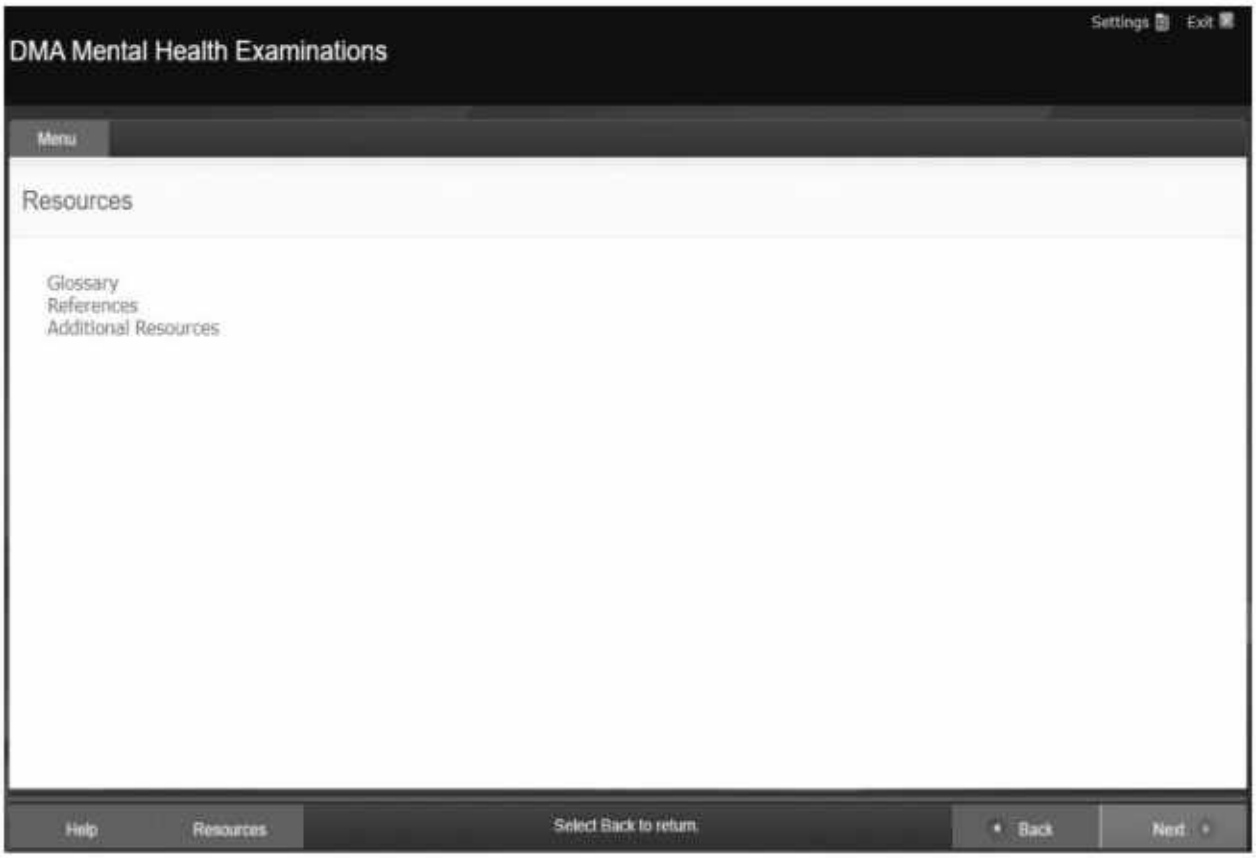
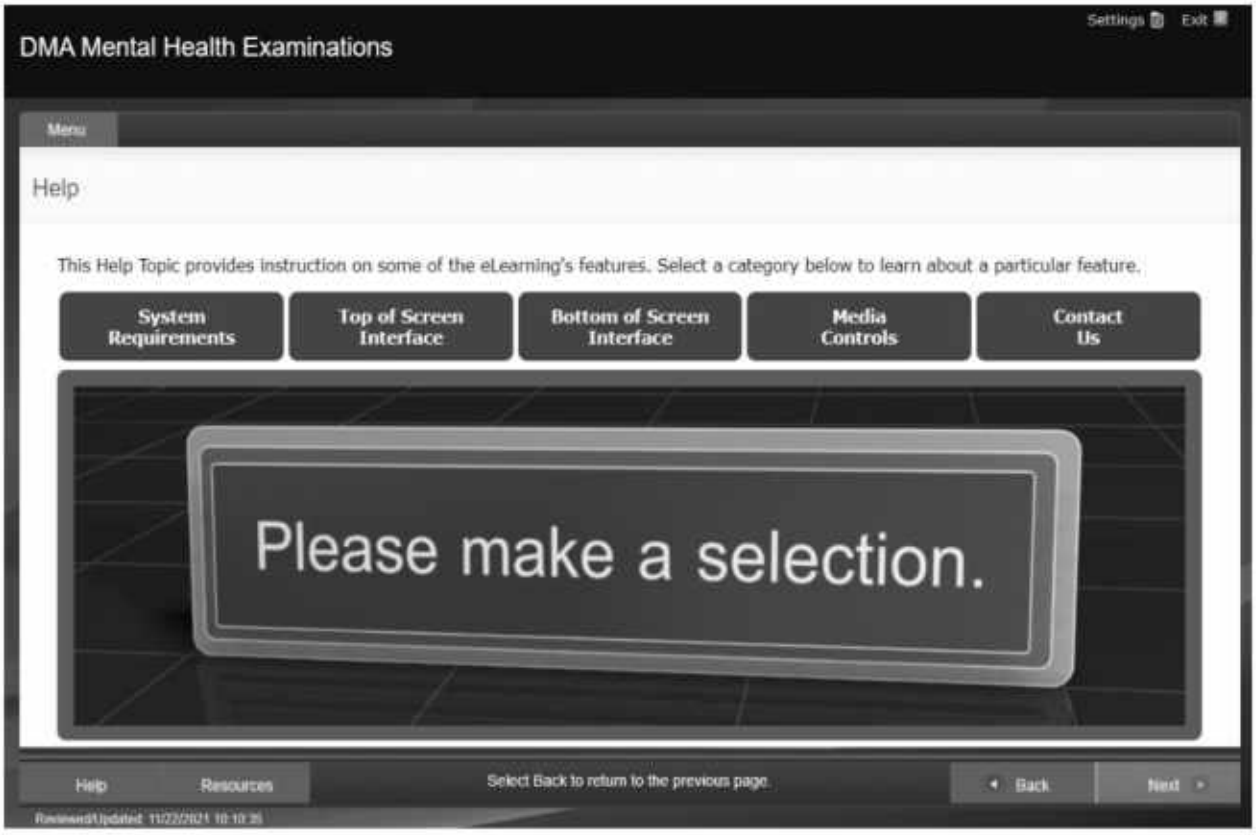
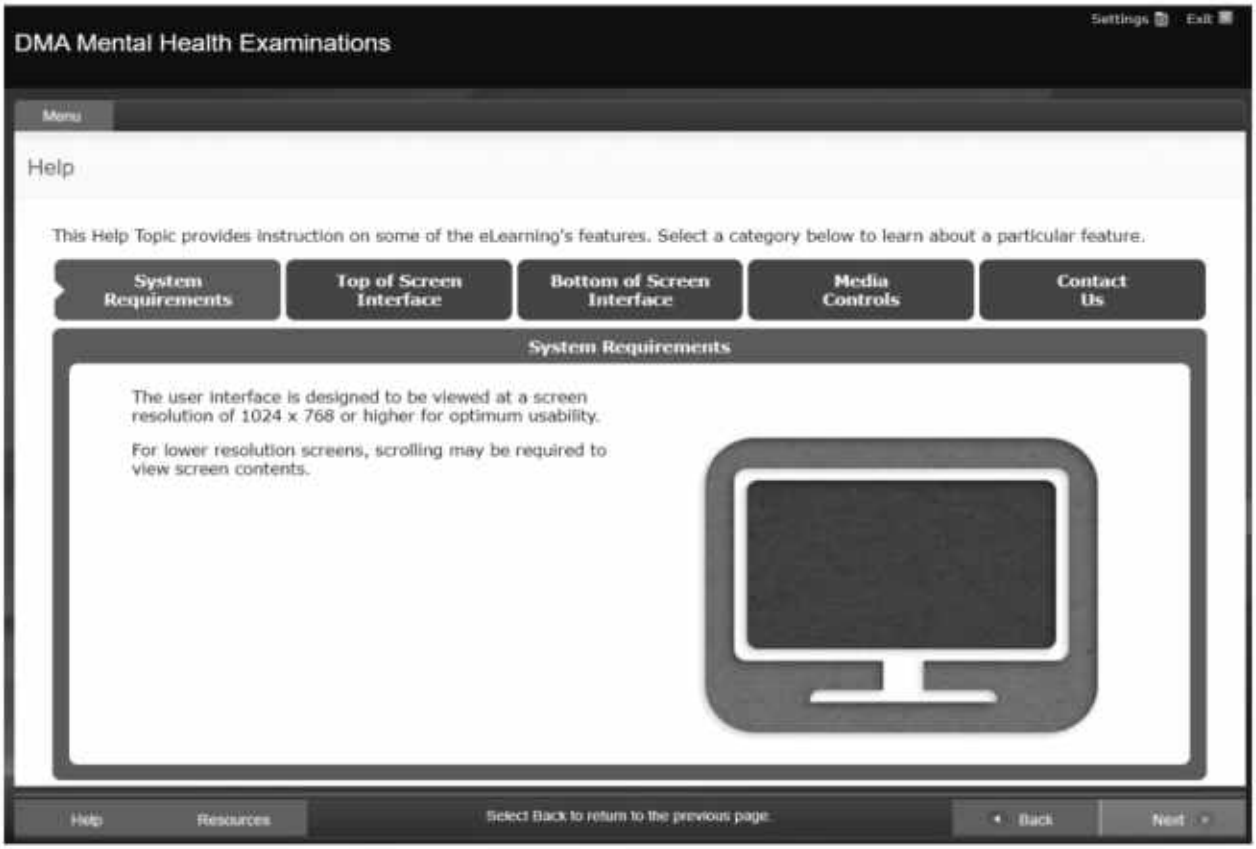
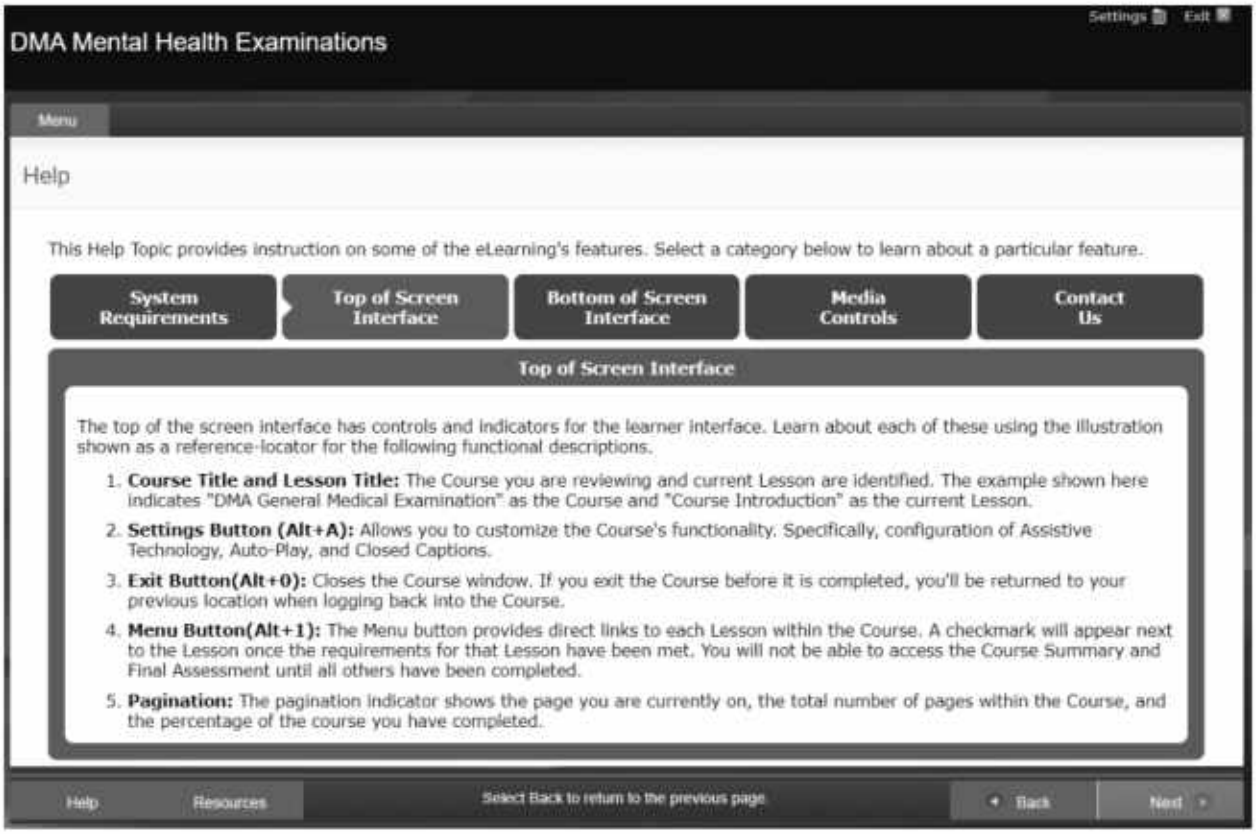
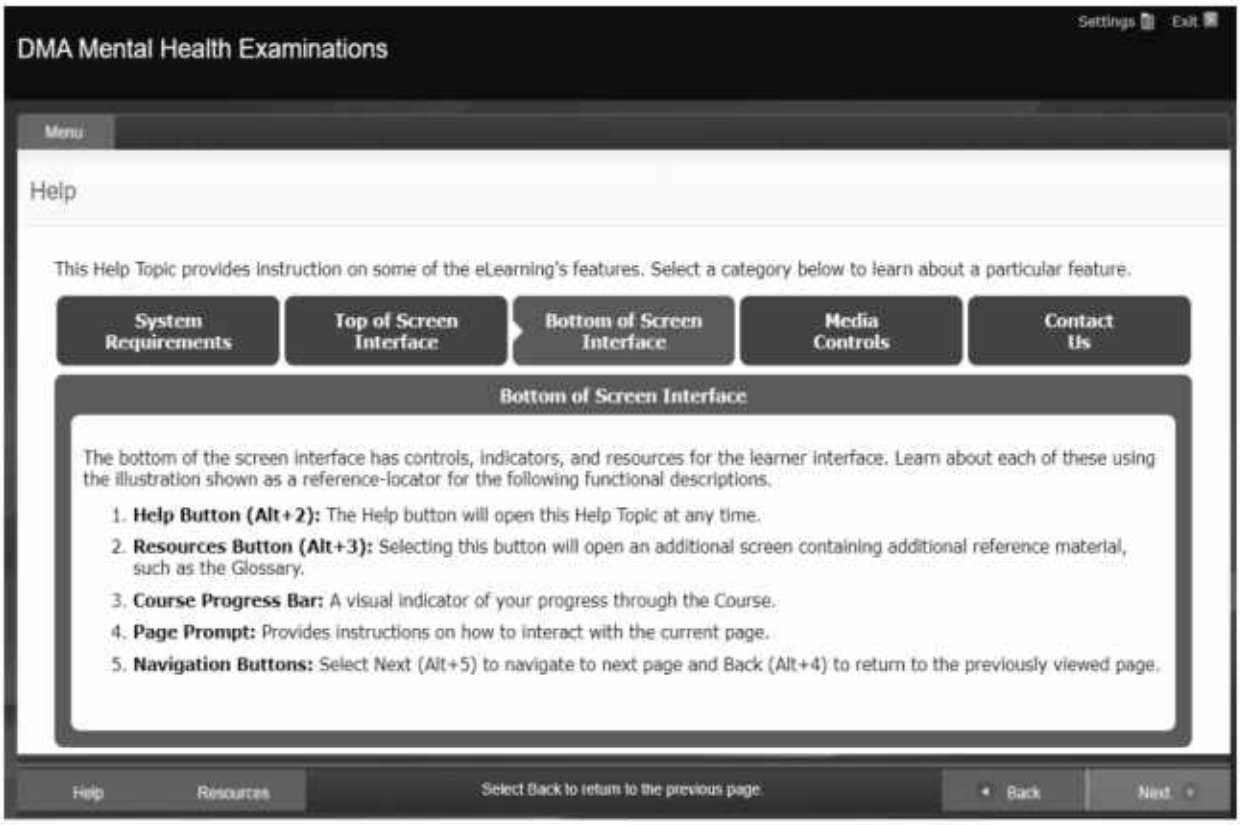

Settings
Exit
DMA Mental Health Examinations
Menu
Resources
Glossary
References
Additional Resources
Help
Resources
Select Back to return.
Back
Next

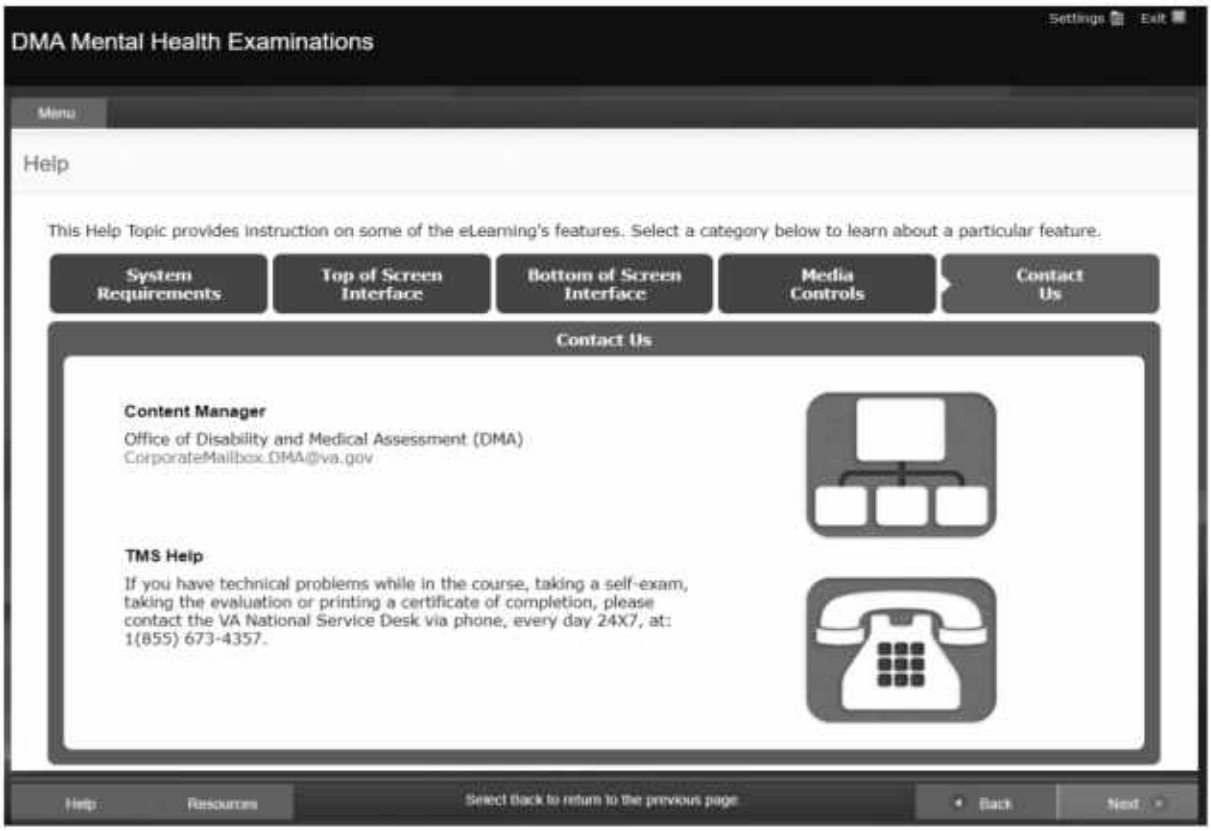

Settings
Exit
DMA Mental Health Examinations
Menu
Help
This Help Topic provides instruction on some of the eLearning's features. Select a category below to learn about a particular feature.
System Requirements
Top of Screen Interface
Bottom of Screen Interface
Media Controls
Contact Us
Please make a selection.
Help
Resources
Select Back to return to the previous page.
Back
Next

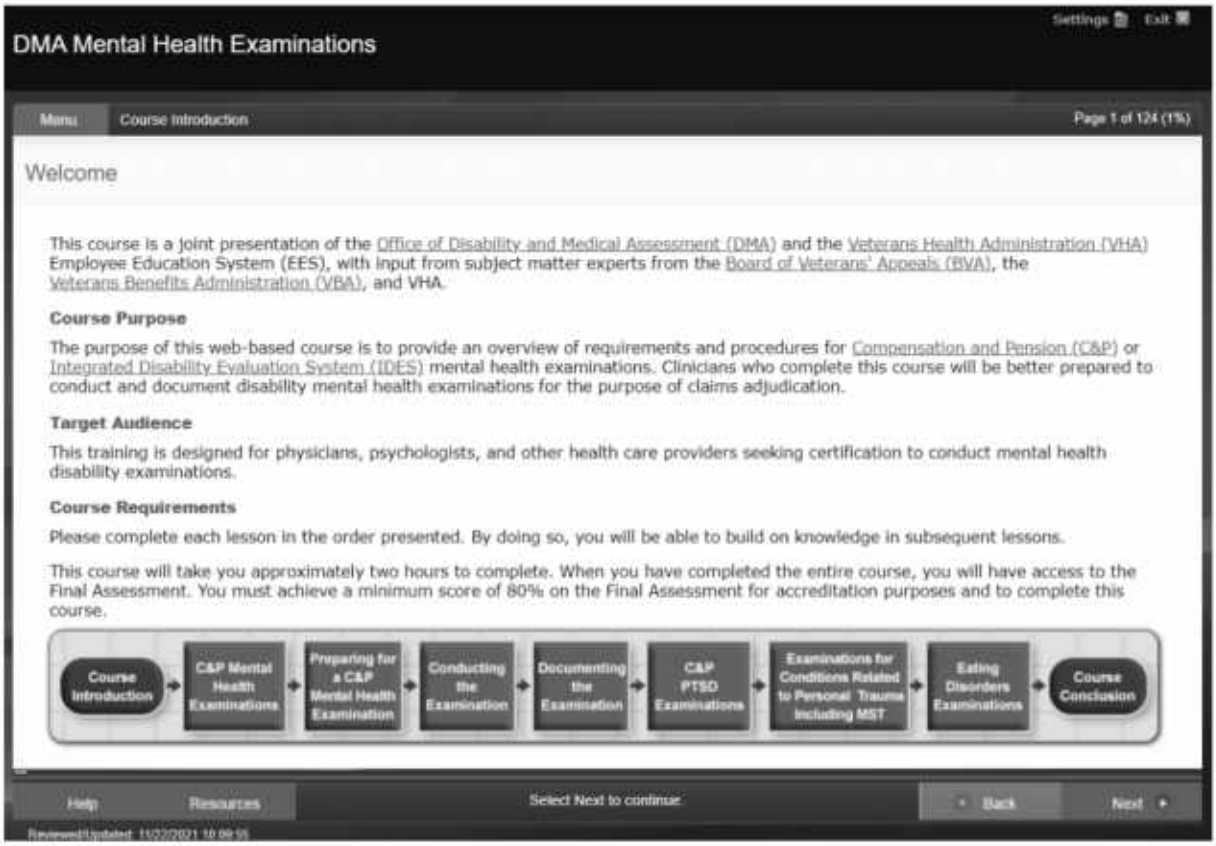

DMA Mental Health Examinations
Settings
Exit
Menu
Help
This Help Topic provides instruction on some of the eLearning's features. Select a category below to learn about a particular feature.
System Requirements
Top of Screen Interface
Bottom of Screen Interface
Media Controls
Contact Us
System Requirements
The user interface is designed to be viewed at a screen resolution of 1024 x 768 or higher for optimum usability.
For lower resolution screens, scrolling may be required to view screen contents.
Help
Resources
Select Back to return to the previous page
Back
Next

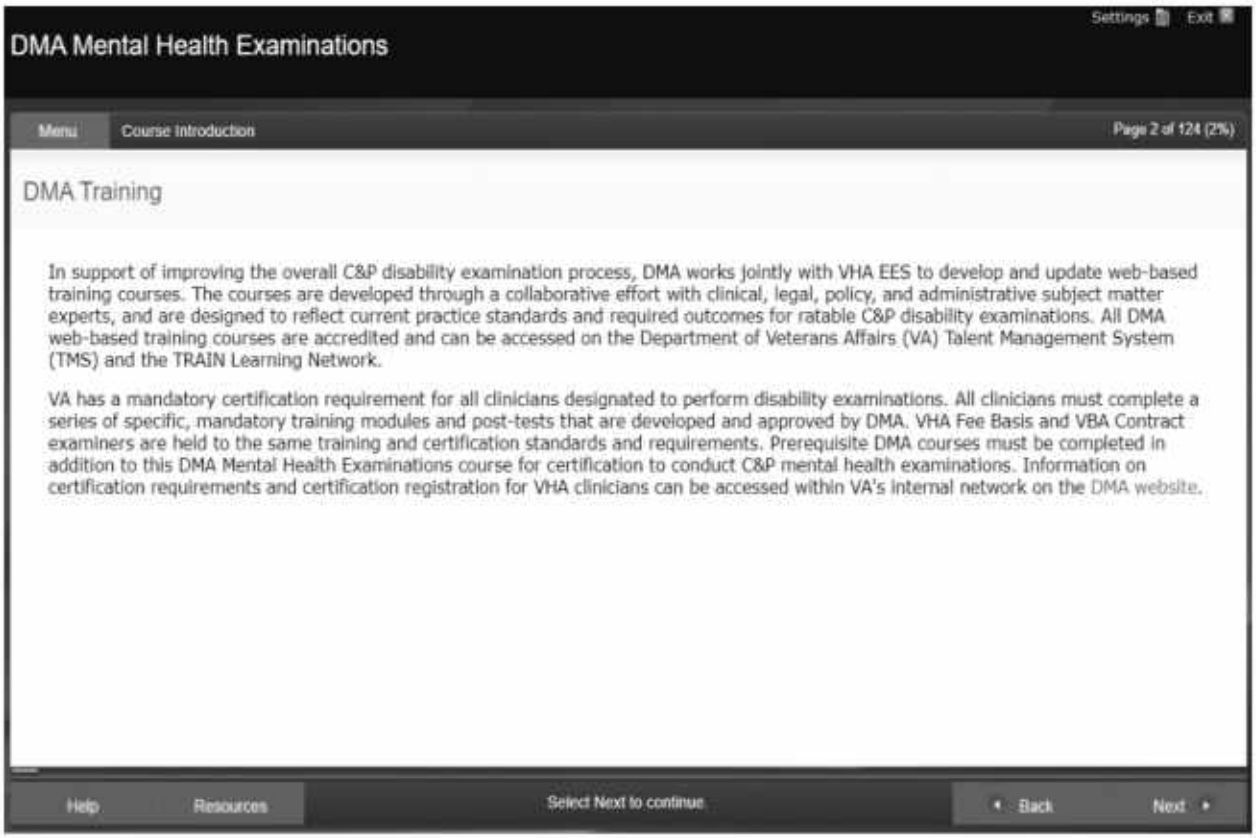

DMA Mental Health Examinations
Settings
Exit
Menu
Help
This Help Topic provides instruction on some of the eLearning's features. Select a category below to learn about a particular feature.
System Requirements
Top of Screen Interface
Bottom of Screen Interface
Media Controls
Contact Us
Top of Screen Interface
The top of the screen interface has controls and indicators for the learner interface. Learn about each of these using the illustration shown as a reference-locator for the following functional descriptions.
1. Course Title and Lesson Title: The Course you are reviewing and current Lesson are identified. The example shown here indicates "DMA General Medical Examination" as the Course and "Course Introduction" as the current Lesson.
2. Settings Button (Alt+A): Allows you to customize the Course's functionality. Specifically, configuration of Assistive Technology, Auto-Play, and Closed Captions.
3. Exit Button(Alt+0): Closes the Course window. If you exit the Course before it is completed, you'll be returned to your previous location when logging back into the Course.
4. Menu Button(Alt+1): The Menu button provides direct links to each Lesson within the Course. A checkmark will appear next to the Lesson once the requirements for that Lesson have been met. You will not be able to access the Course Summary and Final Assessment until all others have been completed.
5. Pagination: The pagination indicator shows the page you are currently on, the total number of pages within the Course, and the percentage of the course you have completed.
Help
Resources
Select Back to return to the previous page
Back
Next

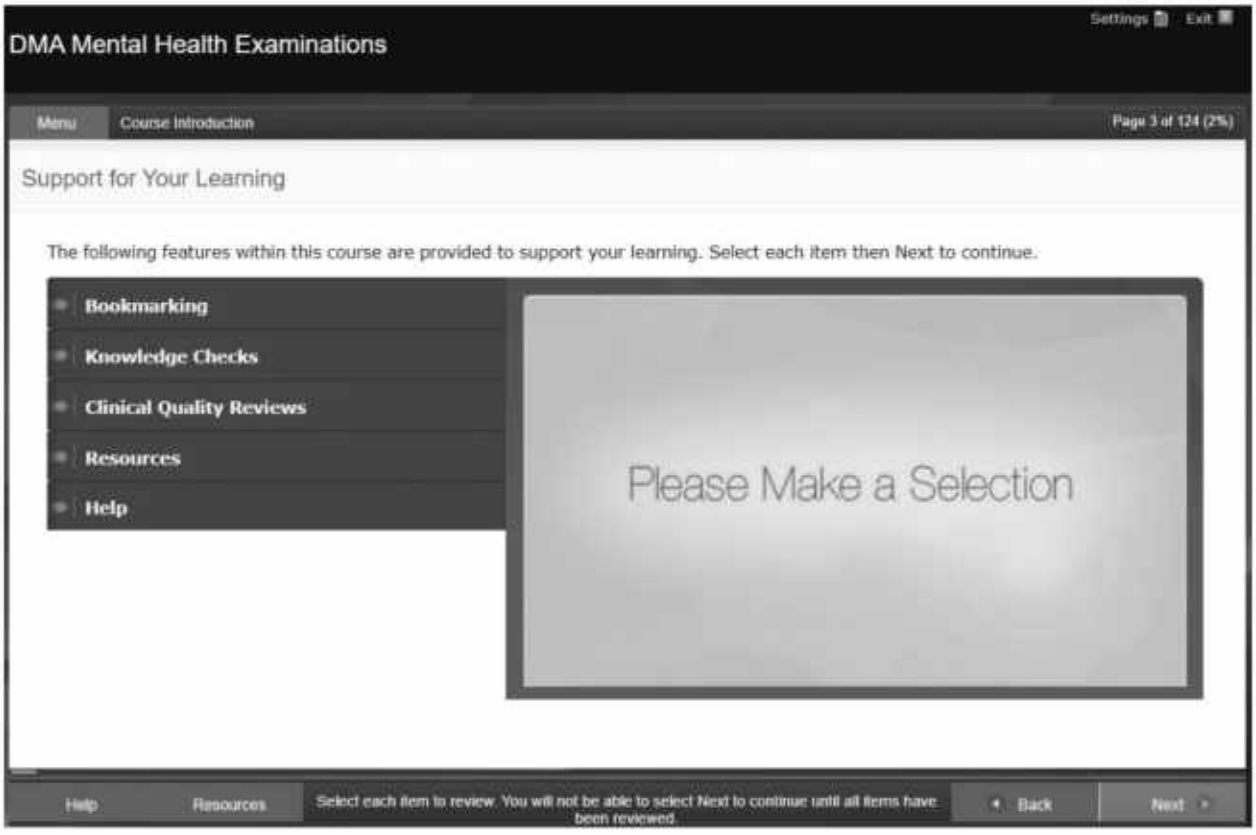

DMA Mental Health Examinations
Settings
Exit
Menu
Help
This Help Topic provides instruction on some of the eLearning's features. Select a category below to learn about a particular feature.
System Requirements
Top of Screen Interface
Bottom of Screen Interface
Media Controls
Contact Us
Bottom of Screen Interface
The bottom of the screen interface has controls, indicators, and resources for the learner interface. Learn about each of these using the illustration shown as a reference-locator for the following functional descriptions.
1. Help Button (Alt+2): The Help button will open this Help Topic at any time.
2. Resources Button (Alt+3): Selecting this button will open an additional screen containing additional reference material, such as the Glossary.
3. Course Progress Bar: A visual indicator of your progress through the Course.
4. Page Prompt: Provides instructions on how to interact with the current page.
5. Navigation Buttons: Select Next (Alt+5) to navigate to next page and Back (Alt+4) to return to the previously viewed page.
Help
Resources
Select Back to return to the previous page
Back
Next

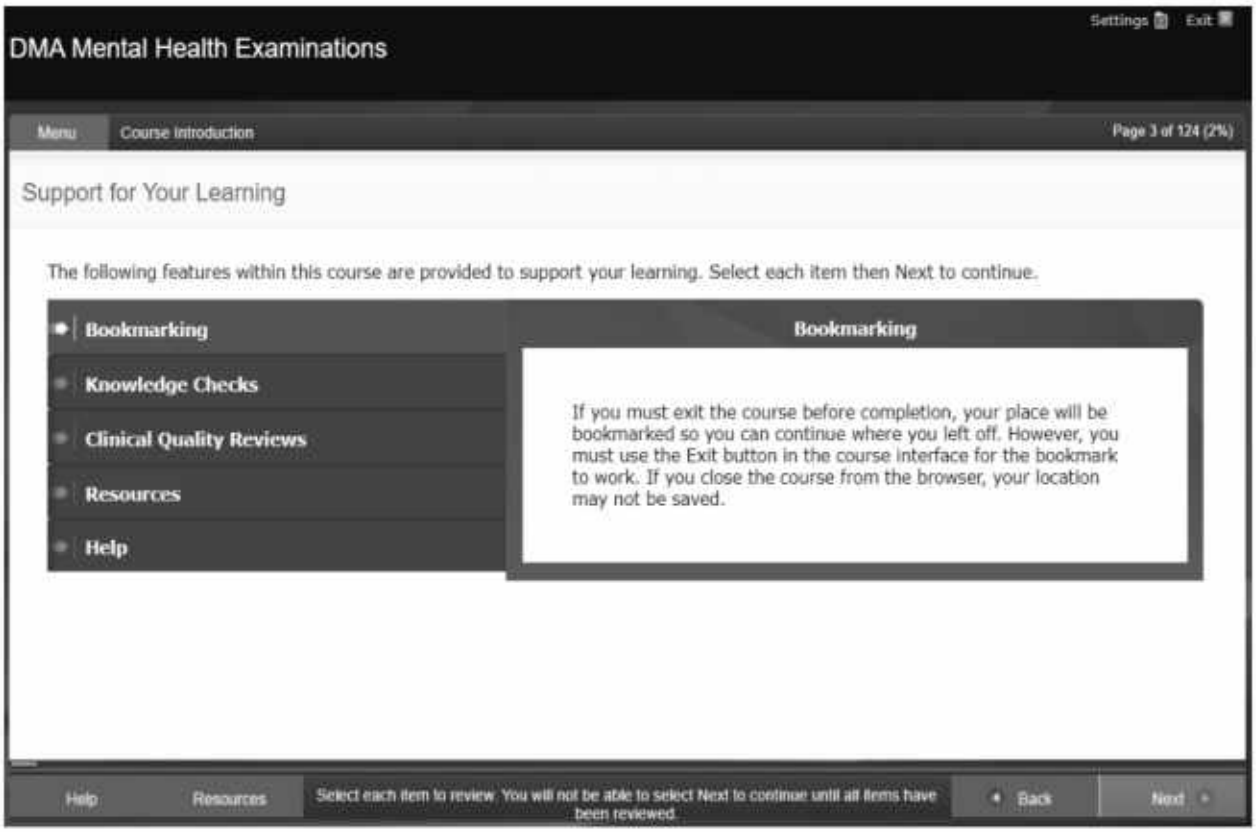

DMA Mental Health Examinations
Settings
Exit
Menu
Help
This Help Topic provides instruction on some of the eLearning's features. Select a category below to learn about a particular feature.
System Requirements
Top of Screen Interface
Bottom of Screen Interface
Media Controls
Contact Us
Media Controls
Media player controls:
1. Play
2. Replay (available after media has finished)
3. Media scroll button and progress indicator
4. Fast forward / Fast rewind
5. Volume
6. Settings (closed captioning)
7. Media played / Total media time
Closed Captions
00:07 / 00:07
1
2
3
4
5
6
7
Help
Resources
Select Back to return to the previous page
Back
Next

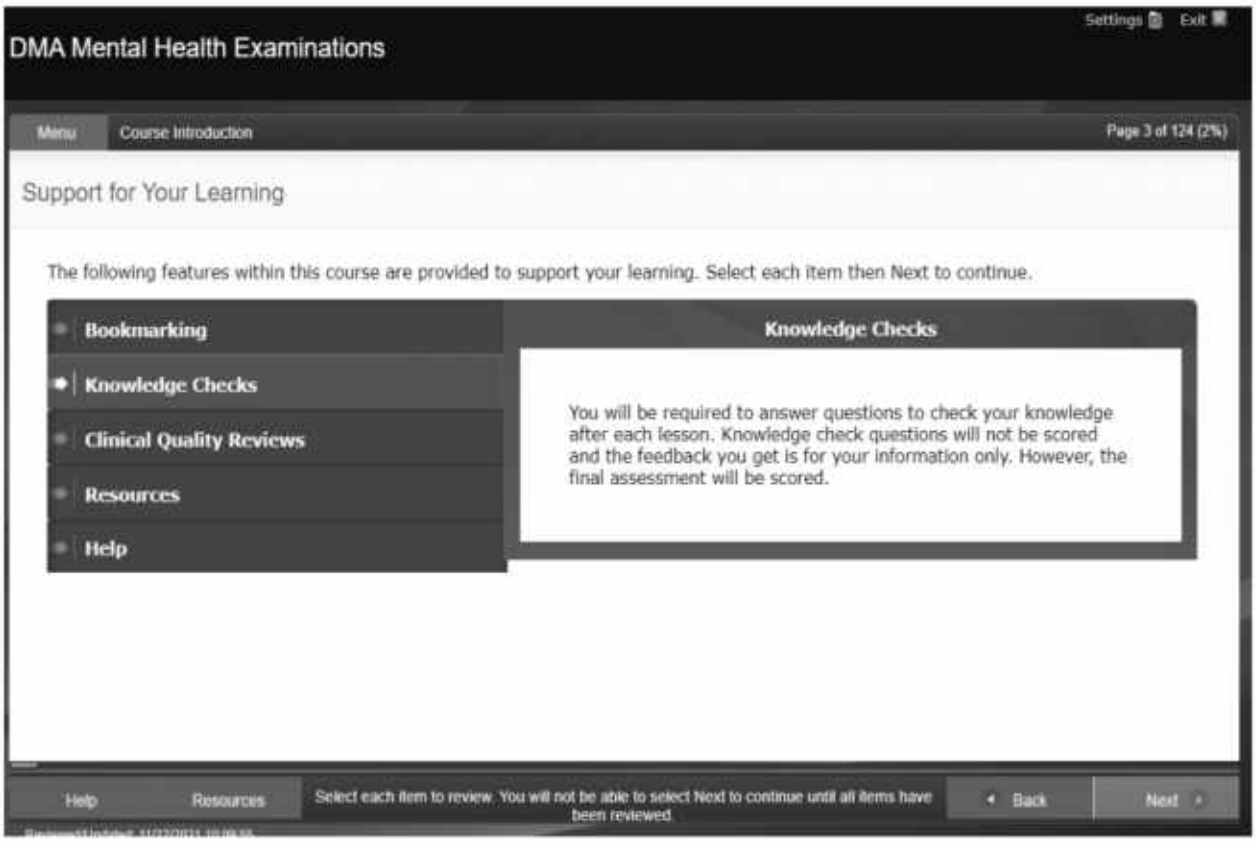

DMA Mental Health Examinations
Settings
Exit
Menu
Help
This Help Topic provides instruction on some of the eLearning's features. Select a category below to learn about a particular feature.
System Requirements
Top of Screen Interface
Bottom of Screen Interface
Media Controls
Contact Us
Contact Us
Content Manager
Office of Disability and Medical Assessment (DMA)
CorporateMailbox.DMA@va.gov
TMS Help
If you have technical problems while in the course, taking a self-exam, taking the evaluation or printing a certificate of completion, please contact the VA National Service Desk via phone, every day 24X7, at: 1(855) 673-4357.
Help
Resources
Select Back to return to the previous page
Back
Next

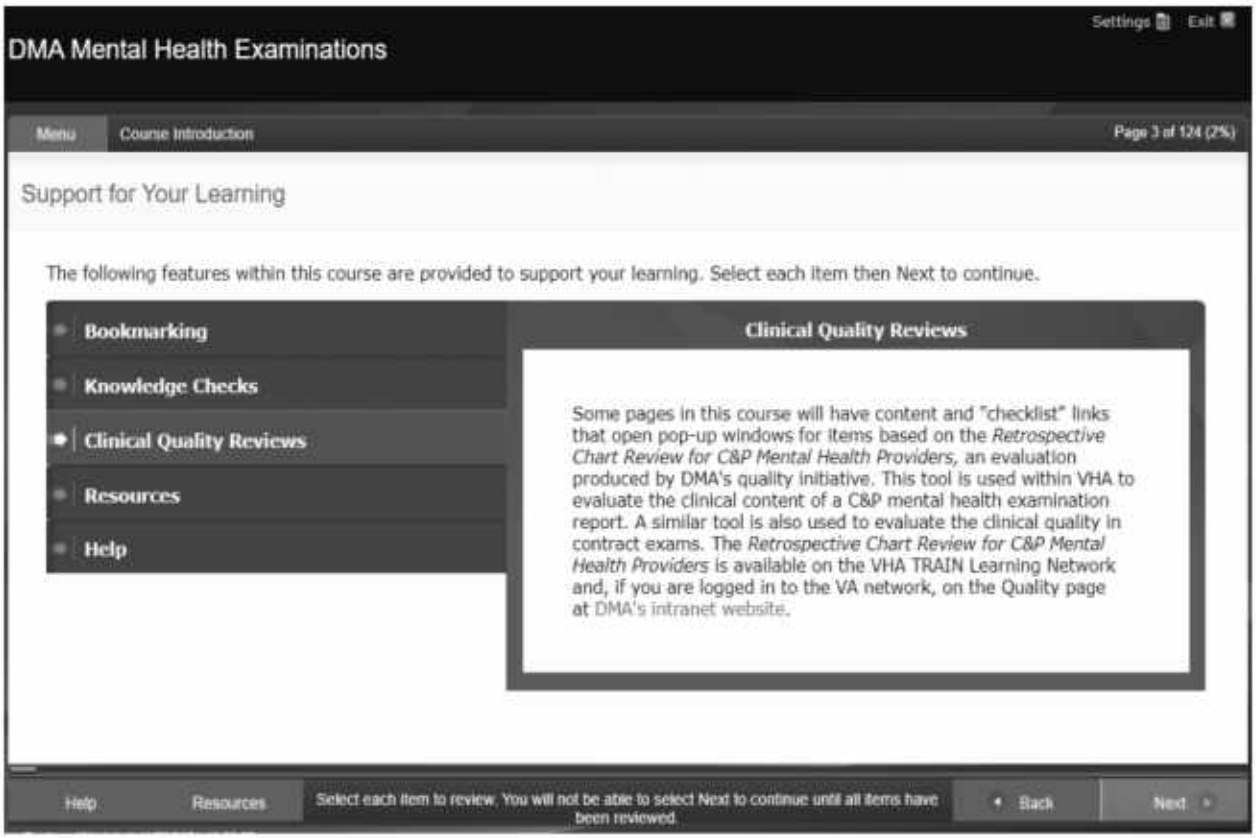

DMA Mental Health Examinations
Settings
Exit
Menu
Course Introduction
Page 1 of 124 (1%)
Welcome
This course is a joint presentation of the Office of Disability and Medical Assessment (DMA) and the Veterans Health Administration (VHA) Employee Education System (EES), with input from subject matter experts from the Board of Veterans' Appeals (BVA), the Veterans Benefits Administration (VBA), and VHA.
Course Purpose
The purpose of this web-based course is to provide an overview of requirements and procedures for Compensation and Pension (C&P) or Integrated Disability Evaluation System (IDES) mental health examinations. Clinicians who complete this course will be better prepared to conduct and document disability mental health examinations for the purpose of claims adjudication.
Target Audience
This training is designed for physicians, psychologists, and other health care providers seeking certification to conduct mental health disability examinations.
Course Requirements
Please complete each lesson in the order presented. By doing so, you will be able to build on knowledge in subsequent lessons.
This course will take you approximately two hours to complete. When you have completed the entire course, you will have access to the Final Assessment. You must achieve a minimum score of 80% on the Final Assessment for accreditation purposes and to complete this course.
Course Introduction
C&P Mental Health Examinations
Preparing for a C&P Mental Health Examination
Conducting the Examination
Documenting the Examination
C&P PTSD Examinations
Examinations for Conditions Related to Personal Trauma Including MST
Eating Disorders Examinations
Course Conclusion
Help
Resources
Select Next to continue
Back
Next

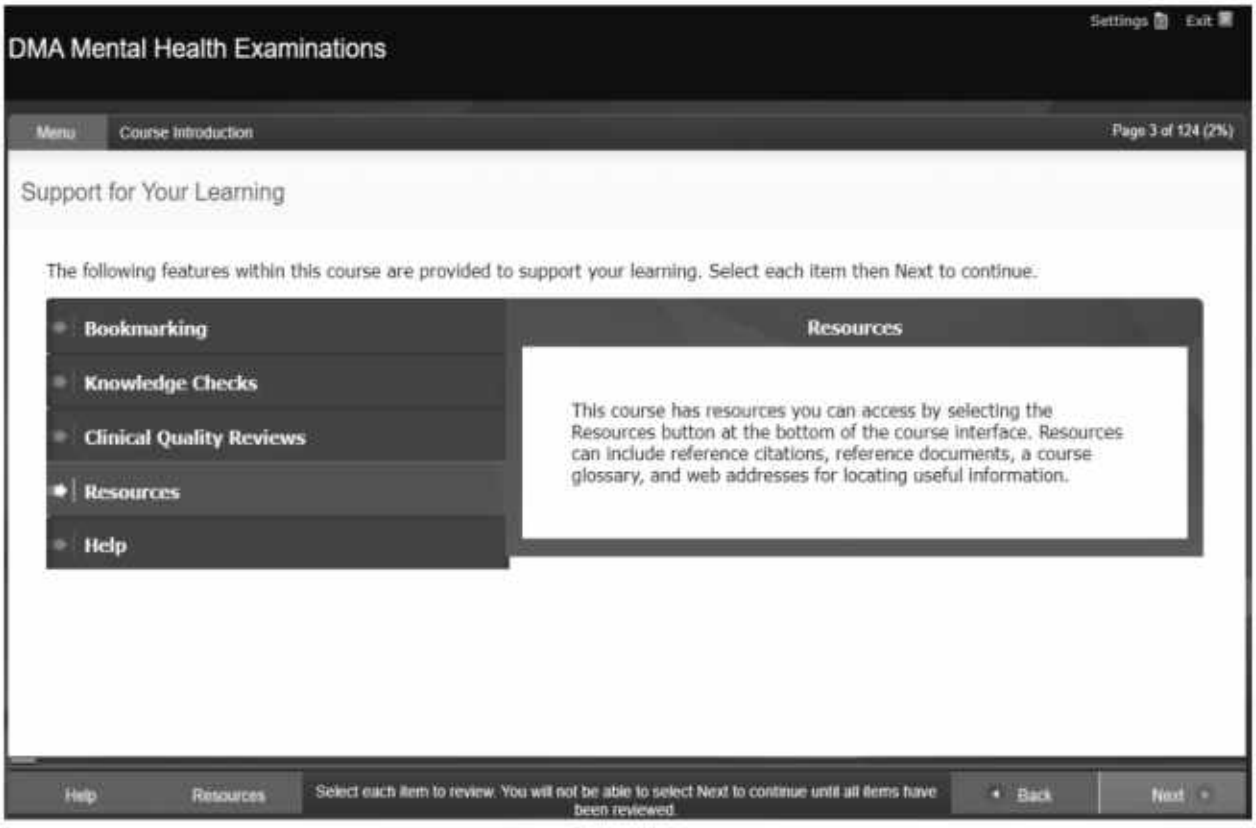

Settings
Exit
DMA Mental Health Examinations
Menu
Course Introduction
Page 2 of 124 (2%)
DMA Training
In support of improving the overall C&P disability examination process, DMA works jointly with VHA EES to develop and update web-based training courses. The courses are developed through a collaborative effort with clinical, legal, policy, and administrative subject matter experts, and are designed to reflect current practice standards and required outcomes for ratable C&P disability examinations. All DMA web-based training courses are accredited and can be accessed on the Department of Veterans Affairs (VA) Talent Management System (TMS) and the TRAIN Learning Network.
VA has a mandatory certification requirement for all clinicians designated to perform disability examinations. All clinicians must complete a series of specific, mandatory training modules and post-tests that are developed and approved by DMA. VHA Fee Basis and VBA Contract examiners are held to the same training and certification standards and requirements. Prerequisite DMA courses must be completed in addition to this DMA Mental Health Examinations course for certification to conduct C&P mental health examinations. Information on certification requirements and certification registration for VHA clinicians can be accessed within VA's internal network on the DMA website.
Help
Resources
Select Next to continue
Back
Next

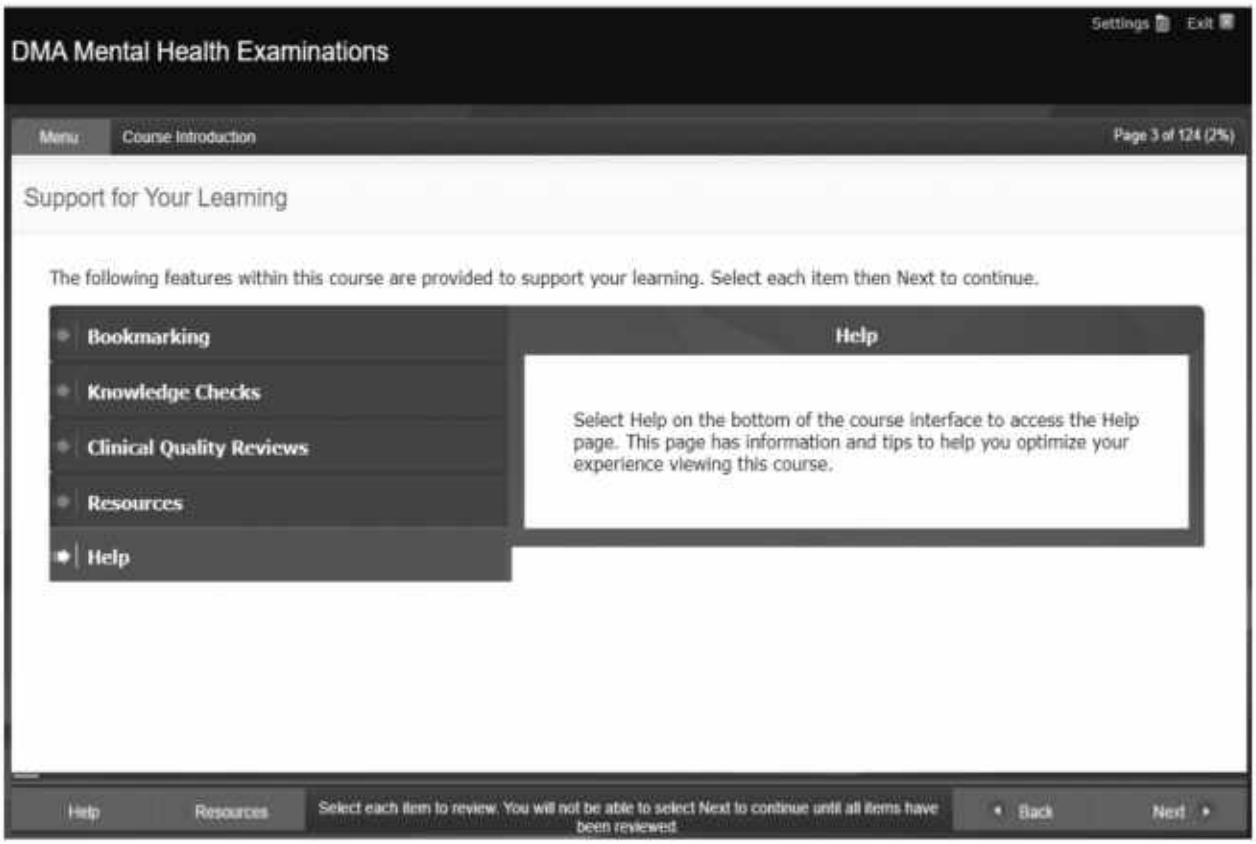

Settings
Exit
DMA Mental Health Examinations
Menu
Course Introduction
Page 3 of 124 (2%)
Support for Your Learning
The following features within this course are provided to support your learning. Select each item then Next to continue.
Bookmarking
Knowledge Checks
Clinical Quality Reviews
Resources
Help
Please Make a Selection
Help
Resources
Select each item to review. You will not be able to select Next to continue until all items have been reviewed.
Back
Next

