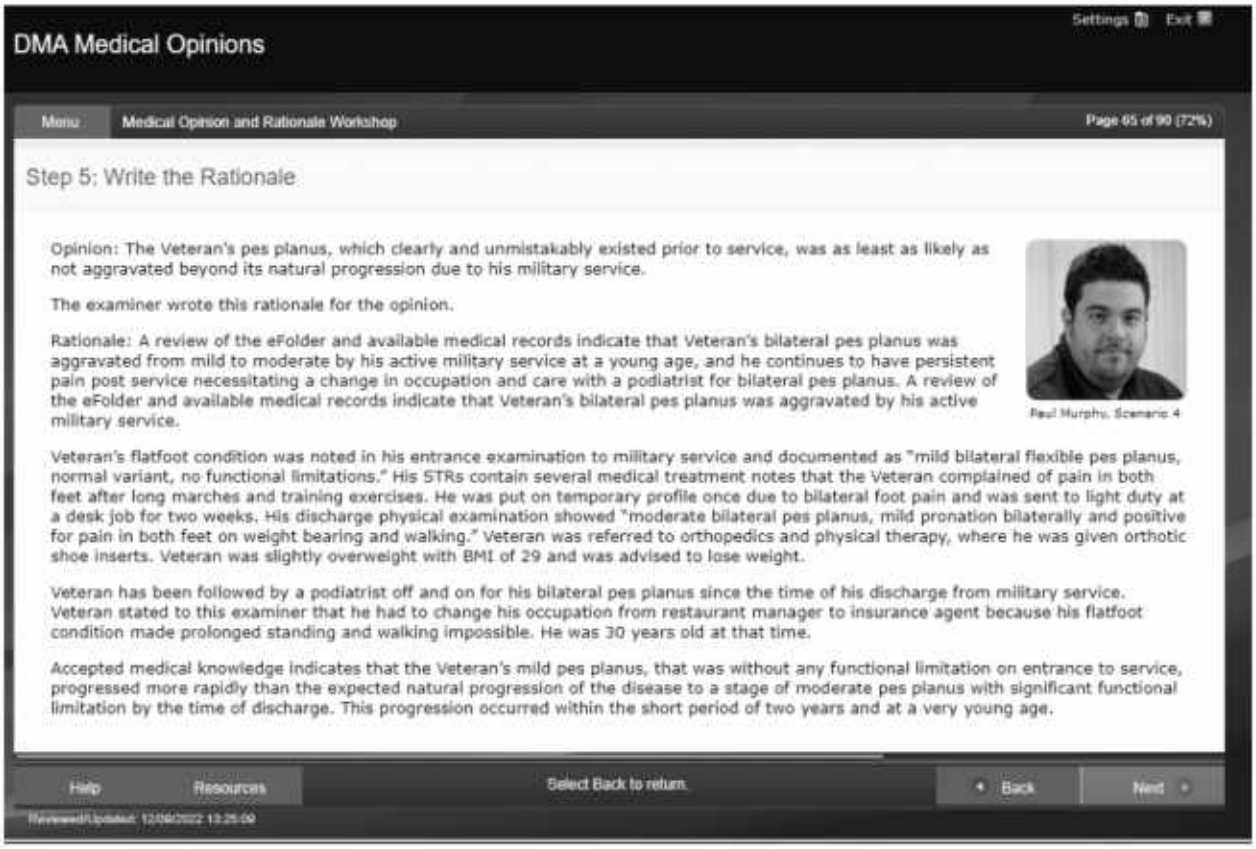

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Did the Service Separation Examination note any worsening of the pes planus?
Yes
Close
Step 4: Determine the Me
Requested opinion:
Was Veteran's bilateral
military service?
The examiner determined that the evidence was positive for aggravation of Mr. Murphy's claimed flat feet. She recorded her opinion on the Medical Opinion DBQ.
The Veteran's pes planus, which clearly and unmistakably existed prior to service, was as likely as not aggravated beyond its natural progression due to his military service.
Paul Murphy, Scenario 4
The Examiner's Considerations
The answers to questions the examiner asked when she reviewed the examination request served as building blocks for her opinion. You may have been answering similar questions as the examiner did. Select each question to compare your answer to hers.
What is the baseline level of severity for the Veteran's bilateral pes planus?
Is there medical evidence that it worsened during service?
Did the Service Separation Examination note any worsening of the pes planus?
If it worsened, how did the extent of worsening compare to natural progression?
Did symptoms continue after service (i.e., evidence of permanent worsening)?
Is there any event or injury after service that would better explain the worsening of this Veteran's condition?
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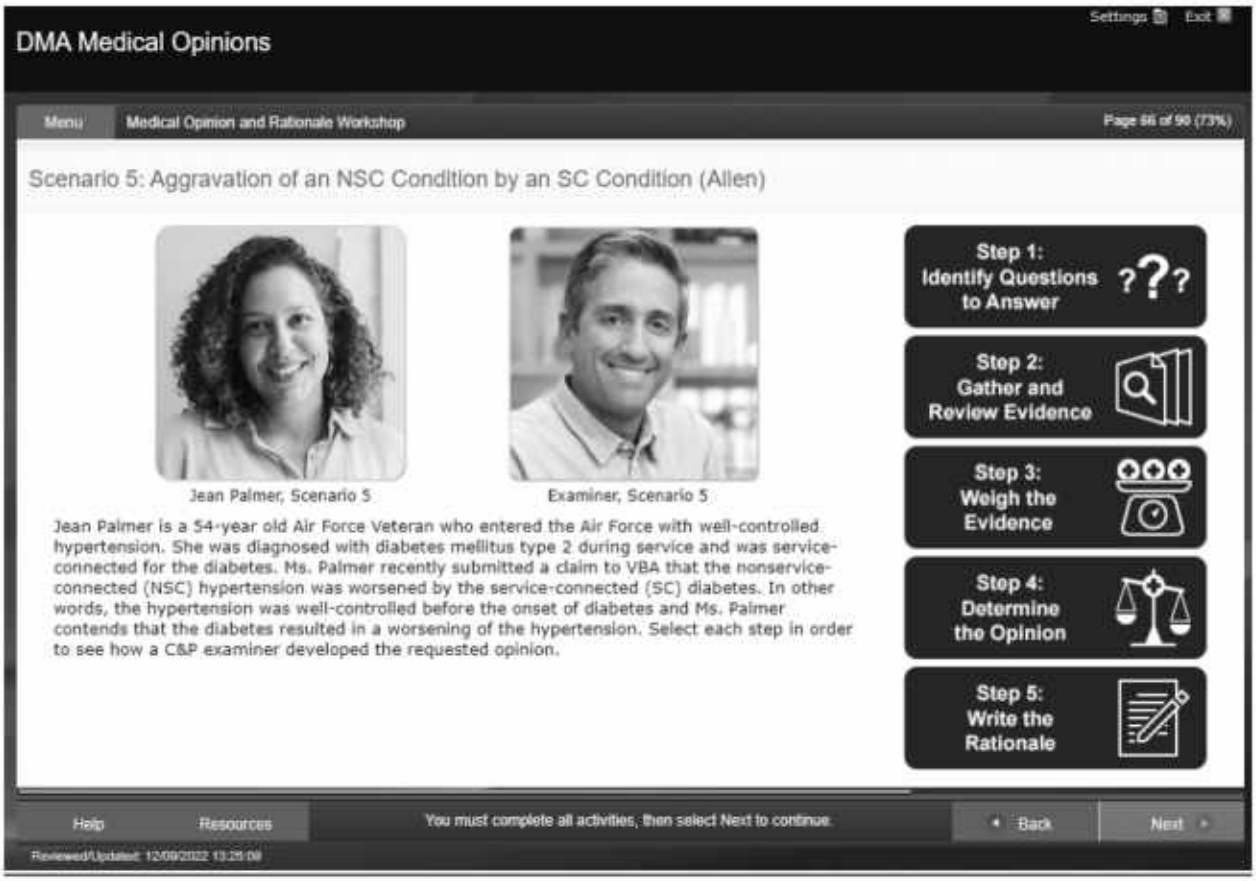

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If it worsened, how did the extent of worsening compare to natural progression?
PM's pes planus showed a rapid progression within the short period of two years and at a very young age
Close
Step 4: Determine the Me
Requested opinion:
Was Veteran's bilateral
military service?
The examiner determined that the evidence was positive for aggravation of Mr. Murphy's claimed flat feet. She recorded her opinion on the Medical Opinion DBQ.
The Veteran's pes planus, which clearly and unmistakably existed prior to service, was as likely as not aggravated beyond its natural progression due to his military service.
Paul Murphy, Scenario 4
The Examiner's Considerations
The answers to questions the examiner asked when she reviewed the examination request served as building blocks for her opinion. You may have been answering similar questions as the examiner did. Select each question to compare your answer to hers.
What is the baseline level of severity for the Veteran's bilateral pes planus?
Is there medical evidence that it worsened during service?
Did the Service Separation Examination note any worsening of the pes planus?
If it worsened, how did the extent of worsening compare to natural progression?
Did symptoms continue after service (i.e., evidence of permanent worsening)?
Is there any event or injury after service that would better explain the worsening of this Veteran's condition?
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Did symptoms continue after service (i.e., evidence of permanent worsening)?
Yes
Close
Step 4: Determine the Me
Requested opinion:
Was Veteran's bilateral pes planus permanently aggravated beyond the natural progression by his active military service?
The examiner determined that the evidence was positive for aggravation of Mr. Murphy's claimed flat feet. She recorded her opinion on the Medical Opinion DBQ.
The Veteran's pes planus, which clearly and unmistakably existed prior to service, was as likely as not aggravated beyond its natural progression due to his military service.
Paul Murphy, Scenario 4
The Examiner's Considerations
The answers to questions the examiner asked when she reviewed the examination request served as building blocks for her opinion. You may have been answering similar questions as the examiner did. Select each question to compare your answer to hers.
What is the baseline level of severity for the Veteran's bilateral pes planus?
Is there medical evidence that it worsened during service?
Did the Service Separation Examination note any worsening of the pes planus?
If it worsened, how did the extent of worsening compare to natural progression?
Did symptoms continue after service (i.e., evidence of permanent worsening)?
Is there any event or injury after service that would better explain the worsening of this Veteran's condition?
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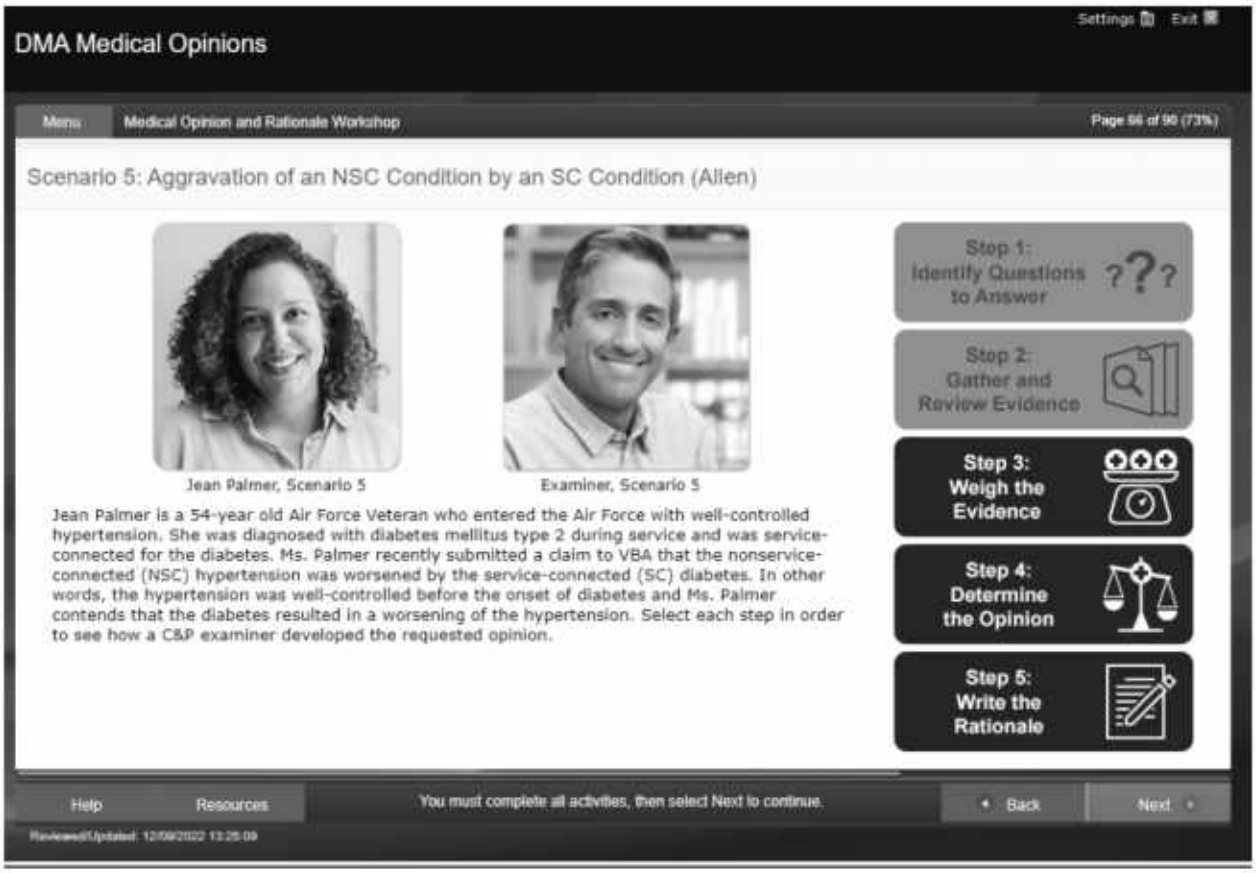

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Is there any event or injury after service that would better explain the worsening of this Veteran's condition?
No
Close
Step 4: Determine the Me
Requested opinion:
Was Veteran's bilateral pes planus permanently aggravated beyond the natural progression by his active military service?
The examiner determined that the evidence was positive for aggravation of Mr. Murphy's claimed flat feet. She recorded her opinion on the Medical Opinion DBQ.
The Veteran's pes planus, which clearly and unmistakably existed prior to service, was as likely as not aggravated beyond its natural progression due to his military service.
Paul Murphy, Scenario 4
The Examiner's Considerations
The answers to questions the examiner asked when she reviewed the examination request served as building blocks for her opinion. You may have been answering similar questions as the examiner did. Select each question to compare your answer to hers.
What is the baseline level of severity for the Veteran's bilateral pes planus?
Is there medical evidence that it worsened during service?
Did the Service Separation Examination note any worsening of the pes planus?
If it worsened, how did the extent of worsening compare to natural progression?
Did symptoms continue after service (i.e., evidence of permanent worsening)?
Is there any event or injury after service that would better explain the worsening of this Veteran's condition?
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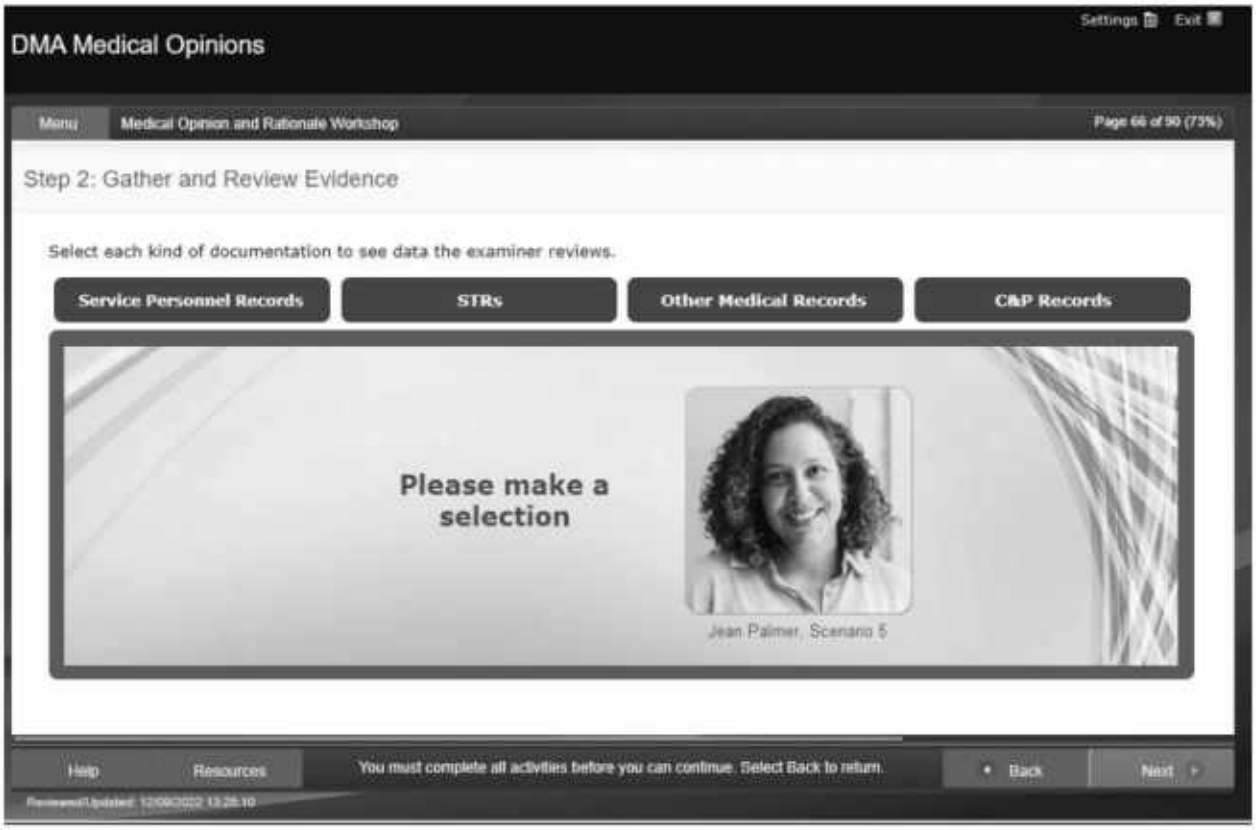

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Scenario 4: Aggravation of a Preexisting Condition
Paul Murphy, Scenario 4
Examiner, Scenario 4
Paul Murphy is a 40-year old U.S. Army Veteran who entered the service with mild pes planus in both feet. He filed a claim with VBA for worsening of his flat foot condition during service. Select each step in order to see how the C&P examiner developed the requested opinion.
Step 1: Identify Questions to Answer
Step 2: Gather and Review Evidence
Step 3: Weigh the Evidence
Step 4: Determine the Opinion
Step 5: Write the Rationale
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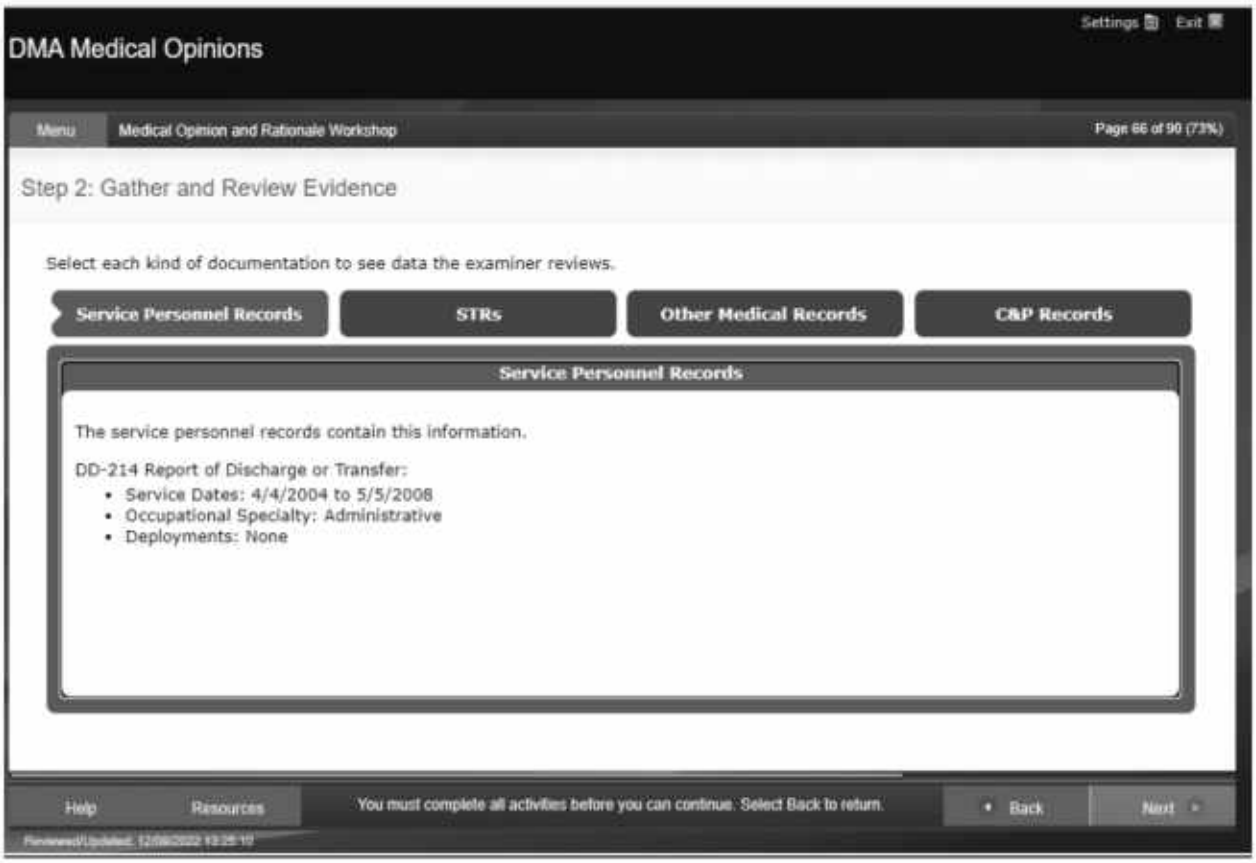

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Step 5: Write the Rationale
Opinion: The Veteran's pes planus, which clearly and unmistakably existed prior to service, was as least as likely as not aggravated beyond its natural progression due to his military service.
The examiner wrote this rationale for the opinion.
Rationale: A review of the eFolder and available medical records indicate that Veteran's bilateral pes planus was aggravated from mild to moderate by his active military service at a young age, and he continues to have persistent pain post service necessitating a change in occupation and care with a podiatrist for bilateral pes planus. A review of the eFolder and available medical records indicate that Veteran's bilateral pes planus was aggravated by his active military service.
Paul Murphy, Scenario 4
Veteran's flatfoot condition was noted in his entrance examination to military service and documented as "mild bilateral flexible pes planus, normal variant, no functional limitations." His STRs contain several medical treatment notes that the Veteran complained of pain in both feet after long marches and training exercises. He was put on temporary profile once due to bilateral foot pain and was sent to light duty at a desk job for two weeks. His discharge physical examination showed "moderate bilateral pes planus, mild pronation bilaterally and positive for pain in both feet on weight bearing and walking." Veteran was referred to orthopedics and physical therapy, where he was given orthotic shoe inserts. Veteran was slightly overweight with BMI of 29 and was advised to lose weight.
Veteran has been followed by a podiatrist off and on for his bilateral pes planus since the time of his discharge from military service. Veteran stated to this examiner that he had to change his occupation from restaurant manager to insurance agent because his flatfoot condition made prolonged standing and walking impossible. He was 30 years old at that time.
Accepted medical knowledge indicates that the Veteran's mild pes planus, that was without any functional limitation on entrance to service, progressed more rapidly than the expected natural progression of the disease to a stage of moderate pes planus with significant functional limitation by the time of discharge. This progression occurred within the short period of two years and at a very young age.
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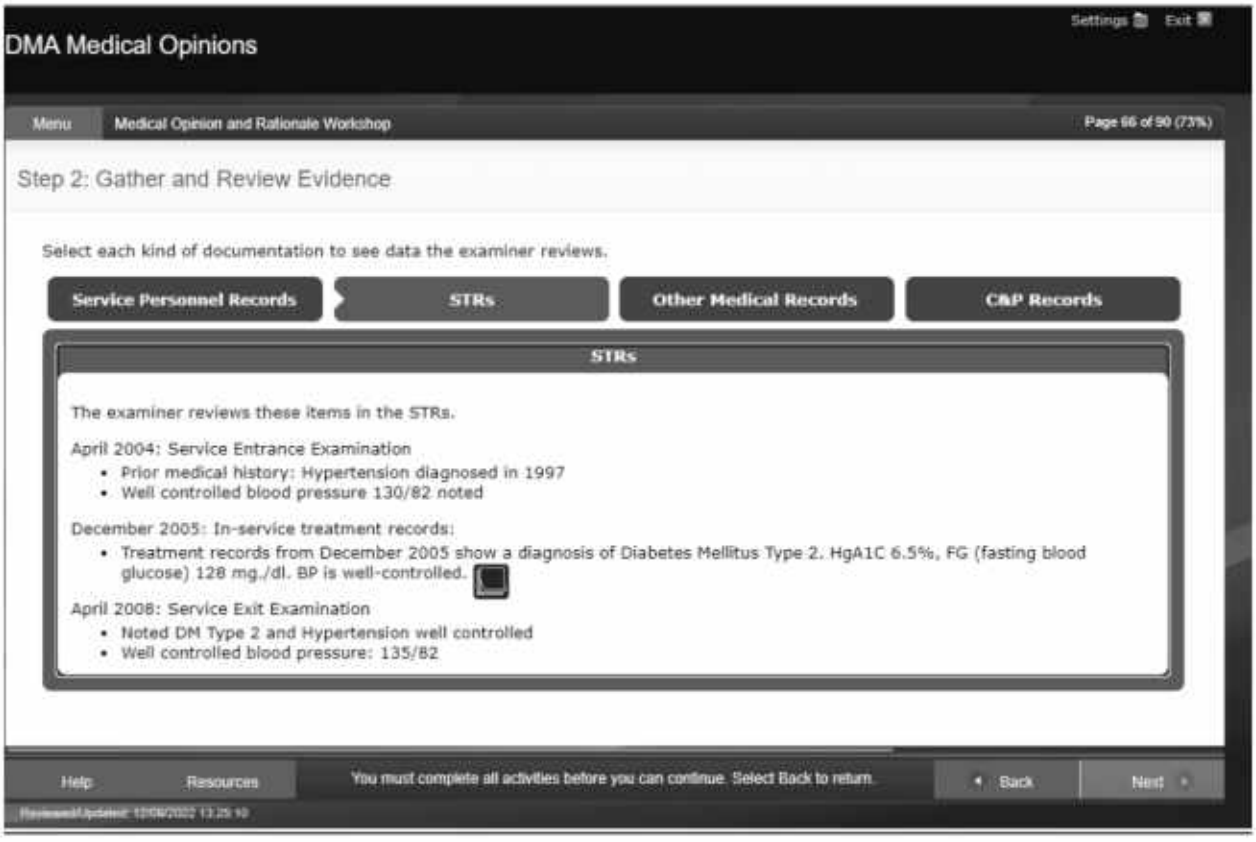

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Scenario 5: Aggravation of an NSC Condition by an SC Condition (Allen)
Jean Palmer, Scenario 5
Examiner, Scenario 5
Jean Palmer is a 54-year old Air Force Veteran who entered the Air Force with well-controlled hypertension. She was diagnosed with diabetes mellitus type 2 during service and was service-connected for the diabetes. Ms. Palmer recently submitted a claim to VBA that the nonservice-connected (NSC) hypertension was worsened by the service-connected (SC) diabetes. In other words, the hypertension was well-controlled before the onset of diabetes and Ms. Palmer contends that the diabetes resulted in a worsening of the hypertension. Select each step in order to see how a C&P examiner developed the requested opinion.
Step 1: Identify Questions to Answer
Step 2: Gather and Review Evidence
Step 3: Weigh the Evidence
Step 4: Determine the Opinion
Step 5: Write the Rationale
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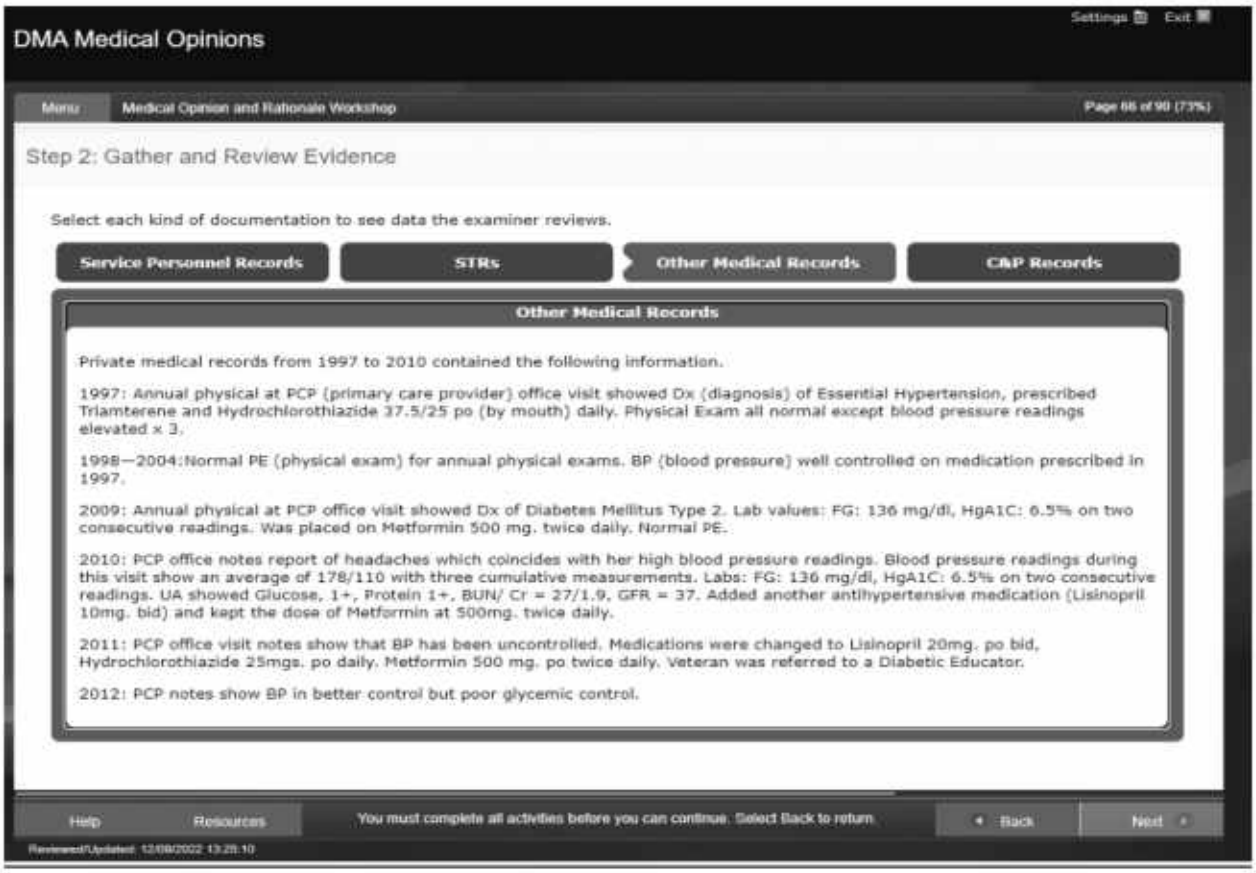

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Step 1: Identify Questions to Answer
The examiner reviews the examination request to identify the questions he must answer for Ms. Palmer's claim.
Service-connected disabilities: Diabetes Mellitus Type 2
Examination Requested: Diabetes Mellitus DBQ, Medical Opinion DBQ
Requested Opinion: Was the Veteran's hypertension at least as likely as not aggravated beyond its natural progression by her SC type 2 diabetes mellitus?
Scenario 5, Jean Palmer
Additional Examiner Considerations
The examiner paused for a moment to consider questions to answer to develop a medical opinion and rationale for VBA. The questions are slightly different for aggravation of a preexisting condition. For example, no question asks about a preexisting (i.e., preexisting service) condition because an NSC condition can manifest at any time and still be aggravated by a service-connected condition. Type in your questions and select "Compare" to see the examiner's list.
Type your questions here, then click Compare.
Compare
Examiner's Questions:
1. When was the NSC hypertension (HTN) diagnosed?
2. What was the baseline level of severity for the HTN and how was it treated?
3. When was the diabetes mellitus diagnosed?
4. How has the HTN and its treatment developed since the diabetes was diagnosed?
5. Has the HTN worsened beyond natural progression?
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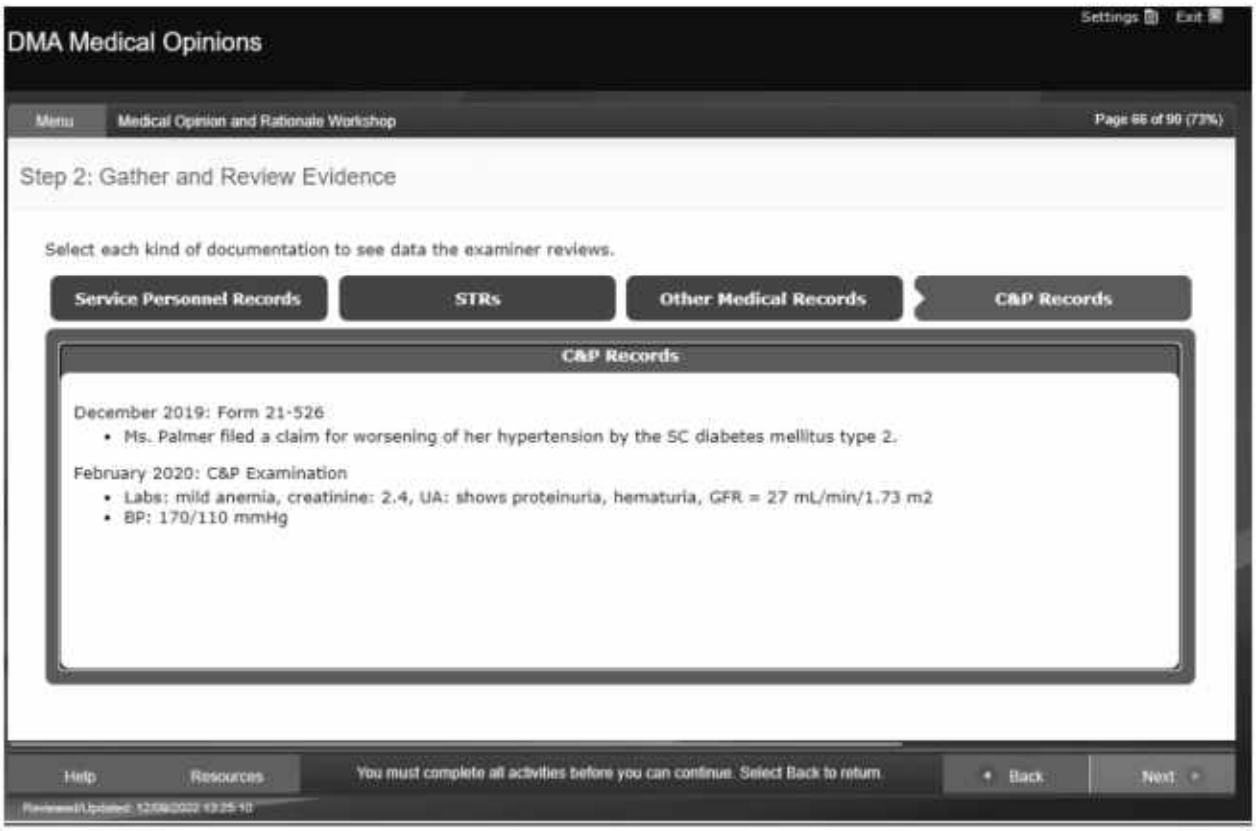

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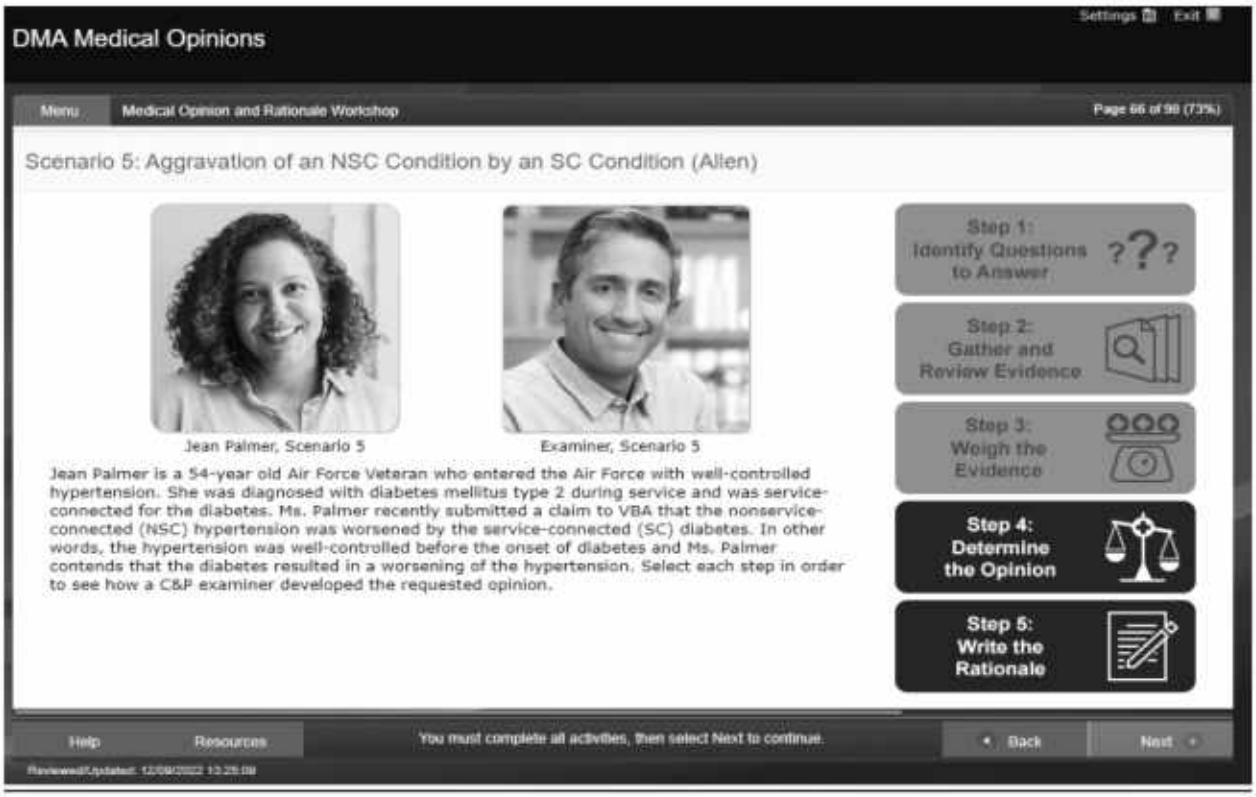

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Step 2: Gather and Review Evidence
Select each kind of documentation to see data the examiner reviews.
Service Personnel Records
STRs
Other Medical Records
C&P Records
Please make a selection
Jean Palmer, Scenario 5
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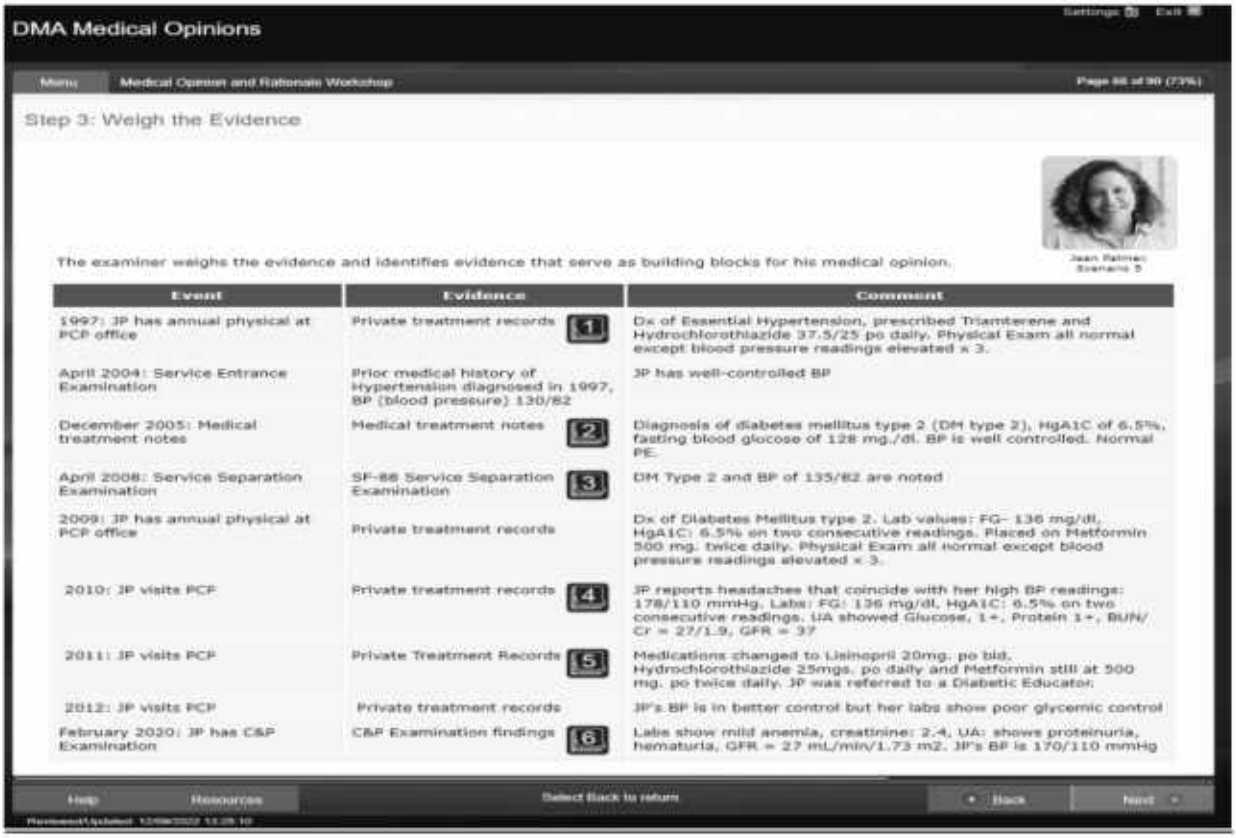

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Step 2: Gather and Review Evidence
Select each kind of documentation to see data the examiner reviews.
Service Personnel Records
STRs
Other Medical Records
C&P Records
Service Personnel Records
The service personnel records contain this information.
DD-214 Report of Discharge or Transfer:
Service Dates: 4/4/2004 to 5/5/2008
Occupational Specialty: Administrative
Deployments: None
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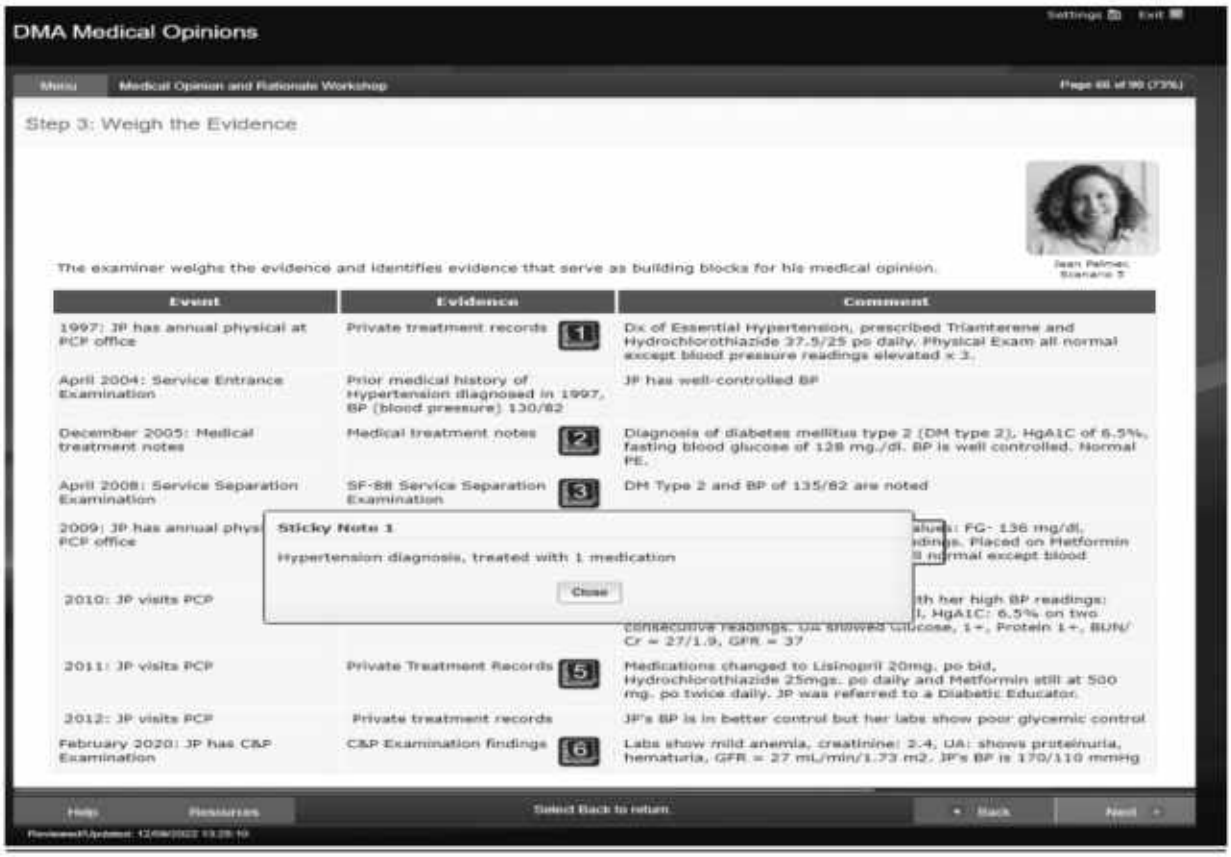

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Step 2: Gather and Review Evidence
Select each kind of documentation to see data the examiner reviews.
Service Personnel Records
STRs
Other Medical Records
C&P Records
STRs
The examiner reviews these items in the STRs.
April 2004: Service Entrance Examination
Prior medical history: Hypertension diagnosed in 1997
Well controlled blood pressure 130/82 noted
December 2005: In-service treatment records:
Treatment records from December 2005 show a diagnosis of Diabetes Mellitus Type 2. HgA1C 6.5%, FG (fasting blood glucose) 128 mg./dl. BP is well-controlled.
April 2008: Service Exit Examination
Noted DM Type 2 and Hypertension well controlled
Well controlled blood pressure: 135/82
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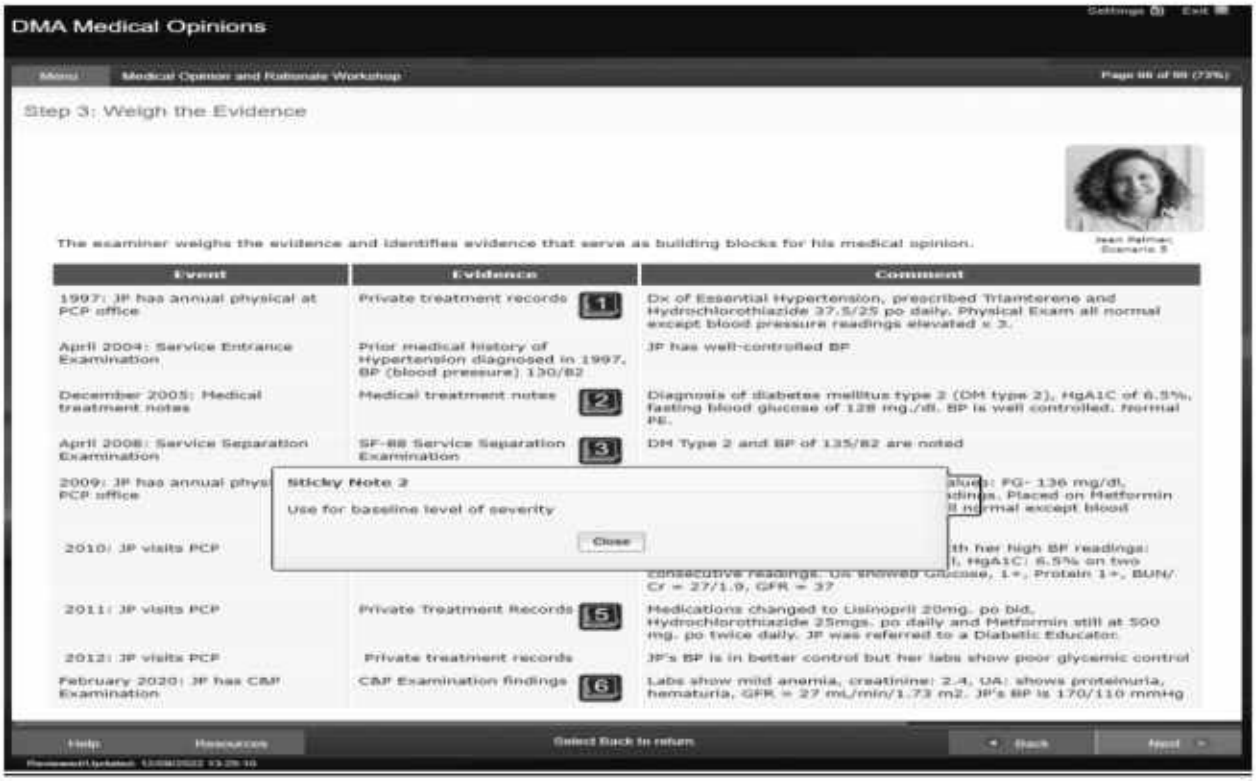

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Step 2: Gather and Review Evidence
Select each kind of documentation to see data the examiner reviews.
Service Personnel Records
STRs
Other Medical Records
C&P Records
Other Medical Records
Private medical records from 1997 to 2010 contained the following information.
1997: Annual physical at PCP (primary care provider) office visit showed Dx (diagnosis) of Essential Hypertension, prescribed Triamterene and Hydrochlorothiazide 37.5/25 po (by mouth) daily. Physical Exam all normal except blood pressure readings elevated x 3.
1998—2004:Normal PE (physical exam) for annual physical exams. BP (blood pressure) well controlled on medication prescribed in 1997.
2009: Annual physical at PCP office visit showed Dx of Diabetes Mellitus Type 2. Lab values: FG: 136 mg/dl, HgA1C: 6.5% on two consecutive readings. Was placed on Metformin 500 mg. twice daily. Normal PE.
2010: PCP office notes report of headaches which coincides with her high blood pressure readings. Blood pressure readings during this visit show an average of 178/110 with three cumulative measurements. Labs: FG: 136 mg/dl, HgA1C: 6.5% on two consecutive readings. UA showed Glucose, 1+, Protein 1+, BUN/ Cr = 27/1.9, GFR = 37. Added another antihypertensive medication (Lisinopril 10mg. bid) and kept the dose of Metformin at 500mg. twice daily.
2011: PCP office visit notes show that BP has been uncontrolled. Medications were changed to Lisinopril 20mg. po bid, Hydrochlorothiazide 25mgs. po daily. Metformin 500 mg. po twice daily. Veteran was referred to a Diabetic Educator.
2012: PCP notes show BP in better control but poor glycemic control.
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Step 2: Gather and Review Evidence
Select each kind of documentation to see data the examiner reviews.
Service Personnel Records
STRs
Other Medical Records
C&P Records
C&P Records
December 2019: Form 21-526
• Ms. Palmer filed a claim for worsening of her hypertension by the SC diabetes mellitus type 2.
February 2020: C&P Examination
• Labs: mild anemia, creatinine: 2.4, UA: shows proteinuria, hematuria, GFR = 27 mL/min/1.73 m2
• BP: 170/110 mmHg
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Scenario 5: Aggravation of an NSC Condition by an SC Condition (Allen)
Jean Palmer, Scenario 5
Examiner, Scenario 5
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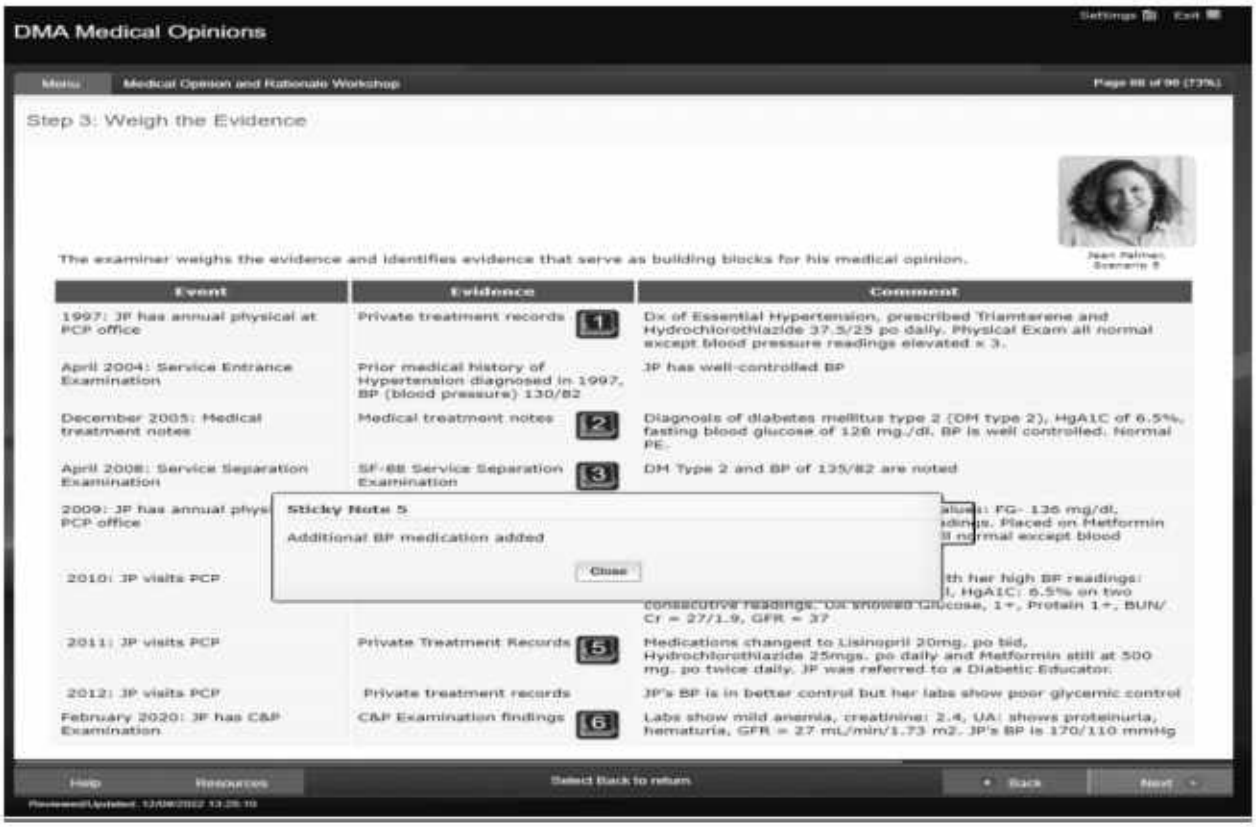