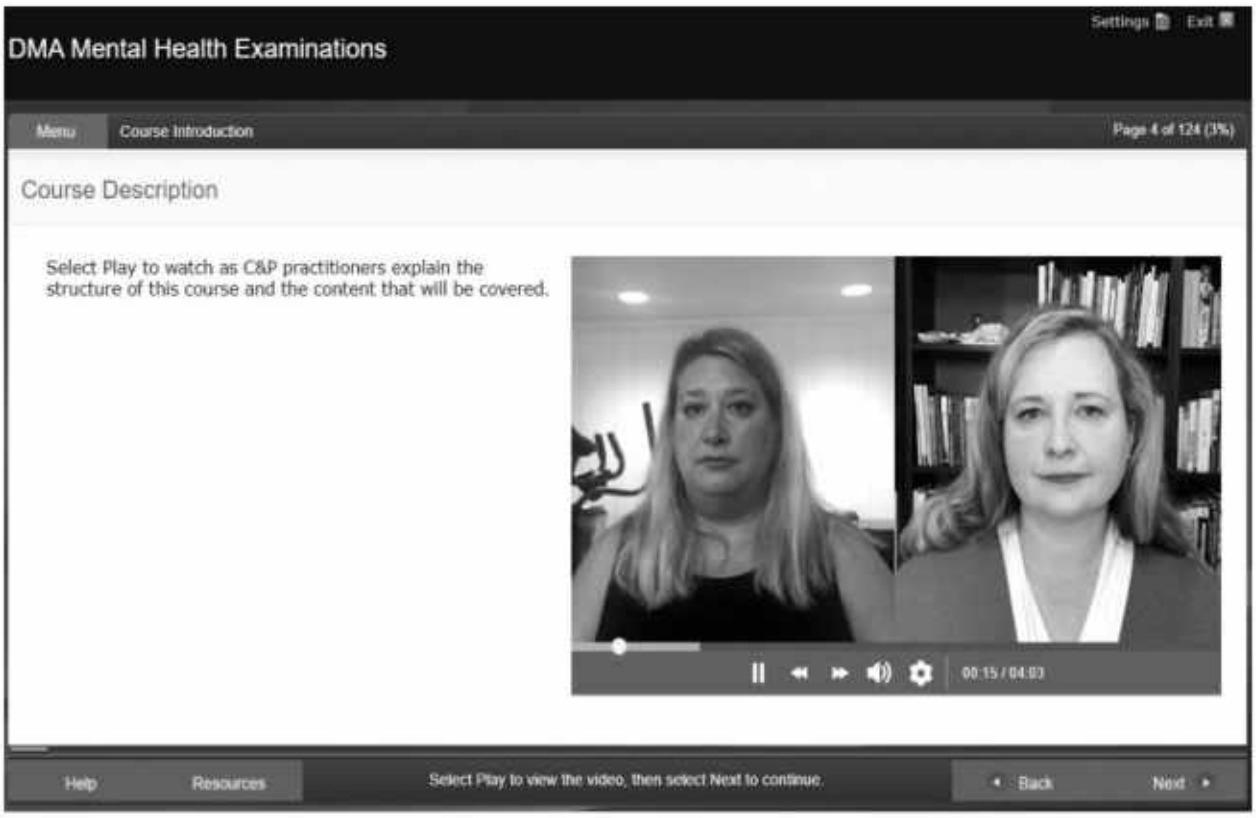

DMA Mental Health Examinations
Settings
Exit
Menu
Course Introduction
Page 3 of 124 (2%)
Support for Your Learning
The following features within this course are provided to support your learning. Select each item then Next to continue.
Bookmarking
Knowledge Checks
Clinical Quality Reviews
Resources
Help
Bookmarking
If you must exit the course before completion, your place will be bookmarked so you can continue where you left off. However, you must 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.
Help
Resources
Select each item to review. You will not be able to select Next to continue until all items have been reviewed.
Back
Next


DMA Mental Health Examinations
Settings
Exit
Menu
Course Introduction
Page 3 of 124 (2%)
Support for Your Learning
The following features within this course are provided to support your learning. Select each item then Next to continue.
Bookmarking
Knowledge Checks
Clinical Quality Reviews
Resources
Help
Knowledge Checks
You will be required to answer questions to check your knowledge after each lesson. Knowledge check questions will not be scored and the feedback you get is for your information only. However, the final assessment will be scored.
Help
Resources
Select each item to review. You will not be able to select Next to continue until all items have been reviewed.
Back
Next

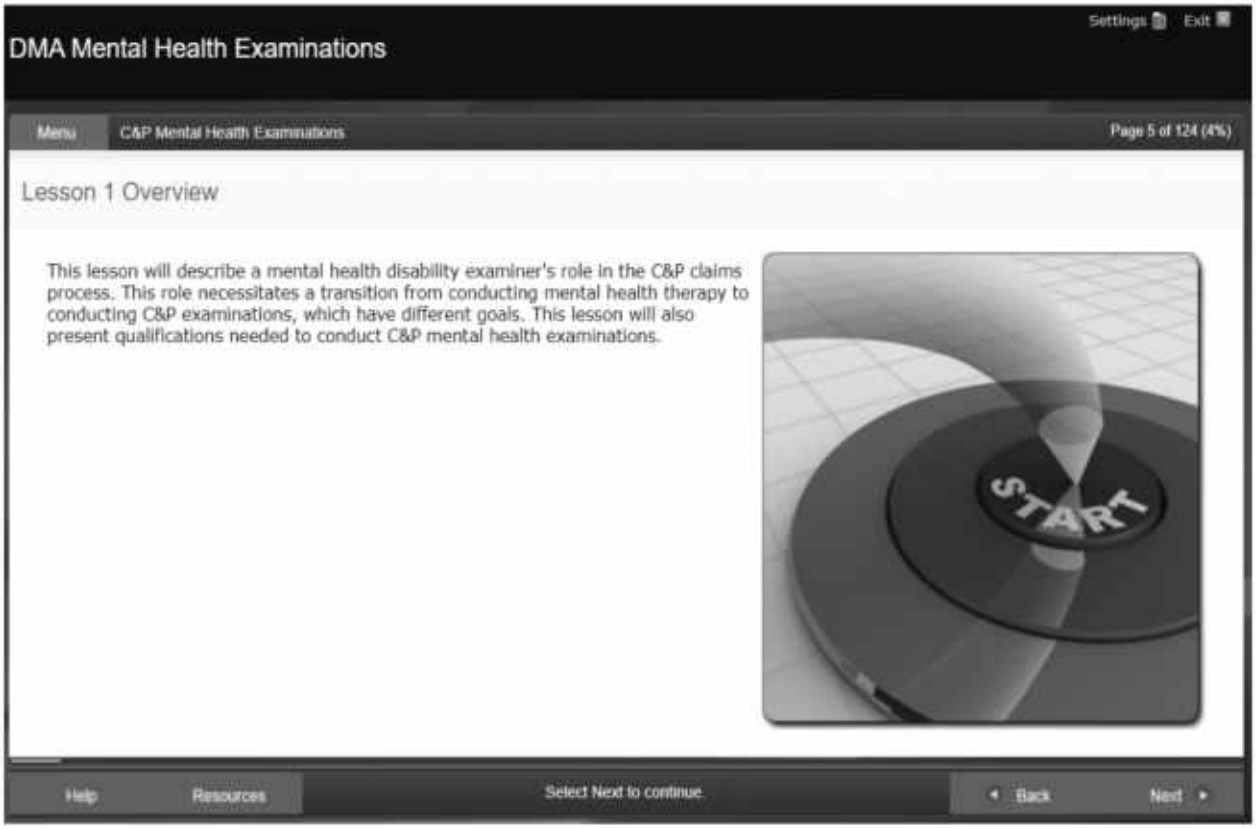

DMA Mental Health Examinations
Settings
Exit
Menu
Course Introduction
Page 3 of 124 (2%)
Support for Your Learning
The following features within this course are provided to support your learning. Select each item then Next to continue.
Bookmarking
Knowledge Checks
Clinical Quality Reviews
Resources
Help
Clinical Quality Reviews
Some pages in this course will have content and "checklist" links that open pop-up windows for items based on the Retrospective Chart Review for C&P Mental Health Providers, an evaluation produced by DMA's quality initiative. This tool is used within VHA to evaluate the clinical content of a C&P mental health examination report. A similar tool is also used to evaluate the clinical quality in contract exams. The Retrospective Chart Review for C&P Mental Health Providers is available on the VHA TRAIN Learning Network and, if you are logged in to the VA network, on the Quality page at DMA's intranet website.
Help
Resources
Select each item to review. You will not be able to select Next to continue until all items have been reviewed.
Back
Next

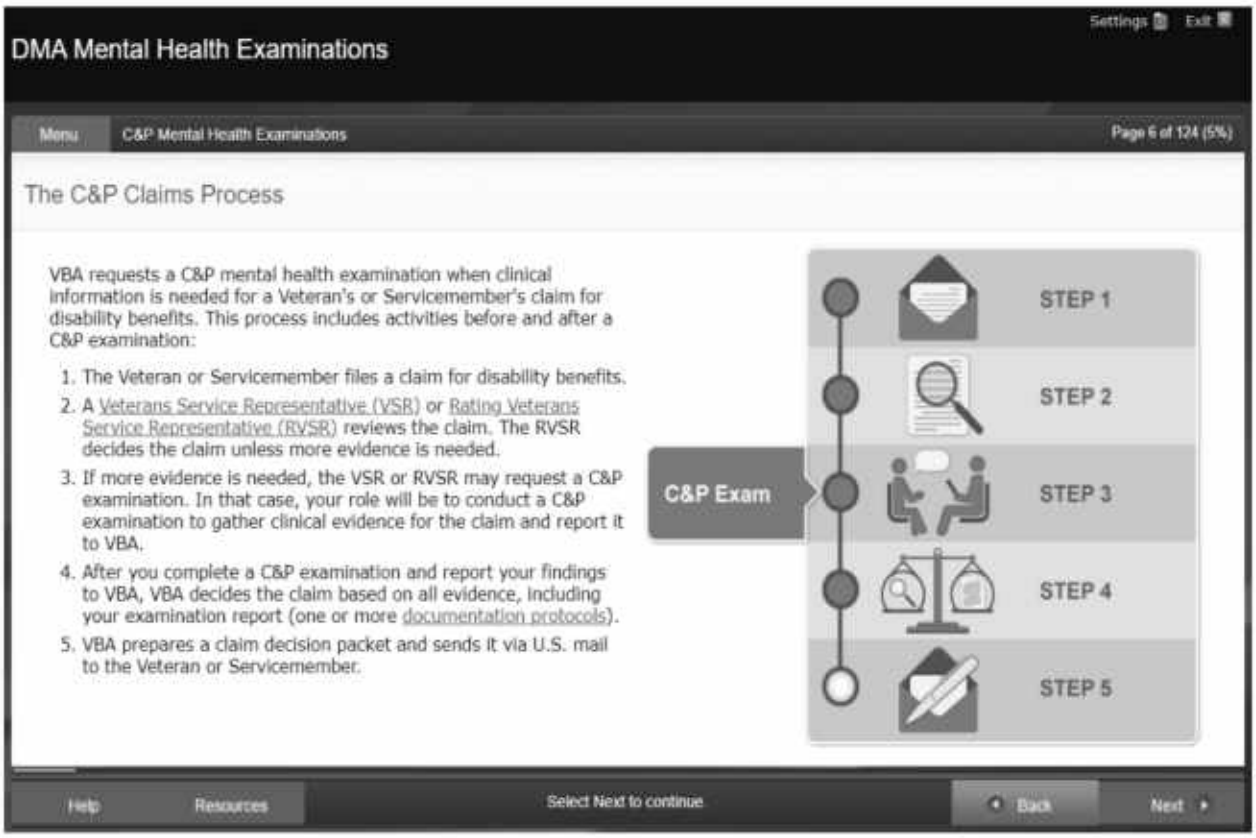

DMA Mental Health Examinations
Settings
Exit
Menu
Course Introduction
Page 3 of 124 (2%)
Support for Your Learning
The following features within this course are provided to support your learning. Select each item then Next to continue.
Bookmarking
Knowledge Checks
Clinical Quality Reviews
Resources
Help
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
Select each item to review. You will not be able to select Next to continue until all items have been reviewed.
Back
Next

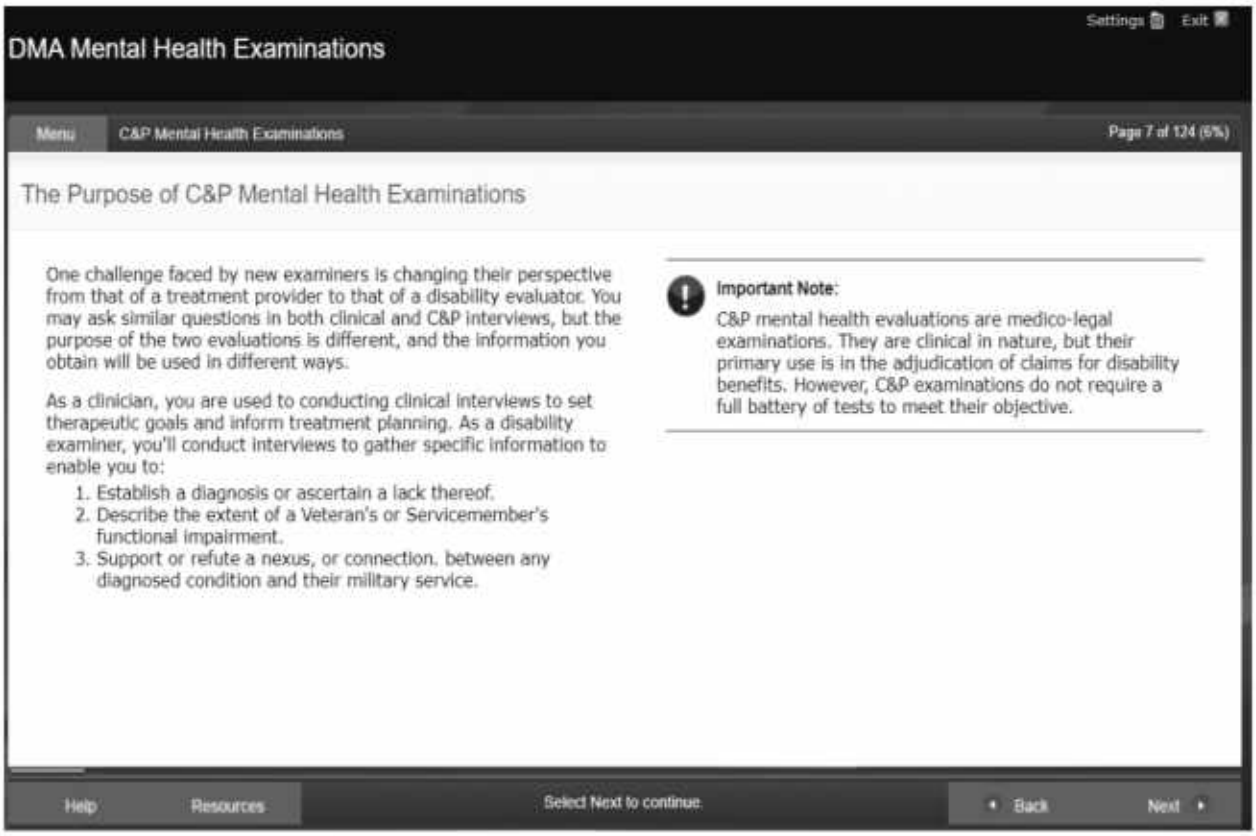

DMA Mental Health Examinations
Settings
Exit
Menu
Course Introduction
Page 3 of 124 (2%)
Support for Your Learning
The following features within this course are provided to support your learning. Select each item then Next to continue.
Bookmarking
Knowledge Checks
Clinical Quality Reviews
Resources
Help
Help
Select Help on the bottom of the course interface to access the Help page. This page has information and tips to help you optimize your experience viewing this course.
Help
Resources
Select each item to review. You will not be able to select Next to continue until all items have been reviewed
Back
Next

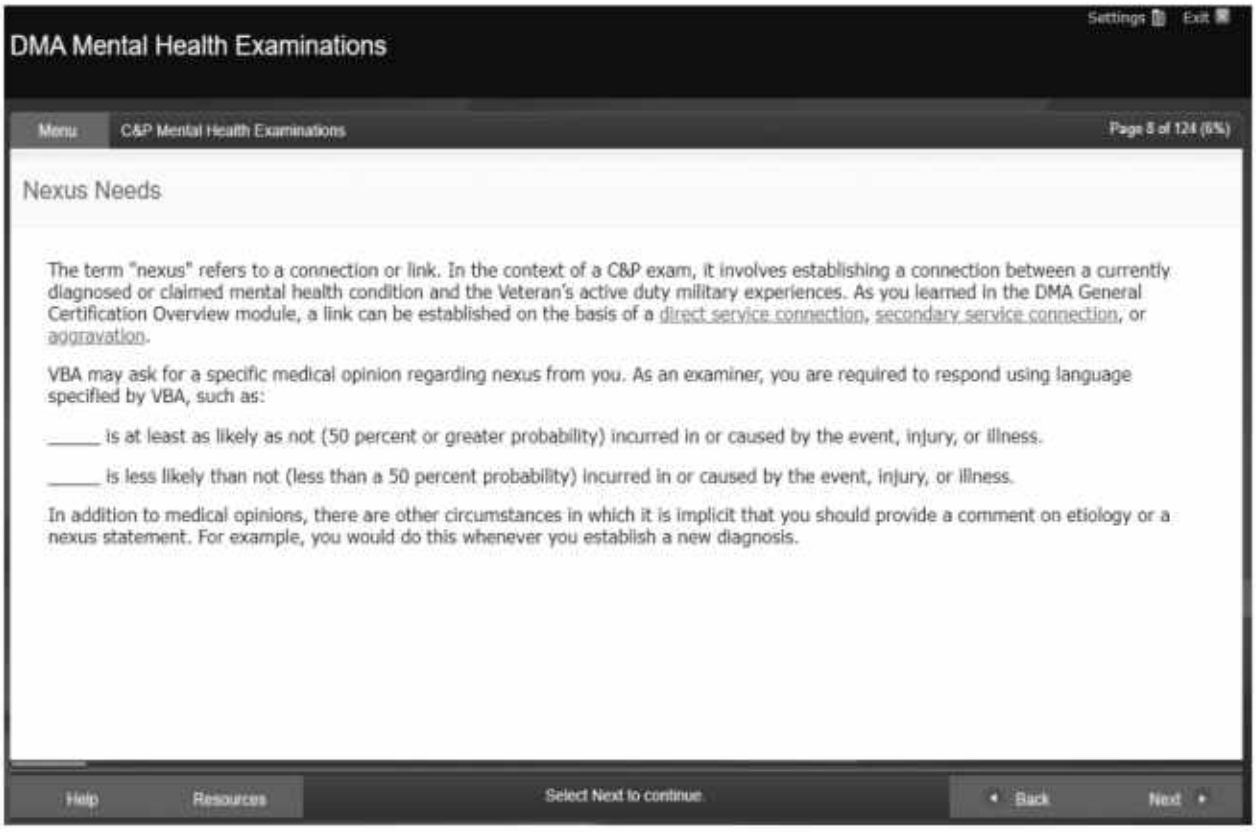

DMA Mental Health Examinations
Settings
Exit
Menu
Course Introduction
Page 4 of 124 (3%)
Course Description
Select Play to watch as C&P practitioners explain the structure of this course and the content that will be covered.
00:15 / 04:03
Help
Resources
Select Play to view the video, then select Next to continue.
Back
Next

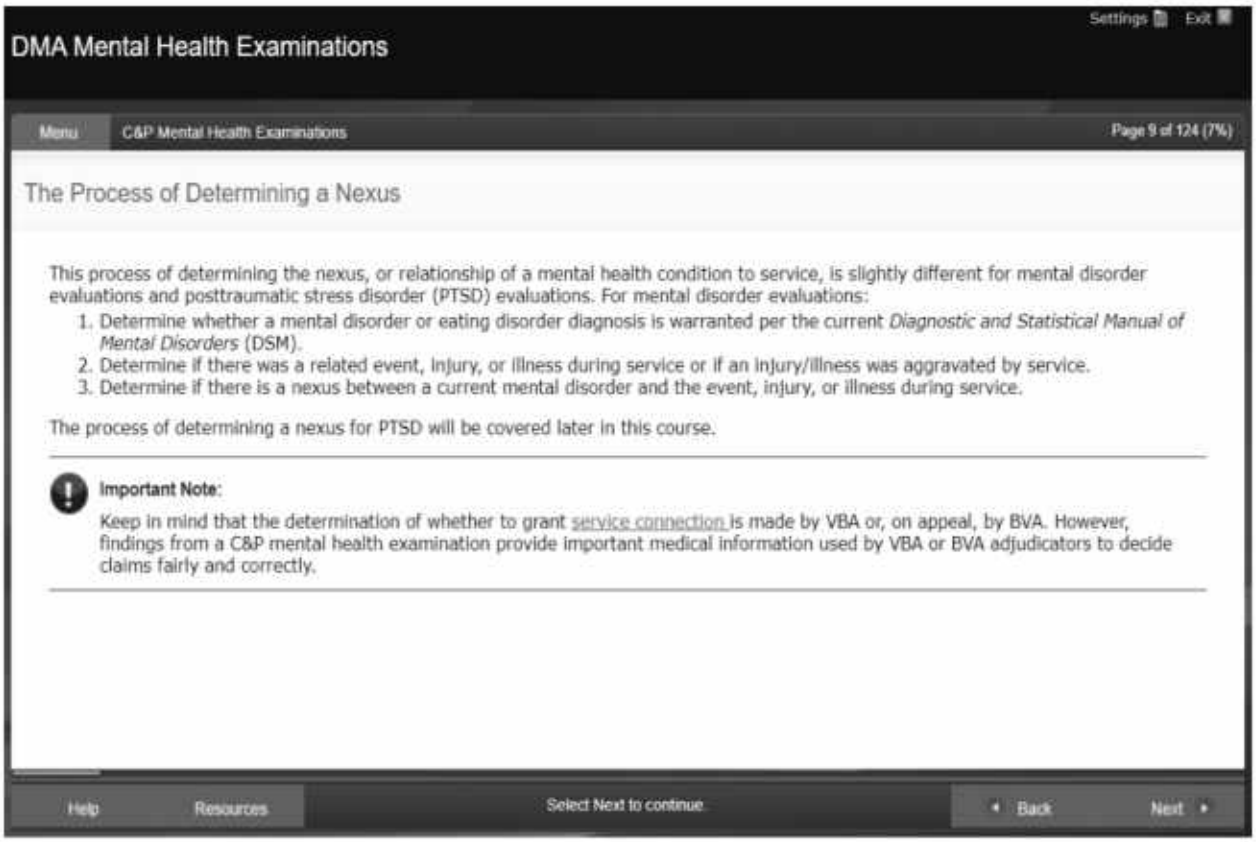
Welcome to the DMA mental health examinations course. I'm Matuskha Lindo, your moderator. Joining us are Dr. Stacy Pollack and Dr. Courtney Pederzani to talk about this course. Dr. Stacy Polack is a clinical psychologist and the national mental health director of program policy implementation in the office of mental health and suicide prevention, or OMHSP at the VA central office or VACO. She has worked in OMHSP for approximately 10 years overseeing issues related to Veterans and mental health disability compensation and working closely with VBA on other mental health related issues. Dr. Pollack also serves on the steering committee of the national center for PTSD, a VA PTSD mentorship program. She has been a subject matter expert on numerous DMA training courses related to C&P. Dr. Courtney Pederzani is a senior mental health officer in the medical disability examination office, MDEO at VBA VACO. She was formerly a certified C&P examiner and behavioral health C&P program director at the Philadelphia Pennsylvania VA medical center. She has served as a subject matter expert for DMA's clinical quality initiative and for the DMA general certification overview, online training course panelists. The DMA initial mental disorders, examination, and initial PTSD examination courses have been part of the DMA C&P certification curriculum for some time. This updated course, DMA mental health examinations, will combine these courses. Would you tell us about the purpose of combining them? The courses have been combined because there is a lot of training overlap no matter which type of mental health disability examination you are conducting. There are foundational components that all of these exams share, but we will also talk about some of the specific differences and considerations for PTSD and mental disorder evaluations. Some of the common themes shared by all mental health examinations are the transition from being a treatment provider, to being a disability evaluator. The preparation for conducting an exam, the process of evaluating a Veteran for a mental health disability in the correct documentation of the examination. Are there other C&P mental health examinations covered in this updated course? Yes, this course will also include information about eating disorder evaluations. When an eating disorder has been claimed, it may be evaluated at the same time as another co-occurring mental health condition, but it has a separate documentation protocol. So we will discuss that. This training course will also contain information about mental health examinations that are related to military sexual trauma or MST. These claims have some unique considerations and it's important for mental health examiners to be knowledgeable about the handling of these claims. There is a separate DMA MST training course that all new examiners must complete. The information contained in this course does not replace the requirement to complete the other course. We will highlight some ways that you might apply the learning from the MST course, in your role as a mental health examiner. Thank you, Stacy and Courtney for your insights into why the C&P initial mental disorders examination, and PTSD examination courses were combined into one course and how this course was expanded to include information about mental health examinations related to MST and eating disorders. We will talk with you again soon.

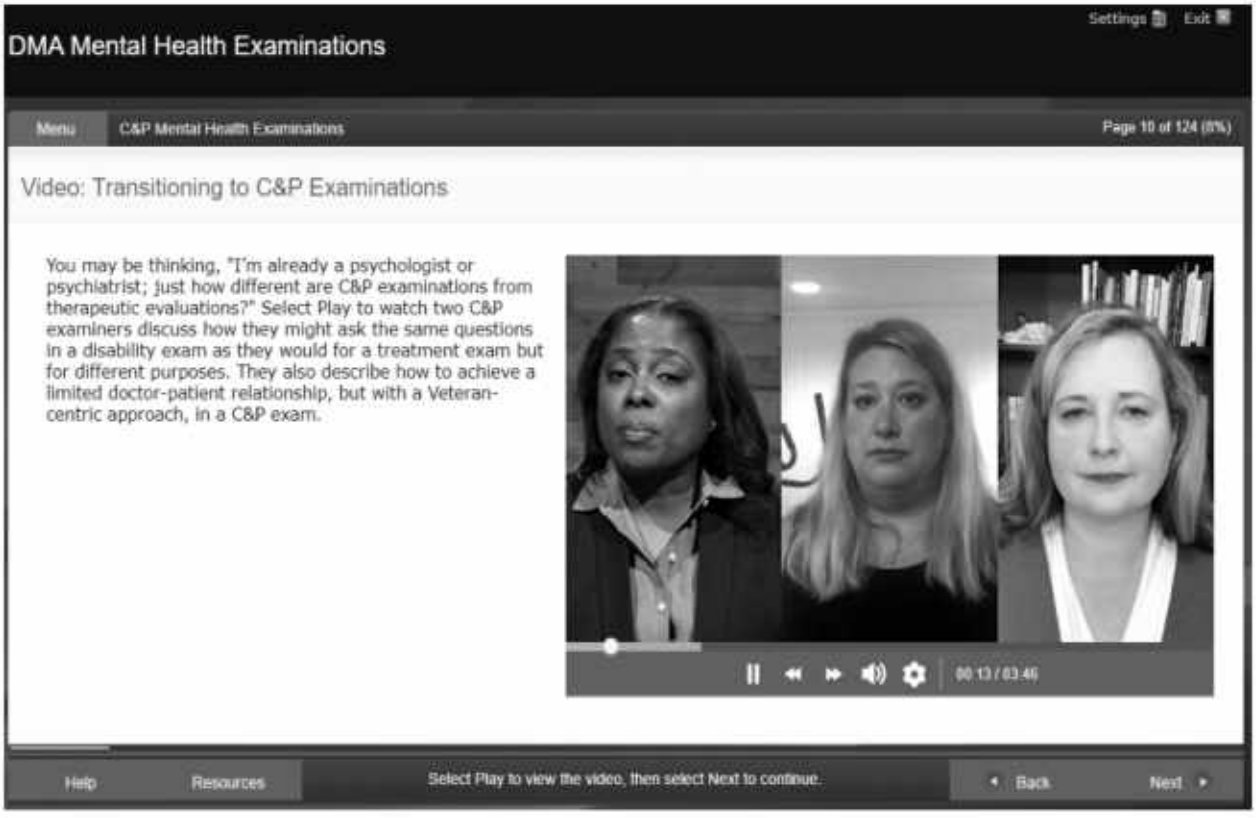

DMA Mental Health Examinations
Settings
Exit
Menu
C&P Mental Health Examinations
Page 5 of 124 (4%)
Lesson 1 Overview
This lesson will describe a mental health disability examiner's role in the C&P claims process. This role necessitates a transition from conducting mental health therapy to conducting C&P examinations, which have different goals. This lesson will also present qualifications needed to conduct C&P mental health examinations.
START
Help
Resources
Select Next to continue
Back
Next


DMA Mental Health Examinations
Settings
Exit
Menu
C&P Mental Health Examinations
Page 6 of 124 (5%)
The C&P Claims Process
VBA requests a C&P mental health examination when clinical information is needed for a Veteran's or Servicemember's claim for disability benefits. This process includes activities before and after a C&P examination:
1. The Veteran or Servicemember files a claim for disability benefits.
2. A Veterans Service Representative (VSR) or Rating Veterans Service Representative (RVSR) reviews the claim. The RVSR decides the claim unless more evidence is needed.
3. If more evidence is needed, the VSR or RVSR may request a C&P examination. In that case, your role will be to conduct a C&P examination to gather clinical evidence for the claim and report it to VBA.
4. After you complete a C&P examination and report your findings to VBA, VBA decides the claim based on all evidence, including your examination report (one or more documentation protocols).
5. VBA prepares a claim decision packet and sends it via U.S. mail to the Veteran or Servicemember.
C&P Exam
STEP 1
STEP 2
STEP 3
STEP 4
STEP 5
Help
Resources
Select Next to continue
Back
Next

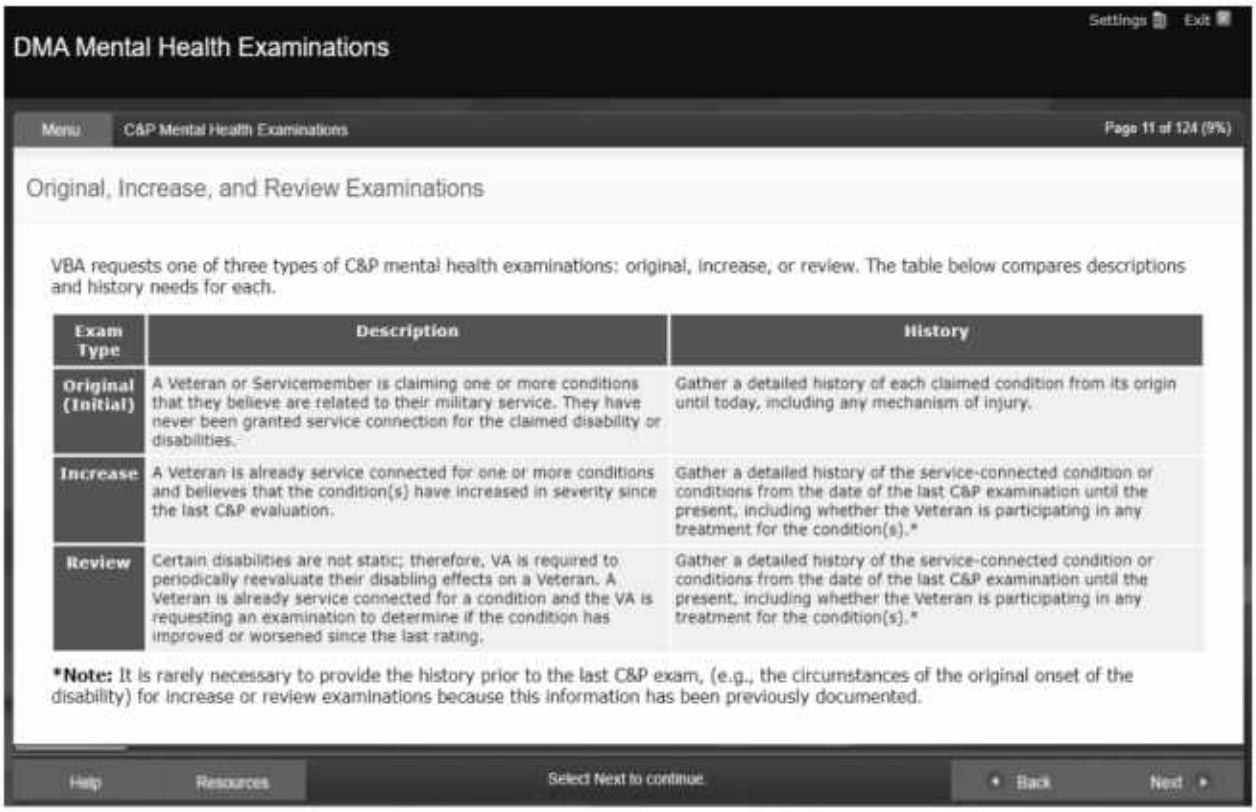

DMA Mental Health Examinations
Settings
Exit
Menu
C&P Mental Health Examinations
Page 7 of 124 (6%)
The Purpose of C&P Mental Health Examinations
One challenge faced by new examiners is changing their perspective from that of a treatment provider to that of a disability evaluator. You may ask similar questions in both clinical and C&P interviews, but the purpose of the two evaluations is different, and the information you obtain will be used in different ways.
As a clinician, you are used to conducting clinical interviews to set therapeutic goals and inform treatment planning. As a disability examiner, you'll conduct interviews to gather specific information to enable you to:
1. Establish a diagnosis or ascertain a lack thereof.
2. Describe the extent of a Veteran's or Servicemember's functional impairment.
3. Support or refute a nexus, or connection. between any diagnosed condition and their military service.
Important Note:
C&P mental health evaluations are medico-legal examinations. They are clinical in nature, but their primary use is in the adjudication of claims for disability benefits. However, C&P examinations do not require a full battery of tests to meet their objective.
Help
Resources
Select Next to continue
Back
Next

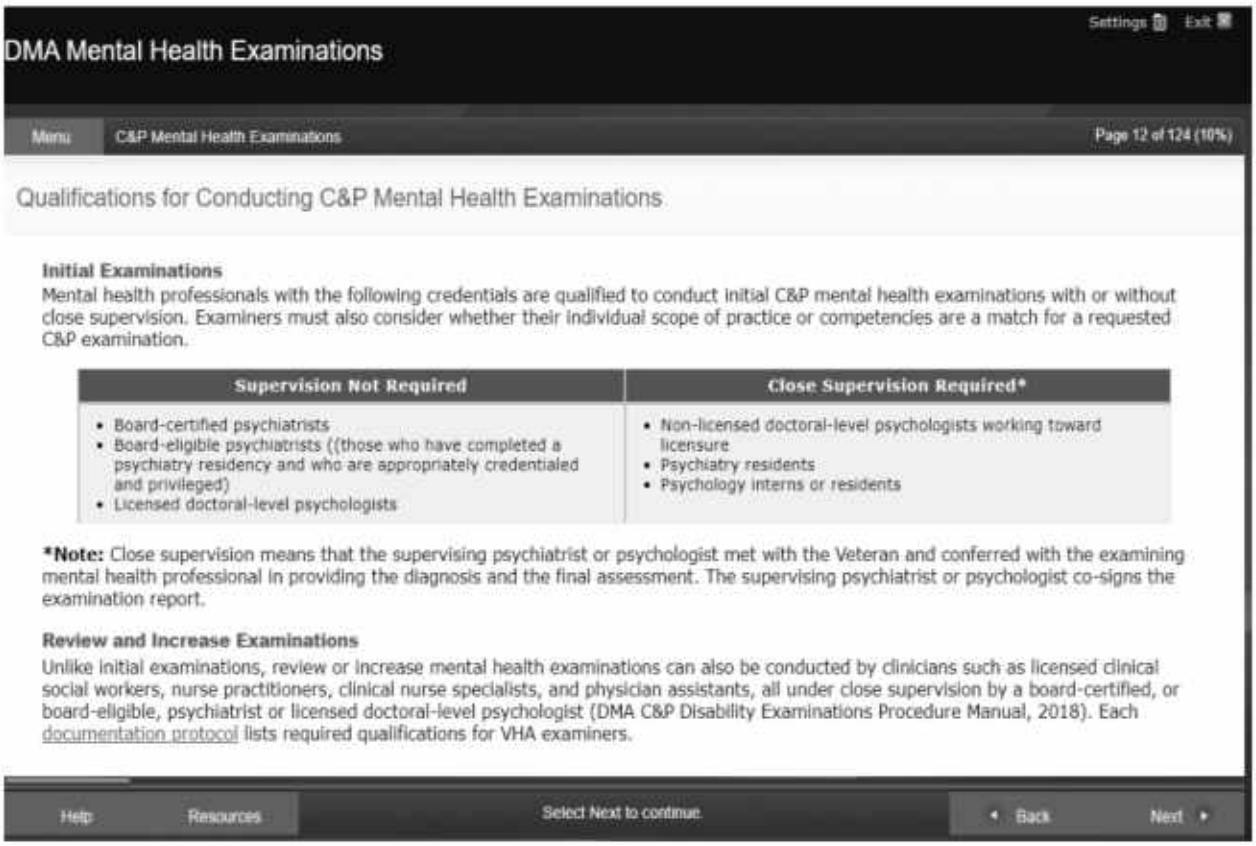

DMA Mental Health Examinations
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Menu
C&P Mental Health Examinations
Page 8 of 124 (6%)
Nexus Needs
The term "nexus" refers to a connection or link. In the context of a C&P exam, it involves establishing a connection between a currently diagnosed or claimed mental health condition and the Veteran's active duty military experiences. As you learned in the DMA General Certification Overview module, a link can be established on the basis of a direct service connection, secondary service connection, or aggravation.
VBA may ask for a specific medical opinion regarding nexus from you. As an examiner, you are required to respond using language specified by VBA, such as:
_____ is at least as likely as not (50 percent or greater probability) incurred in or caused by the event, injury, or illness.
_____ is less likely than not (less than a 50 percent probability) incurred in or caused by the event, injury, or illness.
In addition to medical opinions, there are other circumstances in which it is implicit that you should provide a comment on etiology or a nexus statement. For example, you would do this whenever you establish a new diagnosis.
Help
Resources
Select Next to continue
Back
Next


DMA Mental Health Examinations
Settings
Exit
Menu
C&P Mental Health Examinations
Page 9 of 124 (7%)
The Process of Determining a Nexus
This process of determining the nexus, or relationship of a mental health condition to service, is slightly different for mental disorder evaluations and posttraumatic stress disorder (PTSD) evaluations. For mental disorder evaluations:
1. Determine whether a mental disorder or eating disorder diagnosis is warranted per the current Diagnostic and Statistical Manual of Mental Disorders (DSM).
2. Determine if there was a related event, injury, or illness during service or if an injury/illness was aggravated by service.
3. Determine if there is a nexus between a current mental disorder and the event, injury, or illness during service.
The process of determining a nexus for PTSD will be covered later in this course.
Important Note:
Keep in mind that the determination of whether to grant service connection is made by VBA or, on appeal, by BVA. However, findings from a C&P mental health examination provide important medical information used by VBA or BVA adjudicators to decide claims fairly and correctly.
Help
Resources
Select Next to continue
Back
Next


DMA Mental Health Examinations
Settings
Exit
Menu
C&P Mental Health Examinations
Page 10 of 124 (8%)
Video: Transitioning to C&P Examinations
You may be thinking, "I'm already a psychologist or psychiatrist; just how different are C&P examinations from therapeutic evaluations?" Select Play to watch two C&P examiners discuss how they might ask the same questions in a disability exam as they would for a treatment exam but for different purposes. They also describe how to achieve a limited doctor-patient relationship, but with a Veteran-centric approach, in a C&P exam.
00:13 / 03:46
Help
Resources
Select Play to view the video, then select Next to continue.
Back
Next

Dr. Pollack and Dr. Pederzani are on hand to talk about how C&P mental health disability evaluations are different from treatment evaluations. Stacey, clinicians who are new to C&P mental health examinations are already trained and experienced in conducting examinations. What would you tell them is different about conducting mental health disability examinations? These evaluations are medical legal in nature, meaning that they are clinical exams that are used by VBA to make determinations about benefits. You are looking for different information during a mental health disability evaluation than you would want for, let's say, an intake appointment to establish treatment. A clinician taking this course might be thinking, I'm already a psychologist. What is there to know about this? The interview is gonna be the same as I normally do and the report will be the same, except I check off some boxes. So new examiners should be prepared to do things a little differently than they are used to. Yes, that's correct. At the end of a mental health disability evaluation, you should be able to establish a diagnosis or a lack thereof, describe the extent of functional impairment, and support or refute a connection between the condition and military service. So while you may ask similar questions in both clinical and C&P interviews, the purpose of your question is different. For example, for a therapeutic intake, you might ask a lot of questions and gather details about family of origin and the quality of relationships as part of determining a therapeutic approach, but for a C&P mental health exam, when you ask a Veteran about their pre-military history, you're really listening for pre-military vulnerabilities or predisposing factors that might affect your ability to verify the etiology or provide an opinion about the role that military service or experiences played in the development of the condition. Since new examiners are used to therapeutic examinations, they may wonder what approach to take with Veterans or service members in C&P mental health examinations. Dr. Pollack, what would you tell a new examiner? It's important that new examiners remain Veteran-centric in their approach to evaluations. Clinicians can remain objective while also being kind, respectful, and compassionate and remembering that disability benefits are a component of the VA mission to care for Veterans. Especially as mental health clinicians, we are in a position to recognize Veterans who may be struggling or in crisis. It's possible to find a middle path where you are not trying to treat the person but you also do not try to hurry them out the door because it's not your problem. You can be treatment-minded without becoming a treatment provider. It may be helpful to bear in mind that there a limited doctor-patient relationship for these evaluations. That being said, you are not absolved of your ethical responsibilities. I often remind new examiners of our first ethical charge to do no harm. In the context of these mental health disability evaluations, that means to me that a person should not leave my office in worse shape than when they came in. You will need all of your clinical skills to be able to quickly develop rapport, complete a thorough evaluation, and conclude the appointment in a therapeutic manner. Thank you, panelists, for explaining how goals and examiner roles are different for mental health disability and treatment evaluations while ethical responsibilities and the need for compassion are not different.


DMA Mental Health Examinations
Settings
Exit
Menu
C&P Mental Health Examinations
Page 11 of 124 (9%)
Original, Increase, and Review Examinations
VBA requests one of three types of C&P mental health examinations: original, increase, or review. The table below compares descriptions and history needs for each.
Exam Type
Description
History
Original (Initial)
A Veteran or Servicemember is claiming one or more conditions that they believe are related to their military service. They have never been granted service connection for the claimed disability or disabilities.
Gather a detailed history of each claimed condition from its origin until today, including any mechanism of injury.
Increase
A Veteran is already service connected for one or more conditions and believes that the condition(s) have increased in severity since the last C&P evaluation.
Gather a detailed history of the service-connected condition or conditions from the date of the last C&P examination until the present, including whether the Veteran is participating in any treatment for the condition(s).*
Review
Certain disabilities are not static; therefore, VA is required to periodically reevaluate their disabling effects on a Veteran. A Veteran is already service connected for a condition and the VA is requesting an examination to determine if the condition has improved or worsened since the last rating.
Gather a detailed history of the service-connected condition or conditions from the date of the last C&P examination until the present, including whether the Veteran is participating in any treatment for the condition(s).*
*Note: It is rarely necessary to provide the history prior to the last C&P exam, (e.g., the circumstances of the original onset of the disability) for increase or review examinations because this information has been previously documented.
Help
Resources
Select Next to continue
Back
Next


DMA Mental Health Examinations
Settings
Exit
Menu
C&P Mental Health Examinations
Page 12 of 124 (10%)
Qualifications for Conducting C&P Mental Health Examinations
Initial Examinations
Mental health professionals with the following credentials are qualified to conduct initial C&P mental health examinations with or without close supervision. Examiners must also consider whether their individual scope of practice or competencies are a match for a requested C&P examination.
Supervision Not Required
Close Supervision Required*
• Board-certified psychiatrists
• Board-eligible psychiatrists ((those who have completed a psychiatry residency and who are appropriately credentialed and privileged)
• Licensed doctoral-level psychologists
• Non-licensed doctoral-level psychologists working toward licensure
• Psychiatry residents
• Psychology interns or residents
*Note: Close supervision means that the supervising psychiatrist or psychologist met with the Veteran and conferred with the examining mental health professional in providing the diagnosis and the final assessment. The supervising psychiatrist or psychologist co-signs the examination report.
Review and Increase Examinations
Unlike initial examinations, review or increase mental health examinations can also be conducted by clinicians such as licensed clinical social workers, nurse practitioners, clinical nurse specialists, and physician assistants, all under close supervision by a board-certified, or board-eligible, psychiatrist or licensed doctoral-level psychologist (DMA C&P Disability Examinations Procedure Manual, 2018). Each documentation protocol lists required qualifications for VHA examiners.
Help
Resources
Select Next to continue
Back
Next

DMA Mental Health Examinations

Settings Exit

Menu C&P Mental Health Examinations Page 13 of 124 (10%)

Modes of Evaluation

C&P mental health examinations are conducted either face-to-face or via telemental health technology.

Although many mental health disability examinations are performed face-to-face, VBA has implemented a policy to accept telemental health disability examinations as sufficient for rating purposes for original, increase, or review examinations for mental disorders. VHA, or VBA contractors, are ultimately responsible for deciding whether an examination will be conducted via telemental health technology. This decision will take into account the availability of local resources and access to approved technology, both at the facilities used by the examiner as well as by the Veteran or Servicemember.

In order to assess a Veteran's or Servicemember's mental health via telemental protocol, examiners must be able to see clearly and fully appreciate all

- non-verbal cues,
- mannerisms, and
- manifestations displayed by the Veteran or Servicemember in a manner on par with an in-person examination.

A telephone interview is not permissible for a C&P mental health examination. (DMA Fact Sheet 20-002, Telehealth for Compensation and Pension (C&P) Examinations)



Help Resources Select Next to continue Back Next

DMA Mental Health Examinations

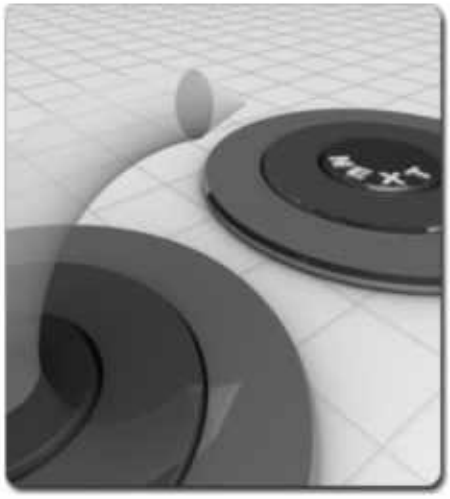
Settings Exit

Menu C&P Mental Health Examinations Page 15 of 124 (12%)

Lesson 1 Summary

This lesson reviewed the C&P claims process. It compared the purposes of therapeutic mental health examinations with those of initial C&P mental health examinations. C&P initial mental health examinations require you to establish a diagnosis or lack thereof, describe the extent of a Veteran's or Servicemember's functional impairment, and support or refute a nexus between any diagnosed condition and Veteran's or Servicemember's military service. The purposes of increase and review C&P mental health examinations were also covered. In addition, this lesson described qualifications needed to conduct C&P mental health examinations. You can use what you've learned to:

- understand your role in the C&P claim process
- transition from conducting evaluations for treatment to evaluations for C&P disability claims
- adhere to eligibility requirements for conducting C&P examinations



Help Resources Select Next to continue Back Next

DMA Mental Health Examinations

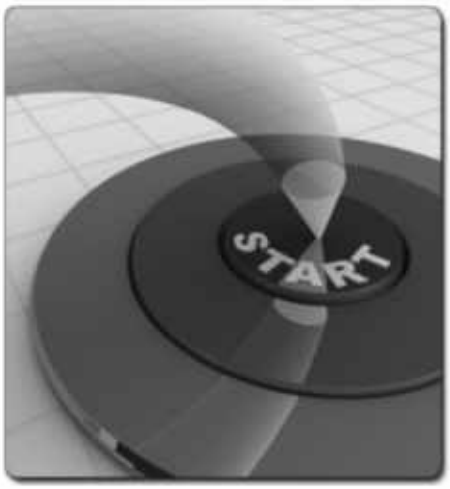
Settings Exit

Menu | Preparing for a C&P Mental Health Examination | Page 16 of 124 (13%)

Lesson 2 Overview

This lesson will describe the documentation that mental health disability examiners review in preparation for a C&P mental health examination. As an examiner, you'll need to review the Request for Examination, the Veteran or Servicemember's claims file, and the documentation protocol(s) for the examination before you conduct the examination. This lesson will describe the kinds of information examiners gather from this documentation review and use for the examination.

Preparing for an examination also means preparing to complete documentation protocols that are aligned with DMA's clinical quality standards for C&P mental health examinations. Contractors have similar standards. To help you understand how clinical quality standards are applied for C&P mental health examinations, this lesson will include relevant information from the *Retrospective Chart Review for C&P Mental Health Providers*.



Help | Resources | Select Next to continue | Back | Next

DMA Mental Health Examinations

Settings Exit

Menu | Preparing for a C&P Mental Health Examination | Page 17 of 124 (14%)

The Request for Examination

When a C&P examination is needed, the Veterans Benefits Administration (VBA) will transmit a Request for Examination to a C&P clinic or to the equivalent Integrated Disability Evaluation System (IDES) clinic. Examiners may refer to this form as a "2507," its form number at VA. VBA sends an examination scheduling request (ESR) to VBA Contractors.

The Request for Examination provides information about the C&P examination, including:

- the examination type: original, increase, or review
- recommended documentation protocols to use (Mental Disorders, Eating Disorders, Initial or Review PTSD)
- specific information VBA may be providing or highlighting for the examiner's consideration
- specific questions to answer for VBA

You must thoroughly review all parts of a Request for Examination before the examination appointment. The "General Remarks" section provides specific instructions for the examination and it may direct you to pertinent information to review for the exam.

If you have questions about requirements or information in a Request for Examination, you should contact the requesting representative (identified in the Request) before the examination, if possible. By doing this, you can avoid having your examination report returned for further information.

DMA clinical quality standards apply for addressing requirements and requests on an examination request.

Tip

Examiners should also check the Request for Examination while completing their examination report to ensure they provide all information requested by VBA.

Help | Resources | Select Next to continue | Back | Next

DMA Mental Health Examinations

Settings Exit

Menu | Preparing for a C&P Mental Health Examination | Page 18 of 124 (15%)

Why Examiners Review Documentation

As a C&P examiner, you need to review documentation for a Veteran's or Servicemember's claim because not all of the information you need for a mental health disability examination will come from examination findings. You need to determine 1) what diagnosis, if any, accounts for the claimed condition or symptoms, and 2) whether the condition can be connected to a claimant's time in service.

To determine whether a condition can be connected to service often requires an examiner to use their clinical training and experience to trace the onset and course of a condition, taking into account any evidence in the claims file (C-file). The C-file will often be in digital form and called an eFolder. Later, you will learn in more detail what evidence and records may be contained in the eFolder.

The Request for Examination may ask the examiner if a diagnosed condition can be related to service in the form of direct service connection, secondary service connection, or aggravation based on all the evidence an examiner evaluates.

Help | Resources | Select Next to continue | Back | Next

DMA Mental Health Examinations

Settings Exit

Menu | Preparing for a C&P Mental Health Examination | Page 19 of 124 (15%)

Case Study: An Initial Mental Disorders Examination

The next few lessons will feature a case study supported by videos to demonstrate aspects of preparing for, conducting, and documenting a C&P mental health examination.



Michael Jones served in the Marine Corps from 1975-1980. He has filed a claim with VBA for service connection of depression and anxiety.

Important Note:
The case-study Veteran and examiner are both fictional and not intended to resemble a specific examiner, Veteran, or Servicemember.



A C&P examiner, Dr. Courtney Smith, will conduct an initial Mental Disorders examination with Mr. Jones. The examination process will begin with reviewing documentation for the examination.

Help | Resources | Select Next to continue | Back | Next

DMA Mental Health Examinations

Settings Exit

Menu | Preparing for a C&P Mental Health Examination | Page 20 of 124 (16%)

Information Gathered from the Request for Mr. Jones's Examination

The examiner reviewed the Request for Examination for Mr. Jones's exam. Here is what she learned:

- Mr. Jones is 63 years old. He served in the Marine Corps from 1975-1980.
- He is already service connected for a back injury he incurred while in service.
- Mr. Jones filed a claim for depression and anxiety.
- VBA is requesting an initial Mental Disorders examination.
- VBA is asking if Mr. Jones's claimed depression and anxiety are at least as likely as not secondary to his service-connected back injury.

The following pages will provide additional guidance about how you can gather similar information in preparation for C&P mental health examinations.



Help | Resources | Select Next to continue. | Back | Next

DMA Mental Health Examinations

Settings Exit

Menu | Preparing for a C&P Mental Health Examination | Page 21 of 124 (17%)

Reviewing Records

You must review the Veteran's or Servicemember's eFolder and any other available medical records for a C&P mental health examination. A best practice is to review records before the examination and again as you complete the documentation protocols(s) for the examination. Veterans Health Administration (VHA) examiners access the eFolder through the Veterans Benefits Management System (VBMS) and contract examiners use their own proprietary systems. The eFolder contains private and sensitive information such as:

- service personnel records
- service treatment records
- other medical records (from VA, private sources, or both)
- lay statements from the claimant and their family, and/or friends
- records pertaining to the current and previous C&P claims

Reviewing an eFolder allows you to gain an understanding of the Veteran's or Servicemember's claim and history before the examination.

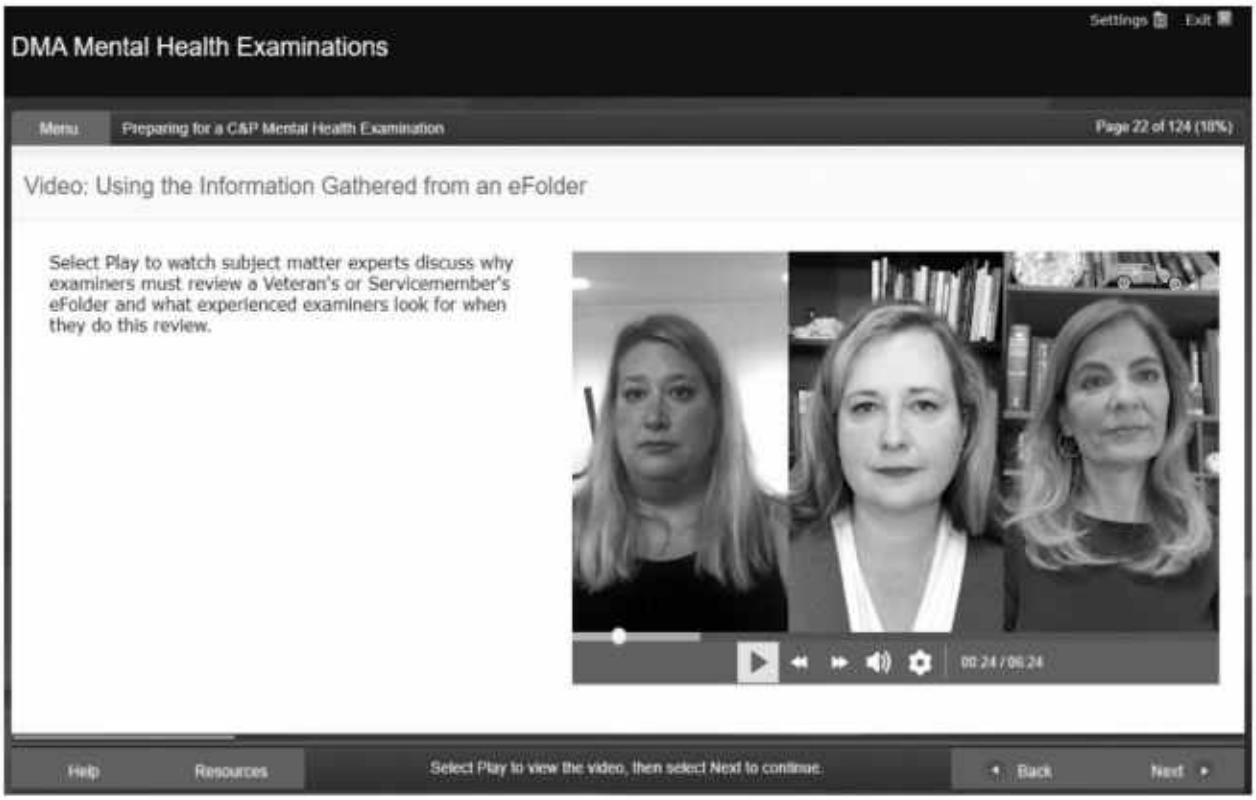
Tabbed Evidence

Sometimes certain information in the eFolder is tabbed (i.e., flagged) by VBA because it is viewed as especially pertinent to the present claim. However, regardless of any tabbing, you remain responsible for reviewing the entire eFolder, not just the tabbed material.

Tip:

How much time an examiner needs to spend reviewing records depends on the amount of information provided in the eFolder and the complexity of the case.

Help | Resources | Select Next to continue | Back | Next



Three panelists have joined me to talk about why examiners review a Veteran's claim file or e-folder for C&P mental health evaluations. They are Dr. Stacy Pollack, Dr. Courtney Pederzani, and Tina Skelly of VBA. Stacy and Courtney were introduced earlier in this course. Tina Skelly has 24 years of C&P experience, including 12 years at the regional office level, serving in both non-supervisory and supervisory roles, and 12 years at VBA central office, located within the VA central office or VACO.Ms. Skelly has been a subject-matter expert on numerous DMA training courses related to C&P. Tina, C&P examiners are required to review the Veterans or service members claims file for every mental health examination. What is the purpose of this review requirement? What does VBA expect clinicians to learn from reviewing the claims file? Reviewing the claims folder helps VBA ensure that the examiner is given the fullest evidentiary picture possible. The claims folder often contains a history of treatment of the disability. It can contain both medical and non-medical evidence that may be relevant to the examiner. In order to provide an adequate basis for the findings and conclusions of an examination, the examiner needs access to the history. Thank you, Tina. Stacy and Courtney, what kinds of information are mental health disability examiners looking for when they review a claims file? It's always important to be aware of the contention, what is being claimed and what is the relationship to service that is at question. You should keep in mind what VBA is asking you to consider, because that may guide you towards the information that is most critical in making a connection, if any, between the condition and military service. A lot of the time, the ability to provide a given medical opinion is based on the chronology. When did the symptoms have onset? What was the course of those symptoms over time? Does this correspond to the timeframe of the in-service event or injury? An important source of information can be the paperwork a Veteran completed at the time they entered military service, as compared to the same paperwork that they completed at the time of discharge. Are there symptoms that were not there

when they enlisted, but are there at discharge? But you have to keep everything in context. Sometimes a Veteran might not admit to a symptom or condition if they are focused on getting out and home as soon as possible. So this process is about weighing the evidence and taking all of the factors into consideration. This is why reviewing the full record is so important. But you shouldn't discount the Veterans own perspective. You shouldn't have your mind made up only on the basis of the record review. I like to have the broad strokes down when I go into an interview. I want to have enough information that I can consider the consistency of their self-report as compared to the documentation that's available. If there are discrepancies, that's important to know. And if you don't realize there's a discrepancy until after they leave, it will be very difficult to reconcile. It's better if you can go into the interview with a sense of what information is missing that you need to have by the time you're done with the conversation. Examiners should expect to review records and documentation, both before and after meeting with a Veteran. You won't be able to read the records one time and predict what evidence will wind up being the most critical. You want to feel prepared, but remain open during the interview and come back to the records afterwards, as you're tying everything together. Thank you, Stacy and Courtney. Tina, sometimes VBA tabs certain specific information in the e-folder for clinicians to review. Why is that? VBA examination requesters will often tab pertinent evidence for ease in the examiner's review of Veteran's claims folders in formulating requested medical opinions and assessments. This is provided to assist the examiner in locating potentially relevant evidence. However, the examiner's review is not limited to the evidence identified on the request form or tabbed in the claims folder. Adjudicators are extremely well versed in the processes of developing a claim. Adjudicators are not, however, clinical professionals. They're therefore not qualified or competent to know what evidence is necessary to the examiner. While tabbing pertinent medical evidence is important for ease in a examiner's review of pertinent evidence, a complete review of the records must still be done since adjudicators are not clinical experts and may miss tabbing an important piece of evidence. It's important for the examiners to know that VBA's tabbing of evidence, in no way, relieves them of their individual responsibility to review all the evidence and determine which pieces of that evidence are pertinent to the question or questions at hand. And to include that evidence in the examination report. VBA sometimes identifies records or evidence that they want examiners to specifically address. And if that is the case, it is very important that examiners do so. You would find this in the examination request. It's also important that examiners do not rely just on evidence that is tabbed or identified for them. It may not be all of the evidence that is relevant to the mental health evaluation. Our clinical training allows us to recognize signs and symptoms of mental health conditions that a lay person would not see. And it might make all the difference to a Veteran's claim. Thank you, Tina, Courtney and Stacy, for explaining for new examiners taking this course, not only why they are required to review a Veteran's entire claims file, but how they benefit from reviewing it before and after an exam. Examiners can use the information they gather to provide a better evaluation.

DMA Mental Health Examinations

Settings Exit

Menu | Preparing for a C&P Mental Health Examination | Page 23 of 124 (19%)

The Examiner's Review of Records

After reviewing the Request for Examination, the examiner reviewed Mr. Jones's eFolder to find answers to some of her questions:

- When did Mr. Jones injure his back?
- Is there anything in Mr. Jones's record that indicates mental health care or a diagnosis of a mental disorder during military service?
- Has Mr. Jones received mental health treatment at the VA?
- Has Mr. Jones received mental health treatment outside of the VA system or at the Vet Centers?

From reviewing his records, the examiner learned that Mr. Jones served stateside when he was in the military. She reviewed medical records indicating that Mr. Jones injured his back and that he separated from service shortly afterward. She found no records indicating that Mr. Jones sought mental health treatment while he was in the service or afterward.

Having reviewed the Veteran's records, the examiner will proceed to review the requested documentation protocol(s). The following pages will describe in more detail how you might review documentation protocols in preparation for C&P mental health examinations.



Help | Resources | Select Next to continue | Back | Next

DMA Mental Health Examinations

Settings Exit

Menu | Preparing for a C&P Mental Health Examination | Page 24 of 124 (19%)

Review the Appropriate Documentation Protocol

VBA uses criteria in the Code of Federal Regulations (CFR) for rating disabilities found in 38 CFR Part 4, the VA Schedule for Rating Disabilities (VASRD). Documentation protocols are templates used by examiners to report C&P exam findings and they reflect the CFR criteria. Documentation protocols are currently called Disability Benefits Questionnaires (DBQs).

As a C&P examiner, you must conduct a thorough assessment in order to fulfill the purposes and needs of the examination and file an adequate report. As a practical matter, however, it is possible to have a perfect examination from a medical perspective, but if the resulting report does not supply information that VBA needs, it is insufficient from an adjudication perspective.

Hence, documentation protocols are used to provide a standardized format for mental health examination reports and ensure that the pertinent results of the examination are fully captured for consideration by the VBA adjudicative staff. They are not meant to guide the sequence of the examination itself, only to provide a framework for documenting the examination findings.

If you are within the VA network, you can access and view C&P mental health documentation protocols from the Disability Benefits Questionnaire Switchboard website. Contract examiners will be supplied these documentation protocols by their leadership.

Important Note:

A fully completed documentation protocol is important evidence for a Veteran's or Servicemember's claim. However, adjudicative staff decide each claim based on all evidence of record, not just the evidence in a completed documentation protocol.

Help | Resources | Select Next to continue | Back | Next

Settings Exit

DMA Mental Health Examinations

Menu | Preparing for a C&P Mental Health Examination | Page 25 of 124 (20%)

Mental Health Documentation Protocols

The documentation protocols for C&P mental health examinations are:

1. Mental Disorders (Initial and Review)
2. Eating Disorders (Initial and Review)
3. Initial PTSD
4. Review PTSD

Separate mental health documentation protocols exist because VBA adjudicators need slightly different information when rating each type of claim. Eating Disorders have rating criteria that are separate from other mental health diagnoses, and this is reflected in the content of the associated documentation protocol. Although PTSD and other Mental Disorders share the same rating criteria, PTSD claims require specific elements to be addressed for adjudication purposes and having separate documentation protocols ensures that this information will be clearly documented.

The Initial PTSD documentation protocol is used for the initial examination for service connection of a Veteran's or Servicemember's claim of PTSD. The Review PTSD documentation protocol is used for review or increase examinations of previously service-connected PTSD. In comparison, Mental Disorders and Eating Disorders examinations use the same documentation protocol for initial, increase, and review examinations.

Tip

The case study examiner will review the Mental Disorders documentation protocol that VBA recommended, before she conducts Mr. Jones's exam, to verify the information she will need to document for adjudicators.

Help | Resources | Select Next to continue | Back | Next

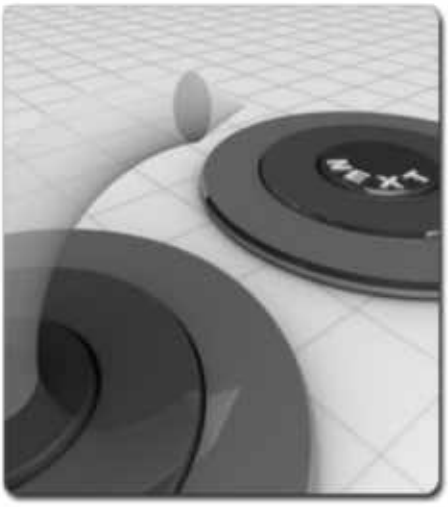
Settings Exit

DMA Mental Health Examinations

Menu | Preparing for a C&P Mental Health Examination | Page 27 of 124 (22%)

Lesson 2 Summary

This lesson explained requirements for reviewing the Request for Examination, the Veteran's or Servicemember's eFolder, and documentation protocol(s) for every C&P mental health examination. Practicing C&P examiners gave examples of how they use information they gather from this review. Since you've completed this lesson, you can use what you've learned to review examination-related documentation with the goals of the examination in mind.



Help | Resources | Select Next to continue | Back | Next

DMA Mental Health Examinations

Settings Exit

Menu | Conducting the Examination | Page 28 of 124 (23%)

Lesson 3 Overview

This lesson will focus on requirements and guidelines for conducting C&P mental health examinations to ensure the goals of the examination are met. It will explain policies regarding a Veteran's or Servicemember's right to request an examiner of a particular gender and provide reasons you should be familiar with military terms and culture. This lesson will also have recommendations for interacting with Veterans and Servicemembers, including keeping both the examiner and the Veteran or Servicemember focused on the goals of the interview. Videos based on the case study with Mr. Jones will demonstrate:

- opening the examination
- taking the history for an original (initial) examination
- evaluating for a nexus between a current mental disorder and circumstances of military service
- assessments for diagnostic purposes, social and occupational impairment, and suicide risk

In addition, this lesson will provide information and resources for behavioral observations, evaluating social and occupational impairment, and assessing suicide risk. It will also point out DMA mental health clinical quality standards that apply to information an examiner gathers and reports.



Help | Resources | Select Next to continue | Back | Next

DMA Mental Health Examinations

Settings Exit

Menu | Conducting the Examination | Page 29 of 124 (23%)

Gender Preference

C&P examiners must be aware that a Veteran's or Servicemember's request for an examiner of a specific gender must be honored. Being sensitive to the claimant's preference for the gender of the examiner is a practice used by VA to support Veterans and Servicemembers who participate in C&P examinations.

For examination requests involving sensitive claims such as military sexual trauma (MST), the Veteran or Servicemember must be specifically asked if there is a preference of gender for the examination.

If a provider of the preferred gender is not available at a particular location, C&P leadership should make reasonable attempts to accommodate the request such as arranging for the exam to be done at another location or employing the use of telehealth technology.



Help | Resources | Select Next to continue | Back | Next

DMA Mental Health Examinations

Settings Exit

Menu | Conducting the Examination | Page 30 of 124 (24%)

Military Terminology and Culture

Your familiarity with military terminology and culture is an important factor that may affect the quantity and quality of information you obtain during a C&P examination. You should have at least a basic knowledge of military culture, including:

- service branches (i.e., Air Force, Navy, Army, Marine Corps, Coast Guard, Space Force)
- service eras (e.g., World War II, Vietnam War, Gulf War, peacetime)
- military occupational specialties (MOS) and their roles (e.g., combat, combat support, administrative)
- official and slang military terms (e.g., activation - an official term for ordering to active duty and bird - slang term for helicopter)

Although a mental health examination is objective, you must show the Veteran or Servicemember all due courtesy and consideration, including being culturally competent in your interactions.

Online training courses about military culture are available on the VA TMS and the TRAIN Learning Network. *Community Care Provider - a Perspective for Veteran Care* is available on the VA TMS (ID 38603). In addition, self-study courses developed by the Veterans Health Administration (VHA) can be accessed on the VHA Train website.



U.S. Air Force Trainees in Basic Training (DVIDS, 2020)

Tip:

If you find yourself unfamiliar with terminology, deployment location or other information a Veteran or Servicemember provides, ask as many questions as needed to make sure you have a full understanding of the information. This practice will also help you establish and maintain rapport.

Help | Resources | Select Next to continue | Back | Next

DMA Mental Health Examinations

Settings Exit

Menu | Conducting the Examination | Page 31 of 124 (25%)

Introduction Considerations

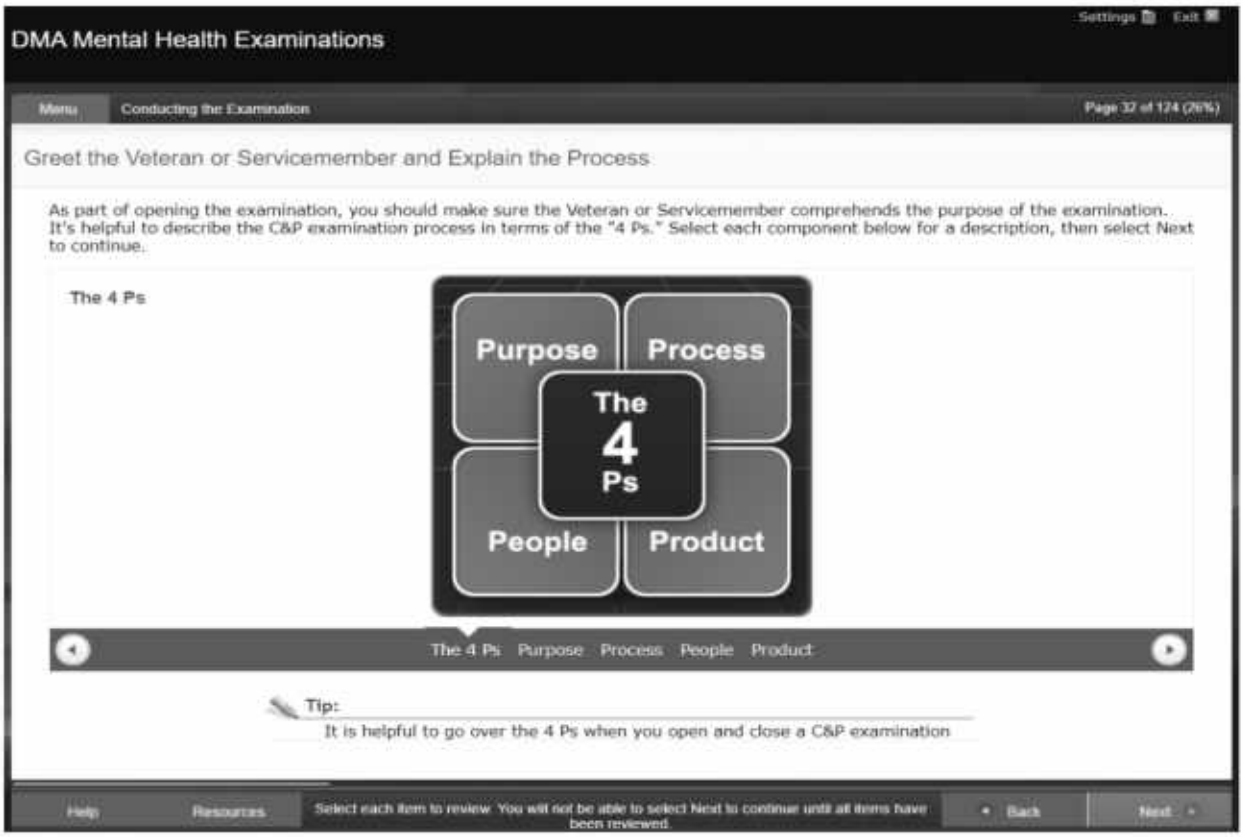
Before proceeding with the examination, it is critical for mental health disability examinations to determine whether the Veteran or Servicemember is able to adequately comprehend the purpose, nature, and scope of the evaluation. This is especially important if the Veteran or Servicemember has an identified neurocognitive disorder, including traumatic brain injury (TBI). In this case, you should be alert to any cognitive impairment or deficits in comprehension and document them in the examination report.

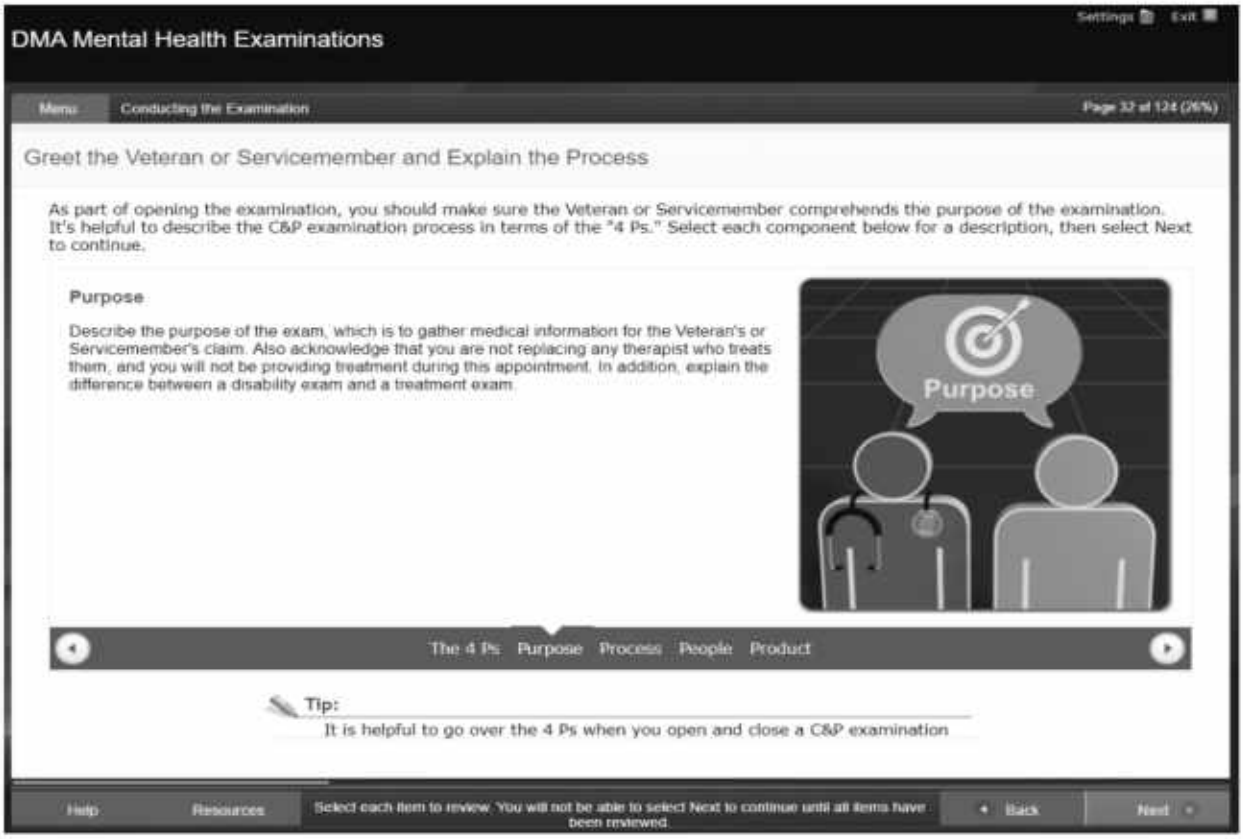
As a mental health examiner, you are not responsible for conducting a TBI Residuals evaluation as part of a mental health disability evaluation, but it is best practice to contact the VA Regional Office (VARO or RO) or your supervisor if you have concerns about a Veteran's or Servicemember's ability to understand the purpose and scope of the examination.

Tip:

TBI can only be diagnosed for C&P purposes by a clinician who is Board certified or Board eligible in physiatry, neurology, neurosurgery, or psychiatry. A psychiatrist certified to complete TBI evaluations may complete a TBI Residuals evaluation and documentation protocol if appropriate.

Help | Resources | Select Next to continue | Back | Next


DMA Mental Health Examinations
Settings
Exit
Menu
Conducting the Examination
Page 32 of 124 (26%)
Greet the Veteran or Servicemember and Explain the Process
As part of opening the examination, you should make sure the Veteran or Servicemember comprehends the purpose of the examination. It's helpful to describe the C&P examination process in terms of the "4 Ps." Select each component below for a description, then select Next to continue.
The 4 Ps
Purpose
Process
The
4
Ps
People
Product
The 4 Ps
Purpose
Process
People
Product
Tip:
It is helpful to go over the 4 Ps when you open and close a C&P examination
Help
Resources
Select each item to review. You will not be able to select Next to continue until all items have been reviewed.
Back
Next


DMA Mental Health Examinations
Settings
Exit
Menu
Conducting the Examination
Page 32 of 124 (26%)
Greet the Veteran or Servicemember and Explain the Process
As part of opening the examination, you should make sure the Veteran or Servicemember comprehends the purpose of the examination. It's helpful to describe the C&P examination process in terms of the "4 Ps." Select each component below for a description, then select Next to continue.
Purpose
Describe the purpose of the exam, which is to gather medical information for the Veteran's or Servicemember's claim. Also acknowledge that you are not replacing any therapist who treats them, and you will not be providing treatment during this appointment. In addition, explain the difference between a disability exam and a treatment exam.
Purpose
The 4 Ps
Purpose
Process
People
Product
Tip:
It is helpful to go over the 4 Ps when you open and close a C&P examination
Help
Resources
Select each item to review. You will not be able to select Next to continue until all items have been reviewed.
Back
Next

DMA Mental Health Examinations

Settings Exit

Menu | Conducting the Examination | Page 32 of 124 (26%)

Greet the Veteran or Servicemember and Explain the Process

As part of opening the examination, you should make sure the Veteran or Servicemember comprehends the purpose of the examination. It's helpful to describe the C&P examination process in terms of the "4 Ps." Select each component below for a description, then select Next to continue.

Process

Remind the Veteran or Servicemember that they filed a claim with the Veterans Benefits Administration (VBA). Explain that VBA has ordered the examination as one source of information for deciding the Veteran's claim. As the examiner, you'll interview the Veteran or Servicemember to gather the information VBA needs as a part of their decision-making process.



The 4 Ps: Purpose | Process | People | Product

Tip:
It is helpful to go over the 4 Ps when you open and close a C&P examination

Help | Resources | Select each item to review. You will not be able to select Next to continue until all items have been reviewed. | Back | Next

DMA Mental Health Examinations

Settings Exit

Menu | Conducting the Examination | Page 32 of 124 (26%)

Greet the Veteran or Servicemember and Explain the Process

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People

List the people involved in the claim process and their role:

- the Veteran or Servicemember pursuing their claim
- you, as an examiner, an independent medical resource
- the people at VBA or the Board of Veterans' Appeals (BVA) who are working on their claim



The 4 Ps: Purpose | Process | People | Product

Tip:
It is helpful to go over the 4 Ps when you open and close a C&P examination

Help | Resources | Select each item to review. You will not be able to select Next to continue until all items have been reviewed. | Back | Next

DMA Mental Health Examinations

Settings Exit

Menu | Conducting the Examination | Page 32 of 124 (26%)

Greet the Veteran or Servicemember and Explain the Process

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Product

Explain the purpose of the documentation protocol and that you will be taking notes during the examination to ensure that you accurately capture what the Veteran or Servicemember is telling you.

Point out that after the examination, you'll complete the documentation protocol, or examination report, and submit it to VBA. In turn, VBA will use the report and all the other information they've gathered to make a determination on the Veteran's or Servicemember's claim and notify them directly.



The 4 Ps | Purpose | Process | People | Product

Tip:

It is helpful to go over the 4 Ps when you open and close a C&P examination

Help | Resources | Select each item to review. You will not be able to select Next to continue until all items have been reviewed. | Back | Next

DMA Mental Health Examinations

Settings Exit

Menu | Conducting the Examination | Page 33 of 124 (27%)

Preparing for the Interview

The examination is likely to be the first and only time a C&P examiner meets a Veteran or Servicemember. Experienced C&P mental health examiners take a few moments to prepare the Veteran or Servicemember for a mental health disability examination. Here are some recommendations to help prepare them for the exam:

1. Acknowledge that you've reviewed the Veteran's or Servicemember's records, but you still need to hear from them about current and past symptoms, problems, and how they are functioning.
2. Explain that you have a limited amount of time to obtain a lot of specific information needed by VBA, so it may be necessary to redirect the Veteran or Servicemember now and then to make sure you get information to support their claim.
3. Acknowledge that some of the questions you ask may cause discomfort.
4. Always ask the Veteran or Servicemember if they have any questions before you begin the examination. Inviting and answering questions can help make sure they understand the purpose of the examination and establishes an open and collaborative tone for the conversation.

Tip:

Some Veterans and Servicemembers may find it difficult to disclose emotional and behavioral issues with an examiner because of cultural and individual factors, as well as the potential for stigma. For these reasons, avoid an authoritarian role, avoid judgmental questions, and remain objective and unbiased. It is also helpful to establish rapport by initially focusing on current life experiences or other discussion to encourage comfort in the interview.

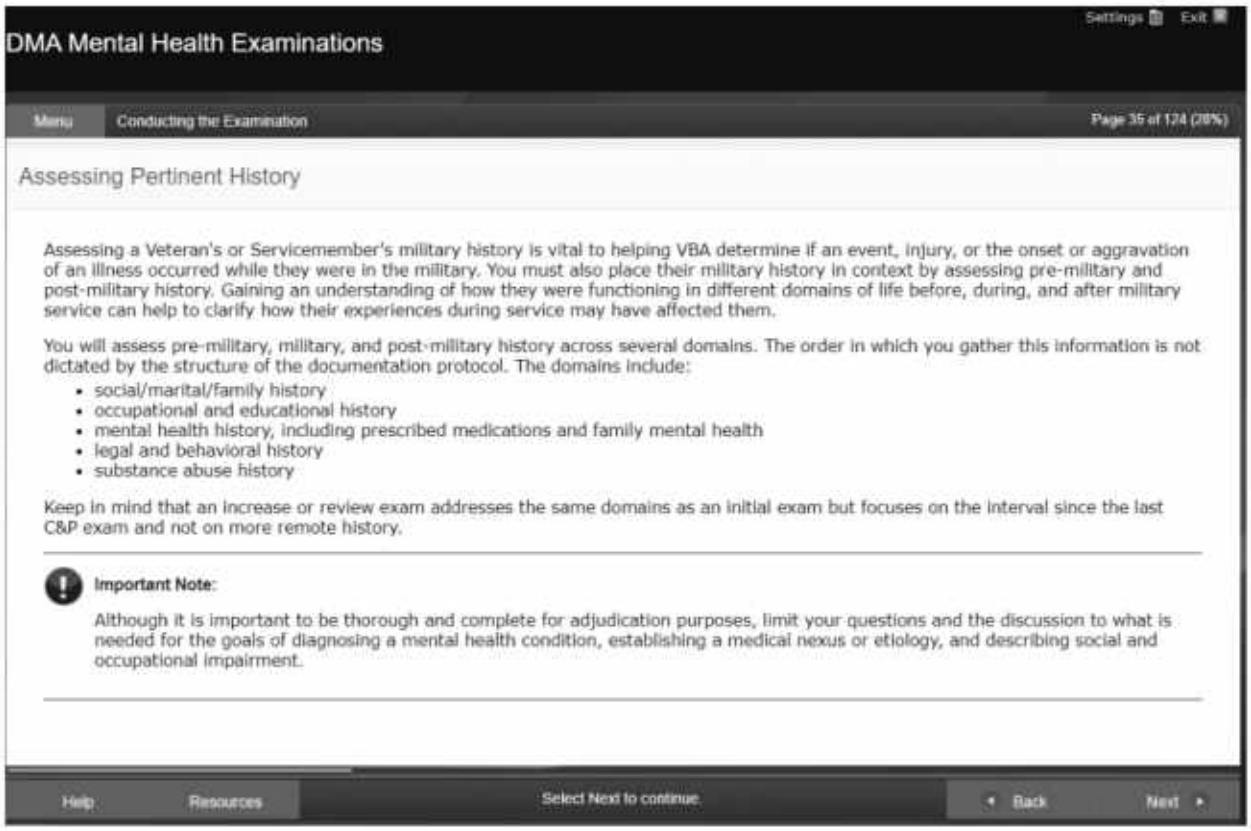
Help | Resources | Select Next to continue. | Back | Next

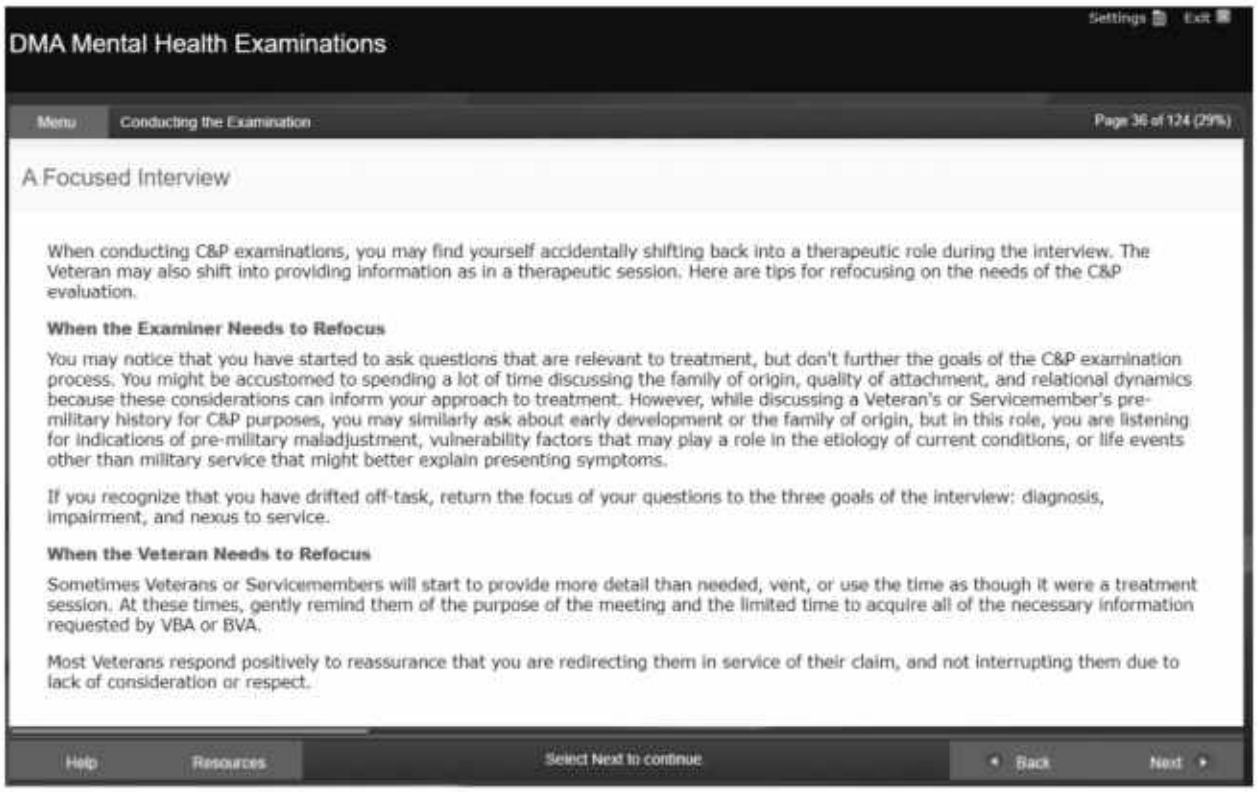


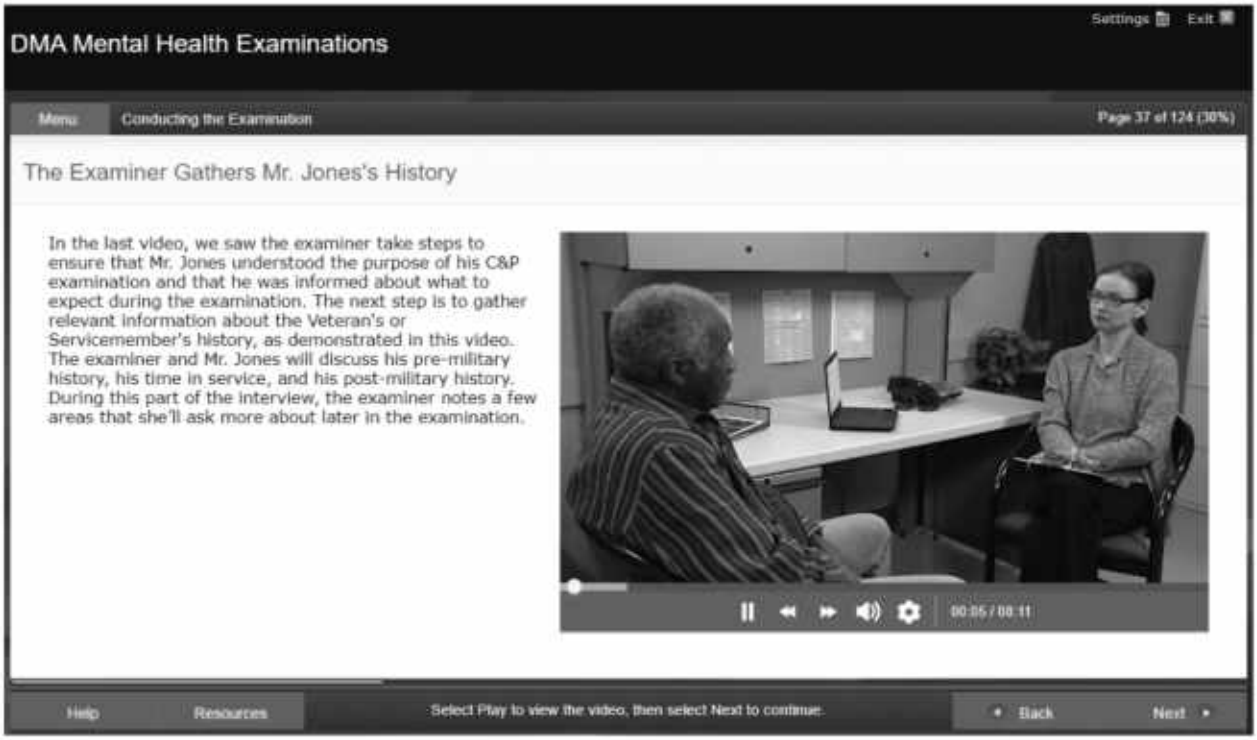
Good morning, Mr. Jones. Thank you so much for coming in today. Sure. I'm Dr. Smith. I'm a psychologist here at the VA Medical Center. Before we get started, I always like to check in with folks to see if they know why we're meeting and what this appointment is for. What's your understanding of why we're meeting? Well, I thought I was here to get a therapist, but when I checked in, they said this was compensation and pension. Sounds like that might've been confusing. Let me explain the purpose of this appointment and how we'll be spending our time today. It's important you understand this appointment is not to provide treatment, although before you leave, I'll make sure you have access to information about accessing mental health care at the VA. This appointment is to address your claim that was filed for compensation benefits for depression, specifically depression that may be related to your time in the military, which we often refer to as service connected. Does that sound familiar? Yeah I remember I did some paperwork with someone from the VFW. That's right. Some Veterans file their claims online. Others mail in a paper application. Others work with Veteran service organizations, like you did. Once the claim has been filed with the VA Benefits Administration, they often need an in-person exam to make sure they have all the information they need to make a determination about your claim. And that's what we'll be doing today, a mental disorders examination. Any questions so far? Yeah. I'm a little nervous about this. What exactly is this, what's involved in this mental, what is it? Mental disorders exam. Exam?

Yes. Let me tell you what we're gonna do today. Okay. So, we're just gonna have a conversation. We'll talk for maybe an hour, hour and a half, depending on how much ground we have to cover. I'll ask you about your life before service. I'll cover the details of your military service. And then, we'll spend most of

our time talking about how you're doing, mentally, emotionally, what symptoms you're experiencing, when they started, how that affects your day-to-day life. I'll be checking a form off and on to make sure I'm covering all the questions that need to be asked. I reviewed your records this morning before we met, and I'll go over them again afterwards to make sure I didn't miss anything. I'll summarize that information along with what you and I talk about today. And the report I write will be sent over to the Veterans Benefits Administration where they make all the decisions about claims. The report is just one source of information they consider. We don't make any decisions about your claim here at the medical center. Does that help in terms of understanding the process and kind of what we'll be doing with our time today? Yeah, I just, since I never done this before, I just, I wasn't certain about the process, but I think you explained everything. You write a report, but you don't have anything to do with whether my claim is accepted or not. That's correct. So my part of the process is to make sure I understand, from talking to you today, the problem you're having, in terms of mental health, and to see if there's a connection between what you're experiencing today and what you experienced during service. But how will you know what happened during the service? I mentioned, I reviewed your records this morning. The records are stored in an electronic claims file that contains all of the documents related to your claim, your military service records, any treatment you had during service and any statements you submitted, including the initial claim. Sometimes, it also includes copies of any treatment you may have received outside of VA or outside of the military, which I don't think it's the case in your situation. At least, I didn't see anything like that. So if everything is already in my C file, why are we doing this? Why are we going through this? Yeah, that's a good question. Even though there's a lot of information in there that's related to things I need to ask you, it's important we meet face to face so I can hear from you directly and also to make sure all the requirements of the mental disorder exam are being met. Okay. Makes sense. Any other questions before we start? No. Okay. Feel free to ask anything as we go along.

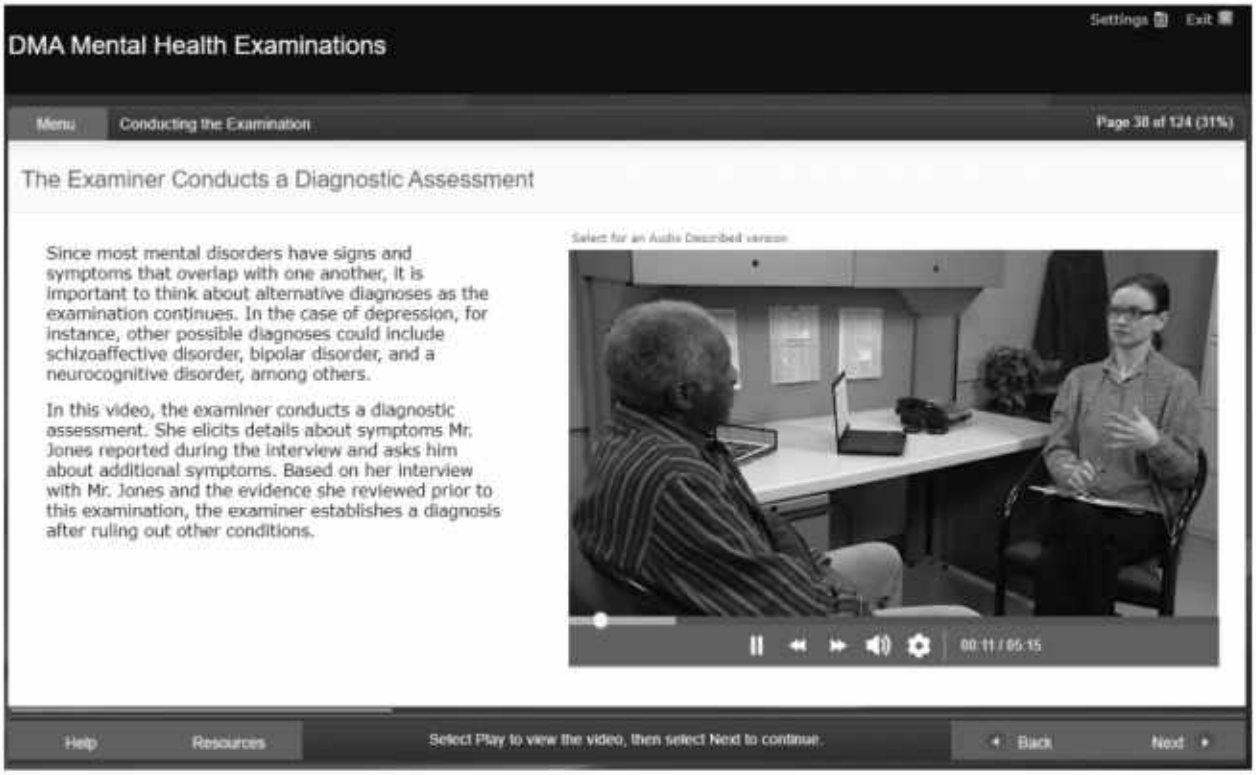

DMA Mental Health Examinations
Settings
Exit
Menu
Conducting the Examination
Page 35 of 124 (28%)
Assessing Pertinent History
Assessing a Veteran's or Servicemember's military history is vital to helping VBA determine if an event, injury, or the onset or aggravation of an illness occurred while they were in the military. You must also place their military history in context by assessing pre-military and post-military history. Gaining an understanding of how they were functioning in different domains of life before, during, and after military service can help to clarify how their experiences during service may have affected them.
You will assess pre-military, military, and post-military history across several domains. The order in which you gather this information is not dictated by the structure of the documentation protocol. The domains include:
social/marital/family history
occupational and educational history
mental health history, including prescribed medications and family mental health
legal and behavioral history
substance abuse history
Keep in mind that an increase or review exam addresses the same domains as an initial exam but focuses on the interval since the last C&P exam and not on more remote history.
Important Note:
Although it is important to be thorough and complete for adjudication purposes, limit your questions and the discussion to what is needed for the goals of diagnosing a mental health condition, establishing a medical nexus or etiology, and describing social and occupational impairment.
Help
Resources
Select Next to continue
Back
Next


DMA Mental Health Examinations
Settings
Exit
Menu
Conducting the Examination
Page 36 of 124 (29%)
A Focused Interview
When conducting C&P examinations, you may find yourself accidentally shifting back into a therapeutic role during the interview. The Veteran may also shift into providing information as in a therapeutic session. Here are tips for refocusing on the needs of the C&P evaluation.
When the Examiner Needs to Refocus
You may notice that you have started to ask questions that are relevant to treatment, but don't further the goals of the C&P examination process. You might be accustomed to spending a lot of time discussing the family of origin, quality of attachment, and relational dynamics because these considerations can inform your approach to treatment. However, while discussing a Veteran's or Servicemember's pre-military history for C&P purposes, you may similarly ask about early development or the family of origin, but in this role, you are listening for indications of pre-military maladjustment, vulnerability factors that may play a role in the etiology of current conditions, or life events other than military service that might better explain presenting symptoms.
If you recognize that you have drifted off-task, return the focus of your questions to the three goals of the interview: diagnosis, impairment, and nexus to service.
When the Veteran Needs to Refocus
Sometimes Veterans or Servicemembers will start to provide more detail than needed, vent, or use the time as though it were a treatment session. At these times, gently remind them of the purpose of the meeting and the limited time to acquire all of the necessary information requested by VBA or BVA.
Most Veterans respond positively to reassurance that you are redirecting them in service of their claim, and not interrupting them due to lack of consideration or respect.
Help
Resources
Select Next to continue
Back
Next



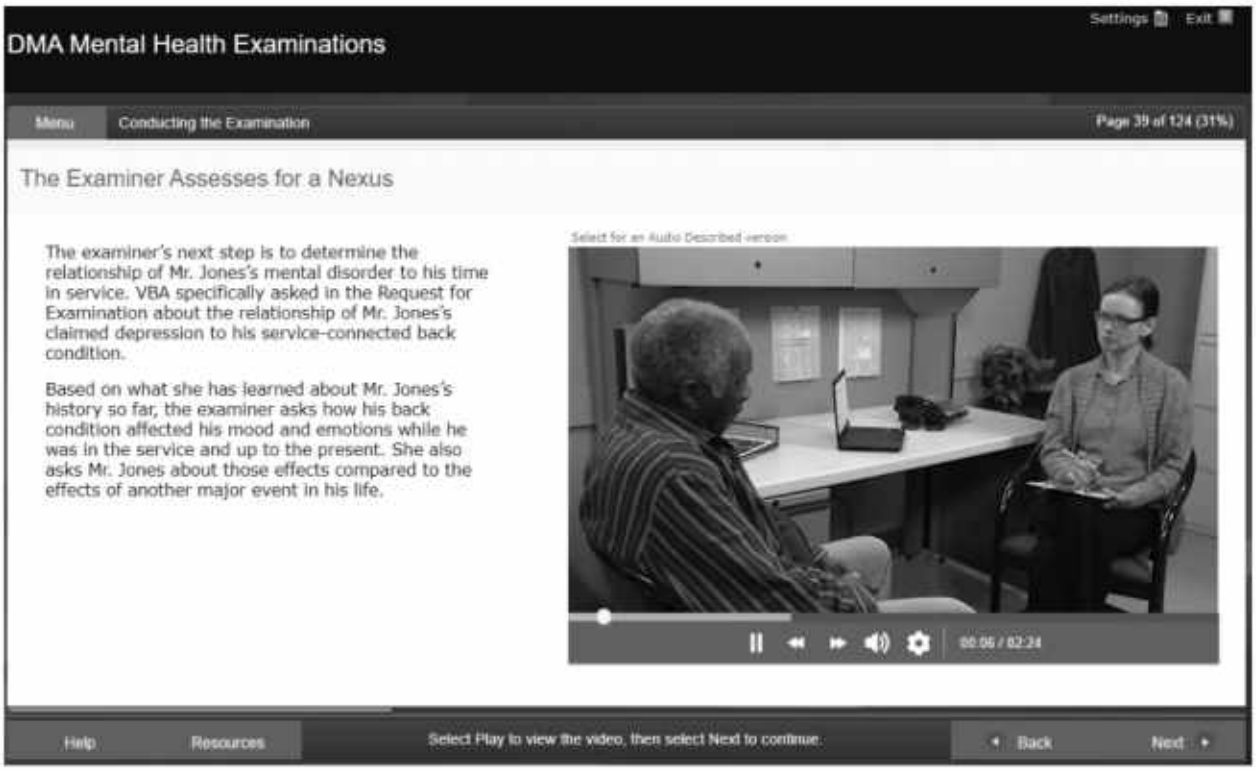
In terms of your life before the military, who was in your family growing up? Parents, brothers, sisters? It was normal, I guess. My dad worked at the factory. My mom stayed home with us. There was seven of us, so she was busy. Hmm. And how would you describe your home life overall? It was a happy time. We played outside, hunting and fishing. I was really close with my brothers back then. Not like it is now. I see. That changed at some point? I'll come back to that in a bit. How about school and your social life when you were growing up? I wasn't too keen on books, but I guess you could say I was well-liked. I played sports. My grades were good enough, but I was never really into school. My dad worked at the factory, and I figured that someday I would do the same. Any disciplinary issues growing up? Getting kicked out of school, trouble with the law? Anything like that? Oh, oh, no (chuckles). My mother wouldn't have stood for that. She ran a tight ship. And tell me a little bit about how you came to be in the military. The dates of service I have are 1975 to 1980. Is that right? Yep. Well, like I said, I always figured I'd work at the factory, but it shut down while I was in high school. Left a lot of people out of work, my dad included. I didn't want to be a burden on the family. I knew money would be tight since some of the little kids were still at home. So I went down to the recruiting station. Said sign me up. I didn't even tell them ahead of time. And why the Marine Corps? To be honest, it was the first recruiting office I passed, and the guy that talked to me about it and said that they were the best. And to this day, I think he was right. I wanted to make a career out of it, but it didn't work out that way.= I see. Let's come back to that in a minute. What was your specialty in the Marines? Well, first and foremost, I was a rifleman. We all are, but my MOS was correction specialist. I worked at the brig, Camp Lejeune. And your military records don't show any deployments. All of your service was stateside? Yes, that's right. And I imagine the answer will be NO based on your military job, but did you have any disciplinary issues in the service? Losses of rank, nonjudicial punishments, counseling statements, that kind of thing? No, no, nothing like that. And I see you had an honorable discharge at the rank of Sergeant E5.I know you

mentioned that you planned to have a career in the military. What happened to that plan? Well, the short story is I got hurt. Back injury while I was on duty. It never was quite right after that. They tried everything, but I couldn't do everything physically that I needed to. They didn't med board me, but my job had to change, desk work. That wasn't what I wanted for myself, but I knew I couldn't depend on my back, which meant no one could depend on me. I didn't want to be that person who would let his fellow Marine down. So when my time was up, I didn't re-up. That must've been a hard decision. What happened next for you? What did you do? Where did you go? Well, I was married at the time. Met my wife while I was in the service. We were ready to start a family, and she wanted to stay close to home. We got our own place. Still live there today. Been together over 40 years. I don't know what I would have done without her. You wanted to start a family. How did that work out? Great. We had two kids. A son got married last year. My granddaughter. Hmm. My daughter had three beautiful girls. They live close to us so we could see them whenever we want. Keeps us busy. Always wish I could do more with them, but with my medical problems, there's only so much. Hmm. Let's come back to that in a minute. I feel like I've a good sense of your family life since you left the military. How about work? Tell me about that. Well, that was tough. I thought I'd work at the factory, but that shut down. Then I thought I'd have a military career, and that shut down. I wasn't much for school like I mentioned earlier. With a young wife and wanting to start a family, I took the first thing that came my way. My father-in-law had a construction company, and they needed some help in the office. So I started doing their invoices and ordering and stuff. And how long did you work there? Oh, I'm still there today. I'm lucky. It's a family business. I think I'd have been gone a long time ago, otherwise. Hmm, I'd like to hear more about that in a bit, but before I do, do you have any other medical conditions that affect you on a daily basis? Hospitalizations? Anything you take medication for and that kind of thing? No, just the back. Well, that and the extra weight I put on so as I can't move around like I used to. Too painful and I worry I might hurt it more. Hmm, okay. And with regards to mental health, you mentioned you thought this was a meeting with a therapist. Can you tell me a little more about that? Well like I said, I'm not much for talking about my feelings. But my primary care provider here, a few weeks ago, asked me a bunch of questions, said it was standard. And after what, he wanted to refer me to a mental health clinic. That I did took some getting used to. But I've been dealing with this a long time by myself, so I thought I'd probably be worth giving it a shot, try something new. So you haven't had any mental health treatment before. How about managing mental health symptoms with medication or supplements? Anything you might have taken for mood, anxiety, sleep? No, no, I'm not much for taking pills. Uh, huh. Couple of questions I ask everyone. Any current or past substance use? Street drugs, misusing prescription drugs? Anything like that? No, nothing. I'm prescribed some painkillers for my back, but I don't even like taking those, to be honest. Maybe it's the Marine in me. Feels like I oughta be able to deal with this on my own. How about alcohol use? Well, I'm a beer drinker, mostly. Not during the week. I might drink a beer or two during the game on Sunday. Anything that ever gives you a problem, like hangovers, blackouts, DUIs, getting into fights? No, especially not fighting. I wouldn't go up against anybody the way I feel most of the time. And again, a couple questions I ask everyone. Have you ever had any trouble with the legal system? Lawsuits, arrests, major citations? Anything like that? No, no, like I said earlier, my mom ran a tight ship. I guess she raised me right. Great. Thank you for all this information. I'd like to change gears now and ask you some more questions about the depression and anxiety on your claim and how you're doing mentally and emotionally. Okay.