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Step 3: Weigh the Evidence
The examiner weighs the evidence and identifies evidence that serve as building blocks for his medical opinion.
Event
Evidence
Comment
1997: JP has annual physical at PCP office
Private treatment records
1
Dx of Essential Hypertension, prescribed Triamterene and Hydrochlorothiazide 37.5/25 po daily. Physical Exam all normal except blood pressure readings elevated x 3.
April 2004: Service Entrance Examination
Prior medical history of Hypertension diagnosed in 1997, BP (blood pressure) 130/82
JP has well-controlled BP
December 2005: Medical treatment notes
Medical treatment notes
2
Diagnosis of diabetes mellitus type 2 (DM type 2), HgA1C of 6.5%, fasting blood glucose of 128 mg./dl. BP is well controlled. Normal PE.
April 2008: Service Separation Examination
SF-88 Service Separation Examination
3
DM Type 2 and BP of 135/82 are noted
2009: JP has annual physical at PCP office
Private treatment records
Dx of Diabetes Mellitus type 2. Lab values: FG- 136 mg/dl, HgA1C: 6.5% on two consecutive readings. Placed on Metformin 500 mg. twice daily. Physical Exam all normal except blood pressure readings elevated x 3.
2010: JP visits PCP
Private treatment records
4
JP reports headaches that coincide with her high BP readings: 178/110 mmHg. Labs: FG: 136 mg/dl, HgA1C: 6.5% on two consecutive readings. UA showed Glucose, 1+, Protein 1+, BUN/Cr = 27/1.9, GFR = 37
2011: JP visits PCP
Private Treatment Records
5
Medications changed to Lisinopril 20mg. po bid, Hydrochlorothiazide 25mgs. po daily and Metformin still at 500 mg. po twice daily. JP was referred to a Diabetic Educator.
2012: JP visits PCP
Private treatment records
JP's BP is in better control but her labs show poor glycemic control
February 2020: JP has C&P Examination
C&P Examination findings
6
Labs show mild anemia, creatinine: 2.4, UA: shows proteinuria, hematuria, GFR = 27 mL/min/1.73 m2. JP's BP is 170/110 mmHg
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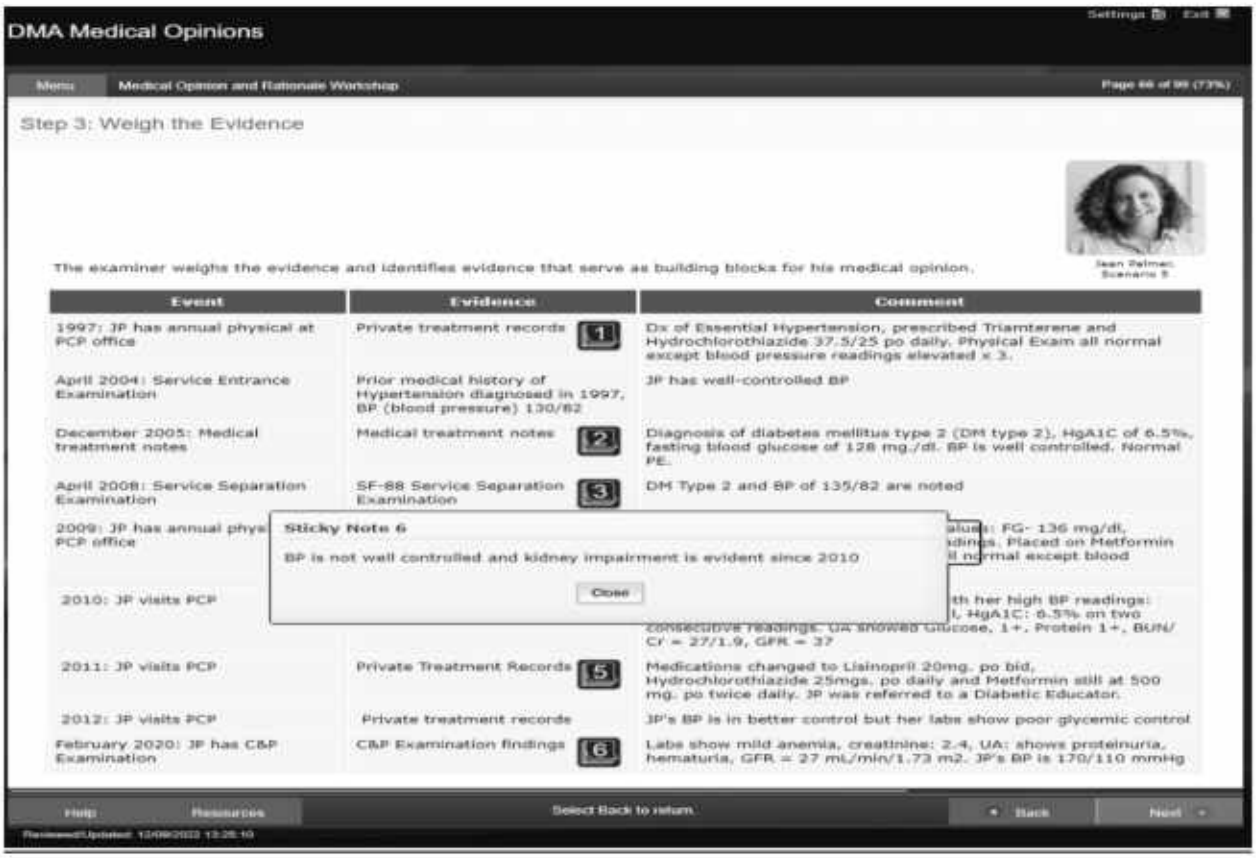

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Step 3: Weigh the Evidence
The examiner weighs the evidence and identifies evidence that serve as building blocks for his medical opinion.
Event
Evidence
Comment
1997: JP has annual physical at PCP office
Private treatment records
1
Dx of Essential Hypertension, prescribed Triamterene and Hydrochlorothiazide 37.5/25 po daily. Physical Exam all normal except blood pressure readings elevated x 3.
April 2004: Service Entrance Examination
Prior medical history of Hypertension diagnosed in 1997, BP (blood pressure) 130/82
JP has well-controlled BP
December 2005: Medical treatment notes
Medical treatment notes
2
Diagnosis of diabetes mellitus type 2 (DM type 2), HgA1C of 6.5%, fasting blood glucose of 128 mg./dl. BP is well controlled. Normal PE.
April 2008: Service Separation Examination
SF-88 Service Separation Examination
3
DM Type 2 and BP of 135/82 are noted
Sticky Note 1
Hypertension diagnosis, treated with 1 medication
Close
2010: JP visits PCP
2011: JP visits PCP
Private Treatment Records
5
Medications changed to Lisinopril 20mg. po bid, Hydrochlorothiazide 25mgs. po daily and Metformin still at 500 mg. po twice daily. JP was referred to a Diabetic Educator.
2012: JP visits PCP
Private treatment records
JP's BP is in better control but her labs show poor glycemic control
February 2020: JP has C&P Examination
C&P Examination findings
6
Labs show mild anemia, creatinine: 2.4, UA: shows proteinuria, hematuria, GFR = 27 mL/min/1.73 m2. JP's BP is 170/110 mmHg
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Step 3: Weigh the Evidence
The examiner weighs the evidence and identifies evidence that serve as building blocks for his medical opinion.
Event
Evidence
Comment
1997: JP has annual physical at PCP office
Private treatment records
1
Dx of Essential Hypertension, prescribed Triamterene and Hydrochlorothiazide 37.5/25 po daily. Physical Exam all normal except blood pressure readings elevated x 3.
April 2004: Service Entrance Examination
Prior medical history of Hypertension diagnosed in 1997, BP (blood pressure) 130/82
JP has well-controlled BP
December 2005: Medical treatment notes
Medical treatment notes
2
Diagnosis of diabetes mellitus type 2 (DM type 2), HgA1C of 6.5%, fasting blood glucose of 128 mg./dl. BP is well controlled. Normal PE.
April 2008: Service Separation Examination
SF-88 Service Separation Examination
3
DM Type 2 and BP of 135/82 are noted
Sticky Note 2
Use for baseline level of severity
Close
2010: JP visits PCP
2011: JP visits PCP
Private Treatment Records
5
Medications changed to Lisinopril 20mg. po bid, Hydrochlorothiazide 25mgs. po daily and Metformin still at 500 mg. po twice daily. JP was referred to a Diabetic Educator.
2012: JP visits PCP
Private treatment records
JP's BP is in better control but her labs show poor glycemic control
February 2020: JP has C&P Examination
C&P Examination findings
6
Labs show mild anemia, creatinine: 2.4, UA: shows proteinuria, hematuria, GFR = 27 mL/min/1.73 m2. JP's BP is 170/110 mmHg
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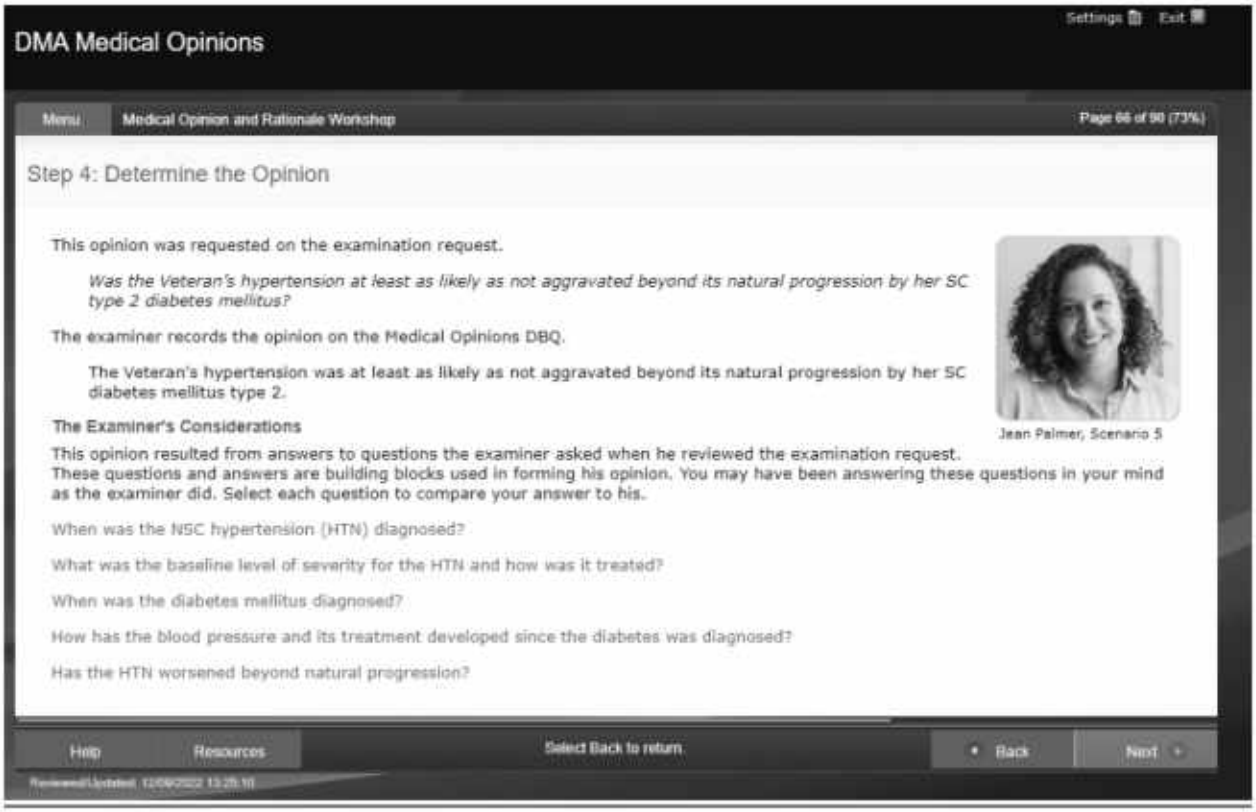

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Step 3: Weigh the Evidence
The examiner weighs the evidence and identifies evidence that serve as building blocks for his medical opinion.
Event
Evidence
Comment
1997: JP has annual physical at PCP office
Private treatment records
1
Dx of Essential Hypertension, prescribed Triamterene and Hydrochlorothiazide 37.5/25 po daily. Physical Exam all normal except blood pressure readings elevated x 3.
April 2004: Service Entrance Examination
Prior medical history of Hypertension diagnosed in 1997, BP (blood pressure) 130/82
JP has well-controlled BP
December 2005: Medical treatment notes
Medical treatment notes
2
Diagnosis of diabetes mellitus type 2 (DM type 2), HgA1C of 6.5%, fasting blood glucose of 128 mg./dl. BP is well controlled. Normal PE.
April 2008: Service Separation Examination
SF-88 Service Separation Examination
3
DM Type 2 and BP of 135/82 are noted
2009: JP has annual phys
PCP office
Sticky Note 3
BP is still well-controlled several years after HTN diagnosis
Close
alues: FG- 136 mg/dl,
dings. Placed on Metformin
ll normal except blood
2010: JP visits PCP
th her high BP readings:
l, HgA1C: 6.5% on two
consecutive readings. UA showed Glucose, 1+, Protein 1+, BUN/Cr = 27/1.9, GFR = 37
2011: JP visits PCP
Private Treatment Records
5
Medications changed to Lisinopril 20mg. po bid, Hydrochlorothiazide 25mgs. po daily and Metformin still at 500 mg. po twice daily. JP was referred to a Diabetic Educator.
2012: JP visits PCP
Private treatment records
JP's BP is in better control but her labs show poor glycemic control
February 2020: JP has C&P Examination
C&P Examination findings
6
Labs show mild anemia, creatinine: 2.4, UA: shows proteinuria, hematuria, GFR = 27 mL/min/1.73 m2. JP's BP is 170/110 mmHg
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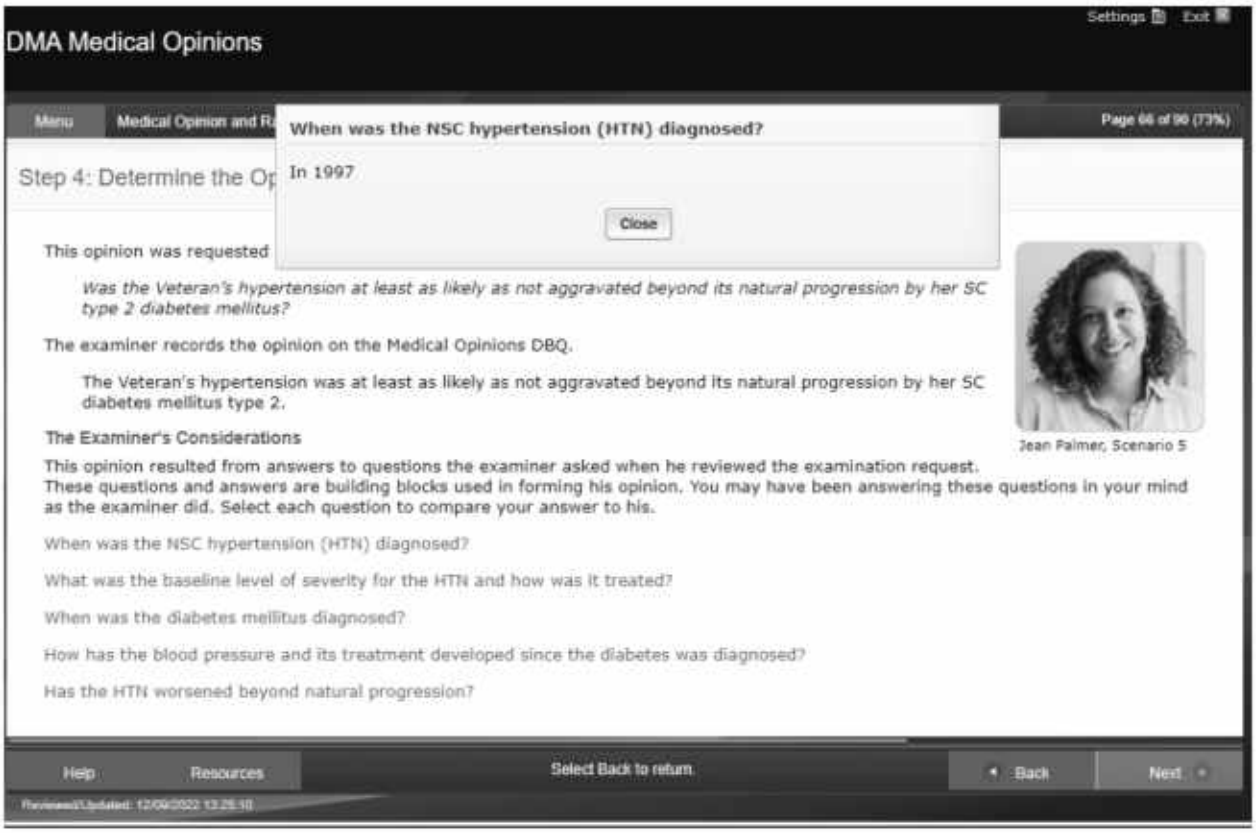

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Step 3: Weigh the Evidence
The examiner weighs the evidence and identifies evidence that serve as building blocks for his medical opinion.
Event
Evidence
Comment
1997: JP has annual physical at PCP office
Private treatment records
1
Dx of Essential Hypertension, prescribed Triamterene and Hydrochlorothiazide 37.5/25 po daily. Physical Exam all normal except blood pressure readings elevated x 3.
April 2004: Service Entrance Examination
Prior medical history of Hypertension diagnosed in 1997, BP (blood pressure) 130/82
JP has well-controlled BP
December 2005: Medical treatment notes
Medical treatment notes
2
Diagnosis of diabetes mellitus type 2 (DM type 2), HgA1C of 6.5%, fasting blood glucose of 128 mg./dl. BP is well controlled. Normal PE.
April 2008: Service Separation Examination
SF-88 Service Separation Examination
3
DM Type 2 and BP of 135/82 are noted
2009: JP has annual phys
PCP office
Sticky Note 4
BP readings are higher and labs indicate kidney impairment
Close
alues: FG- 136 mg/dl,
dings. Placed on Metformin
ll normal except blood
2010: JP visits PCP
th her high BP readings:
l, HgA1C: 6.5% on two
consecutive readings. UA showed Glucose, 1+, Protein 1+, BUN/Cr = 27/1.9, GFR = 37
2011: JP visits PCP
Private Treatment Records
5
Medications changed to Lisinopril 20mg. po bid, Hydrochlorothiazide 25mgs. po daily and Metformin still at 500 mg. po twice daily. JP was referred to a Diabetic Educator.
2012: JP visits PCP
Private treatment records
JP's BP is in better control but her labs show poor glycemic control
February 2020: JP has C&P Examination
C&P Examination findings
6
Labs show mild anemia, creatinine: 2.4, UA: shows proteinuria, hematuria, GFR = 27 mL/min/1.73 m2. JP's BP is 170/110 mmHg
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Medical Opinion and Rationale Workshop
Step 3: Weigh the Evidence
The examiner weighs the evidence and identifies evidence that serve as building blocks for his medical opinion.
Event
Evidence
Comment
1997: JP has annual physical at PCP office
Private treatment records
1
Dx of Essential Hypertension, prescribed Triamterene and Hydrochlorothiazide 37.5/25 po daily. Physical Exam all normal except blood pressure readings elevated x 3.
April 2004: Service Entrance Examination
Prior medical history of Hypertension diagnosed in 1997, BP (blood pressure) 130/82
JP has well-controlled BP
December 2005: Medical treatment notes
Medical treatment notes
2
Diagnosis of diabetes mellitus type 2 (DM type 2), HgA1C of 6.5%, fasting blood glucose of 128 mg./dl. BP is well controlled. Normal PE.
April 2008: Service Separation Examination
SF-88 Service Separation Examination
3
DM Type 2 and BP of 135/82 are noted
2009: JP has annual phys
PCP office
Sticky Note 5
Additional BP medication added
Close
2010: JP visits PCP
2011: JP visits PCP
Private Treatment Records
5
Medications changed to Lisinopril 20mg. po bid, Hydrochlorothiazide 25mgs. po daily and Metformin still at 500 mg. po twice daily. JP was referred to a Diabetic Educator.
2012: JP visits PCP
Private treatment records
JP's BP is in better control but her labs show poor glycemic control
February 2020: JP has C&P Examination
C&P Examination findings
6
Labs show mild anemia, creatinine: 2.4, UA: shows proteinuria, hematuria, GFR = 27 mL/min/1.73 m2. JP's BP is 170/110 mmHg
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Medical Opinion and Rationale Workshop
Step 3: Weigh the Evidence
The examiner weighs the evidence and identifies evidence that serve as building blocks for his medical opinion.
Event
Evidence
Comment
1997: JP has annual physical at PCP office
Private treatment records
1
Dx of Essential Hypertension, prescribed Triamterene and Hydrochlorothiazide 37.5/25 po daily. Physical Exam all normal except blood pressure readings elevated x 3.
April 2004: Service Entrance Examination
Prior medical history of Hypertension diagnosed in 1997, BP (blood pressure) 130/82
JP has well-controlled BP
December 2005: Medical treatment notes
Medical treatment notes
2
Diagnosis of diabetes mellitus type 2 (DM type 2), HgA1C of 6.5%, fasting blood glucose of 128 mg./dl. BP is well controlled. Normal PE.
April 2008: Service Separation Examination
SF-88 Service Separation Examination
3
DM Type 2 and BP of 135/82 are noted
2009: JP has annual phys
PCP office
Sticky Note 6
BP is not well controlled and kidney impairment is evident since 2010
Close
2010: JP visits PCP
2011: JP visits PCP
Private Treatment Records
5
Medications changed to Lisinopril 20mg. po bid, Hydrochlorothiazide 25mgs. po daily and Metformin still at 500 mg. po twice daily. JP was referred to a Diabetic Educator.
2012: JP visits PCP
Private treatment records
JP's BP is in better control but her labs show poor glycemic control
February 2020: JP has C&P Examination
C&P Examination findings
6
Labs show mild anemia, creatinine: 2.4, UA: shows proteinuria, hematuria, GFR = 27 mL/min/1.73 m2. JP's BP is 170/110 mmHg
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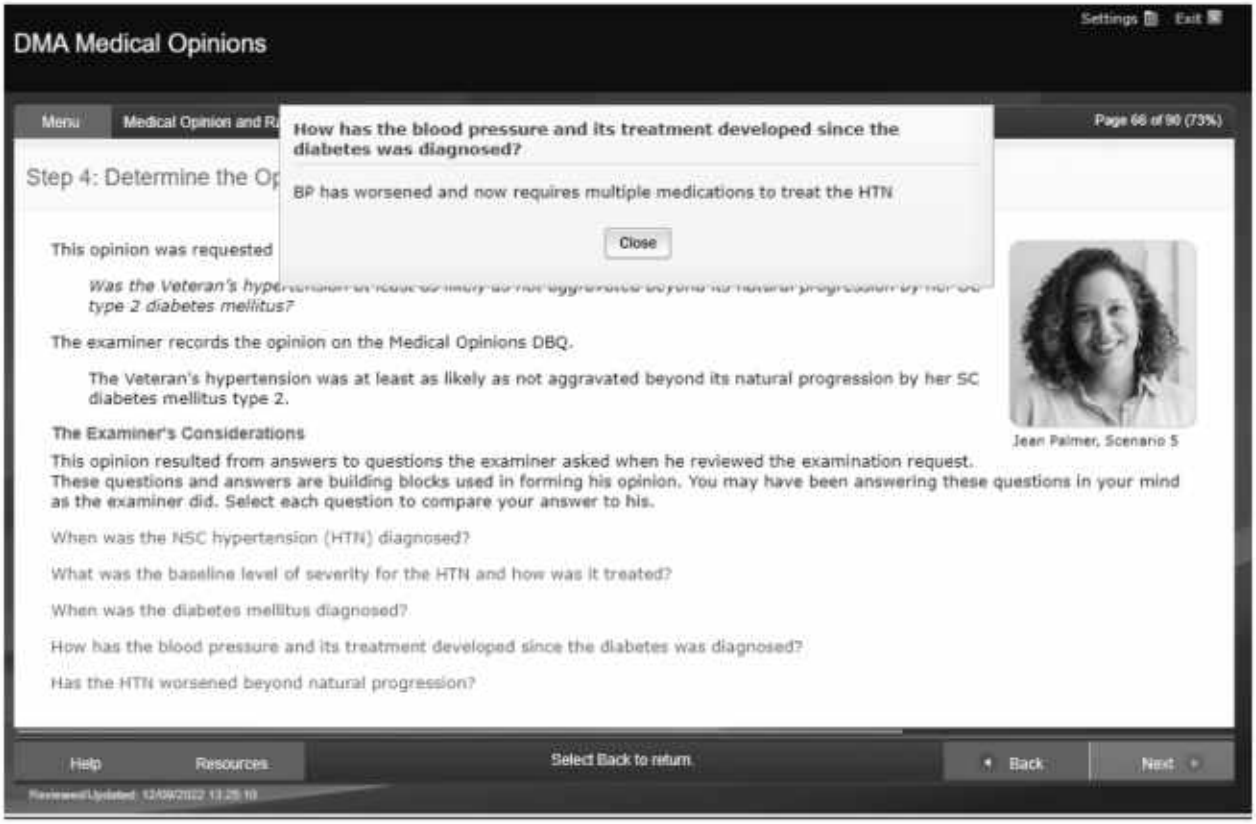

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Scenario 5: Aggravation of an NSC Condition by an SC Condition (Allen)
Jean Palmer, Scenario 5
Examiner, Scenario 5
Jean Palmer is a 54-year old Air Force Veteran who entered the Air Force with well-controlled hypertension. She was diagnosed with diabetes mellitus type 2 during service and was service-connected for the diabetes. Ms. Palmer recently submitted a claim to VBA that the nonservice-connected (NSC) hypertension was worsened by the service-connected (SC) diabetes. In other words, the hypertension was well-controlled before the onset of diabetes and Ms. Palmer contends that the diabetes resulted in a worsening of the hypertension. Select each step in order to see how a C&P examiner developed the requested opinion.
Step 1: Identify Questions to Answer
Step 2: Gather and Review Evidence
Step 3: Weigh the Evidence
Step 4: Determine the Opinion
Step 5: Write the Rationale
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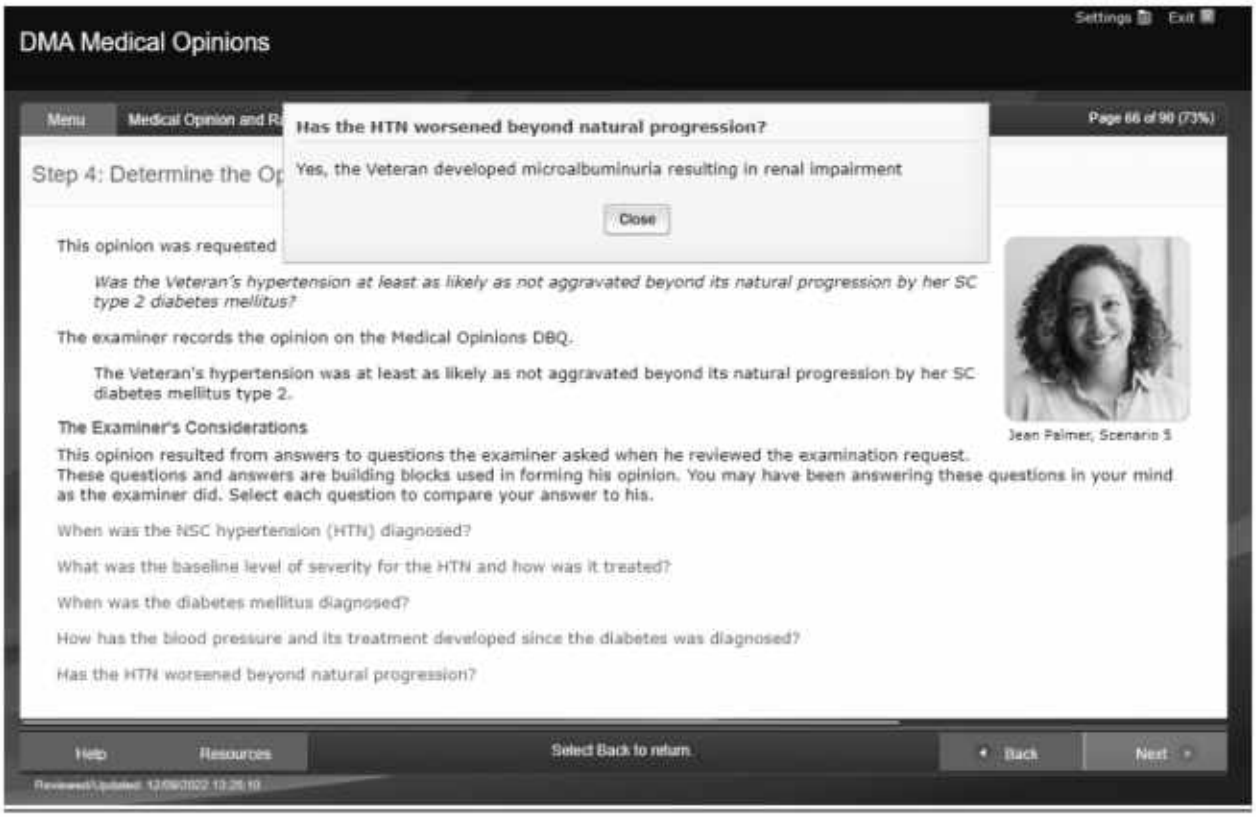

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Step 4: Determine the Opinion
This opinion was requested on the examination request.
Was the Veteran's hypertension at least as likely as not aggravated beyond its natural progression by her SC type 2 diabetes mellitus?
The examiner records the opinion on the Medical Opinions DBQ.
The Veteran's hypertension was at least as likely as not aggravated beyond its natural progression by her SC diabetes mellitus type 2.
Jean Palmer, Scenario 5
The Examiner's Considerations
This opinion resulted from answers to questions the examiner asked when he reviewed the examination request. These questions and answers are building blocks used in forming his opinion. You may have been answering these questions in your mind as the examiner did. Select each question to compare your answer to his.
When was the NSC hypertension (HTN) diagnosed?
What was the baseline level of severity for the HTN and how was it treated?
When was the diabetes mellitus diagnosed?
How has the blood pressure and its treatment developed since the diabetes was diagnosed?
Has the HTN worsened beyond natural progression?
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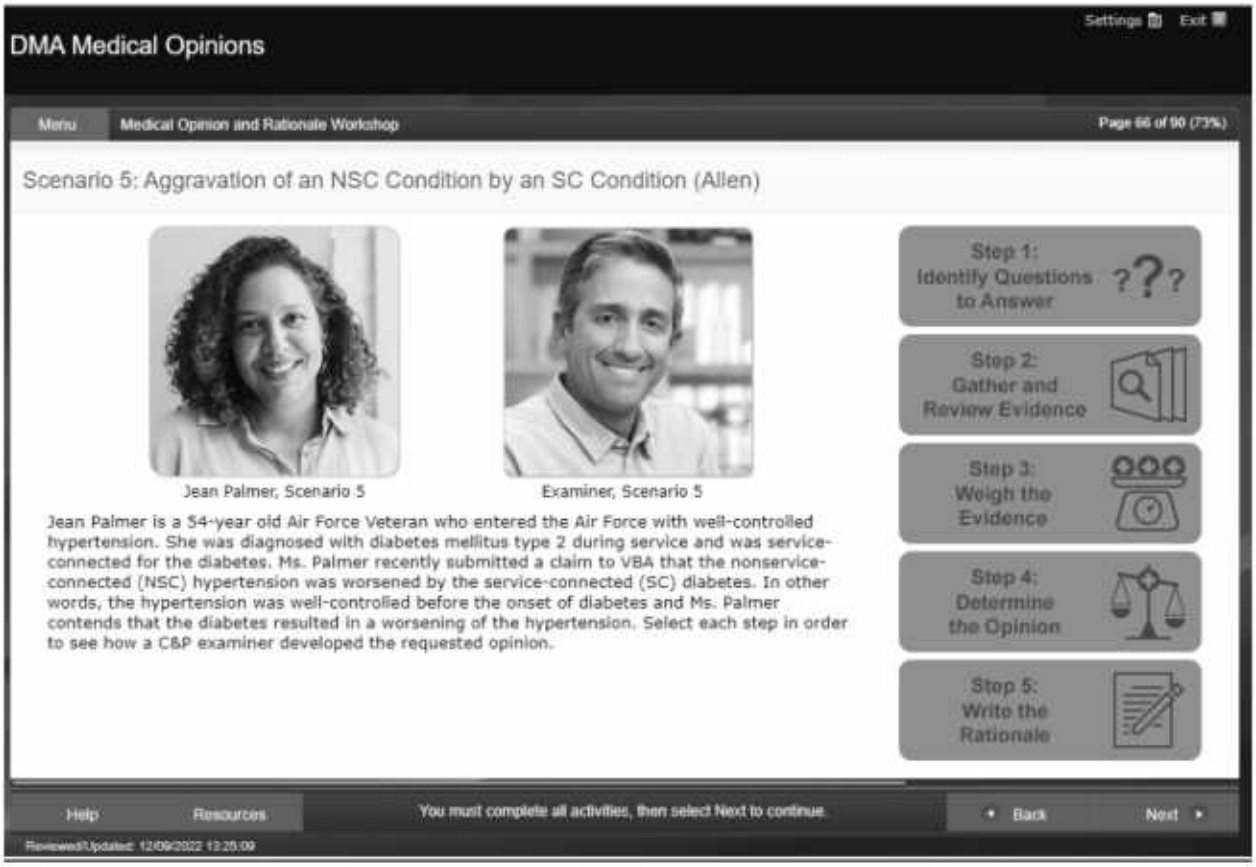

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Medical Opinion and R
When was the NSC hypertension (HTN) diagnosed?
In 1997
Close
Page 66 of 90 (73%)
Step 4: Determine the Op
This opinion was requested
Was the Veteran's hypertension at least as likely as not aggravated beyond its natural progression by her SC type 2 diabetes mellitus?
The examiner records the opinion on the Medical Opinions DBQ.
The Veteran's hypertension was at least as likely as not aggravated beyond its natural progression by her SC diabetes mellitus type 2.
Jean Palmer, Scenario 5
The Examiner's Considerations
This opinion resulted from answers to questions the examiner asked when he reviewed the examination request. These questions and answers are building blocks used in forming his opinion. You may have been answering these questions in your mind as the examiner did. Select each question to compare your answer to his.
When was the NSC hypertension (HTN) diagnosed?
What was the baseline level of severity for the HTN and how was it treated?
When was the diabetes mellitus diagnosed?
How has the blood pressure and its treatment developed since the diabetes was diagnosed?
Has the HTN worsened beyond natural progression?
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Medical Opinion and R
What was the baseline level of severity for the HTN and how was it treated?
It was noted as well controlled, BP 130/82, treated with Triamterene and Hydrochlorothiazide 37.5/25 po (by mouth) daily
Close
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Step 4: Determine the Op
This opinion was requested
Was the Veteran's hype
type 2 diabetes mellitus?
The examiner records the opinion on the Medical Opinions DBQ.
The Veteran's hypertension was at least as likely as not aggravated beyond its natural progression by her SC diabetes mellitus type 2.
Jean Palmer, Scenario 5
The Examiner's Considerations
This opinion resulted from answers to questions the examiner asked when he reviewed the examination request. These questions and answers are building blocks used in forming his opinion. You may have been answering these questions in your mind as the examiner did. Select each question to compare your answer to his.
When was the NSC hypertension (HTN) diagnosed?
What was the baseline level of severity for the HTN and how was it treated?
When was the diabetes mellitus diagnosed?
How has the blood pressure and its treatment developed since the diabetes was diagnosed?
Has the HTN worsened beyond natural progression?
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When was the diabetes mellitus diagnosed?
December 2005, while in service
Close
Step 4: Determine the Op
This opinion was requested
Was the Veteran's hypertension at least as likely as not aggravated beyond its natural progression by her SC type 2 diabetes mellitus?
The examiner records the opinion on the Medical Opinions DBQ.
The Veteran's hypertension was at least as likely as not aggravated beyond its natural progression by her SC diabetes mellitus type 2.
Jean Palmer, Scenario 5
The Examiner's Considerations
This opinion resulted from answers to questions the examiner asked when he reviewed the examination request. These questions and answers are building blocks used in forming his opinion. You may have been answering these questions in your mind as the examiner did. Select each question to compare your answer to his.
When was the NSC hypertension (HTN) diagnosed?
What was the baseline level of severity for the HTN and how was it treated?
When was the diabetes mellitus diagnosed?
How has the blood pressure and its treatment developed since the diabetes was diagnosed?
Has the HTN worsened beyond natural progression?
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How has the blood pressure and its treatment developed since the diabetes was diagnosed?
BP has worsened and now requires multiple medications to treat the HTN
Close
Step 4: Determine the Op
This opinion was requested
type 2 diabetes mellitus?
The examiner records the opinion on the Medical Opinions DBQ.
The Veteran's hypertension was at least as likely as not aggravated beyond its natural progression by her SC diabetes mellitus type 2.
Jean Palmer, Scenario 5
The Examiner's Considerations
This opinion resulted from answers to questions the examiner asked when he reviewed the examination request. These questions and answers are building blocks used in forming his opinion. You may have been answering these questions in your mind as the examiner did. Select each question to compare your answer to his.
When was the NSC hypertension (HTN) diagnosed?
What was the baseline level of severity for the HTN and how was it treated?
When was the diabetes mellitus diagnosed?
How has the blood pressure and its treatment developed since the diabetes was diagnosed?
Has the HTN worsened beyond natural progression?
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Has the HTN worsened beyond natural progression?
Yes, the Veteran developed microalbuminuria resulting in renal impairment
Close
Step 4: Determine the Op
This opinion was requested
Was the Veteran's hypertension at least as likely as not aggravated beyond its natural progression by her SC type 2 diabetes mellitus?
The examiner records the opinion on the Medical Opinions DBQ.
The Veteran's hypertension was at least as likely as not aggravated beyond its natural progression by her SC diabetes mellitus type 2.
Jean Palmer, Scenario 5
The Examiner's Considerations
This opinion resulted from answers to questions the examiner asked when he reviewed the examination request. These questions and answers are building blocks used in forming his opinion. You may have been answering these questions in your mind as the examiner did. Select each question to compare your answer to his.
When was the NSC hypertension (HTN) diagnosed?
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Jean Palmer, Scenario 5
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Jean Palmer is a 54-year old Air Force Veteran who entered the Air Force with well-controlled hypertension. She was diagnosed with diabetes mellitus type 2 during service and was service-connected for the diabetes. Ms. Palmer recently submitted a claim to VBA that the nonservice-connected (NSC) hypertension was worsened by the service-connected (SC) diabetes. In other words, the hypertension was well-controlled before the onset of diabetes and Ms. Palmer contends that the diabetes resulted in a worsening of the hypertension. Select each step in order to see how a C&P examiner developed the requested opinion.
Step 1: Identify Questions to Answer
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Step 3: Weigh the Evidence
Step 4: Determine the Opinion
Step 5: Write the Rationale
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Step 5: Write the Rationale

Opinion: The Veteran's hypertension was at least as likely as not aggravated beyond its natural progression by her SC diabetes mellitus type2.

The examiner adds this supporting rationale.

Rationale: Prior to the onset of diabetes, this Veteran's laboratory results showed no evidence of chronic kidney disease.



Jean Palmer, Scenario 5

After onset of diabetes, this Veteran's laboratory results demonstrated onset and progression of chronic kidney disease and diabetes. The increased association between hypertension and diabetes can be explained in part by the presence of a maladaptive interaction of factors such as excessive caloric intake, decreased activity, and associated insulin resistance, chronic activation of the renin angiotensin aldosterone system, the sympathetic nervous system and abnormalities of the innate immunity, inflammation, and oxidative stress. (Reference: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3648858/ from Hypertension May 2013; 61(5): 943-947).

Hypertension is related to diabetes in the presence of chronic kidney disease due to the interaction of all three systems as noted above.

Although this Veteran did have hypertension prior to diagnosis of diabetes, this condition was aggravated beyond the baseline which was present and stable prior to diagnosis. She had been stable on the same medication for 10 years. After onset of diabetes two additional antihypertensive medications were added without adequate response.

The baseline for hypertension is considered to be as well-controlled BP with one medication and normal physical exam as she was found with during her visit to a private physician's office in 2005 at the onset of her service-connected type 2 diabetes mellitus.

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Scenarios Conclusion

Congratulations! You completed all scenarios in this workshop lesson. Each scenario followed the five steps for determining an opinion. As part of reviewing an examination request, each examiner analyzed the requested type of opinion to determine the questions they needed to answer before they could render a medical opinion. They gathered and reviewed evidence to answer those questions while also selecting evidence they could cite in a rationale to support their opinion.

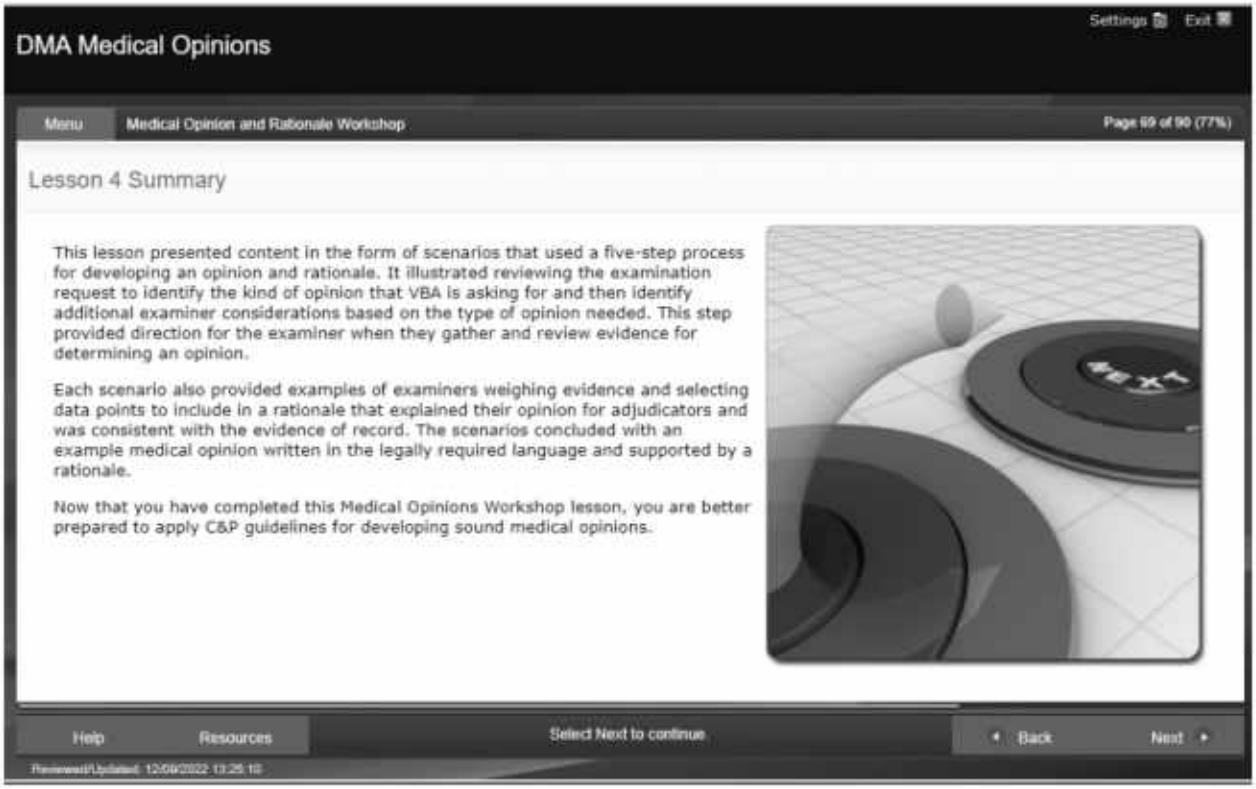
Each scenario culminated when the examiner rendered a medical opinion using the legally required language and wrote a supporting rationale for the non-clinician adjudicators who would read it.

The end-of-lesson assessment on the next page will test your understanding of the considerations and processes illustrated in the scenarios

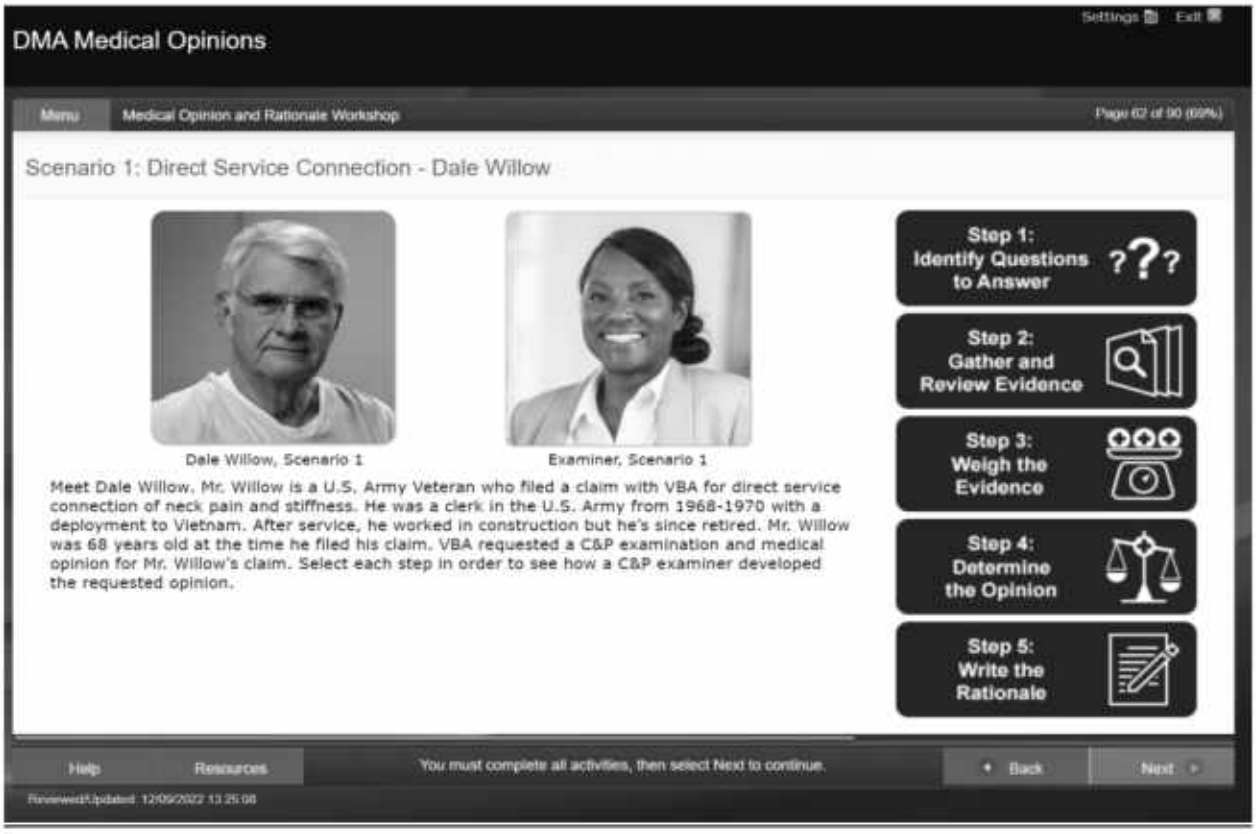


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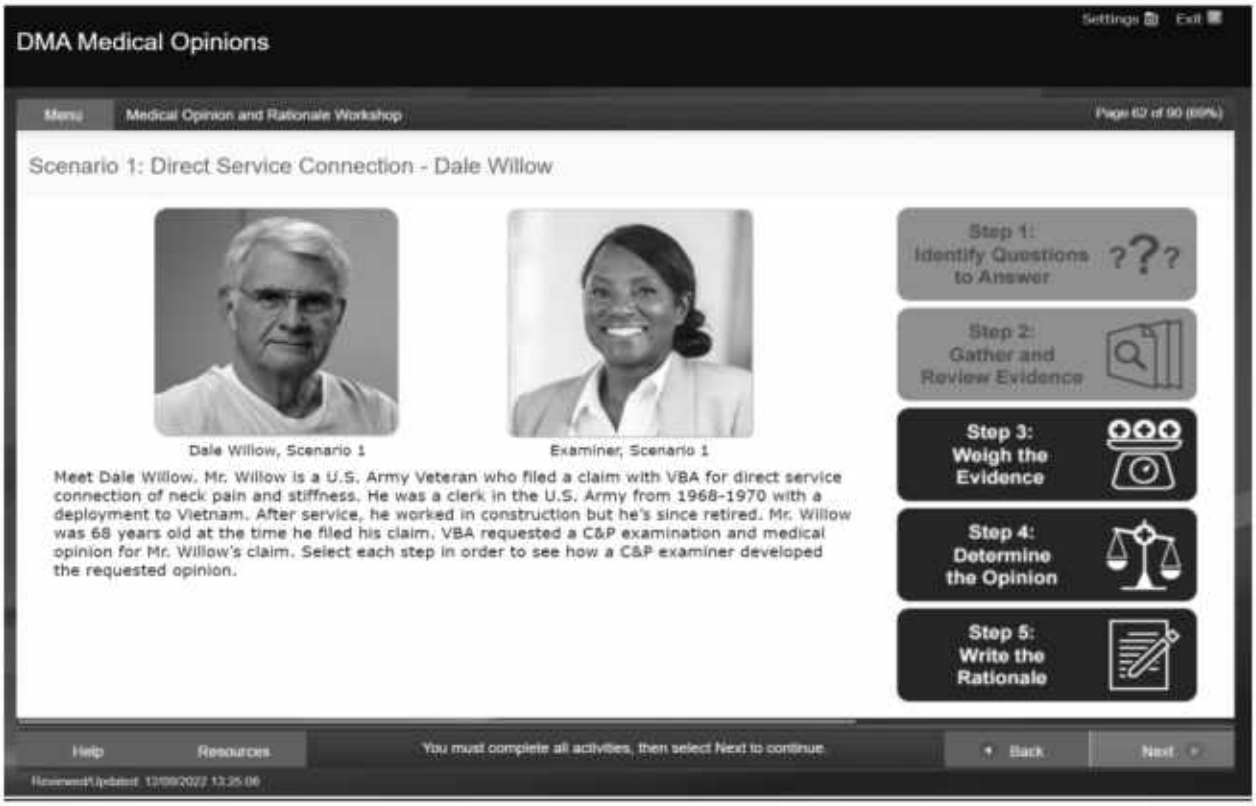
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Lesson 4 Summary
This lesson presented content in the form of scenarios that used a five-step process for developing an opinion and rationale. It illustrated reviewing the examination request to identify the kind of opinion that VBA is asking for and then identify additional examiner considerations based on the type of opinion needed. This step provided direction for the examiner when they gather and review evidence for determining an opinion.
Each scenario also provided examples of examiners weighing evidence and selecting data points to include in a rationale that explained their opinion for adjudicators and was consistent with the evidence of record. The scenarios concluded with an example medical opinion written in the legally required language and supported by a rationale.
Now that you have completed this Medical Opinions Workshop lesson, you are better prepared to apply C&P guidelines for developing sound medical opinions.
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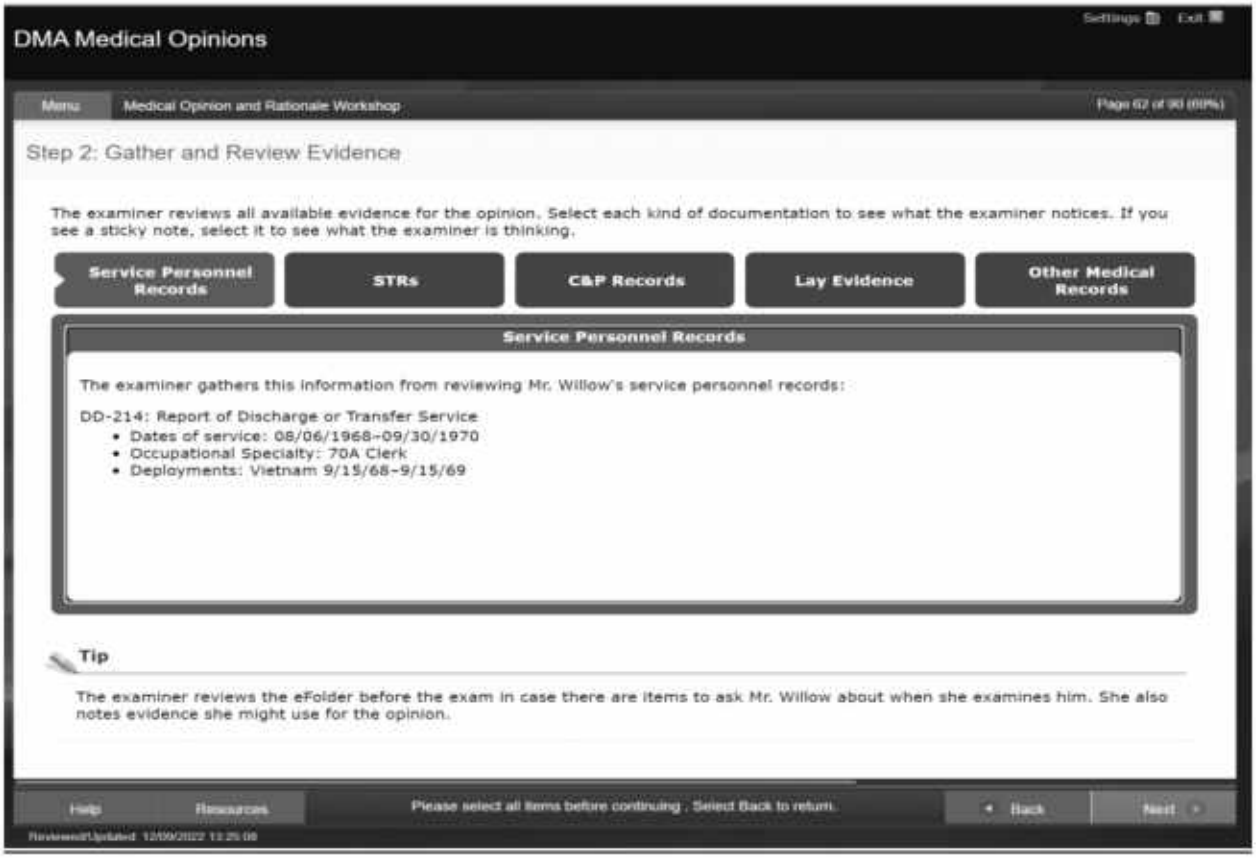