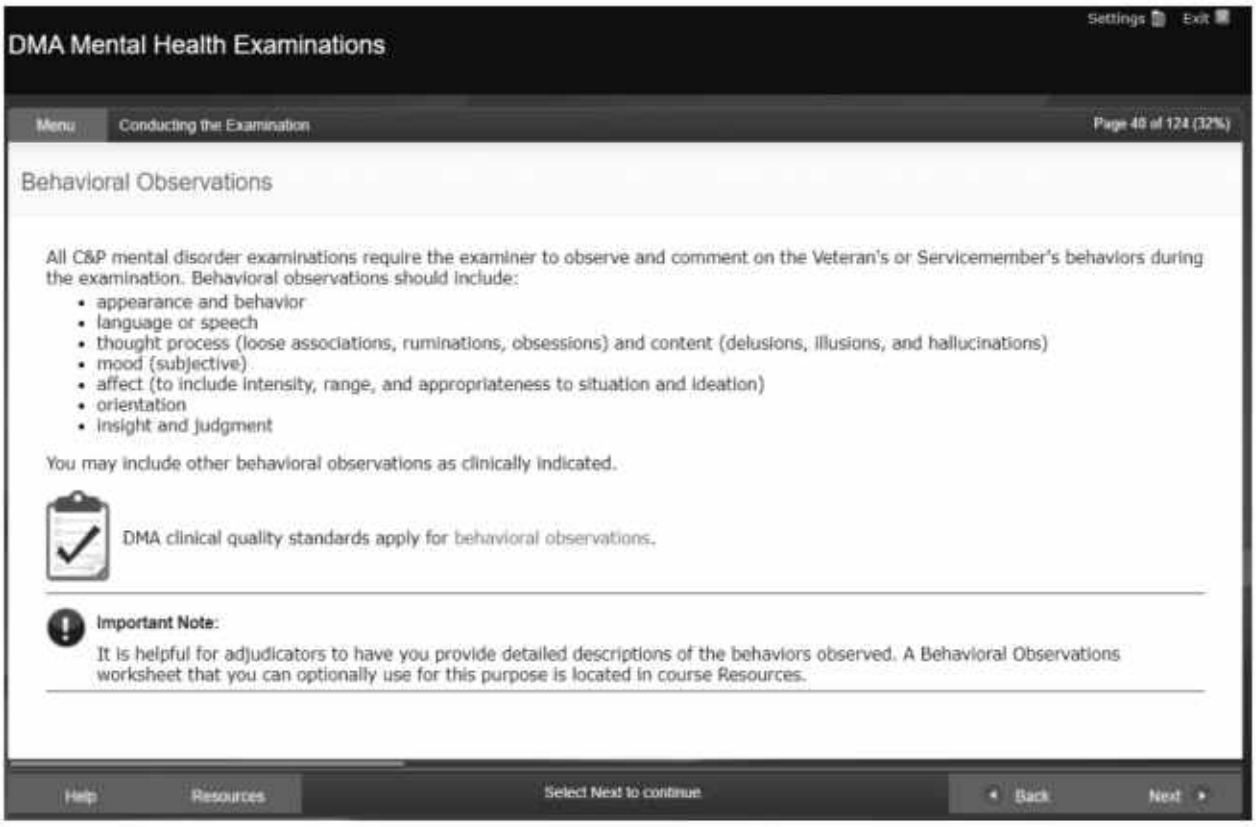


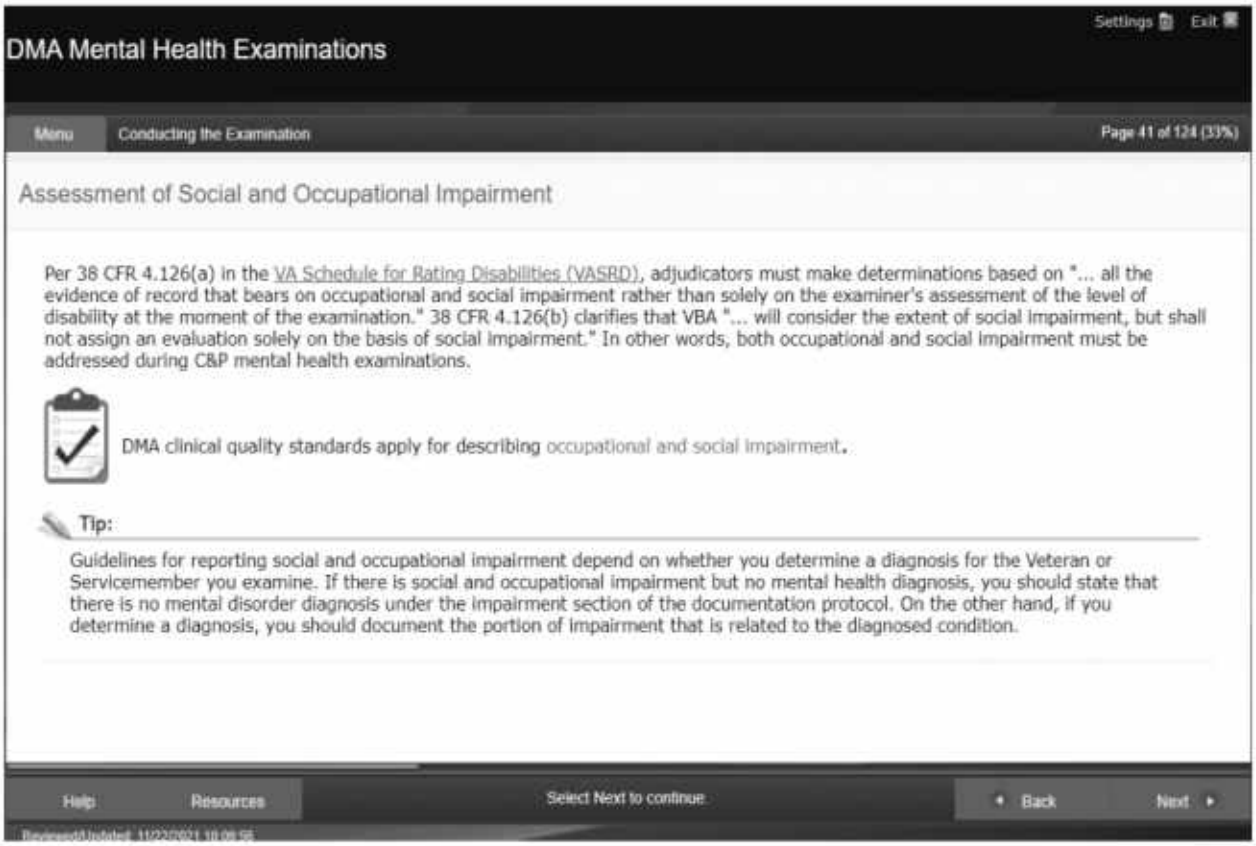
Mr. Jones, as we've been talking, there are a number of symptoms you've mentioned, just in passing. One thing, for instance, was you sometimes feel really low on energy and have trouble getting yourself going. Can you tell me more about that? Well, in the morning sometimes, I have trouble getting out the bed. I wake up, but then I just lie there. Most days, I wind up being late to work, even though I wake up much earlier than I need to. Mm, I see. So you wake up very early. Is that usual? It's funny now that you mention it. Ah, because I'm so tired all the time. I just never feel rested. But then my brain just pops awake at 4 a.m., which is a hard time of day because it feels like the only thing I can do is lay there and think about all the things that's gone wrong for me. That sounds really difficult. What kind of thoughts are you having? Just, you know, I thought my life would be different. I love my wife and family, so this is not about them. But I always thought I'd be the big strong guy taking care of them and protecting them. Now I work in a office, can't even walk around much because of my back. And so lot's of things I can't do, like, last summer. They all wanted to go to the amusement park. So I just decided to stay home. I didn't want them feeling sorry for me. So, I put on a cheerful face and made a joke about it. But it was about the saddest I felt in a long while. Do you notice this sadness mostly when things are happening related to your back? Yeah, you know. Sometimes I'll be distracted, and I'll forget I even have a problem. Feel like my old self for a few minutes. Then I move around and snap, right back to reality. If this back thing had never happened, I believe I'd be a totally different person. Okay, so it's sounds as though you mostly feel down when you're being most affected by your back and medical symptoms related to your injury. Do you ever notice your mood changing when it's not related to your injury? Especially any times you might feel unusually energetic or your mind is racing so fast you can barely keep up. No. That would be a good change. Seems like I'm kinda normal, trying to be cheerful and not think about how sad I am. Feeling down and weary about my back flaring up. Okay, and this question might be kind of hard to

answer. But would you say that you're more worried about the symptoms you're having, like the back pain, or your more worried about your health and the possibility that something might be wrong? Well, I guess I'm more worried about the symptoms. It's not a possibility that something is wrong. It's dealing with what's actually wrong. It's not that I'm off on the deep end. I listen to the doctors, do what I'm supposed to do. I try not to let it hold me back. But I have to respect my limits. I understand. That makes sense. Can I ask, are you service connected for the back condition. Yeah. I didn't wanna admit it how much pain I was in or how much it was bothering me. But it just seemed to get worse over time. I had a military buddy who said I should look into it. You also said something earlier about sometimes feeling anxious. You might do something to hurt your back more. Can you tell me a little about that? Well, like I said, I just think ahead of time. And sometimes I think if it's too risky, like the amusement park thing. I could a gone and been with everyone else. But I was too nervous about it. Are there other things you worry about? Well, things like money, you know. If I can't work anymore because my back gets too bad. And I worry about what my wife thinks of me. If she thinks less of me because I'm not the strong tough guy I was when we met. I think she'd be surprised to know that I worry about that. Thanks for bearing with me. I know it's a lot of questions. I appreciate you sharing all this with me.(keyboard clicking).



Mr. Jones, we've spoken about this a little bit already, but can you recall the first time you remember experiencing the depression and anxiety we've been talking about today? Well, like I've been saying, I hurt my back in the Service around 1978. For a while I was hopeful things would get back to normal quickly. It took a few months before I realized it wasn't gonna be that easy. I was a Marine. I wasn't about to admit that I was in so much pain or that I felt so bad about it. I see. So there were changes you were aware of but tried to keep private and not talk about? That's right. That makes sense. Because I saw records about your back condition in your Military treatment records, but I didn't see anything about any mental health treatment or diagnoses during service. Oh no. Marines don't do that. So there were changes you were aware of, but kept private. How did those changes progress during the years since you left the Military? Did the depression and anxiety ever get better, get worse, go away completely? I guess you could say it's always been about the same. Maybe there were times when I noticed it more, like when the kids were little or now when the grandkids are little. I wish I could do more with them, but...I couldn't, so I always tried to keep that to myself. And looking back, are there any other times you can think of or things you went through that left you feeling a similar way? Well, when my mother died. I took that pretty hard. But that was different. It's like, this stuff with my back, is like it's always in the background. Other things happen, they come and go, but I can never get away from dealing with my back. (keyboard clicking)


DMA Mental Health Examinations
Settings
Exit
Menu
Conducting the Examination
Page 40 of 124 (32%)
Behavioral Observations
All C&P mental disorder examinations require the examiner to observe and comment on the Veteran's or Servicemember's behaviors during the examination. Behavioral observations should include:
appearance and behavior
language or speech
thought process (loose associations, ruminations, obsessions) and content (delusions, illusions, and hallucinations)
mood (subjective)
affect (to include intensity, range, and appropriateness to situation and ideation)
orientation
insight and judgment
You may include other behavioral observations as clinically indicated.
DMA clinical quality standards apply for behavioral observations.
Important Note:
It is helpful for adjudicators to have you provide detailed descriptions of the behaviors observed. A Behavioral Observations worksheet that you can optionally use for this purpose is located in course Resources.
Help
Resources
Select Next to continue
Back
Next


DMA Mental Health Examinations
Settings
Exit
Menu
Conducting the Examination
Page 41 of 124 (33%)
Assessment of Social and Occupational Impairment
Per 38 CFR 4.126(a) in the VA Schedule for Rating Disabilities (VASRD), adjudicators must make determinations based on "... all the evidence of record that bears on occupational and social impairment rather than solely on the examiner's assessment of the level of disability at the moment of the examination." 38 CFR 4.126(b) clarifies that VBA "... will consider the extent of social impairment, but shall not assign an evaluation solely on the basis of social impairment." In other words, both occupational and social impairment must be addressed during C&P mental health examinations.
DMA clinical quality standards apply for describing occupational and social impairment.
Tip:
Guidelines for reporting social and occupational impairment depend on whether you determine a diagnosis for the Veteran or Servicemember you examine. If there is social and occupational impairment but no mental health diagnosis, you should state that there is no mental disorder diagnosis under the impairment section of the documentation protocol. On the other hand, if you determine a diagnosis, you should document the portion of impairment that is related to the diagnosed condition.
Help
Resources
Select Next to continue
Back
Next

DMA Mental Health Examinations

Settings Exit

Menu | Conducting the Examination | Page 42 of 124 (34%)

Resources for Assessing Social and Occupational Impairment

Assessing social and occupational impairment is complex and challenging. Several interview and self-report instruments have been developed to assess for occupational and social impairment, but no single instrument is perfect for every C&P mental health evaluation.

To date, only two of these tools, the World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0) and the Inventory of Psychological Functioning (IPF) have been studied in the context of C&P disability examinations, specifically among Veterans seeking compensation for PTSD. Although research specific to C&P application is currently limited, the strong reliability and validity demonstrated in other clinical applications suggest that C&P examiners should view the WHODAS 2.0, the IPF, and the instruments covered on the next page as important information resources. Examiners should be familiar with each of these tools so that they can make an educated decision about whether to use them and for which examination.



Important Note:

When describing occupational and social impairment, examiners should report on current and past employment but should not opine on whether a Veteran is employable.

Help | Resources | Select Next to continue. | Back | Next

DMA Mental Health Examinations

Settings Exit

Menu | Conducting the Examination | Page 43 of 124 (35%)

Instruments for Assessing Social and Occupational Impairment

The following instruments represent a selection of measures designed to capture functional impairment. They can be used as is or serve as information resources. Their use should always be guided by your clinical judgement. Select each instrument for more information, then Next to continue.

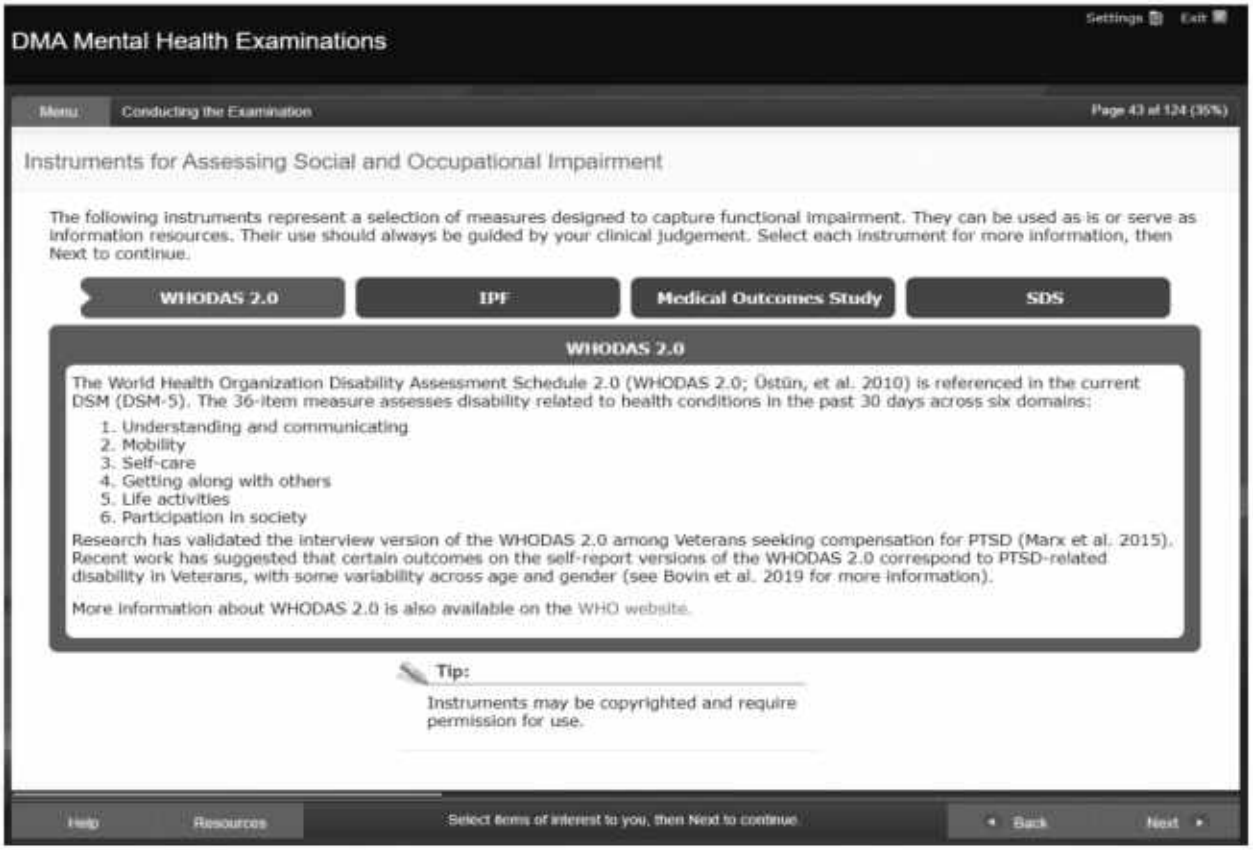
WHODAS 2.0 | IPF | Medical Outcomes Study | SDS

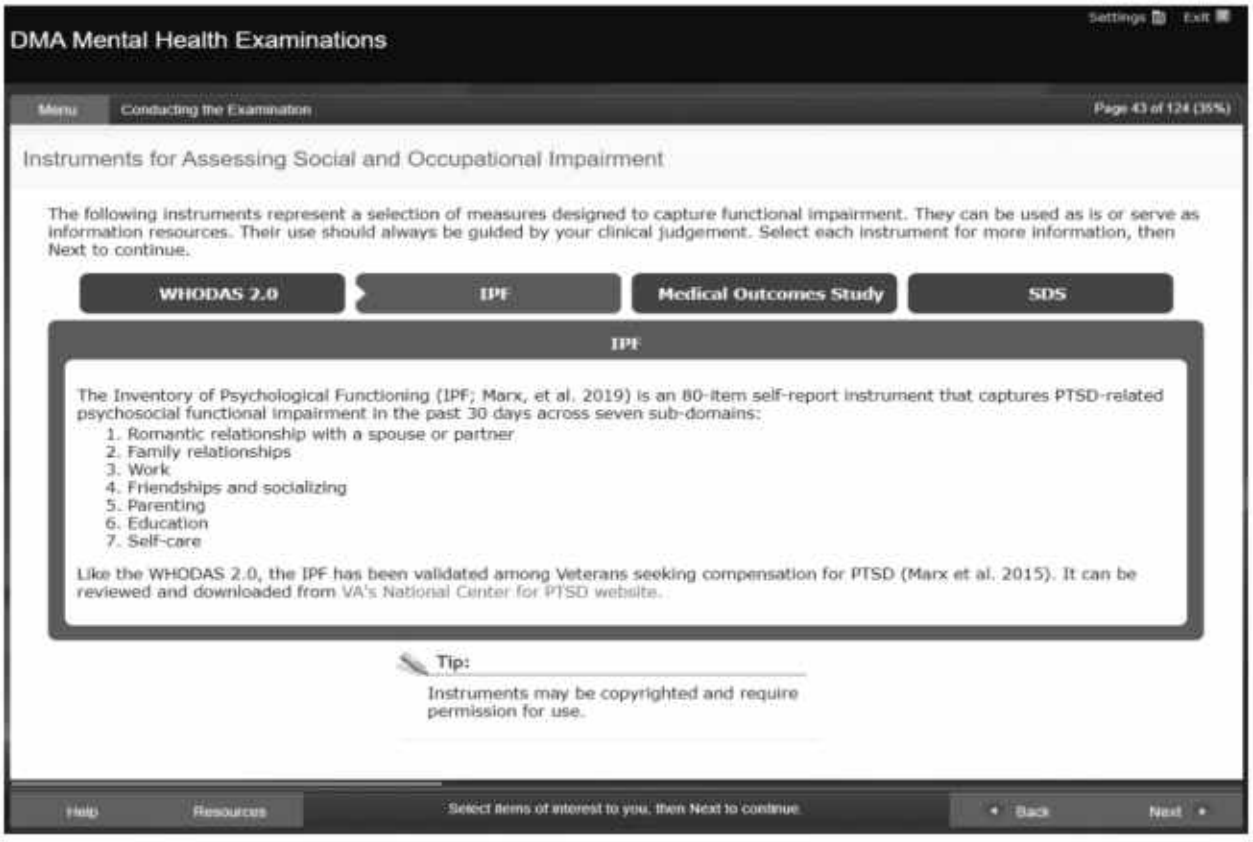
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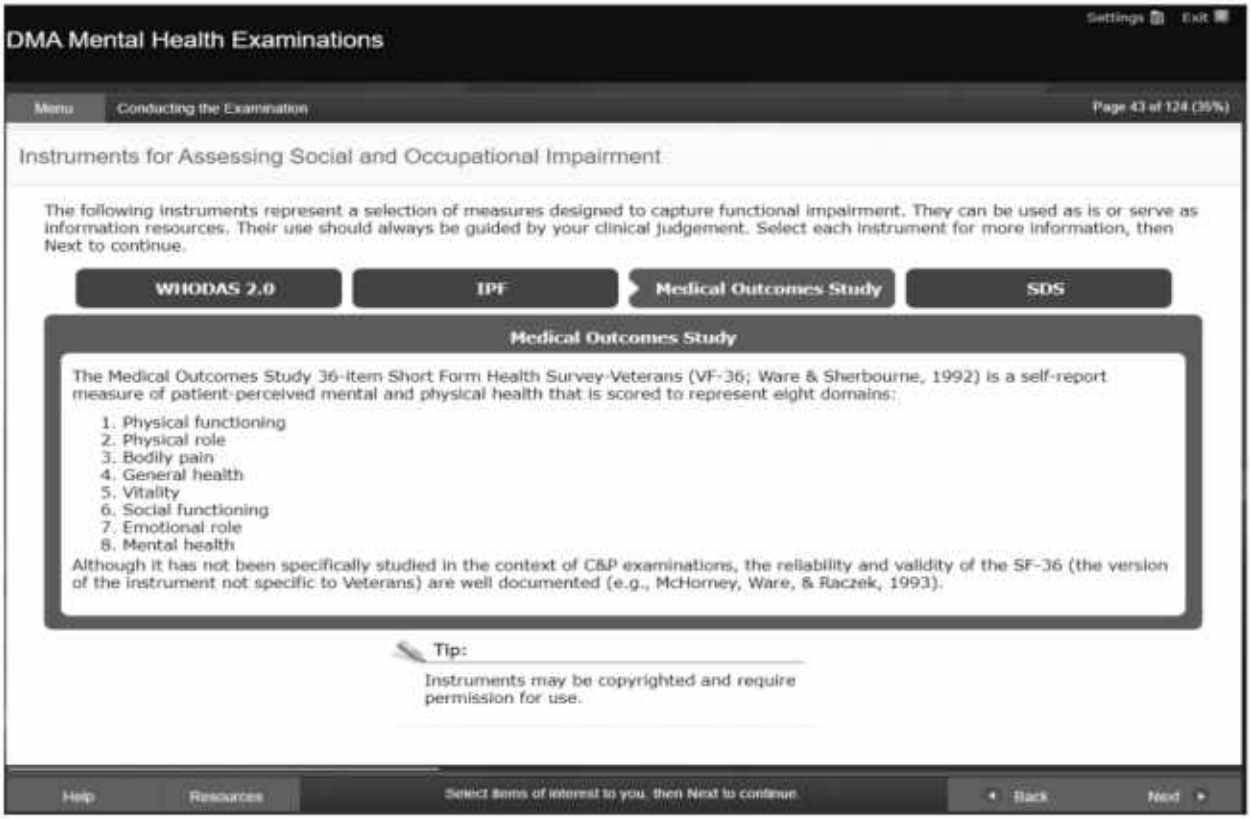
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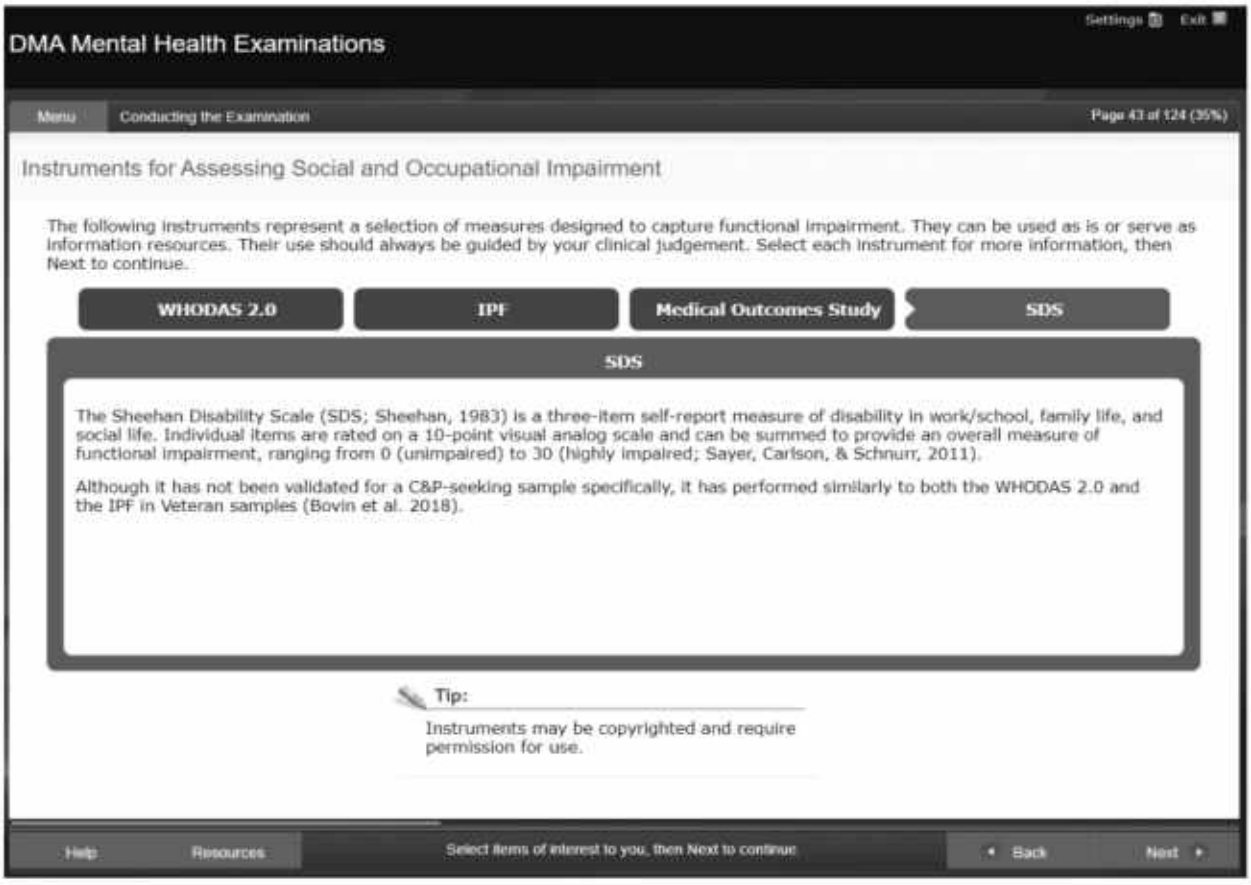
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Help | Resources | Select items of interest to you, then Next to continue. | Back | Next


DMA Mental Health Examinations
Settings
Exit
Menu
Conducting the Examination
Page 43 of 124 (35%)
Instruments for Assessing Social and Occupational Impairment
The following instruments represent a selection of measures designed to capture functional impairment. They can be used as is or serve as information resources. Their use should always be guided by your clinical judgement. Select each instrument for more information, then Next to continue.
WHODAS 2.0
IPF
Medical Outcomes Study
SDS
WHODAS 2.0
The World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0; Üstün, et al. 2010) is referenced in the current DSM (DSM-5). The 36-item measure assesses disability related to health conditions in the past 30 days across six domains:
1. Understanding and communicating
2. Mobility
3. Self-care
4. Getting along with others
5. Life activities
6. Participation in society
Research has validated the interview version of the WHODAS 2.0 among Veterans seeking compensation for PTSD (Marx et al. 2015). Recent work has suggested that certain outcomes on the self-report versions of the WHODAS 2.0 correspond to PTSD-related disability in Veterans, with some variability across age and gender (see Bovin et al. 2019 for more information).
More information about WHODAS 2.0 is also available on the WHO website.
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Help
Resources
Select items of interest to you, then Next to continue
Back
Next


DMA Mental Health Examinations
Settings
Exit
Menu
Conducting the Examination
Page 43 of 124 (35%)
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WHODAS 2.0
IPF
Medical Outcomes Study
SDS
IPF
The Inventory of Psychological Functioning (IPF; Marx, et al. 2019) is an 80-item self-report instrument that captures PTSD-related psychosocial functional impairment in the past 30 days across seven sub-domains:
1. Romantic relationship with a spouse or partner
2. Family relationships
3. Work
4. Friendships and socializing
5. Parenting
6. Education
7. Self-care
Like the WHODAS 2.0, the IPF has been validated among Veterans seeking compensation for PTSD (Marx et al. 2015). It can be reviewed and downloaded from VA's National Center for PTSD website.
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Help
Resources
Select items of interest to you, then Next to continue
Back
Next


DMA Mental Health Examinations
Settings
Exit
Menu
Conducting the Examination
Page 43 of 124 (35%)
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WHODAS 2.0
IPF
Medical Outcomes Study
SDS
Medical Outcomes Study
The Medical Outcomes Study 36-item Short Form Health Survey-Veterans (VF-36; Ware & Sherbourne, 1992) is a self-report measure of patient-perceived mental and physical health that is scored to represent eight domains:
1. Physical functioning
2. Physical role
3. Bodily pain
4. General health
5. Vitality
6. Social functioning
7. Emotional role
8. Mental health
Although it has not been specifically studied in the context of C&P examinations, the reliability and validity of the SF-36 (the version of the instrument not specific to Veterans) are well documented (e.g., McHorney, Ware, & Raczek, 1993).
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Help
Resources
Select items of interest to you, then Next to continue
Back
Next


DMA Mental Health Examinations
Settings
Exit
Menu
Conducting the Examination
Page 43 of 124 (35%)
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WHODAS 2.0
IPF
Medical Outcomes Study
SDS
SDS
The Sheehan Disability Scale (SDS; Sheehan, 1983) is a three-item self-report measure of disability in work/school, family life, and social life. Individual items are rated on a 10-point visual analog scale and can be summed to provide an overall measure of functional impairment, ranging from 0 (unimpaired) to 30 (highly impaired; Sayer, Carlson, & Schnurr, 2011).
Although it has not been validated for a C&P-seeking sample specifically, it has performed similarly to both the WHODAS 2.0 and the IPF in Veteran samples (Bovin et al. 2018).
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Help
Resources
Select items of interest to you, then Next to continue
Back
Next

DMA Mental Health Examinations

Settings Exit

Menu | Conducting the Examination | Page 44 of 124 (35%)

Questions for Assessing Social and Occupational Impairment

If examiners choose not to use validated instruments in full, they can also consider integrating language about impairment from validated instruments, such as the Structured Clinical Interview for DSM-5 (SCID-5; First, Williams, Karg, & Spitzer, 2015) or the Clinician Administered PTSD Scale for DSM-5 (CAPS-5; Weathers, et al. 2013) into the examination. Although the instruments were not validated to be used in this manner, asking these questions can guide examiners in determining how mental health symptoms may be impacting a Veteran's or Servicemember's social and occupational functioning. Questions from these instruments that may be useful include:

Questions about Social Functioning

- How have (YOUR SYMPTOMS) affected your relationships or your interactions with other people?
- How have (YOUR SYMPTOMS) affected your relationships with your family, romantic partner, or friends?

Questions about Work/School Functioning

- How have (YOUR SYMPTOMS) affected your school/work or your ability to go to school/work?
- How have (YOUR SYMPTOMS) affected your attendance at work or school?
- How have (YOUR SYMPTOMS) affected the quality of your work/schoolwork?

Questions about Other Aspects of Occupational Functioning

- How have (YOUR SYMPTOMS) affected your ability to take care of things at home or to be involved in things that are important to you like religious activities, physical activities like sports, or hobbies?
- How have (YOUR SYMPTOMS) affected any other important part of your life, such as parenting, housework, or volunteer work?

Help | Resources | Select Next to continue | Back | Next

DMA Mental Health Examinations

Settings Exit

Menu | Conducting the Examination | Page 45 of 124 (36%)

The Examiner Evaluates Social and Occupational Impairment

In this video, the examiner evaluates the extent of social and occupational impairment resulting from Mr. Jones's symptoms. She asks Mr. Jones questions similar to those on the previous page. The examiner revisits some things Mr. Jones said earlier in the interview about his relationships with family members, friends, and how he gets along at work. In addition, she asks Mr. Jones how his symptoms affect his ability to work and participate in activities he values.



Help | Resources | Select Play to view the video, then select Next to continue. | Back | Next

Thanks for hanging in there with me. I know these are a lot of questions about things that can be difficult to talk about. We're almost done. I just wanna go over a couple things you mentioned earlier. One of them was wishing you were still close to your brothers. Is that in any way related to things that we've been talking about today? It's sad to say, but I guess it is. I just had a hard time relating to them once I got back from the service. Like I said, we were real active growing up. Outdoors, hunting and fishing. We were like peas in a pod. Then I went into the military, and I thought I'd be helping to support everyone and taking care of everyone. Instead, I came back broken. It was hard to phase people after that, so I stayed away. It was a good excuse when I got married and didn't have to go back home. That sounds like it must've been very difficult. How about your life now? It sounds like, well, you live with your wife at home. It sounds like you have a good relationship with your kids and grandkids. Anyone else you see or talk to on a regular basis? Pretty much no one. My wife, she's the social one. Her friends are my friends. Her family is my family. I don't really have any friends or family relationships on my own. I was never like that before. Like we talked about. In school, I was very outgoing and liked being around people. These days, I'd just as soon be left alone. And tell me a little about things you do for fun. Any hobbies you have, things that you look forward to? Well, I like watching the games, following my teams. I'd love to go to some games, but I can't because I can't walk that far and can't sit that long. I can't risk being bumped around in a big crowd, so I'll watch at home. Sometimes, my wife's family will come over, but I'm not a big talker. Tell me a little about a typical day for you. What's a good day look like? Oh, well, I don't get too many of those. I guess a good day is where I get a good night's rest and I can get up and not be too slow in the morning and get everything done and out the house and to work on time. If I'm in a good mood, I might visit my grandkids or watch a movie with my wife. How about a bad day? More bad days than good ones, unfortunately. Not sleeping well, up before dawn. Trouble getting out of bed because I don't wanna deal with the day. Maybe I skip a shower so I can make it to work on time, so I'm not late. I'm grumpy with everyone. Short temper. When I get home, all I wanna do is eat dinner and go to bed. I make excuses if my wife wants to do something or the kids call or visit. You mentioned earlier, you felt lucky that you work for a family company because otherwise, you think you'd be long gone. What did you mean by that? Well, like I said, on bad days, I have trouble getting to work on time and I have more bad days than good ones, so that's been a problem. Have you ever been disciplined or received any warnings? Well, not as such since it's a family business, but my brother-in-law, he pulled me aside a couple of times and said something needing to pull my weight. That kind of stuff. I felt terrible. How about absences? Calling in sick or taking leave because of how you're feeling emotionally? Well, I missed some time because the pain is too bad and I need to stay in the bed. But other days, I tell people it's because of the pain, but it's really, I'm just so exhausted and tired and I can't push through. I guess that's what the doctor calls depression. How many days of work do you miss? Let's say in a month, how many days late or absent? Oh, boy. I'm late three days a week. Maybe once a month, I call out because of my back and probably twice a month, I call out because of depression. And how about taking care of yourself on a daily basis? Taking a shower when you need to, putting on clean clothes, cooking, chores, that kind of thing? Well, my wife, she's a saint. She does the cooking and the cleaning. The cleaning is hard because of my back. I think she'd prefer not to eat my cooking. I do what I can in the yard. Take the car to the shop, that kind of thing. Like I said, when I'm having a hard time, I might try to skip showers. She won't let me get away with that for too long. Like I said. I don't know what I'd do without her. Thank you. I know some of that is hard to share.

DMA Mental Health Examinations

Settings Exit

Menu | Conducting the Examination | Page 46 of 124 (37%)

Suicide Risk: A Significant Issue for Veterans

The next few slides will present data about suicide risk and Veterans, as this is a significant issue to the Veteran community. Suicide rates are higher among Veterans than for the non-Veteran adult population.

As you conduct your evaluation, it is important to be mindful of factors that may put Veterans and Servicemembers at higher risk for suicide. These include, but are not limited to, challenges associated with the transition from service, mental health issues, relationship concerns, and problems in employment.

You should be aware of how to assess for suicidality as part of your examination.



Help | Resources | Select Next to continue | Back | Next

DMA Mental Health Examinations

Settings Exit

Menu | Conducting the Examination | Page 47 of 124 (38%)

The Prevalence of Suicide in Veterans

Suicide in the United States is a national public health problem as defined by the CDC.

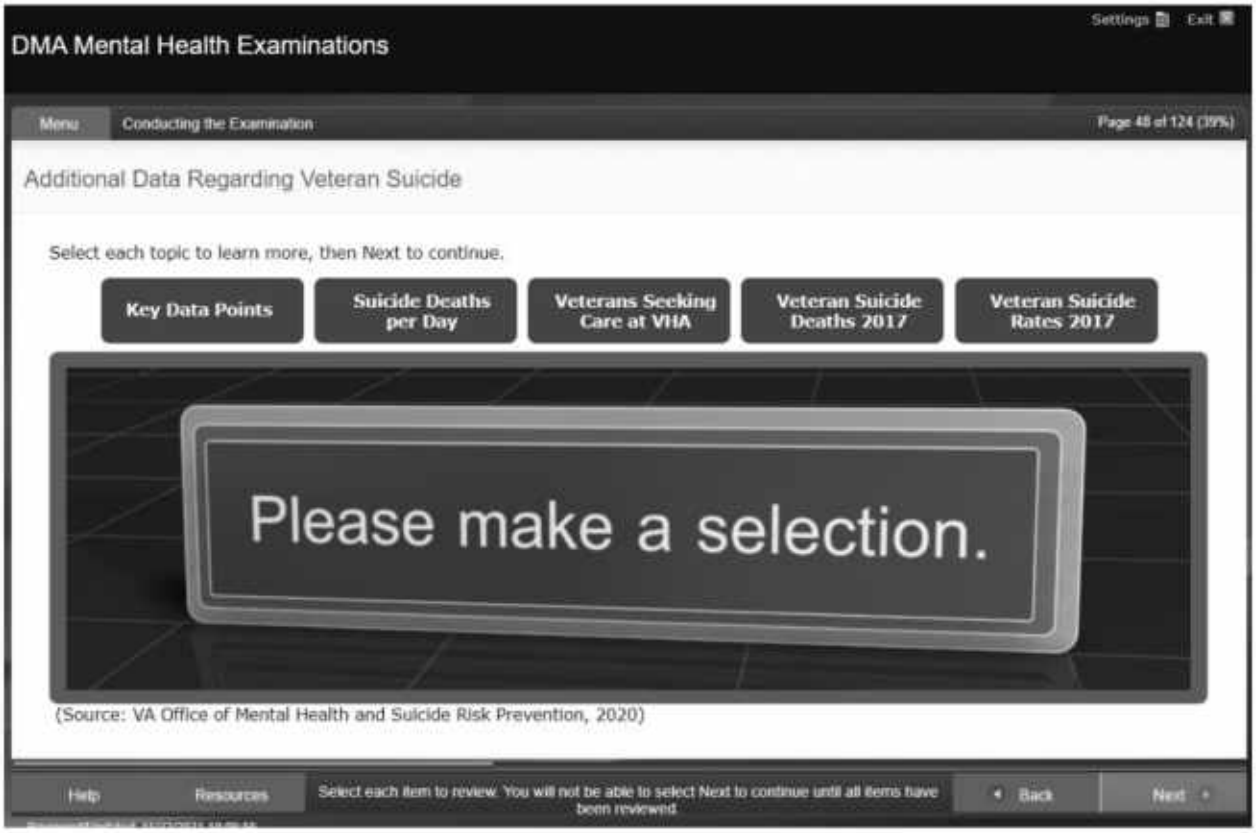
In 2017, 45,390 American adults died by suicide, including over 6,000 Veterans—the suicide rate for Veterans was 1.5 times higher than the rate for non-Veteran adults.