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Lesson 4 Introduction
Welcome to the Medical Opinion and Rationale Workshop! Scenarios in this lesson will demonstrate processes that examiners utilize when formulating sound medical opinions with effective rationales for types of opinions often requested by VBA. Examples include:
• A positive opinion for direct service connection
• A negative opinion for direct service connection
• An opinion for secondary service connection
• An opinion for aggravation of a preexisting condition
• An opinion for aggravation of a nonservice-connected condition (Allen)
The Process Outlined in Steps
The processes for each sample opinion will follow the steps outlined in Lesson 3.
1. Identify questions to answer for VBA and/or BVA.
2. Gather and review evidence.
3. Weigh the evidence.
4. Determine the medical opinion.
5. Write the supporting rationale.
When you complete this lesson, you should understand C&P guidelines for developing sound medical opinions.
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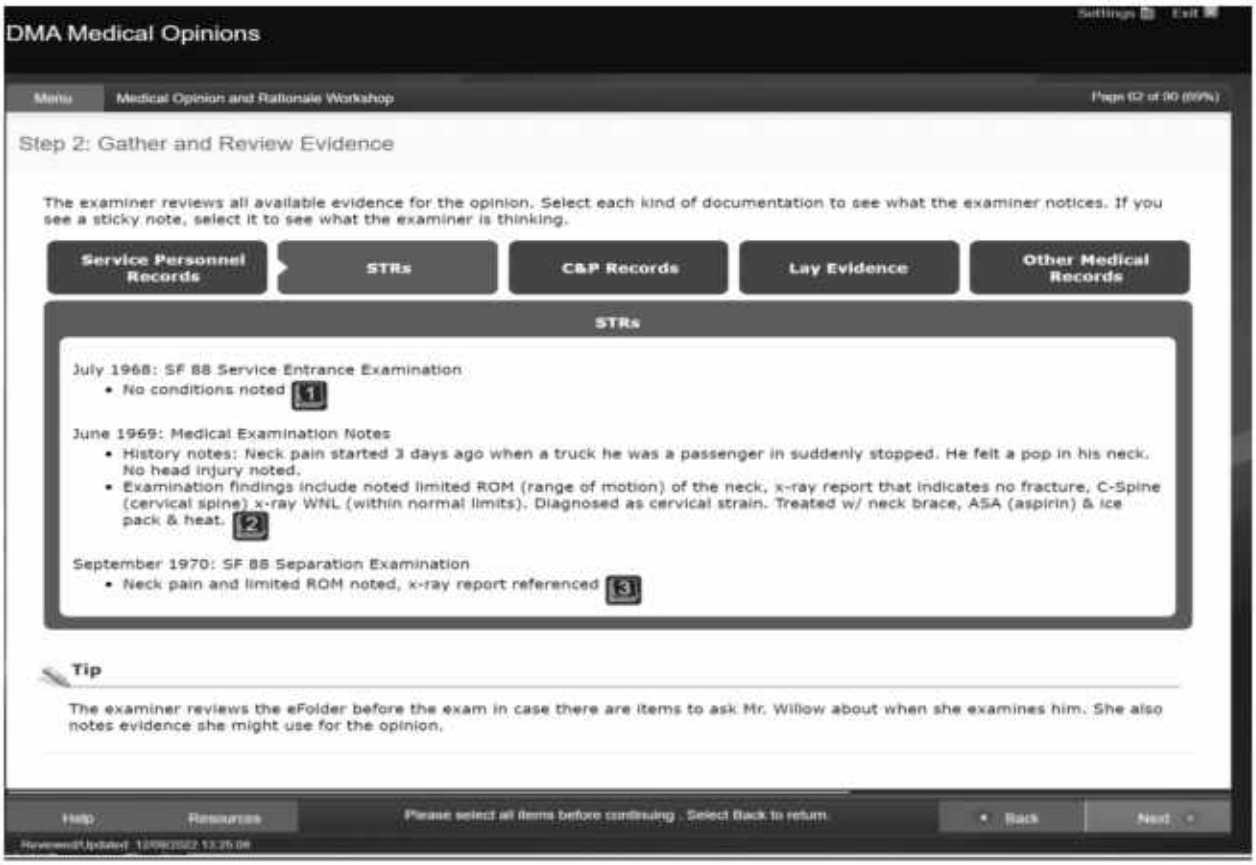

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Scenario 1: Direct Service Connection - Dale Willow
Dale Willow, Scenario 1
Examiner, Scenario 1
Meet Dale Willow. Mr. Willow is a U.S. Army Veteran who filed a claim with VBA for direct service connection of neck pain and stiffness. He was a clerk in the U.S. Army from 1968-1970 with a deployment to Vietnam. After service, he worked in construction but he's since retired. Mr. Willow was 68 years old at the time he filed his claim. VBA requested a C&P examination and medical opinion for Mr. Willow's claim. Select each step in order to see how a C&P examiner developed the requested opinion.
Step 1: Identify Questions to Answer
Step 2: Gather and Review Evidence
Step 3: Weigh the Evidence
Step 4: Determine the Opinion
Step 5: Write the Rationale
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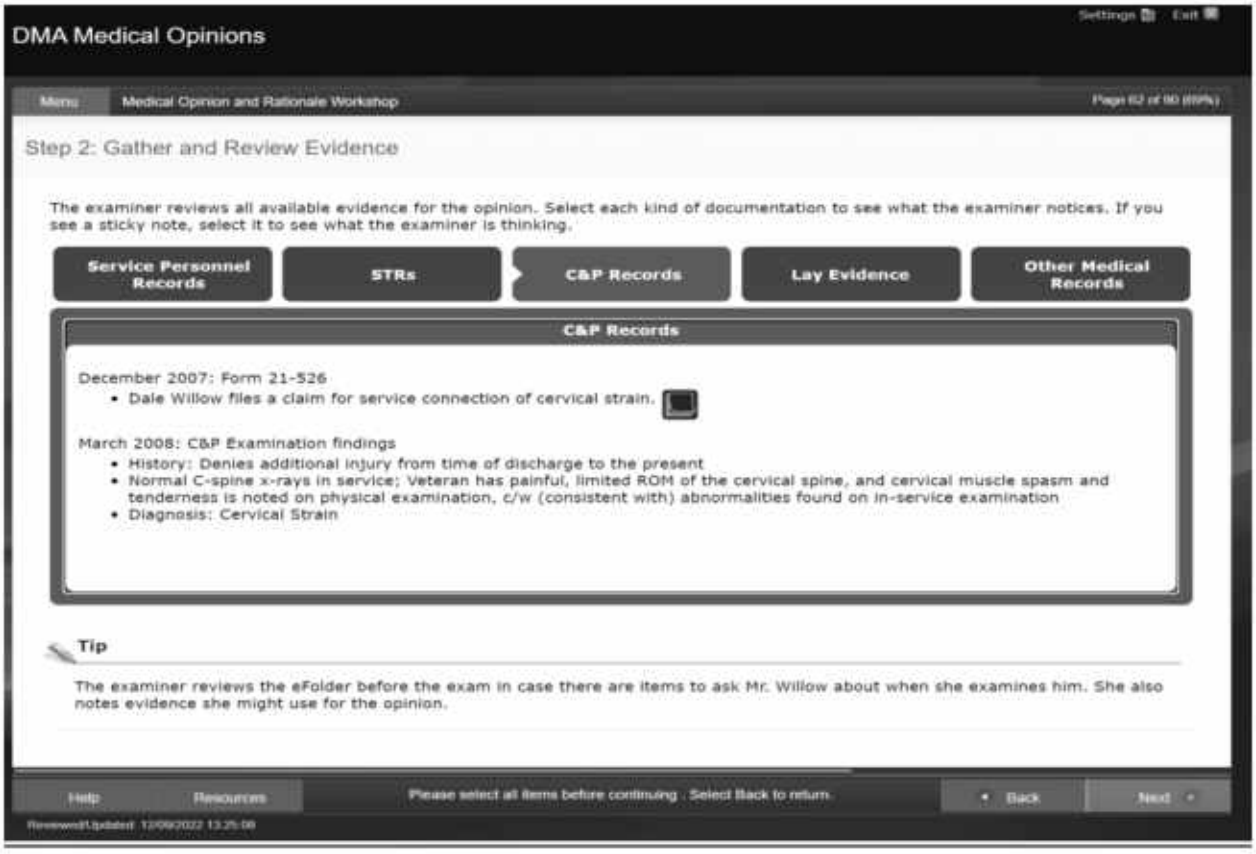

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Step 1: Identify Questions to Answer
The examiner reviews the examination request to identify the questions she must answer for VBA. She takes in this information:
Service-connected disabilities: None
Claimed disabilities: Neck pain and stiffness
Examination requested: Cervical Spine DBQ, Medical Opinion DBQ
The Veteran claims service connection for neck pain and stiffness. Please determine whether the Veteran's current neck pain and stiffness is at least as likely as not (likelihood is at least approximately balanced or nearly equal, if not higher) due to or caused by events during military service.
Dale Willow, Scenario 1
The first question is whether Mr. Willow's neck pain is caused by events in service.
Additional Examiner Considerations
To arrive at an answer, the examiner must answer other questions. Type in the questions you can think of, then select "Compare" to compare your questions with the examiner's.
Type your questions here, then click Compare.
Compare
Examiner's Questions:
1. Is there a current, diagnosable cervical condition?
2. Was there an injury, illness or event in service that could result in neck pain and stiffness?
3. Has a neck condition been present since service?
4. Was there an injury, illness or event after service that would better explain the neck pain and stiffness?
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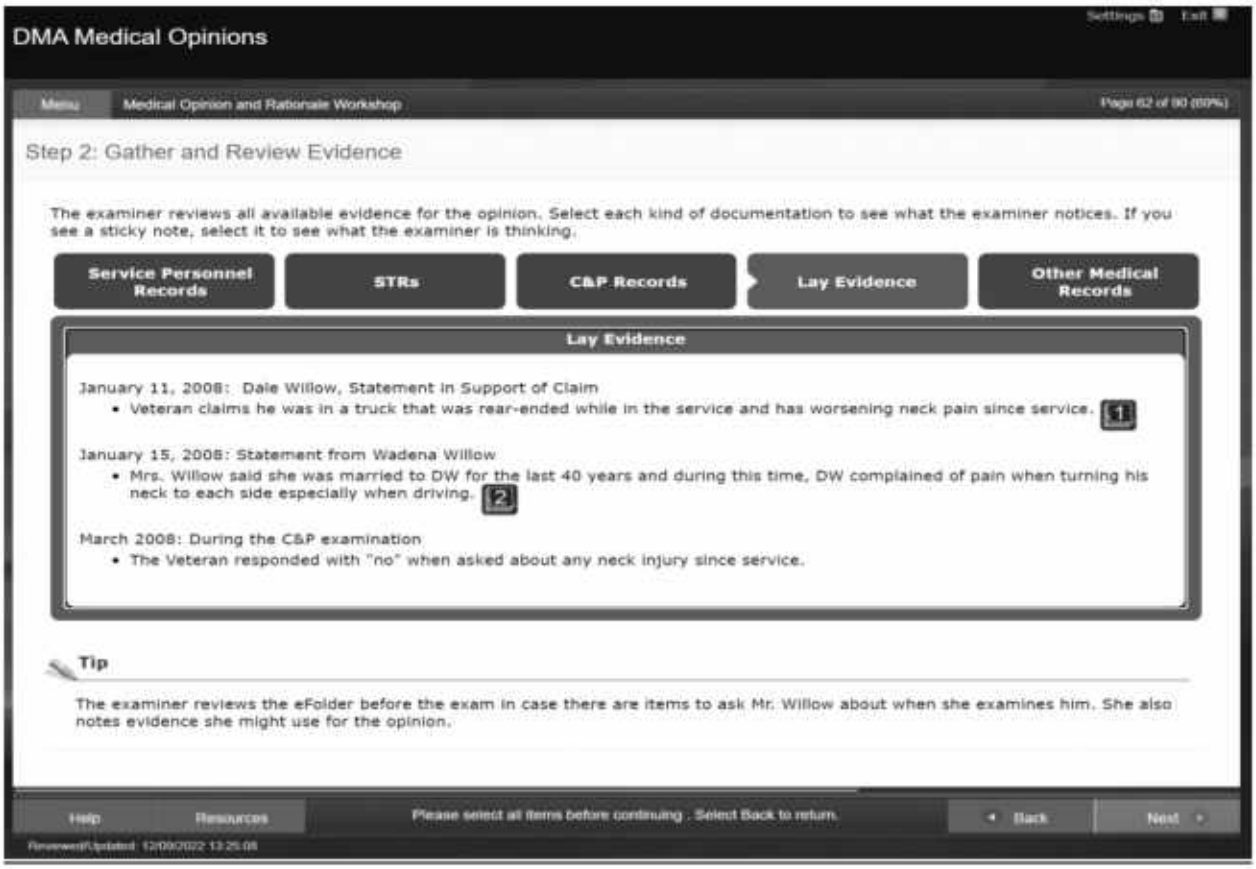

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Dale Willow, Scenario 1
Examiner, Scenario 1
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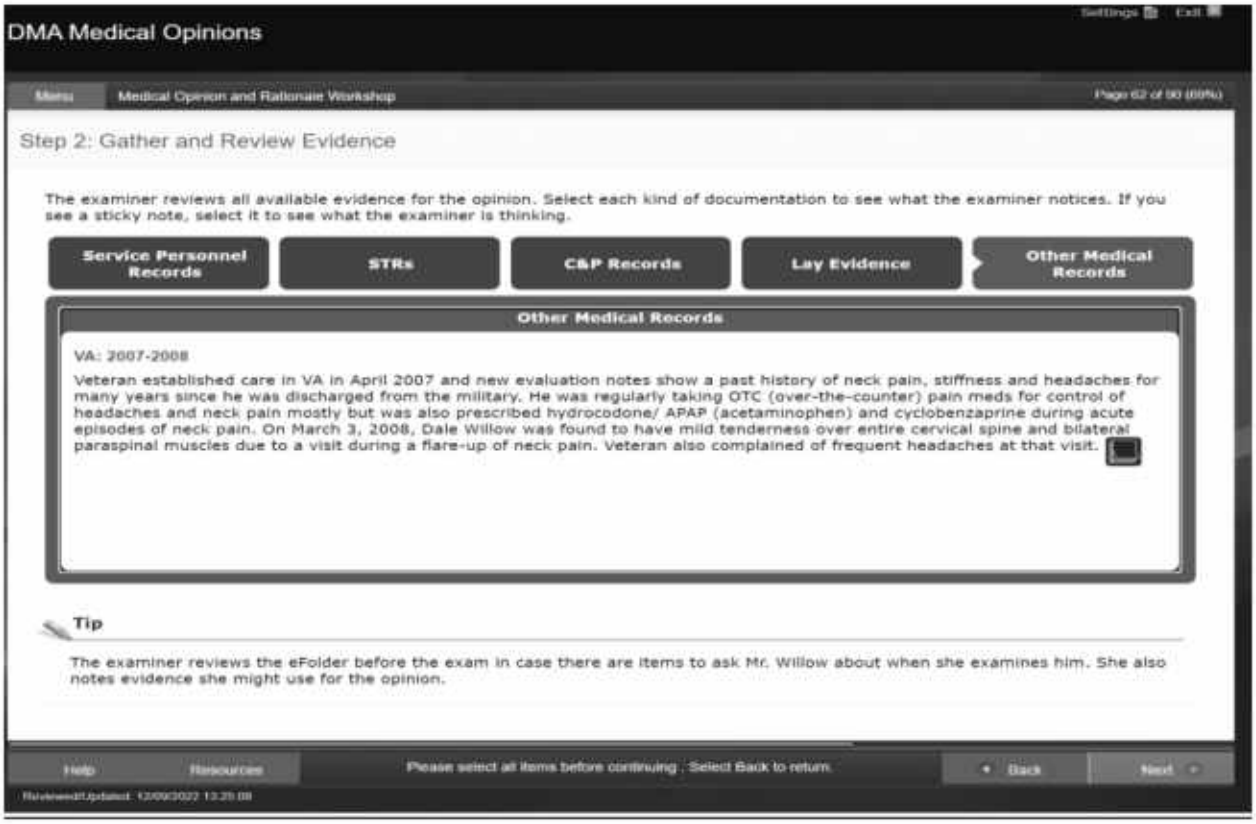

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Step 2: Gather and Review Evidence
The examiner reviews all available evidence for the opinion. Select each kind of documentation to see what the examiner notices. If you see a sticky note, select it to see what the examiner is thinking.
Service Personnel Records
STRs
C&P Records
Lay Evidence
Other Medical Records
Please make a selection
Dale Willow, Scenario 1
Tip
The examiner reviews the eFolder before the exam in case there are items to ask Mr. Willow about when she examines him. She also notes evidence she might use for the opinion.
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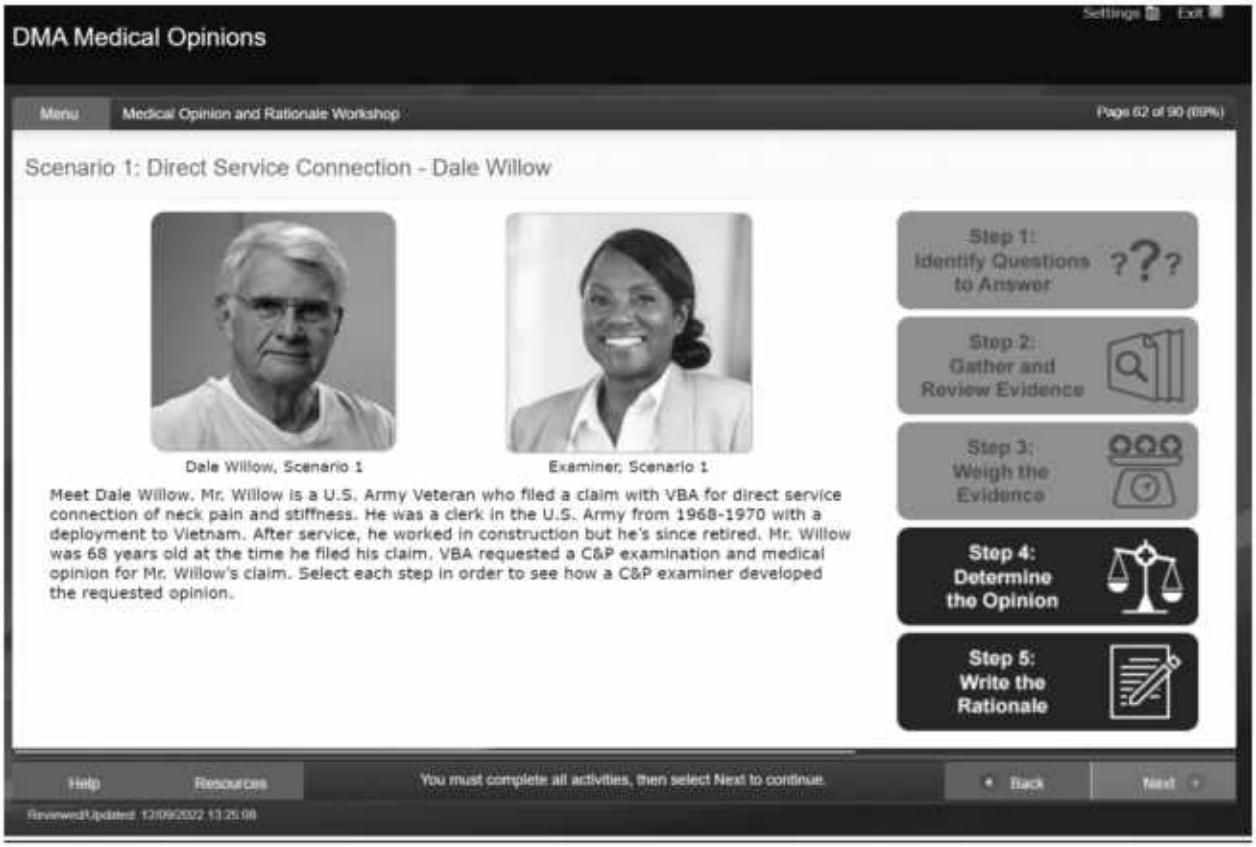

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The examiner reviews all available evidence for the opinion. Select each kind of documentation to see what the examiner notices. If you see a sticky note, select it to see what the examiner is thinking.
Service Personnel Records
STRs
C&P Records
Lay Evidence
Other Medical Records
Service Personnel Records
The examiner gathers this information from reviewing Mr. Willow's service personnel records:
DD-214: Report of Discharge or Transfer Service
Dates of service: 08/06/1968-09/30/1970
Occupational Specialty: 70A Clerk
Deployments: Vietnam 9/15/68-9/15/69
Tip
The examiner reviews the eFolder before the exam in case there are items to ask Mr. Willow about when she examines him. She also notes evidence she might use for the opinion.
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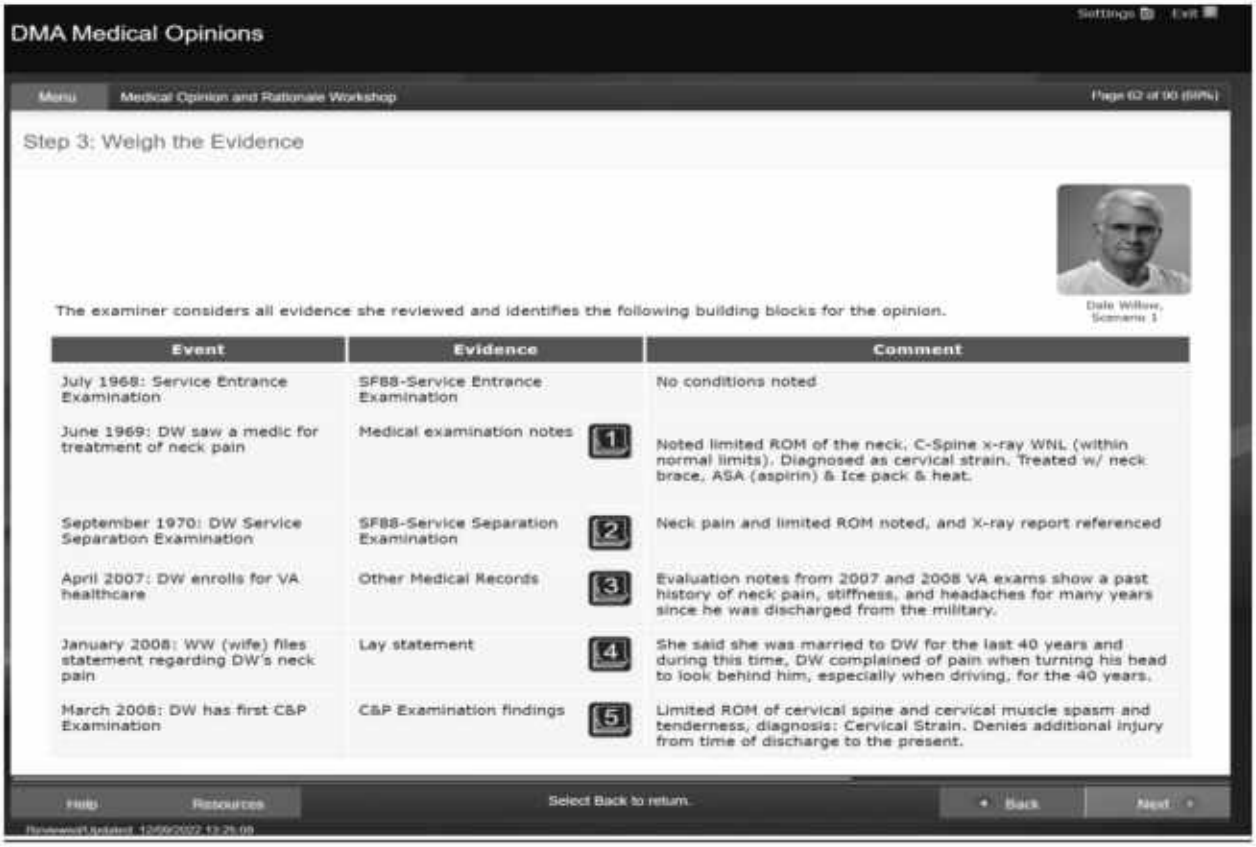

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Step 2: Gather and Review Evidence
The examiner reviews all available evidence for the opinion. Select each kind of documentation to see what the examiner notices. If you see a sticky note, select it to see what the examiner is thinking.
Service Personnel Records
STRs
C&P Records
Lay Evidence
Other Medical Records
STRs
July 1968: SF 88 Service Entrance Examination
• No conditions noted 1
June 1969: Medical Examination Notes
• History notes: Neck pain started 3 days ago when a truck he was a passenger in suddenly stopped. He felt a pop in his neck. No head injury noted.
• Examination findings include noted limited ROM (range of motion) of the neck, x-ray report that indicates no fracture, C-Spine (cervical spine) x-ray WNL (within normal limits). Diagnosed as cervical strain. Treated w/ neck brace, ASA (aspirin) & ice pack & heat. 2
September 1970: SF 88 Separation Examination
• Neck pain and limited ROM noted, x-ray report referenced 3
Tip
The examiner reviews the eFolder before the exam in case there are items to ask Mr. Willow about when she examines him. She also notes evidence she might use for the opinion.
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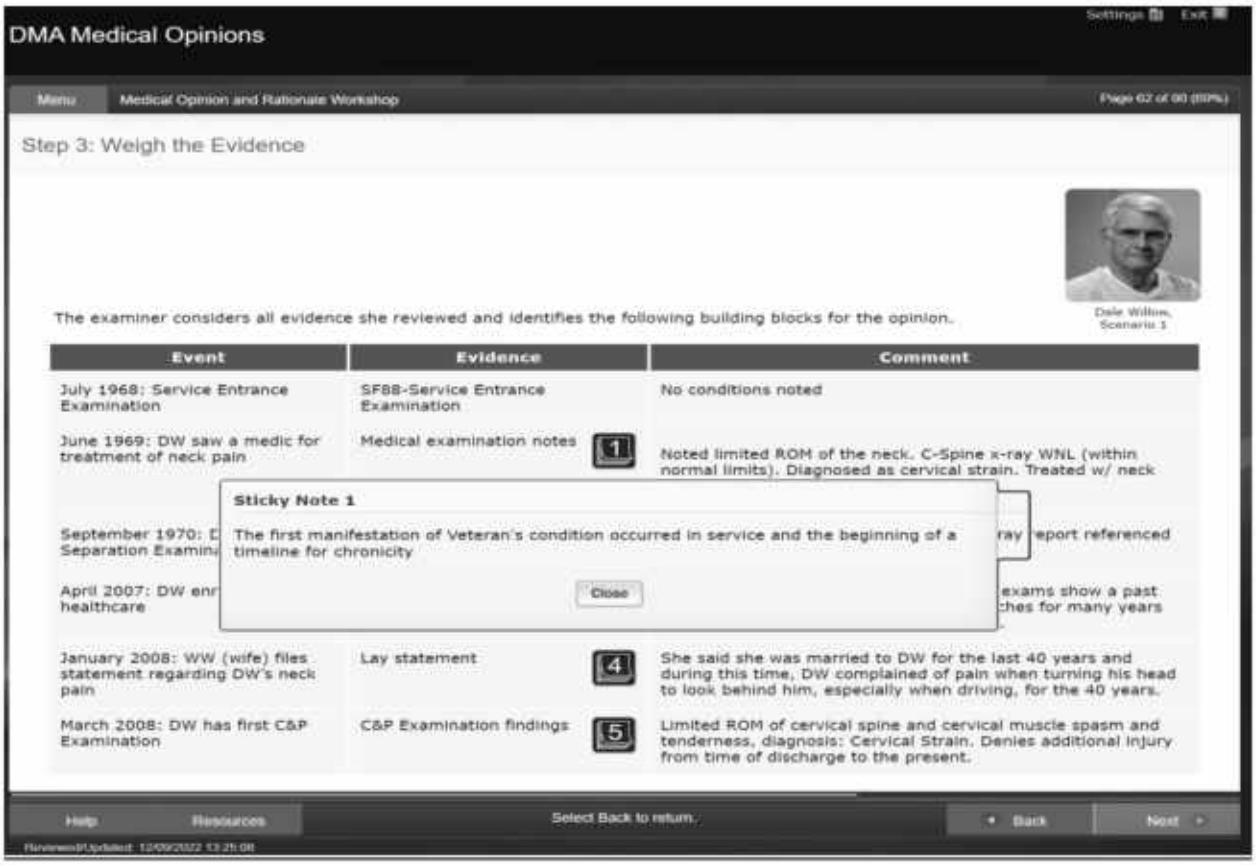

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Step 2: Gather and Review Evidence
The examiner reviews all available evidence for the opinion. Select each kind of documentation to see what the examiner notices. If you see a sticky note, select it to see what the examiner is thinking.
Service Personnel Records
STRs
C&P Records
Lay Evidence
Other Medical Records
C&P Records
December 2007: Form 21-526
• Dale Willow files a claim for service connection of cervical strain.
March 2008: C&P Examination findings
• History: Denies additional injury from time of discharge to the present
• Normal C-spine x-rays in service; Veteran has painful, limited ROM of the cervical spine, and cervical muscle spasm and tenderness is noted on physical examination, c/w (consistent with) abnormalities found on in-service examination
• Diagnosis: Cervical Strain
Tip
The examiner reviews the eFolder before the exam in case there are items to ask Mr. Willow about when she examines him. She also notes evidence she might use for the opinion.
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The examiner reviews all available evidence for the opinion. Select each kind of documentation to see what the examiner notices. If you see a sticky note, select it to see what the examiner is thinking.
Service Personnel Records
STRs
C&P Records
Lay Evidence
Other Medical Records
Lay Evidence
January 11, 2008: Dale Willow, Statement in Support of Claim
• Veteran claims he was in a truck that was rear-ended while in the service and has worsening neck pain since service. 1
January 15, 2008: Statement from Wadena Willow
• Mrs. Willow said she was married to DW for the last 40 years and during this time, DW complained of pain when turning his neck to each side especially when driving. 2
March 2008: During the C&P examination
• The Veteran responded with "no" when asked about any neck injury since service.
Tip
The examiner reviews the eFolder before the exam in case there are items to ask Mr. Willow about when she examines him. She also notes evidence she might use for the opinion.
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Service Personnel Records
STRs
C&P Records
Lay Evidence
Other Medical Records
Other Medical Records
VA: 2007-2008
Veteran established care in VA in April 2007 and new evaluation notes show a past history of neck pain, stiffness and headaches for many years since he was discharged from the military. He was regularly taking OTC (over-the-counter) pain meds for control of headaches and neck pain mostly but was also prescribed hydrocodone/ APAP (acetaminophen) and cyclobenzaprine during acute episodes of neck pain. On March 3, 2008, Dale Willow was found to have mild tenderness over entire cervical spine and bilateral paraspinal muscles due to a visit during a flare-up of neck pain. Veteran also complained of frequent headaches at that visit.
Tip
The examiner reviews the eFolder before the exam in case there are items to ask Mr. Willow about when she examines him. She also notes evidence she might use for the opinion.
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Please select all items before continuing. Select Back to return.
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Scenario 1: Direct Service Connection - Dale Willow
Dale Willow, Scenario 1
Examiner, Scenario 1
Meet Dale Willow. Mr. Willow is a U.S. Army Veteran who filed a claim with VBA for direct service connection of neck pain and stiffness. He was a clerk in the U.S. Army from 1968-1970 with a deployment to Vietnam. After service, he worked in construction but he's since retired. Mr. Willow was 68 years old at the time he filed his claim. VBA requested a C&P examination and medical opinion for Mr. Willow's claim. Select each step in order to see how a C&P examiner developed the requested opinion.
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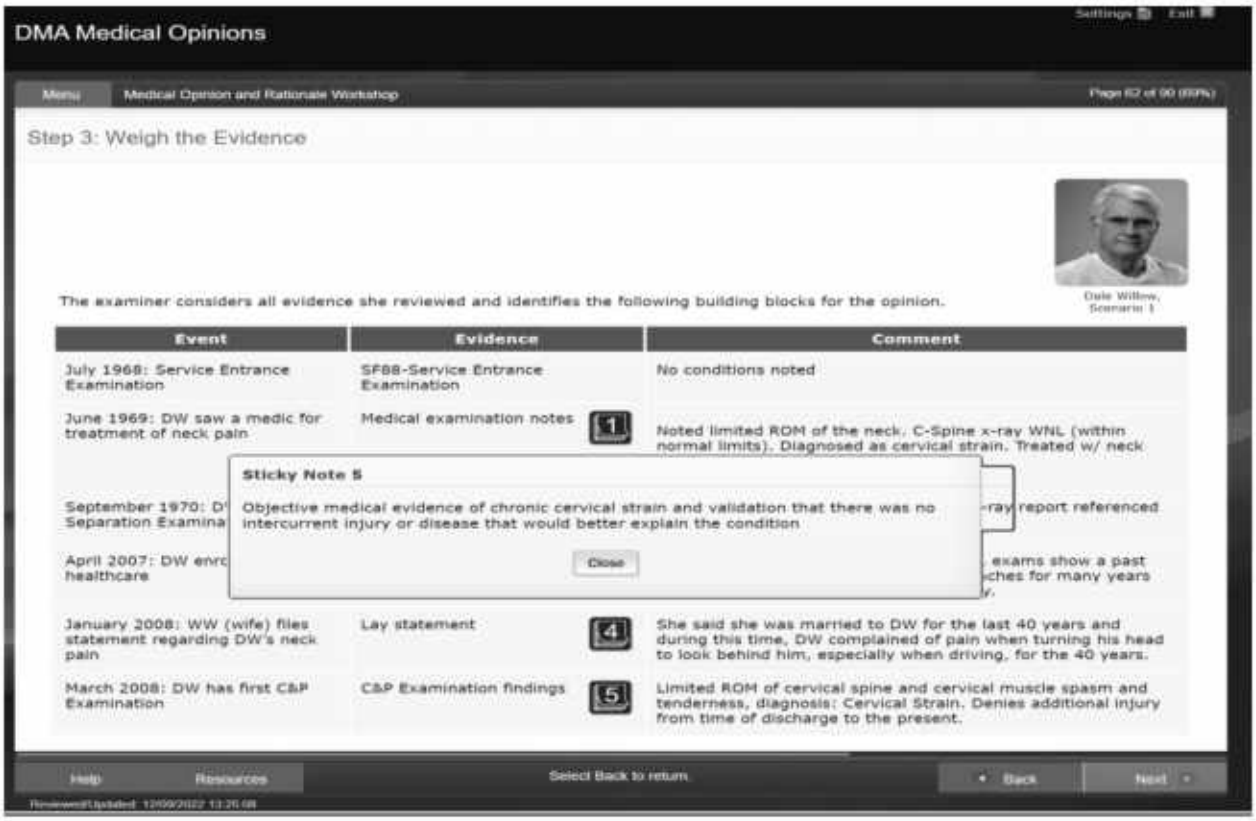

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Step 3: Weigh the Evidence
Dale Willow, Scenario 1
The examiner considers all evidence she reviewed and identifies the following building blocks for the opinion.
Event
Evidence
Comment
July 1968: Service Entrance Examination
SF88-Service Entrance Examination
No conditions noted
June 1969: DW saw a medic for treatment of neck pain
Medical examination notes
1
Noted limited ROM of the neck. C-Spine x-ray WNL (within normal limits). Diagnosed as cervical strain. Treated w/ neck brace, ASA (aspirin) & Ice pack & heat.
September 1970: DW Service Separation Examination
SF88-Service Separation Examination
2
Neck pain and limited ROM noted, and X-ray report referenced
April 2007: DW enrolls for VA healthcare
Other Medical Records
3
Evaluation notes from 2007 and 2008 VA exams show a past history of neck pain, stiffness, and headaches for many years since he was discharged from the military.
January 2008: WW (wife) files statement regarding DW's neck pain
Lay statement
4
She said she was married to DW for the last 40 years and during this time, DW complained of pain when turning his head to look behind him, especially when driving, for the 40 years.
March 2008: DW has first C&P Examination
C&P Examination findings
5
Limited ROM of cervical spine and cervical muscle spasm and tenderness, diagnosis: Cervical Strain. Denies additional injury from time of discharge to the present.
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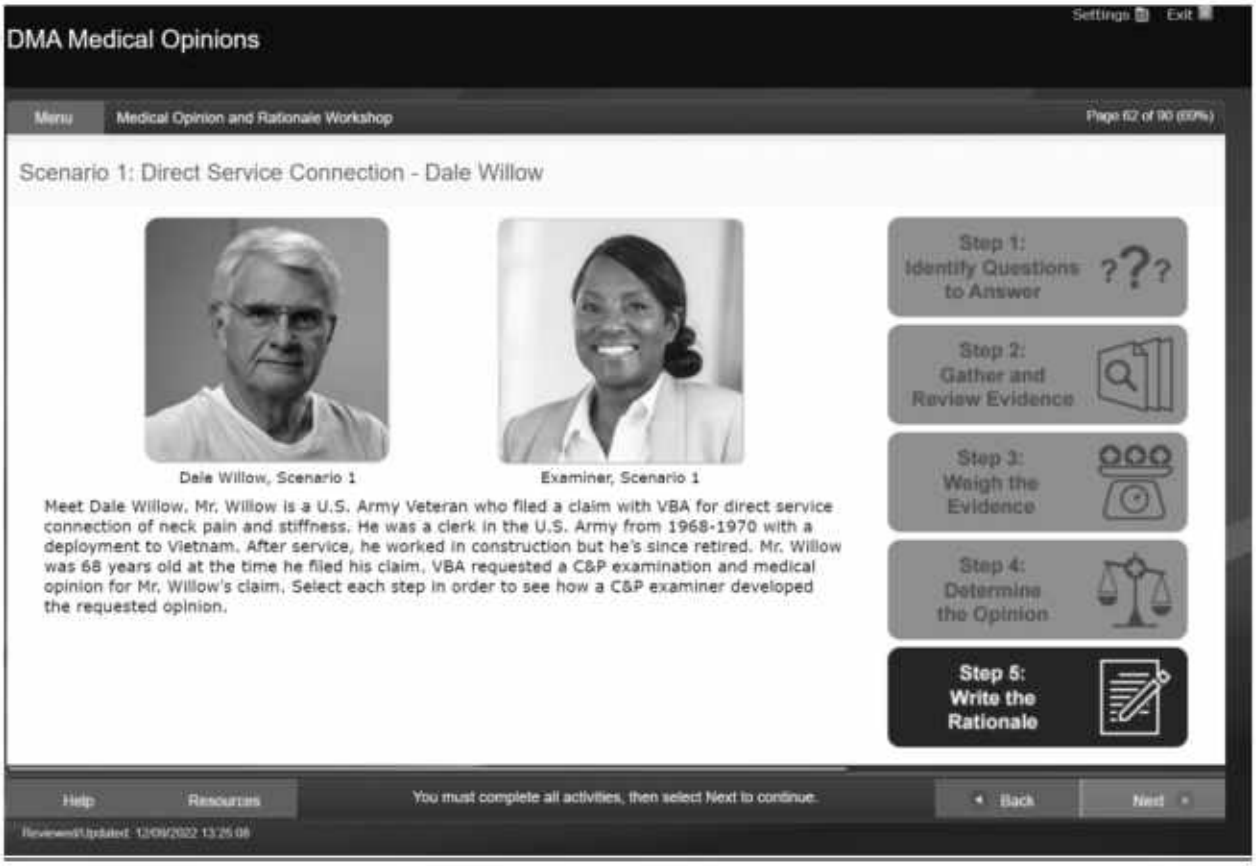

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Dale Willow, Scenario 1
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Evidence
Comment
July 1968: Service Entrance Examination
SF88-Service Entrance Examination
No conditions noted
June 1969: DW saw a medic for treatment of neck pain
Medical examination notes
1
Noted limited ROM of the neck. C-Spine x-ray WNL (within normal limits). Diagnosed as cervical strain. Treated w/ neck
Sticky Note 1
The first manifestation of Veteran's condition occurred in service and the beginning of a timeline for chronicity
Close
report referenced
exams show a past
ches for many years
January 2008: WW (wife) files statement regarding DW's neck pain
Lay statement
4
She said she was married to DW for the last 40 years and during this time, DW complained of pain when turning his head to look behind him, especially when driving, for the 40 years.
March 2008: DW has first C&P Examination
C&P Examination findings
5
Limited ROM of cervical spine and cervical muscle spasm and tenderness, diagnosis: Cervical Strain. Denies additional injury from time of discharge to the present.
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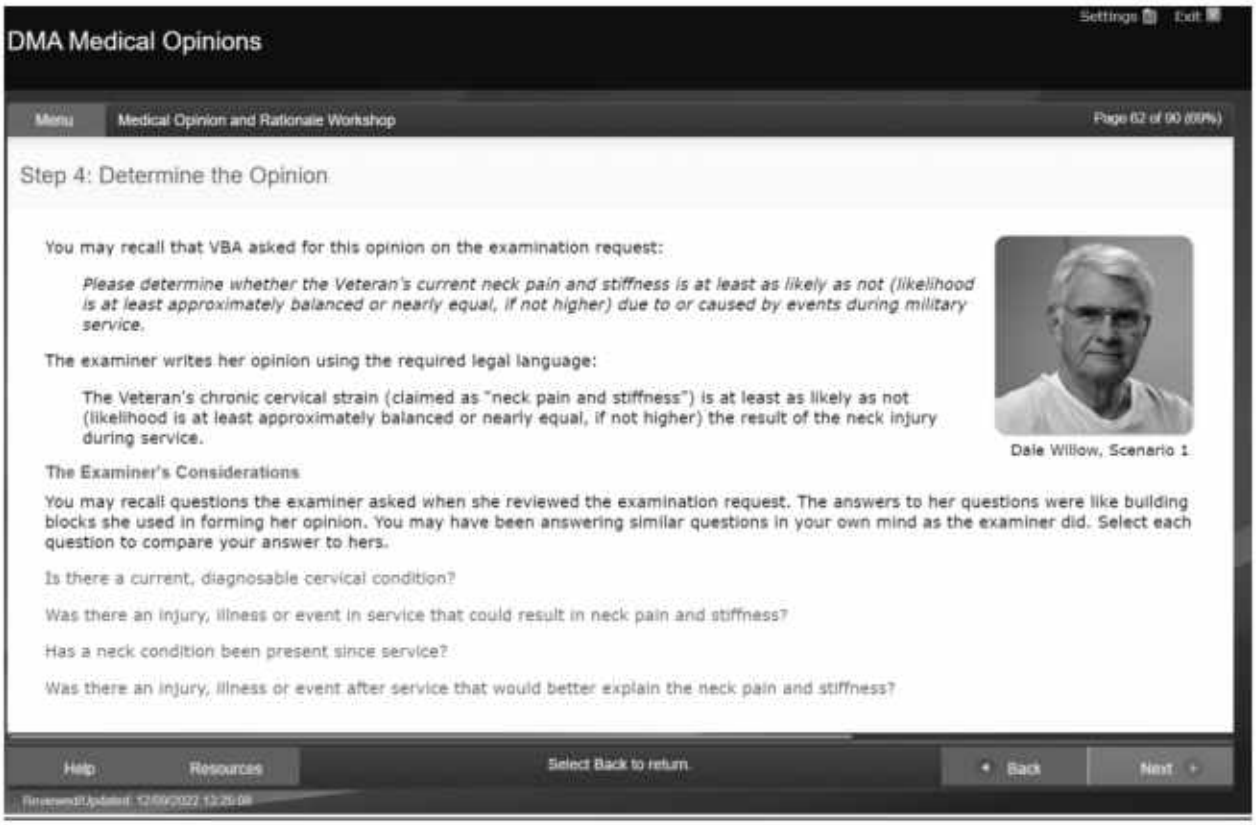

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Dale Willow, Scenario 1
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Event
Evidence
Comment
July 1968: Service Entrance Examination
SF88-Service Entrance Examination
No conditions noted
June 1969: DW saw a medic for treatment of neck pain
Medical examination notes
1
Noted limited ROM of the neck. C-Spine x-ray WNL (within normal limits). Diagnosed as cervical strain. Treated w/ neck
Sticky Note 2
DW still had neck pain and limited ROM when he separated from service
Close
X-ray report referenced
08 VA exams show a past
headaches for many years
since he was discharged from the military.
January 2008: WW (wife) files statement regarding DW's neck pain
Lay statement
4
She said she was married to DW for the last 40 years and during this time, DW complained of pain when turning his head to look behind him, especially when driving, for the 40 years.
March 2008: DW has first C&P Examination
C&P Examination findings
5
Limited ROM of cervical spine and cervical muscle spasm and tenderness, diagnosis: Cervical Strain. Denies additional injury from time of discharge to the present.
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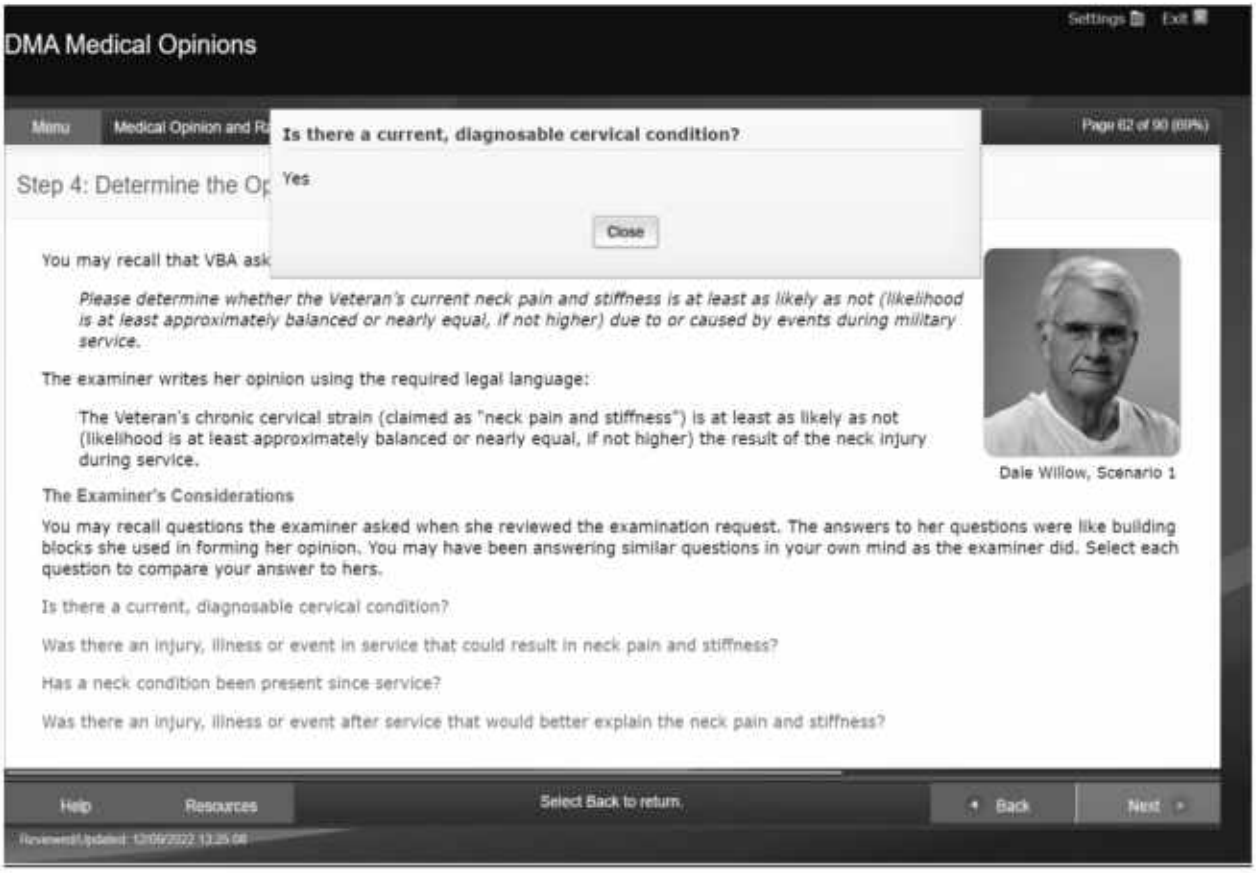

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Step 3: Weigh the Evidence
Dale Willow, Scenario 1
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Event
Evidence
Comment
July 1968: Service Entrance Examination
SF88-Service Entrance Examination
No conditions noted
June 1969: DW saw a medic for treatment of neck pain
Medical examination notes
1
Noted limited ROM of the neck. C-Spine x-ray WNL (within normal limits). Diagnosed as cervical strain. Treated w/ neck
Sticky Note 3
Evidence that the condition is chronic and not improving
Close
September 1970: DW Ser
Separation Examination
x-ray report referenced
April 2007: DW enrolls fo
healthcare
08 VA exams show a past
headaches for many years
since he was discharged from the military.
January 2008: WW (wife) files statement regarding DW's neck pain
Lay statement
4
She said she was married to DW for the last 40 years and during this time, DW complained of pain when turning his head to look behind him, especially when driving, for the 40 years.
March 2008: DW has first C&P Examination
C&P Examination findings
5
Limited ROM of cervical spine and cervical muscle spasm and tenderness, diagnosis: Cervical Strain. Denies additional injury from time of discharge to the present.
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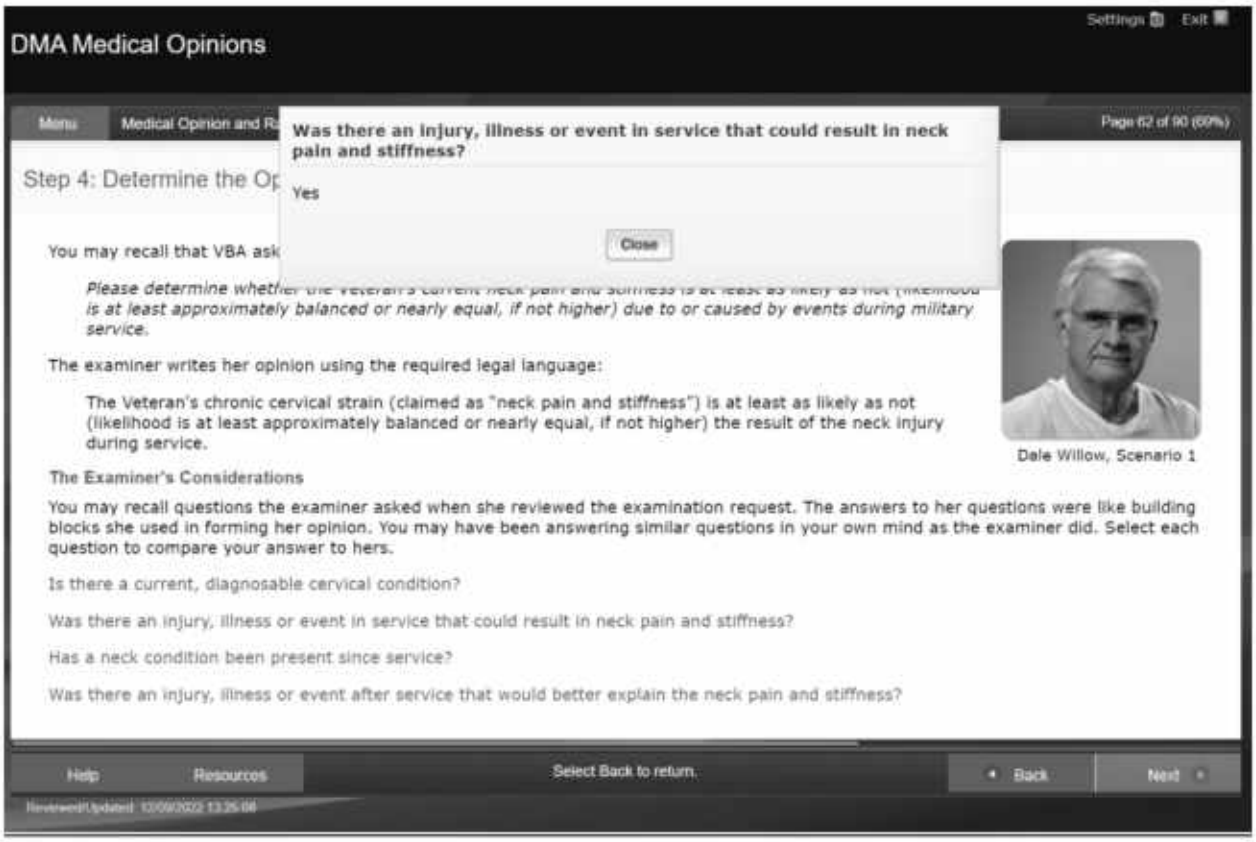

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Dale Willow, Scenario 1
The examiner considers all evidence she reviewed and identifies the following building blocks for the opinion.
Event
Evidence
Comment
July 1968: Service Entrance Examination
SF88-Service Entrance Examination
No conditions noted
June 1969: DW saw a medic for treatment of neck pain
Medical examination notes
1
Noted limited ROM of the neck. C-Spine x-ray WNL (within normal limits). Diagnosed as cervical strain. Treated w/ neck
Sticky Note 4
Evidence that the neck pain has been chronic and not improving
Close
September 1970: DW Ser
Separation Examination
x-ray report referenced
April 2007: DW enrolls fo
healthcare
08 VA exams show a past
headaches for many years
since he was discharged from the military.
January 2008: WW (wife) files statement regarding DW's neck pain
Lay statement
4
She said she was married to DW for the last 40 years and during this time, DW complained of pain when turning his head to look behind him, especially when driving, for the 40 years.
March 2008: DW has first C&P Examination
C&P Examination findings
5
Limited ROM of cervical spine and cervical muscle spasm and tenderness, diagnosis: Cervical Strain. Denies additional injury from time of discharge to the present.
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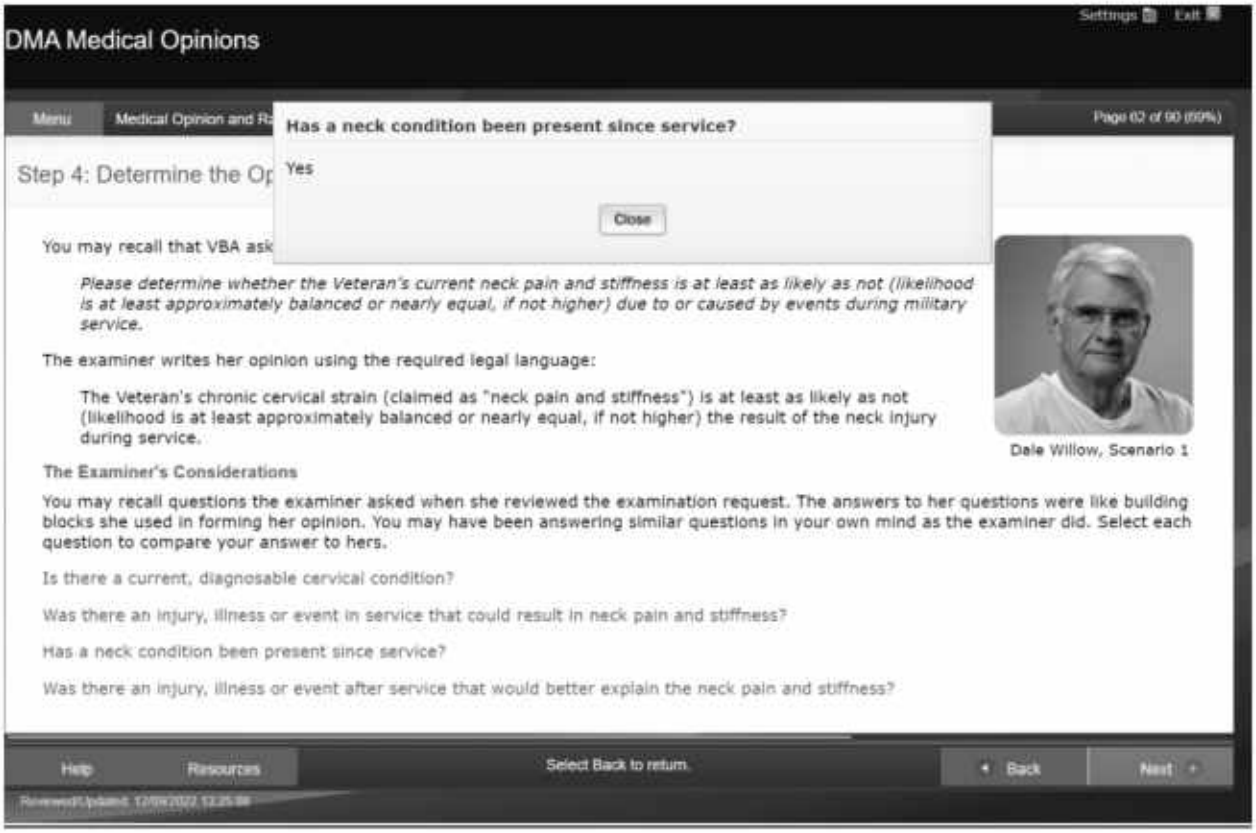