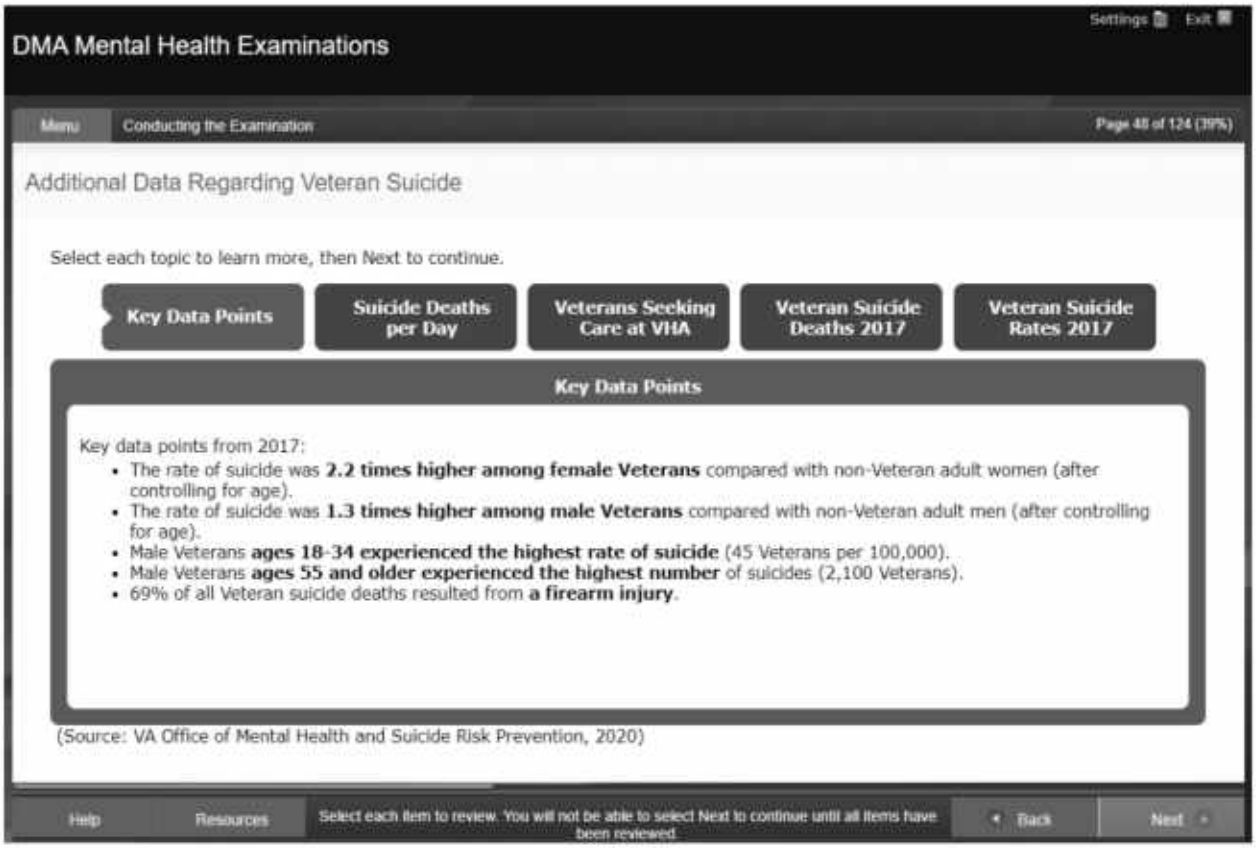
Within the Veteran population, there are those with an even higher risk for suicide than the general Veteran population, including:

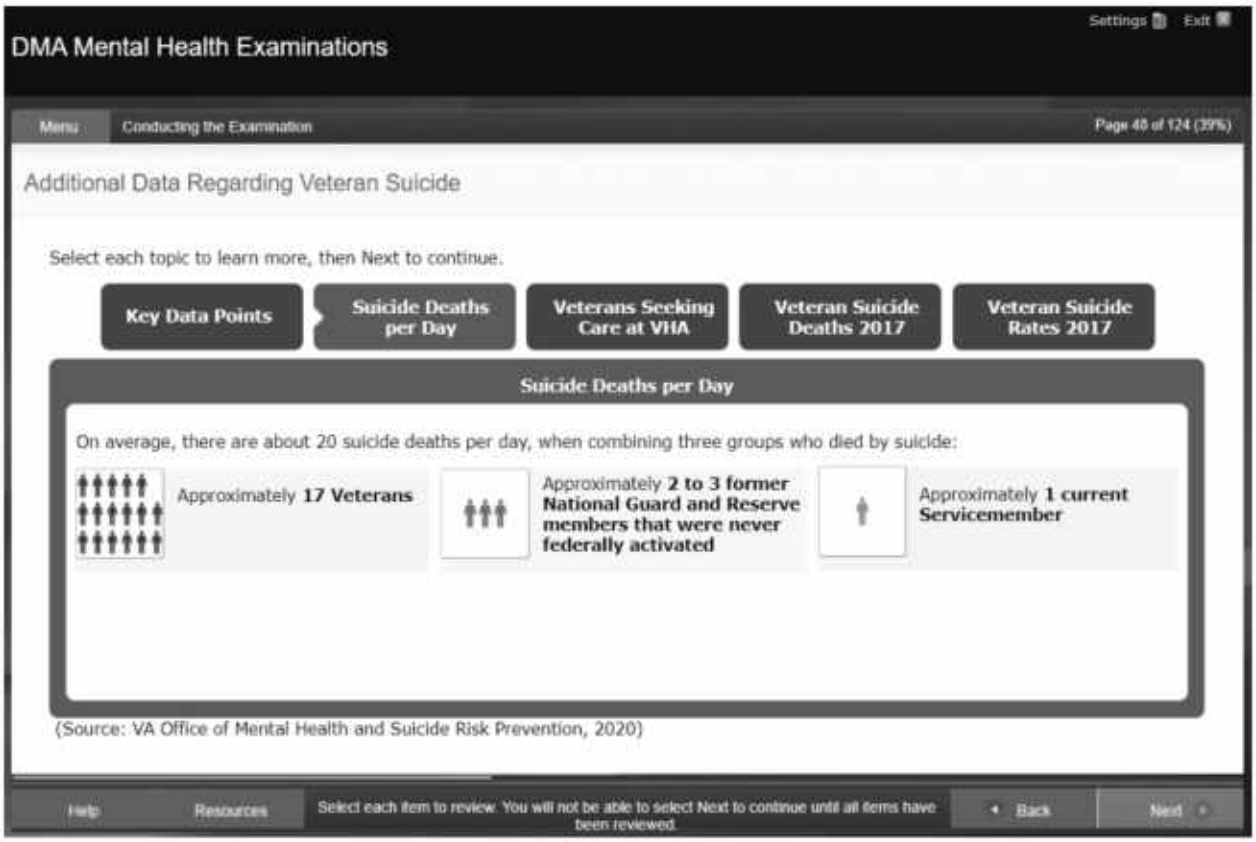
- Younger Veterans
- Female Veterans
- Veterans in a period of transition
- Veterans who have been impacted by suicide
- Veterans with substance use disorders
- Veterans with access to lethal means

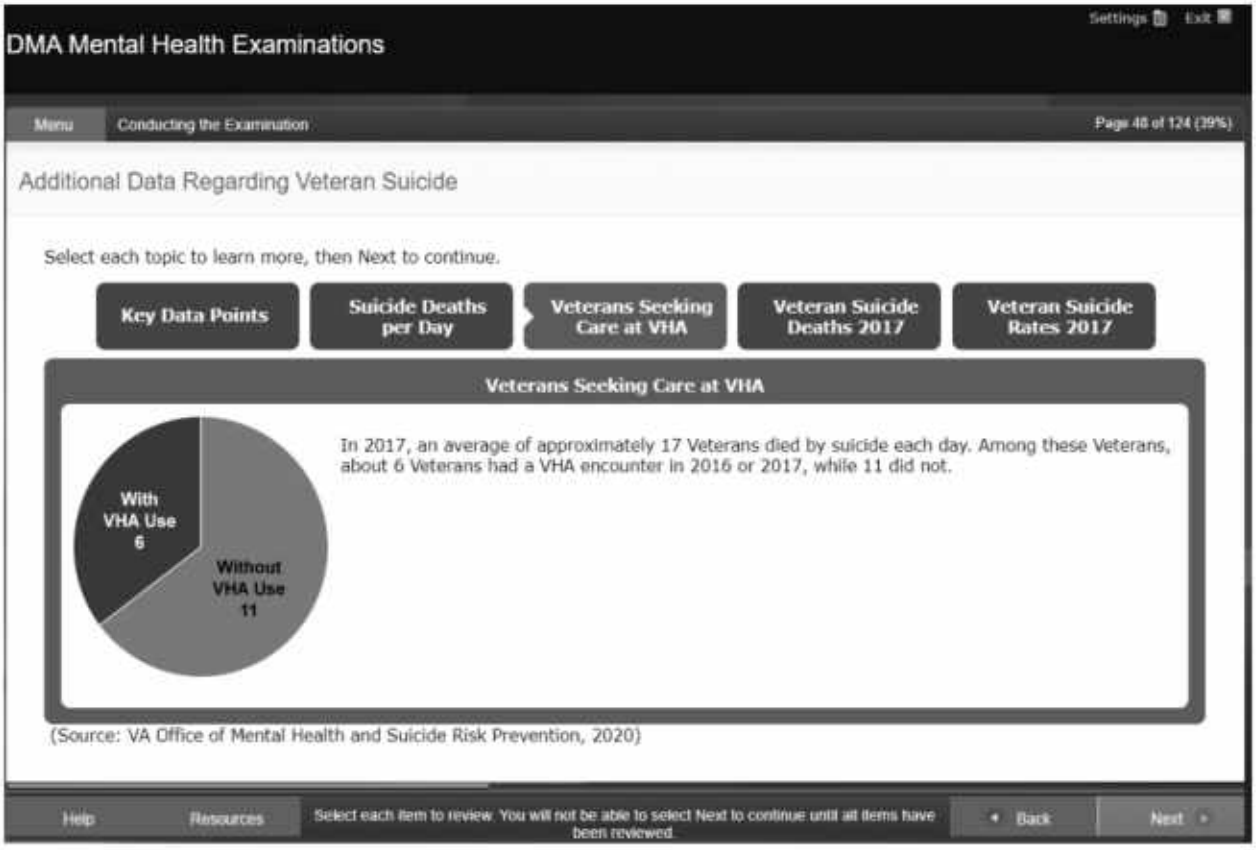
(Source: VA Office of Mental Health and Suicide Risk Prevention, 2020)

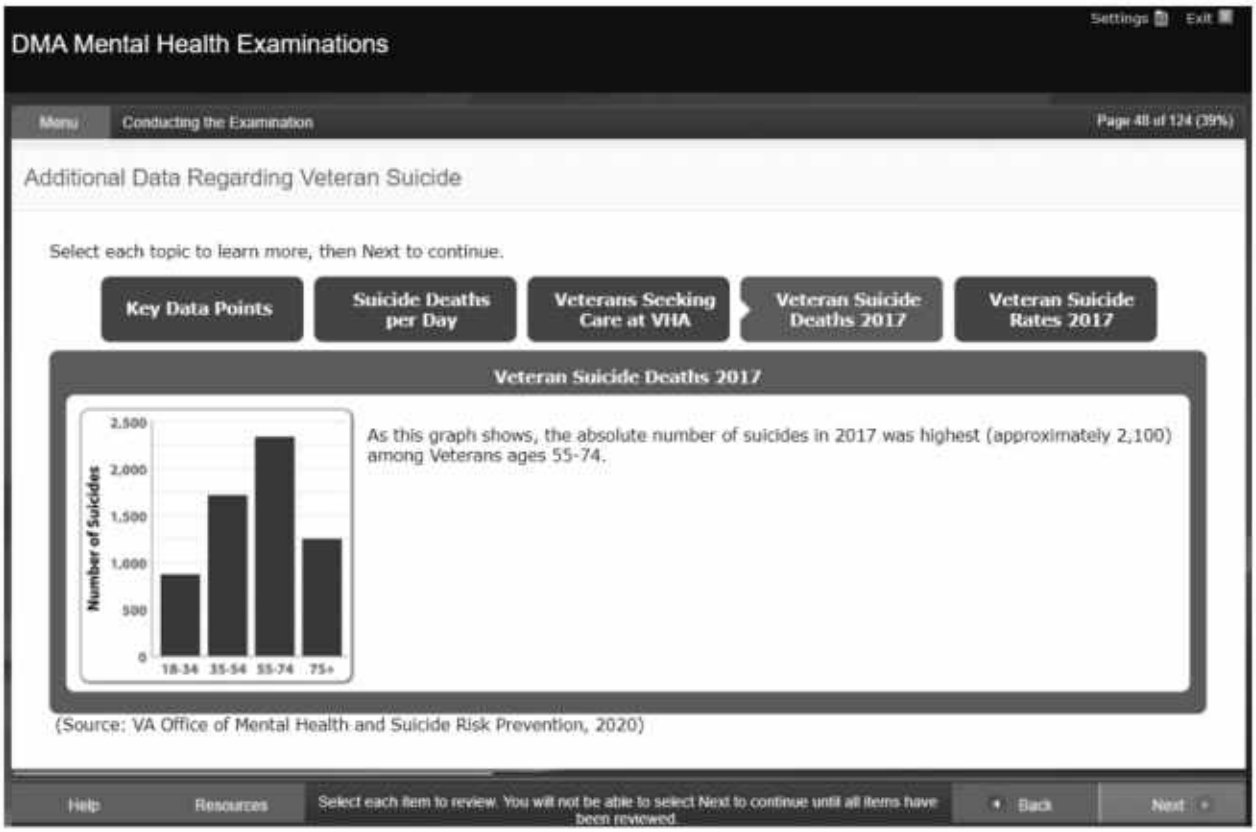
Help | Resources | Select Next to continue | Back | Next

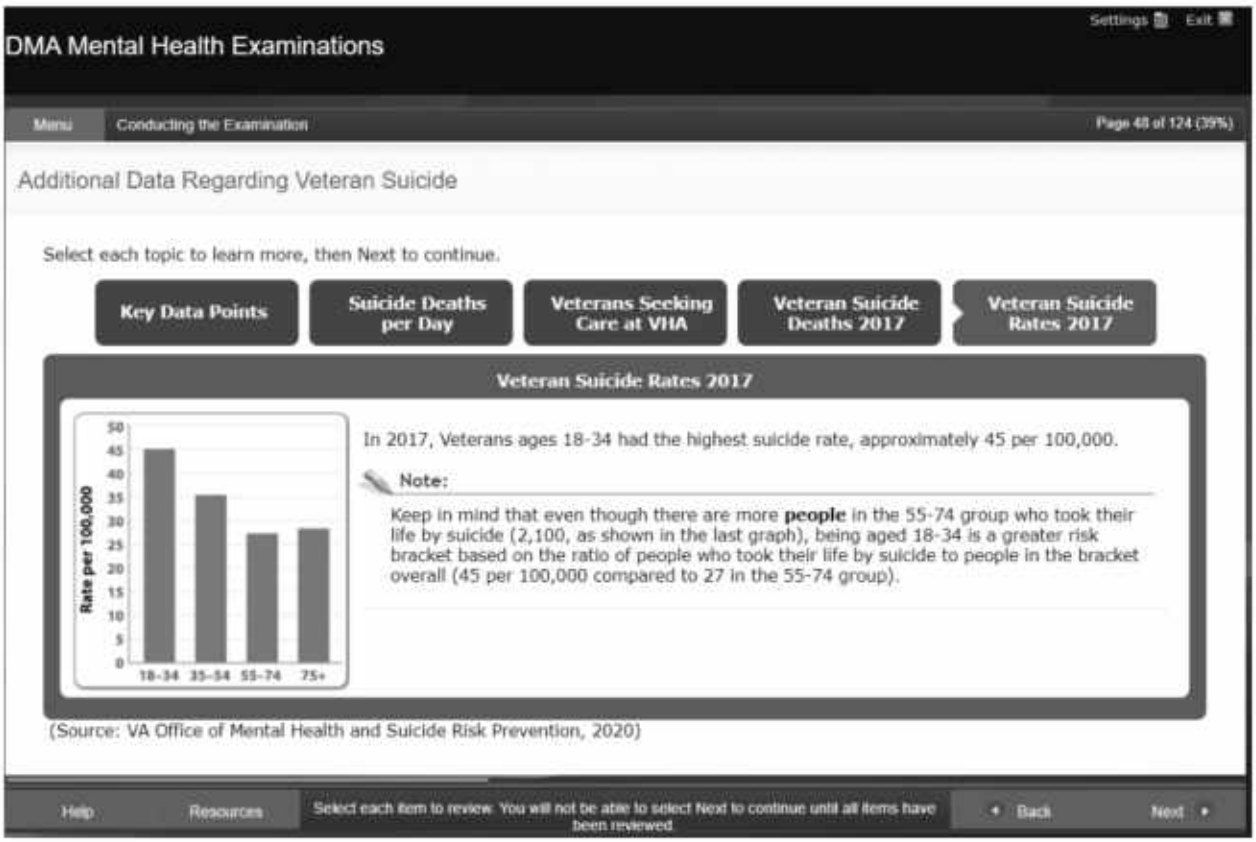

DMA Mental Health Examinations
Settings
Exit
Menu
Conducting the Examination
Page 48 of 124 (39%)
Additional Data Regarding Veteran Suicide
Select each topic to learn more, then Next to continue.
Key Data Points
Suicide Deaths per Day
Veterans Seeking Care at VHA
Veteran Suicide Deaths 2017
Veteran Suicide Rates 2017
Please make a selection.
(Source: VA Office of Mental Health and Suicide Risk Prevention, 2020)
Help
Resources
Select each item to review. You will not be able to select Next to continue until all items have been reviewed.
Back
Next


DMA Mental Health Examinations
Settings
Exit
Menu
Conducting the Examination
Page 48 of 124 (39%)
Additional Data Regarding Veteran Suicide
Select each topic to learn more, then Next to continue.
Key Data Points
Suicide Deaths per Day
Veterans Seeking Care at VHA
Veteran Suicide Deaths 2017
Veteran Suicide Rates 2017
Key Data Points
Key data points from 2017:
• The rate of suicide was 2.2 times higher among female Veterans compared with non-Veteran adult women (after controlling for age).
• The rate of suicide was 1.3 times higher among male Veterans compared with non-Veteran adult men (after controlling for age).
• Male Veterans ages 18-34 experienced the highest rate of suicide (45 Veterans per 100,000).
• Male Veterans ages 55 and older experienced the highest number of suicides (2,100 Veterans).
• 69% of all Veteran suicide deaths resulted from a firearm injury.
(Source: VA Office of Mental Health and Suicide Risk Prevention, 2020)
Help
Resources
Select each item to review. You will not be able to select Next to continue until all items have been reviewed.
Back
Next


DMA Mental Health Examinations
Settings
Exit
Menu
Conducting the Examination
Page 48 of 124 (39%)
Additional Data Regarding Veteran Suicide
Select each topic to learn more, then Next to continue.
Key Data Points
Suicide Deaths per Day
Veterans Seeking Care at VHA
Veteran Suicide Deaths 2017
Veteran Suicide Rates 2017
Suicide Deaths per Day
On average, there are about 20 suicide deaths per day, when combining three groups who died by suicide:
Approximately 17 Veterans
Approximately 2 to 3 former National Guard and Reserve members that were never federally activated
Approximately 1 current Servicemember
(Source: VA Office of Mental Health and Suicide Risk Prevention, 2020)
Help
Resources
Select each item to review. You will not be able to select Next to continue until all items have been reviewed.
Back
Next


DMA Mental Health Examinations
Settings
Exit
Menu
Conducting the Examination
Page 48 of 124 (39%)
Additional Data Regarding Veteran Suicide
Select each topic to learn more, then Next to continue.
Key Data Points
Suicide Deaths per Day
Veterans Seeking Care at VHA
Veteran Suicide Deaths 2017
Veteran Suicide Rates 2017
Veterans Seeking Care at VHA
With VHA Use 6
Without VHA Use 11
In 2017, an average of approximately 17 Veterans died by suicide each day. Among these Veterans, about 6 Veterans had a VHA encounter in 2016 or 2017, while 11 did not.
(Source: VA Office of Mental Health and Suicide Risk Prevention, 2020)
Help
Resources
Select each item to review. You will not be able to select Next to continue until all items have been reviewed.
Back
Next


DMA Mental Health Examinations
Settings
Exit
Menu
Conducting the Examination
Page 48 of 124 (39%)
Additional Data Regarding Veteran Suicide
Select each topic to learn more, then Next to continue.
Key Data Points
Suicide Deaths per Day
Veterans Seeking Care at VHA
Veteran Suicide Deaths 2017
Veteran Suicide Rates 2017
Veteran Suicide Deaths 2017
Number of Suicides
2,500
2,000
1,500
1,000
500
0
18-34
35-54
55-74
75+
As this graph shows, the absolute number of suicides in 2017 was highest (approximately 2,100) among Veterans ages 55-74.
(Source: VA Office of Mental Health and Suicide Risk Prevention, 2020)
Help
Resources
Select each item to review. You will not be able to select Next to continue until all items have been reviewed.
Back
Next


DMA Mental Health Examinations
Settings
Exit
Menu
Conducting the Examination
Page 48 of 124 (39%)
Additional Data Regarding Veteran Suicide
Select each topic to learn more, then Next to continue.
Key Data Points
Suicide Deaths per Day
Veterans Seeking Care at VHA
Veteran Suicide Deaths 2017
Veteran Suicide Rates 2017
Veteran Suicide Rates 2017
Rate per 100,000
50
45
40
35
30
25
20
15
10
5
0
18-34
35-54
55-74
75+
In 2017, Veterans ages 18-34 had the highest suicide rate, approximately 45 per 100,000.
Note:
Keep in mind that even though there are more people in the 55-74 group who took their life by suicide (2,100, as shown in the last graph), being aged 18-34 is a greater risk bracket based on the ratio of people who took their life by suicide to people in the bracket overall (45 per 100,000 compared to 27 in the 55-74 group).
(Source: VA Office of Mental Health and Suicide Risk Prevention, 2020)
Help
Resources
Select each item to review. You will not be able to select Next to continue until all items have been reviewed.
Back
Next

Settings Exit

DMA Mental Health Examinations

Menu | Conducting the Examination | Page 49 of 124 (40%)

Suicide Risk and Transitioning from Service

Are you examining a Veteran or Servicemember who is in transition from service? As an examiner, it is important to note that Veterans or Servicemembers may be at higher risk for suicide while undergoing any transitions, including the compensation and pension exam process.

Research shows that most suicide attempts by those who are or will become Veterans occur shortly after separation from military service. In particular, the first 12 months after separation from service are a critical period, marked by elevated risk for suicide among Veterans. Some Veterans report experiencing difficulties in reintegrating into civilian life. Transitional difficulties can manifest as:

- challenges with garnering employment
- problems with productivity at work or in school
- an inability to complete household activities
- difficulty interacting with friends and family members



Help | Resources | Select Next to continue | Back | Next

Settings Exit

DMA Mental Health Examinations

Menu | Conducting the Examination | Page 50 of 124 (40%)

Suicide Risk and the Presence of Mental Illness

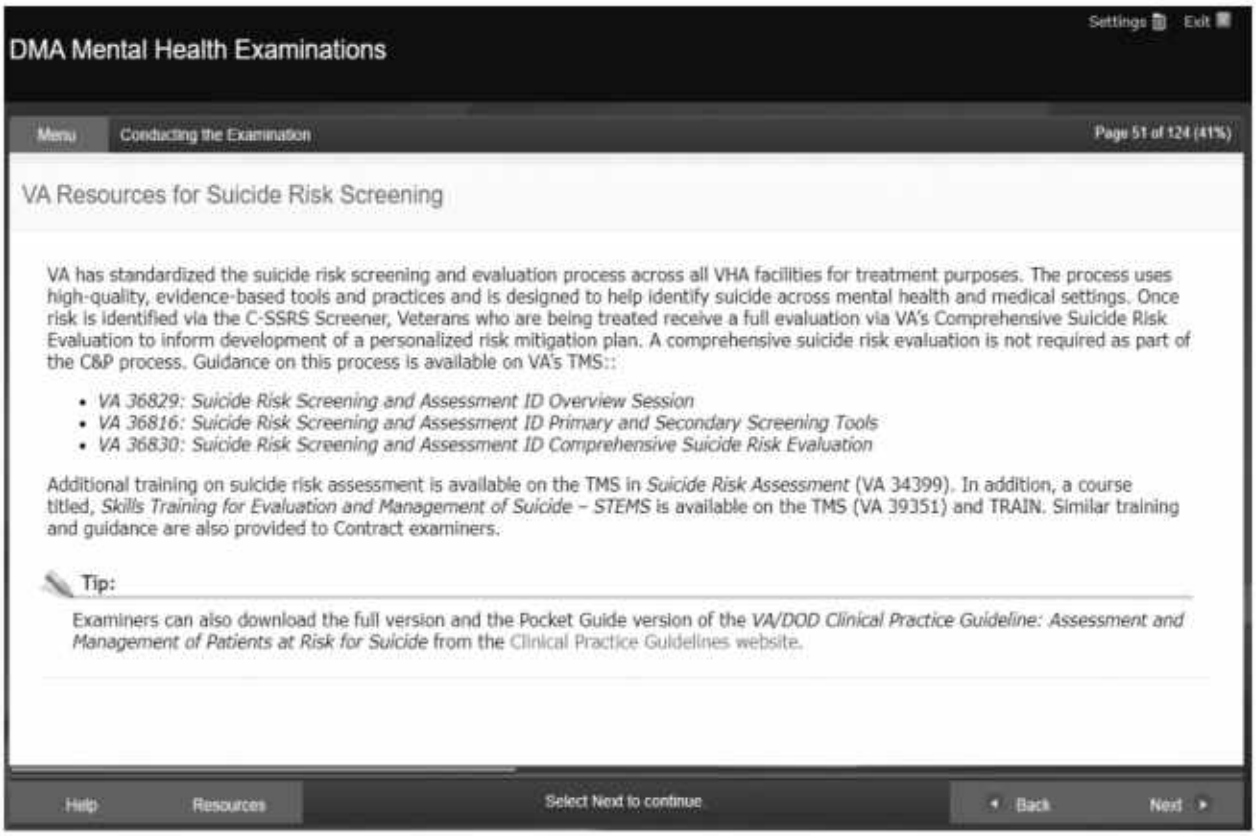
Mental health issues are another important risk factor for suicidality among Veterans and Servicemembers.

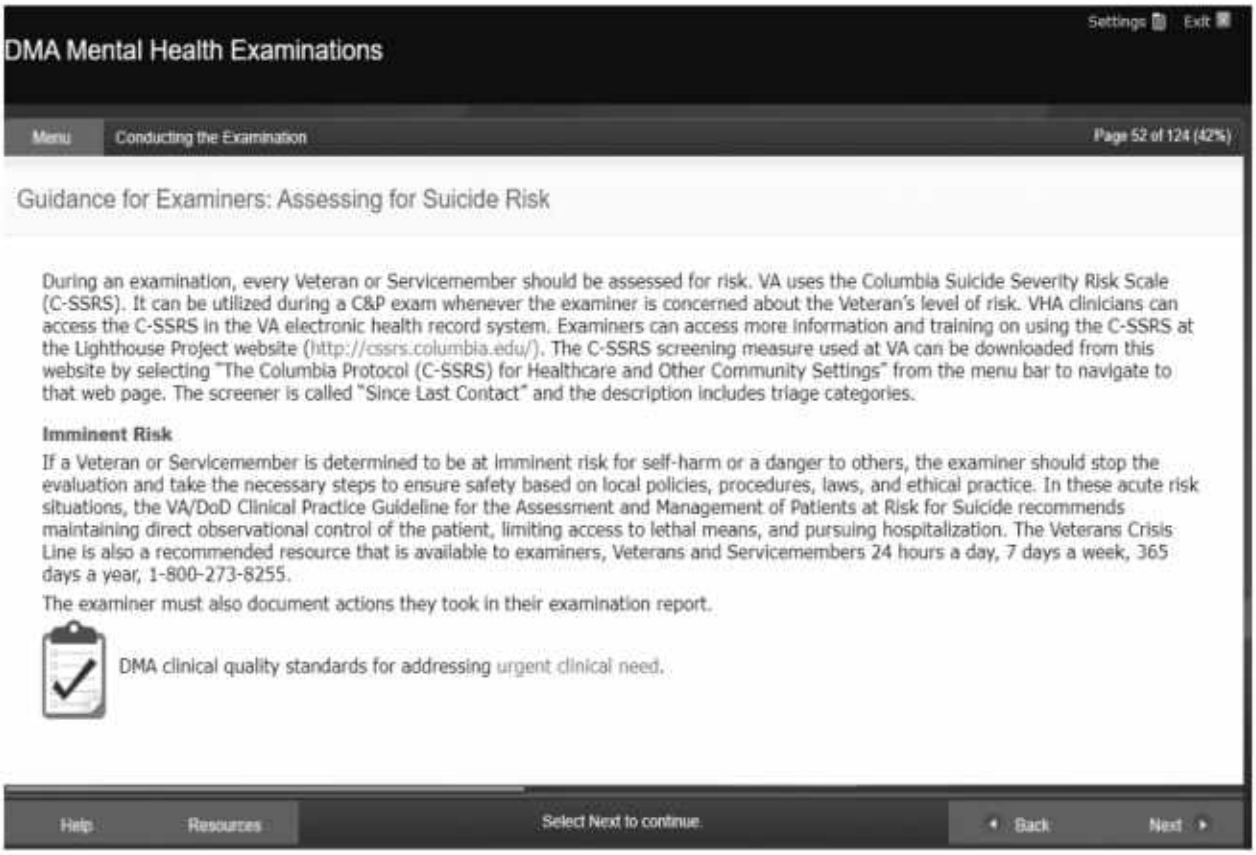
Suicidal thoughts and behaviors are commonly found at increased rates among individuals with psychiatric disorders, especially major depressive disorder, bipolar disorders, schizophrenia, PTSD, anxiety, chemical dependency, and personality disorders. A history of a suicide attempt is the strongest predictor of both future suicide attempts and death by suicide. Intentional self-harm (i.e., intentional self-injury without the expressed intent to die) is also associated with long-term risk for repeated suicide attempts as well as death by suicide. Additionally, the risk of suicide may increase with the severity of Veterans' and Servicemembers' war-related injuries.

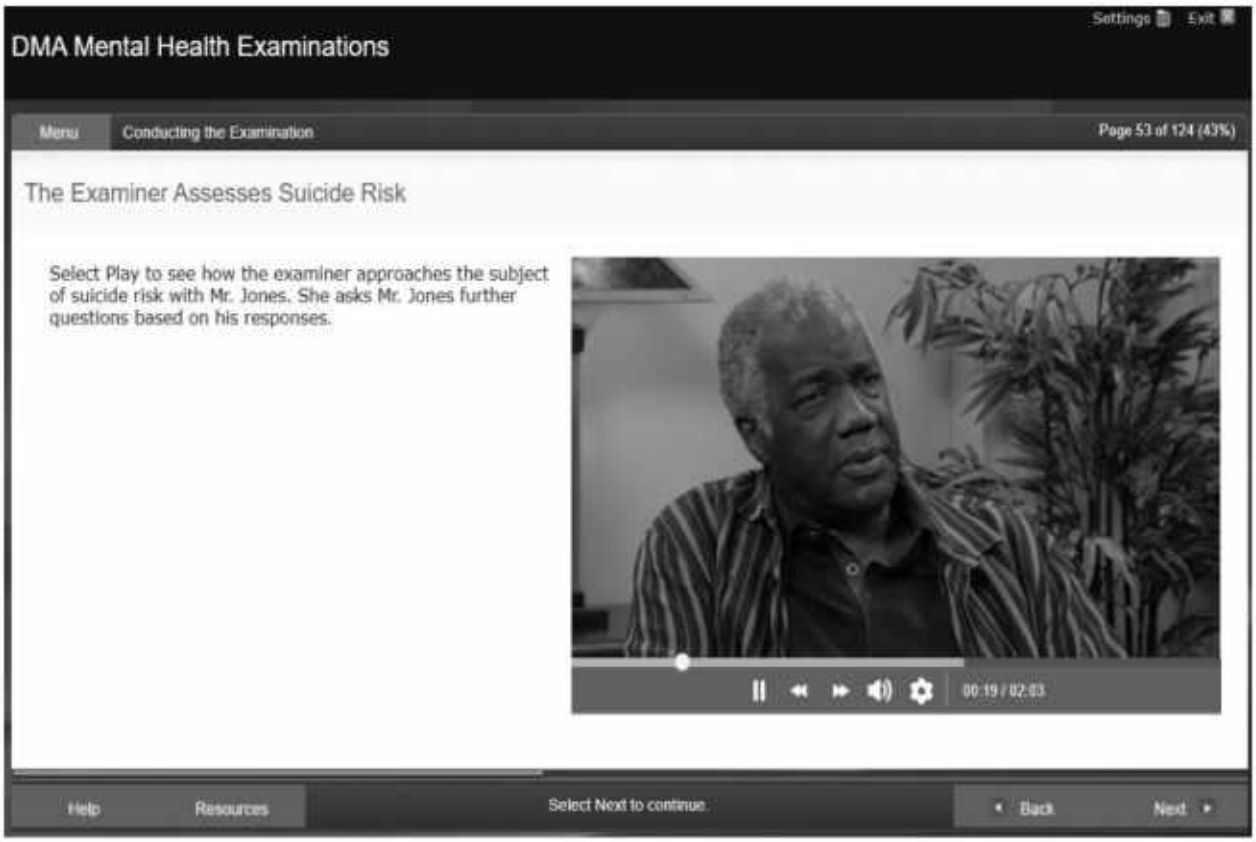
Important Note:

All Veterans and Servicemembers who have a previous mental health diagnosis or who present with any of the suicide warning signs and risk factors should undergo a further suicide risk assessment.

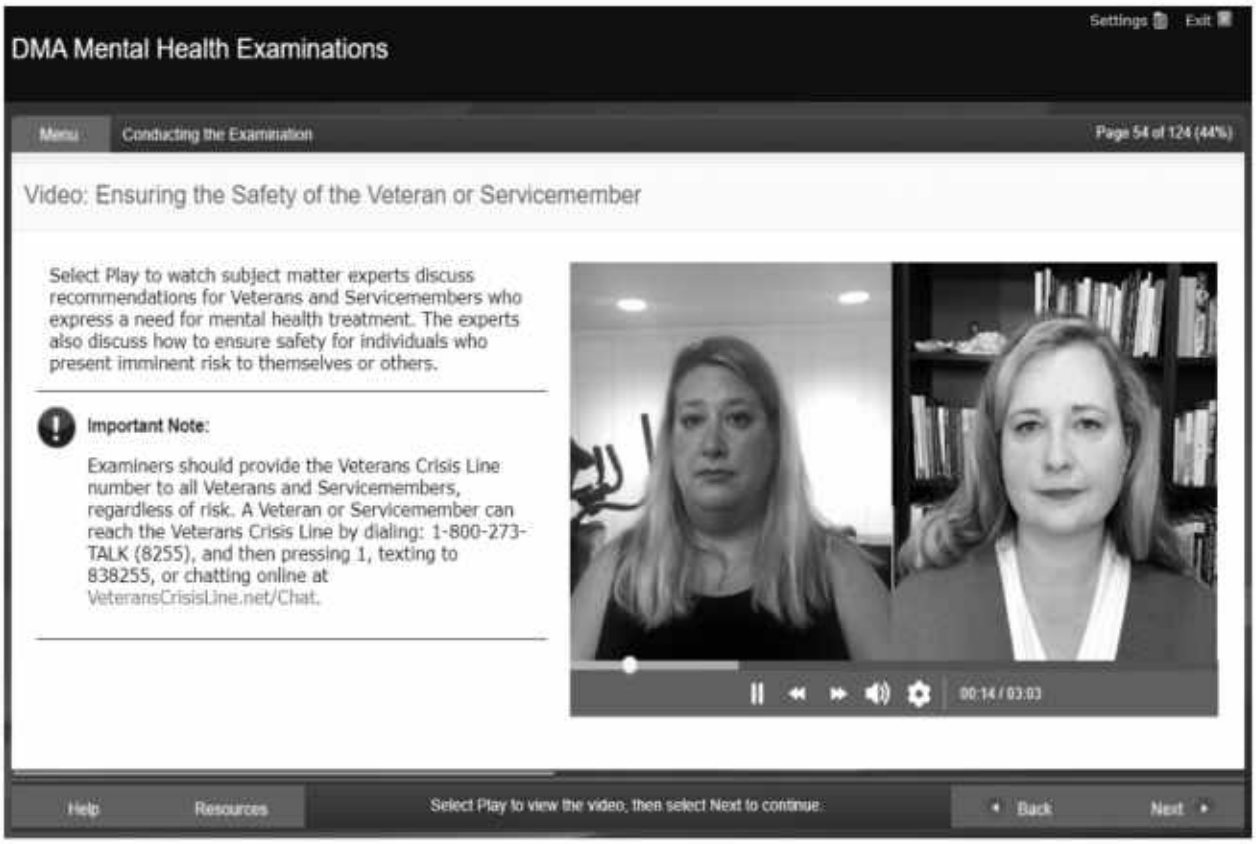
Help | Resources | Select Next to continue | Back | Next


Settings
Exit
DMA Mental Health Examinations
Menu
Conducting the Examination
Page 51 of 124 (41%)
VA Resources for Suicide Risk Screening
VA has standardized the suicide risk screening and evaluation process across all VHA facilities for treatment purposes. The process uses high-quality, evidence-based tools and practices and is designed to help identify suicide across mental health and medical settings. Once risk is identified via the C-SSRS Screener, Veterans who are being treated receive a full evaluation via VA's Comprehensive Suicide Risk Evaluation to inform development of a personalized risk mitigation plan. A comprehensive suicide risk evaluation is not required as part of the C&P process. Guidance on this process is available on VA's TMS::
VA 36829: Suicide Risk Screening and Assessment ID Overview Session
VA 36816: Suicide Risk Screening and Assessment ID Primary and Secondary Screening Tools
VA 36830: Suicide Risk Screening and Assessment ID Comprehensive Suicide Risk Evaluation
Additional training on suicide risk assessment is available on the TMS in Suicide Risk Assessment (VA 34399). In addition, a course titled, Skills Training for Evaluation and Management of Suicide – STEMS is available on the TMS (VA 39351) and TRAIN. Similar training and guidance are also provided to Contract examiners.
Tip:
Examiners can also download the full version and the Pocket Guide version of the VA/DOD Clinical Practice Guideline: Assessment and Management of Patients at Risk for Suicide from the Clinical Practice Guidelines website.
Help
Resources
Select Next to continue
Back
Next


Settings
Exit
DMA Mental Health Examinations
Menu
Conducting the Examination
Page 52 of 124 (42%)
Guidance for Examiners: Assessing for Suicide Risk
During an examination, every Veteran or Servicemember should be assessed for risk. VA uses the Columbia Suicide Severity Risk Scale (C-SSRS). It can be utilized during a C&P exam whenever the examiner is concerned about the Veteran's level of risk. VHA clinicians can access the C-SSRS in the VA electronic health record system. Examiners can access more information and training on using the C-SSRS at the Lighthouse Project website (http://cssrs.columbia.edu/). The C-SSRS screening measure used at VA can be downloaded from this website by selecting "The Columbia Protocol (C-SSRS) for Healthcare and Other Community Settings" from the menu bar to navigate to that web page. The screener is called "Since Last Contact" and the description includes triage categories.
Imminent Risk
If a Veteran or Servicemember is determined to be at imminent risk for self-harm or a danger to others, the examiner should stop the evaluation and take the necessary steps to ensure safety based on local policies, procedures, laws, and ethical practice. In these acute risk situations, the VA/DoD Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide recommends maintaining direct observational control of the patient, limiting access to lethal means, and pursuing hospitalization. The Veterans Crisis Line is also a recommended resource that is available to examiners, Veterans and Servicemembers 24 hours a day, 7 days a week, 365 days a year, 1-800-273-8255.
The examiner must also document actions they took in their examination report.
DMA clinical quality standards for addressing urgent clinical need.
Help
Resources
Select Next to continue
Back
Next

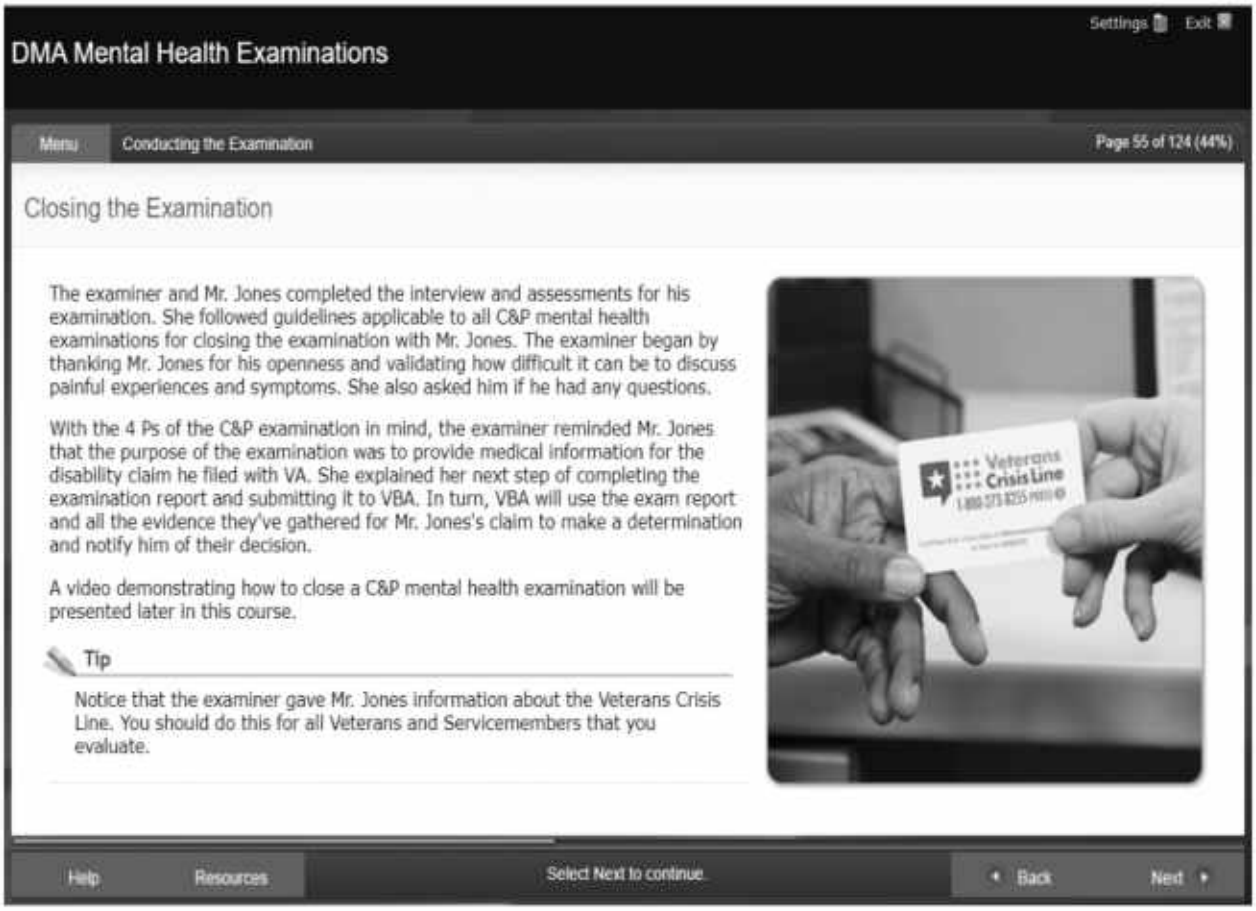


As you've been talking about your experiences with depression, I'm wondering if you've ever had times where you've thought about harming yourself for taking your life? I thought. I thought about dying many times but killing myself, maybe at some point, but I don't think I would ever go through with it, not leave my family behind like that. So you've thought about it in the past. Have you ever had thoughts about how you might end your life? What you would do? No, it's more like if I died in my sleep that it might be better for everybody. Do you remember how often you've thought about suicide? Oh, I don't know. Not even every year. Can you remember the last time you thought about it? I don't know for certain. Not for a few years, anyway. Have you ever attempted to take your life or made preparations to end your life? No. Just the thoughts. Thank you. I know those were hard questions to answer. I want to be sure to give you this card before you leave with the number for the VA Crisis Hotline. I know you're not feeling suicidal right now and you haven't for some time, but this is a number that's free of charge to Veterans 24 hours a day, 365 days a year. And should you ever find yourself feeling that way, having those thoughts, feeling like you're in a crisis, having a difficult time, this is a number you can call at any time. Okay.



Ensuring the safety of Veterans and service members is a critical aspect of a mental health disability evaluation. Stacey and Courtney are with me to discuss how examiners respond to this need. Panelists, Veterans, or service members are asked to discuss difficult areas of their lives and sometimes they are asked to relate traumatic events during a C&P mental health examination. There is a need to provide closure in the sense that you've now opened up some very delicate personal traumas or stressors. Do Veterans or service members sometimes ask an examiner to refer them for clinical care as a result? Yes. How would an examiner respond? This process may be different for VA employees versus contract examiners. And there will also be variations depending on local resources and processes. What is most important is that you have an established protocol to follow, especially for assisting Veterans who are in crisis. Even if a Veteran is not in crisis or denies having thoughts of suicide, it is good clinical practice to provide the Veterans Crisis Line number and to review the availability of additional resources, such as 911, emergency rooms at the VA or in the community, and VA urgent care clinics. For Veterans who are not in crisis but are interested in starting or returning to treatment, having a process for a warm handoff or a direct referral can facilitate the process and reduce the likelihood that the Veteran might fall through the cracks and not receive care. I understand that since an examiner has done a thorough psychological exam, that can sometimes raise the emotional state. It can even make an examiner reach a conclusion that there's an elevated level of risk. Are there times when the examiner should make sure the Veteran gets treatment? Yes, some Veterans report thoughts of suicide or homicide and these situations may trigger your clinical obligations of duty to warn and duty to protect. It is important that you have a protocol in place before you encounter this scenario. You should also have a protocol in place for ensuring safety in the event that a Veteran becomes violent or disruptive. As we discussed

earlier, being a disability examiner does not remove your clinical and ethical responsibilities. VBA may be your client, but you have an ethical responsibility to the person in front of you and to your license and to the VA that you are not sending anybody home who is in crisis. So it is critically important for examiners to be prepared and know the protocols for helping Veterans in these kinds of situations. Yes, it is. Thank you, panelists, for clarifying how examiners can ensure safety for the Veterans and service members they evaluate.



DMA Mental Health Examinations

Settings Exit

Menu | Conducting the Examination | Page 56 of 124 (45%)

Asking and Answering Questions

This table shows recommendations for appropriate topics to talk about or avoid when answering common questions from Veterans and Servicemembers. If you are not the person who can address a question, be sure to direct them to the appropriate resource.

Appropriate Topics	Topics to Avoid
Appropriate topics to discuss include: • the next steps in the disability examination process • the importance for the Veteran or Servicemember to discuss treatment-related questions with their treatment provider • potential VHA and non-VHA resources • how to access the Veteran Crisis Line: 1-800-273-TALK	Never discuss these topics: • the merits of the Veteran's or Servicemember's claim • the percentage of service-connected disability to be granted • the likely outcome of the claim as a result of the examination • any opinion regarding the relationship of a disorder to service

Tip

Remember, it is VBA's role to determine the claim based on all the evidence they have. Even when asked by a Veteran or Servicemember to speculate on the outcome, you should never do so. Instead, you can inform Veterans and Servicemembers that they can get answers to questions about their claims by visiting the Department of Veterans Affairs website (www.va.gov) or calling VBA's toll-free number: 800-827-1000.

Help | Resources | Select Next to continue | Back | Next

DMA Mental Health Examinations

Settings Exit

Menu | Conducting the Examination | Page 58 of 124 (47%)

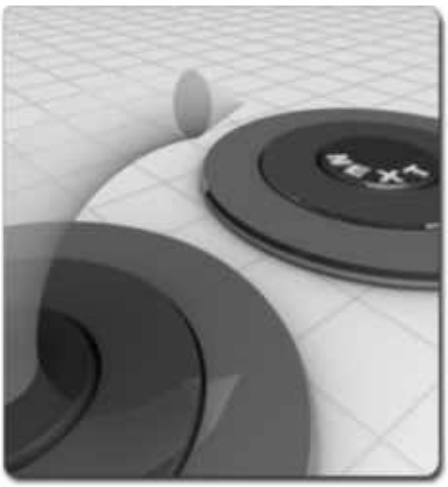
Lesson 3 Summary

This lesson focused on guidelines and requirements for conducting C&P mental health examinations. Before conducting a mental health examination, you can use what you've learned to:

- Increase your awareness of military culture and terminology.
- Be aware of policy regarding Veterans' or Servicemembers' preferences for the gender of examiner.
- Access several measures used for assessing social and occupational impairment.
- Ensure you know protocols in place at your facility for addressing imminent risk to the safety of a Veteran or Servicemember and others.

You can use what you've learned during an examination to:

- Greet the Veteran or Servicemember and explain the purpose, process, people, and end product for their C&P examination.
- Gather information about the Veteran's or Servicemember's history.
- Conduct diagnostic, nexus, social and occupational impairment, and suicide risk assessments.
- Provide helpful information for the Veteran or Servicemember as you close the examination.



Help | Resources | Select Next to continue | Back | Next

Settings Exit

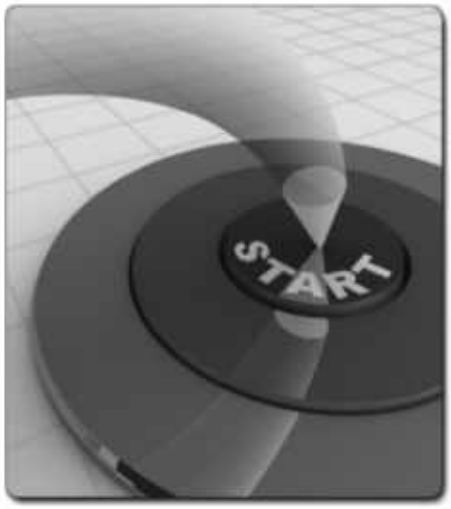
DMA Mental Health Examinations

Menu | Documenting the Examination | Page 59 of 124 (48%)

Lesson 4 Overview

This lesson will focus on completing C&P mental health documentation protocol(s) for reporting examination findings to adjudicators. Documentation protocols you submit must be complete and address VBA's requirements and requests as stated on a Request for Examination. There are also requirements for determinations of financial competency, diagnoses, and medical opinions.

In addition, this lesson will provide common reasons for VBA to return examination reports to be remediated. Since C&P mental health examination reports are evaluated using DMA mental health clinical quality standards, those will be presented and summarized at the end of the lesson.



Help | Resources | Select Next to continue | Back | Next

Settings Exit

DMA Mental Health Examinations

Menu | Documenting the Examination | Page 60 of 124 (48%)

C&P Examination Reports

It is essential to complete the documentation protocol(s) that are used to report the examination, as they have been designed to elicit information legally required under VA laws and regulations to decide a Veteran's or Servicemember's claim. While the questions, order, and organization of a documentation protocol may seem strange or puzzling to you, the structure of the documentation protocol prioritizes the information that is needed by VBA to fulfill specific legal requirements.

In addition to providing all of the required information, you can include additional information that substantiates your findings, but which is not specifically requested in the documentation protocol. At a minimum, you should address pertinent findings from the claimant's records, including lay evidence or information that VBA tabs or identifies, to support diagnoses and nexus statements or opinions.

The documentation protocol(s) you complete will be used along with all other evidence to determine whether service connection is warranted and what level of compensation may be afforded the Veteran or Servicemember. If your documentation includes incomplete or inaccurate information, the Veteran or Servicemember may not receive the benefits to which they are entitled. It is also important to address any discrepancies in the data you have considered in order to ensure that your clinical rationales are fully reasoned and well supported.

Purpose and Audience

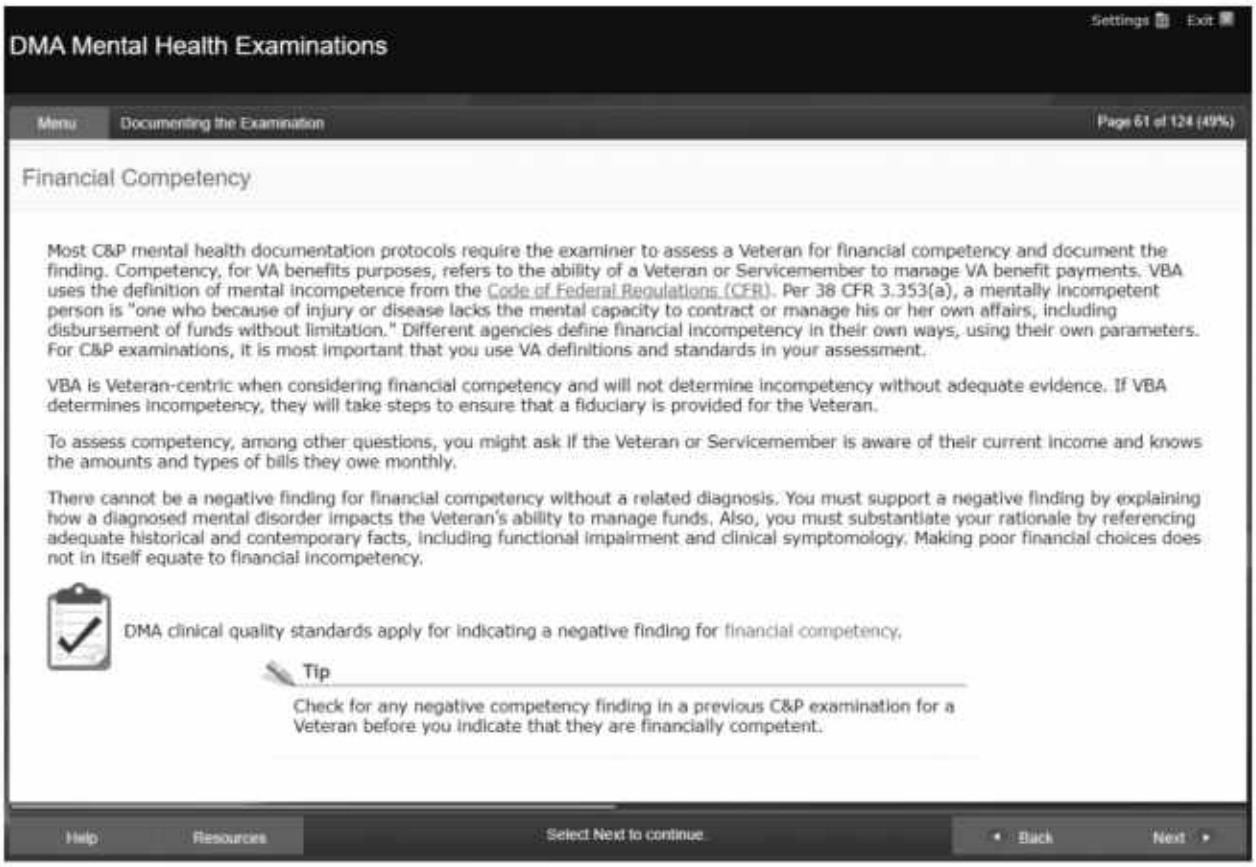
Just as there is a difference between treatment and C&P disability evaluations, there is a difference between reports for each. A treatment evaluation report requires information for treatment purposes and is written primarily for clinicians to understand.

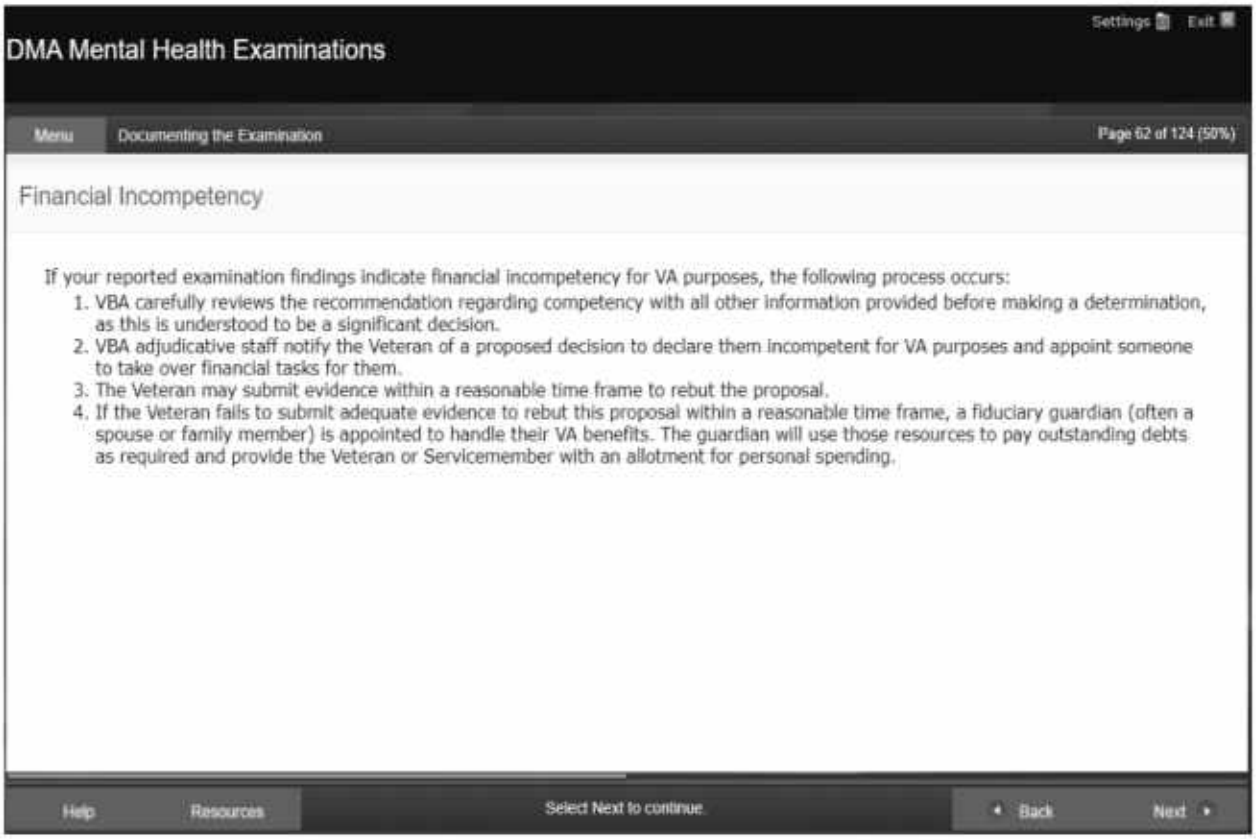
However, a C&P evaluation report requires medical information for legal purposes and the intended audience is primarily Veterans Benefits Administration (VBA) adjudicative staff. If the adjudication decision is appealed, the audience can include lawyers and judges. The report should be understandable and usable for all of these individuals, keeping in mind that they are not medical professionals.



DMA clinical quality standards apply for consistency.

Help | Resources | Select Next to continue | Back | Next


DMA Mental Health Examinations
Settings
Exit
Menu
Documenting the Examination
Page 61 of 124 (49%)
Financial Competency
Most C&P mental health documentation protocols require the examiner to assess a Veteran for financial competency and document the finding. Competency, for VA benefits purposes, refers to the ability of a Veteran or Servicemember to manage VA benefit payments. VBA uses the definition of mental incompetence from the Code of Federal Regulations (CFR). Per 38 CFR 3.353(a), a mentally incompetent person is "one who because of injury or disease lacks the mental capacity to contract or manage his or her own affairs, including disbursement of funds without limitation." Different agencies define financial incompetency in their own ways, using their own parameters. For C&P examinations, it is most important that you use VA definitions and standards in your assessment.
VBA is Veteran-centric when considering financial competency and will not determine incompetency without adequate evidence. If VBA determines incompetency, they will take steps to ensure that a fiduciary is provided for the Veteran.
To assess competency, among other questions, you might ask if the Veteran or Servicemember is aware of their current income and knows the amounts and types of bills they owe monthly.
There cannot be a negative finding for financial competency without a related diagnosis. You must support a negative finding by explaining how a diagnosed mental disorder impacts the Veteran's ability to manage funds. Also, you must substantiate your rationale by referencing adequate historical and contemporary facts, including functional impairment and clinical symptomology. Making poor financial choices does not in itself equate to financial incompetency.
DMA clinical quality standards apply for indicating a negative finding for financial competency.
Tip
Check for any negative competency finding in a previous C&P examination for a Veteran before you indicate that they are financially competent.
Help
Resources
Select Next to continue
Back
Next


DMA Mental Health Examinations
Settings
Exit
Menu
Documenting the Examination
Page 62 of 124 (50%)
Financial Incompetency
If your reported examination findings indicate financial incompetency for VA purposes, the following process occurs:
1. VBA carefully reviews the recommendation regarding competency with all other information provided before making a determination, as this is understood to be a significant decision.
2. VBA adjudicative staff notify the Veteran of a proposed decision to declare them incompetent for VA purposes and appoint someone to take over financial tasks for them.
3. The Veteran may submit evidence within a reasonable time frame to rebut the proposal.
4. If the Veteran fails to submit adequate evidence to rebut this proposal within a reasonable time frame, a fiduciary guardian (often a spouse or family member) is appointed to handle their VA benefits. The guardian will use those resources to pay outstanding debts as required and provide the Veteran or Servicemember with an allotment for personal spending.
Help
Resources
Select Next to continue
Back
Next

DMA Mental Health Examinations

Settings Exit

Menu | Documenting the Examination | Page 63 of 124 (51%)

Diagnosis Needs

A C&P mental health examination should provide a complete review of a Veteran's or Servicemember's psychiatric symptoms when establishing a well-supported diagnosis. Here are basic needs for a C&P diagnosis:

- **Provide a diagnosis based on the Veteran's or Servicemember's whole history and current examination.**
- **If any additional information is needed to confirm the diagnosis, obtain it before submitting your report.** Otherwise the examination is incomplete and will be returned as insufficient.
- **Provide a definitive diagnosis:** Do not use phrases such as "differential diagnosis" or "rule out."
- **Provide a clinically accurate diagnosis, if any:** Provide a diagnosis in accordance with the current DSM rather than using symptoms (e.g., hallucinations) or signs (e.g., agitation).*
- **Explain how the Veteran or Servicemember meets the current DSM diagnostic criteria for the mental disorder(s) diagnosed or does not meet the diagnostic criteria for a claimed condition. ***

*These requirements come from the VA Schedule for Rating Disabilities (VASRD), per 38 CFR 4.125(a).



DMA clinical quality standards apply for testing and diagnosis.

Help | Resources | Select Next to continue | Back | Next

DMA Mental Health Examinations

Settings Exit

Menu | Documenting the Examination | Page 64 of 124 (52%)

Diagnoses for Conditions Other Than Claimed

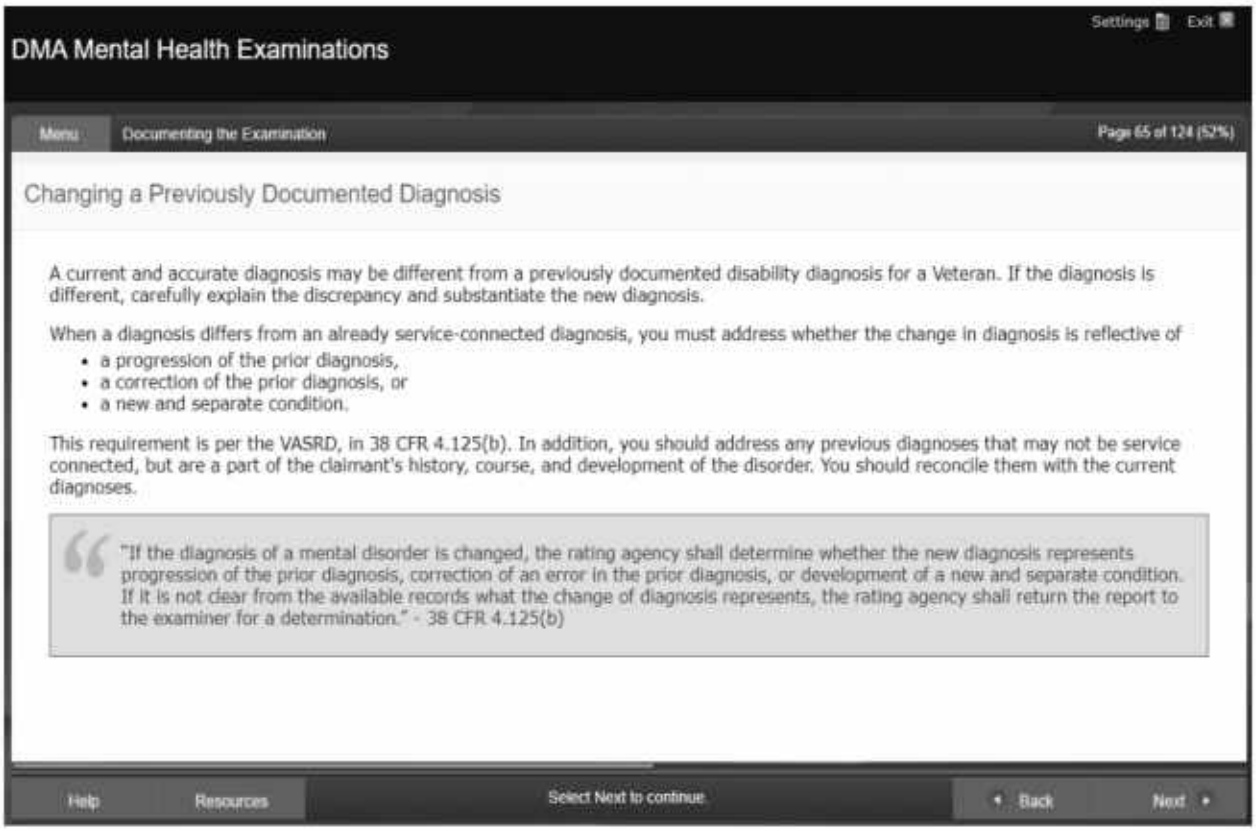
VBA will sometimes request an examination for a specifically identified mental disorder that the Veteran or Servicemember listed on his or her claim. Because of the *Clemons v. Shinseki* case, however, you should consider other diagnoses, or additional comorbid or related disorders, that more accurately capture the symptoms being reported (e.g., anxiety was claimed but a depressive disorder was found on examination).

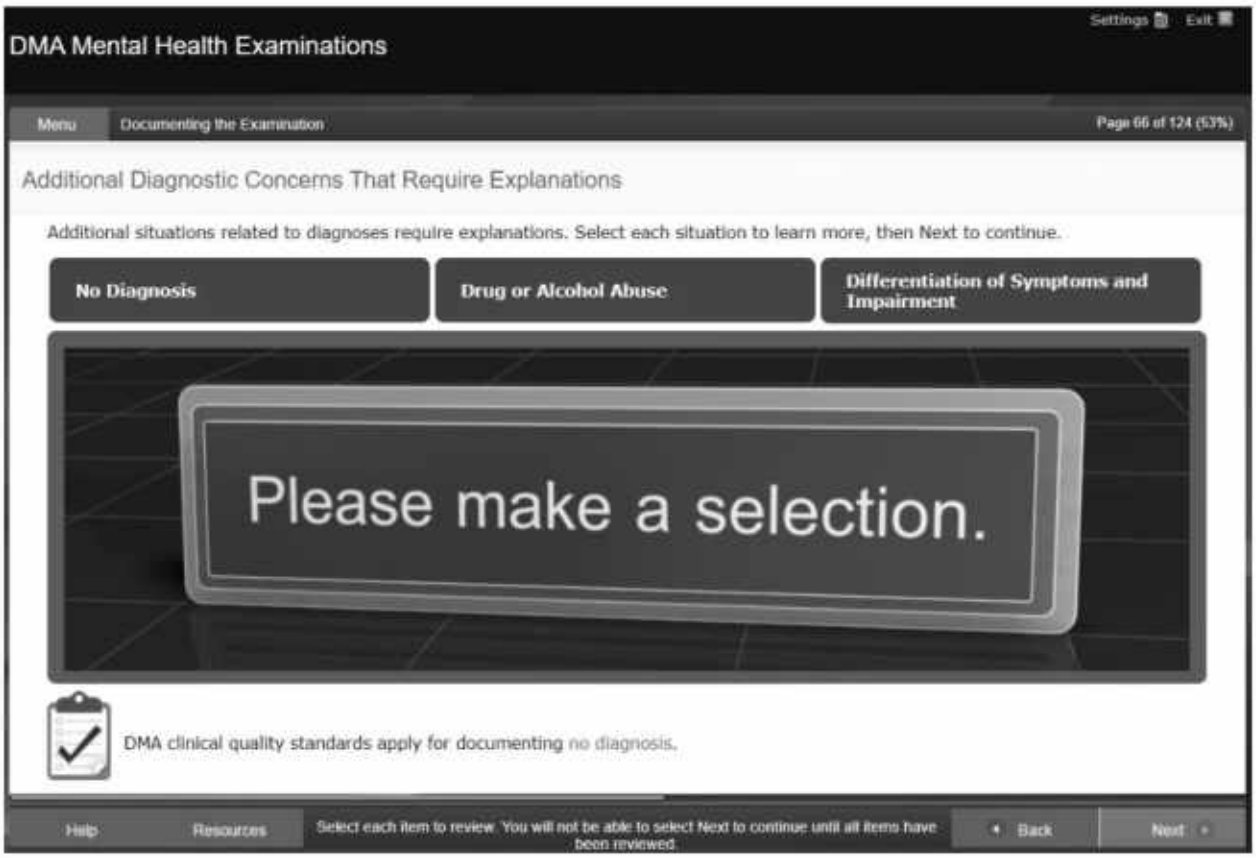
As you learned in the DMA General Certification Overview course, the court decision for *Clemons v. Shinseki*, (23 Vet.App. 1) found that a claimant may identify a particular mental condition, such as PTSD, on their claim application, but the scope of the claim cannot be limited by VA only to the condition stated. Rather, it must be considered a claim for any mental disability that may reasonably be encompassed by several factors, including

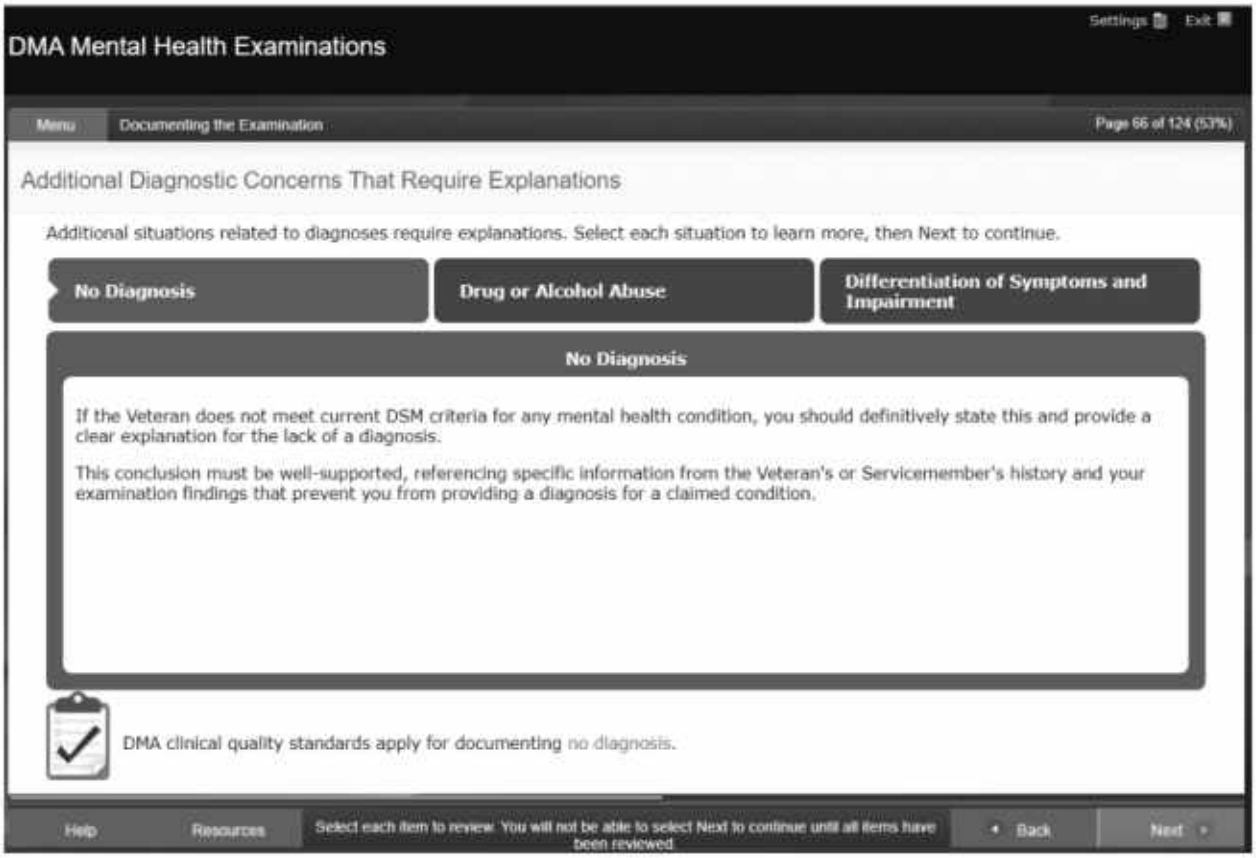
- the Veteran's or Servicemember's description of the claim,
- the symptoms the Veteran or Servicemember describes, and
- the information the Veteran or Servicemember submits or that VA obtains in support of the claim.

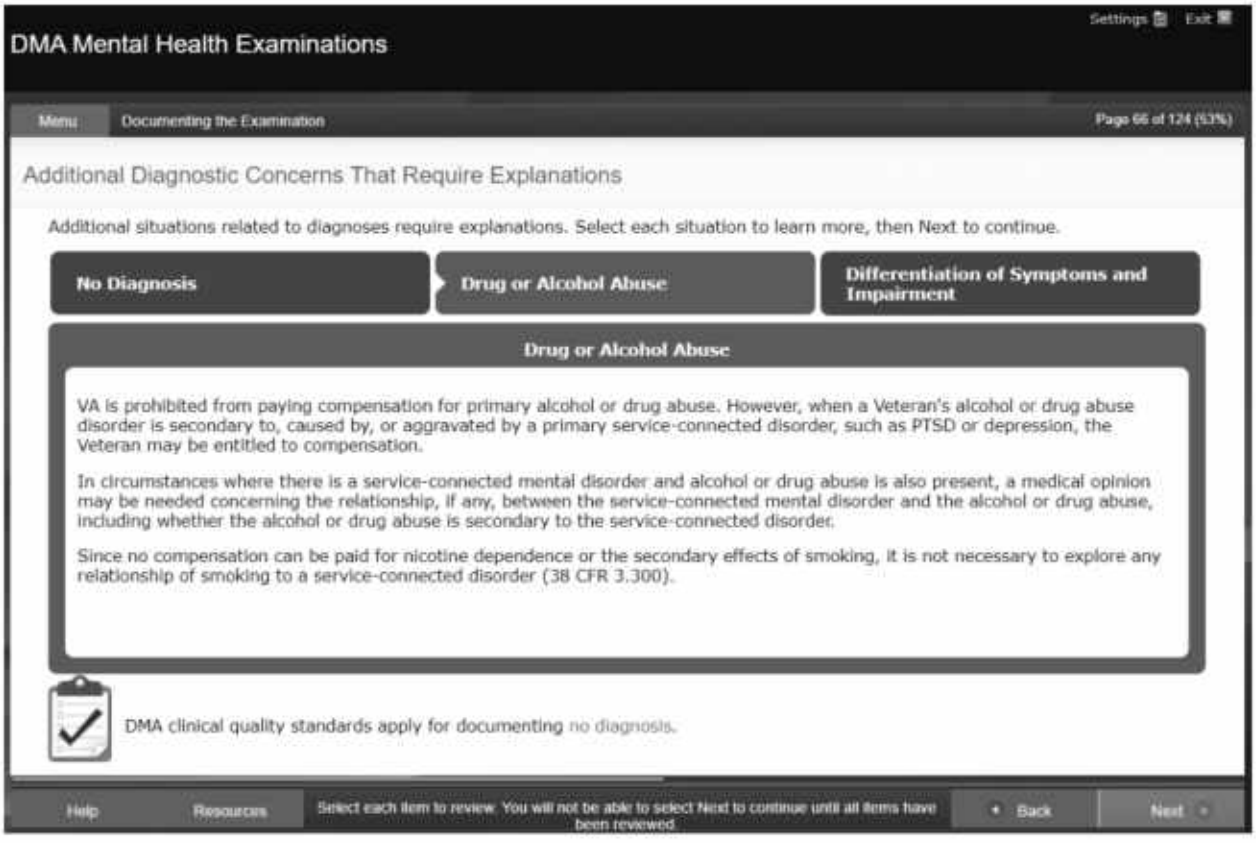
When you diagnose multiple or alternative mental disorders, you must explain their etiology and how they are related to each other. This is a situation where an explanation is not solicited by VBA, yet you must supply one.

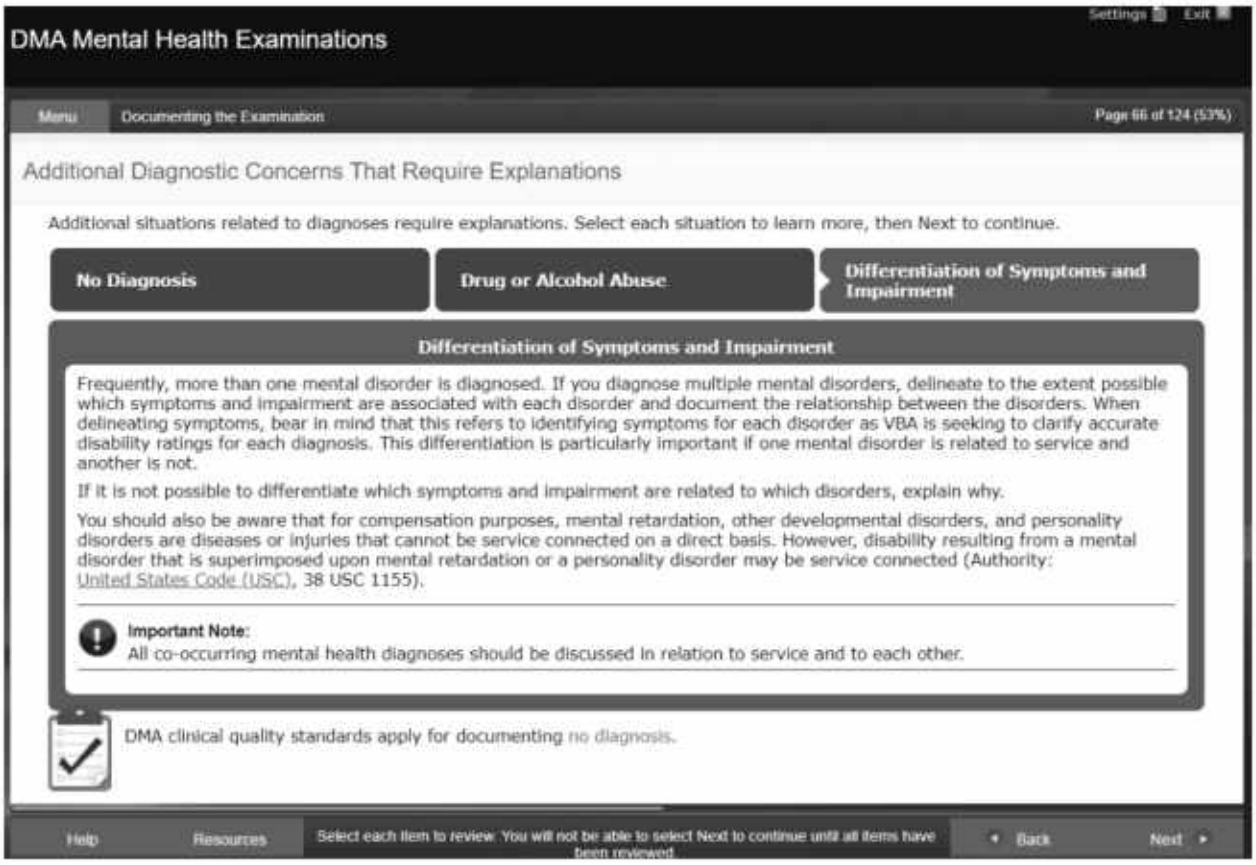
Help | Resources | Select Next to continue | Back | Next

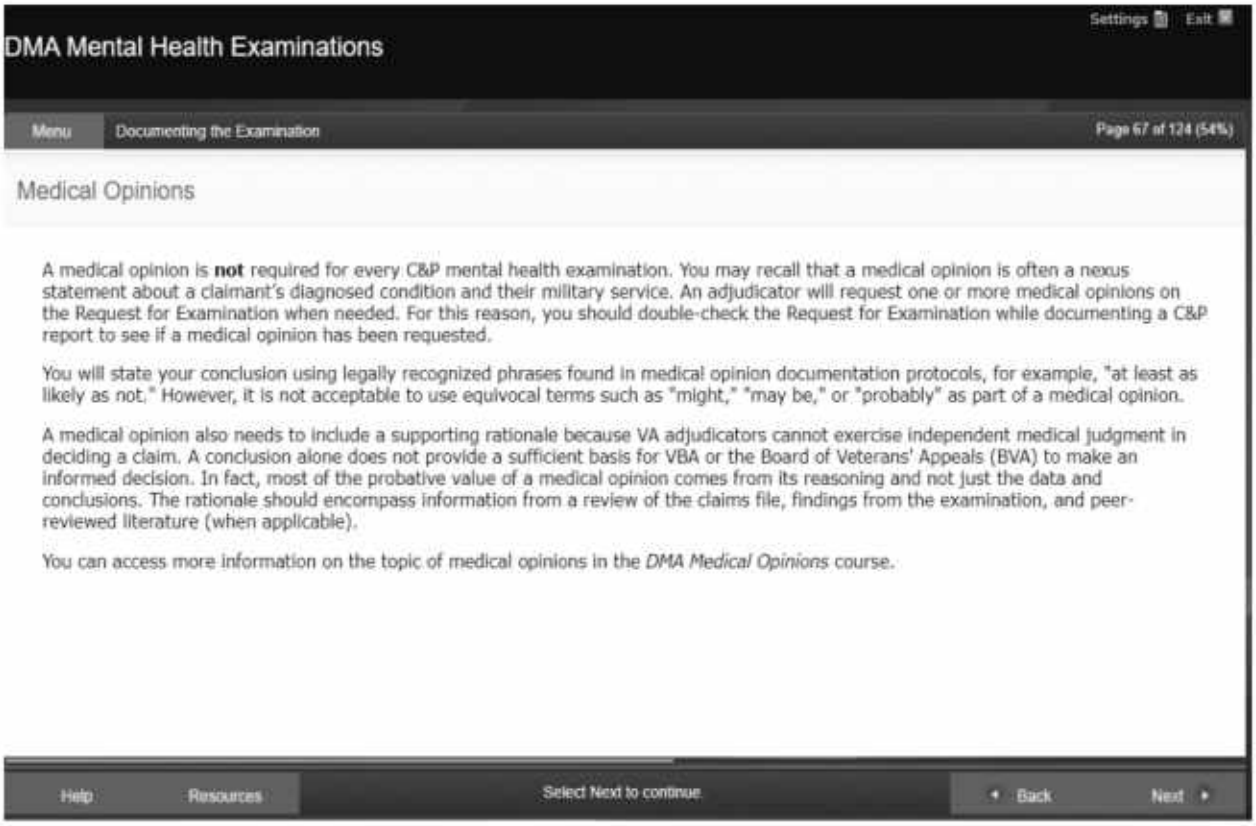

DMA Mental Health Examinations
Settings
Exit
Menu
Documenting the Examination
Page 65 of 124 (52%)
Changing a Previously Documented Diagnosis
A current and accurate diagnosis may be different from a previously documented disability diagnosis for a Veteran. If the diagnosis is different, carefully explain the discrepancy and substantiate the new diagnosis.
When a diagnosis differs from an already service-connected diagnosis, you must address whether the change in diagnosis is reflective of
• a progression of the prior diagnosis,
• a correction of the prior diagnosis, or
• a new and separate condition.
This requirement is per the VASRD, in 38 CFR 4.125(b). In addition, you should address any previous diagnoses that may not be service connected, but are a part of the claimant's history, course, and development of the disorder. You should reconcile them with the current diagnoses.
"If the diagnosis of a mental disorder is changed, the rating agency shall determine whether the new diagnosis represents progression of the prior diagnosis, correction of an error in the prior diagnosis, or development of a new and separate condition. If it is not clear from the available records what the change of diagnosis represents, the rating agency shall return the report to the examiner for a determination." - 38 CFR 4.125(b)
Help
Resources
Select Next to continue
Back
Next

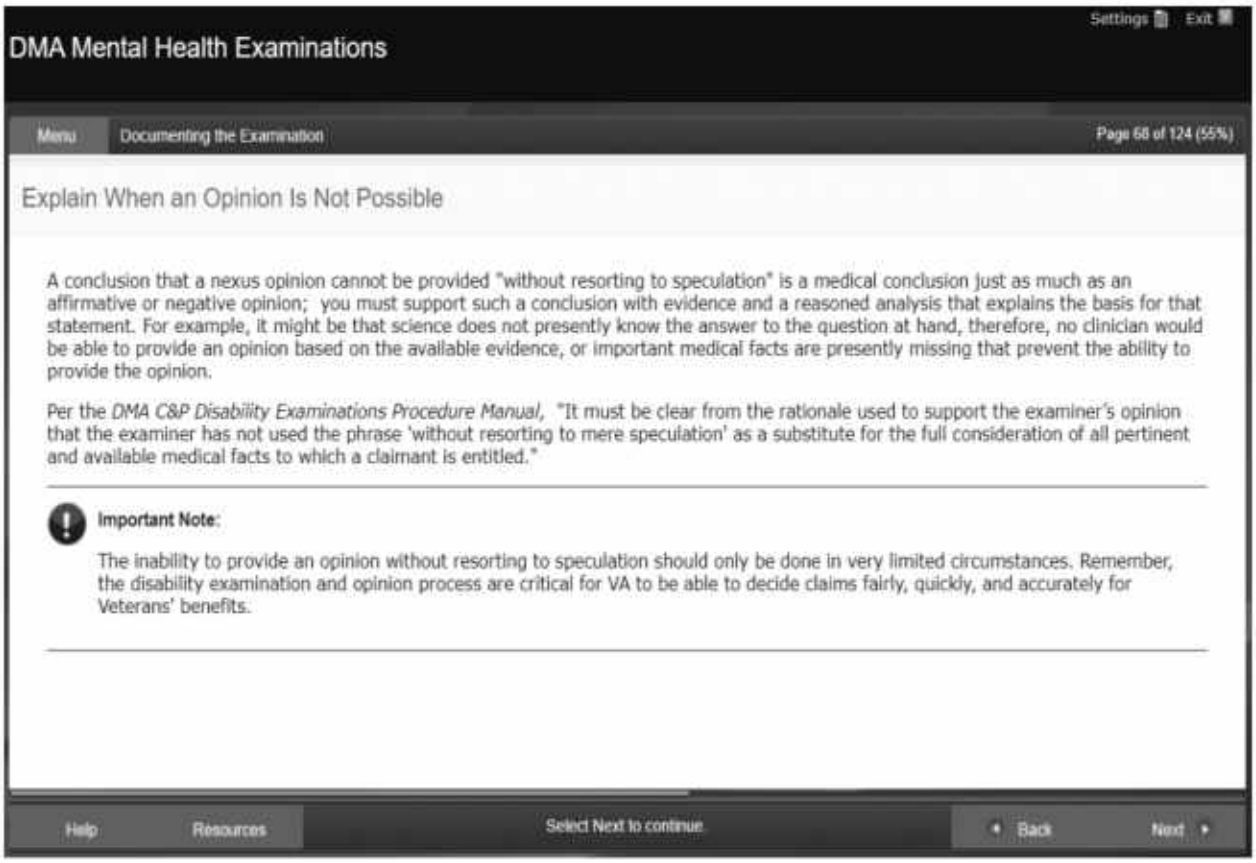

DMA Mental Health Examinations
Settings
Exit
Menu
Documenting the Examination
Page 66 of 124 (53%)
Additional Diagnostic Concerns That Require Explanations
Additional situations related to diagnoses require explanations. Select each situation to learn more, then Next to continue.
No Diagnosis
Drug or Alcohol Abuse
Differentiation of Symptoms and Impairment
Please make a selection.
DMA clinical quality standards apply for documenting no diagnosis.
Help
Resources
Select each item to review. You will not be able to select Next to continue until all items have been reviewed
Back
Next

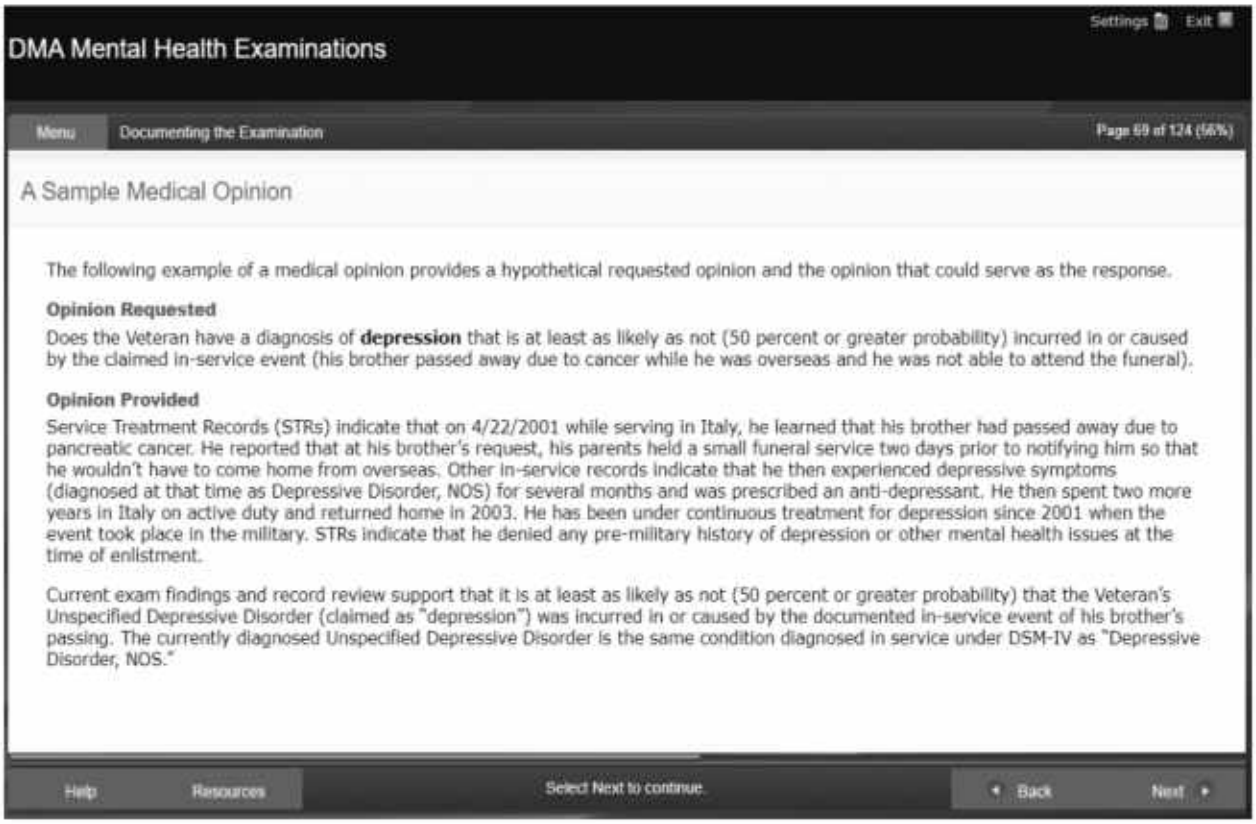

DMA Mental Health Examinations
Settings
Exit
Menu
Documenting the Examination
Page 66 of 124 (53%)
Additional Diagnostic Concerns That Require Explanations
Additional situations related to diagnoses require explanations. Select each situation to learn more, then Next to continue.
No Diagnosis
Drug or Alcohol Abuse
Differentiation of Symptoms and Impairment
No Diagnosis
If the Veteran does not meet current DSM criteria for any mental health condition, you should definitively state this and provide a clear explanation for the lack of a diagnosis.
This conclusion must be well-supported, referencing specific information from the Veteran's or Servicemember's history and your examination findings that prevent you from providing a diagnosis for a claimed condition.
DMA clinical quality standards apply for documenting no diagnosis.
Help
Resources
Select each item to review. You will not be able to select Next to continue until all items have been reviewed.
Back
Next

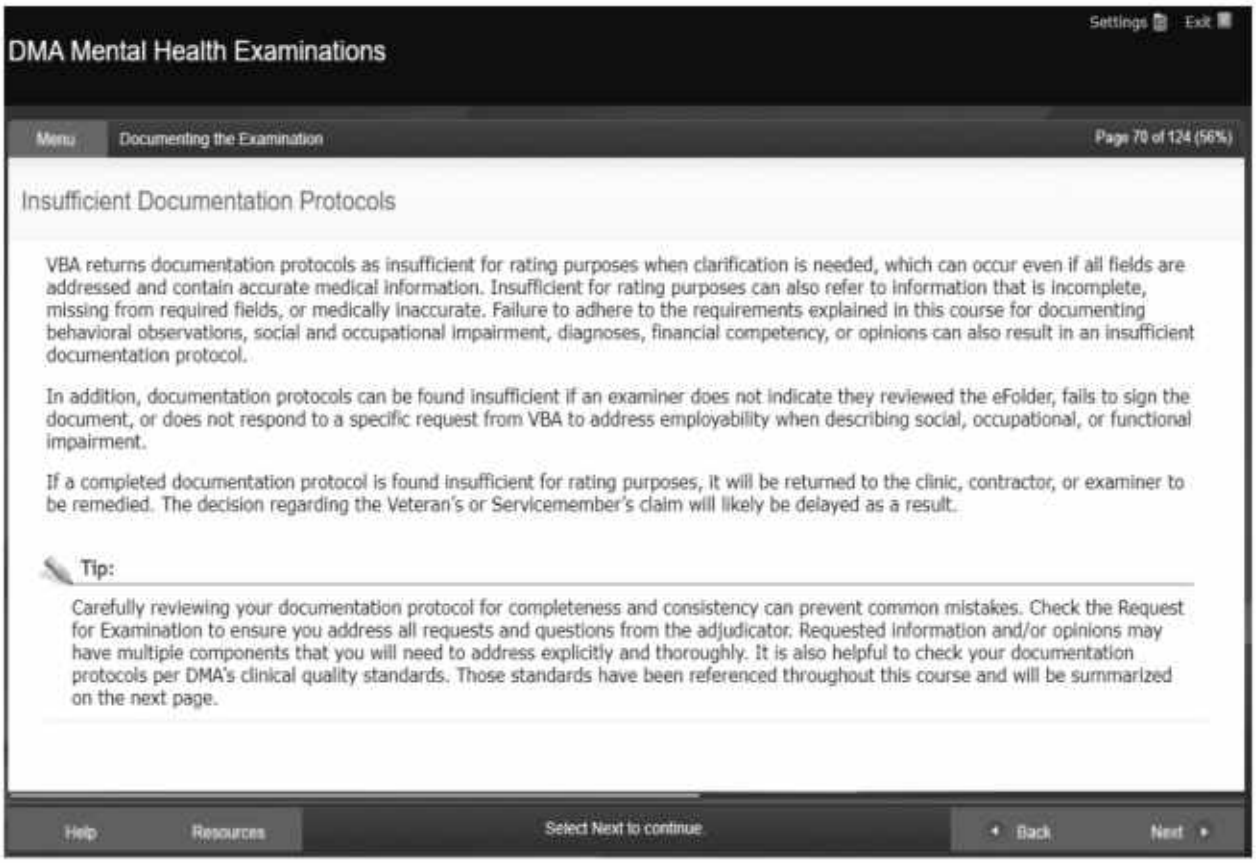

DMA Mental Health Examinations
Settings
Exit
Menu
Documenting the Examination
Page 66 of 124 (53%)
Additional Diagnostic Concerns That Require Explanations
Additional situations related to diagnoses require explanations. Select each situation to learn more, then Next to continue.
No Diagnosis
Drug or Alcohol Abuse
Differentiation of Symptoms and Impairment
Drug or Alcohol Abuse
VA is prohibited from paying compensation for primary alcohol or drug abuse. However, when a Veteran's alcohol or drug abuse disorder is secondary to, caused by, or aggravated by a primary service-connected disorder, such as PTSD or depression, the Veteran may be entitled to compensation.
In circumstances where there is a service-connected mental disorder and alcohol or drug abuse is also present, a medical opinion may be needed concerning the relationship, if any, between the service-connected mental disorder and the alcohol or drug abuse, including whether the alcohol or drug abuse is secondary to the service-connected disorder.
Since no compensation can be paid for nicotine dependence or the secondary effects of smoking, it is not necessary to explore any relationship of smoking to a service-connected disorder (38 CFR 3.300).
DMA clinical quality standards apply for documenting no diagnosis.
Help
Resources
Select each item to review. You will not be able to select Next to continue until all items have been reviewed.
Back
Next

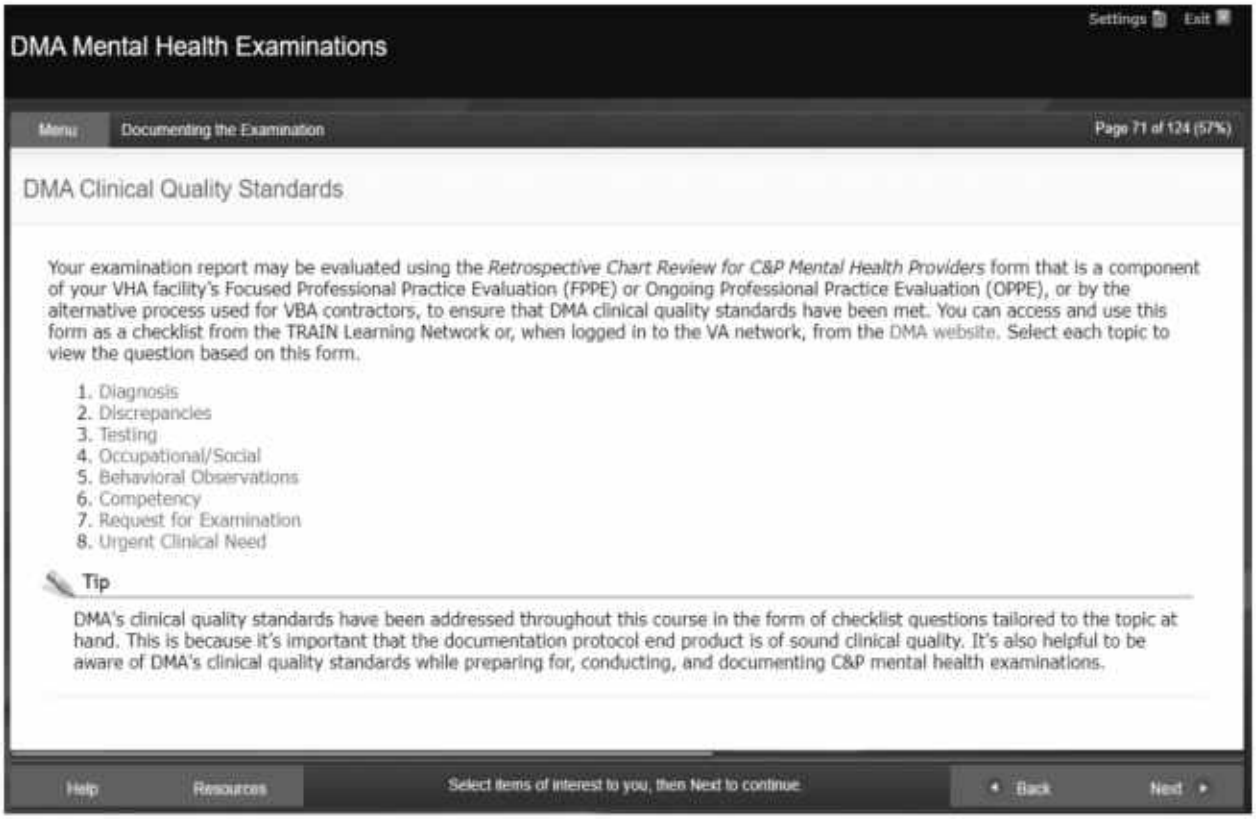

DMA Mental Health Examinations
Settings
Exit
Menu
Documenting the Examination
Page 66 of 124 (53%)
Additional Diagnostic Concerns That Require Explanations
Additional situations related to diagnoses require explanations. Select each situation to learn more, then Next to continue.
No Diagnosis
Drug or Alcohol Abuse
Differentiation of Symptoms and Impairment
Differentiation of Symptoms and Impairment
Frequently, more than one mental disorder is diagnosed. If you diagnose multiple mental disorders, delineate to the extent possible which symptoms and impairment are associated with each disorder and document the relationship between the disorders. When delineating symptoms, bear in mind that this refers to identifying symptoms for each disorder as VBA is seeking to clarify accurate disability ratings for each diagnosis. This differentiation is particularly important if one mental disorder is related to service and another is not.
If it is not possible to differentiate which symptoms and impairment are related to which disorders, explain why.
You should also be aware that for compensation purposes, mental retardation, other developmental disorders, and personality disorders are diseases or injuries that cannot be service connected on a direct basis. However, disability resulting from a mental disorder that is superimposed upon mental retardation or a personality disorder may be service connected (Authority: United States Code (USC), 38 USC 1155).
Important Note:
All co-occurring mental health diagnoses should be discussed in relation to service and to each other.
DMA clinical quality standards apply for documenting no diagnosis.
Help
Resources
Select each item to review. You will not be able to select Next to continue until all items have been reviewed.
Back
Next


DMA Mental Health Examinations
Settings
Exit
Menu
Documenting the Examination
Page 67 of 124 (54%)
Medical Opinions
A medical opinion is **not** required for every C&P mental health examination. You may recall that a medical opinion is often a nexus statement about a claimant's diagnosed condition and their military service. An adjudicator will request one or more medical opinions on the Request for Examination when needed. For this reason, you should double-check the Request for Examination while documenting a C&P report to see if a medical opinion has been requested.
You will state your conclusion using legally recognized phrases found in medical opinion documentation protocols, for example, "at least as likely as not." However, it is not acceptable to use equivocal terms such as "might," "may be," or "probably" as part of a medical opinion.
A medical opinion also needs to include a supporting rationale because VA adjudicators cannot exercise independent medical judgment in deciding a claim. A conclusion alone does not provide a sufficient basis for VBA or the Board of Veterans' Appeals (BVA) to make an informed decision. In fact, most of the probative value of a medical opinion comes from its reasoning and not just the data and conclusions. The rationale should encompass information from a review of the claims file, findings from the examination, and peer-reviewed literature (when applicable).
You can access more information on the topic of medical opinions in the *DMA Medical Opinions* course.
Help
Resources
Select Next to continue
Back
Next


Settings
Exit
DMA Mental Health Examinations
Menu
Documenting the Examination
Page 68 of 124 (55%)
Explain When an Opinion Is Not Possible
A conclusion that a nexus opinion cannot be provided "without resorting to speculation" is a medical conclusion just as much as an affirmative or negative opinion; you must support such a conclusion with evidence and a reasoned analysis that explains the basis for that statement. For example, it might be that science does not presently know the answer to the question at hand, therefore, no clinician would be able to provide an opinion based on the available evidence, or important medical facts are presently missing that prevent the ability to provide the opinion.
Per the DMA C&P Disability Examinations Procedure Manual, "It must be clear from the rationale used to support the examiner's opinion that the examiner has not used the phrase 'without resorting to mere speculation' as a substitute for the full consideration of all pertinent and available medical facts to which a claimant is entitled."
Important Note:
The inability to provide an opinion without resorting to speculation should only be done in very limited circumstances. Remember, the disability examination and opinion process are critical for VA to be able to decide claims fairly, quickly, and accurately for Veterans' benefits.
Help
Resources
Select Next to continue
Back
Next


Settings
Exit
DMA Mental Health Examinations
Menu
Documenting the Examination
Page 69 of 124 (56%)
A Sample Medical Opinion
The following example of a medical opinion provides a hypothetical requested opinion and the opinion that could serve as the response.
Opinion Requested
Does the Veteran have a diagnosis of depression that is at least as likely as not (50 percent or greater probability) incurred in or caused by the claimed in-service event (his brother passed away due to cancer while he was overseas and he was not able to attend the funeral).
Opinion Provided
Service Treatment Records (STRs) indicate that on 4/22/2001 while serving in Italy, he learned that his brother had passed away due to pancreatic cancer. He reported that at his brother's request, his parents held a small funeral service two days prior to notifying him so that he wouldn't have to come home from overseas. Other in-service records indicate that he then experienced depressive symptoms (diagnosed at that time as Depressive Disorder, NOS) for several months and was prescribed an anti-depressant. He then spent two more years in Italy on active duty and returned home in 2003. He has been under continuous treatment for depression since 2001 when the event took place in the military. STRs indicate that he denied any pre-military history of depression or other mental health issues at the time of enlistment.
Current exam findings and record review support that it is at least as likely as not (50 percent or greater probability) that the Veteran's Unspecified Depressive Disorder (claimed as "depression") was incurred in or caused by the documented in-service event of his brother's passing. The currently diagnosed Unspecified Depressive Disorder is the same condition diagnosed in service under DSM-IV as "Depressive Disorder, NOS."
Help
Resources
Select Next to continue
Back
Next


Settings
Exit
DMA Mental Health Examinations
Menu
Documenting the Examination
Page 70 of 124 (56%)
Insufficient Documentation Protocols
VBA returns documentation protocols as insufficient for rating purposes when clarification is needed, which can occur even if all fields are addressed and contain accurate medical information. Insufficient for rating purposes can also refer to information that is incomplete, missing from required fields, or medically inaccurate. Failure to adhere to the requirements explained in this course for documenting behavioral observations, social and occupational impairment, diagnoses, financial competency, or opinions can also result in an insufficient documentation protocol.
In addition, documentation protocols can be found insufficient if an examiner does not indicate they reviewed the eFolder, fails to sign the document, or does not respond to a specific request from VBA to address employability when describing social, occupational, or functional impairment.
If a completed documentation protocol is found insufficient for rating purposes, it will be returned to the clinic, contractor, or examiner to be remedied. The decision regarding the Veteran's or Servicemember's claim will likely be delayed as a result.
Tip:
Carefully reviewing your documentation protocol for completeness and consistency can prevent common mistakes. Check the Request for Examination to ensure you address all requests and questions from the adjudicator. Requested information and/or opinions may have multiple components that you will need to address explicitly and thoroughly. It is also helpful to check your documentation protocols per DMA's clinical quality standards. Those standards have been referenced throughout this course and will be summarized on the next page.
Help
Resources
Select Next to continue
Back
Next


Settings
Exit
DMA Mental Health Examinations
Menu
Documenting the Examination
Page 71 of 124 (57%)
DMA Clinical Quality Standards
Your examination report may be evaluated using the Retrospective Chart Review for C&P Mental Health Providers form that is a component of your VHA facility's Focused Professional Practice Evaluation (FPPE) or Ongoing Professional Practice Evaluation (OPPE), or by the alternative process used for VBA contractors, to ensure that DMA clinical quality standards have been met. You can access and use this form as a checklist from the TRAIN Learning Network or, when logged in to the VA network, from the DMA website. Select each topic to view the question based on this form.
1. Diagnosis
2. Discrepancies
3. Testing
4. Occupational/Social
5. Behavioral Observations
6. Competency
7. Request for Examination
8. Urgent Clinical Need
Tip
DMA's clinical quality standards have been addressed throughout this course in the form of checklist questions tailored to the topic at hand. This is because it's important that the documentation protocol end product is of sound clinical quality. It's also helpful to be aware of DMA's clinical quality standards while preparing for, conducting, and documenting C&P mental health examinations.
Help
Resources
Select items of interest to you, then Next to continue
Back
Next

DMA Mental Health Examinations

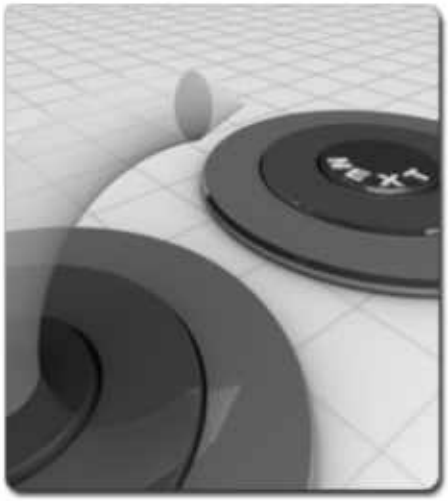
Settings Exit

Menu | Documenting the Examination | Page 73 of 124 (59%)

Lesson 4 Summary

This lesson presented requirements for documenting a C&P mental health examination. You can use this information to ensure you provide all required information on appropriate documentation protocol(s) used to report examination results. In doing so, you can use what you've learned to:

- Address financial competency per C&P guidelines.
- Provide and support an accurate diagnosis or explain a lack of diagnosis.
- Include a supporting rationale for any diagnosis you provide that differs from a claimed diagnosis, an already documented diagnosis, or for substance use secondary to a diagnosed condition.
- Provide a medical opinion and supporting rationale when requested or explain and support why an opinion is not possible.
- Apply DMA quality standards to your report.
- Avoid documentation protocols being returned as insufficient.