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The examiner considers all evidence she reviewed and identifies the following building blocks for the opinion.
Event
Evidence
Comment
July 1968: Service Entrance Examination
SF88-Service Entrance Examination
No conditions noted
June 1969: DW saw a medic for treatment of neck pain
Medical examination notes
1
Noted limited ROM of the neck. C-Spine x-ray WNL (within normal limits). Diagnosed as cervical strain. Treated w/ neck
Sticky Note 5
Objective medical evidence of chronic cervical strain and validation that there was no intercurrent injury or disease that would better explain the condition
Close
September 1970: D
Separation Examina
-ray report referenced
April 2007: DW enrc
healthcare
exams show a past
ches for many years
January 2008: WW (wife) files statement regarding DW's neck pain
Lay statement
4
She said she was married to DW for the last 40 years and during this time, DW complained of pain when turning his head to look behind him, especially when driving, for the 40 years.
March 2008: DW has first C&P Examination
C&P Examination findings
5
Limited ROM of cervical spine and cervical muscle spasm and tenderness, diagnosis: Cervical Strain. Denies additional injury from time of discharge to the present.
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Scenario 1: Direct Service Connection - Dale Willow
Dale Willow, Scenario 1
Examiner, Scenario 1
Meet Dale Willow. Mr. Willow is a U.S. Army Veteran who filed a claim with VBA for direct service connection of neck pain and stiffness. He was a clerk in the U.S. Army from 1968-1970 with a deployment to Vietnam. After service, he worked in construction but he's since retired. Mr. Willow was 68 years old at the time he filed his claim. VBA requested a C&P examination and medical opinion for Mr. Willow's claim. Select each step in order to see how a C&P examiner developed the requested opinion.
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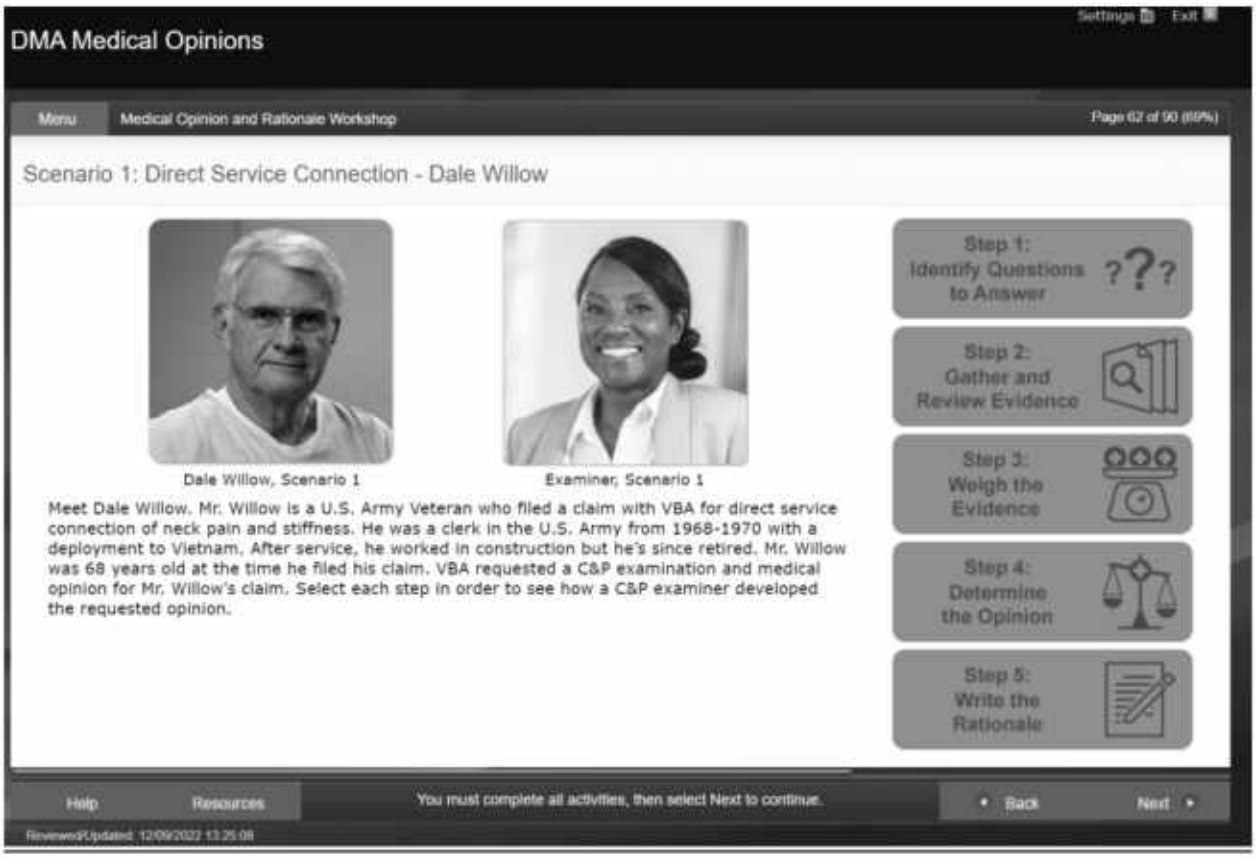

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Step 4: Determine the Opinion
You may recall that VBA asked for this opinion on the examination request:
Please determine whether the Veteran's current neck pain and stiffness is at least as likely as not (likelihood is at least approximately balanced or nearly equal, if not higher) due to or caused by events during military service.
The examiner writes her opinion using the required legal language:
The Veteran's chronic cervical strain (claimed as "neck pain and stiffness") is at least as likely as not (likelihood is at least approximately balanced or nearly equal, if not higher) the result of the neck injury during service.
Dale Willow, Scenario 1
The Examiner's Considerations
You may recall questions the examiner asked when she reviewed the examination request. The answers to her questions were like building blocks she used in forming her opinion. You may have been answering similar questions in your own mind as the examiner did. Select each question to compare your answer to hers.
Is there a current, diagnosable cervical condition?
Was there an injury, illness or event in service that could result in neck pain and stiffness?
Has a neck condition been present since service?
Was there an injury, illness or event after service that would better explain the neck pain and stiffness?
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Is there a current, diagnosable cervical condition?
Yes
Close
Step 4: Determine the Op
You may recall that VBA ask
Please determine whether the Veteran's current neck pain and stiffness is at least as likely as not (likelihood is at least approximately balanced or nearly equal, if not higher) due to or caused by events during military service.
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Dale Willow, Scenario 1
The Examiner's Considerations
You may recall questions the examiner asked when she reviewed the examination request. The answers to her questions were like building blocks she used in forming her opinion. You may have been answering similar questions in your own mind as the examiner did. Select each question to compare your answer to hers.
Is there a current, diagnosable cervical condition?
Was there an injury, illness or event in service that could result in neck pain and stiffness?
Has a neck condition been present since service?
Was there an injury, illness or event after service that would better explain the neck pain and stiffness?
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Was there an injury, illness or event in service that could result in neck pain and stiffness?
Yes
Close
Step 4: Determine the Op
You may recall that VBA ask
Please determine whether the Veteran's current neck pain and stiffness is at least as likely as not (likelihood is at least approximately balanced or nearly equal, if not higher) due to or caused by events during military service.
The examiner writes her opinion using the required legal language:
The Veteran's chronic cervical strain (claimed as "neck pain and stiffness") is at least as likely as not (likelihood is at least approximately balanced or nearly equal, if not higher) the result of the neck injury during service.
Dale Willow, Scenario 1
The Examiner's Considerations
You may recall questions the examiner asked when she reviewed the examination request. The answers to her questions were like building blocks she used in forming her opinion. You may have been answering similar questions in your own mind as the examiner did. Select each question to compare your answer to hers.
Is there a current, diagnosable cervical condition?
Was there an injury, illness or event in service that could result in neck pain and stiffness?
Has a neck condition been present since service?
Was there an injury, illness or event after service that would better explain the neck pain and stiffness?
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Has a neck condition been present since service?
Yes
Close
Step 4: Determine the Op
You may recall that VBA ask
Please determine whether the Veteran's current neck pain and stiffness is at least as likely as not (likelihood is at least approximately balanced or nearly equal, if not higher) due to or caused by events during military service.
The examiner writes her opinion using the required legal language:
The Veteran's chronic cervical strain (claimed as "neck pain and stiffness") is at least as likely as not (likelihood is at least approximately balanced or nearly equal, if not higher) the result of the neck injury during service.
Dale Willow, Scenario 1
The Examiner's Considerations
You may recall questions the examiner asked when she reviewed the examination request. The answers to her questions were like building blocks she used in forming her opinion. You may have been answering similar questions in your own mind as the examiner did. Select each question to compare your answer to hers.
Is there a current, diagnosable cervical condition?
Was there an injury, illness or event in service that could result in neck pain and stiffness?
Has a neck condition been present since service?
Was there an injury, illness or event after service that would better explain the neck pain and stiffness?
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Was there an injury, illness or event after service that would better explain the neck pain and stiffness?
No
Close
Step 4: Determine the Op
You may recall that VBA ask
Please determine whether the Veteran's current neck pain and stiffness is at least as likely as not (likelihood is at least approximately balanced or nearly equal, if not higher) due to or caused by events during military service.
The examiner writes her opinion using the required legal language:
The Veteran's chronic cervical strain (claimed as "neck pain and stiffness") is at least as likely as not (likelihood is at least approximately balanced or nearly equal, if not higher) the result of the neck injury during service.
Dale Willow, Scenario 1
The Examiner's Considerations
You may recall questions the examiner asked when she reviewed the examination request. The answers to her questions were like building blocks she used in forming her opinion. You may have been answering similar questions in your own mind as the examiner did. Select each question to compare your answer to hers.
Is there a current, diagnosable cervical condition?
Was there an injury, illness or event in service that could result in neck pain and stiffness?
Has a neck condition been present since service?
Was there an injury, illness or event after service that would better explain the neck pain and stiffness?
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Scenario 1: Direct Service Connection - Dale Willow
Dale Willow, Scenario 1
Examiner, Scenario 1
Meet Dale Willow. Mr. Willow is a U.S. Army Veteran who filed a claim with VBA for direct service connection of neck pain and stiffness. He was a clerk in the U.S. Army from 1968-1970 with a deployment to Vietnam. After service, he worked in construction but he's since retired. Mr. Willow was 68 years old at the time he filed his claim. VBA requested a C&P examination and medical opinion for Mr. Willow's claim. Select each step in order to see how a C&P examiner developed the requested opinion.
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Step 5: Write the Rationale

Opinion: The Veteran's chronic cervical strain (claimed as "neck pain and stiffness") is at least as likely as not (likelihood is at least approximately balanced or nearly equal, if not higher) the result of the neck injury during service.

The examiner adds this rationale.

Rationale: The evidence of record documents that the Veteran experienced pain and limited range of motion after a motor vehicle incident while on active duty. Medical treatment during service confirms the onset of symptoms and supports that there were no pre-existing cervical abnormalities. Objective and subjective post-service records support that the neck condition has persisted and progressed in severity since the Veteran's military service.



Dale Willow, Scenario 1

- STRs indicate that the Veteran presented with neck pain following a sudden stop while riding in a truck. Per treatment notes, he was evaluated for persistent neck symptoms and limited ROM. X-rays were negative for significant findings of cervical abnormalities. (June 1969).
- The separation exam noted reduced ROM with tightness in neck at time of separation from service (September 1970).
- The Veteran reported in-service and current neck pain and stiffness during a 2007 exam.
- A buddy statement (wife) notes Veteran's difficulty for many years turning head while driving (January 2008).
- There is no objective evidence of intercurrent injury following separation from service to the present.
- The diagnosis and clinical findings of cervical pathology from the current C&P exam.

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Scenario 2: Direct Service Connection - Sonia Gutierrez



Sonia Gutierrez, Scenario 2



Examiner, Scenario 2

Sonia Gutierrez, a 30-year-old Air Force Veteran, filed a direct service-connection claim with VBA for a back condition. She was in the Security Forces and served from 6/4/14 to 6/5/19. VBA requested a C&P examination and medical opinion for Ms. Gutierrez's claim. Select each step in order to see how a C&P examiner developed the requested opinion.

Step 1: Identify Questions to Answer ???

Step 2: Gather and Review Evidence

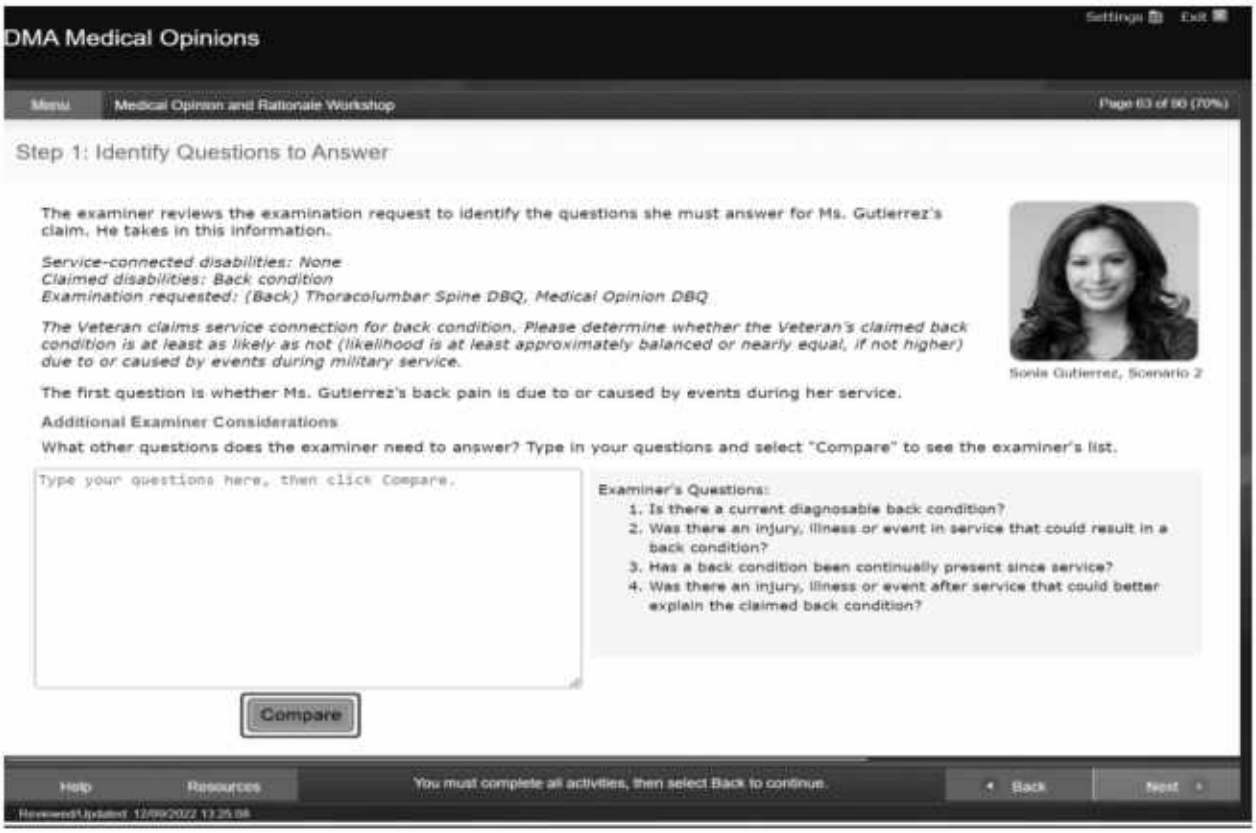
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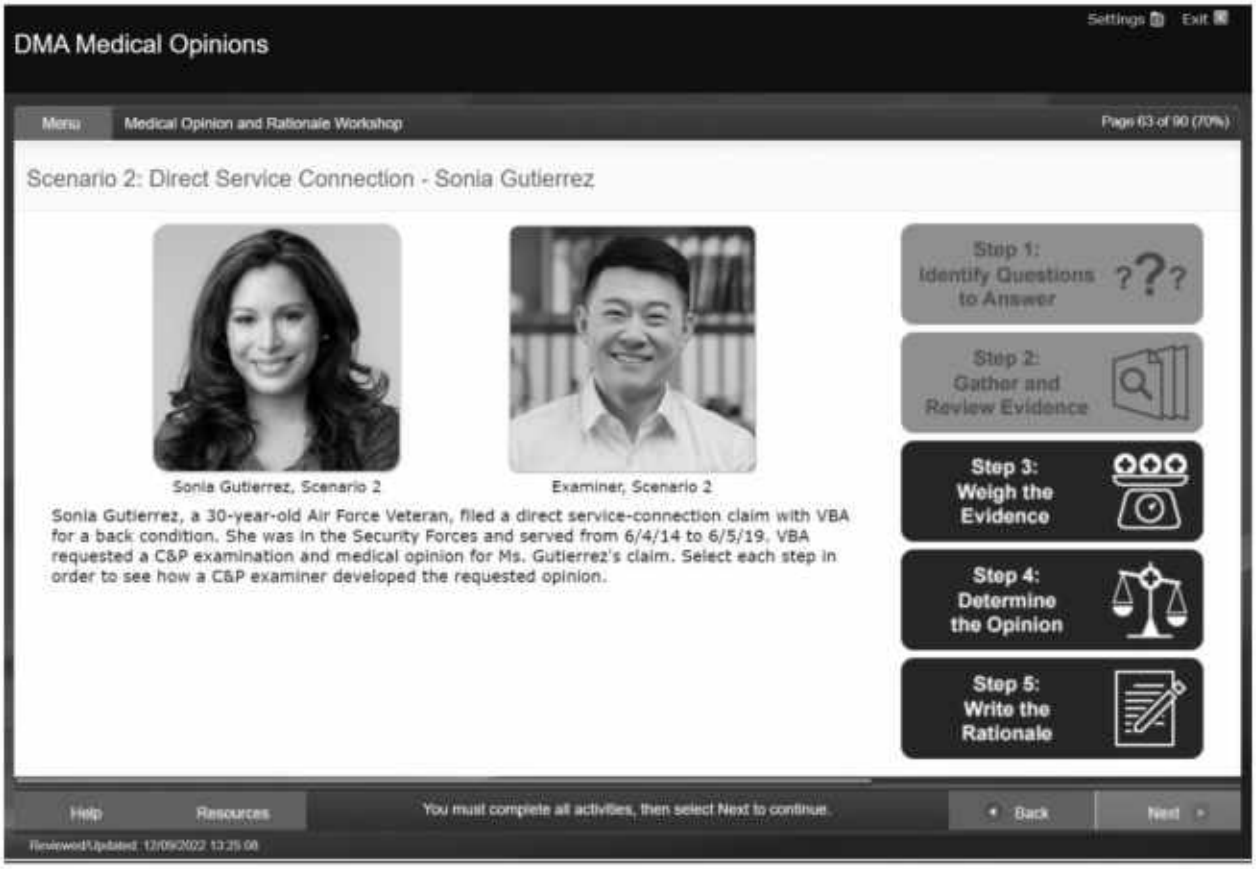
Step 4: Determine the Opinion

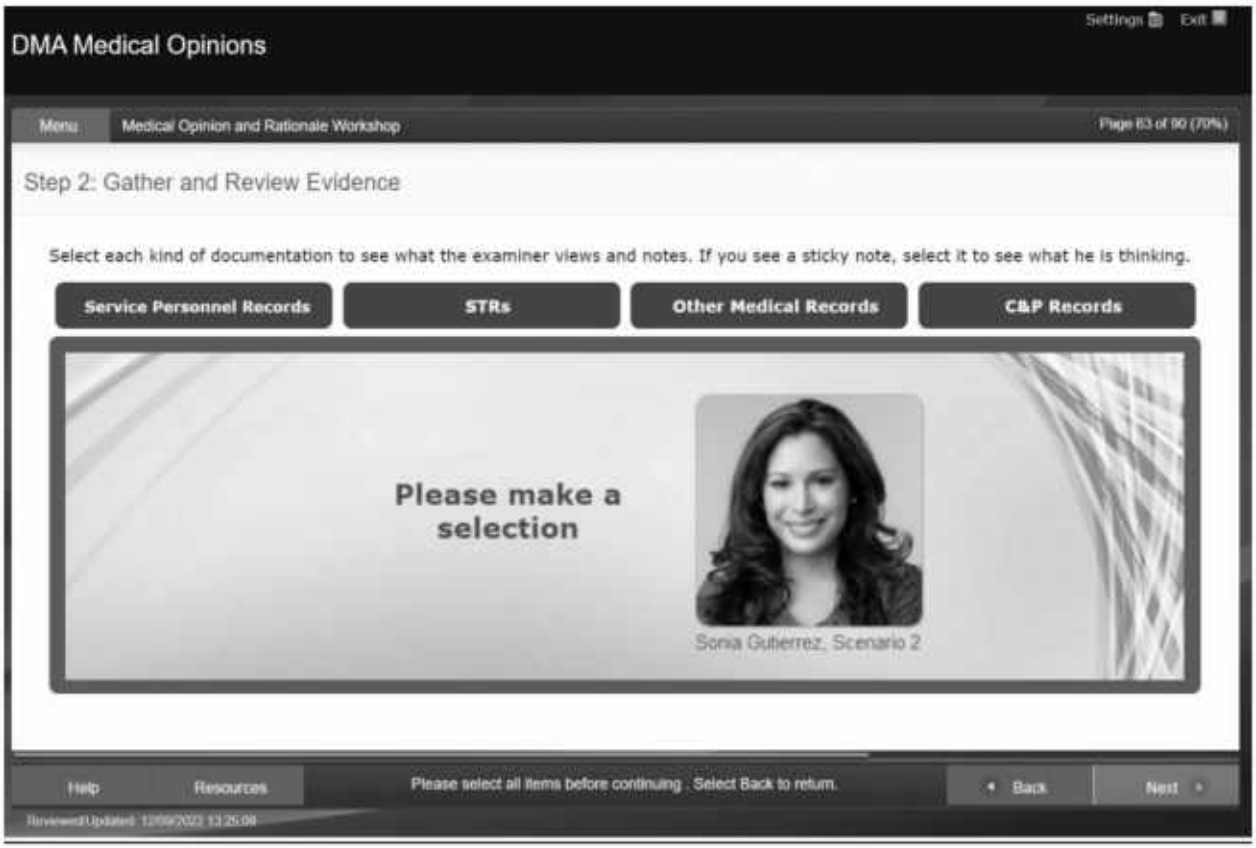
Step 5: Write the Rationale

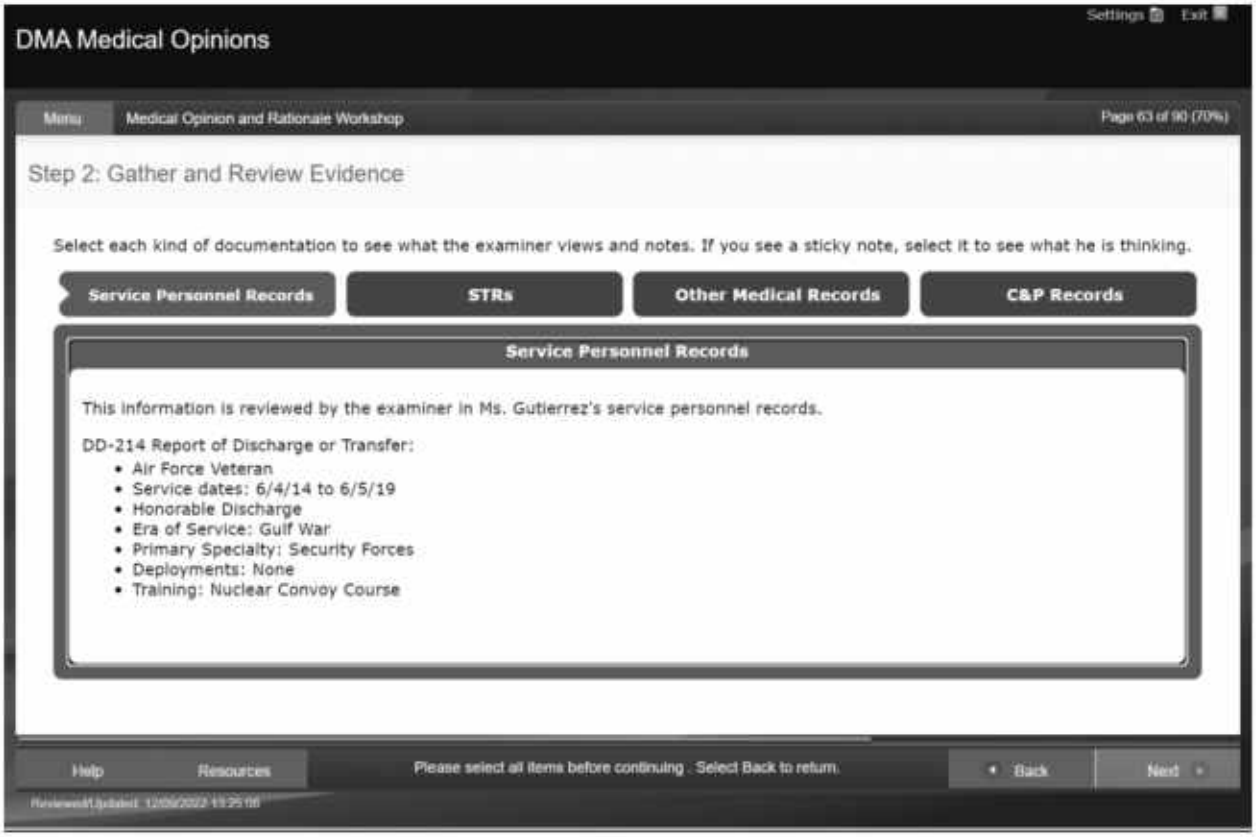
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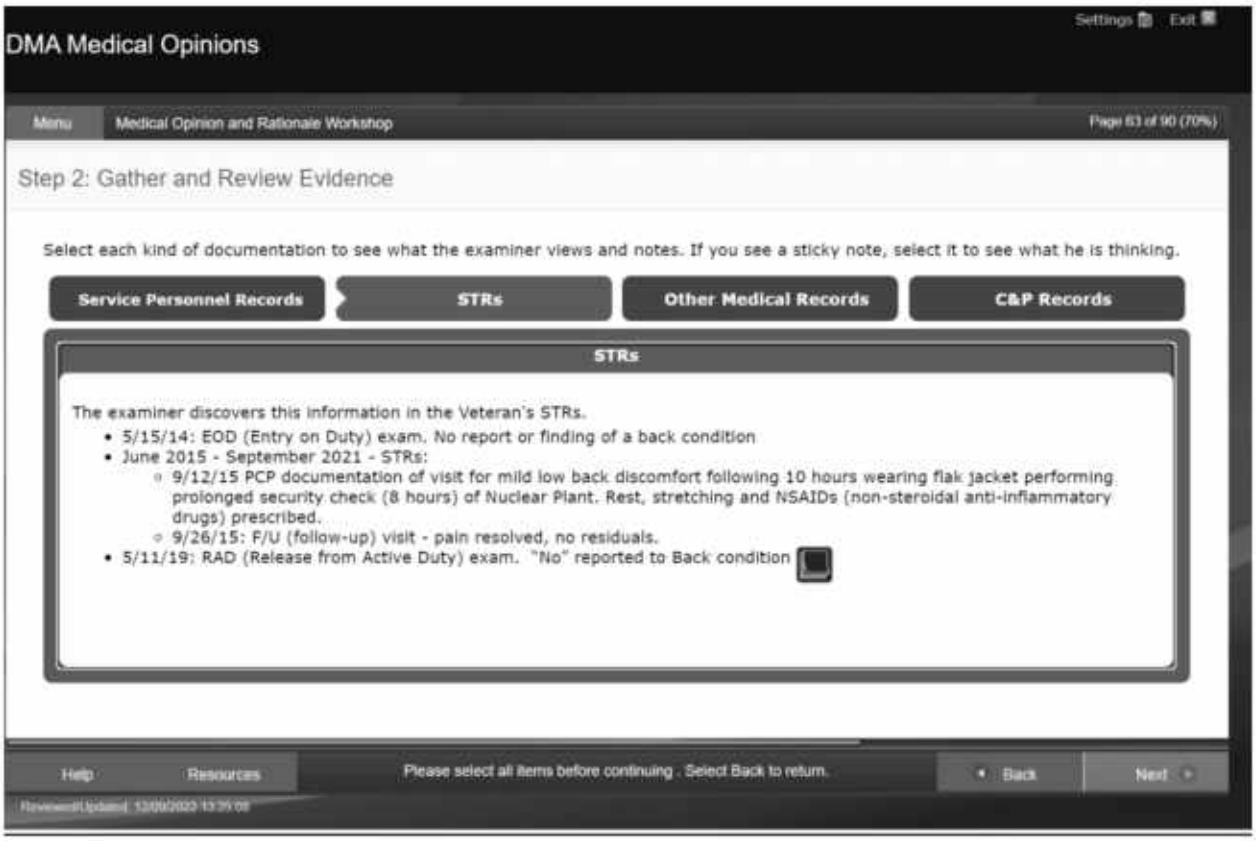
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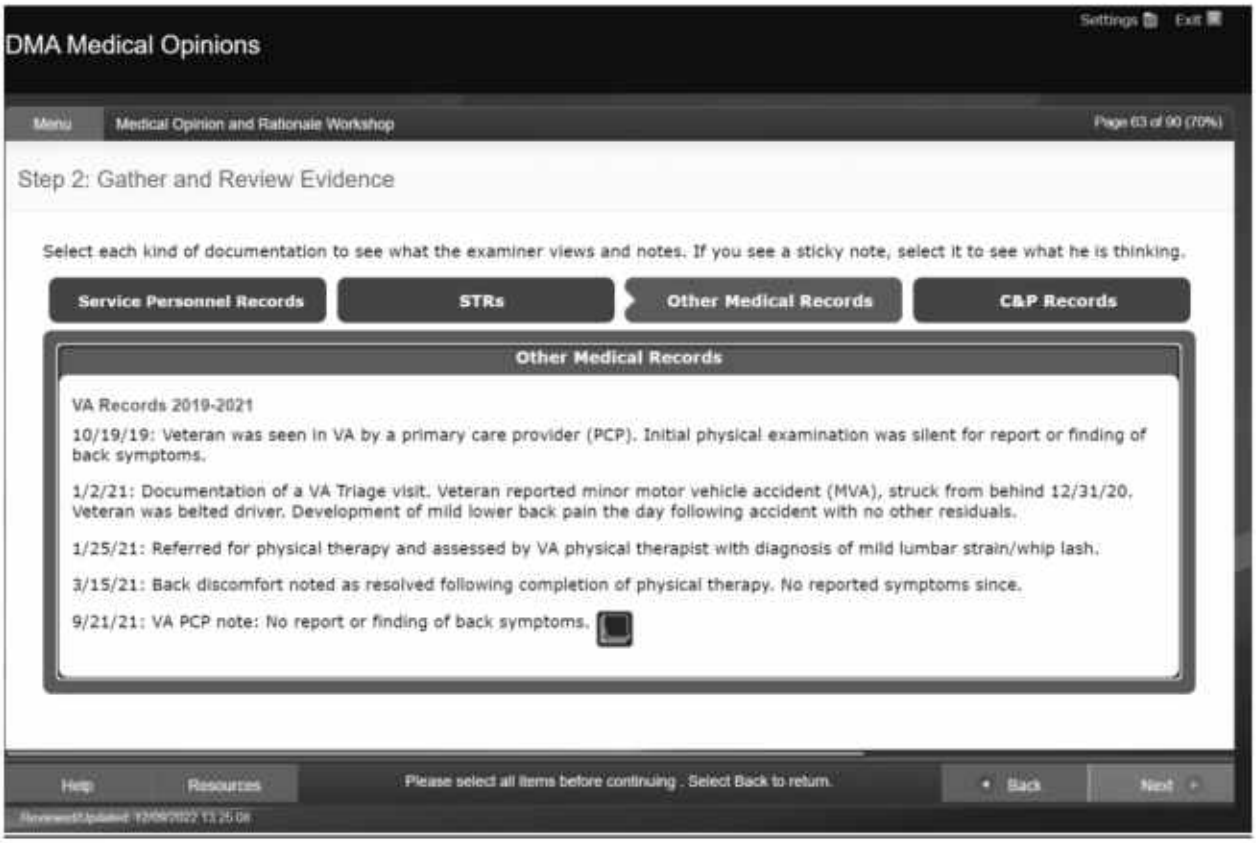

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Step 1: Identify Questions to Answer
The examiner reviews the examination request to identify the questions she must answer for Ms. Gutierrez's claim. He takes in this information.
Service-connected disabilities: None
Claimed disabilities: Back condition
Examination requested: (Back) Thoracolumbar Spine DBQ, Medical Opinion DBQ
The Veteran claims service connection for back condition. Please determine whether the Veteran's claimed back condition is at least as likely as not (likelihood is at least approximately balanced or nearly equal, if not higher) due to or caused by events during military service.
Sonia Gutierrez, Scenario 2
The first question is whether Ms. Gutierrez's back pain is due to or caused by events during her service.
Additional Examiner Considerations
What other questions does the examiner need to answer? Type in your questions and select "Compare" to see the examiner's list.
Type your questions here, then click Compare.
Examiner's Questions:
1. Is there a current diagnosable back condition?
2. Was there an injury, illness or event in service that could result in a back condition?
3. Has a back condition been continually present since service?
4. Was there an injury, illness or event after service that could better explain the claimed back condition?
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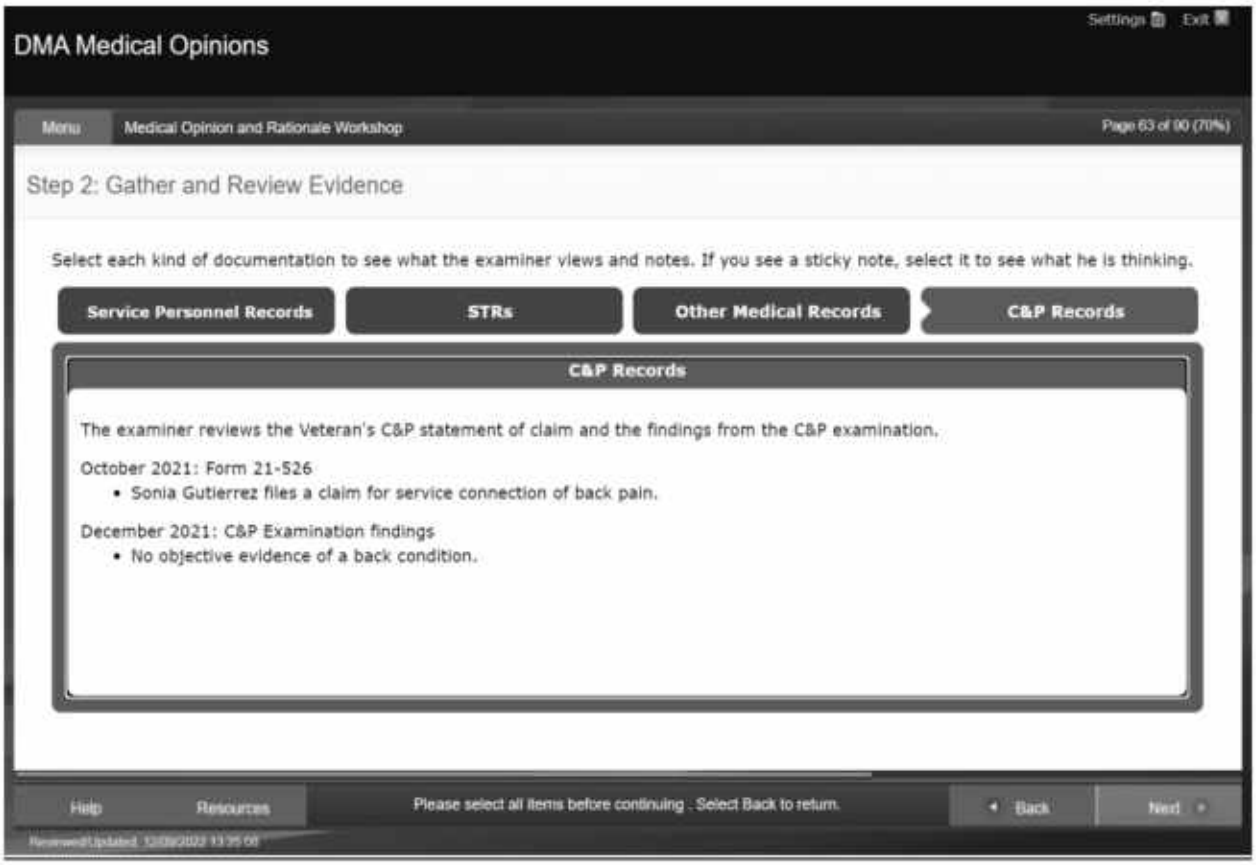

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Scenario 2: Direct Service Connection - Sonia Gutierrez
Sonia Gutierrez, Scenario 2
Examiner, Scenario 2
Sonia Gutierrez, a 30-year-old Air Force Veteran, filed a direct service-connection claim with VBA for a back condition. She was in the Security Forces and served from 6/4/14 to 6/5/19. VBA requested a C&P examination and medical opinion for Ms. Gutierrez's claim. Select each step in order to see how a C&P examiner developed the requested opinion.
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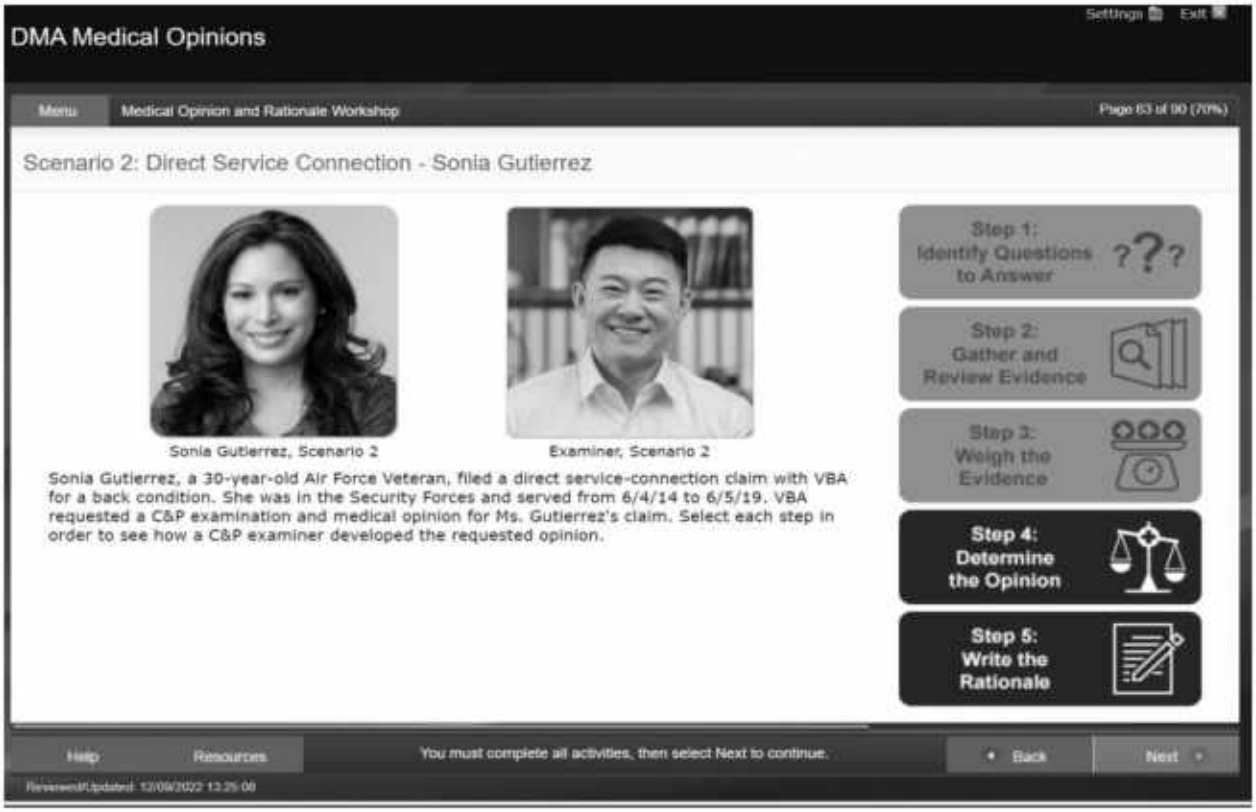

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Step 2: Gather and Review Evidence
Select each kind of documentation to see what the examiner views and notes. If you see a sticky note, select it to see what he is thinking.
Service Personnel Records
STRs
Other Medical Records
C&P Records
Please make a selection
Sonia Gutierrez, Scenario 2
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Step 2: Gather and Review Evidence
Select each kind of documentation to see what the examiner views and notes. If you see a sticky note, select it to see what he is thinking.
Service Personnel Records
STRs
Other Medical Records
C&P Records
Service Personnel Records
This information is reviewed by the examiner in Ms. Gutierrez's service personnel records.
DD-214 Report of Discharge or Transfer:
Air Force Veteran
Service dates: 6/4/14 to 6/5/19
Honorable Discharge
Era of Service: Gulf War
Primary Specialty: Security Forces
Deployments: None
Training: Nuclear Convoy Course
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Step 2: Gather and Review Evidence
Select each kind of documentation to see what the examiner views and notes. If you see a sticky note, select it to see what he is thinking.
Service Personnel Records
STRs
Other Medical Records
C&P Records
STRs
The examiner discovers this information in the Veteran's STRs.
5/15/14: EOD (Entry on Duty) exam. No report or finding of a back condition
June 2015 - September 2021 - STRs:
9/12/15 PCP documentation of visit for mild low back discomfort following 10 hours wearing flak jacket performing prolonged security check (8 hours) of Nuclear Plant. Rest, stretching and NSAIDs (non-steroidal anti-inflammatory drugs) prescribed.
9/26/15: F/U (follow-up) visit - pain resolved, no residuals.
5/11/19: RAD (Release from Active Duty) exam. "No" reported to Back condition
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Step 2: Gather and Review Evidence
Select each kind of documentation to see what the examiner views and notes. If you see a sticky note, select it to see what he is thinking.
Service Personnel Records
STRs
Other Medical Records
C&P Records
Other Medical Records
VA Records 2019-2021
10/19/19: Veteran was seen in VA by a primary care provider (PCP). Initial physical examination was silent for report or finding of back symptoms.
1/2/21: Documentation of a VA Triage visit. Veteran reported minor motor vehicle accident (MVA), struck from behind 12/31/20. Veteran was belted driver. Development of mild lower back pain the day following accident with no other residuals.
1/25/21: Referred for physical therapy and assessed by VA physical therapist with diagnosis of mild lumbar strain/whip lash.
3/15/21: Back discomfort noted as resolved following completion of physical therapy. No reported symptoms since.
9/21/21: VA PCP note: No report or finding of back symptoms.
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Step 2: Gather and Review Evidence
Select each kind of documentation to see what the examiner views and notes. If you see a sticky note, select it to see what he is thinking.
Service Personnel Records
STRs
Other Medical Records
C&P Records
C&P Records
The examiner reviews the Veteran's C&P statement of claim and the findings from the C&P examination.
October 2021: Form 21-526
• Sonia Gutierrez files a claim for service connection of back pain.
December 2021: C&P Examination findings
• No objective evidence of a back condition.
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Scenario 2: Direct Service Connection - Sonia Gutierrez
Sonia Gutierrez, Scenario 2
Examiner, Scenario 2
Sonia Gutierrez, a 30-year-old Air Force Veteran, filed a direct service-connection claim with VBA for a back condition. She was in the Security Forces and served from 6/4/14 to 6/5/19. VBA requested a C&P examination and medical opinion for Ms. Gutierrez's claim. Select each step in order to see how a C&P examiner developed the requested opinion.
Step 1: Identify Questions to Answer
Step 2: Gather and Review Evidence
Step 3: Weigh the Evidence
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Step 3: Weigh the Evidence
Sonia Gutierrez, Scenario 2
The examiner weighs the evidence and identifies the following building blocks for his opinion.
Event
Evidence
Comment
May 2014: SG has Service Entrance Examination
EOD 5/5/14
1
No report or finding of a back condition
September 2015: SG sees a PCP for back pain
STRs
2
SG was seen for mild low back discomfort following 10 hours wearing flak jacket performing prolonged security check. Rest, stretching and non-steroidal anti-inflammatory drugs (NSAIDS) prescribed. F/U visit 9/26/21 pain resolved. No residuals.
May 2019: SG has Service Exit Examination
RAD 5/11/19
3
"No" reported to Back condition
October 2019: SG enrolls for VA health care
Notes from 10/19/19
Initial physical exam silent for report or finding of back symptoms.
January 2021: SG has VA Triage Visit
Notes from 1/2/21
4
Minor MVA, struck from behind 12/31/20. Veteran was belted driver. Development of mild lower back pain the day following accident with no other residuals.
January 2021: SG visits a VA PCP
Notes from 1/25/21
Referred for physical therapy and assessed by VA PT 1/25/21 with diagnosis of mild lumbar strain/whip lash.
March 2021: SG PT Visits
Notes from PT 3/15/20
5
Back discomfort noted as resolved following completion of Physical Therapy 3/15/20. No reported symptoms since.
September 2021: SG visits a VA PCP
Notes from PCP 9/21/21
6
No report or findings of back symptoms.
December 2021: SG has C&P Examination
C&P Examination findings
7
No objective evidence of a back condition.
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Step 3: Weigh the Evidence
Sonia Gutierrez, Scenario 2
The examiner weighs the evidence and identifies the following building blocks for his opinion.
Event
Evidence
Comment
May 2014: SG has Service Entrance Examination
EOD 5/5/14
1
No report or finding of a back condition
September 2015: SG sees a PCP for back pain
STRs
2
SG was seen for mild low back discomfort following 10 hours wearing flak jacket performing prolonged security check. Rest, stretching and non-steroidal anti-inflammatory drugs (NSAIDS) prescribed. F/U visit 9/26/21 pain resolved. No residuals.
May 2019: SG has Service Exit Examination
RAD 5/11/19
3
"No" reported to Back condition
Sticky Note 1
No preexisting back condition noted
Close
March 2021: SG PT Visits
Notes from PT 3/15/20
5
Back discomfort noted as resolved following completion of Physical Therapy 3/15/20. No reported symptoms since.
September 2021: SG visits a VA PCP
Notes from PCP 9/21/21
6
No report or findings of back symptoms.
December 2021: SG has C&P Examination
C&P Examination findings
7
No objective evidence of a back condition.
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Step 3: Weigh the Evidence
Sonia Gutierrez, Scenario 2
The examiner weighs the evidence and identifies the following building blocks for his opinion.
Event
Evidence
Comment
May 2014: SG has Service Entrance Examination
EOD 5/5/14
1
No report or finding of a back condition
September 2015: SG sees a PCP for back pain
STRs
2
SG was seen for mild low back discomfort following 10 hours wearing flak jacket performing prolonged security check. Rest, stretching and non-steroidal anti-inflammatory drugs (NSAIDS) prescribed. F/U visit 9/26/21 pain resolved. No residuals.
May 2019: SG has Service Exit Examination
RAD 5/11/19
3
"No" reported to Back condition
October 2019: SG enrolls
or finding of back
Sticky Note 2
Back symptoms resolved
Close
January 2021: SG has VA
/20. Veteran was belted
back pain the day following
January 2021: SG visits a
assessed by VA PT 1/25/21
with diagnosis of mild lumbar strain/whip lash.
March 2021: SG PT Visits
Notes from PT 3/15/20
5
Back discomfort noted as resolved following completion of Physical Therapy 3/15/20. No reported symptoms since.
September 2021: SG visits a VA PCP
Notes from PCP 9/21/21
6
No report or findings of back symptoms.
December 2021: SG has C&P Examination
C&P Examination findings
7
No objective evidence of a back condition.
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Step 3: Weigh the Evidence
Sonia Gutierrez, Scenario 2
The examiner weighs the evidence and identifies the following building blocks for his opinion.
Event
Evidence
Comment
May 2014: SG has Service Entrance Examination
EOD 5/5/14
1
No report or finding of a back condition
September 2015: SG sees a PCP for back pain
STRs
2
SG was seen for mild low back discomfort following 10 hours wearing flak jacket performing prolonged security check. Rest, stretching and non-steroidal anti-inflammatory drugs (NSAIDS) prescribed. F/U visit 9/26/21 pain resolved. No residuals.
May 2019: SG has Service Exit Examination
RAD 5/11/19
3
"No" reported to Back condition
October 2019: SG enrolls
or finding of back
Sticky Note 3
No back symptoms when separating from service, no chronicity
Close
January 2021: SG has VA
/20. Veteran was belted
back pain the day following
January 2021: SG visits a
assessed by VA PT 1/25/21
with diagnosis of mild lumbar strain/whip lash.
March 2021: SG PT Visits
Notes from PT 3/15/20
5
Back discomfort noted as resolved following completion of Physical Therapy 3/15/20. No reported symptoms since.
September 2021: SG visits a VA PCP
Notes from PCP 9/21/21
6
No report or findings of back symptoms.
December 2021: SG has C&P Examination
C&P Examination findings
7
No objective evidence of a back condition.
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Step 3: Weigh the Evidence
The examiner weighs the evidence and identifies the following building blocks for his opinion.
Event
Evidence
Comment
May 2014: SG has Service Entrance Examination
EOD 5/5/14
1
No report or finding of a back condition
September 2015: SG sees a PCP for back pain
STRs
2
SG was seen for mild low back discomfort following 10 hours wearing flak jacket performing prolonged security check. Rest, stretching and non-steroidal anti-inflammatory drugs (NSAIDS) prescribed. F/U visit 9/26/21 pain resolved. No residuals.
May 2019: SG has Service Exit Examination
RAD 5/11/19
3
"No" reported to Back condition
Sticky Note 4
Evidence of injury after service: symptoms reported
Close
March 2021: SG PT Visits
Notes from PT 3/15/20
5
Back discomfort noted as resolved following completion of Physical Therapy 3/15/20. No reported symptoms since.
September 2021: SG visits a VA PCP
Notes from PCP 9/21/21
6
No report or findings of back symptoms.
December 2021: SG has C&P Examination
C&P Examination findings
7
No objective evidence of a back condition.
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Step 3: Weigh the Evidence
The examiner weighs the evidence and identifies the following building blocks for his opinion.
Event
Evidence
Comment
May 2014: SG has Service Entrance Examination
EOD 5/5/14
1
No report or finding of a back condition
September 2015: SG sees a PCP for back pain
STRs
2
SG was seen for mild low back discomfort following 10 hours wearing flak jacket performing prolonged security check. Rest, stretching and non-steroidal anti-inflammatory drugs (NSAIDS) prescribed. F/U visit 9/26/21 pain resolved. No residuals.
May 2019: SG has Service Exit Examination
RAD 5/11/19
3
"No" reported to Back condition
Sticky Note 5
Back symptoms resolved, no chronicity
Close
March 2021: SG PT Visits
Notes from PT 3/15/20
5
Back discomfort noted as resolved following completion of Physical Therapy 3/15/20. No reported symptoms since.
September 2021: SG visits a VA PCP
Notes from PCP 9/21/21
6
No report or findings of back symptoms.
December 2021: SG has C&P Examination
C&P Examination findings
7
No objective evidence of a back condition.
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Step 3: Weigh the Evidence
Sonia Gutierrez, Scenario 2
The examiner weighs the evidence and identifies the following building blocks for his opinion.
Event
Evidence
Comment
May 2014: SG has Service Entrance Examination
EOD 5/5/14
1
No report or finding of a back condition
September 2015: SG sees a PCP for back pain
STRs
2
SG was seen for mild low back discomfort following 10 hours wearing flak jacket performing prolonged security check. Rest, stretching and non-steroidal anti-inflammatory drugs (NSAIDS) prescribed. F/U visit 9/26/21 pain resolved. No residuals.
May 2019: SG has Service Exit Examination
RAD 5/11/19
3
"No" reported to Back condition
October 2019: SG enrolls
or finding of back
care
Sticky Note 6
Symptoms from MVA resolved
Close
January 2021: SG has VA
/20. Veteran was belted
back pain the day following
January 2021: SG visits a
assessed by VA PT 1/25/21
with diagnosis of mild lumbar strain/whip lash.
March 2021: SG PT Visits
Notes from PT 3/15/20
5
Back discomfort noted as resolved following completion of Physical Therapy 3/15/20. No reported symptoms since.
September 2021: SG visits a VA PCP
Notes from PCP 9/21/21
6
No report or findings of back symptoms.
December 2021: SG has C&P Examination
C&P Examination findings
7
No objective evidence of a back condition.
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Step 3: Weigh the Evidence
Sonia Gutierrez, Scenario 2
The examiner weighs the evidence and identifies the following building blocks for his opinion.
Event
Evidence
Comment
May 2014: SG has Service Entrance Examination
EOD 5/5/14
1
No report or finding of a back condition
September 2015: SG sees a PCP for back pain
STRs
2
SG was seen for mild low back discomfort following 10 hours wearing flak jacket performing prolonged security check. Rest, stretching and non-steroidal anti-inflammatory drugs (NSAIDS) prescribed. F/U visit 9/26/21 pain resolved. No residuals.
May 2019: SG has Service Exit Examination
RAD 5/11/19
3
"No" reported to Back condition
October 2019: SG enrolls
or finding of back
care
Sticky Note 7
No diagnosable back condition
Close
January 2021: SG has VA
/20. Veteran was belted
back pain the day following
January 2021: SG visits a
assessed by VA PT 1/25/21
with diagnosis of mild lumbar strain/whip lash.
March 2021: SG PT Visits
Notes from PT 3/15/20
5
Back discomfort noted as resolved following completion of Physical Therapy 3/15/20. No reported symptoms since.
September 2021: SG visits a VA PCP
Notes from PCP 9/21/21
6
No report or findings of back symptoms.
December 2021: SG has C&P Examination
C&P Examination findings
7
No objective evidence of a back condition.
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Scenario 2: Direct Service Connection - Sonia Gutierrez



Sonia Gutierrez, Scenario 2



Examiner, Scenario 2

Sonia Gutierrez, a 30-year-old Air Force Veteran, filed a direct service-connection claim with VBA for a back condition. She was in the Security Forces and served from 6/4/14 to 6/5/19. VBA requested a C&P examination and medical opinion for Ms. Gutierrez's claim. Select each step in order to see how a C&P examiner developed the requested opinion.

- Step 1: Identify Questions to Answer
- Step 2: Gather and Review Evidence
- Step 3: Weigh the Evidence
- Step 4: Determine the Opinion
- **Step 5: Write the Rationale**

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Step 4: Determine the Opinion

The examination request asked for this opinion:

> *Please determine whether the Veteran's claimed back condition is at least as likely as not (likelihood is at least approximately balanced or nearly equal, if not higher due to or caused by events during military service.*

The examiner's opinion was not favorable for direct service connection:

> Veteran's claimed back condition was less likely than not (likelihood is at least approximately balanced or nearly equal, if not higher) incurred in or caused by the claimed in-service injury.



Sonia Gutierrez, Scenario 2

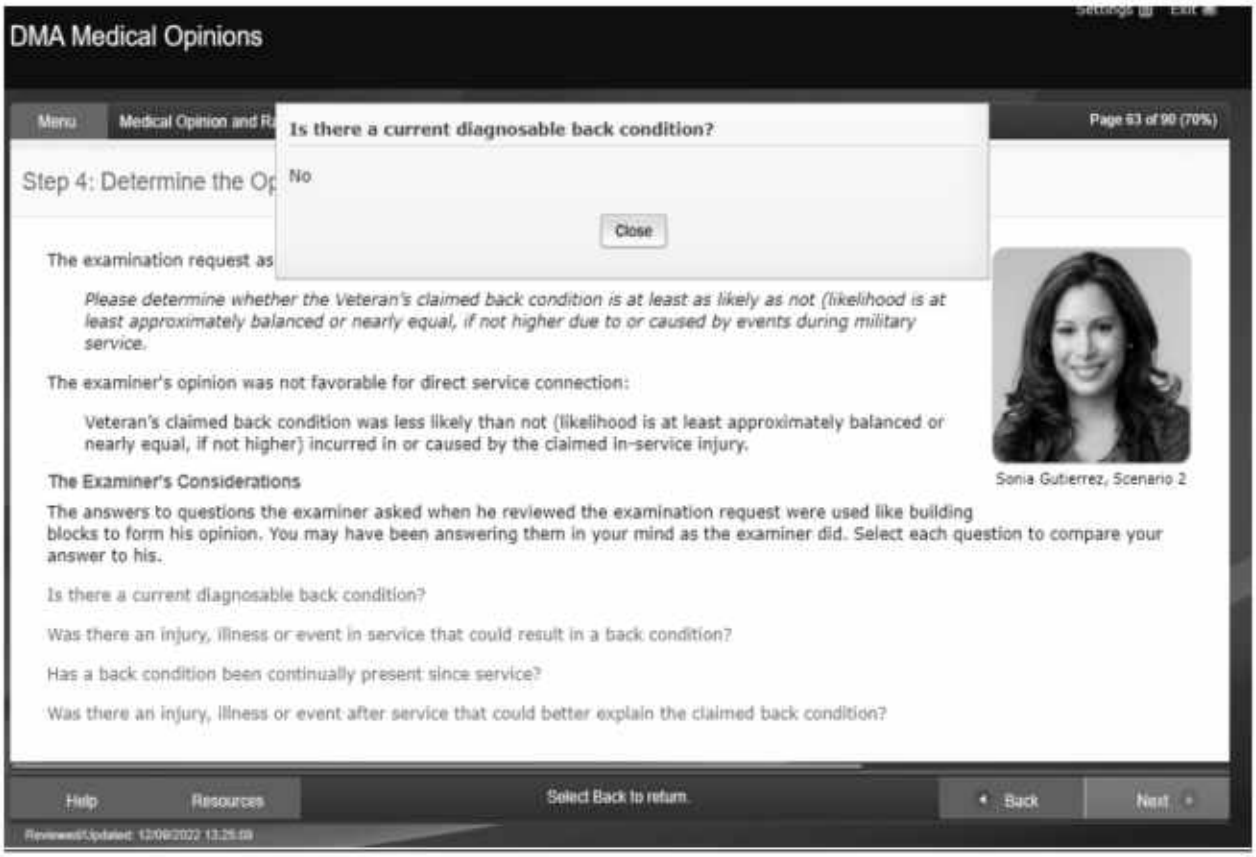
The Examiner's Considerations

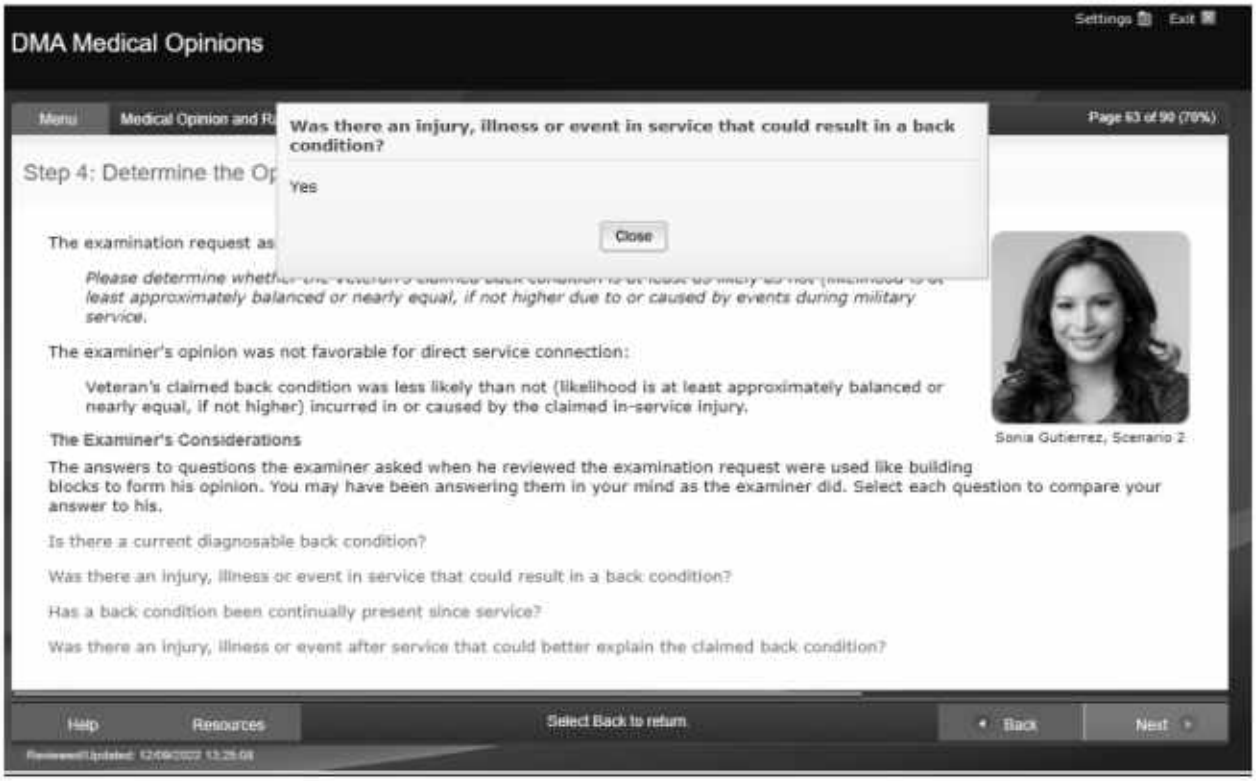
The answers to questions the examiner asked when he reviewed the examination request were used like building blocks to form his opinion. You may have been answering them in your mind as the examiner did. Select each question to compare your answer to his.

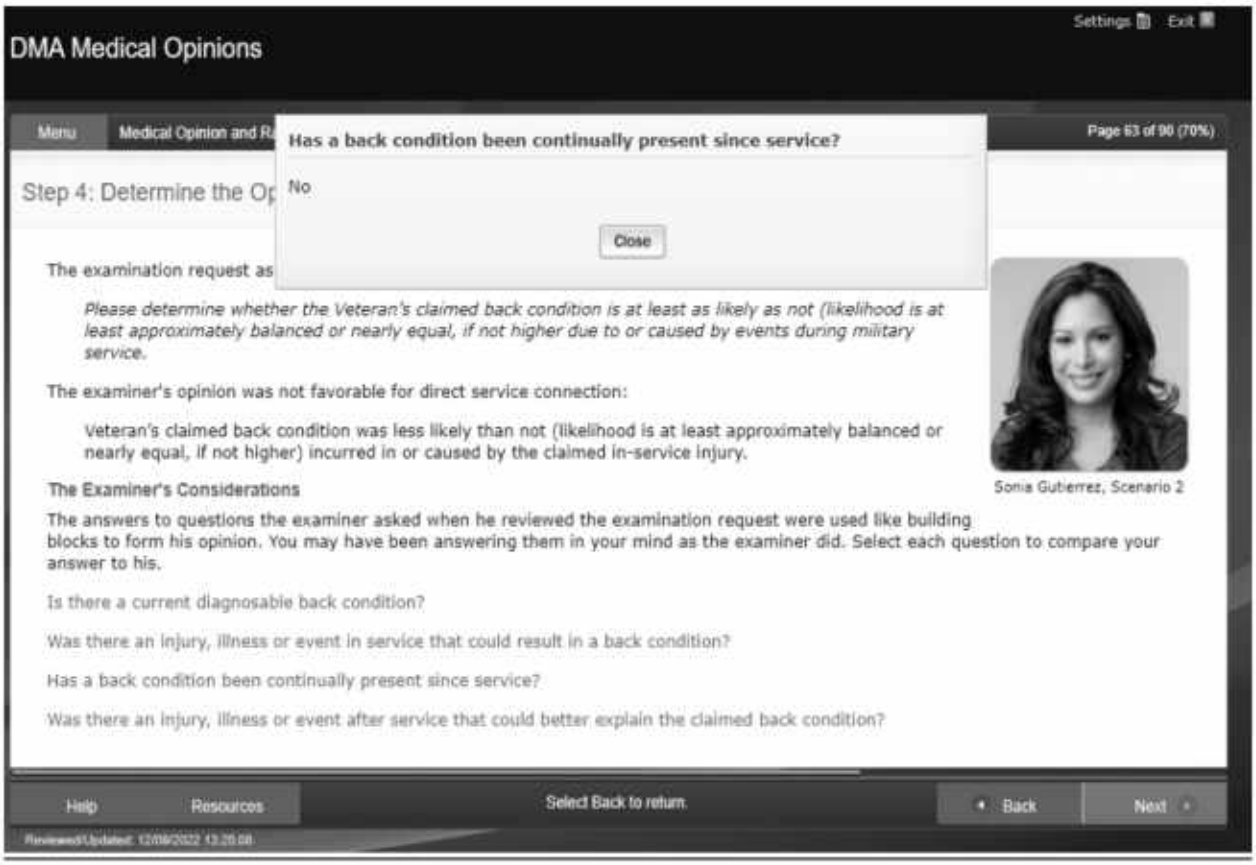
- Is there a current diagnosable back condition?
- Was there an injury, illness or event in service that could result in a back condition?
- Has a back condition been continually present since service?
- Was there an injury, illness or event after service that could better explain the claimed back condition?

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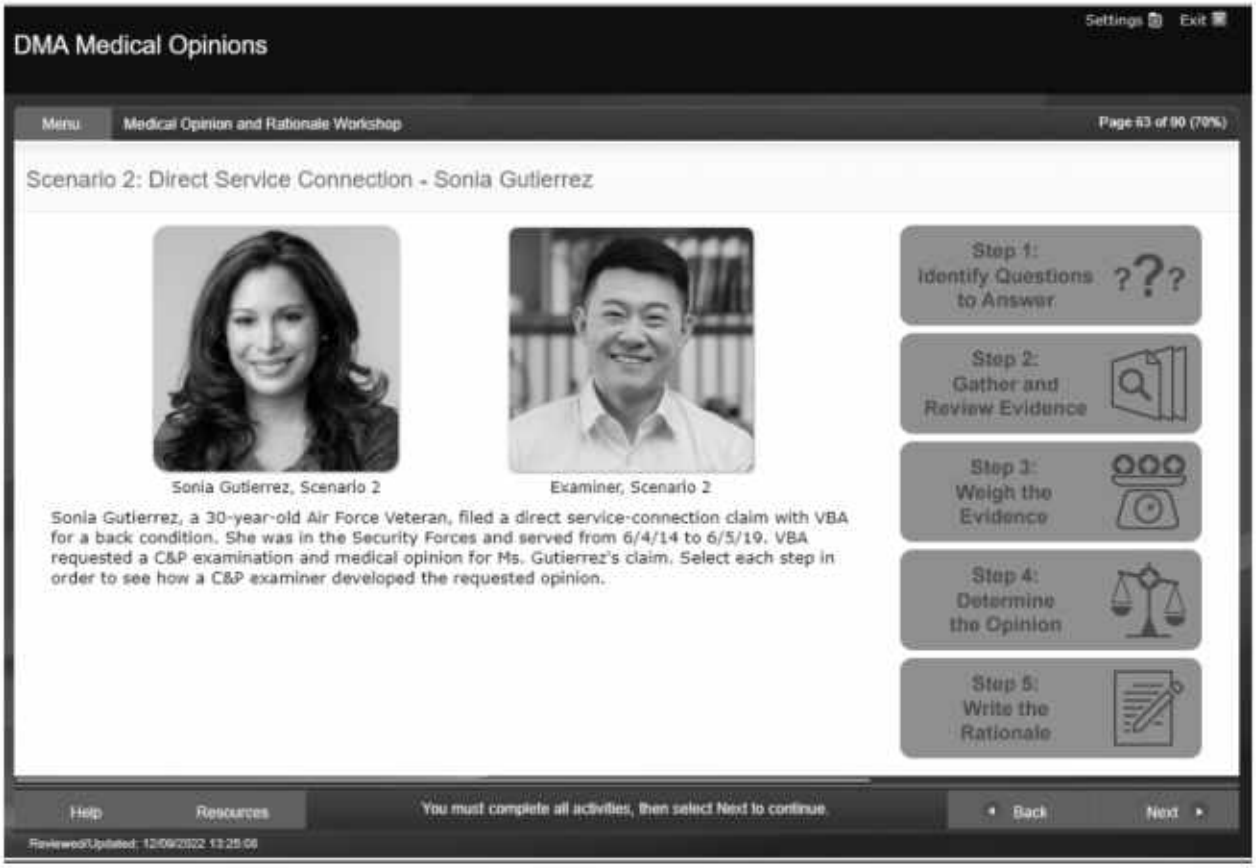
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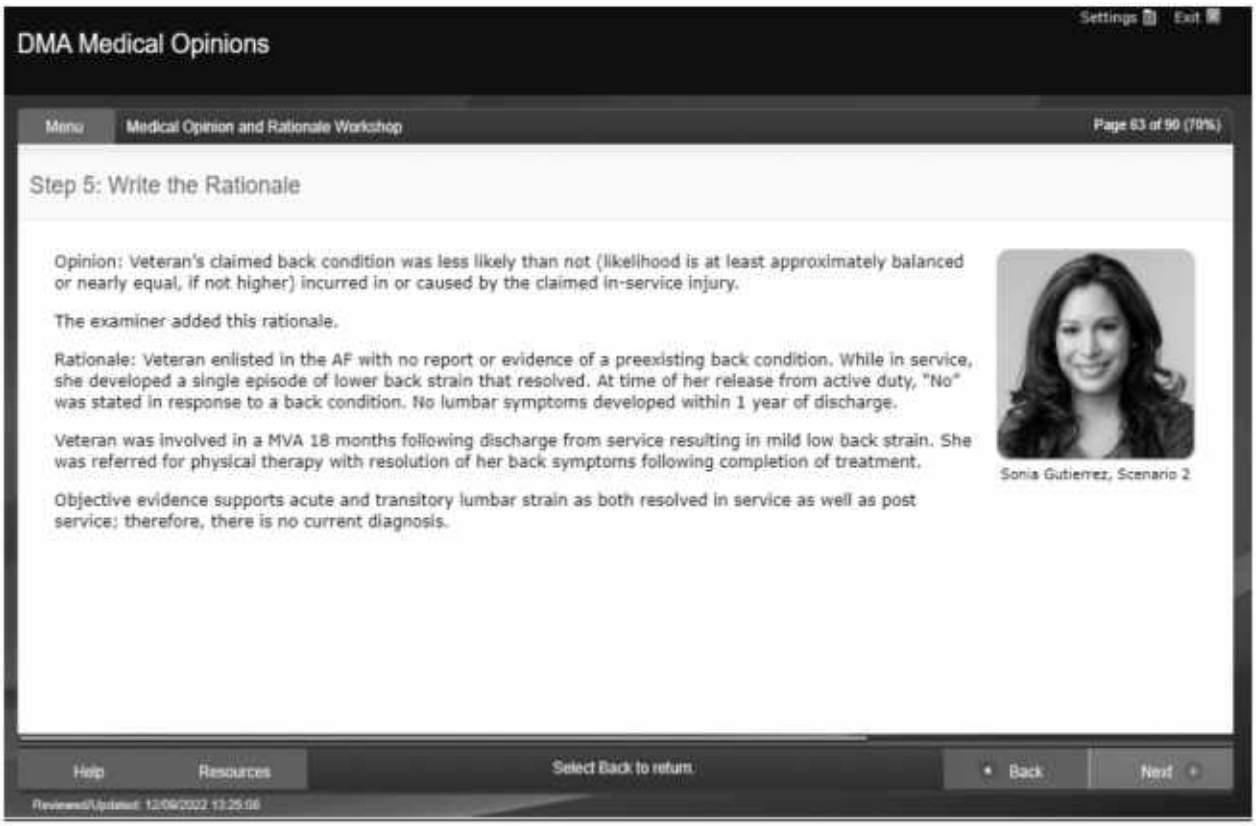

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Is there a current diagnosable back condition?
No
Close
Step 4: Determine the Op
The examination request as
Please determine whether the Veteran's claimed back condition is at least as likely as not (likelihood is at least approximately balanced or nearly equal, if not higher due to or caused by events during military service.
The examiner's opinion was not favorable for direct service connection:
Veteran's claimed back condition was less likely than not (likelihood is at least approximately balanced or nearly equal, if not higher) incurred in or caused by the claimed in-service injury.
Sonia Gutierrez, Scenario 2
The Examiner's Considerations
The answers to questions the examiner asked when he reviewed the examination request were used like building blocks to form his opinion. You may have been answering them in your mind as the examiner did. Select each question to compare your answer to his.
Is there a current diagnosable back condition?
Was there an injury, illness or event in service that could result in a back condition?
Has a back condition been continually present since service?
Was there an injury, illness or event after service that could better explain the claimed back condition?
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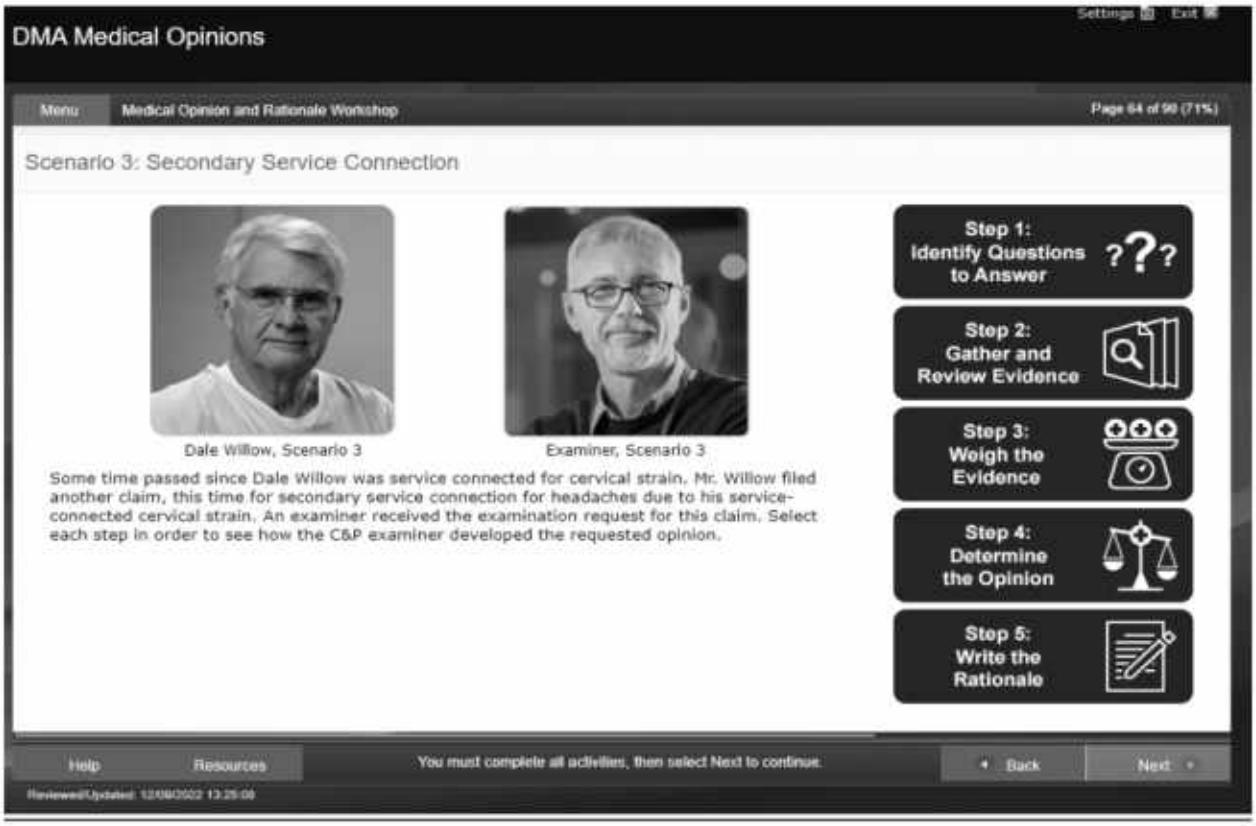

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Was there an injury, illness or event in service that could result in a back condition?
Yes
Close
Step 4: Determine the Op
The examination request as
Please determine whether the Veteran's claimed back condition is at least as likely as not (likelihood is at least approximately balanced or nearly equal, if not higher due to or caused by events during military service.
The examiner's opinion was not favorable for direct service connection:
Veteran's claimed back condition was less likely than not (likelihood is at least approximately balanced or nearly equal, if not higher) incurred in or caused by the claimed in-service injury.
Sonia Gutierrez, Scenario 2
The Examiner's Considerations
The answers to questions the examiner asked when he reviewed the examination request were used like building blocks to form his opinion. You may have been answering them in your mind as the examiner did. Select each question to compare your answer to his.
Is there a current diagnosable back condition?
Was there an injury, illness or event in service that could result in a back condition?
Has a back condition been continually present since service?
Was there an injury, illness or event after service that could better explain the claimed back condition?
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Has a back condition been continually present since service?
No
Close
Step 4: Determine the Op
The examination request as
Please determine whether the Veteran's claimed back condition is at least as likely as not (likelihood is at least approximately balanced or nearly equal, if not higher due to or caused by events during military service.
The examiner's opinion was not favorable for direct service connection:
Veteran's claimed back condition was less likely than not (likelihood is at least approximately balanced or nearly equal, if not higher) incurred in or caused by the claimed in-service injury.
Sonia Gutierrez, Scenario 2
The Examiner's Considerations
The answers to questions the examiner asked when he reviewed the examination request were used like building blocks to form his opinion. You may have been answering them in your mind as the examiner did. Select each question to compare your answer to his.
Is there a current diagnosable back condition?
Was there an injury, illness or event in service that could result in a back condition?
Has a back condition been continually present since service?
Was there an injury, illness or event after service that could better explain the claimed back condition?
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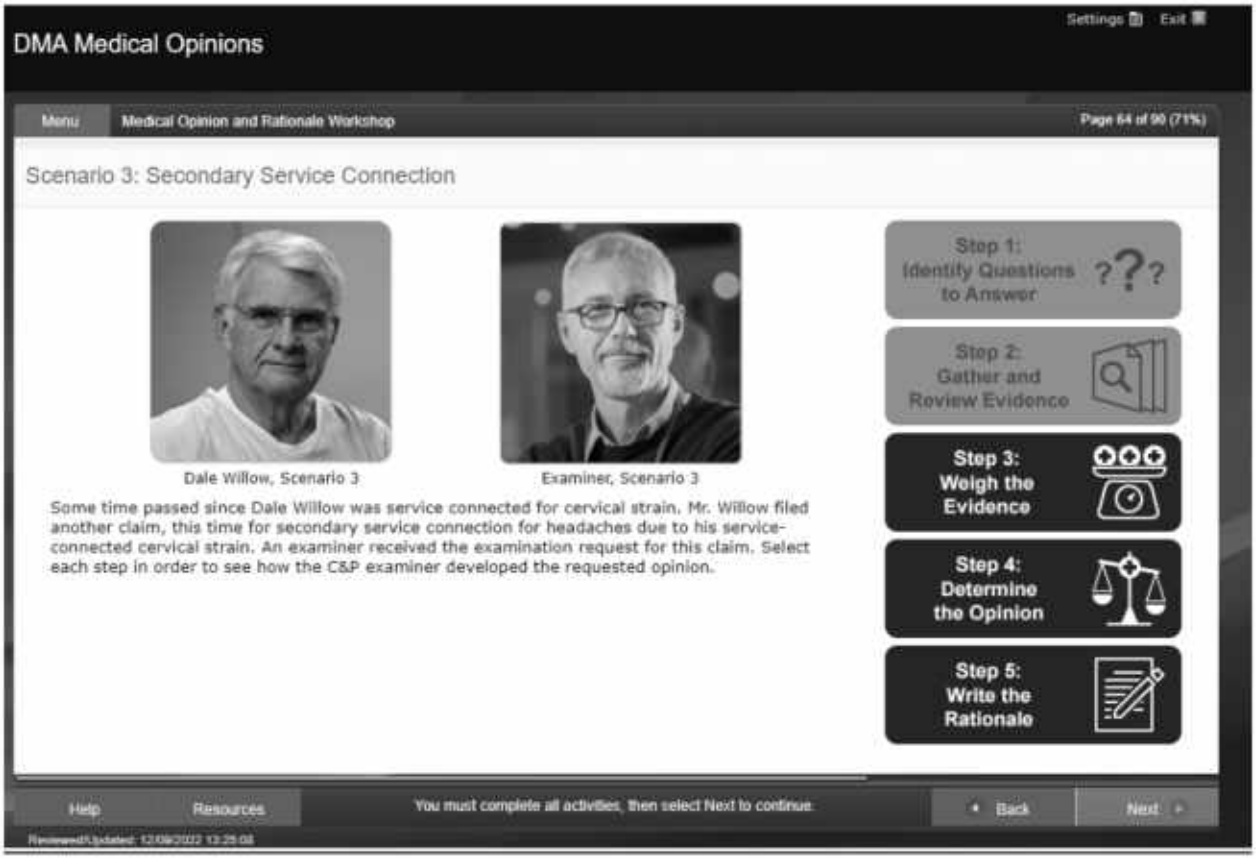

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Was there an injury, illness or event after service that could better explain the claimed back condition?
Yes
Close
Step 4: Determine the Op
The examination request as
least approximately balanced or nearly equal, if not higher due to or caused by events during military service.
The examiner's opinion was not favorable for direct service connection:
Veteran's claimed back condition was less likely than not (likelihood is at least approximately balanced or nearly equal, if not higher) incurred in or caused by the claimed in-service injury.
Sonia Gutierrez, Scenario 2
The Examiner's Considerations
The answers to questions the examiner asked when he reviewed the examination request were used like building blocks to form his opinion. You may have been answering them in your mind as the examiner did. Select each question to compare your answer to his.
Is there a current diagnosable back condition?
Was there an injury, illness or event in service that could result in a back condition?
Has a back condition been continually present since service?
Was there an injury, illness or event after service that could better explain the claimed back condition?
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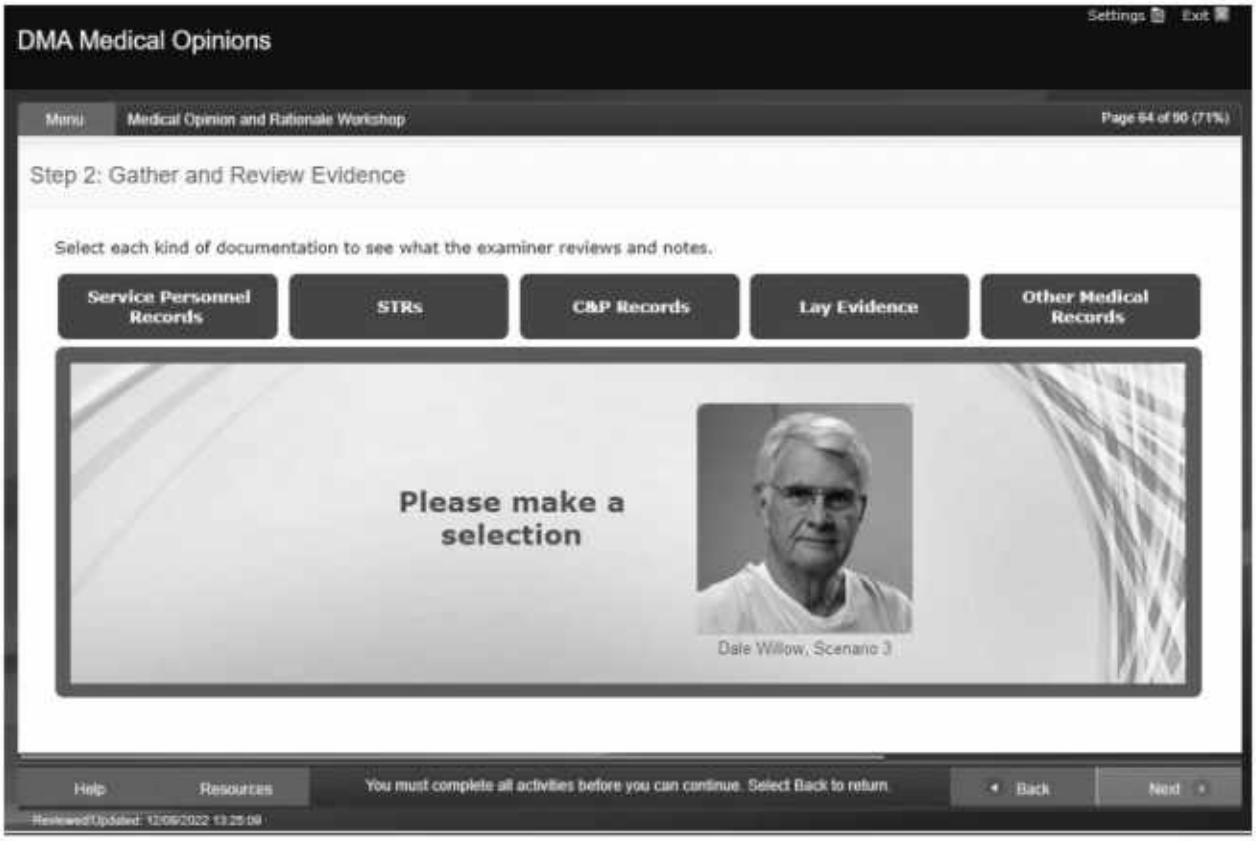

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Scenario 2: Direct Service Connection - Sonia Gutierrez
Sonia Gutierrez, Scenario 2
Examiner, Scenario 2
Sonia Gutierrez, a 30-year-old Air Force Veteran, filed a direct service-connection claim with VBA for a back condition. She was in the Security Forces and served from 6/4/14 to 6/5/19. VBA requested a C&P examination and medical opinion for Ms. Gutierrez's claim. Select each step in order to see how a C&P examiner developed the requested opinion.
Step 1: Identify Questions to Answer
Step 2: Gather and Review Evidence
Step 3: Weigh the Evidence
Step 4: Determine the Opinion
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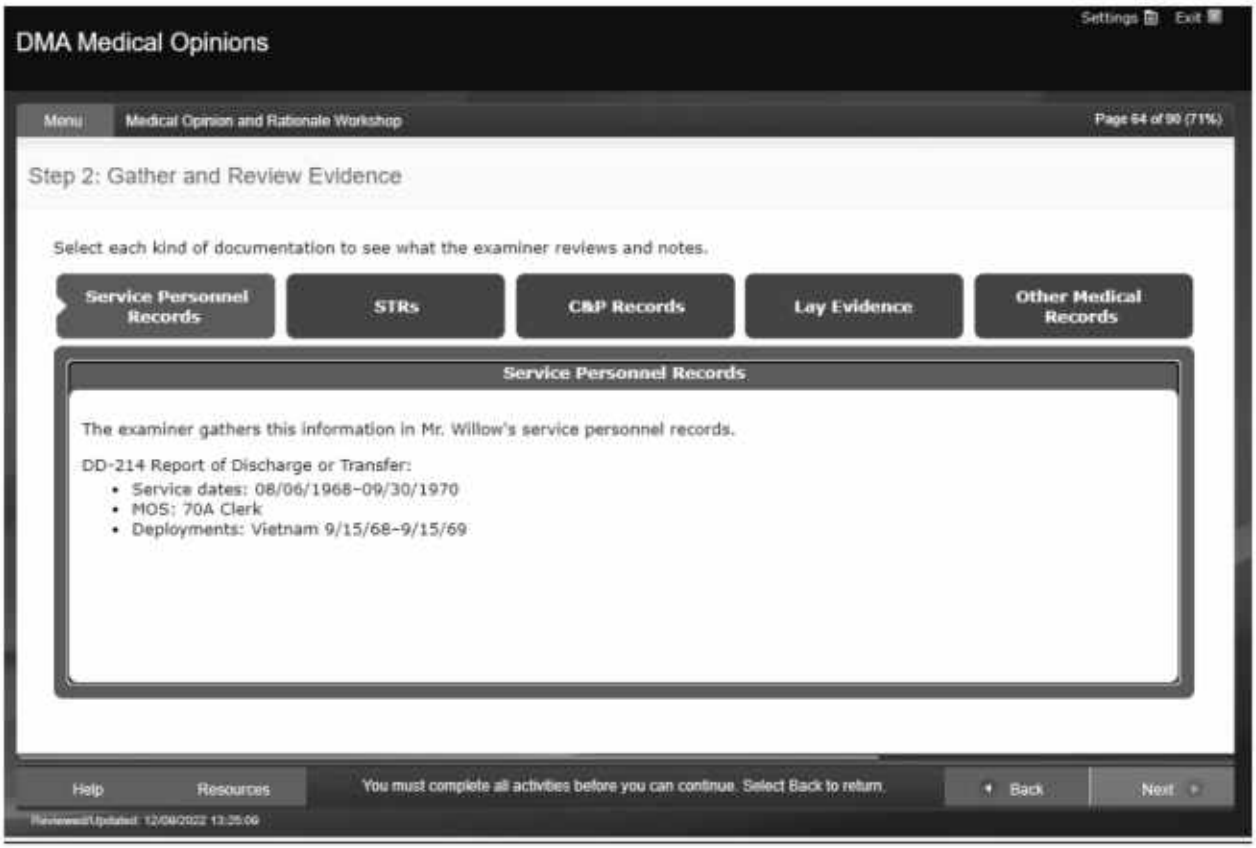

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Step 5: Write the Rationale
Opinion: Veteran's claimed back condition was less likely than not (likelihood is at least approximately balanced or nearly equal, if not higher) incurred in or caused by the claimed in-service injury.
The examiner added this rationale.
Rationale: Veteran enlisted in the AF with no report or evidence of a preexisting back condition. While in service, she developed a single episode of lower back strain that resolved. At time of her release from active duty, "No" was stated in response to a back condition. No lumbar symptoms developed within 1 year of discharge.
Veteran was involved in a MVA 18 months following discharge from service resulting in mild low back strain. She was referred for physical therapy with resolution of her back symptoms following completion of treatment.
Objective evidence supports acute and transitory lumbar strain as both resolved in service as well as post service; therefore, there is no current diagnosis.
Sonia Gutierrez, Scenario 2
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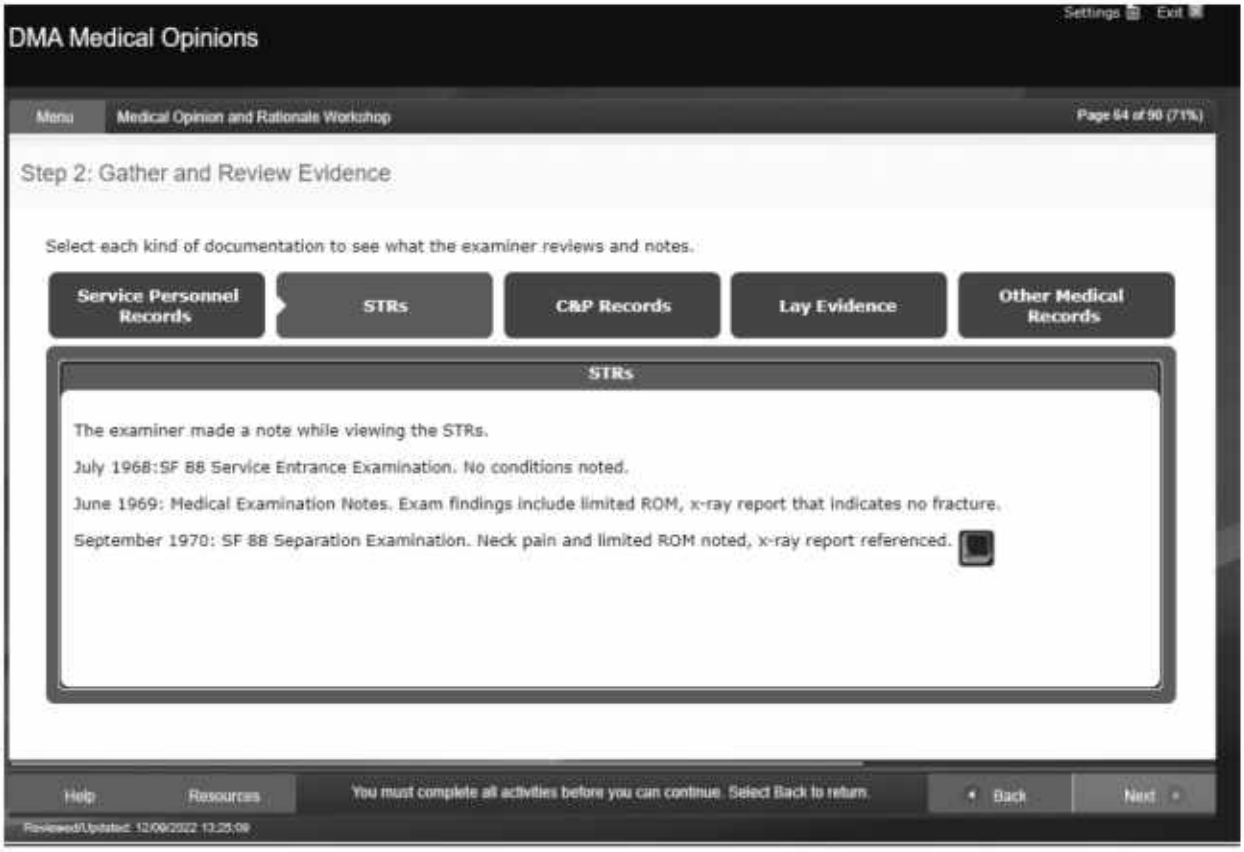

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Scenario 3: Secondary Service Connection
Dale Willow, Scenario 3
Examiner, Scenario 3
Some time passed since Dale Willow was service connected for cervical strain. Mr. Willow filed another claim, this time for secondary service connection for headaches due to his service-connected cervical strain. An examiner received the examination request for this claim. Select each step in order to see how the C&P examiner developed the requested opinion.
Step 1: Identify Questions to Answer
Step 2: Gather and Review Evidence
Step 3: Weigh the Evidence
Step 4: Determine the Opinion
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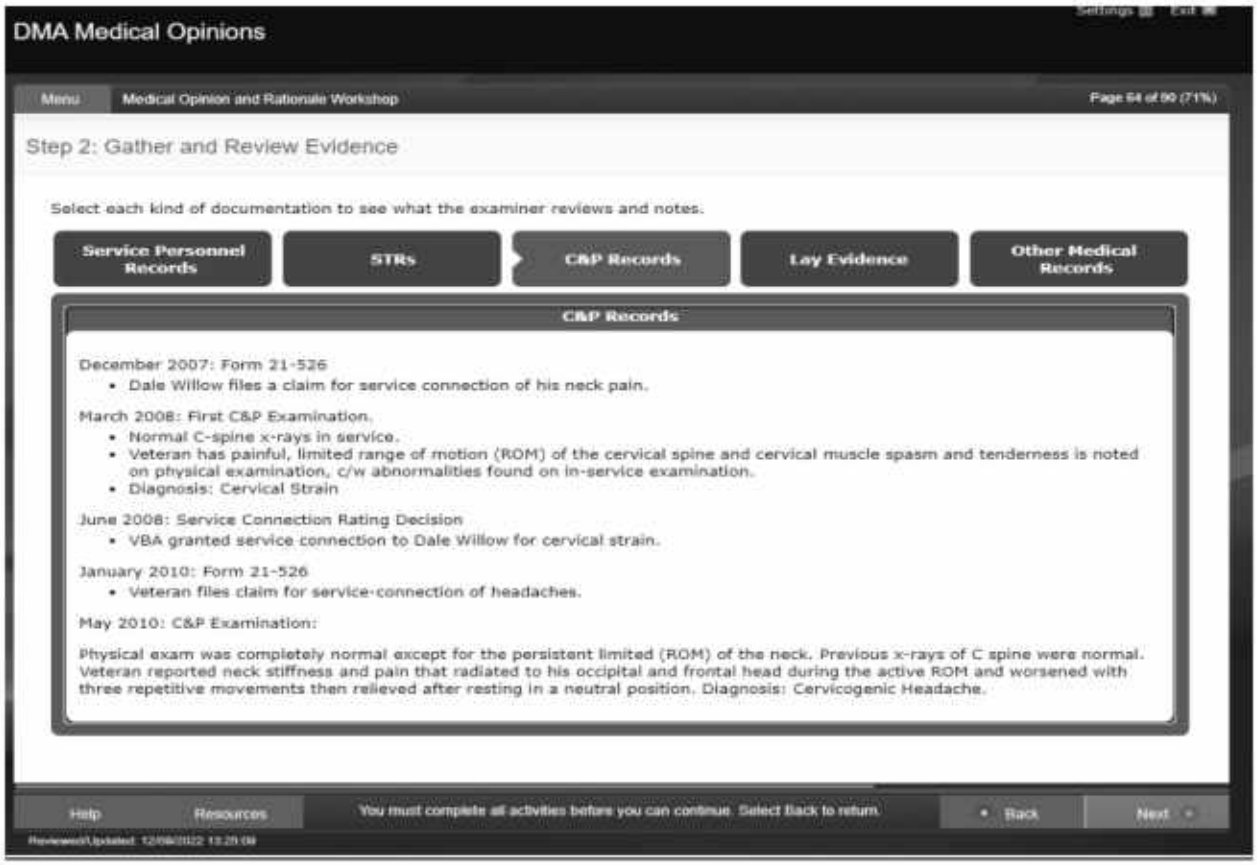

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Step 1: Identify Questions to Answer
The examiner reviews the examination request to identify the questions to answer for Mr. Willow's claim. He reviews this information.
Service-connected disabilities: Cervical neck strain
Claimed disabilities: Veteran claims headaches secondary to service-connected cervical neck strain.
Examination requested: DBQ NEURO HEADACHES, DBQ MEDICAL OPINION
The Veteran is claiming service connection for headaches secondary to service-connected cervical neck strain. Are the current headaches at least as likely as not (likelihood is at least approximately balanced or nearly equal, if not higher) proximately due to or caused by the SC cervical strain?
Dale Willow, Scenario 3
The first question to answer is whether Mr. Willow's headaches are caused by his service-connected cervical strain.
Additional Examiner Considerations
The examiner can think of other questions he must answer to provide a medical opinion and rationale. Type in the questions you can think of, then select "Compare" to compare your list of questions with his.
Type your questions here, then click Compare.
Examiner's Questions:
1. What kind of headaches are they (i.e., can they be related to the cervical strain)?
2. When did they start?
3. What is the course of the headaches over time?
4. Are there any other conditions that can better explain the symptoms?
Compare
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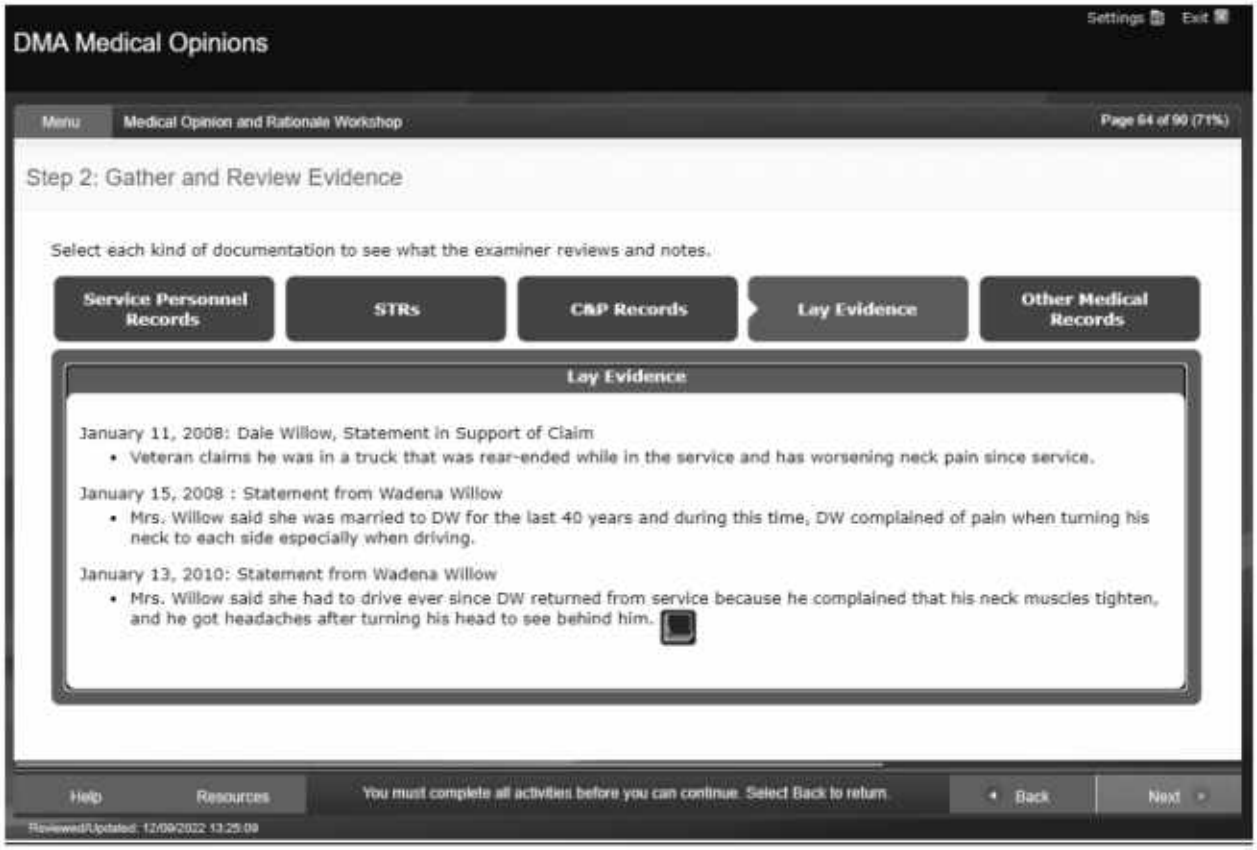

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Scenario 3: Secondary Service Connection
Dale Willow, Scenario 3
Examiner, Scenario 3
Some time passed since Dale Willow was service connected for cervical strain. Mr. Willow filed another claim, this time for secondary service connection for headaches due to his service-connected cervical strain. An examiner received the examination request for this claim. Select each step in order to see how the C&P examiner developed the requested opinion.
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Step 2: Gather and Review Evidence
Step 3: Weigh the Evidence
Step 4: Determine the Opinion
Step 5: Write the Rationale
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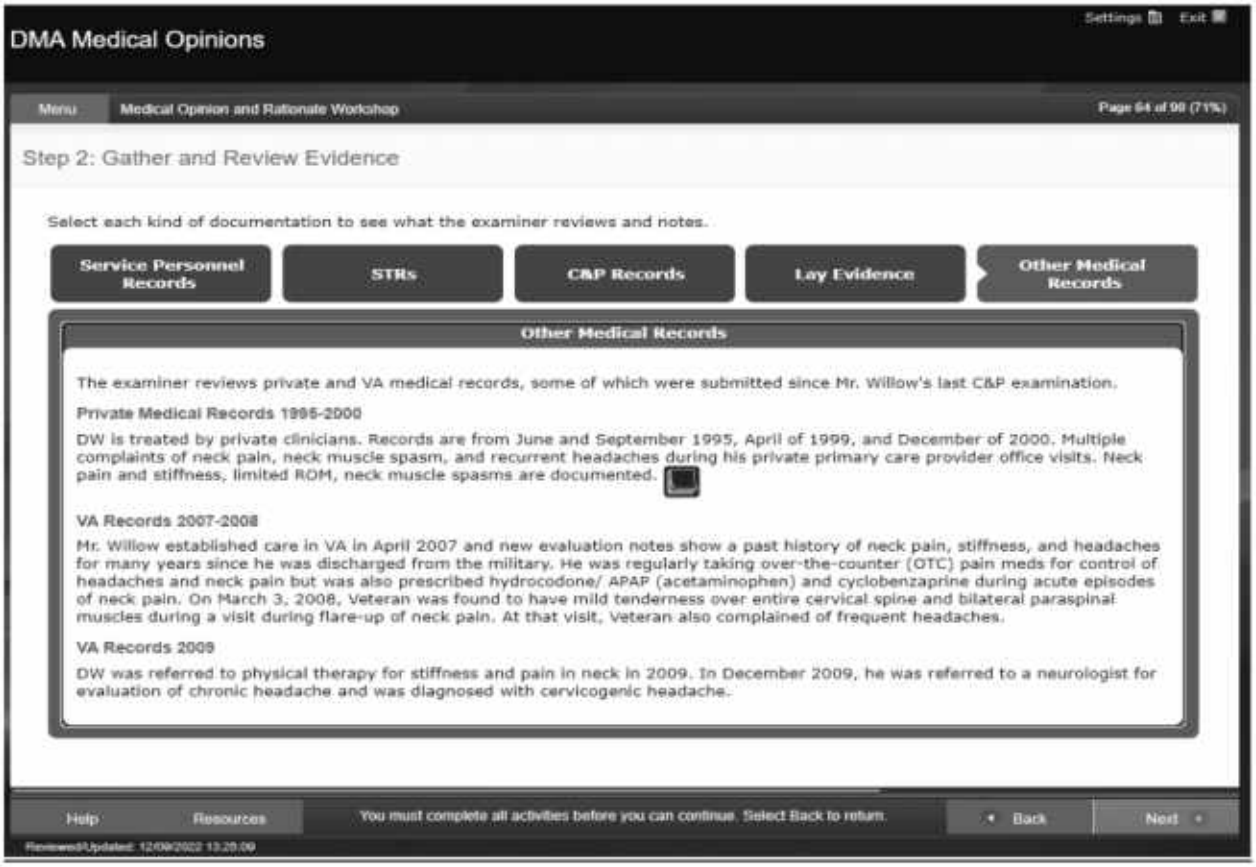

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Step 2: Gather and Review Evidence
Select each kind of documentation to see what the examiner reviews and notes.
Service Personnel Records
STRs
C&P Records
Lay Evidence
Other Medical Records
Please make a selection
Dale Willow, Scenario 3
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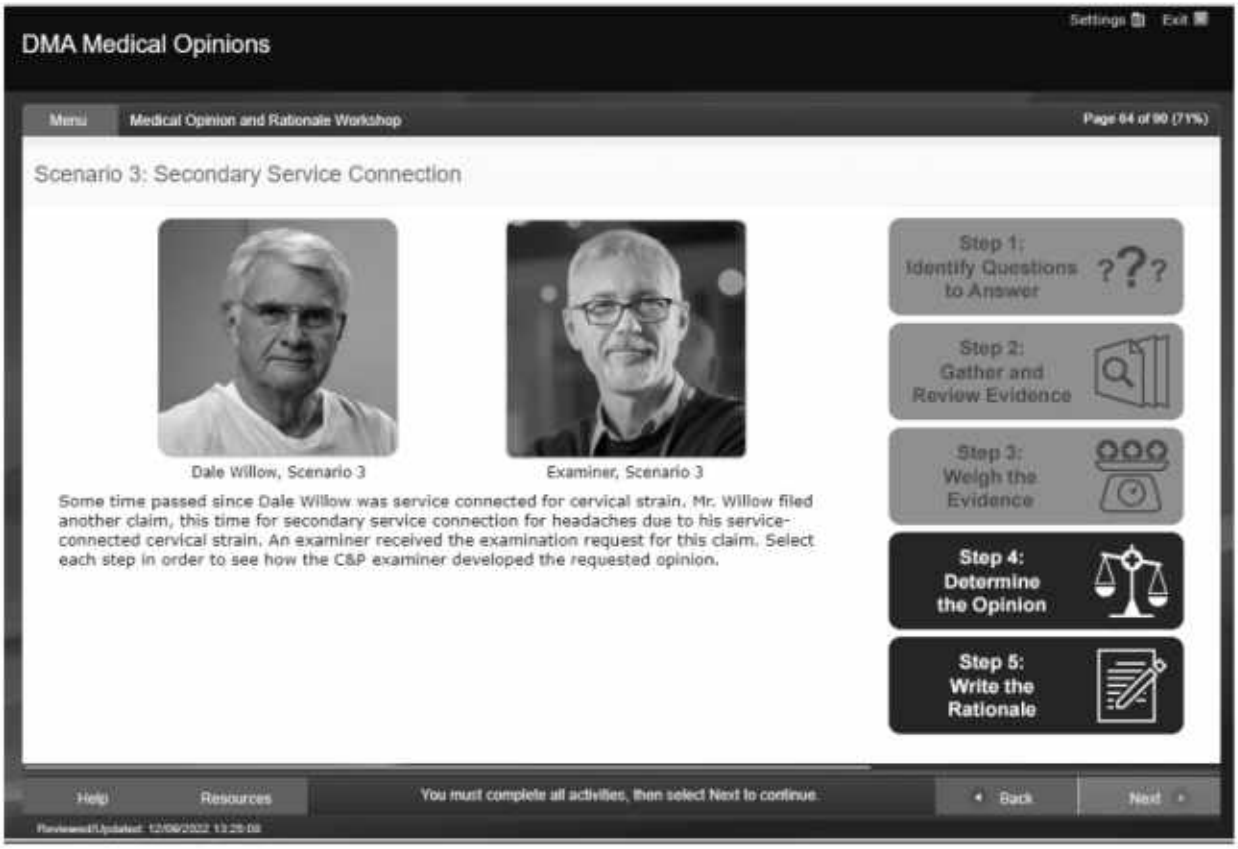