Help | Resources | Select Next to continue | Back | Next

DMA Mental Health Examinations

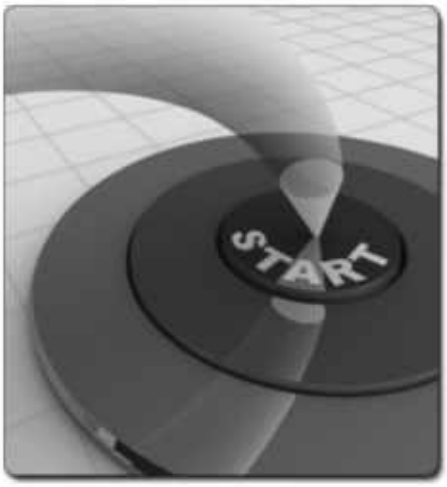
Settings Exit

Menu C&P PTSD Examinations Page 74 of 124 (60%)

Lesson 5 Overview

This lesson will focus on specific requirements and guidelines for conducting C&P PTSD examinations. It will provide information about evaluating combat-related stressors, non-combat-related stressors, and fear of hostile military or terrorist activity. Requirements for diagnosing PTSD per current DSM criteria will also be presented, along with descriptions of measures from which you can draw information to use when evaluating PTSD symptoms.

Content for this lesson will be supported by a case study with video demonstrations of assessing a PTSD stressor, assessing PTSD symptoms, and closing a C&P mental health examination.



Help Resources Select Next to continue Back Next

DMA Mental Health Examinations

Settings Exit

Menu C&P PTSD Examinations Page 75 of 124 (60%)

PTSD Examination

A C&P PTSD examination has several components in common with other mental disorders examinations, which have already been covered. These include reviewing the Request for Examination, the Veteran's or Servicemember's eFolder, and the documentation protocol for the examination as presented in Lesson 2. Lesson 3 covered many components that are common to all mental health examinations, including PTSD examinations:

- opening the examination
- behavioral observations
- gathering history
- diagnostic assessment
- assessment of social and occupational impairment
- suicide risk assessment
- closing the examination

This lesson will focus on the unique requirements of initial and review PTSD examinations.

Help Resources Select Next to continue Back Next

DMA Mental Health Examinations

Settings Exit

Menu | C&P PTSD Examinations | Page 76 of 124 (61%)

Initial and Review PTSD Examinations

Like other mental health examinations, initial PTSD examinations elicit information that is important to VBA in the adjudication of claims. For PTSD initial examinations, this information includes evaluating:

1. whether a diagnosis of PTSD is warranted per the current DSM. (Alternatively, you may determine that another diagnosis is more appropriate, or that there is no diagnosis. Be sure to provide a clinical rationale to support your diagnostic determination.)
2. in the event of a PTSD diagnosis, whether there is sufficient data to support that the diagnosed PTSD (1) is related to an in-service stressor and (2) whether the stressor meets Criterion A, is related to a fear of hostile military or terrorist activity, or is due to personal assault to include military sexual trauma.
3. whether and how functioning is impaired as a result of the diagnosis.

The initial examination for PTSD must provide a thorough review of a Veteran's or Servicemember's pre-military, military, and post-military history; psychiatric symptoms; and traumatic events that they have experienced.

By comparison, an increase or review PTSD examination focuses on history and symptoms only since the last C&P examination. Because traumatic stressors are already a matter of record, there is generally no need to compel the Veteran to restate traumatic events other than to assess the impact of new traumatic stressors that may have occurred in the interim. As an examiner, it is necessary that you review previous C&P examinations to obtain the history of record. You will also need to know and understand the stressor to appropriately address the trauma-relatedness of any presenting symptoms.

Help | Resources | Select Next to continue | Back | Next

DMA Mental Health Examinations

Settings Exit

Menu | C&P PTSD Examinations | Page 77 of 124 (62%)

Case Study: An Initial PTSD Examination

A C&P examiner, Dr. Stacey Wilson, will conduct a PTSD examination with Ms. Johnson.



Amanda Johnson is a Veteran who filed a claim with the Veterans Benefits Administration (VBA) for PTSD.



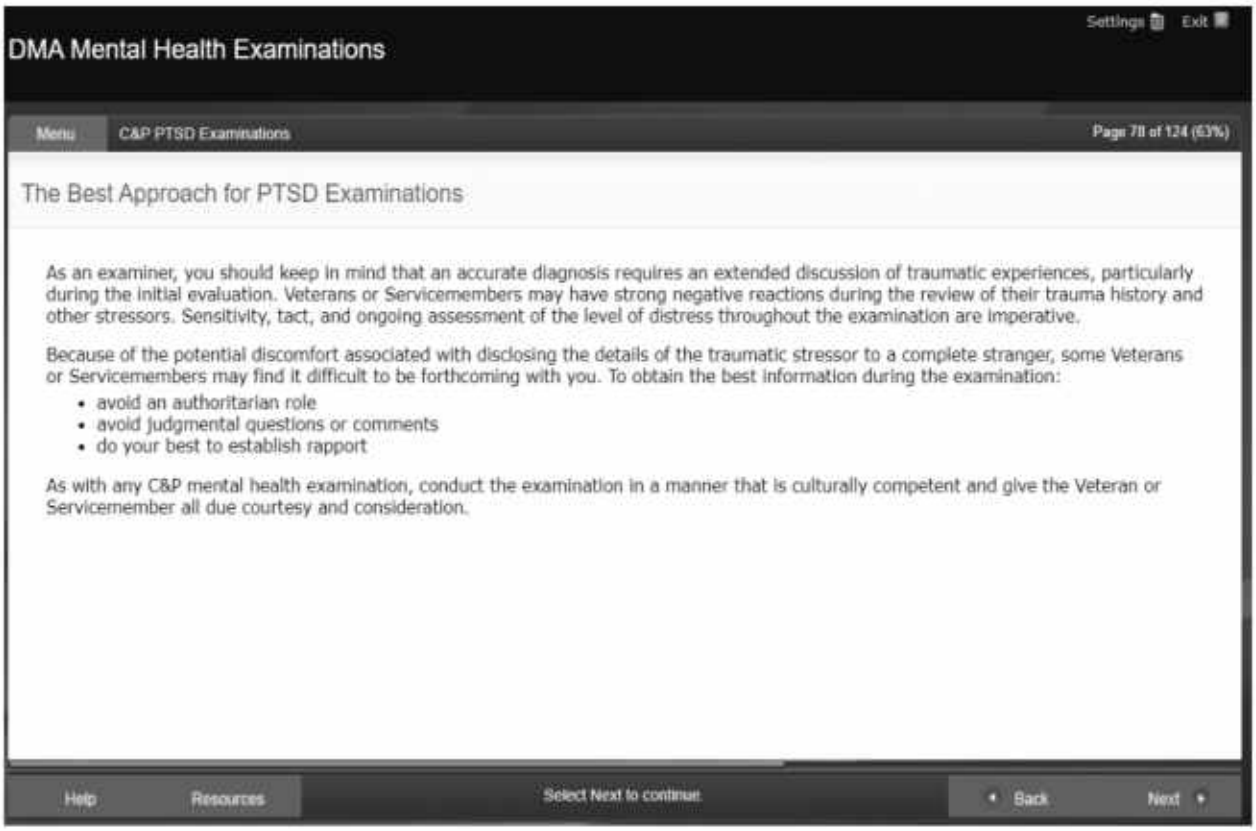
A C&P examiner, Dr. Stacey Wilson, will conduct a PTSD examination with Ms. Johnson. She gathered the following information from the Request for Examination:

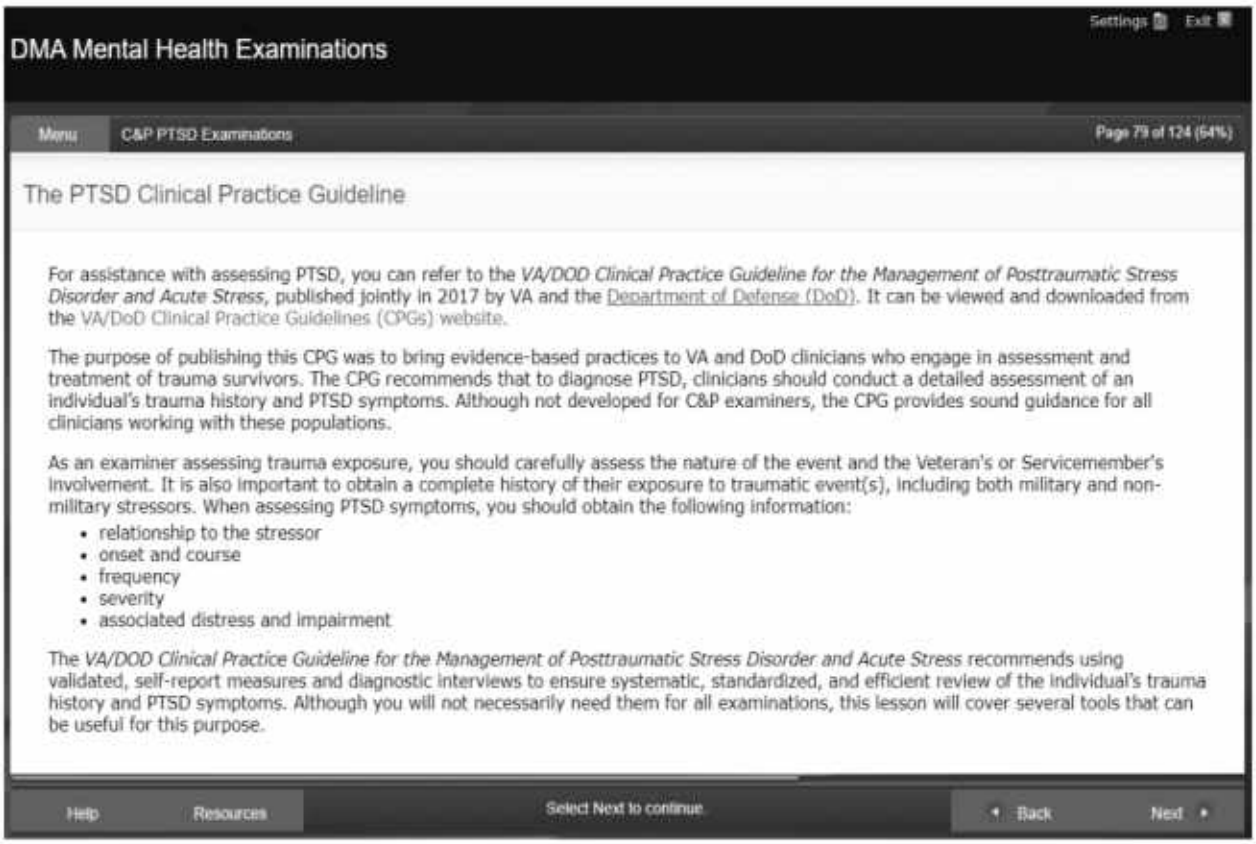
- Ms. Johnson was in the U.S. Army.
- She was deployed to Iraq.
- This will be an original examination for Ms. Johnson's PTSD claim.
- VBA suggests using the Initial PTSD documentation protocol.

Important Note:

The case-study Veteran and examiner are both fictional and not intended to resemble a specific examiner, Veteran, or Servicemember.

Help | Resources | Select Next to continue | Back | Next


DMA Mental Health Examinations
Settings
Exit
Menu
C&P PTSD Examinations
Page 78 of 124 (63%)
The Best Approach for PTSD Examinations
As an examiner, you should keep in mind that an accurate diagnosis requires an extended discussion of traumatic experiences, particularly during the initial evaluation. Veterans or Servicemembers may have strong negative reactions during the review of their trauma history and other stressors. Sensitivity, tact, and ongoing assessment of the level of distress throughout the examination are imperative.
Because of the potential discomfort associated with disclosing the details of the traumatic stressor to a complete stranger, some Veterans or Servicemembers may find it difficult to be forthcoming with you. To obtain the best information during the examination:
• avoid an authoritarian role
• avoid judgmental questions or comments
• do your best to establish rapport
As with any C&P mental health examination, conduct the examination in a manner that is culturally competent and give the Veteran or Servicemember all due courtesy and consideration.
Help
Resources
Select Next to continue
Back
Next


DMA Mental Health Examinations
Settings
Exit
Menu
C&P PTSD Examinations
Page 79 of 124 (64%)
The PTSD Clinical Practice Guideline
For assistance with assessing PTSD, you can refer to the VA/DOD Clinical Practice Guideline for the Management of Posttraumatic Stress Disorder and Acute Stress, published jointly in 2017 by VA and the Department of Defense (DoD). It can be viewed and downloaded from the VA/DoD Clinical Practice Guidelines (CPGs) website.
The purpose of publishing this CPG was to bring evidence-based practices to VA and DoD clinicians who engage in assessment and treatment of trauma survivors. The CPG recommends that to diagnose PTSD, clinicians should conduct a detailed assessment of an individual's trauma history and PTSD symptoms. Although not developed for C&P examiners, the CPG provides sound guidance for all clinicians working with these populations.
As an examiner assessing trauma exposure, you should carefully assess the nature of the event and the Veteran's or Servicemember's involvement. It is also important to obtain a complete history of their exposure to traumatic event(s), including both military and non-military stressors. When assessing PTSD symptoms, you should obtain the following information:
• relationship to the stressor
• onset and course
• frequency
• severity
• associated distress and impairment
The VA/DOD Clinical Practice Guideline for the Management of Posttraumatic Stress Disorder and Acute Stress recommends using validated, self-report measures and diagnostic interviews to ensure systematic, standardized, and efficient review of the individual's trauma history and PTSD symptoms. Although you will not necessarily need them for all examinations, this lesson will cover several tools that can be useful for this purpose.
Help
Resources
Select Next to continue
Back
Next

DMA Mental Health Examinations

Settings Exit

Menu | C&P PTSD Examinations | Page 80 of 124 (65%)

PTSD Stressors

Consistent with the current DSM and the VA/DoD CPG for PTSD, an examiner needs to determine whether a claimed stressor meets the threshold of a Criterion A event as defined by the DSM to diagnose PTSD. In order to do so, using both standardized measures (interview and self-report) as well as documenting a description of the trauma in the Veteran's or Servicemember's own words is recommended. An examiner should use all sources of information that are provided to them, complementing self-reported data with information from objective documentation such as military records.

Importantly, because disclosing some details of the trauma may be difficult and unpleasant for a Veteran or Servicemember, you should keep in mind that they only need to provide enough information to help you determine whether the event or events 1) meet the current DSM definition of a Criterion A stressor and 2) are related to their military service. The Veteran or Servicemember doesn't need to provide explicit details of their experience beyond what is needed to meet these objectives.

Several different types of stressor situations are recognized in the disability examination process: combat, non-combat such as military sexual trauma (MST) or personal trauma, and other specialized situations.

Help | Resources | Select Next to continue | Back | Next

DMA Mental Health Examinations

Settings Exit

Menu | C&P PTSD Examinations | Page 81 of 124 (65%)

Combat Stressors

A combat stressor results from directly engaging in combat with the enemy, meaning that the individual personally participated in events constituting an actual fight or encounter with a military foe, hostile unit, and/or related weaponry (e.g., an improvised explosive device (IED)). It can also include performing duty in support of combatants (e.g., providing medical care to the wounded). Many military decorations can be considered as evidence of exposure to combat-related stressors, including the Combat Infantry Badge (CIB) or Purple Heart.

Veterans may have served in a general combat area or combat zone, but this does not necessarily mean their claimed stressor is combat related. VBA will make this determination.

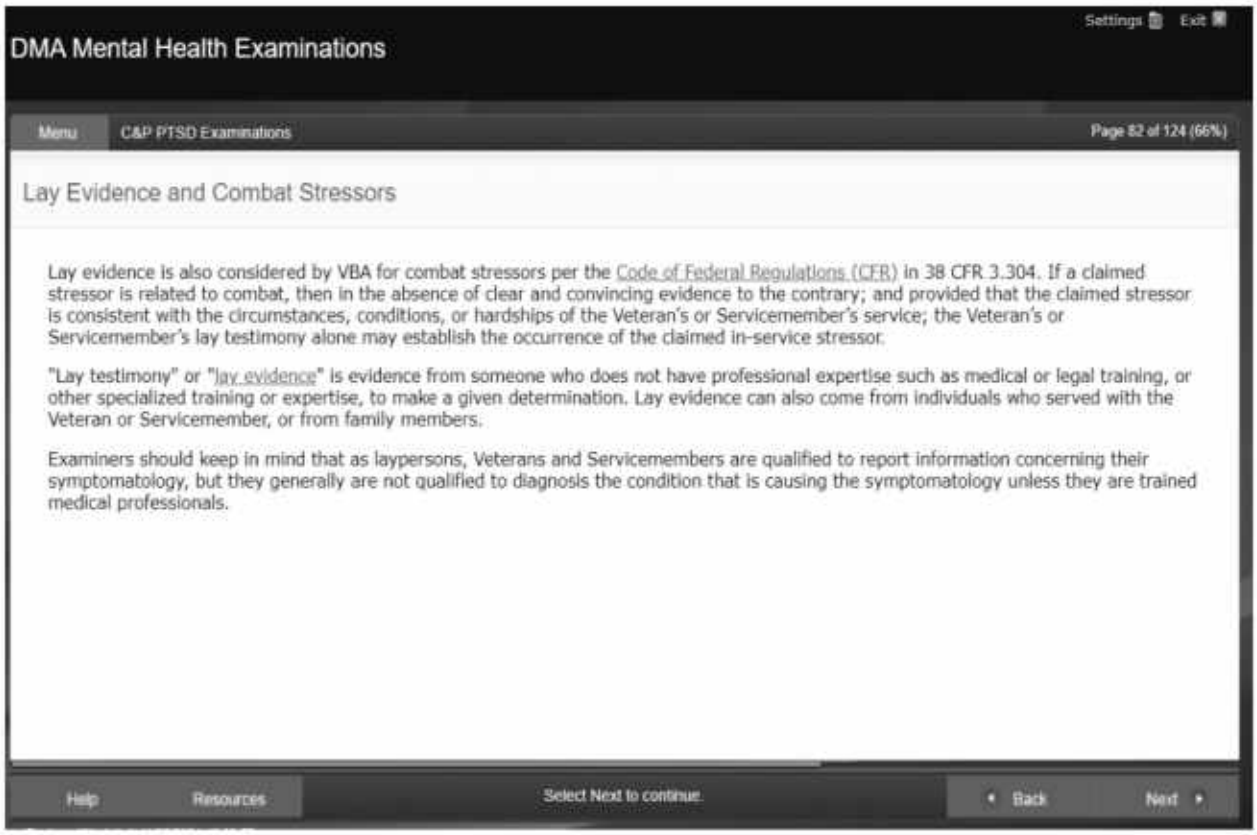
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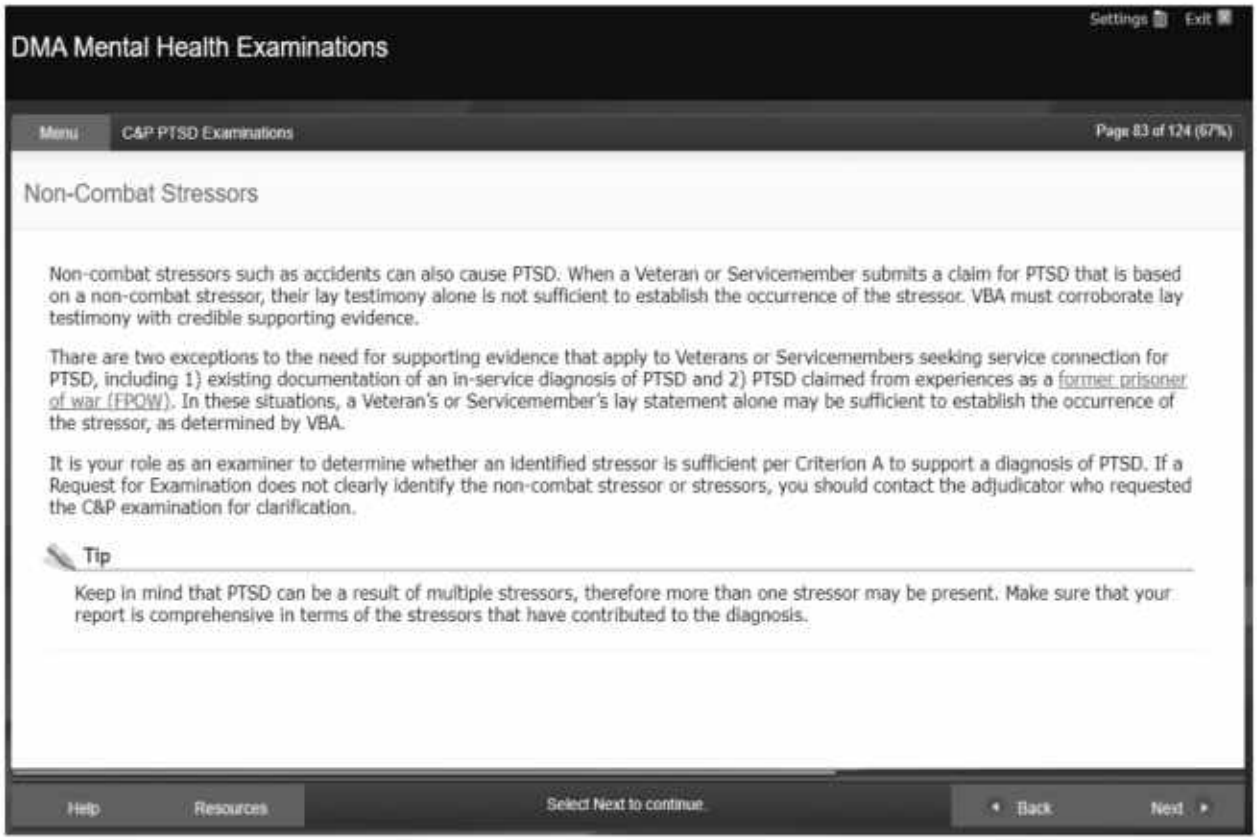
An examiner's role does not include proving or disproving the occurrence of the stressor. Your role as an examiner is to evaluate the stressor VBA concedes and to determine if that stressor is a Criterion A event per the current DSM.



A U.S. soldier in Afghanistan (Defense Visual Information Distribution Service, 2019)

Help | Resources | Select Next to continue | Back | Next


DMA Mental Health Examinations
Settings
Exit
Menu
C&P PTSD Examinations
Page 82 of 124 (66%)
Lay Evidence and Combat Stressors
Lay evidence is also considered by VBA for combat stressors per the Code of Federal Regulations (CFR) in 38 CFR 3.304. If a claimed stressor is related to combat, then in the absence of clear and convincing evidence to the contrary; and provided that the claimed stressor is consistent with the circumstances, conditions, or hardships of the Veteran's or Servicemember's service; the Veteran's or Servicemember's lay testimony alone may establish the occurrence of the claimed in-service stressor.
"Lay testimony" or "lay evidence" is evidence from someone who does not have professional expertise such as medical or legal training, or other specialized training or expertise, to make a given determination. Lay evidence can also come from individuals who served with the Veteran or Servicemember, or from family members.
Examiners should keep in mind that as laypersons, Veterans and Servicemembers are qualified to report information concerning their symptomatology, but they generally are not qualified to diagnosis the condition that is causing the symptomatology unless they are trained medical professionals.
Help
Resources
Select Next to continue
Back
Next


DMA Mental Health Examinations
Settings
Exit
Menu
C&P PTSD Examinations
Page 83 of 124 (67%)
Non-Combat Stressors
Non-combat stressors such as accidents can also cause PTSD. When a Veteran or Servicemember submits a claim for PTSD that is based on a non-combat stressor, their lay testimony alone is not sufficient to establish the occurrence of the stressor. VBA must corroborate lay testimony with credible supporting evidence.
Thare are two exceptions to the need for supporting evidence that apply to Veterans or Servicemembers seeking service connection for PTSD, including 1) existing documentation of an in-service diagnosis of PTSD and 2) PTSD claimed from experiences as a former prisoner of war (FPOW). In these situations, a Veteran's or Servicemember's lay statement alone may be sufficient to establish the occurrence of the stressor, as determined by VBA.
It is your role as an examiner to determine whether an identified stressor is sufficient per Criterion A to support a diagnosis of PTSD. If a Request for Examination does not clearly identify the non-combat stressor or stressors, you should contact the adjudicator who requested the C&P examination for clarification.
Tip
Keep in mind that PTSD can be a result of multiple stressors, therefore more than one stressor may be present. Make sure that your report is comprehensive in terms of the stressors that have contributed to the diagnosis.
Help
Resources
Select Next to continue
Back
Next

DMA Mental Health Examinations

Settings Exit

Menu | C&P PTSD Examinations | Page 84 of 124 (68%)

Stressors Related to Fear of Hostile Military or Terrorist Activity

Based on 38 CFR 3.304, fear of hostile military or terrorist activity means that a Veteran reported an event or circumstance that involved actual or threatened death or serious injury of the Veteran or others from causes including

- an actual or potential IED;
- vehicle-imbedded explosive device;
- incoming artillery, rocket, or mortar fire;
- grenade;
- small arms fire, including suspected sniper fire; or
- attack upon friendly military aircraft.



Guard duty in Iraq (Defense Visual Information Distribution Service, 2009)

In determining whether a stressor related to fear of hostile military or terrorist activity occurred, VBA considers places, types, and circumstances of service where risks or danger from such activity are most likely to exist. Deployed service overseas related to combat, security, or support of combat or security missions are the most likely to involve danger from hostile military forces or terrorist attacks. The adjudicator's evaluation of evidence for service in a location associated with hostile military or terrorist activity must be done on a case-by-case basis and it can include military service not involving direct combat but where there was always a potential for hostile military or terrorist activity.

A VBA adjudicator will include a statement on the Request for Examination for a PTSD examination when they have established credible circumstances for fear of hostile military or terrorist activity. This does not concede that a Criterion A event occurred, but rather that the Veteran has confirmed service in an area where a Criterion A event *may* have occurred.

Help | Resources | Select Next to continue | Back | Next

DMA Mental Health Examinations

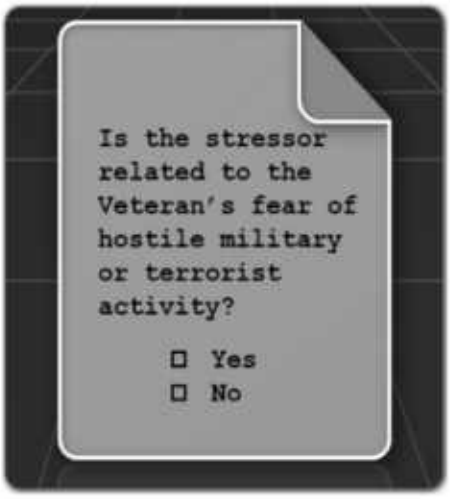
Settings Exit

Menu | C&P PTSD Examinations | Page 85 of 124 (69%)

Endorsing Fear of Hostile Military or Terrorist Activity

The Initial PTSD documentation protocol includes a place to indicate if a stressor is related to fear of hostile military or terrorist activity. If a Veteran who deployed to a theater of war (as confirmed by VBA) presents a credible stressor event that involved fear of hostile military or terrorist activity, an examiner should check the box indicating that "the stressor is related to fear of hostile military or terrorist activity" based on the assumption that in general, an individual deployed to a theater of war could reasonably experience this fear. If an examiner indicates that a stressor is not so related, they must explain why.

Bear in mind that some stressors happen to occur during deployment, but the location is incidental, for example, a minor automobile accident that occurred on base. Such an event is not related to fear of hostile military or terrorist activity even though it was in a theater of war.



Help | Resources | Select Next to continue. | Back | Next

DMA Mental Health Examinations

Settings Exit

Menu C&P PTSD Examinations Page 86 of 124 (69%)

Stressors Related to In-Service Personal Trauma including Military Sexual Trauma (MST)

Per the Veterans Benefits Administration (VBA) *Adjudication Procedures Manual*, military personal trauma for the purpose of C&P disability claims for PTSD refers broadly to stressor events involving harm perpetrated by a person who is not considered part of an enemy force. Examples include assault, battery, robbery, mugging, stalking, and harassment.

Military sexual trauma (MST) is a subset of personal trauma and refers to sexual harassment, sexual assault, or rape.

Stressors for military personal trauma claims are generally non-combat related. Consequently, the Veteran's or Servicemember's lay testimony must be corroborated by VBA with supporting evidence. Providing this type of supporting evidence, however, is often difficult for Veterans and Servicemembers because many incidents of personal trauma are not officially reported in service records.

For this reason, special rules have been established to allow VBA to consider evidence more broadly, allowing an alternative approach to corroborating the occurrence of the traumatic event in cases of PTSD. These rules allow for the consideration of indirect, circumstantial evidence referred to as "markers." VBA's M21-1 Adjudication Procedures Manual lists alternative sources of marker evidence that include military and civilian police reports and personal diaries or journals.

Circumstantial marker evidence can be significant for purposes of showing evidence of behavioral changes that occurred at the time of or subsequent to the reported military personal assault/MST stressor incident. More details about markers and how an examiner works with them will be discussed in the next lesson.

Help Resources Select Next to continue. Back Next

DMA Mental Health Examinations

Settings Exit

Menu C&P PTSD Examinations Page 87 of 124 (70%)

Stressors Reported During an Initial PTSD Examination

You've just learned about the types of stressors that VBA's request for an initial PTSD examination may ask you to evaluate. It's important to note, however, that a Veteran or Servicemember may relate stressor(s) during your interview with them that they have not previously reported to VBA. When this happens, you should evaluate the additional stressor or stressors and document your findings.

Select Play to hear subject matter experts discuss reasons for Veterans or Servicemembers to disclose previously unreported stressors during initial PTSD examination. In addition, they will explain why you need to evaluate and document these stressors.



Help Resources Select Play to view the video, then select Next to continue. Back Next

Examiners evaluate stressors on behalf of VBA, as well as the Veteran or service member during an initial PTSD examination. Stacey, Tina and Courtney have joined me to explain how this works. Stacey, when a C&P mental health examiner conducts an initial PTSD examination, they evaluate a stressor for VBA to see if it meets DSM criterion A. Does the Veteran or service member ever tell the examiner about another stressor during an examination? Yes, that is not uncommon. Many of our Veterans have had multiple experiences that could serve as stressors. They may have submitted a statement to VBA that did not include all of the events that are relevant to understanding their mental health condition. Sometimes Veterans have stressors that they are more comfortable disclosing in person, or they decide at the last minute to disclose a stressor they didn't think they would talk about. It is helpful for examiners to remember, that they are the bridge between a clinical understanding of a Veteran and a legal process that has limitations and restrictions. You should never be changing your clinical assessment because of the legal ramifications on the Veteran's claim. But, at the same time, you should be aware that there can be legal ramifications. And that is why it is very important to be mindful of the role that VBA is asking you to fill. As Stacey mentioned, this is not uncommon. If during the examination, the Veteran brings up a stressor related to service that has not been previously brought up, VBA will undertake additional development, if required, to verify or confirm the stressor prior to making a decision. Therefore, if the Veteran provides any information about any stressor, you should document the stressor and provide a clinical assessment. You're saying that when a Veteran, or service member relates a stressor that is different than the one conceded by VBA an examiner should assess the stressor and document it for VBA? Yes, the best course of action is to evaluate and document the claimed stressor, and also to document the additional stressor reported by the Veteran. VBA may have to follow up with the Veteran about new stressors that were disclosed, but that process falls outside of your role as an examiner. Again, while you should be aware that VBA is bound by legal regulations, your clinical decision should not be influenced by that. Ultimately, your clinical assessment must reflect what is actually happening with the Veteran. Sometimes the mental health condition is related to one stressor, but not another, or maybe both stressors contribute to the symptoms the Veteran is experiencing. You need to respond to VBA's questions, but also use your clinical expertise to translate the Veteran's experience, symptoms and impairment into language that is actionable for VBA. When in doubt, you should make an effort to reach out to VBA for consultation. Thank you, panelists, for explaining that examiners can evaluate stressors they learn about during a disability evaluation, and facilitate VBA's awareness of stressors they may not have learned about from a Veteran or service member.

DMA Mental Health Examinations

Settings Exit

Menu | C&P PTSD Examinations | Page 88 of 124 (71%)

DSM Criterion A for Diagnosing PTSD

The examiner will interview Ms. Johnson to assess for a Criterion A stressor event. For Criterion A, an individual must have been exposed to actual or threatened death, serious injury or sexual violence. This exposure may include:

- directly experiencing the traumatic event(s),
- witnessing the event(s) as it occurred to others,
- learning that the traumatic event(s) occurred to a close family member or friend, and/or
- repeated or extreme exposure to aversive details of the traumatic event(s).

You can view additional Criterion A details specified by the current DSM here.

Interview Tip for Identifying Criterion A

The Veteran's index event (i.e., the event to which the PTSD symptoms are linked) can be the Veteran's most distressing event, a series of related events, or parts of a single event. During an exam, Veterans will sometimes struggle to know which event to focus on. To distinguish the index event(s), you can ask, "What was the most distressing event(s) you experienced while you were in the military? This may be the one you think about most, especially when you don't have other things to distract you. Or, it may be the one you avoid the most. It may be the one that you are hoping I will not ask you about today."

Help | Resources | Select Next to continue | Back | Next

DMA Mental Health Examinations

Settings Exit

Menu | C&P PTSD Examinations | Page 89 of 124 (72%)

The Examiner Conducts a Stressor Assessment

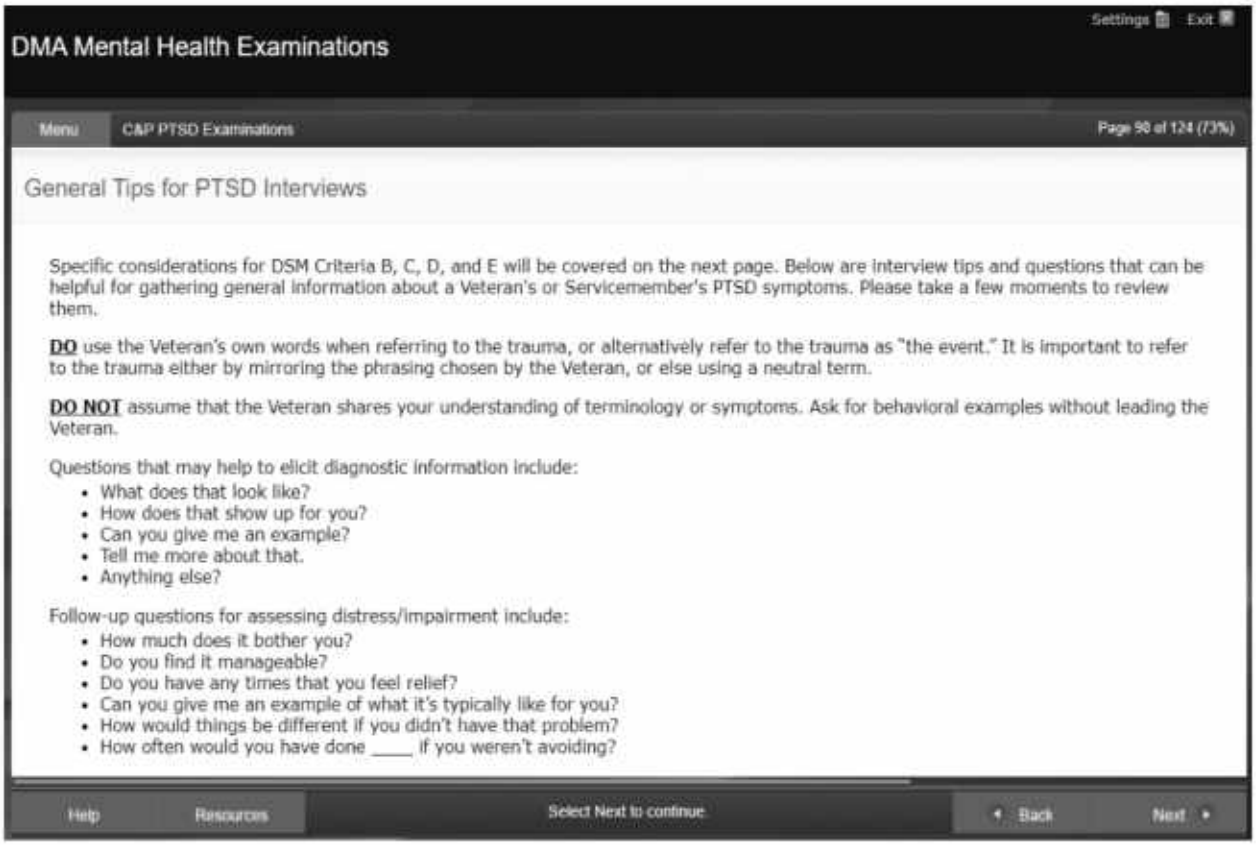
In this and other videos in this lesson, you will see how a C&P Initial PTSD examination diverges from a C&P Mental Disorders examination.

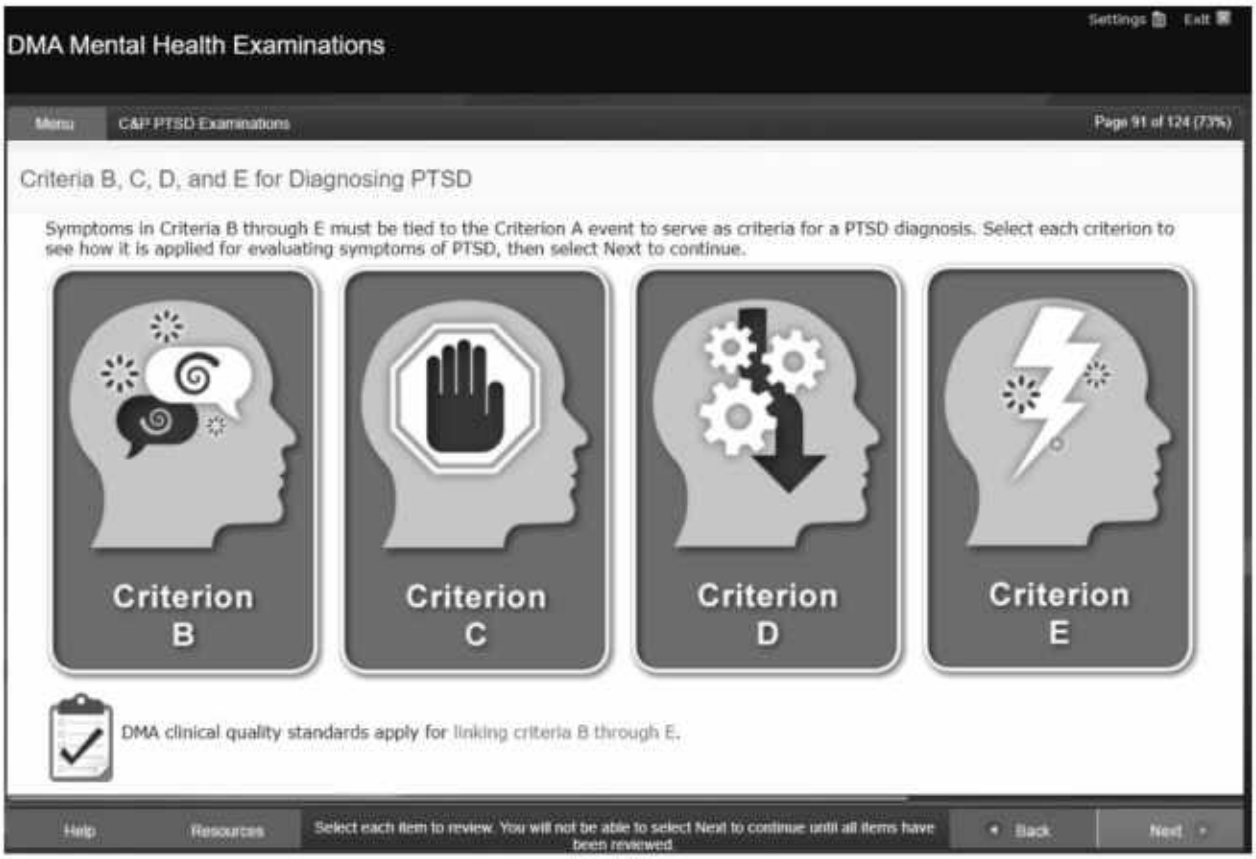
The examiner has been conducting Ms. Johnson's PTSD examination. She has already introduced herself and explained the 4Ps of the examination. She gathered information about Mrs. Johnson's history, following the same approach to the interview as the examiner for Mr. Jone's Mental Disorders examination. Select Play to watch as this examiner asks about Ms. Johnson's combat-related stressors.

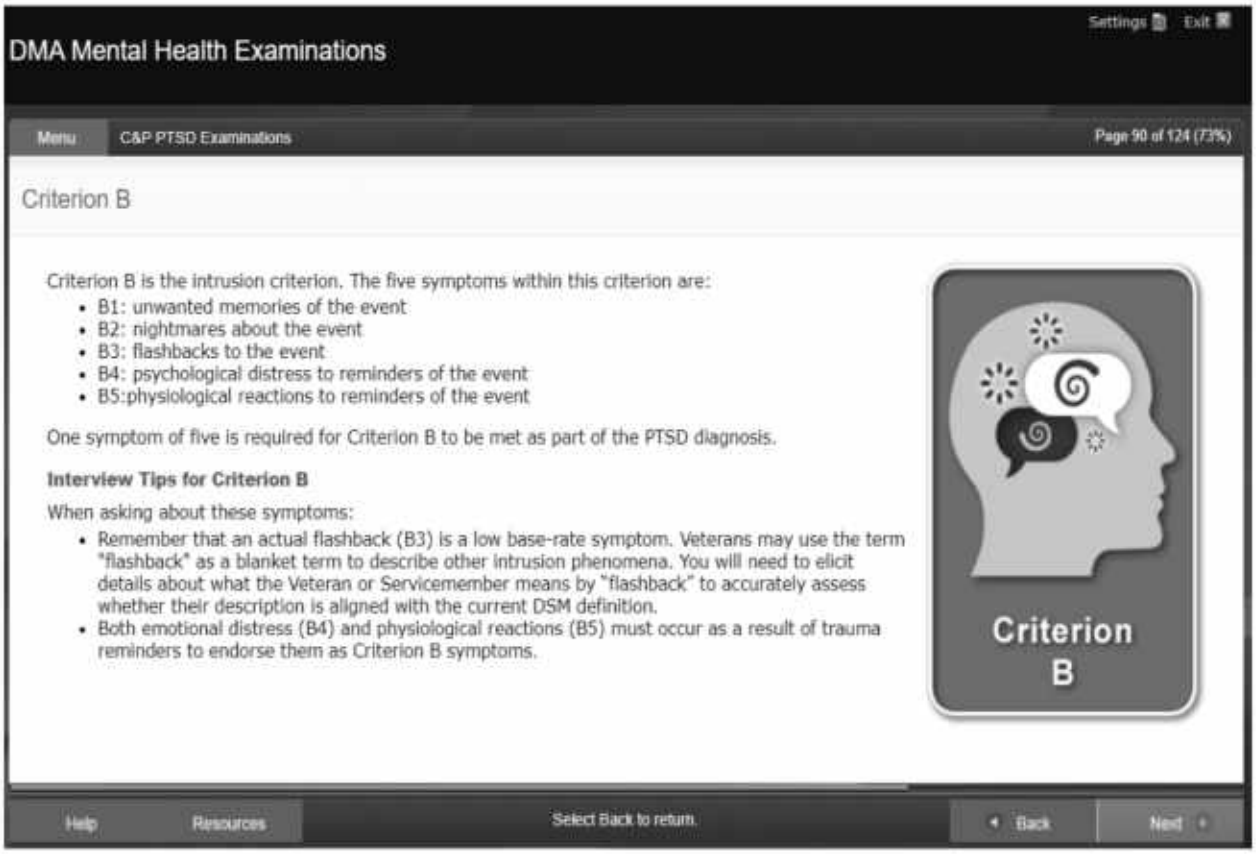


Help | Resources | Select Play to view the video, then select Next to continue | Back | Next

So Ms. Johnson, you filed a claim for PTSD. I've already looked through your records and see that you were deployed to Iraq on three different occasions. As part of the evaluation for PTSD, can you share with me one or two of the traumatic experiences that you experienced while on active duty? It's usually most helpful to talk about the events that you feel are most connected to your symptoms. Okay. So I know that this can be really difficult to talk about and for the sake of this evaluation, you don't have to share everything that you experienced with me or in great depth. But if you can, if you can provide me with a brief summary of what you've been through, just so I can have a sense of what you're going through. I figured you'd ask about this. I just wish I didn't have to talk about it. It can be really difficult to talk about these thing sand it might even be more difficult today because this is the first time that you and I are meeting. So just take your time and you can begin when you're ready to share. Okay. Well, there were sounds of mortars and explosions and talk of suicide bombers. A lot of times, I felt like a lame duck .One time, I was leaving the mess hall with my buddy Katrina and I was teasing her about her new haircut. It was St. Patrick's Day. We were playing and joking and she ran ahead, pretending she was pissed off at me. And suddenly, I heard an explosion. It was about a hundred feet away from me. I felt the ground shake. It felt like an earthquake. My first thought was Katrina, so I ran ahead. I ran ahead and I realized she was hit. Three people were killed that day and Katrina, well, she wasn't killed, but she eventually had to be evacuated out. She lost a leg and an arm. If I hadn't been teasing her, playing a joke, you know? It was my fault. It was my fault. Thank you so much for sharing this experience with me. I can tell that it's hard for you to talk about. You wanna take a few minutes and take a couple deep breaths before we move on, we can do that, okay? I want you to know, I really appreciate you sharing what you've been through with me.




DMA Mental Health Examinations
Settings
Exit
Menu
C&P PTSD Examinations
Page 91 of 124 (73%)
Criteria B, C, D, and E for Diagnosing PTSD
Symptoms in Criteria B through E must be tied to the Criterion A event to serve as criteria for a PTSD diagnosis. Select each criterion to see how it is applied for evaluating symptoms of PTSD, then select Next to continue.
Criterion B
Criterion C
Criterion D
Criterion E
DMA clinical quality standards apply for linking criteria B through E.
Help
Resources
Select each item to review. You will not be able to select Next to continue until all items have been reviewed
Back
Next


DMA Mental Health Examinations
Settings
Exit
Menu
C&P PTSD Examinations
Page 90 of 124 (73%)
Criterion B
Criterion B is the intrusion criterion. The five symptoms within this criterion are:
B1: unwanted memories of the event
B2: nightmares about the event
B3: flashbacks to the event
B4: psychological distress to reminders of the event
B5:physiological reactions to reminders of the event
One symptom of five is required for Criterion B to be met as part of the PTSD diagnosis.
Interview Tips for Criterion B
When asking about these symptoms:
Remember that an actual flashback (B3) is a low base-rate symptom. Veterans may use the term "flashback" as a blanket term to describe other intrusion phenomena. You will need to elicit details about what the Veteran or Servicemember means by "flashback" to accurately assess whether their description is aligned with the current DSM definition.
Both emotional distress (B4) and physiological reactions (B5) must occur as a result of trauma reminders to endorse them as Criterion B symptoms.
Criterion B
Help
Resources
Select Back to return.
Back
Next

DMA Mental Health Examinations

Settings Exit

Menu | C&P PTSD Examinations | Page 90 of 124 (73%)

Criterion C

Criterion C is the avoidance criterion (i.e., avoidance of trauma-related stimuli after the trauma). There are two symptoms in this Criterion:

- C1: avoidance of internal reminders of the event
- C2: avoidance of external reminders of the event

At least one of these symptoms is required for Criterion C to be met as part of the PTSD diagnosis.



Interview Tips for Criterion C

- To avoid thoughts or feelings associated with the traumatic event(s) (C1), many Veterans or Servicemembers will report using distraction techniques. Some of these, such as deep breathing, may be clinically indicated. However, even clinically indicated avoidance can still be a symptom! Remember that they wouldn't need to employ avoidance strategies, healthy or otherwise, if there was nothing to avoid.
- When probing about avoidance of external reminders (C2), many Veterans or Servicemembers will have grown accustomed to this avoidance, so they will tell you that their avoidance behaviors don't interfere with their lives, even if the behaviors meet the symptom threshold. For example, a Veteran who is used to driving a different way to work so that she doesn't have to pass a building that reminds her of where she was assaulted may tell you that this behavior does not interfere with her daily activities. Instead, ask about how things would be different if the Veteran didn't have to avoid these things. For example, how much extra time does it take this Veteran to drive this alternate route? Some Veterans are so practiced at avoidance that they don't recognize it when asked. However, careful querying about daily life, habits, and behavior patterns can reveal avoidance symptoms.

Help | Resources | Select Back to return | Back | Next

DMA Mental Health Examinations

Settings Exit

Menu | C&P PTSD Examinations | Page 90 of 124 (73%)

Criterion D

Criterion D captures negative alterations in cognition and mood that have resulted from the traumatic event. The seven symptoms in this cluster include:

- D1: inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs)
- D2: persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am bad," "No one can be trusted," "The world is completely dangerous," and "My whole nervous system is completely ruined")
- D3: persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others
- D4: persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame)
- D5: anhedonia, (i.e., markedly diminished interest or participation in significant activities)
- D6: feelings of detachment or estrangement from others
- D7: persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings)

At least two of these seven symptoms are required for Criterion D to be met as part of the PTSD diagnosis.



Interview Tips for Criterion D

- For Criteria B and C, all the symptoms are linked to the content of the Criterion A event(s). For example, symptom B1 asks whether the individual has unwanted memories about the Criterion A event(s) itself/themselves. In contrast, many of the Criterion D symptoms do not reflect the content of the Criterion A event(s). For example, anhedonia (D5) does not refer to lack of interest in activities that remind the individual of the trauma – instead, it refers to lack of interest in activities in general. To establish that symptoms not related to the content of the Criterion A event(s) are still part of the PTSD constellation, you will need to verify a temporal link between the Criterion A event and the symptom. Specifically, if the symptom started or got worse after the Criterion A event(s), you can consider it a symptom. It may be helpful to ask Veterans about how they see themselves, relationships, or the world differently when comparing "before" and "after" the event. Many Veterans struggle to recognize or acknowledge emotions or internal experiences; offering a framework for them to consider and express the ways in which they have been "altered" can elicit important diagnostic data.
- Be careful not to confuse anhedonia (D5) with external avoidance (C2). To separate these, it can often be helpful to ask, "If we were able to make sure that there were no people around and it was completely safe, do you think you would enjoy doing X?" If the Veterans says no, it is likely due to anhedonia. However, if the Veteran says yes, the symptom may be better explained as avoidance.