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Step 2: Gather and Review Evidence
Select each kind of documentation to see what the examiner reviews and notes.
Service Personnel Records
STRs
C&P Records
Lay Evidence
Other Medical Records
Service Personnel Records
The examiner gathers this information in Mr. Willow's service personnel records.
DD-214 Report of Discharge or Transfer:
Service dates: 08/06/1968-09/30/1970
MOS: 70A Clerk
Deployments: Vietnam 9/15/68-9/15/69
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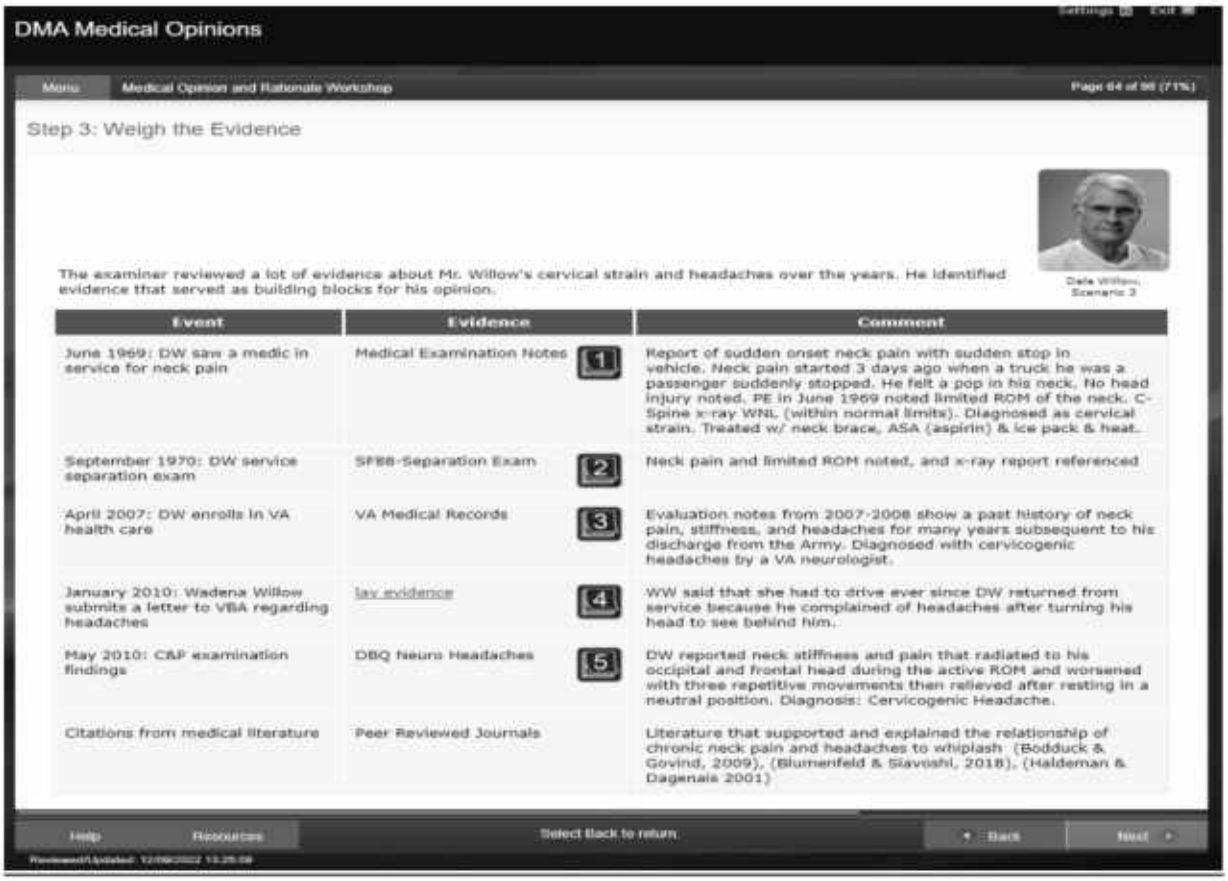

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Select each kind of documentation to see what the examiner reviews and notes.
Service Personnel Records
STRs
C&P Records
Lay Evidence
Other Medical Records
STRs
The examiner made a note while viewing the STRs.
July 1968:SF 88 Service Entrance Examination. No conditions noted.
June 1969: Medical Examination Notes. Exam findings include limited ROM, x-ray report that indicates no fracture.
September 1970: SF 88 Separation Examination. Neck pain and limited ROM noted, x-ray report referenced.
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Step 2: Gather and Review Evidence
Select each kind of documentation to see what the examiner reviews and notes.
Service Personnel Records
STRs
C&P Records
Lay Evidence
Other Medical Records
C&P Records
December 2007: Form 21-526
• Dale Willow files a claim for service connection of his neck pain.
March 2008: First C&P Examination.
• Normal C-spine x-rays in service.
• Veteran has painful, limited range of motion (ROM) of the cervical spine and cervical muscle spasm and tenderness is noted on physical examination, c/w abnormalities found on in-service examination.
• Diagnosis: Cervical Strain
June 2008: Service Connection Rating Decision
• VBA granted service connection to Dale Willow for cervical strain.
January 2010: Form 21-526
• Veteran files claim for service-connection of headaches.
May 2010: C&P Examination:
Physical exam was completely normal except for the persistent limited (ROM) of the neck. Previous x-rays of C spine were normal. Veteran reported neck stiffness and pain that radiated to his occipital and frontal head during the active ROM and worsened with three repetitive movements then relieved after resting in a neutral position. Diagnosis: Cervicogenic Headache.
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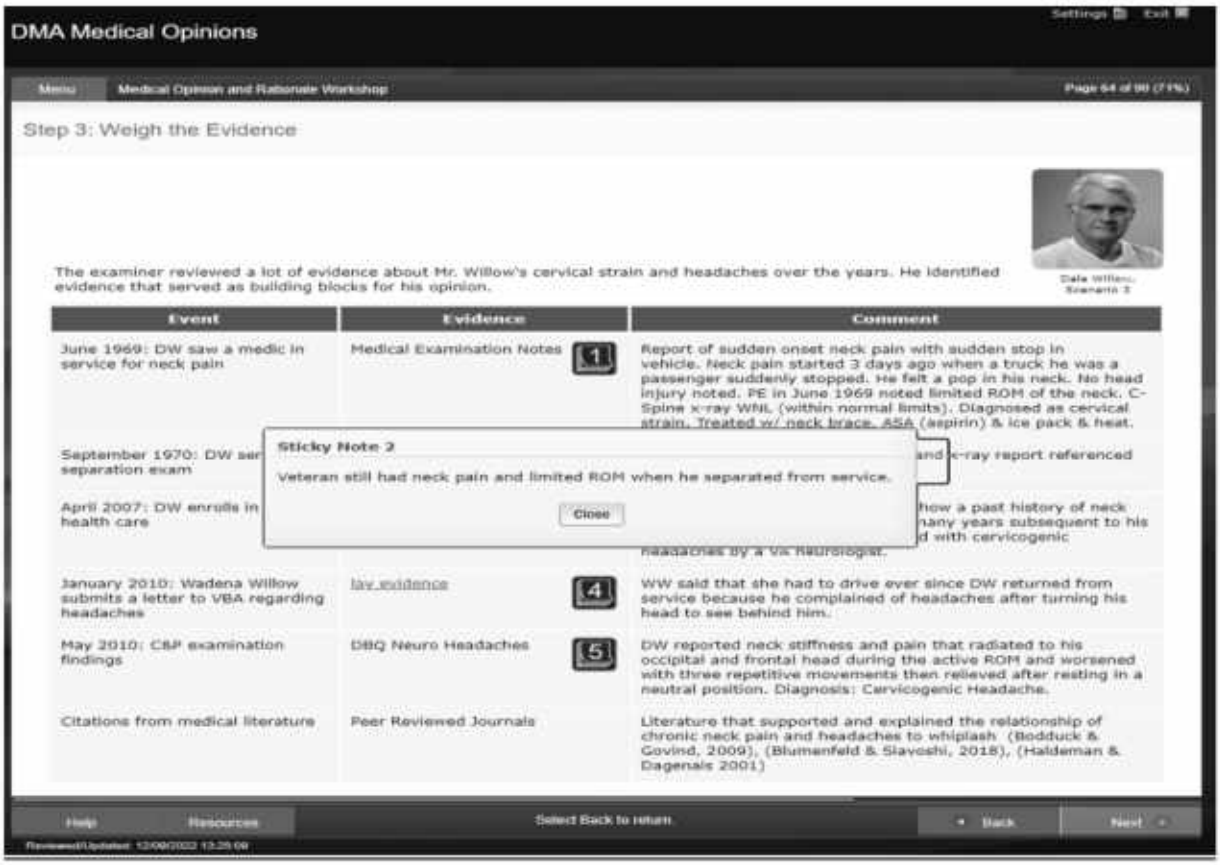

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Step 2: Gather and Review Evidence
Select each kind of documentation to see what the examiner reviews and notes.
Service Personnel Records
STRs
C&P Records
Lay Evidence
Other Medical Records
Lay Evidence
January 11, 2008: Dale Willow, Statement in Support of Claim
• Veteran claims he was in a truck that was rear-ended while in the service and has worsening neck pain since service.
January 15, 2008 : Statement from Wadena Willow
• Mrs. Willow said she was married to DW for the last 40 years and during this time, DW complained of pain when turning his neck to each side especially when driving.
January 13, 2010: Statement from Wadena Willow
• Mrs. Willow said she had to drive ever since DW returned from service because he complained that his neck muscles tighten, and he got headaches after turning his head to see behind him.
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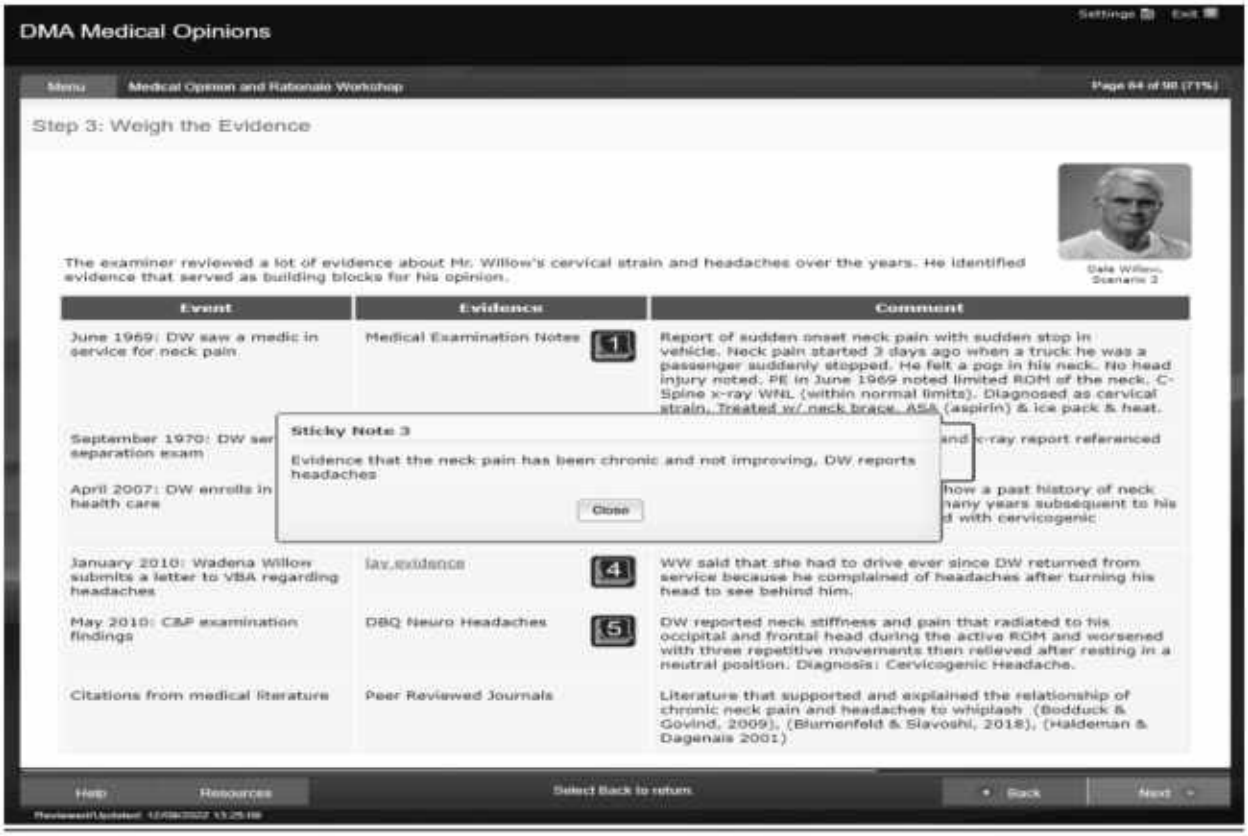

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Step 2: Gather and Review Evidence
Select each kind of documentation to see what the examiner reviews and notes.
Service Personnel Records
STRs
C&P Records
Lay Evidence
Other Medical Records
Other Medical Records
The examiner reviews private and VA medical records, some of which were submitted since Mr. Willow's last C&P examination.
Private Medical Records 1995-2000
DW is treated by private clinicians. Records are from June and September 1995, April of 1999, and December of 2000. Multiple complaints of neck pain, neck muscle spasm, and recurrent headaches during his private primary care provider office visits. Neck pain and stiffness, limited ROM, neck muscle spasms are documented.
VA Records 2007-2008
Mr. Willow established care in VA in April 2007 and new evaluation notes show a past history of neck pain, stiffness, and headaches for many years since he was discharged from the military. He was regularly taking over-the-counter (OTC) pain meds for control of headaches and neck pain but was also prescribed hydrocodone/ APAP (acetaminophen) and cyclobenzaprine during acute episodes of neck pain. On March 3, 2008, Veteran was found to have mild tenderness over entire cervical spine and bilateral paraspinal muscles during a visit during flare-up of neck pain. At that visit, Veteran also complained of frequent headaches.
VA Records 2009
DW was referred to physical therapy for stiffness and pain in neck in 2009. In December 2009, he was referred to a neurologist for evaluation of chronic headache and was diagnosed with cervicogenic headache.
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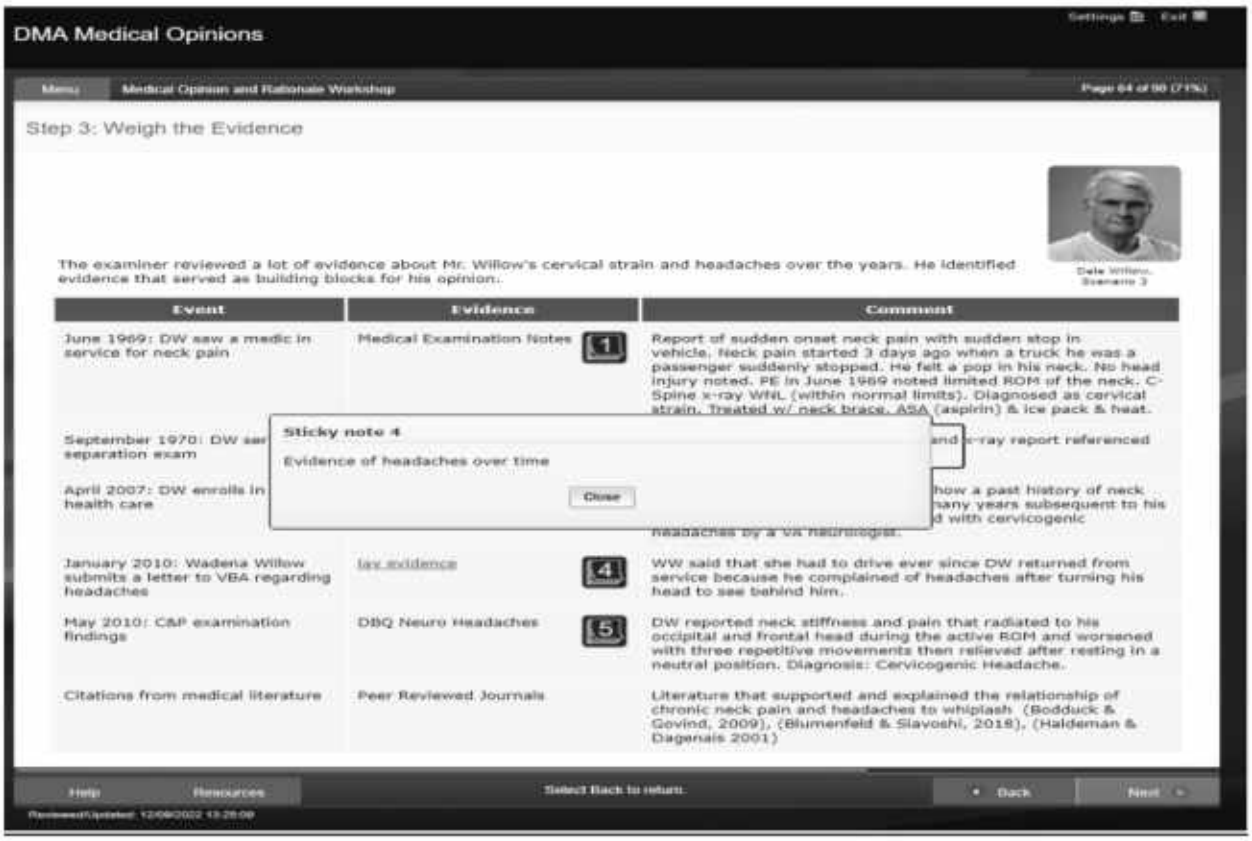

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Scenario 3: Secondary Service Connection
Dale Willow, Scenario 3
Examiner, Scenario 3
Some time passed since Dale Willow was service connected for cervical strain. Mr. Willow filed another claim, this time for secondary service connection for headaches due to his service-connected cervical strain. An examiner received the examination request for this claim. Select each step in order to see how the C&P examiner developed the requested opinion.
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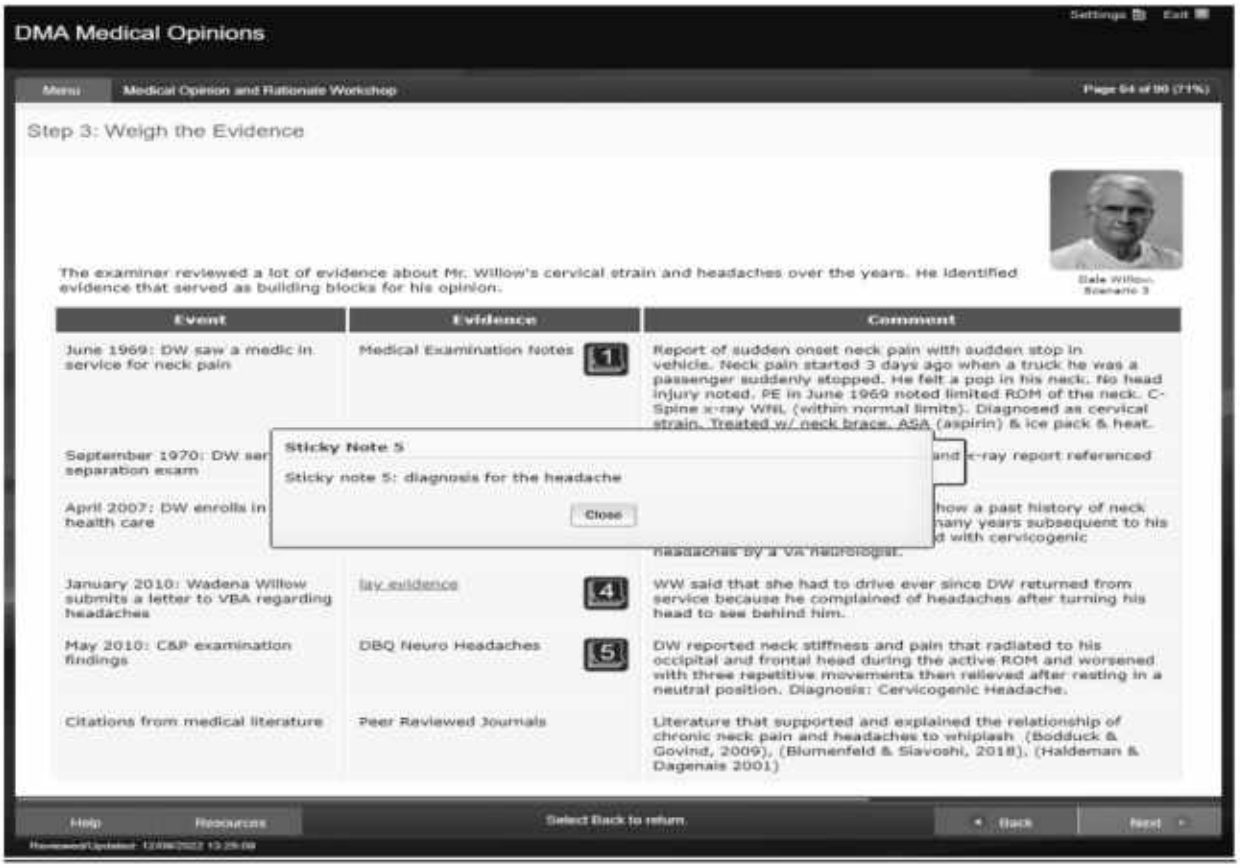

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Step 3: Weigh the Evidence
Dale Willow, Scenario 3
The examiner reviewed a lot of evidence about Mr. Willow's cervical strain and headaches over the years. He identified evidence that served as building blocks for his opinion.
Event
Evidence
Comment
June 1969: DW saw a medic in service for neck pain
Medical Examination Notes
1
Report of sudden onset neck pain with sudden stop in vehicle. Neck pain started 3 days ago when a truck he was a passenger suddenly stopped. He felt a pop in his neck. No head injury noted. PE in June 1969 noted limited ROM of the neck. C-Spine x-ray WNL (within normal limits). Diagnosed as cervical strain. Treated w/ neck brace, ASA (aspirin) & ice pack & heat.
September 1970: DW service separation exam
SF88-Separation Exam
2
Neck pain and limited ROM noted, and x-ray report referenced
April 2007: DW enrolls in VA health care
VA Medical Records
3
Evaluation notes from 2007-2008 show a past history of neck pain, stiffness, and headaches for many years subsequent to his discharge from the Army. Diagnosed with cervicogenic headaches by a VA neurologist.
January 2010: Wadena Willow submits a letter to VBA regarding headaches
lay evidence
4
WW said that she had to drive ever since DW returned from service because he complained of headaches after turning his head to see behind him.
May 2010: C&P examination findings
DBQ Neuro Headaches
5
DW reported neck stiffness and pain that radiated to his occipital and frontal head during the active ROM and worsened with three repetitive movements then relieved after resting in a neutral position. Diagnosis: Cervicogenic Headache.
Citations from medical literature
Peer Reviewed Journals
Literature that supported and explained the relationship of chronic neck pain and headaches to whiplash (Bodduck & Govind, 2009), (Blumenfeld & Slavoshi, 2018), (Haldeman & Dagenais 2001)
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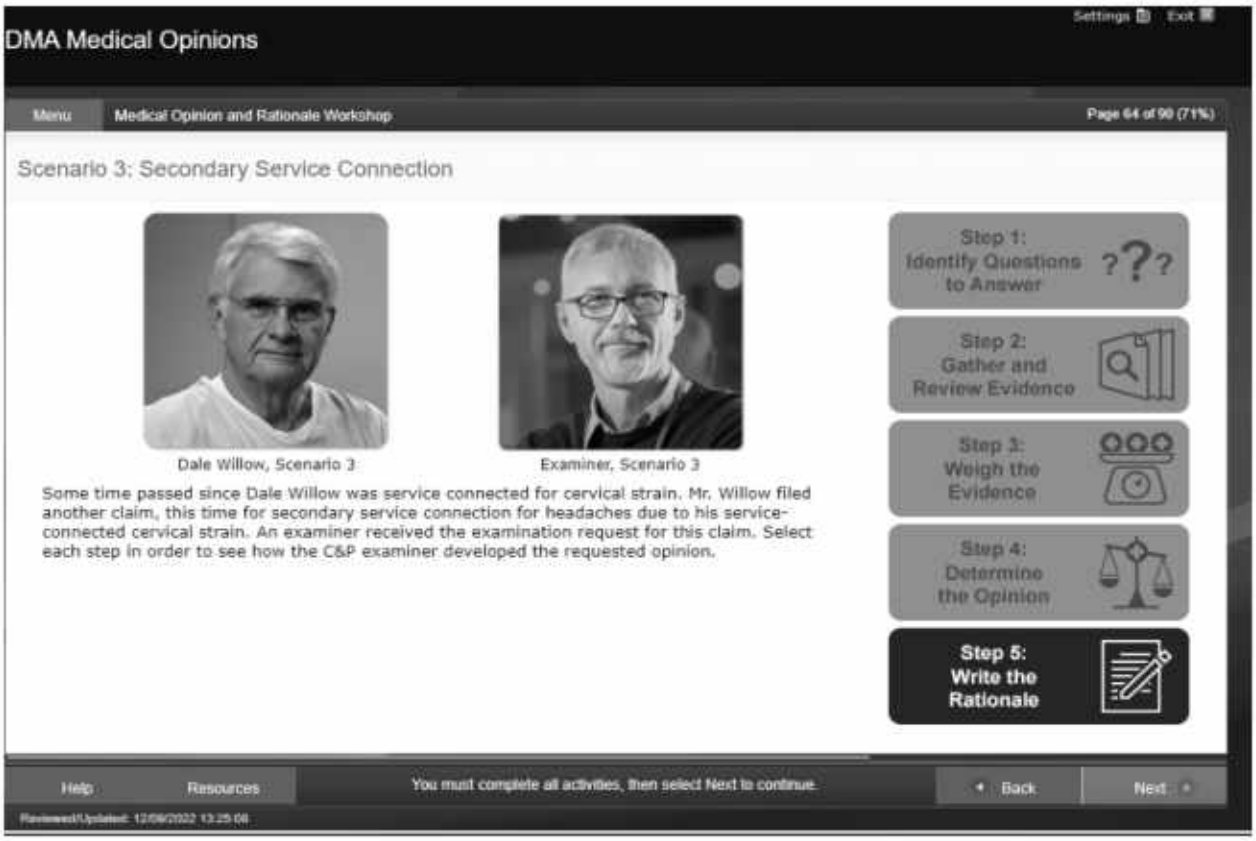

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Step 3: Weigh the Evidence
Dale Willow, Scenario 3
The examiner reviewed a lot of evidence about Mr. Willow's cervical strain and headaches over the years. He identified evidence that served as building blocks for his opinion.
Event
Evidence
Comment
June 1969: DW saw a medic in service for neck pain
Medical Examination Notes
1
Report of sudden onset neck pain with sudden stop in vehicle. Neck pain started 3 days ago when a truck he was a passenger suddenly stopped. He felt a pop in his neck. No head injury noted. PE in June 1969 noted limited ROM of the neck. C-Spine x-ray WNL (within normal limits). Diagnosed as cervical strain. Treated w/ neck brace, ASA (aspirin) & ice pack & heat.
Sticky Note 1
Starting point for Veteran's neck condition
Close
September 1970: DW ser
separation exam
x-ray report referenced
April 2007: DW enrolls in
health care
how a past history of neck
many years subsequent to his
d with cervicogenic
headaches by a VA neurologist.
January 2010: Wadena Willow submits a letter to VBA regarding headaches
lay evidence
4
WW said that she had to drive ever since DW returned from service because he complained of headaches after turning his head to see behind him.
May 2010: C&P examination findings
DBQ Neuro Headaches
5
DW reported neck stiffness and pain that radiated to his occipital and frontal head during the active ROM and worsened with three repetitive movements then relieved after resting in a neutral position. Diagnosis: Cervicogenic Headache.
Citations from medical literature
Peer Reviewed Journals
Literature that supported and explained the relationship of chronic neck pain and headaches to whiplash (Bodduck & Govind, 2009), (Blumenfeld & Slavoshi, 2018), (Haldeman & Dagenais 2001)
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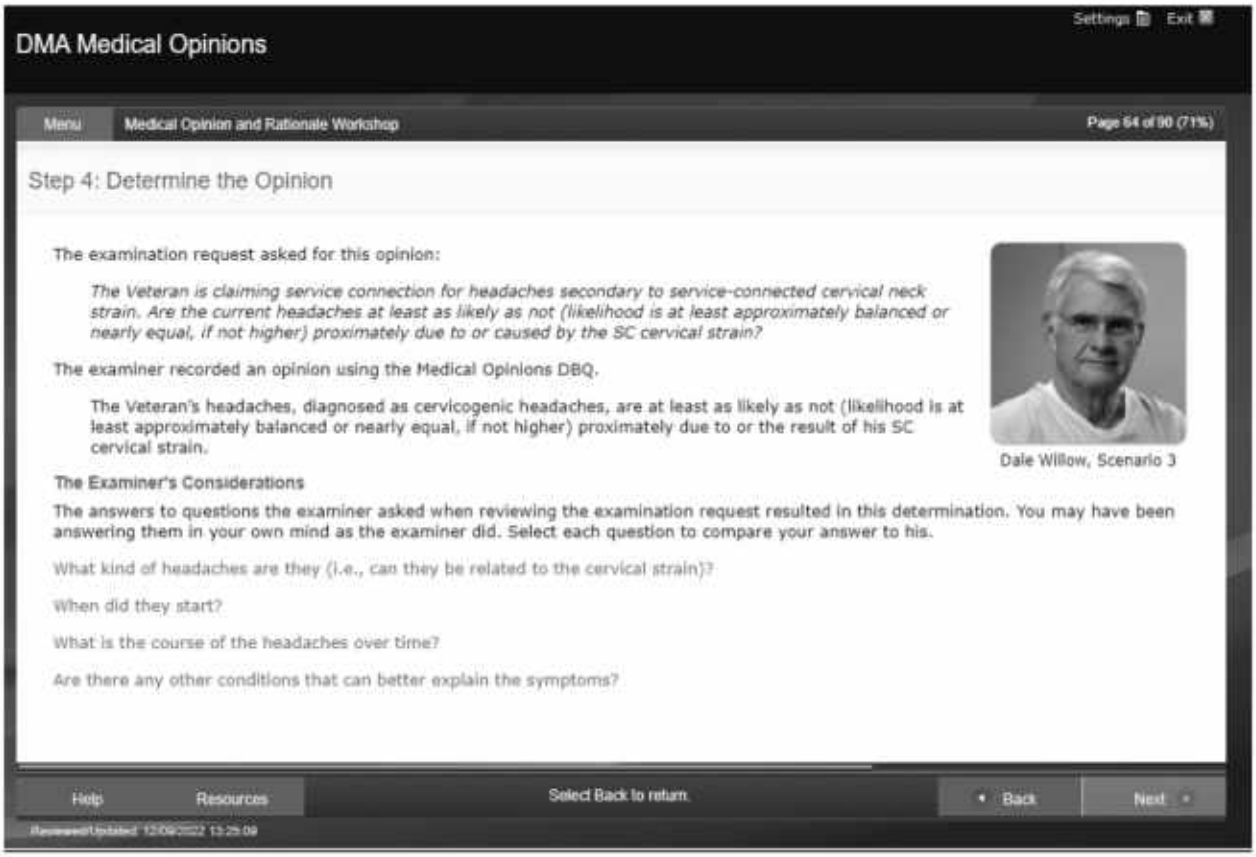

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Step 3: Weigh the Evidence
The examiner reviewed a lot of evidence about Mr. Willow's cervical strain and headaches over the years. He identified evidence that served as building blocks for his opinion.
Event
Evidence
Comment
June 1969: DW saw a medic in service for neck pain
Medical Examination Notes
1
Report of sudden onset neck pain with sudden stop in vehicle. Neck pain started 3 days ago when a truck he was a passenger suddenly stopped. He felt a pop in his neck. No head injury noted. PE in June 1969 noted limited ROM of the neck. C-Spine x-ray WNL (within normal limits). Diagnosed as cervical strain. Treated w/ neck brace, ASA (aspirin) & ice pack & heat.
Sticky Note 2
Veteran still had neck pain and limited ROM when he separated from service.
Close
January 2010: Wadena Willow submits a letter to VBA regarding headaches
lay evidence
4
WW said that she had to drive ever since DW returned from service because he complained of headaches after turning his head to see behind him.
May 2010: C&P examination findings
DBQ Neuro Headaches
5
DW reported neck stiffness and pain that radiated to his occipital and frontal head during the active ROM and worsened with three repetitive movements then relieved after resting in a neutral position. Diagnosis: Cervicogenic Headache.
Citations from medical literature
Peer Reviewed Journals
Literature that supported and explained the relationship of chronic neck pain and headaches to whiplash (Bodduck & Govind, 2009), (Blumenfeld & Slavoshi, 2018), (Haldeman & Dagenais 2001)
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Step 3: Weigh the Evidence
The examiner reviewed a lot of evidence about Mr. Willow's cervical strain and headaches over the years. He identified evidence that served as building blocks for his opinion.
Event
Evidence
Comment
June 1969: DW saw a medic in service for neck pain
Medical Examination Notes
1
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Sticky Note 3
Evidence that the neck pain has been chronic and not improving, DW reports headaches
Close
January 2010: Wadena Willow submits a letter to VBA regarding headaches
lay evidence
4
WW said that she had to drive ever since DW returned from service because he complained of headaches after turning his head to see behind him.
May 2010: C&P examination findings
DBQ Neuro Headaches
5
DW reported neck stiffness and pain that radiated to his occipital and frontal head during the active ROM and worsened with three repetitive movements then relieved after resting in a neutral position. Diagnosis: Cervicogenic Headache.
Citations from medical literature
Peer Reviewed Journals
Literature that supported and explained the relationship of chronic neck pain and headaches to whiplash (Bodduck & Govind, 2009), (Blumenfeld & Slavoshi, 2018), (Haldeman & Dagenais 2001)
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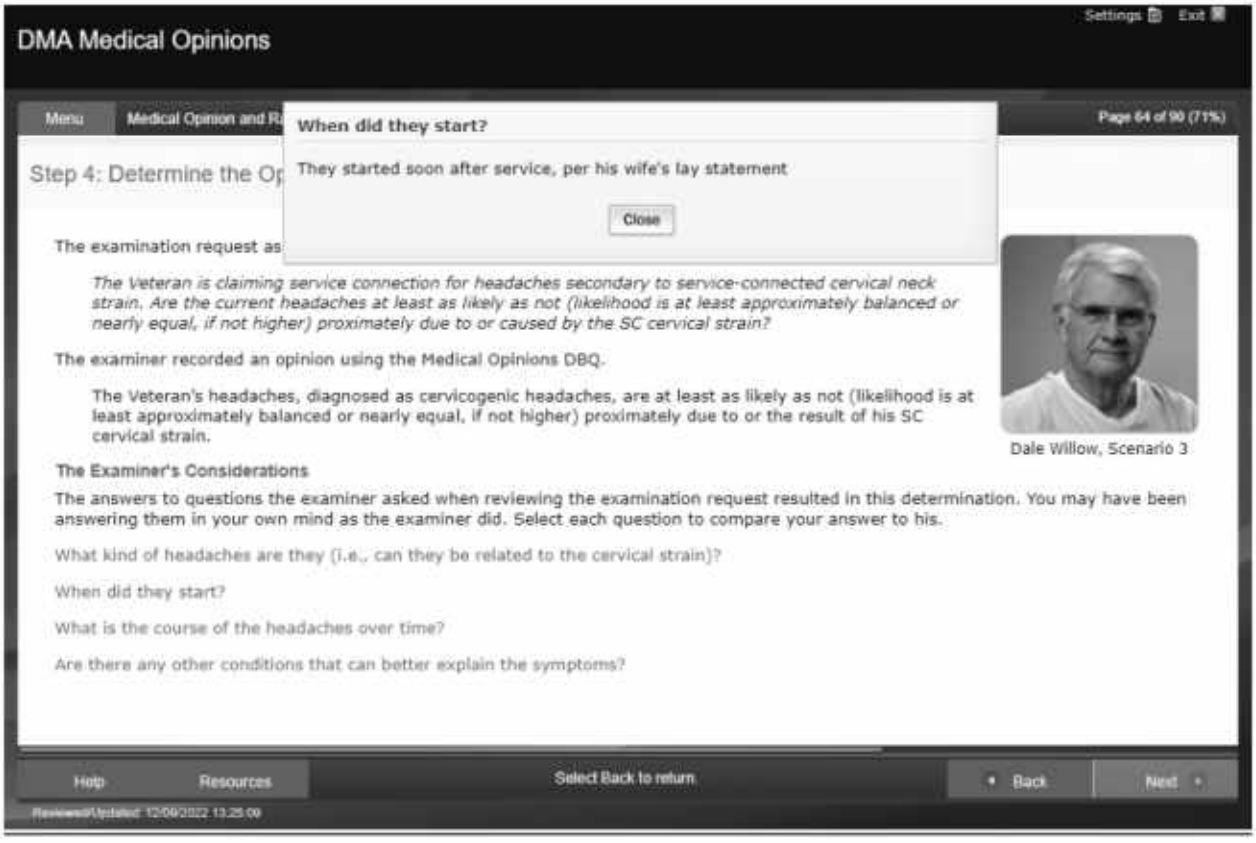

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Step 3: Weigh the Evidence
The examiner reviewed a lot of evidence about Mr. Willow's cervical strain and headaches over the years. He identified evidence that served as building blocks for his opinion.
Event
Evidence
Comment
June 1969: DW saw a medic in service for neck pain
Medical Examination Notes
1
Report of sudden onset neck pain with sudden stop in vehicle. Neck pain started 3 days ago when a truck he was a passenger suddenly stopped. He felt a pop in his neck. No head injury noted. PE in June 1969 noted limited ROM of the neck. C-Spine x-ray WNL (within normal limits). Diagnosed as cervical strain. Treated w/ neck brace, ASA (aspirin) & ice pack & heat.
Sticky note 4
Evidence of headaches over time
Close
September 1970: DW sep separation exam
x-ray report referenced
April 2007: DW enrolls in health care
how a past history of neck many years subsequent to his with cervicogenic
headaches by a VA neurologist.
January 2010: Wadena Willow submits a letter to VBA regarding headaches
lay evidence
4
WW said that she had to drive ever since DW returned from service because he complained of headaches after turning his head to see behind him.
May 2010: C&P examination findings
DBQ Neuro Headaches
5
DW reported neck stiffness and pain that radiated to his occipital and frontal head during the active ROM and worsened with three repetitive movements then relieved after resting in a neutral position. Diagnosis: Cervicogenic Headache.
Citations from medical literature
Peer Reviewed Journals
Literature that supported and explained the relationship of chronic neck pain and headaches to whiplash (Bodduck & Govind, 2009), (Blumenfeld & Slavoshi, 2018), (Haldeman & Dagenais 2001)
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Step 3: Weigh the Evidence
The examiner reviewed a lot of evidence about Mr. Willow's cervical strain and headaches over the years. He identified evidence that served as building blocks for his opinion.
Event
Evidence
Comment
June 1969: DW saw a medic in service for neck pain
Medical Examination Notes
1
Report of sudden onset neck pain with sudden stop in vehicle. Neck pain started 3 days ago when a truck he was a passenger suddenly stopped. He felt a pop in his neck. No head injury noted. PE in June 1969 noted limited ROM of the neck. C-Spine x-ray WNL (within normal limits). Diagnosed as cervical strain. Treated w/ neck brace, ASA (aspirin) & ice pack & heat.
Sticky Note 5
Sticky note 5: diagnosis for the headache
Close
September 1970: DW sep separation exam
x-ray report referenced
April 2007: DW enrolls in health care
how a past history of neck many years subsequent to his with cervicogenic
headaches by a VA neurologist.
January 2010: Wadena Willow submits a letter to VBA regarding headaches
lay evidence
4
WW said that she had to drive ever since DW returned from service because he complained of headaches after turning his head to see behind him.
May 2010: C&P examination findings
DBQ Neuro Headaches
5
DW reported neck stiffness and pain that radiated to his occipital and frontal head during the active ROM and worsened with three repetitive movements then relieved after resting in a neutral position. Diagnosis: Cervicogenic Headache.
Citations from medical literature
Peer Reviewed Journals
Literature that supported and explained the relationship of chronic neck pain and headaches to whiplash (Bodduck & Govind, 2009), (Blumenfeld & Slavoshi, 2018), (Haldeman & Dagenais 2001)
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Scenario 3: Secondary Service Connection
Dale Willow, Scenario 3
Examiner, Scenario 3
Some time passed since Dale Willow was service connected for cervical strain. Mr. Willow filed another claim, this time for secondary service connection for headaches due to his service-connected cervical strain. An examiner received the examination request for this claim. Select each step in order to see how the C&P examiner developed the requested opinion.
Step 1: Identify Questions to Answer
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Step 3: Weigh the Evidence
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Step 4: Determine the Opinion
The examination request asked for this opinion:
The Veteran is claiming service connection for headaches secondary to service-connected cervical neck strain. Are the current headaches at least as likely as not (likelihood is at least approximately balanced or nearly equal, if not higher) proximately due to or caused by the SC cervical strain?
The examiner recorded an opinion using the Medical Opinions DBQ.
The Veteran's headaches, diagnosed as cervicogenic headaches, are at least as likely as not (likelihood is at least approximately balanced or nearly equal, if not higher) proximately due to or the result of his SC cervical strain.
Dale Willow, Scenario 3
The Examiner's Considerations
The answers to questions the examiner asked when reviewing the examination request resulted in this determination. You may have been answering them in your own mind as the examiner did. Select each question to compare your answer to his.
What kind of headaches are they (i.e., can they be related to the cervical strain)?
When did they start?
What is the course of the headaches over time?
Are there any other conditions that can better explain the symptoms?
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What kind of headaches are they (i.e., can they be related to the cervical strain)?
Cervicogenic headaches and yes, they are related to the SC cervical strain
Close
Step 4: Determine the Op
The examination request as
The Veteran is claiming service connection for headaches secondary to service-connected cervical neck strain. Are the current headaches at least as likely as not (likelihood is at least approximately balanced or nearly equal, if not higher) proximately due to or caused by the SC cervical strain?
The examiner recorded an opinion using the Medical Opinions DBQ.
The Veteran's headaches, diagnosed as cervicogenic headaches, are at least as likely as not (likelihood is at least approximately balanced or nearly equal, if not higher) proximately due to or the result of his SC cervical strain.
Dale Willow, Scenario 3
The Examiner's Considerations
The answers to questions the examiner asked when reviewing the examination request resulted in this determination. You may have been answering them in your own mind as the examiner did. Select each question to compare your answer to his.
What kind of headaches are they (i.e., can they be related to the cervical strain)?
When did they start?
What is the course of the headaches over time?
Are there any other conditions that can better explain the symptoms?
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When did they start?
They started soon after service, per his wife's lay statement
Close
Step 4: Determine the Op
The examination request as
The Veteran is claiming service connection for headaches secondary to service-connected cervical neck strain. Are the current headaches at least as likely as not (likelihood is at least approximately balanced or nearly equal, if not higher) proximately due to or caused by the SC cervical strain?
The examiner recorded an opinion using the Medical Opinions DBQ.
The Veteran's headaches, diagnosed as cervicogenic headaches, are at least as likely as not (likelihood is at least approximately balanced or nearly equal, if not higher) proximately due to or the result of his SC cervical strain.
Dale Willow, Scenario 3
The Examiner's Considerations
The answers to questions the examiner asked when reviewing the examination request resulted in this determination. You may have been answering them in your own mind as the examiner did. Select each question to compare your answer to his.
What kind of headaches are they (i.e., can they be related to the cervical strain)?
When did they start?
What is the course of the headaches over time?
Are there any other conditions that can better explain the symptoms?
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What is the course of the headaches over time?
Medical and lay evidence indicate DW had headaches related to his cervical strain subsequent to his discharge from service to the present.
Close
Step 4: Determine the Op
The examination request as
The Veteran is claiming service connection for headaches secondary to service-connected cervical neck strain. Are the current headaches at least as likely as not (likelihood is at least approximately balanced or nearly equal, if not higher) proximately due to or caused by the SC cervical strain?
The examiner recorded an opinion using the Medical Opinions DBQ.
The Veteran's headaches, diagnosed as cervicogenic headaches, are at least as likely as not (likelihood is at least approximately balanced or nearly equal, if not higher) proximately due to or the result of his SC cervical strain.
Dale Willow, Scenario 3
The Examiner's Considerations
The answers to questions the examiner asked when reviewing the examination request resulted in this determination. You may have been answering them in your own mind as the examiner did. Select each question to compare your answer to his.
What kind of headaches are they (i.e., can they be related to the cervical strain)?
When did they start?
What is the course of the headaches over time?
Are there any other conditions that can better explain the symptoms?
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Are there any other conditions that can better explain the symptoms?
No
Close
Step 4: Determine the Op
The examination request as
The Veteran is claiming service connection for headaches secondary to service-connected cervical neck strain. Are the current headaches at least as likely as not (likelihood is at least approximately balanced or nearly equal, if not higher) proximately due to or caused by the SC cervical strain?
The examiner recorded an opinion using the Medical Opinions DBQ.
The Veteran's headaches, diagnosed as cervicogenic headaches, are at least as likely as not (likelihood is at least approximately balanced or nearly equal, if not higher) proximately due to or the result of his SC cervical strain.
Dale Willow, Scenario 3
The Examiner's Considerations
The answers to questions the examiner asked when reviewing the examination request resulted in this determination. You may have been answering them in your own mind as the examiner did. Select each question to compare your answer to his.
What kind of headaches are they (i.e., can they be related to the cervical strain)?
When did they start?
What is the course of the headaches over time?
Are there any other conditions that can better explain the symptoms?
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Scenario 3: Secondary Service Connection



Dale Willow, Scenario 3



Examiner, Scenario 3

Some time passed since Dale Willow was service connected for cervical strain. Mr. Willow filed another claim, this time for secondary service connection for headaches due to his service-connected cervical strain. An examiner received the examination request for this claim. Select each step in order to see how the C&P examiner developed the requested opinion.

- Step 1: Identify Questions to Answer
- Step 2: Gather and Review Evidence
- Step 3: Weigh the Evidence
- Step 4: Determine the Opinion
- Step 5: Write the Rationale

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Step 5: Write the Rationale



Dale Willow, Scenario 3

Opinion: The Veteran's headaches, diagnosed as cervicogenic headaches, are at least as likely as not (likelihood is at least approximately balanced or nearly equal, if not higher) proximately due to or the result of his SC cervical strain.

The examiner supported his opinion with this rationale.

Rationale: The Veteran's headaches are proximately due to his service-connected cervical strain encompassing radiculopathy of the cervical spine, which results in pain and stiffness of his neck with radiating pain to his occipital and frontal head. A review of the STRs, other medical records and the lay evidence provided by the Veteran and his wife showed that he reported neck pain since June 1969 while in service. The separation physical examination in 1970 also noted that he had neck pain. His cervical spine x-ray was unremarkable.

- Veteran was seen by a VA neurologist in 2007 due to chronic neck pain, stiffness and headache. He was diagnosed with cervicogenic headaches. Veteran submitted a lay statement by his wife stating that ever since his time service, the Veteran complained about pain and headache when turning his head to either side.
- The physical examination today showed limited active ROM due to pain and stiffness of his neck with radiating pain to his occipital and frontal head.
- Peer-reviewed medical literature supports that neck pain is one of the common causes of cervicogenic headache. Headaches due to cervical spine condition are referred to as cervicogenic headaches. The involvement of the joints, discs and muscles of the neck contain nerve endings which are sensitive to neck injury or strain.

The following articles also support that cervical strain can cause cervicogenic headaches and explains the notion that headaches may originate from disorders of the cervical spine.

Bogduk, N. & Govind, J. (2009). Cervicogenic headache: an assessment of the evidence on clinical diagnosis, invasive tests, and treatment. *Lancet Neurology, 8(10)*, 959-68. doi: 10.1016/S1474-4422(09)70209-1.

Blumenfeld, A. & Slavoshi, S. (2018) The Challenges of Cervicogenic Headache. *Current Pain Headache Reports, 22(7)*,47. doi: 10.1007/s11916-018-0699-z.

Haldeman S. & Dagenais S. (2001). Cervicogenic headaches: a critical review. *Spine Journal,1(1)*, 31-46. doi: 10.1016/s1529-9430(01)00024-9.

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Lesson 5 Introduction

This lesson presents content to help you remember guidelines for addressing special circumstances that affect the scope or procedures for writing medical opinions. Several special circumstances described in this lesson can be part of the information provided to you on requests for examination.

Some special circumstances affect the scope for an opinion. For example, the scope might be to address matters related to an appealed claim decision, a claim filed by dependents of a deceased Veteran, or a military reservist's dates of active duty and inactive duty.

This lesson will also explain special circumstances that affect procedures for developing opinions. For example, presumptive conditions do not require an opinion. Special circumstances can also include claims related to events that occurred during combat in service and claims based on hazardous exposures.



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Remand Medical Opinions

If BVA has made a determination that it needs additional evidence to fully or fairly adjudicate an appeal, they will issue a remand. A remanded appeal is one that BVA returns to VBA for the development of additional evidence for reasons of due process or reconsideration of issues. When the remand instructs VBA to obtain an examination or medical opinion, VBA will ask for a medical opinion or examination using an examination request and include instructions from BVA.

When you provide a medical opinion, for a remand, you must exactly follow all of BVA's remand instructions on the examination request. The information needed may exceed the information typically required on a DBQ. Answer all questions in the remand instructions because VBA is required to obtain all requested information (*Stegall v. West*, 1998).

Source: *Stegall v. West*, 11 Vet. App. 268 (1998)

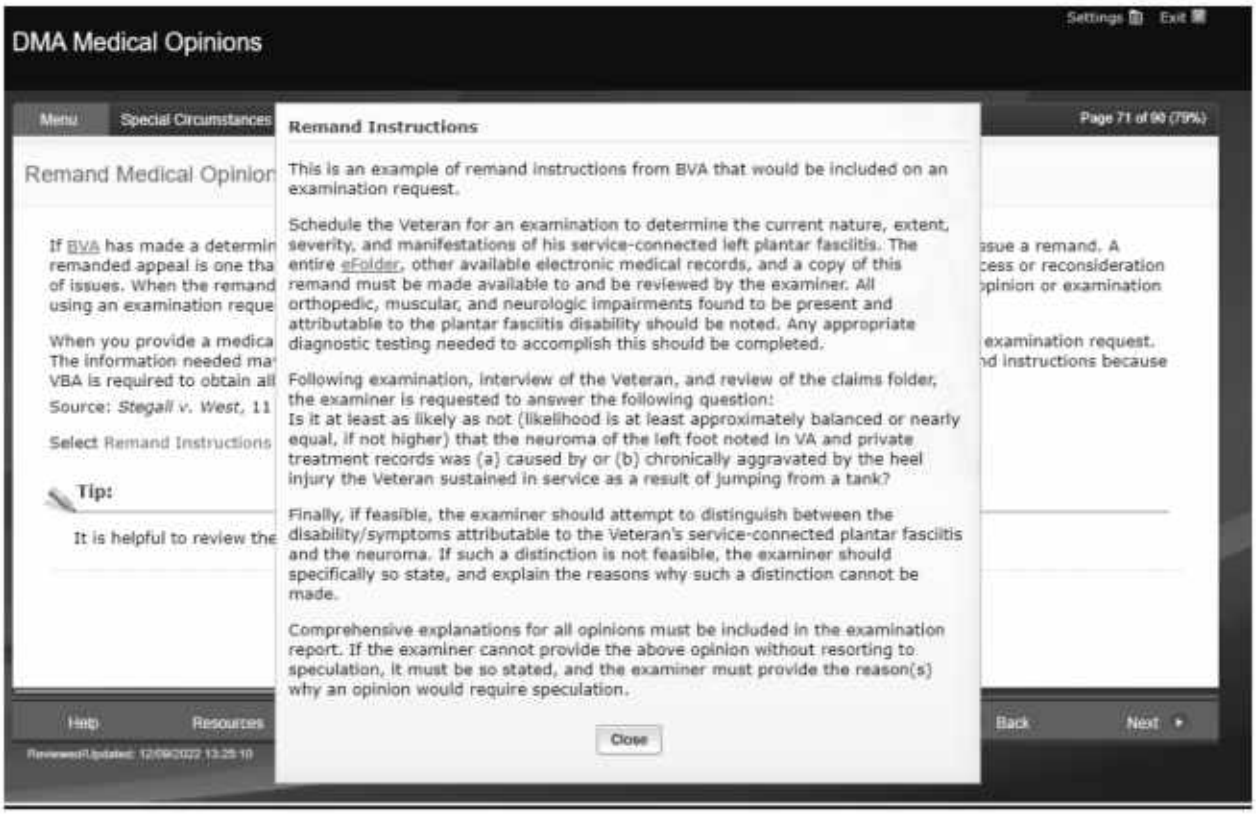
Select Remand Instructions to view fictional sample remand instructions.

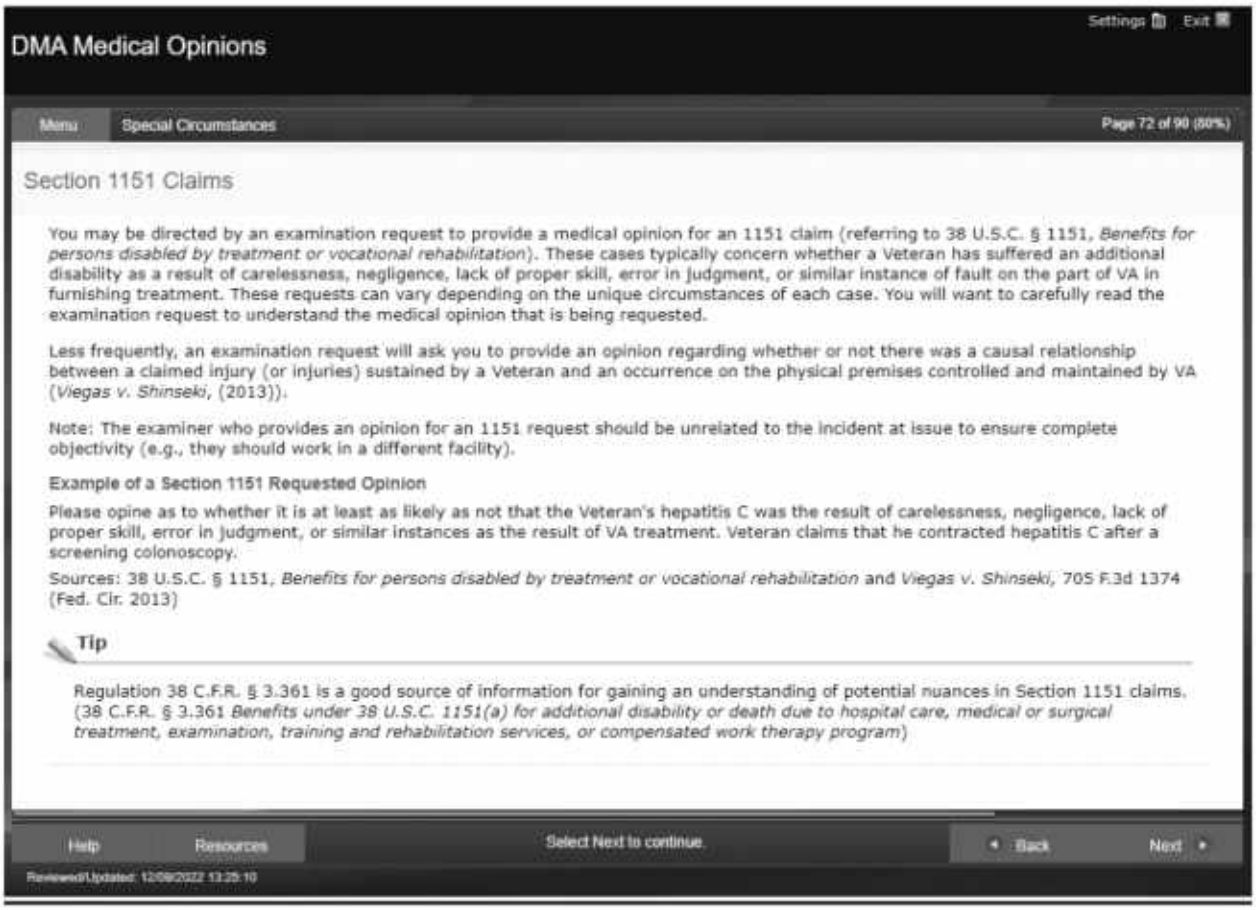
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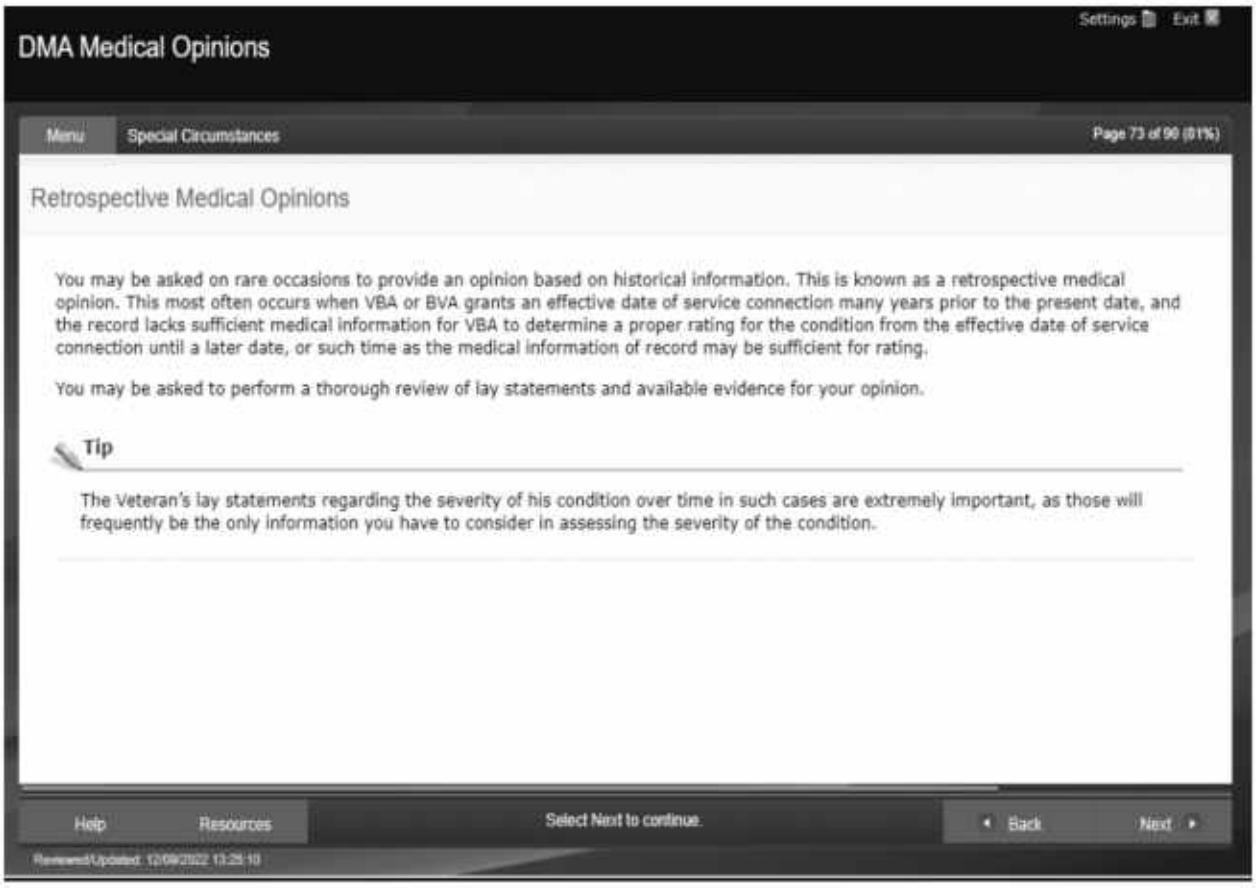
It is helpful to review the BVA remand in its entirety in the Veteran's records.

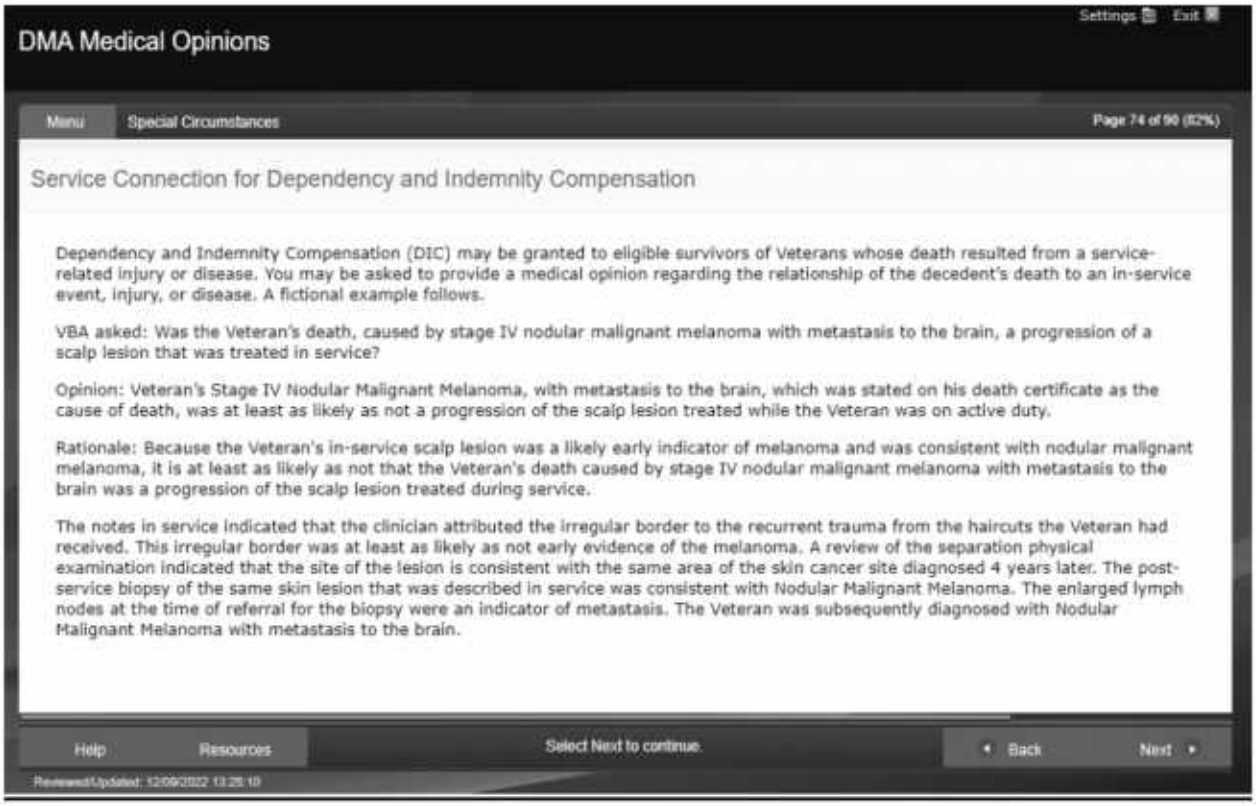
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Remand Medical Opinion
If BVA has made a determin
remanded appeal is one tha
of issues. When the remand
using an examination reque
When you provide a medica
The information needed ma
VBA is required to obtain all
Source: Stegall v. West, 11
Select Remand Instructions
Tip:
It is helpful to review the
Remand Instructions
This is an example of remand instructions from BVA that would be included on an examination request.
Schedule the Veteran for an examination to determine the current nature, extent, severity, and manifestations of his service-connected left plantar fasciitis. The entire eFolder, other available electronic medical records, and a copy of this remand must be made available to and be reviewed by the examiner. All orthopedic, muscular, and neurologic impairments found to be present and attributable to the plantar fasciitis disability should be noted. Any appropriate diagnostic testing needed to accomplish this should be completed.
Following examination, interview of the Veteran, and review of the claims folder, the examiner is requested to answer the following question:
Is it at least as likely as not (likelihood is at least approximately balanced or nearly equal, if not higher) that the neuroma of the left foot noted in VA and private treatment records was (a) caused by or (b) chronically aggravated by the heel injury the Veteran sustained in service as a result of jumping from a tank?
Finally, if feasible, the examiner should attempt to distinguish between the disability/symptoms attributable to the Veteran's service-connected plantar fasciitis and the neuroma. If such a distinction is not feasible, the examiner should specifically so state, and explain the reasons why such a distinction cannot be made.
Comprehensive explanations for all opinions must be included in the examination report. If the examiner cannot provide the above opinion without resorting to speculation, it must be so stated, and the examiner must provide the reason(s) why an opinion would require speculation.
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sue a remand. A
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Section 1151 Claims
You may be directed by an examination request to provide a medical opinion for an 1151 claim (referring to 38 U.S.C. § 1151, Benefits for persons disabled by treatment or vocational rehabilitation). These cases typically concern whether a Veteran has suffered an additional disability as a result of carelessness, negligence, lack of proper skill, error in judgment, or similar instance of fault on the part of VA in furnishing treatment. These requests can vary depending on the unique circumstances of each case. You will want to carefully read the examination request to understand the medical opinion that is being requested.
Less frequently, an examination request will ask you to provide an opinion regarding whether or not there was a causal relationship between a claimed injury (or injuries) sustained by a Veteran and an occurrence on the physical premises controlled and maintained by VA (Viegas v. Shinseki, (2013)).
Note: The examiner who provides an opinion for an 1151 request should be unrelated to the incident at issue to ensure complete objectivity (e.g., they should work in a different facility).
Example of a Section 1151 Requested Opinion
Please opine as to whether it is at least as likely as not that the Veteran's hepatitis C was the result of carelessness, negligence, lack of proper skill, error in judgment, or similar instances as the result of VA treatment. Veteran claims that he contracted hepatitis C after a screening colonoscopy.
Sources: 38 U.S.C. § 1151, Benefits for persons disabled by treatment or vocational rehabilitation and Viegas v. Shinseki, 705 F.3d 1374 (Fed. Cir. 2013)
Tip
Regulation 38 C.F.R. § 3.361 is a good source of information for gaining an understanding of potential nuances in Section 1151 claims. (38 C.F.R. § 3.361 Benefits under 38 U.S.C. 1151(a) for additional disability or death due to hospital care, medical or surgical treatment, examination, training and rehabilitation services, or compensated work therapy program)
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Retrospective Medical Opinions
You may be asked on rare occasions to provide an opinion based on historical information. This is known as a retrospective medical opinion. This most often occurs when VBA or BVA grants an effective date of service connection many years prior to the present date, and the record lacks sufficient medical information for VBA to determine a proper rating for the condition from the effective date of service connection until a later date, or such time as the medical information of record may be sufficient for rating.
You may be asked to perform a thorough review of lay statements and available evidence for your opinion.
Tip
The Veteran's lay statements regarding the severity of his condition over time in such cases are extremely important, as those will frequently be the only information you have to consider in assessing the severity of the condition.
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Service Connection for Dependency and Indemnity Compensation
Dependency and Indemnity Compensation (DIC) may be granted to eligible survivors of Veterans whose death resulted from a service-related injury or disease. You may be asked to provide a medical opinion regarding the relationship of the decedent's death to an in-service event, injury, or disease. A fictional example follows.
VBA asked: Was the Veteran's death, caused by stage IV nodular malignant melanoma with metastasis to the brain, a progression of a scalp lesion that was treated in service?
Opinion: Veteran's Stage IV Nodular Malignant Melanoma, with metastasis to the brain, which was stated on his death certificate as the cause of death, was at least as likely as not a progression of the scalp lesion treated while the Veteran was on active duty.
Rationale: Because the Veteran's in-service scalp lesion was a likely early indicator of melanoma and was consistent with nodular malignant melanoma, it is at least as likely as not that the Veteran's death caused by stage IV nodular malignant melanoma with metastasis to the brain was a progression of the scalp lesion treated during service.
The notes in service indicated that the clinician attributed the irregular border to the recurrent trauma from the haircuts the Veteran had received. This irregular border was at least as likely as not early evidence of the melanoma. A review of the separation physical examination indicated that the site of the lesion is consistent with the same area of the skin cancer site diagnosed 4 years later. The post-service biopsy of the same skin lesion that was described in service was consistent with Nodular Malignant Melanoma. The enlarged lymph nodes at the time of referral for the biopsy were an indicator of metastasis. The Veteran was subsequently diagnosed with Nodular Malignant Melanoma with metastasis to the brain.
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Service in the Armed Forces and Reserves

In general, when you are asked to conduct an examination and/or provide a medical opinion, VBA will first have determined that the Veteran or Servicemember has basic eligibility for benefits because of having served on active duty in the Armed Forces. According to statute 38 U.S.C. § 101, *Definitions*, items (10) and (21), the Armed Forces consist of the Army, Navy, Marine Corps, Air Force, Coast Guard, and Space Force plus their reserve components. Reserve components include the Army, Navy, Marine Corps, Air Force, and Coast Guard Reserves, and the Air National Guard of the United States. This list pertains to the Armed Services. Other categories of service may eligible. A complete list is found in 38 U.S.C. § 101.



A Veteran's service personnel records might have information like this example.

Simon Marcus, an Army photographer, served in the U.S. Army from June 1981 to June 1985, and then served as an Army reservist. He was called back to active duty a few times, for Desert Storm, February 1991–March 1992; Iraq 2007–2008; and Afghanistan 2011–2012.

Pertinent Service History
Entry on Duty (EOD): June 17, 1981
Released from Active Duty (RAD): June 16, 1985

Mr. Marcus had additional service in the Army Reserves. He was continuously an Army Reservist from 1985 to 2015, but he was only on active duty during certain dates. Outside of these dates, Mr. Marcus was on inactive duty. For this reason, an examiner would need to discover all the pertinent information, not only during the active duty, determined by VBA, but also his inactive duty. This would include gathering details about Mr. Marcus's civilian occupation and hobbies. It is essential to gather data about both periods because the data can impact decisions made regarding service connection.

Tip

You may see more than one DD 214, Certificate of Release or Discharge from Active Duty, in records for Veterans who were reservists.

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Active and Inactive Duty for Training

In the case of Mr. Marcus, his periods of active duty were deployments during wartime. Additional kinds of activities have been determined to constitute active duty under certain circumstances. Understanding which activities are considered active duty may assist you in addressing questions that might arise from an examination request.

VA statutes and regulations state that the following activities are also considered to be active military, naval, or air service. They include (but are not limited to):

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

Sometimes, you may be asked to provide a medical opinion about any of these types of disabilities. You should follow your local procedure for obtaining clarification or guidance if you have a question concerning active or inactive duty while preparing a medical opinion.

Sources: 38 U.S.C. § 101, *Definitions*, items (22) (23) and (24) and 38 C.F.R. § 3.6(a), *Duty periods, Active military, naval, and air service*

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Example Opinion: Aggravation of a Preexisting Condition During ACDUTRA



Yoshi Soto is a 35-year-old U.S. Army and Army National Guard Veteran. He filed a claim with VBA claiming that a right shoulder condition he incurred as a civilian got worse while he was in the Army National Guard. As a member of the National Guard, Mr. Soto has periods where he is not active duty (i.e., is a civilian) and periods of active duty in the National Guard. Since his discharge from the U.S. Army, Mr. Soto worked in construction as a civilian. He was also on active-duty in the Army National Guard, including being ACDUTRA on training weekends. The examiner will examine Mr. Soto and review all available records to provide an opinion whether his right shoulder condition (a preexisting condition) was permanently aggravated during his active duty on training weekends (ACTDUTRA).

VBA asked for this opinion on the examination request for Mr. Soto:

Was Veteran's right shoulder condition which clearly occurred during an inactive period of Army National Guard service, permanently aggravated by service in the Army National Guard?

Select each link to view the evidence gathered by the examiner, Physician Assistant Anderson, and the medical opinion she provided.

Evidence for the Opinion

Medical Opinion for Mr. Soto

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Evidence for the Opinion

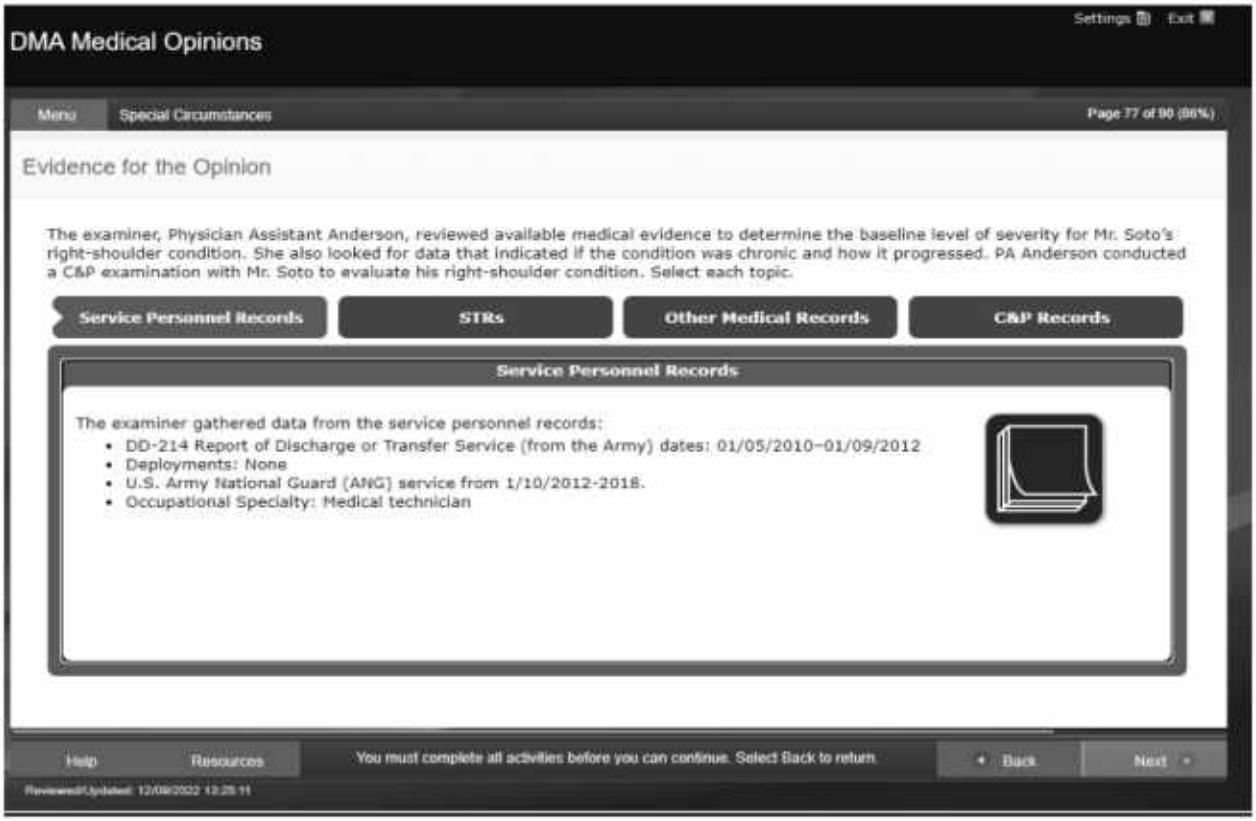
The examiner, Physician Assistant Anderson, reviewed available medical evidence to determine the baseline level of severity for Mr. Soto's right-shoulder condition. She also looked for data that indicated if the condition was chronic and how it progressed. PA Anderson conducted a C&P examination with Mr. Soto to evaluate his right-shoulder condition. Select each topic.

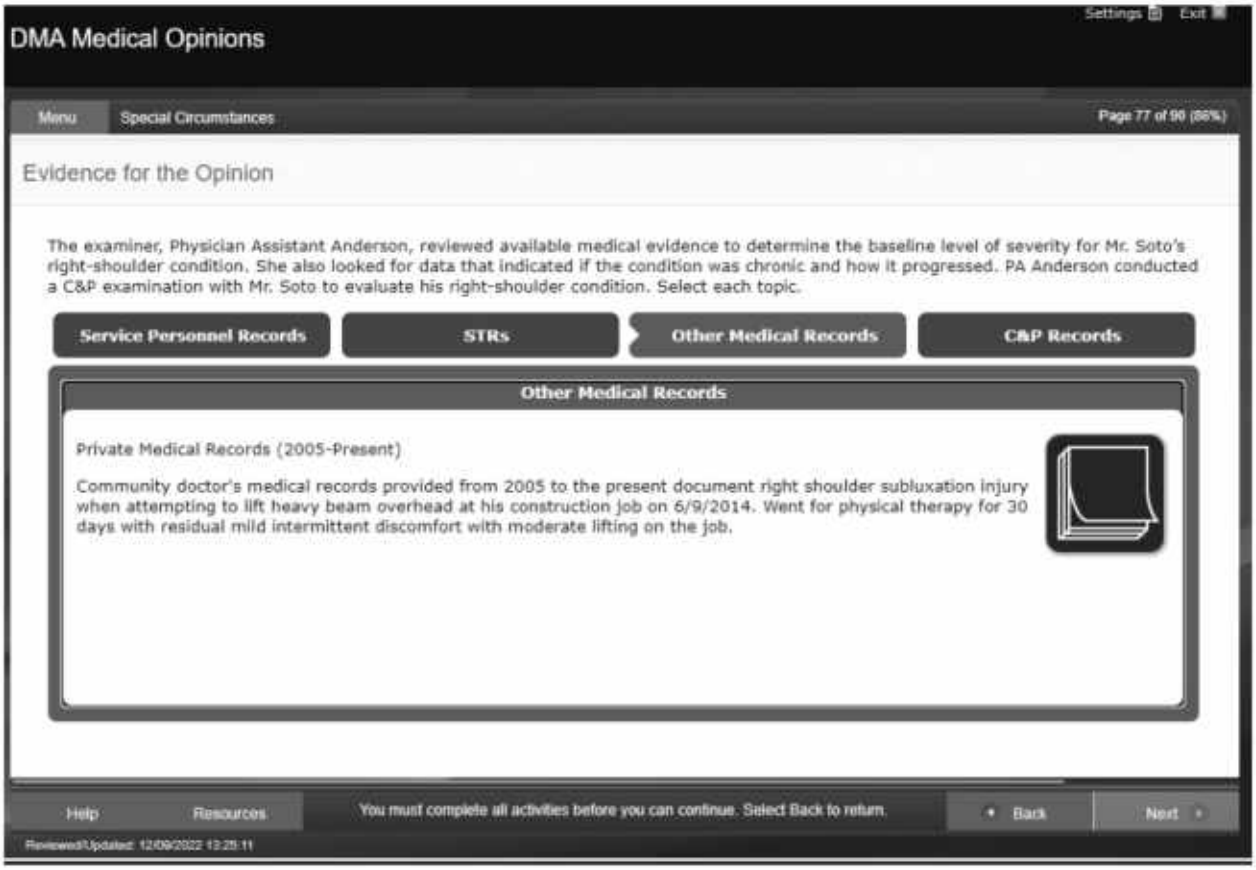
Service Personnel Records | **STRs** | **Other Medical Records** | **C&P Records**

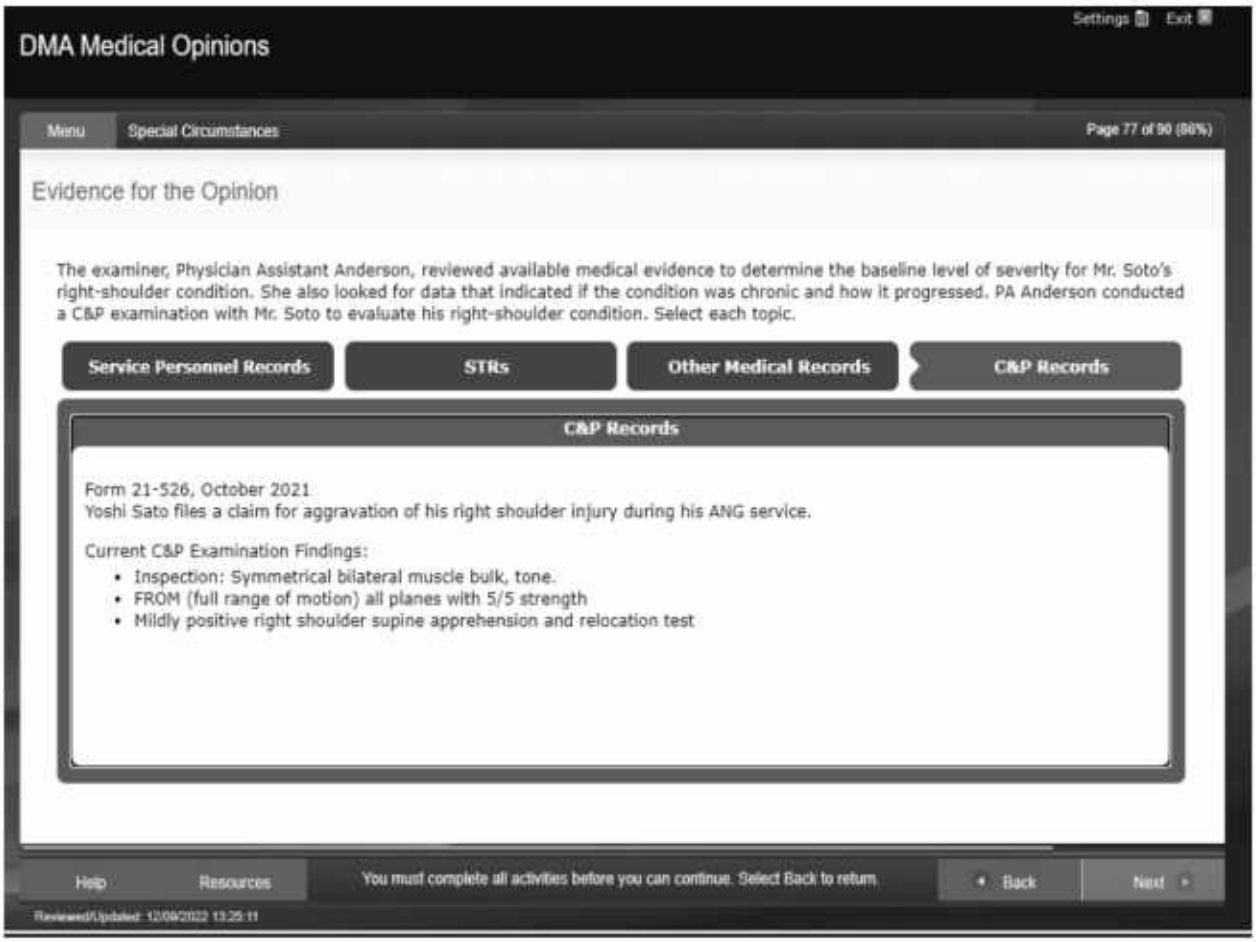
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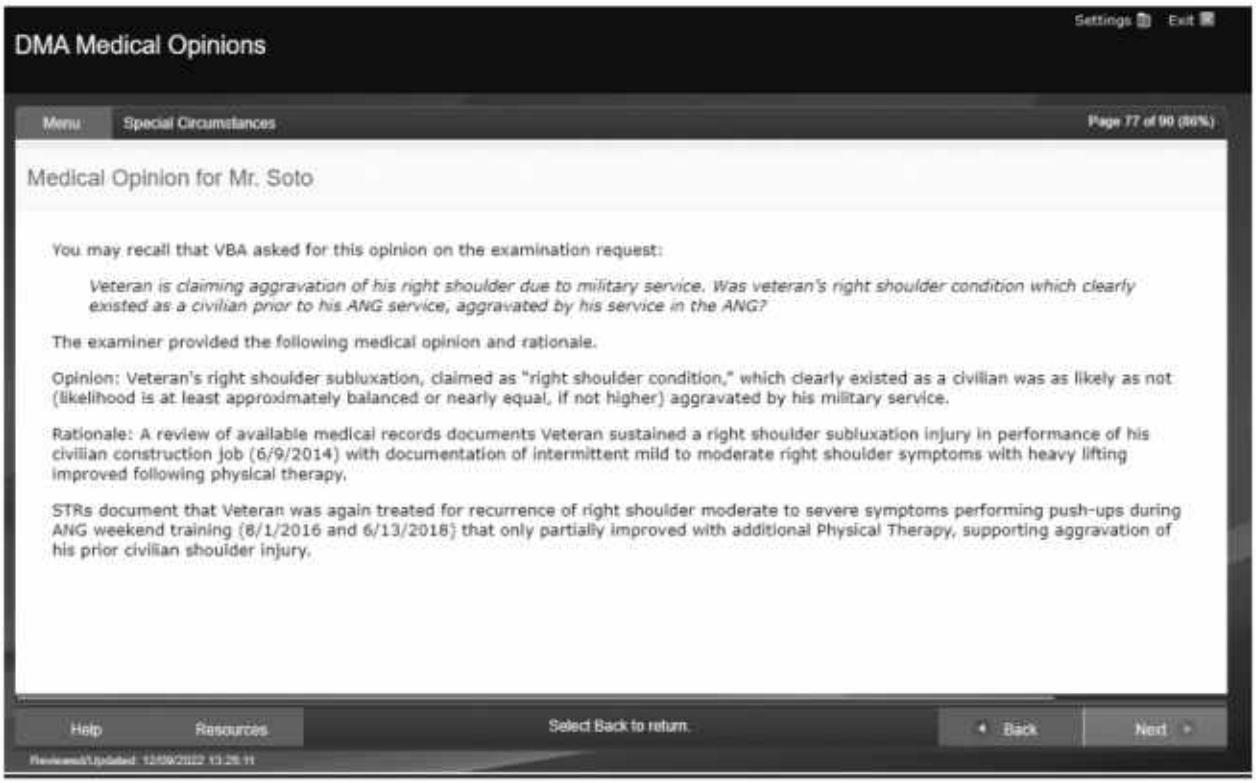
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Evidence for the Opinion
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Service Personnel Records
STRs
Other Medical Records
C&P Records
Service Personnel Records
The examiner gathered data from the service personnel records:
DD-214 Report of Discharge or Transfer Service (from the Army) dates: 01/05/2010–01/09/2012
Deployments: None
U.S. Army National Guard (ANG) service from 1/10/2012-2018.
Occupational Specialty: Medical technician
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Evidence for the Opinion
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Service Personnel Records
STRs
Other Medical Records
C&P Records
Other Medical Records
Private Medical Records (2005-Present)
Community doctor's medical records provided from 2005 to the present document right shoulder subluxation injury when attempting to lift heavy beam overhead at his construction job on 6/9/2014. Went for physical therapy for 30 days with residual mild intermittent discomfort with moderate lifting on the job.
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Evidence for the Opinion
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Service Personnel Records
STRs
Other Medical Records
C&P Records
C&P Records
Form 21-526, October 2021
Yoshi Sato files a claim for aggravation of his right shoulder injury during his ANG service.
Current C&P Examination Findings:
Inspection: Symmetrical bilateral muscle bulk, tone.
FROM (full range of motion) all planes with 5/5 strength
Mildly positive right shoulder supine apprehension and relocation test
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Medical Opinion for Mr. Soto
You may recall that VBA asked for this opinion on the examination request:
Veteran is claiming aggravation of his right shoulder due to military service. Was veteran's right shoulder condition which clearly existed as a civilian prior to his ANG service, aggravated by his service in the ANG?
The examiner provided the following medical opinion and rationale.
Opinion: Veteran's right shoulder subluxation, claimed as "right shoulder condition," which clearly existed as a civilian was as likely as not (likelihood is at least approximately balanced or nearly equal, if not higher) aggravated by his military service.
Rationale: A review of available medical records documents Veteran sustained a right shoulder subluxation injury in performance of his civilian construction job (6/9/2014) with documentation of intermittent mild to moderate right shoulder symptoms with heavy lifting improved following physical therapy.
STRs document that Veteran was again treated for recurrence of right shoulder moderate to severe symptoms performing push-ups during ANG weekend training (8/1/2016 and 6/13/2018) that only partially improved with additional Physical Therapy, supporting aggravation of his prior civilian shoulder injury.
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Presumptive Conditions

Under certain specific circumstances, VA will consider a condition to have been incurred in or aggravated by service even though there is no evidence of such disease during the period of service. This is known as presumptive service connection, and the specific condition allowed is called a presumptive condition. This determination results in presumptive service connection, removing the legal burden of a Veteran to prove a relationship of one of the specified conditions to a certain exposure or experience in service. Presumptive conditions include:

- Certain chronic diseases
- Certain tropical diseases
- Prisoner of war-related diseases
- Diseases associated with radiation exposure
- Diseases associated with exposure to certain herbicide agents
- Diseases associated with exposure to particulate matter

Examiners are not required to provide a nexus opinion for presumptive conditions. For example, when a Veteran who served in the Southwest Asia theater of operations during the Persian Gulf War is diagnosed with asthma, the condition will be presumed to be related to service.

Sources:
38 C.F.R. § 3.309, *Disease subject to presumptive service connection*, 38 C.F.R. § 3.317 *Compensation for certain disabilities occurring in Persian Gulf veterans*, and 38 C.F.R. § 3.320, *Claims based on exposure to particulate matter*

Note

Please note that presumptive conditions, although usually granted, may not be given service connection in the setting of another documented condition that better explains the claimed condition. A thorough rationale supporting the alternative etiology is required. For example, a Veteran may file a claim for presumptive service connection for hypothyroidism due to their exposure to Agent Orange. However, their medical records may include documentation of post-operative hypothyroidism after an unrelated neck surgery that included removal of their thyroid.

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Combat-Related Considerations

You may recall from the *DMA General Certification Overview* course that STRs may not record events, illnesses, or injuries incurred during combat. If service personnel records indicate the claimant was likely in combat situations, the evidence for events, illness, or injuries may have to come from other sources. Based on U.S.C. and C.F.R., this evidentiary rule accommodates the difficulty a Veteran may encounter in gathering conclusive evidence of condition(s) incurred during the rigors of combat or as a prisoner of war.

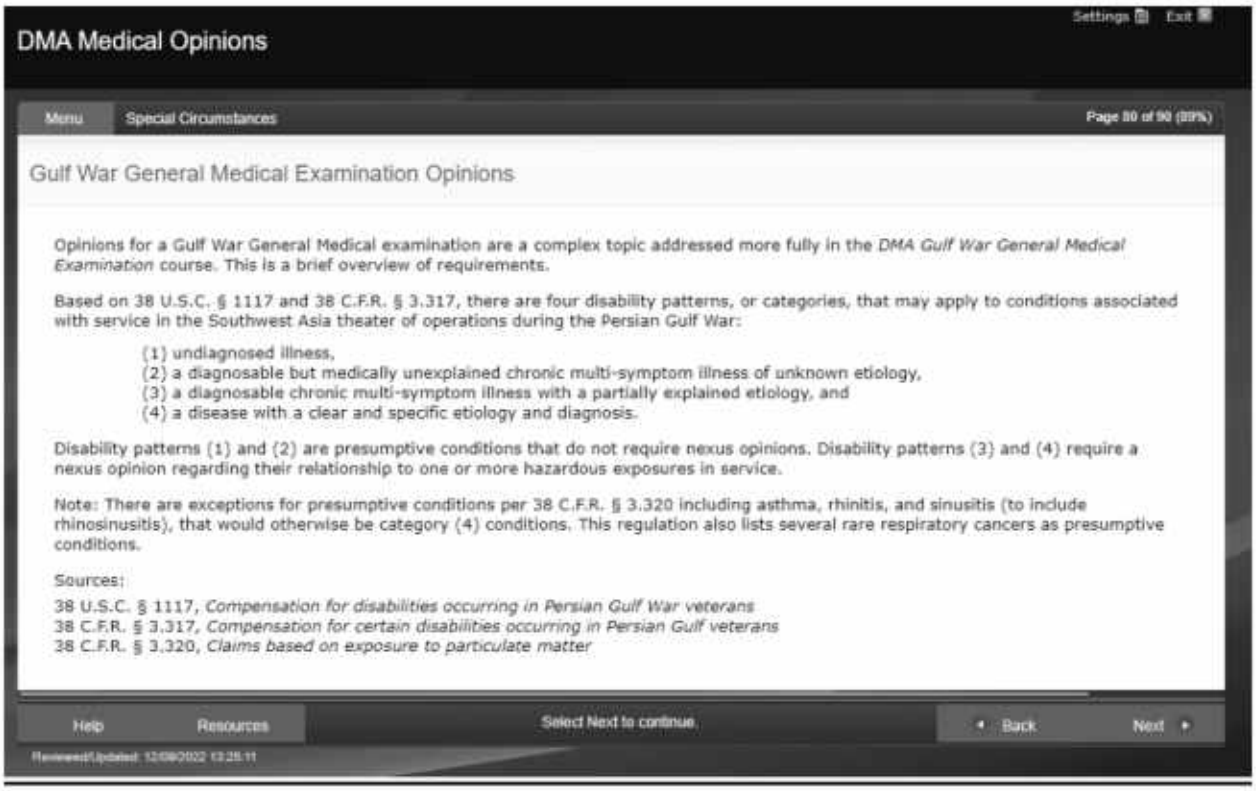
When VBA verifies that a Veteran or Service member has had combat service and notes it on the examination request, the claimant's lay evidence becomes an even more important source of evidence for a medical opinion. Consider this lay evidence regarding signs or symptoms that occurred during combat even if there is nothing in the STRs documenting the claimed in-service event, injury, or disease.

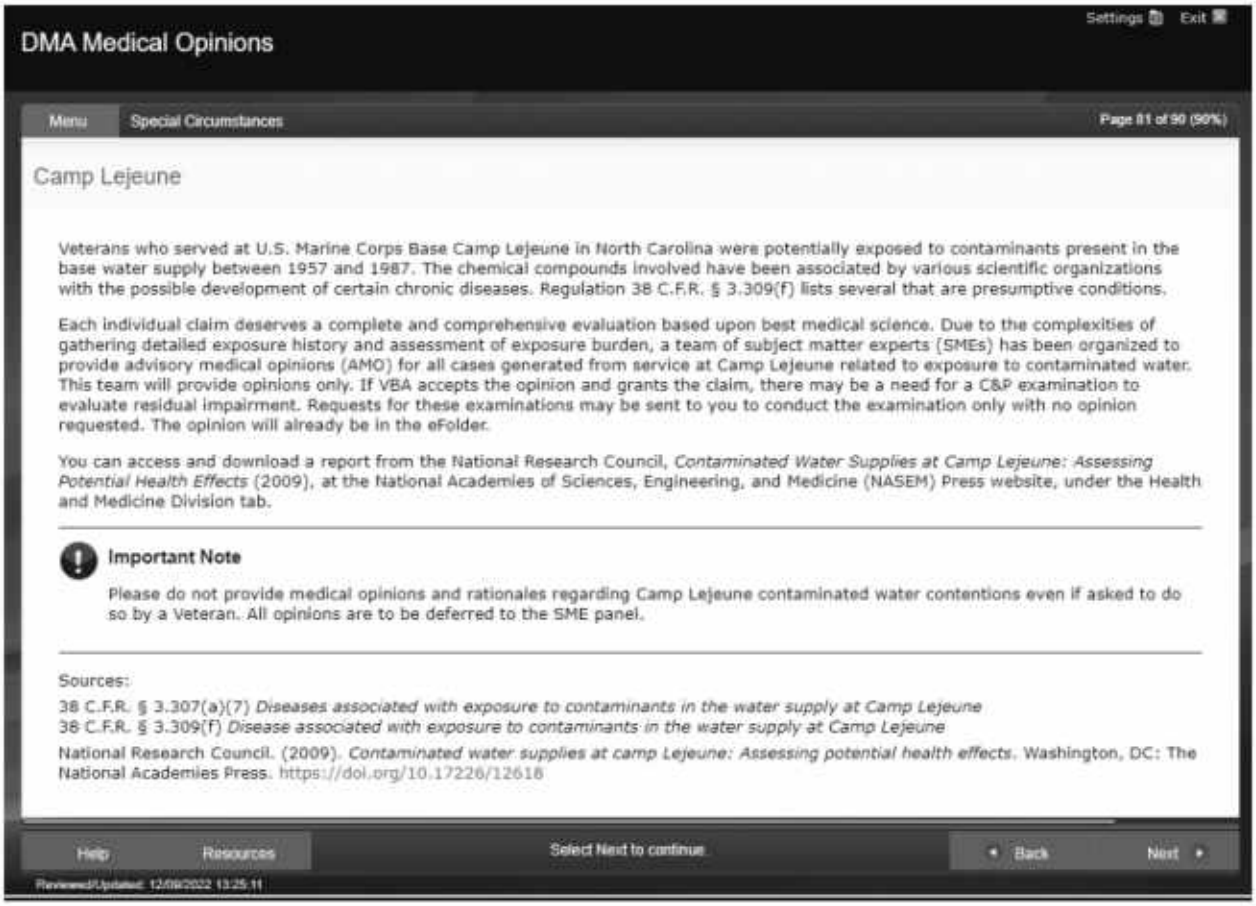


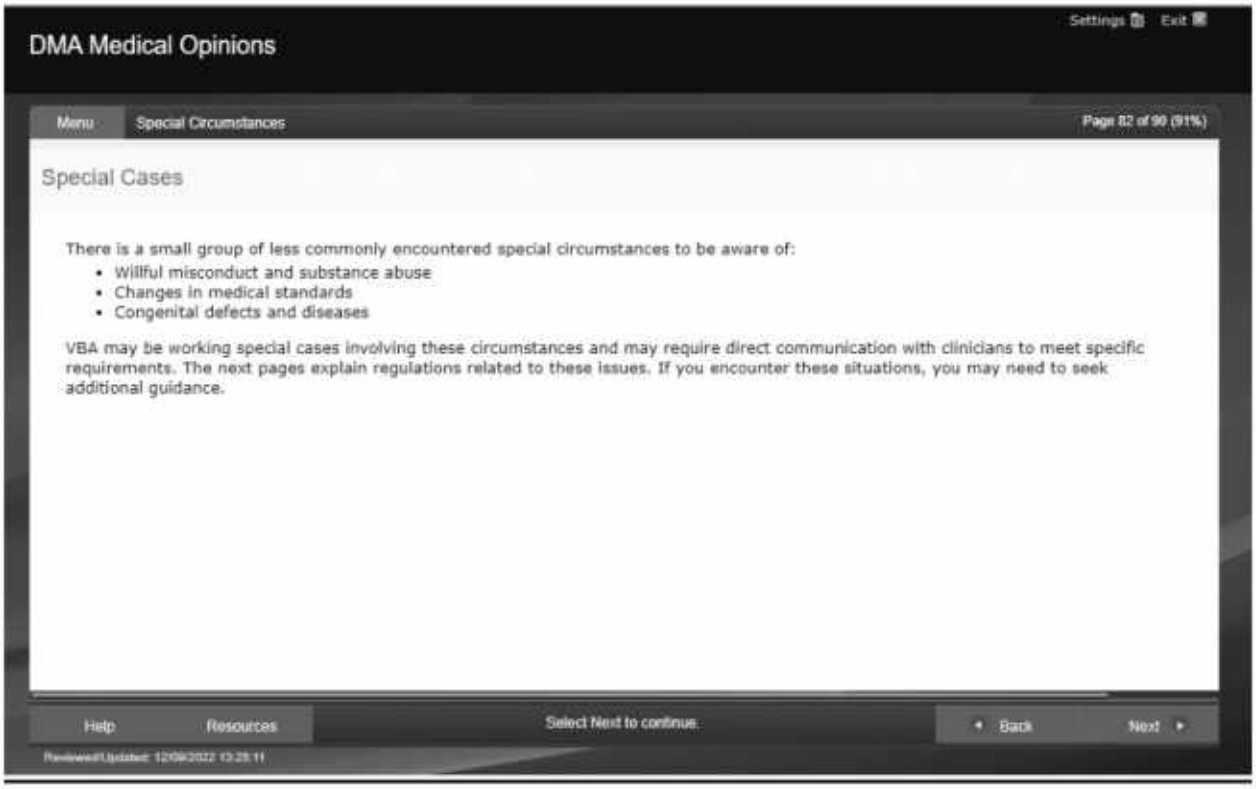
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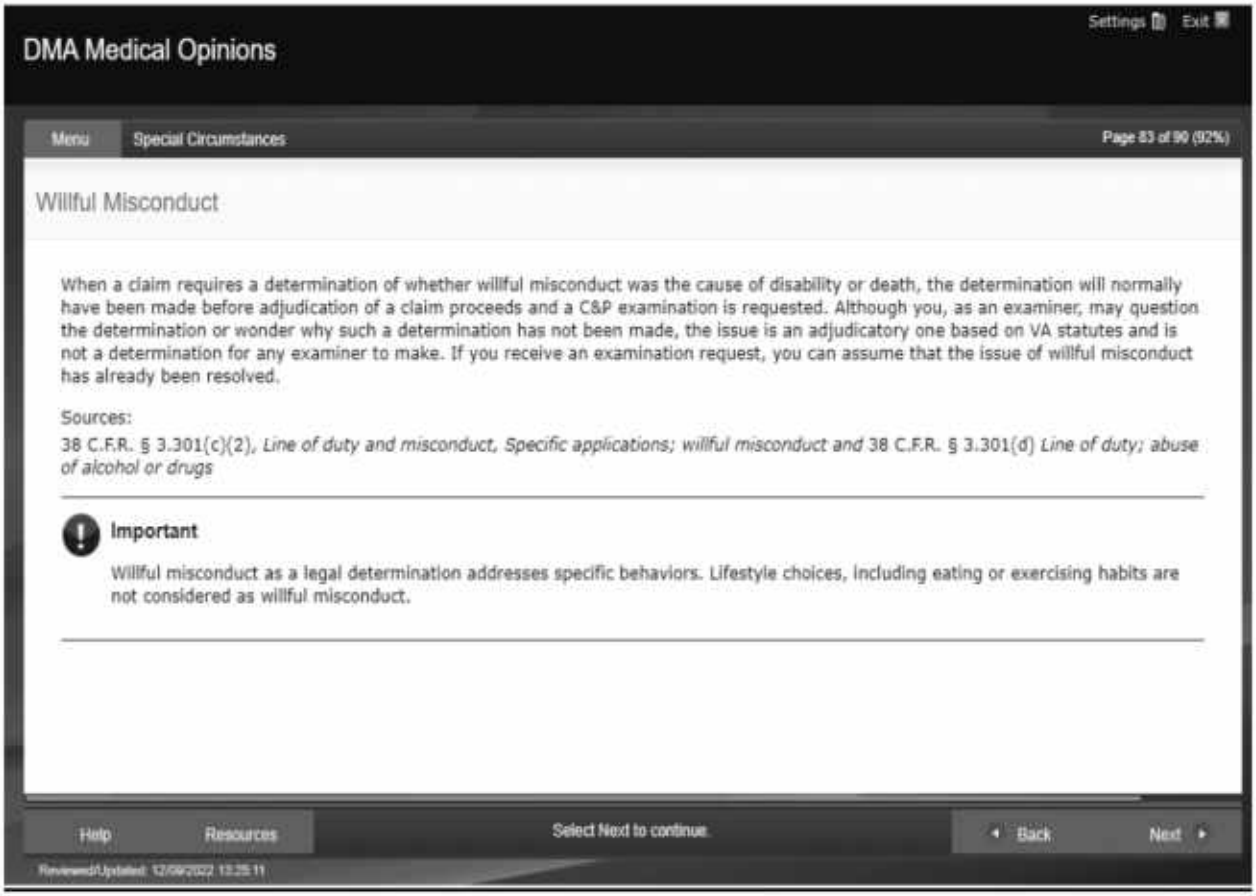
38 U.S.C. § 1154(b), *Consideration to be accorded time, place, and circumstances of service*
38 C.F.R. § 3.304(d), *Direct service connection; wartime and peace time*
38 C.F.R. § 3.306(b)(2), *Aggravation of preservice disability*

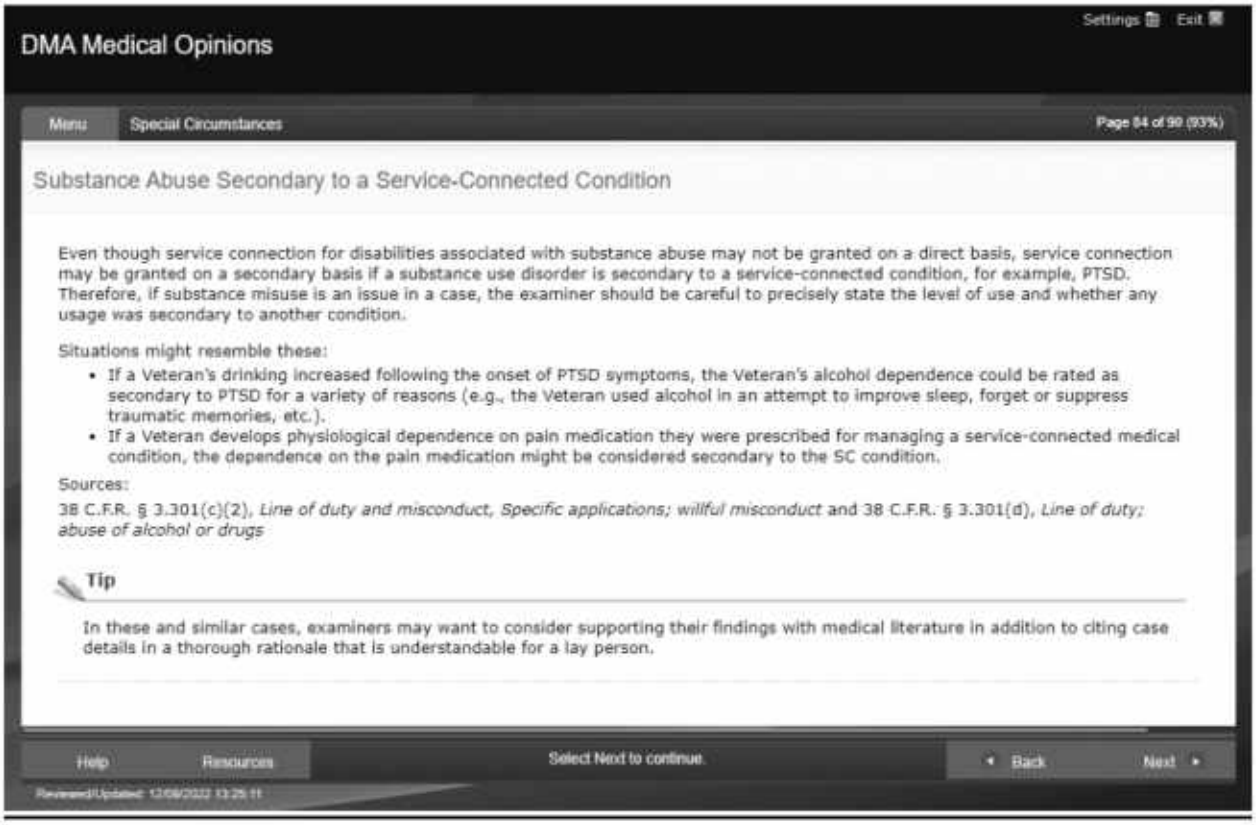
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Gulf War General Medical Examination Opinions
Opinions for a Gulf War General Medical examination are a complex topic addressed more fully in the DMA Gulf War General Medical Examination course. This is a brief overview of requirements.
Based on 38 U.S.C. § 1117 and 38 C.F.R. § 3.317, there are four disability patterns, or categories, that may apply to conditions associated with service in the Southwest Asia theater of operations during the Persian Gulf War:
(1) undiagnosed illness,
(2) a diagnosable but medically unexplained chronic multi-symptom illness of unknown etiology,
(3) a diagnosable chronic multi-symptom illness with a partially explained etiology, and
(4) a disease with a clear and specific etiology and diagnosis.
Disability patterns (1) and (2) are presumptive conditions that do not require nexus opinions. Disability patterns (3) and (4) require a nexus opinion regarding their relationship to one or more hazardous exposures in service.
Note: There are exceptions for presumptive conditions per 38 C.F.R. § 3.320 including asthma, rhinitis, and sinusitis (to include rhinosinusitis), that would otherwise be category (4) conditions. This regulation also lists several rare respiratory cancers as presumptive conditions.
Sources:
38 U.S.C. § 1117, Compensation for disabilities occurring in Persian Gulf War veterans
38 C.F.R. § 3.317, Compensation for certain disabilities occurring in Persian Gulf veterans
38 C.F.R. § 3.320, Claims based on exposure to particulate matter
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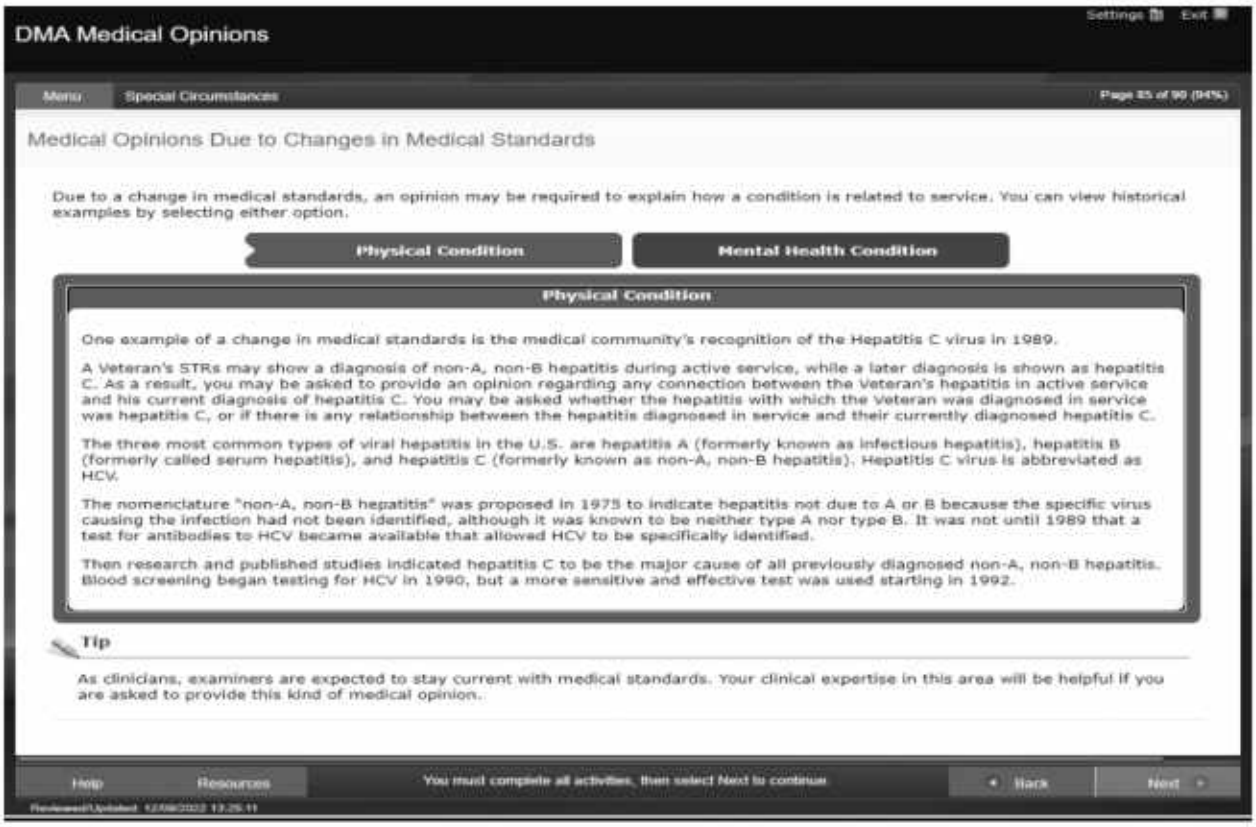

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Camp Lejeune
Veterans who served at U.S. Marine Corps Base Camp Lejeune in North Carolina were potentially exposed to contaminants present in the base water supply between 1957 and 1987. The chemical compounds involved have been associated by various scientific organizations with the possible development of certain chronic diseases. Regulation 38 C.F.R. § 3.309(f) lists several that are presumptive conditions.
Each individual claim deserves a complete and comprehensive evaluation based upon best medical science. Due to the complexities of gathering detailed exposure history and assessment of exposure burden, a team of subject matter experts (SMEs) has been organized to provide advisory medical opinions (AMO) for all cases generated from service at Camp Lejeune related to exposure to contaminated water. This team will provide opinions only. If VBA accepts the opinion and grants the claim, there may be a need for a C&P examination to evaluate residual impairment. Requests for these examinations may be sent to you to conduct the examination only with no opinion requested. The opinion will already be in the eFolder.
You can access and download a report from the National Research Council, Contaminated Water Supplies at Camp Lejeune: Assessing Potential Health Effects (2009), at the National Academies of Sciences, Engineering, and Medicine (NASEM) Press website, under the Health and Medicine Division tab.
Important Note
Please do not provide medical opinions and rationales regarding Camp Lejeune contaminated water contentions even if asked to do so by a Veteran. All opinions are to be deferred to the SME panel.
Sources:
38 C.F.R. § 3.307(a)(7) Diseases associated with exposure to contaminants in the water supply at Camp Lejeune
38 C.F.R. § 3.309(f) Disease associated with exposure to contaminants in the water supply at Camp Lejeune
National Research Council. (2009). Contaminated water supplies at camp Lejeune: Assessing potential health effects. Washington, DC: The National Academies Press. https://doi.org/10.17226/12616
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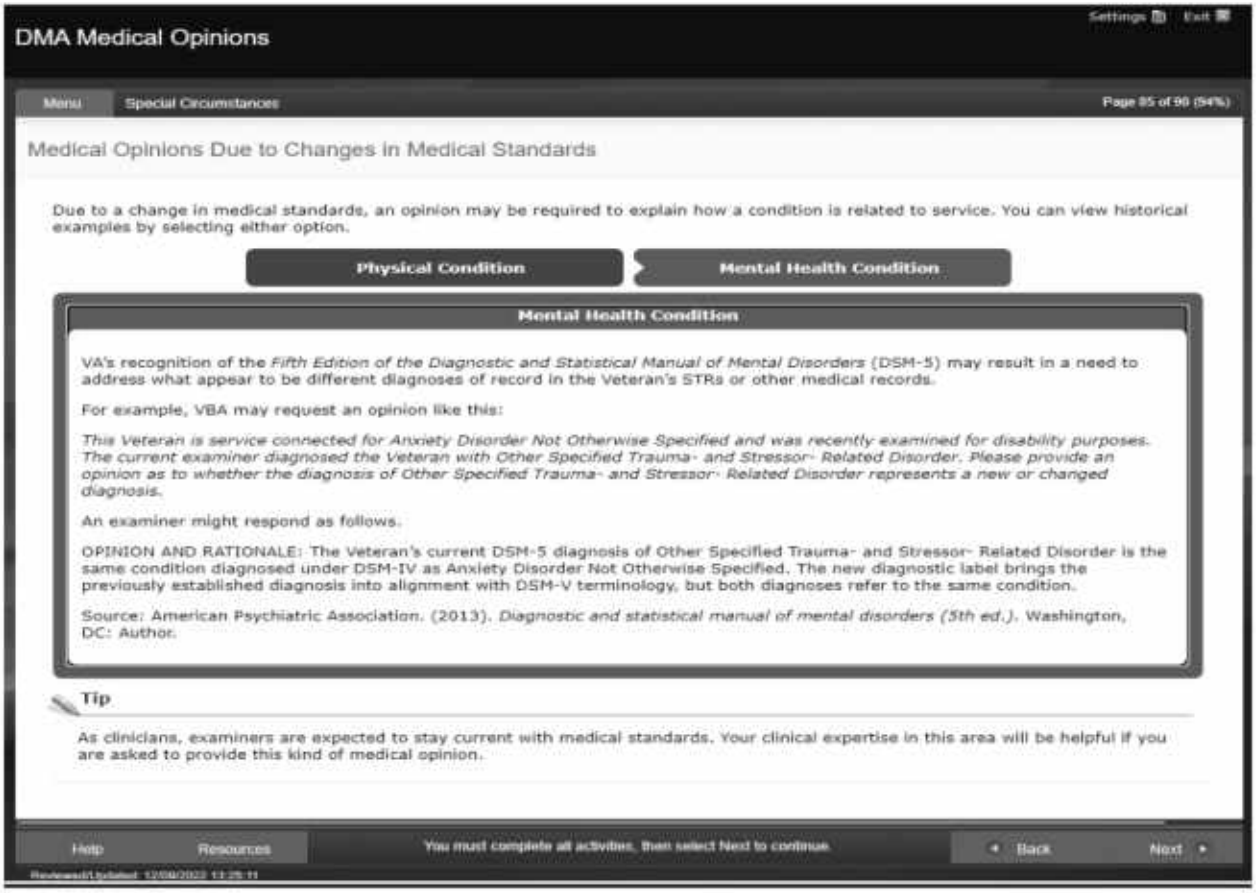

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Special Cases
There is a small group of less commonly encountered special circumstances to be aware of:
• Willful misconduct and substance abuse
• Changes in medical standards
• Congenital defects and diseases
VBA may be working special cases involving these circumstances and may require direct communication with clinicians to meet specific requirements. The next pages explain regulations related to these issues. If you encounter these situations, you may need to seek additional guidance.
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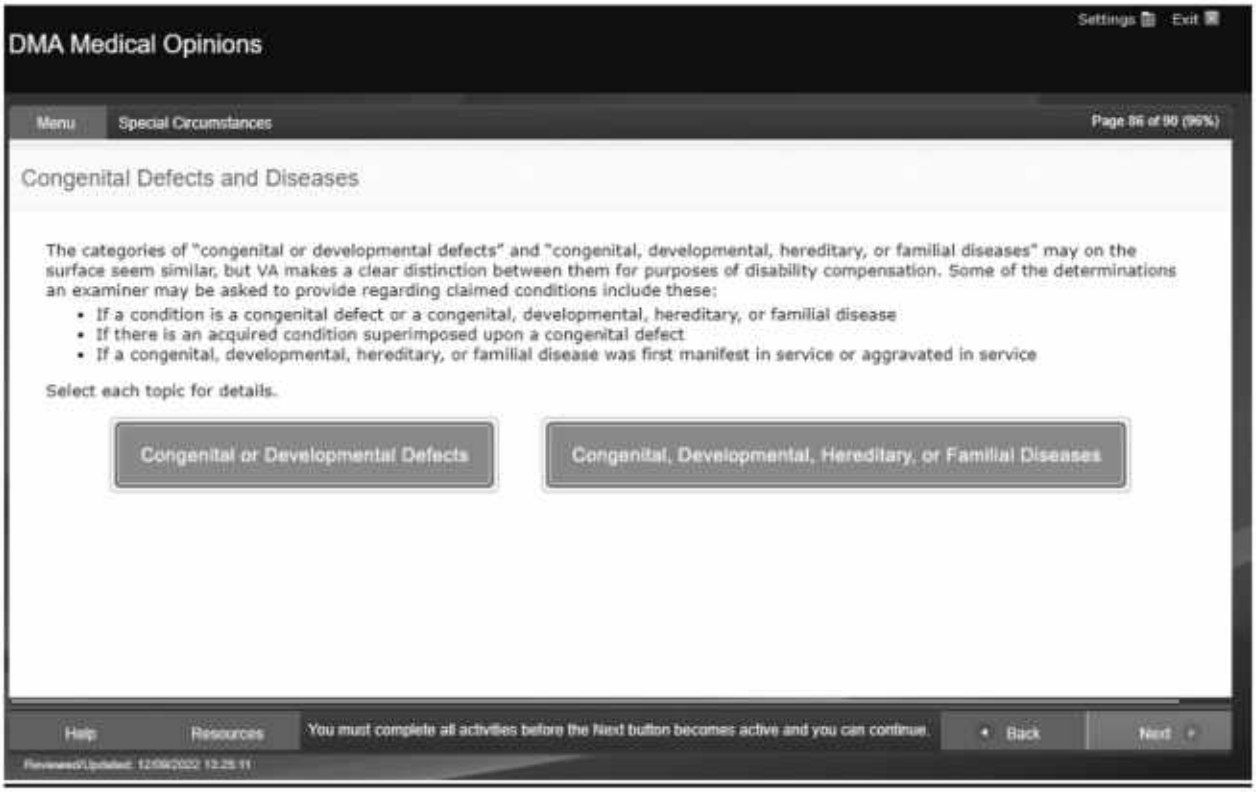

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Willful Misconduct
When a claim requires a determination of whether willful misconduct was the cause of disability or death, the determination will normally have been made before adjudication of a claim proceeds and a C&P examination is requested. Although you, as an examiner, may question the determination or wonder why such a determination has not been made, the issue is an adjudicatory one based on VA statutes and is not a determination for any examiner to make. If you receive an examination request, you can assume that the issue of willful misconduct has already been resolved.
Sources:
38 C.F.R. § 3.301(c)(2), Line of duty and misconduct, Specific applications; willful misconduct and 38 C.F.R. § 3.301(d) Line of duty; abuse of alcohol or drugs
Important
Willful misconduct as a legal determination addresses specific behaviors. Lifestyle choices, including eating or exercising habits are not considered as willful misconduct.
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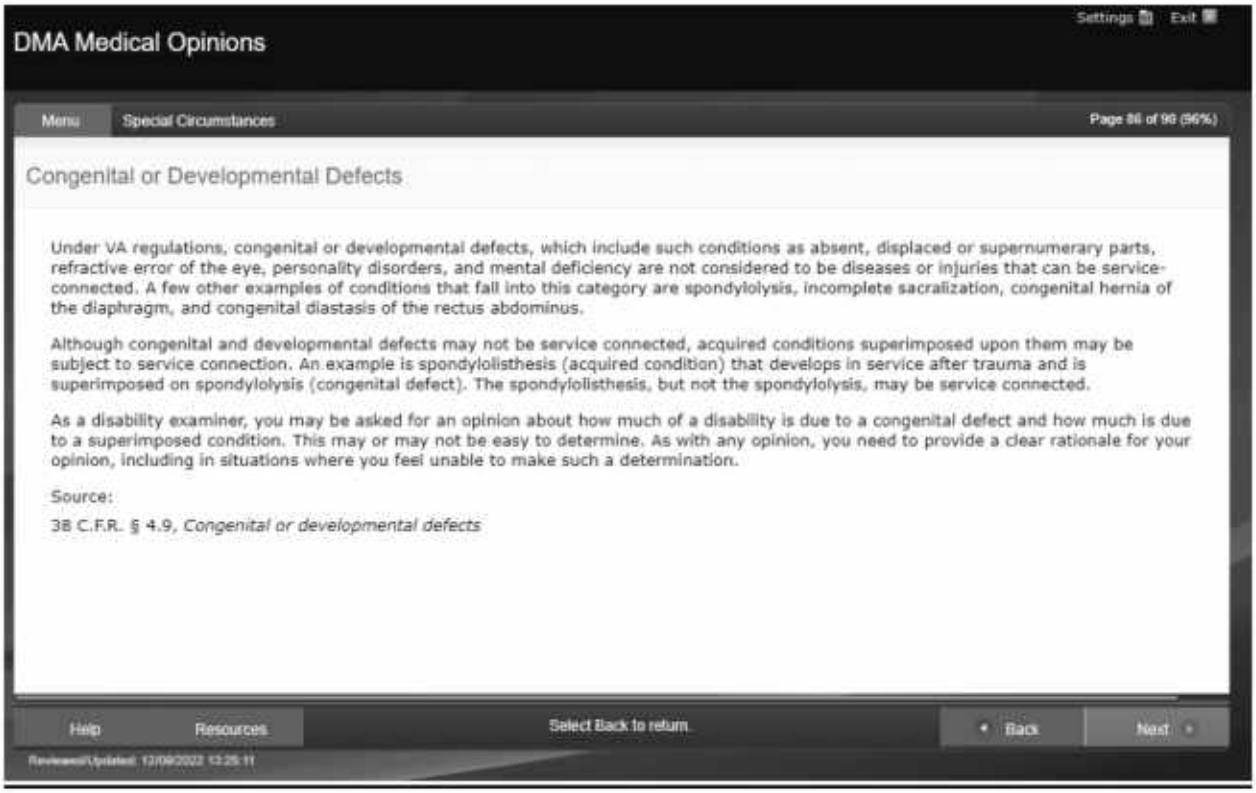

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Substance Abuse Secondary to a Service-Connected Condition
Even though service connection for disabilities associated with substance abuse may not be granted on a direct basis, service connection may be granted on a secondary basis if a substance use disorder is secondary to a service-connected condition, for example, PTSD. Therefore, if substance misuse is an issue in a case, the examiner should be careful to precisely state the level of use and whether any usage was secondary to another condition.
Situations might resemble these:
If a Veteran's drinking increased following the onset of PTSD symptoms, the Veteran's alcohol dependence could be rated as secondary to PTSD for a variety of reasons (e.g., the Veteran used alcohol in an attempt to improve sleep, forget or suppress traumatic memories, etc.).
If a Veteran develops physiological dependence on pain medication they were prescribed for managing a service-connected medical condition, the dependence on the pain medication might be considered secondary to the SC condition.
Sources:
38 C.F.R. § 3.301(c)(2), Line of duty and misconduct, Specific applications; willful misconduct and 38 C.F.R. § 3.301(d), Line of duty; abuse of alcohol or drugs
Tip
In these and similar cases, examiners may want to consider supporting their findings with medical literature in addition to citing case details in a thorough rationale that is understandable for a lay person.
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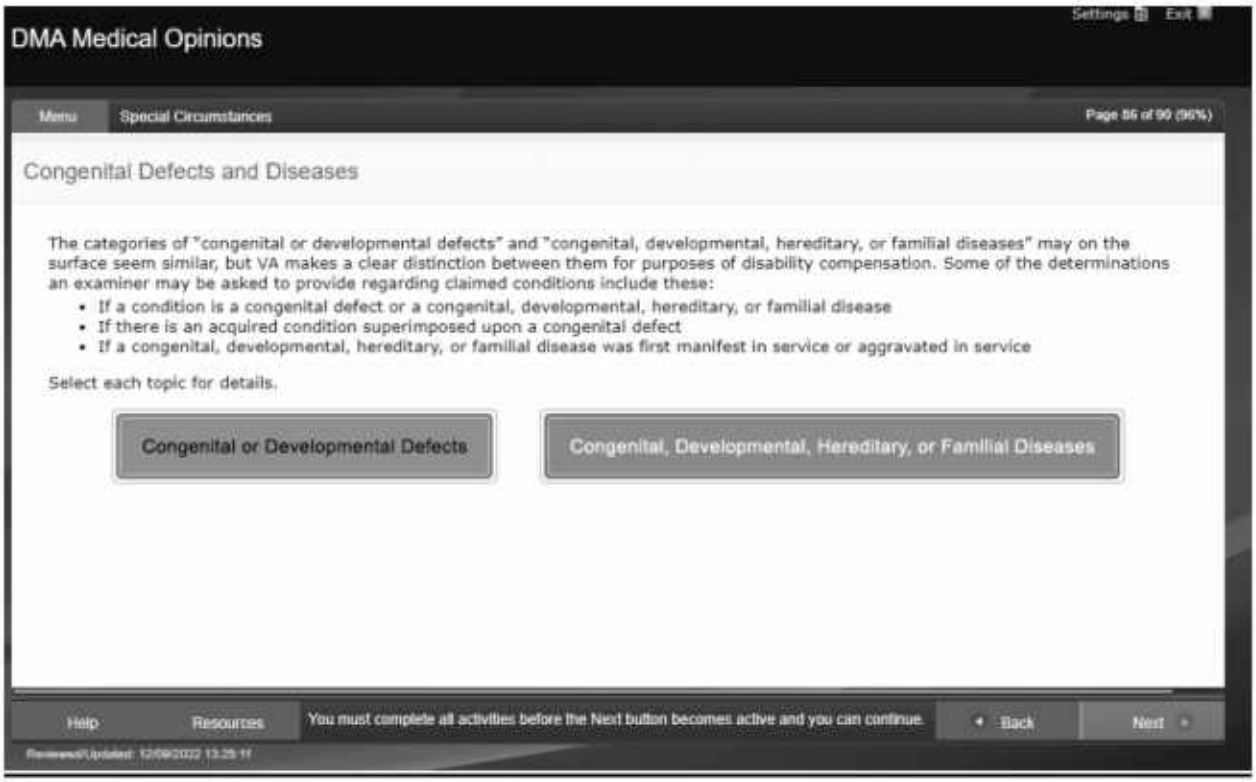

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Medical Opinions Due to Changes in Medical Standards
Due to a change in medical standards, an opinion may be required to explain how a condition is related to service. You can view historical examples by selecting either option.
Physical Condition
Mental Health Condition
Please make a selection.
Tip
As clinicians, examiners are expected to stay current with medical standards. Your clinical expertise in this area will be helpful if you are asked to provide this kind of medical opinion.
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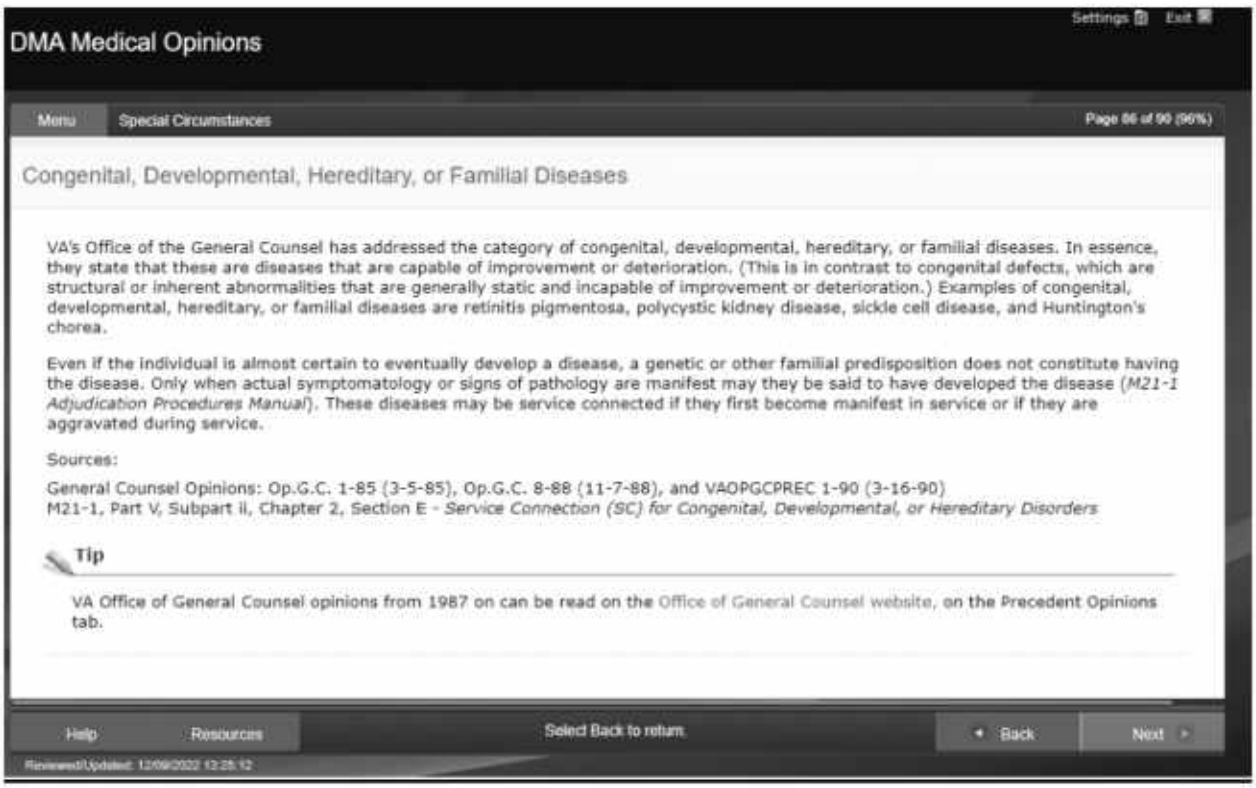

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Medical Opinions Due to Changes in Medical Standards
Due to a change in medical standards, an opinion may be required to explain how a condition is related to service. You can view historical examples by selecting either option.
Physical Condition
Mental Health Condition
Physical Condition
One example of a change in medical standards is the medical community's recognition of the Hepatitis C virus in 1989.
A Veteran's STRs may show a diagnosis of non-A, non-B hepatitis during active service, while a later diagnosis is shown as hepatitis C. As a result, you may be asked to provide an opinion regarding any connection between the Veteran's hepatitis in active service and his current diagnosis of hepatitis C. You may be asked whether the hepatitis with which the Veteran was diagnosed in service was hepatitis C, or if there is any relationship between the hepatitis diagnosed in service and their currently diagnosed hepatitis C.
The three most common types of viral hepatitis in the U.S. are hepatitis A (formerly known as infectious hepatitis), hepatitis B (formerly called serum hepatitis), and hepatitis C (formerly known as non-A, non-B hepatitis). Hepatitis C virus is abbreviated as HCV.
The nomenclature "non-A, non-B hepatitis" was proposed in 1975 to indicate hepatitis not due to A or B because the specific virus causing the infection had not been identified, although it was known to be neither type A nor type B. It was not until 1989 that a test for antibodies to HCV became available that allowed HCV to be specifically identified.
Then research and published studies indicated hepatitis C to be the major cause of all previously diagnosed non-A, non-B hepatitis. Blood screening began testing for HCV in 1990, but a more sensitive and effective test was used starting in 1992.
Tip
As clinicians, examiners are expected to stay current with medical standards. Your clinical expertise in this area will be helpful if you are asked to provide this kind of medical opinion.
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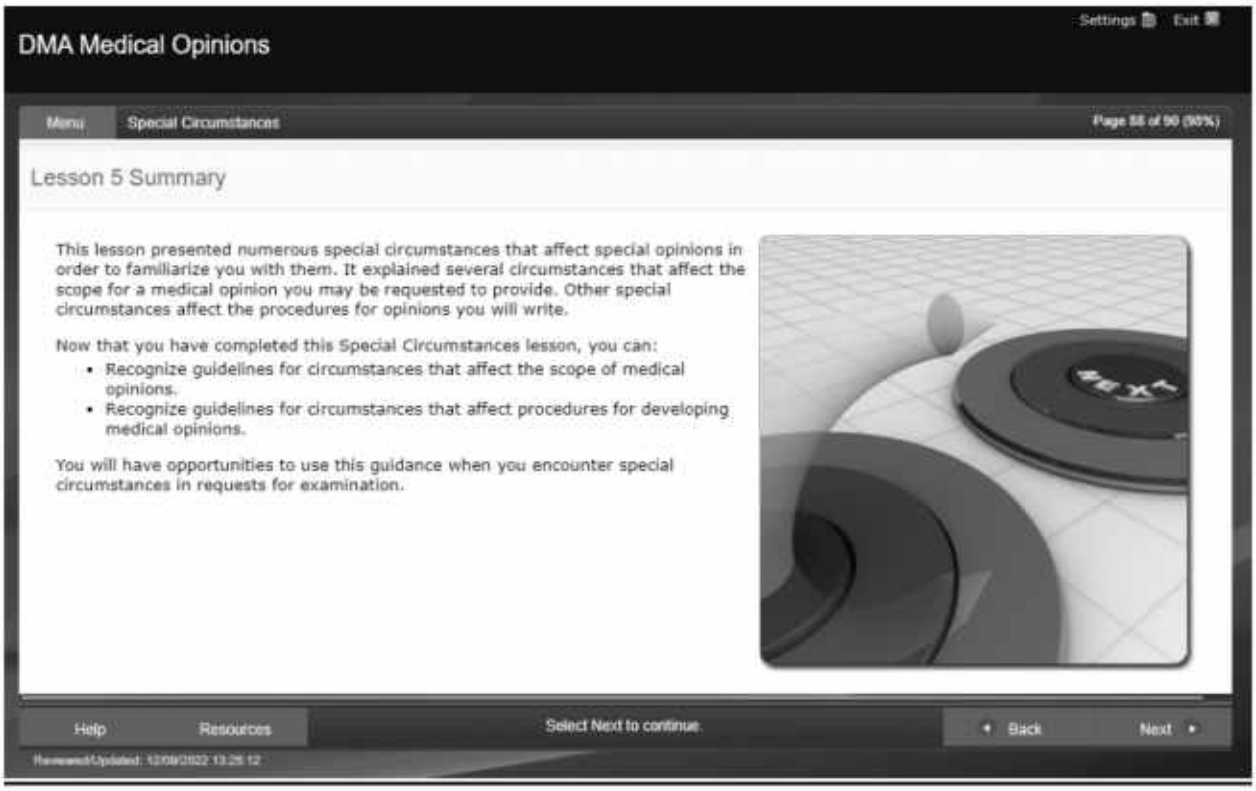

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Medical Opinions Due to Changes in Medical Standards
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Physical Condition
Mental Health Condition
Mental Health Condition
VA's recognition of the *Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) may result in a need to address what appear to be different diagnoses of record in the Veteran's STRs or other medical records.
For example, VBA may request an opinion like this:
This Veteran is service connected for Anxiety Disorder Not Otherwise Specified and was recently examined for disability purposes. The current examiner diagnosed the Veteran with Other Specified Trauma- and Stressor- Related Disorder. Please provide an opinion as to whether the diagnosis of Other Specified Trauma- and Stressor- Related Disorder represents a new or changed diagnosis.
An examiner might respond as follows.
OPINION AND RATIONALE: The Veteran's current DSM-5 diagnosis of Other Specified Trauma- and Stressor- Related Disorder is the same condition diagnosed under DSM-IV as Anxiety Disorder Not Otherwise Specified. The new diagnostic label brings the previously established diagnosis into alignment with DSM-V terminology, but both diagnoses refer to the same condition.
Source: American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (5th ed.)*. Washington, DC: Author.
Tip
As clinicians, examiners are expected to stay current with medical standards. Your clinical expertise in this area will be helpful if you are asked to provide this kind of medical opinion.
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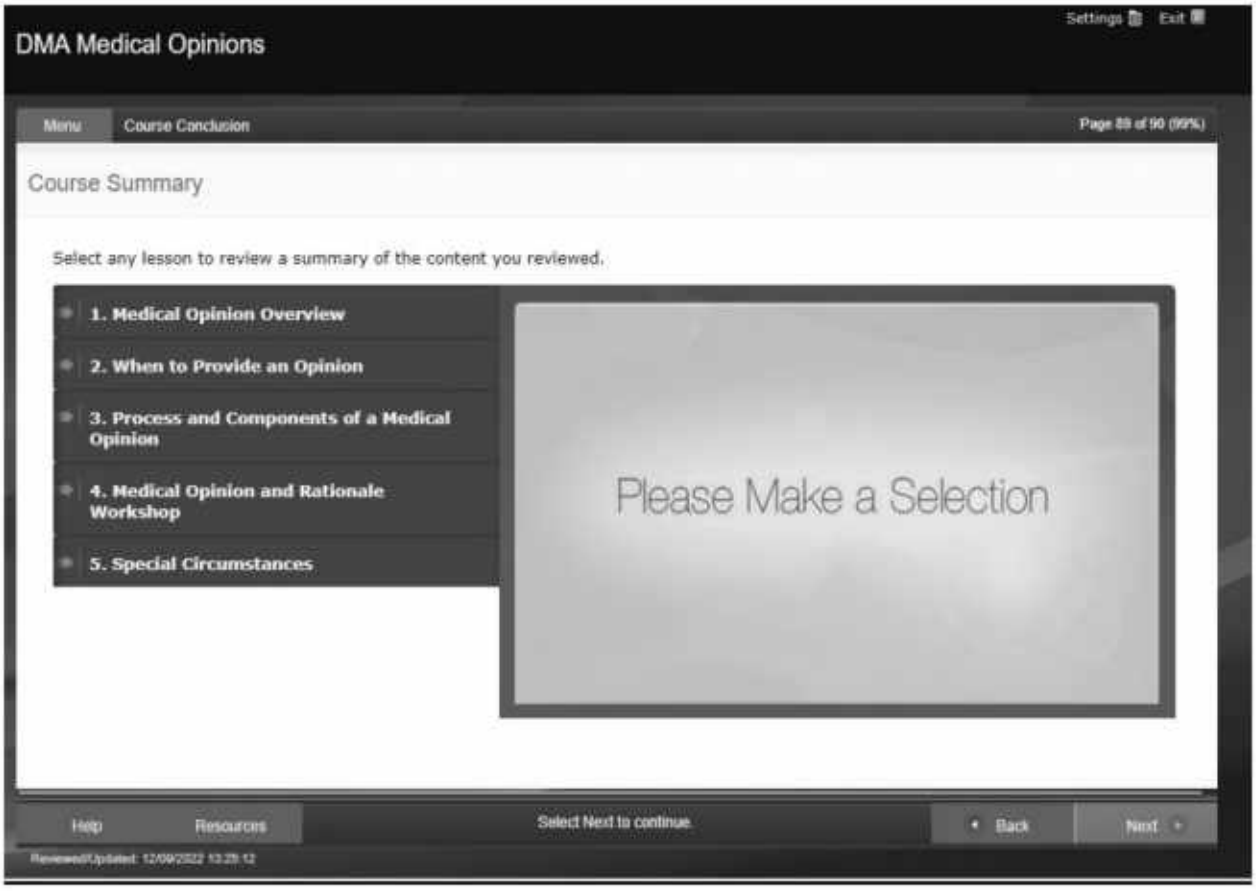

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Congenital Defects and Diseases
The categories of "congenital or developmental defects" and "congenital, developmental, hereditary, or familial diseases" may on the surface seem similar, but VA makes a clear distinction between them for purposes of disability compensation. Some of the determinations an examiner may be asked to provide regarding claimed conditions include these:
• If a condition is a congenital defect or a congenital, developmental, hereditary, or familial disease
• If there is an acquired condition superimposed upon a congenital defect
• If a congenital, developmental, hereditary, or familial disease was first manifest in service or aggravated in service
Select each topic for details.
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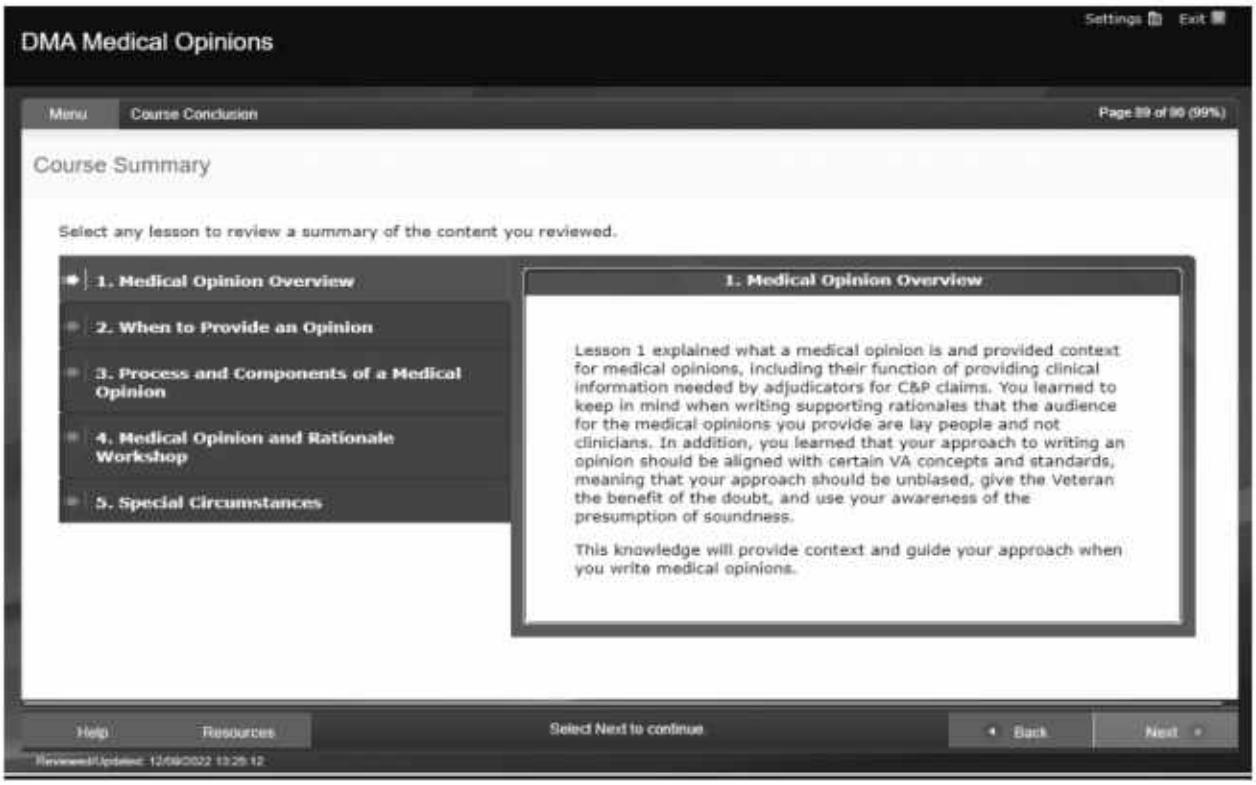

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Congenital or Developmental Defects
Under VA regulations, congenital or developmental defects, which include such conditions as absent, displaced or supernumerary parts, refractive error of the eye, personality disorders, and mental deficiency are not considered to be diseases or injuries that can be service-connected. A few other examples of conditions that fall into this category are spondylolysis, incomplete sacralization, congenital hernia of the diaphragm, and congenital diastasis of the rectus abdominus.
Although congenital and developmental defects may not be service connected, acquired conditions superimposed upon them may be subject to service connection. An example is spondylolisthesis (acquired condition) that develops in service after trauma and is superimposed on spondylolysis (congenital defect). The spondylolisthesis, but not the spondylolysis, may be service connected.
As a disability examiner, you may be asked for an opinion about how much of a disability is due to a congenital defect and how much is due to a superimposed condition. This may or may not be easy to determine. As with any opinion, you need to provide a clear rationale for your opinion, including in situations where you feel unable to make such a determination.
Source:
38 C.F.R. § 4.9, Congenital or developmental defects
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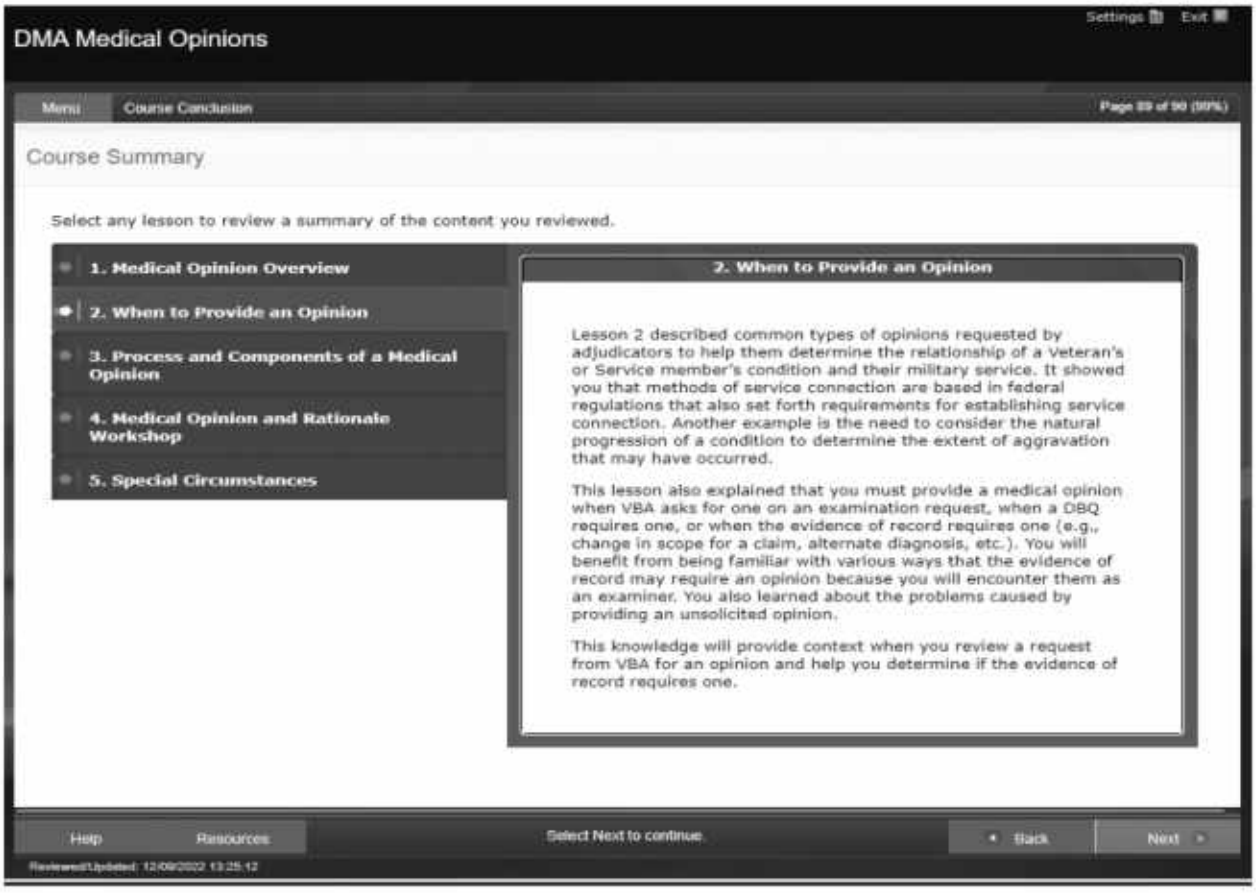

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If a condition is a congenital defect or a congenital, developmental, hereditary, or familial disease
If there is an acquired condition superimposed upon a congenital defect
If a congenital, developmental, hereditary, or familial disease was first manifest in service or aggravated in service
Select each topic for details.
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Congenital, Developmental, Hereditary, or Familial Diseases
VA's Office of the General Counsel has addressed the category of congenital, developmental, hereditary, or familial diseases. In essence, they state that these are diseases that are capable of improvement or deterioration. (This is in contrast to congenital defects, which are structural or inherent abnormalities that are generally static and incapable of improvement or deterioration.) Examples of congenital, developmental, hereditary, or familial diseases are retinitis pigmentosa, polycystic kidney disease, sickle cell disease, and Huntington's chorea.
Even if the individual is almost certain to eventually develop a disease, a genetic or other familial predisposition does not constitute having the disease. Only when actual symptomatology or signs of pathology are manifest may they be said to have developed the disease (M21-1 Adjudication Procedures Manual). These diseases may be service connected if they first become manifest in service or if they are aggravated during service.
Sources:
General Counsel Opinions: Op.G.C. 1-85 (3-5-85), Op.G.C. 8-88 (11-7-88), and VAOPGCPREC 1-90 (3-16-90)
M21-1, Part V, Subpart ii, Chapter 2, Section E - Service Connection (SC) for Congenital, Developmental, or Hereditary Disorders
Tip
VA Office of General Counsel opinions from 1987 on can be read on the Office of General Counsel website, on the Precedent Opinions tab.
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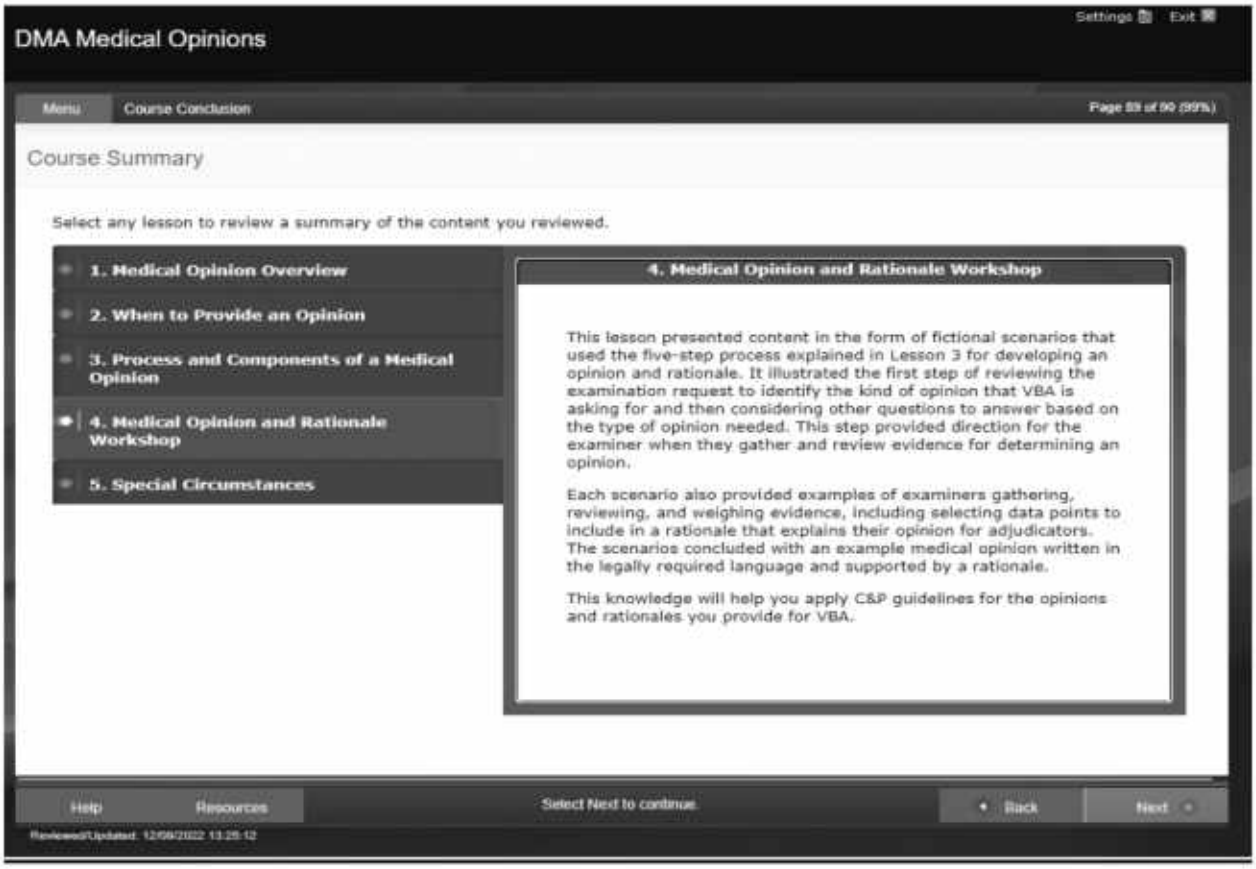

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Lesson 5 Summary
This lesson presented numerous special circumstances that affect special opinions in order to familiarize you with them. It explained several circumstances that affect the scope for a medical opinion you may be requested to provide. Other special circumstances affect the procedures for opinions you will write.
Now that you have completed this Special Circumstances lesson, you can:
• Recognize guidelines for circumstances that affect the scope of medical opinions.
• Recognize guidelines for circumstances that affect procedures for developing medical opinions.
You will have opportunities to use this guidance when you encounter special circumstances in requests for examination.
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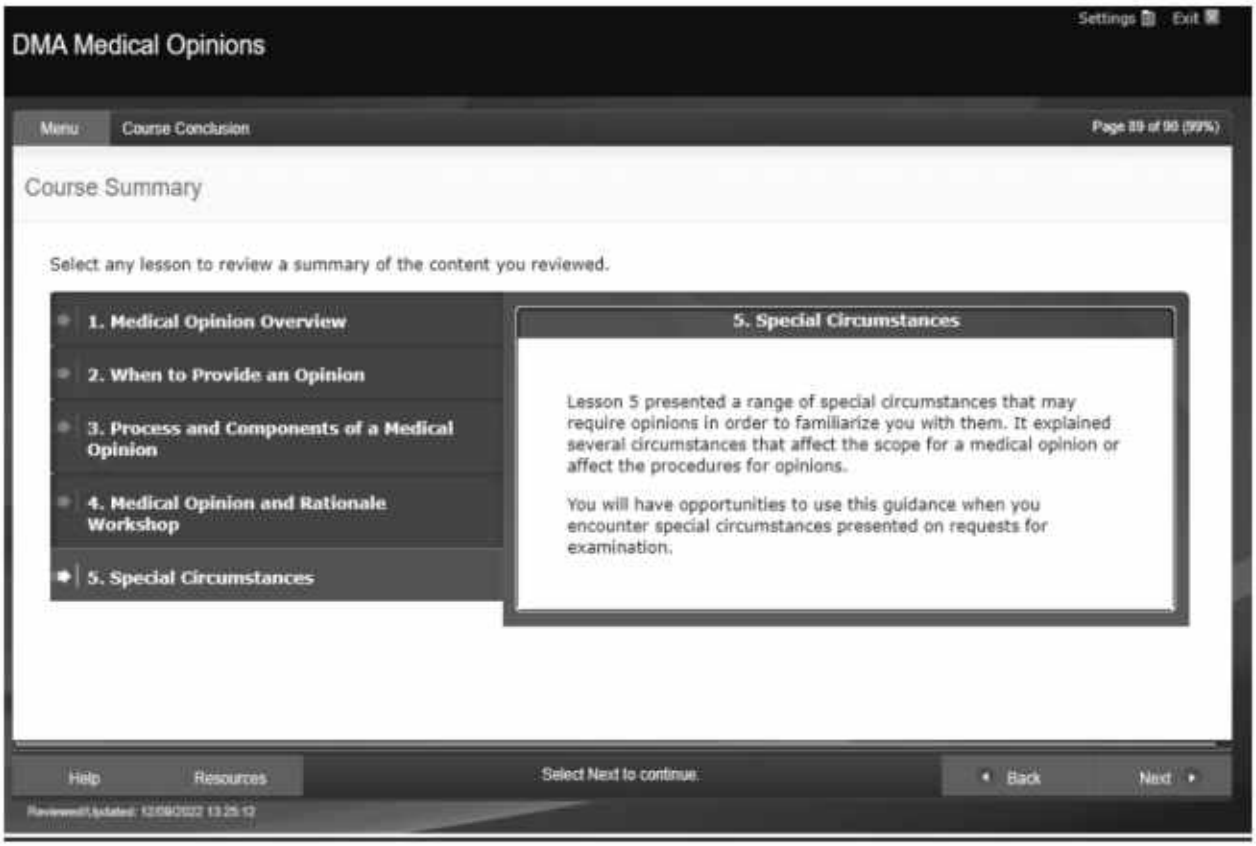

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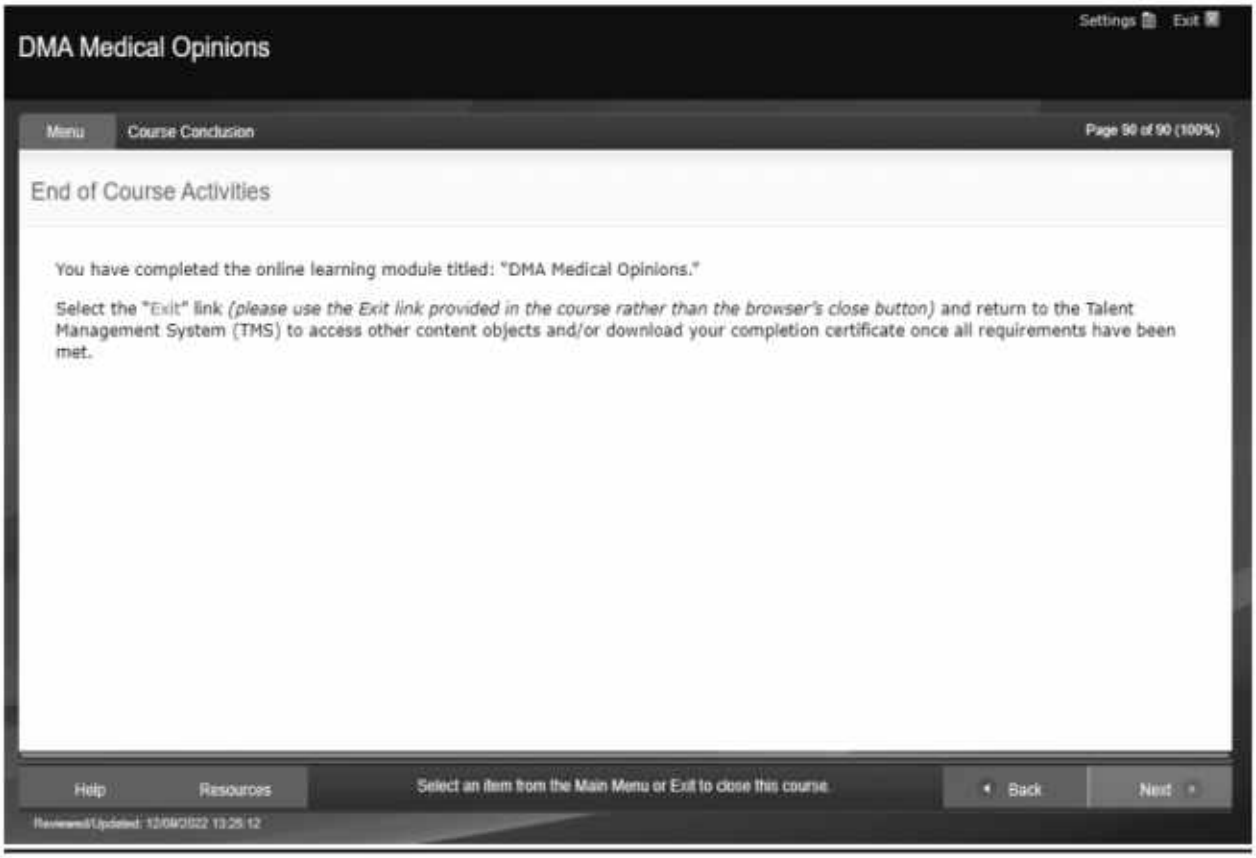

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1. Medical Opinion Overview
Lesson 1 explained what a medical opinion is and provided context for medical opinions, including their function of providing clinical information needed by adjudicators for C&P claims. You learned to keep in mind when writing supporting rationales that the audience for the medical opinions you provide are lay people and not clinicians. In addition, you learned that your approach to writing an opinion should be aligned with certain VA concepts and standards, meaning that your approach should be unbiased, give the Veteran the benefit of the doubt, and use your awareness of the presumption of soundness.
This knowledge will provide context and guide your approach when you write medical opinions.
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2. When to Provide an Opinion
Lesson 2 described common types of opinions requested by adjudicators to help them determine the relationship of a Veteran's or Service member's condition and their military service. It showed you that methods of service connection are based in federal regulations that also set forth requirements for establishing service connection. Another example is the need to consider the natural progression of a condition to determine the extent of aggravation that may have occurred.
This lesson also explained that you must provide a medical opinion when VBA asks for one on an examination request, when a DBQ requires one, or when the evidence of record requires one (e.g., change in scope for a claim, alternate diagnosis, etc.). You will benefit from being familiar with various ways that the evidence of record may require an opinion because you will encounter them as an examiner. You also learned about the problems caused by providing an unsolicited opinion.
This knowledge will provide context when you review a request from VBA for an opinion and help you determine if the evidence of record requires one.
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3. Process and Components of a Medical Opinion
Lesson 3 presented the process of writing an opinion in five steps, with details for accomplishing each step. It also described how writing an opinion and writing a rationale are usually done at the same time. In practice, the order of steps is not as important as how thoroughly and precisely you complete them:
1. Identify questions to answer for VBA or BVA.
2. Gather and review evidence.
3. Weigh the evidence.
4. Write the opinion.
5. Write the rationale.
This lesson explained qualities of sound medical opinions for adjudication purposes and illustrated them in an example opinion for a claim of service connection of asbestosis. This lesson also described common errors that you should avoid as well. One method for avoiding insufficient opinions is to use a Medical Opinion checklist like the one provided in lesson 3 and course Resources.
This knowledge will enable you to be systematic and thorough when you develop medical opinions.
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4. Medical Opinion and Rationale Workshop
This lesson presented content in the form of fictional scenarios that used the five-step process explained in Lesson 3 for developing an opinion and rationale. It illustrated the first step of reviewing the examination request to identify the kind of opinion that VBA is asking for and then considering other questions to answer based on the type of opinion needed. This step provided direction for the examiner when they gather and review evidence for determining an opinion.
Each scenario also provided examples of examiners gathering, reviewing, and weighing evidence, including selecting data points to include in a rationale that explains their opinion for adjudicators. The scenarios concluded with an example medical opinion written in the legally required language and supported by a rationale.
This knowledge will help you apply C&P guidelines for the opinions and rationales you provide for VBA.
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5. Special Circumstances
5. Special Circumstances
Lesson 5 presented a range of special circumstances that may require opinions in order to familiarize you with them. It explained several circumstances that affect the scope for a medical opinion or affect the procedures for opinions.
You will have opportunities to use this guidance when you encounter special circumstances presented on requests for examination.
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