Help | Resources | Select Back to return | Back | Next

DMA Mental Health Examinations

Settings Exit

Menu | C&P PTSD Examinations | Page 90 of 124 (73%)

Criterion E

Criterion E is the arousal criterion. There are six symptoms in this cluster:

- E1: irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects
- E2: reckless or self-destructive behavior
- E3: hypervigilance
- E4: exaggerated startle response
- E5: problems with concentration
- E6: sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep)

At least two symptoms of the six are required for Criterion E to be met as part of the PTSD diagnosis.



Interview Tips for Criterion E

- Like many of the Criterion D symptoms, the way that the Criterion E symptoms manifest may not relate to the nature of the Criterion A event(s). For example, when you probe about startle responses, these responses do not necessarily need to be caused by trauma reminders; you are assessing whether the startle is greater than average, not the content which causes it. Instead, you will need to rely on the temporal relationship. If the symptom started or got worse after the Criterion A event, and the frequency or intensity of the symptom is clinically significant, you can consider endorsing it as a symptom.
- For reckless or self-destructive behaviors (E2), you are looking for behaviors that are objectively dangerous, usually in a physical manner, in which the Veteran doesn't seem to care if they live or die.
- For sleep disturbances (E6), remember that there are a range of mental and medical conditions that can be associated with poor sleep, many of which are not related to trauma exposure. Be sure to query carefully, asking questions such as, "Tell me what a typical night of sleep looks like for you. What happens? How do sleep difficulties show up for you?" This will help to establish whether the sleep disturbance reported is part of the PTSD constellation.

Help | Resources | Select Back to return. | Back | Next

DMA Mental Health Examinations

Settings Exit

Menu | C&P PTSD Examinations | Page 92 of 124 (74%)

DSM Criteria F, G, and H

This table summarizes Criteria F, G, and H for diagnosing PTSD. Please take a moment to review these criteria and the interview tips for each.

Criteria	Interview Tips
Criterion F specifies that the duration of symptoms must have been at least 30 days.	Make sure that all the symptoms the Veteran endorses have occurred within the same 30-day period.
Criterion G indicates that the symptoms must cause clinically significant distress or impairment.	If the symptoms do not cause distress or impairment, PTSD cannot be diagnosed. See Lesson 3, Conducting the Examination, for guidance on how to assess for social and occupational impairment.
Criterion H requires that the symptoms are not better explained by a substance or medical condition.	Although no assessment measure explicitly assesses for this, examiners can ascertain whether symptoms are better explained by substances/medications by querying throughout the assessment. Of note, PTSD is often comorbid with other diagnoses, including substance use, so the use of substances in and of itself is not grounds for discounting the presence of PTSD.

Help | Resources | Select Next to continue | Back | Next

DMA Mental Health Examinations

Settings Exit

Menu | C&P PTSD Examinations | Page 93 of 124 (75%)

Measures for Assessing PTSD Symptoms

Interview and self-report instruments covered on the following pages have been developed for assessing PTSD. They are discussed because they can be useful for assessing PTSD in a C&P examination.

Note that it may not be practical or necessary to use them in every C&P examination, and many of them have not been tested explicitly with Veterans seeking compensation and pension.

In addition, structured-interview and self-report measures in general have limitations:

- Interview instruments can be used to obtain a definitive diagnosis, but they are often prohibitive because of the training and the time required to administer them during an examination.
- Self-report measures may have a response bias. For this reason, they are not used alone to diagnose PTSD. The results can indicate probable PTSD rather than a definitive PTSD diagnosis. In addition, cutoff scores for self-report measures need to be considered in the context of the population and the purpose of the screening.

Despite these limitations, a familiarity with these tools is important for ensuring that you can conduct the most thorough, efficient, and accurate evaluation of each Veteran and Servicemember.



Help | Resources | Select Next to continue | Back | Next

DMA Mental Health Examinations

Settings Exit

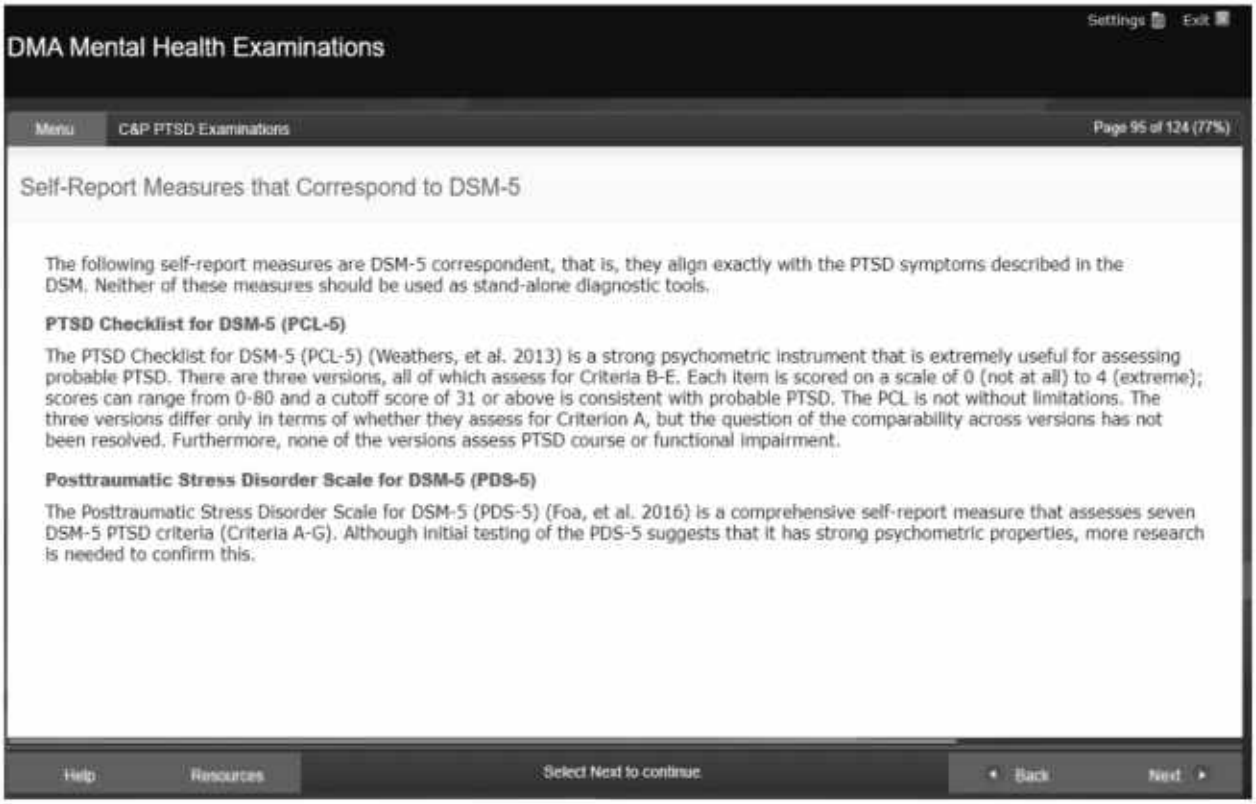
Menu | C&P PTSD Examinations | Page 94 of 124 (76%)

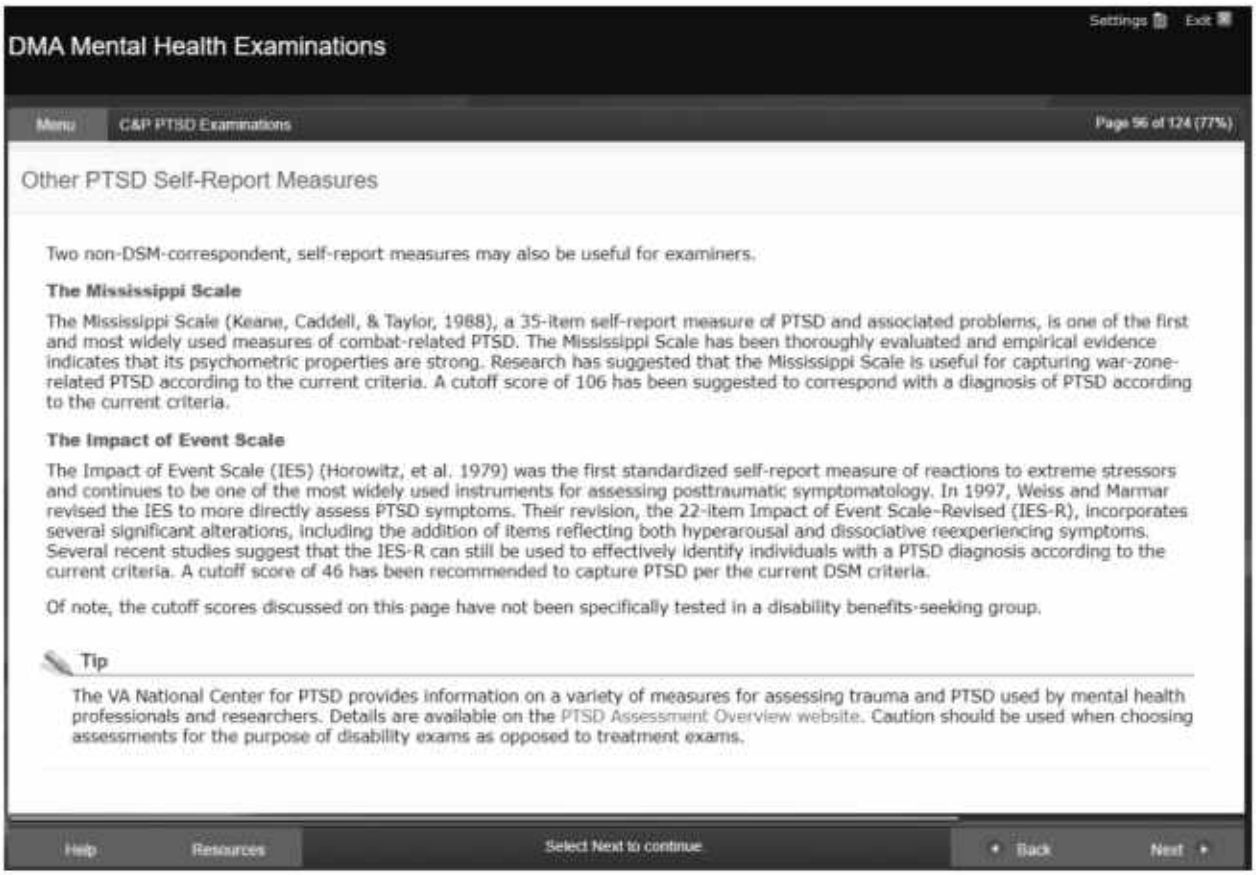
Diagnostic Interview Measures

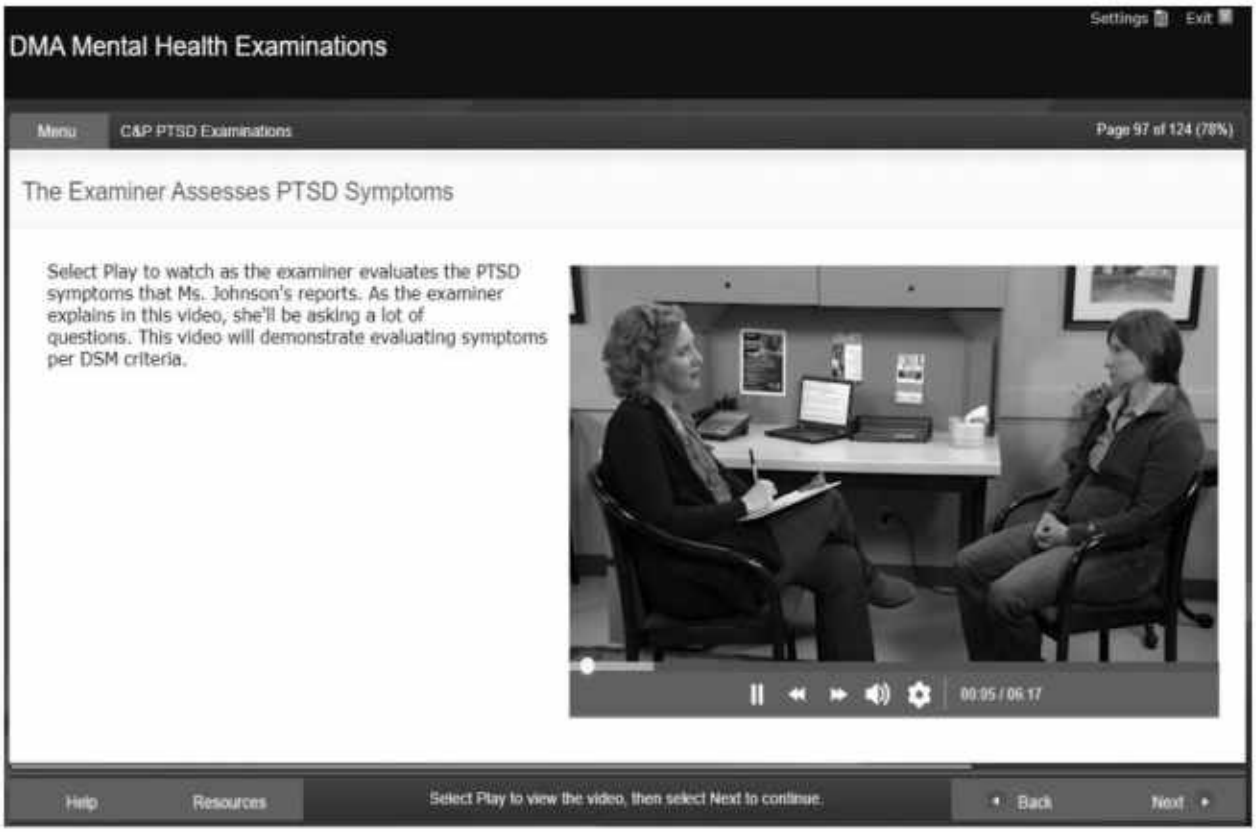
This table shows three interview measures used for assessing PTSD symptoms.

Instrument	Details
Clinician-Administered PTSD Scale for DSM-5 (CAPS-5)	The CAPS-5 is a reliable and valid PTSD structured interview that allows for the assessment of PTSD Criteria A-G and provides information on diagnostic status and symptom severity. The main limitations of the CAPS are that it typically takes longer to administer than other PTSD interviews and it requires more extensive training and experience to master its administration and scoring. A self-study training course for using the CAPS-5 is available. Details are available on the Continuing Education page at VA's National PTSD website.
Structured Clinical Interview for DSM-5 (SCID-5)	The SCID-5 is a psychometrically strong interview of PTSD. Although useful for providing diagnostic information, it yields essentially dichotomous present/absent ratings for symptoms and diagnostic status, and thus does not provide a continuous measure of PTSD symptom severity. As with other interviews, the length of time required may be a limitation.
PTSD Symptom Scale Interview for DSM-5 (PSSI-5)	The PSSI-5 (Foa, et al. 2016) is an interview for PTSD that is relatively brief, provides information about PTSD diagnostic status as well as symptom severity, and has strong psychometric properties. However, it provides only a single question per symptom, which may limit its ability to fully capture any given symptom.

Help | Resources | Select Next to continue | Back | Next


DMA Mental Health Examinations
Settings
Exit
Menu
C&P PTSD Examinations
Page 95 of 124 (77%)
Self-Report Measures that Correspond to DSM-5
The following self-report measures are DSM-5 correspondent, that is, they align exactly with the PTSD symptoms described in the DSM. Neither of these measures should be used as stand-alone diagnostic tools.
PTSD Checklist for DSM-5 (PCL-5)
The PTSD Checklist for DSM-5 (PCL-5) (Weathers, et al. 2013) is a strong psychometric instrument that is extremely useful for assessing probable PTSD. There are three versions, all of which assess for Criteria B-E. Each item is scored on a scale of 0 (not at all) to 4 (extreme); scores can range from 0-80 and a cutoff score of 31 or above is consistent with probable PTSD. The PCL is not without limitations. The three versions differ only in terms of whether they assess for Criterion A, but the question of the comparability across versions has not been resolved. Furthermore, none of the versions assess PTSD course or functional impairment.
Posttraumatic Stress Disorder Scale for DSM-5 (PDS-5)
The Posttraumatic Stress Disorder Scale for DSM-5 (PDS-5) (Foa, et al. 2016) is a comprehensive self-report measure that assesses seven DSM-5 PTSD criteria (Criteria A-G). Although initial testing of the PDS-5 suggests that it has strong psychometric properties, more research is needed to confirm this.
Help
Resources
Select Next to continue
Back
Next


DMA Mental Health Examinations
Settings
Exit
Menu
C&P PTSD Examinations
Page 96 of 124 (77%)
Other PTSD Self-Report Measures
Two non-DSM-correspondent, self-report measures may also be useful for examiners.
The Mississippi Scale
The Mississippi Scale (Keane, Caddell, & Taylor, 1988), a 35-item self-report measure of PTSD and associated problems, is one of the first and most widely used measures of combat-related PTSD. The Mississippi Scale has been thoroughly evaluated and empirical evidence indicates that its psychometric properties are strong. Research has suggested that the Mississippi Scale is useful for capturing war-zone-related PTSD according to the current criteria. A cutoff score of 106 has been suggested to correspond with a diagnosis of PTSD according to the current criteria.
The Impact of Event Scale
The Impact of Event Scale (IES) (Horowitz, et al. 1979) was the first standardized self-report measure of reactions to extreme stressors and continues to be one of the most widely used instruments for assessing posttraumatic symptomatology. In 1997, Weiss and Marmar revised the IES to more directly assess PTSD symptoms. Their revision, the 22-item Impact of Event Scale-Revised (IES-R), incorporates several significant alterations, including the addition of items reflecting both hyperarousal and dissociative reexperiencing symptoms. Several recent studies suggest that the IES-R can still be used to effectively identify individuals with a PTSD diagnosis according to the current criteria. A cutoff score of 46 has been recommended to capture PTSD per the current DSM criteria.
Of note, the cutoff scores discussed on this page have not been specifically tested in a disability benefits-seeking group.
Tip
The VA National Center for PTSD provides information on a variety of measures for assessing trauma and PTSD used by mental health professionals and researchers. Details are available on the PTSD Assessment Overview website. Caution should be used when choosing assessments for the purpose of disability exams as opposed to treatment exams.
Help
Resources
Select Next to continue
Back
Next



Ms. Johnson, now that you've told me about some of your traumatic experiences, I'm gonna be asking you several questions about symptoms that you may or may not be having. For each symptom, I'll ask you if you've had it in the past month and if so, how often and how much it bothers you. Okay. Are you ready to get started? Yeah. So Ms. Johnson, in the past month, have you had any unpleasant dreams about your experiences? Actually, I had one last night. Can you describe a typical dream for me? I dream about dead people sometimes, but I also dream about my buddy Katrina and what happened in Iraq. It's just like what happened. Okay, and when you have these dreams, do they wake you up? Almost always.[Therapist[Almost always. Yeah. I wake up in a cold sweat. My sheets are completely soaked. It's pretty bad. Okay, and what happens when you wake up? Well, typically, I walk around the house a bit, maybe turn on the TV, just something to help my mind stay off of it. Okay, so walking around the house and watching TV. Yeah, typically I walk around the house a bit and actually, I think the nightmares are what caused problems between me and my girlfriend. Okay, we'll circle back later to discuss those problems with your girlfriend. But first, let's talk about these nightmares. How long does it take you to get back to sleep on an average night after you've had a nightmare? I would say about three hours. Yeah. Okay, and how much do these dreams bother you? A lot. A lot, okay. And how often have you had these dreams in the past month? About two to three times a week. Two to three times a week. Okay. In the past month, have there been times where you have felt especially irritable or angry and showed it in your behavior? Yeah. Can you give me some examples? Well, to think about it at work, for sure. I had problems with a coworker. Quite often, it had gotten pretty bad. Another coworker had to intervene and pretty much tell us to cut it out. And even today, earlier today I was coming here, pulling up in the parking lot and some guy just cut me off and takes my parking space. I got out of the car. It was really

heated. I just started yelling. I just feel so pissed a lot. So when you're angry, how do you show your anger? It sounds like sometimes you raise your voice and yell. What about throwing or hitting things or pushing people, getting physically aggressive? No. No, I don't do anything physical. Okay. I don't allow myself to get that way. Definitely yelling, though. A lot of yelling. People definitely know when I'm angry. I get really heated and loud. Look, I'm not proud of it, but I just don't know how to help it. Okay, and how often have you gotten angry in the last month? I don't know. One, two, three times a week. Something like that. Okay, so a couple of times a week? Yeah. Okay, and in this anger, looking back, can you tell me a little bit about when you noticed it or when you think it started to really affect your life? It definitely got worse when I came home. It's like when I got home, it definitely got worse. It's like when I was in Iraq, I just didn't have time to be upset. And do you think your anger is related to your experiences in Iraq? Yes. Hell, yes. Yes, it's like when I got home, my short fuse, everything started to bother me. Actually, that's one of the reasons me and my girlfriend broke up. We were always arguing and she started to like, hate the way I was responding to things, you know? She was always talking about my temper, how I was overreacting to some things. Our relationship was good before all of this. So Ms. Johnson, you previously told me that you're working at a trucking company. Yeah, I work at a trucking company giving out assignments. I 've been there about five months now. Okay, and in the past month, how have these symptoms that we've discussed affected your work or your ability to work? Well, I'll say this. Before my current job, I was fired from my last job, so I would say it affects my ability to work. And what led up to you getting fired? Fighting, my attitude, having problems with coworkers. I received several complaints and I was told I would be let go if I received more. I received more, so I was let go. Pissed me off. And in the last month, are there ways that your symptoms have impacted your ability to work? Yeah, a little bit. When I have to deal with my supervisor, that can surely be a pain. I have to keep myself in check. I have to watch out when he's around, you know? And also, I forget things sometimes, like we talked about. I lose focus and just can't concentrate. Okay. Believe it or not, I used to work at Walmart before I joined the military and I really liked it. Customers love me. I couldn't do that now. I certainly can't deal with the people and I would have a hard time being in a crowded store. It just wouldn't happen. Okay. So it sounds like in a lot of ways, your symptoms have impacted your ability to work. Yeah. What about attendance? Any difficulties with attendance at work? Well, sometimes. I manage to always get to work, but sometimes, I'm late. It's hard to get motivated in the morning. So it sounds like from what you're saying, there have been some big changes since you come home in terms of functioning at work. Yeah. I just have to be careful because I don't wanna get fired from this job, too.

DMA Mental Health Examinations

Settings Exit

Menu | C&P PTSD Examinations | Page 98 of 124 (79%)

When Full PTSD Criteria Are Not Met

An important issue concerns Veterans and Servicemembers who have been significantly affected by military trauma such as combat, sexual, or other trauma, but who do not meet full DSM-5 diagnostic criteria for PTSD. Clinicians often diagnose these Veterans as having "sub-threshold PTSD," however, there is no explicit diagnosis of sub-threshold PTSD in DSM-5. Therefore, when PTSD is not met, it is important to consider alternate diagnoses to determine if a fully developed mental disorder is present. In DSM-5, alternate diagnoses can be found in the *Trauma-and Stressor-Related Disorders* section. Diagnoses that may be appropriate include but are not limited to: Other Specified Trauma- and Stressor-Related Disorder, Unspecified Trauma- and Stressor-Related Disorder, and Adjustment Disorder. It is also possible the Veteran or Servicemember may have experienced a traumatic stressor but may have a depressive or anxiety disorder rather than a trauma- or stressor-related disorder.

Please keep in mind that the special regulations regarding the evidentiary burden for Veterans applying for service connection for PTSD do not extend to alternate diagnoses; more evidence may be needed to establish service connection for an alternate diagnosis. However, this should not influence you in making an accurate diagnosis based on a Veteran's presentation. Please also consider that in some cases, Veterans will not meet the current DSM criteria for any diagnosis; therefore, the use of No Diagnosis may be warranted with an accompanying rationale.

Tip

If you are experiencing difficulties with differential diagnosis, please remember that you can request consultation from the VA PTSD Consultation Program at 866-948-7880 or through the Consultation Program website. This program is available to VHA and contract examiners. Select VA PTSD Consultation Program flyer to view and download a flyer for this program. This flyer is also available in course Resources.

Help | Resources | Select Next to continue | Back | Next

DMA Mental Health Examinations

Settings Exit

Menu | C&P PTSD Examinations | Page 99 of 124 (80%)

The Examiner Closes the Examination with Ms. Johnson

You may recall guidelines from Lesson 3 for examiners closing a mental health examination with a Veteran or Servicemember.

PTSD examinations in particular may require an examiner to open up discussions and memories about significant traumatic and distressing events. The examiner keeps this in mind as she closes the examination with Ms. Johnson. She also explains the next steps in the claims process and provides Ms. Johnson with resources. While the Veterans Crisis Line should be presented for all mental health examinations, some resources provided to a Veteran or Servicemember can depend on their diagnosed condition(s) (e.g. PTSD).

Select Play to watch as the examiner closes the exam with Ms. Johnson.



Help | Resources | Select Play to view the video, then select Next to continue. | Back | Next

Well, Ms. Johnson, we've almost completed the examination for today and I want to thank you again for all the information that you've provided. Before we end today, I want to make sure that you've had a chance to say everything that you've wanted. Is there anything additional that you wanted to share before this information is sent to VBA so they can adjudicate your claim? No, I think you've covered everything. You asked a lot of questions. So what happens now? I did ask a lot of questions. So, what will happen next is I will prepare a report that will be based on the information that I obtained here with you today and the examination, as well as some information that was already available in your record. The report will then be sent to VBA, where they will use the report and all the other information that they have in your claims file to make a decision about your claim. So once VBA has made the decision, they will notify you in a letter. It's called a decision letter. And in that letter, in addition to the decision itself, you will see the VBAs legal or adjudication process, in terms of how they arrived at that decision. The letter will include contact information, so if you have any questions, you will know who to call. Okay. Ms. Johnson, I realized that this type of examination that you participated in today can be very difficult. So before we end, I want to just check in and make sure that you're doing okay. Okay? I also want to thank you for being so open with me and your willingness to answer so many questions. I know it's not easy to talk about these experiences. I'm good. You did a good job explaining the purpose of the evaluation before we started. I'm just a little anxious to get the decision. I understand. But before we leave today, I want to give you two pieces of information, okay? A card that has the Veteran's crisis line phone number on it and some information about the National Center for PTSD. The Veteran's Crisis Line is a telephone number that you can call or text and it's going to be available to Veterans 24 hours a day, seven days per week. This is a resource that's available to you anytime. So if you need it, use it. I'm also going to give you the website to the National Center for PTSD and on that website, you'll find all sorts of information about PTSD. Thanks. I appreciate it. And I know that before we started today, I had said that I'll help you get to the VHA Eligibility Office so that you can find out additional information about how to enroll in VHA. Yes. So I'm going to walk you over to the clerk and she can explain to you how to get to eligibility, where they can talk about the process of enrolling in VHA. Okay? Great. Any questions for me? No, I think I'll check out this website when I get home. Thank you.


DMA Mental Health Examinations
Settings
Exit
Menu
C&P PTSD Examinations
Page 101 of 124 (81%)
Lesson 5 Summary
This lesson presented guidelines for conducting a PTSD examination and requirements for diagnosing PTSD. You can use what you've learned to access available resources, including:
• the VA/DOD Clinical Practice Guideline for the Management of Posttraumatic Stress Disorder and Acute Stress
• several measures used to evaluate PTSD symptoms and resulting impairment
• the VA PTSD Consultation Program website
• the M21-1 Adjudication Procedures Manual
You can also use what you've learned to:
• Approach discussions of potentially traumatic events with a Veteran or Servicemember using sensitivity and tact.
• Evaluate stressor(s) related to combat, fear of hostile military or terrorist activity, and military personal trauma including MST per DSM Criterion A.
• Evaluate potential PTSD symptoms per DSM Criteria B, C, D, E, F, G, and H.
Help
Resources
Select Next to continue
Back
Next

DMA Mental Health Examinations

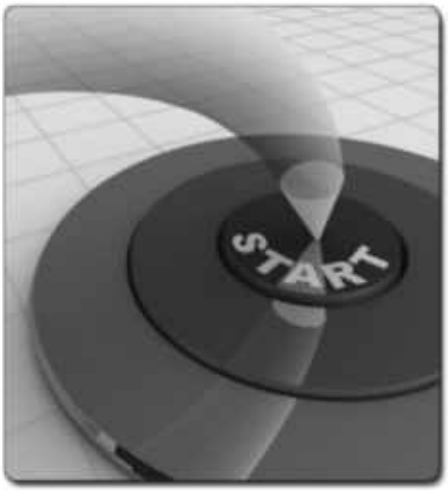
Settings Exit

Menu | Examinations for Conditions Related to Military Personal Trauma Including Military Sexual Trauma | Page 102 of 124 (82%)

Lesson 6 Overview

This lesson will present information specific to mental health examinations for claimed conditions related to military personal trauma, including military sexual trauma (MST), starting with a reminder of how these terms are defined for C&P purposes. This lesson will also describe the prevalence of mental health conditions, including PTSD, that are associated with experiences of military personal trauma.

Guidance will be provided for talking to claimants about military personal trauma experiences and for relating claimed stressor events to potential markers documented in a Veteran's or Servicemember's eFolder. Finally, this lesson will present information about opinions examiners must provide for claims of PTSD related to personal trauma.



Help | Resources | Select Next to continue | Back | Next

DMA Mental Health Examinations

Settings Exit

Menu | Examinations for Conditions Related to Military Personal Trauma Including Military Sexual Trauma | Page 103 of 124 (83%)

Military Personal Trauma

As explained earlier in this course, military personal trauma stressor events involve harm (e.g., assault, battery, robbery, mugging, stalking, and harassment) perpetrated by a person who is not considered part of an enemy force.

Military sexual trauma (MST) is a subset of personal trauma. VA's definition of military MST comes from the United States Code (USC). Based on 38 USC 1720D, MST refers to sexual assault or threatening sexual harassment.

MST is an experience, not a diagnosis, and it may be experienced by a Servicemember during military service, regardless of the geographic location, the gender of the Servicemember, or the relationship to the perpetrator. Both men and women can experience MST. Perpetrators may be male or female and they may or may not be Servicemembers. Perpetrators could be strangers, intimate partners, or friends. Why the MST occurred, for example, as part of a hazing incident, does not matter. Veterans from all eras of service have reported experiencing MST.

Important Note

Keep in mind that not all MST experiences meet Criterion A as defined by the current DSM. Therefore, a Veteran or Servicemember may be entitled to free care at VA because of the experience of MST and yet will not meet criteria for PTSD based on that event.

Help | Resources | Select Next to continue | Back | Next

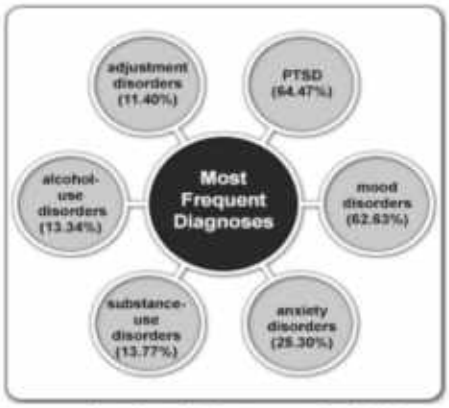
DMA Mental Health Examinations

Settings Exit

Menu | Examinations for Conditions Related to Military Personal Trauma Including Military Sexual Trauma | Page 104 of 124 (84%)

Mental Health Diagnoses Associated with MST

Although PTSD is common after experiences of personal trauma, it is not the only relevant diagnosis. For example, VA's national monitoring data shows that Veterans seen for MST-related mental health care are at risk for a range of psychiatric diagnoses. Per the VHA National MST Support Team, in FY18, Veterans receiving MST-related mental health care were most frequently diagnosed with the psychiatric diagnoses shown here.



Studies have found a link between MST and increased suicide risk. This increased risk holds even after accounting for specific mental health conditions such as PTSD and depression.

Help | Resources | Select Next to continue | Back | Next

DMA Mental Health Examinations

Settings Exit

Menu | Examinations for Conditions Related to Military Personal Trauma Including Military Sexual Trauma | Page 105 of 124 (85%)

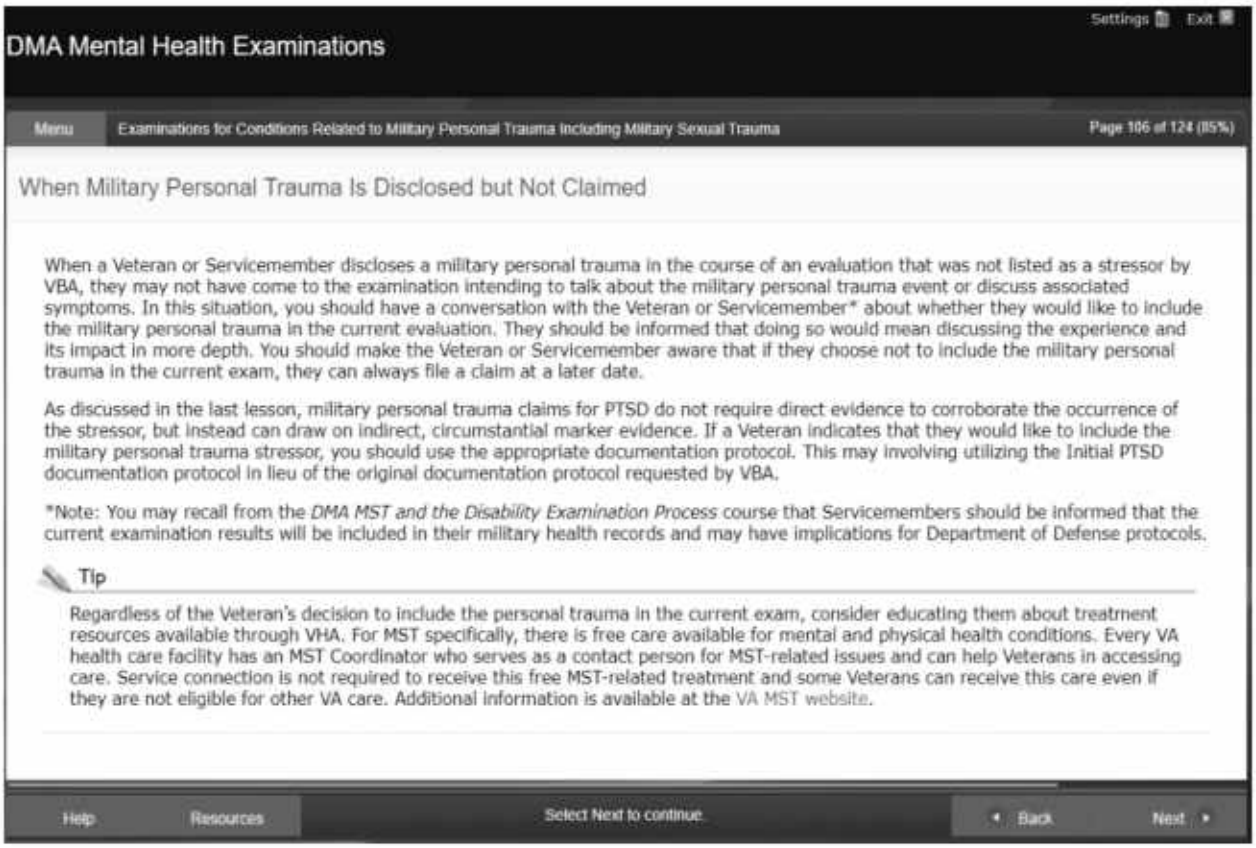
Disclosure of Military Personal Trauma

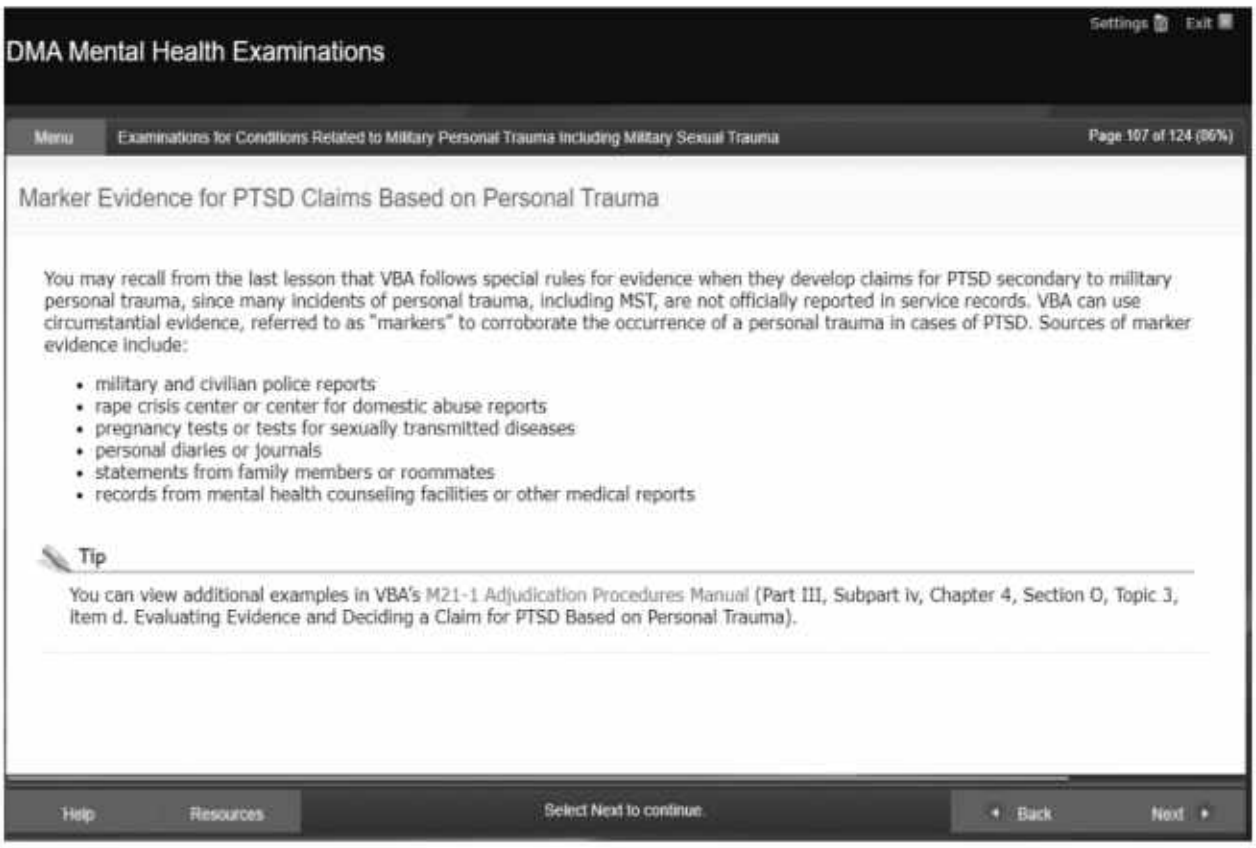
Most of the time, you will go into an examination aware that a Veteran has experienced military personal trauma, particularly when the examination you are conducting is related to a claim filed for PTSD secondary to military personal trauma. However, there may be occasions when a Veteran or Servicemember spontaneously discloses an experience of military personal trauma. When this happens, it is important to respond with sensitivity and respect. This is particularly true if the military personal trauma is MST, as some Veterans experience a great deal of self-blame about sexual trauma experiences.

An appropriate initial response can be as simple as, "I'm sorry that happened to you, but I'm glad you felt able to share it with me. Thank you." Make sure that your nonverbal behavior and tone of voice convey compassion and respect.

Although examiners do not need to routinely screen for traumatic experiences beyond those listed as a stressor by VBA, there may be times when you suspect a Veteran or Servicemember has experienced military personal trauma and that it might be relevant to your assessment. In these situations, you might consider inquiring about military personal trauma. A brief online video, How to Screen Sensitively for Military Sexual Trauma, discusses best practices for screening for MST. Additional resources on screening for MST are available when logged on to the VA intranet at the VA Military Sexual Trauma Resource website or by contacting the VA's free MST Consultation Program at mstconsult@va.gov.This program is available to VHA employees and contractors.

Help | Resources | Select each item to review. You will not be able to select Next to continue until all items have been reviewed | Back | Next


Settings
Exit
DMA Mental Health Examinations
Menu
Examinations for Conditions Related to Military Personal Trauma Including Military Sexual Trauma
Page 106 of 124 (85%)
When Military Personal Trauma Is Disclosed but Not Claimed
When a Veteran or Servicemember discloses a military personal trauma in the course of an evaluation that was not listed as a stressor by VBA, they may not have come to the examination intending to talk about the military personal trauma event or discuss associated symptoms. In this situation, you should have a conversation with the Veteran or Servicemember* about whether they would like to include the military personal trauma in the current evaluation. They should be informed that doing so would mean discussing the experience and its impact in more depth. You should make the Veteran or Servicemember aware that if they choose not to include the military personal trauma in the current exam, they can always file a claim at a later date.
As discussed in the last lesson, military personal trauma claims for PTSD do not require direct evidence to corroborate the occurrence of the stressor, but instead can draw on indirect, circumstantial marker evidence. If a Veteran indicates that they would like to include the military personal trauma stressor, you should use the appropriate documentation protocol. This may involving utilizing the Initial PTSD documentation protocol in lieu of the original documentation protocol requested by VBA.
*Note: You may recall from the DMA MST and the Disability Examination Process course that Servicemembers should be informed that the current examination results will be included in their military health records and may have implications for Department of Defense protocols.
Tip
Regardless of the Veteran's decision to include the personal trauma in the current exam, consider educating them about treatment resources available through VHA. For MST specifically, there is free care available for mental and physical health conditions. Every VA health care facility has an MST Coordinator who serves as a contact person for MST-related issues and can help Veterans in accessing care. Service connection is not required to receive this free MST-related treatment and some Veterans can receive this care even if they are not eligible for other VA care. Additional information is available at the VA MST website.
Help
Resources
Select Next to continue
Back
Next


Settings
Exit
DMA Mental Health Examinations
Menu
Examinations for Conditions Related to Military Personal Trauma Including Military Sexual Trauma
Page 107 of 124 (86%)
Marker Evidence for PTSD Claims Based on Personal Trauma
You may recall from the last lesson that VBA follows special rules for evidence when they develop claims for PTSD secondary to military personal trauma, since many incidents of personal trauma, including MST, are not officially reported in service records. VBA can use circumstantial evidence, referred to as "markers" to corroborate the occurrence of a personal trauma in cases of PTSD. Sources of marker evidence include:
• military and civilian police reports
• rape crisis center or center for domestic abuse reports
• pregnancy tests or tests for sexually transmitted diseases
• personal diaries or journals
• statements from family members or roommates
• records from mental health counseling facilities or other medical reports
Tip
You can view additional examples in VBA's M21-1 Adjudication Procedures Manual (Part III, Subpart iv, Chapter 4, Section O, Topic 3, Item d. Evaluating Evidence and Deciding a Claim for PTSD Based on Personal Trauma).
Help
Resources
Select Next to continue
Back
Next

DMA Mental Health Examinations

Settings Exit

Menu | Examinations for Conditions Related to Military Personal Trauma Including Military Sexual Trauma | Page 108 of 124 (87%)

Marker Evidence of Behavioral Changes

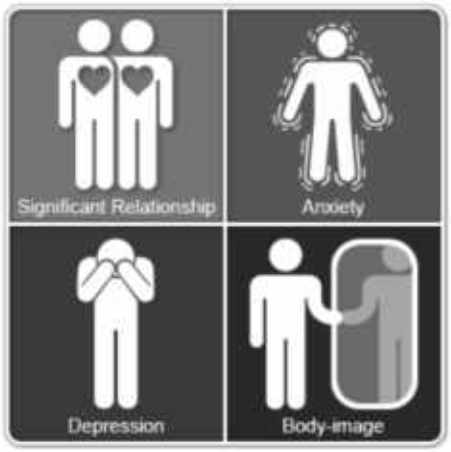
Documented evidence of behavior changes may circumstantially support the possibility that the claimed stressor occurred. Examples of evidence that may be a marker of a trauma from VBA's *M21-1 Adjudication Procedures Manual* include:

- a sudden request for transfer to another military duty assignment
- deterioration in work performance, use of leave, or both
- substance abuse or changes in use of prescription or over-the-counter medications
- episodes of depression, panic attacks, or anxiety
- unexplained economic or social behavior changes, such as obsessive behavior or changes in eating habits
- breakup of a primary relationship

Additional examples can be found in the *M21-1 Adjudication Procedures Manual*.

These kinds of indicators may be markers in some cases and not others. The context in which they appear is critical to making that determination. Therefore, the examiner must determine on a case-by-case basis whether any documented changes are consistent with the personal trauma reported by the Veteran.

Per the *M21-1 Manual*, an adjudicator may request a medical opinion "as to whether the credible factual evidence of behavior changes demonstrated by the Veteran is consistent with the expected reaction or adjustment of a person who has been subjected to an assault." For this reason, a Request for Examination may ask you to provide a medical opinion as to whether the personal trauma or MST stressor event described by the Veteran is at least as likely as not supported by and consistent with the in-service marker evidence.



Help | Resources | Select Next to continue | Back | Next

DMA Mental Health Examinations

Settings Exit

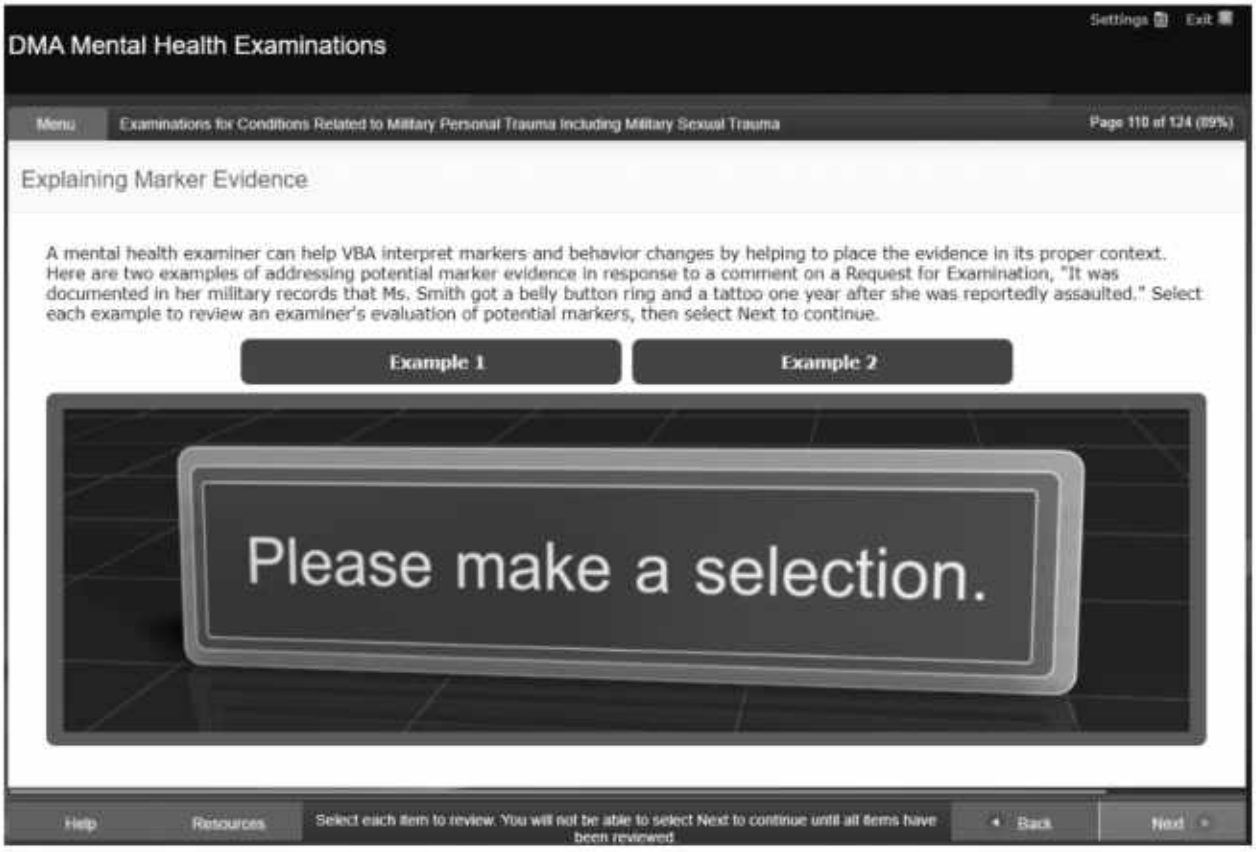
Menu | Examinations for Conditions Related to Military Personal Trauma Including Military Sexual Trauma | Page 109 of 124 (88%)

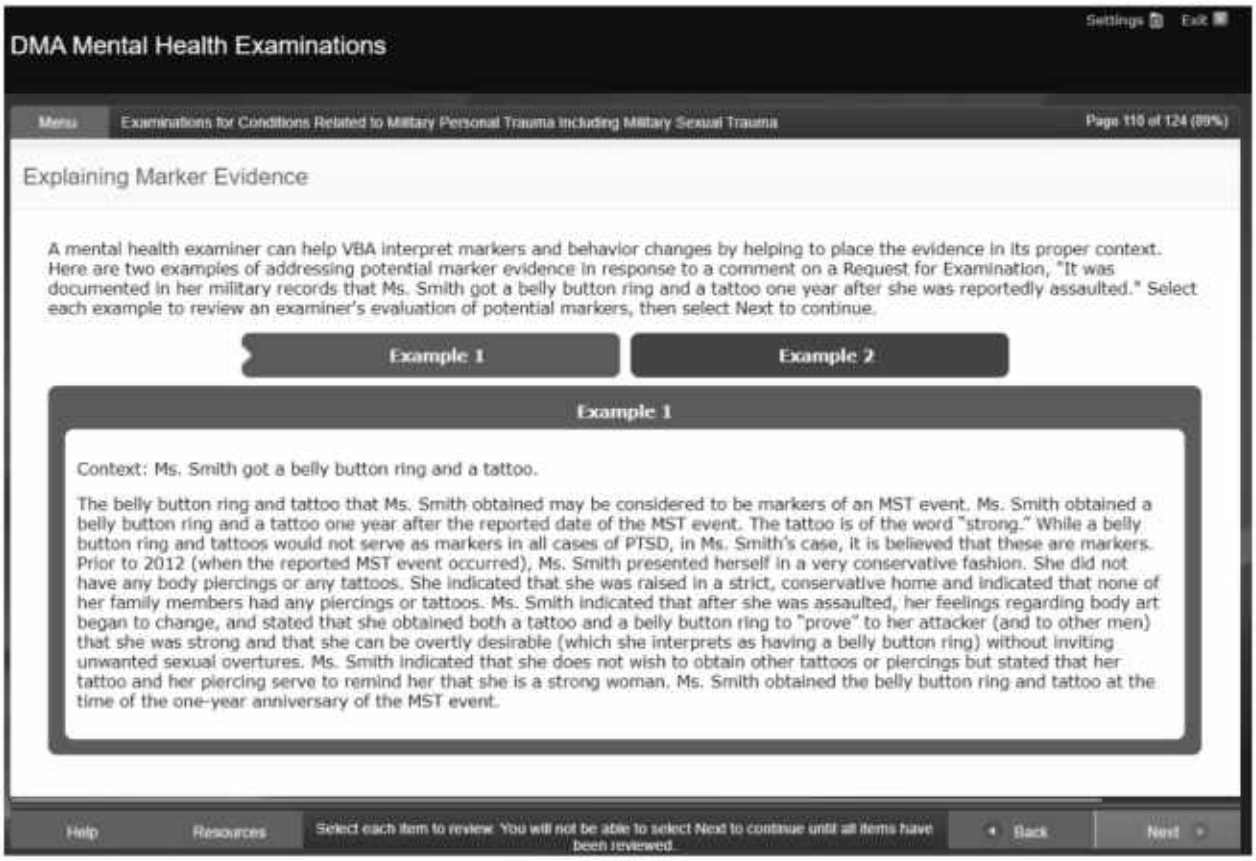
Reviewing the Records for Marker Evidence

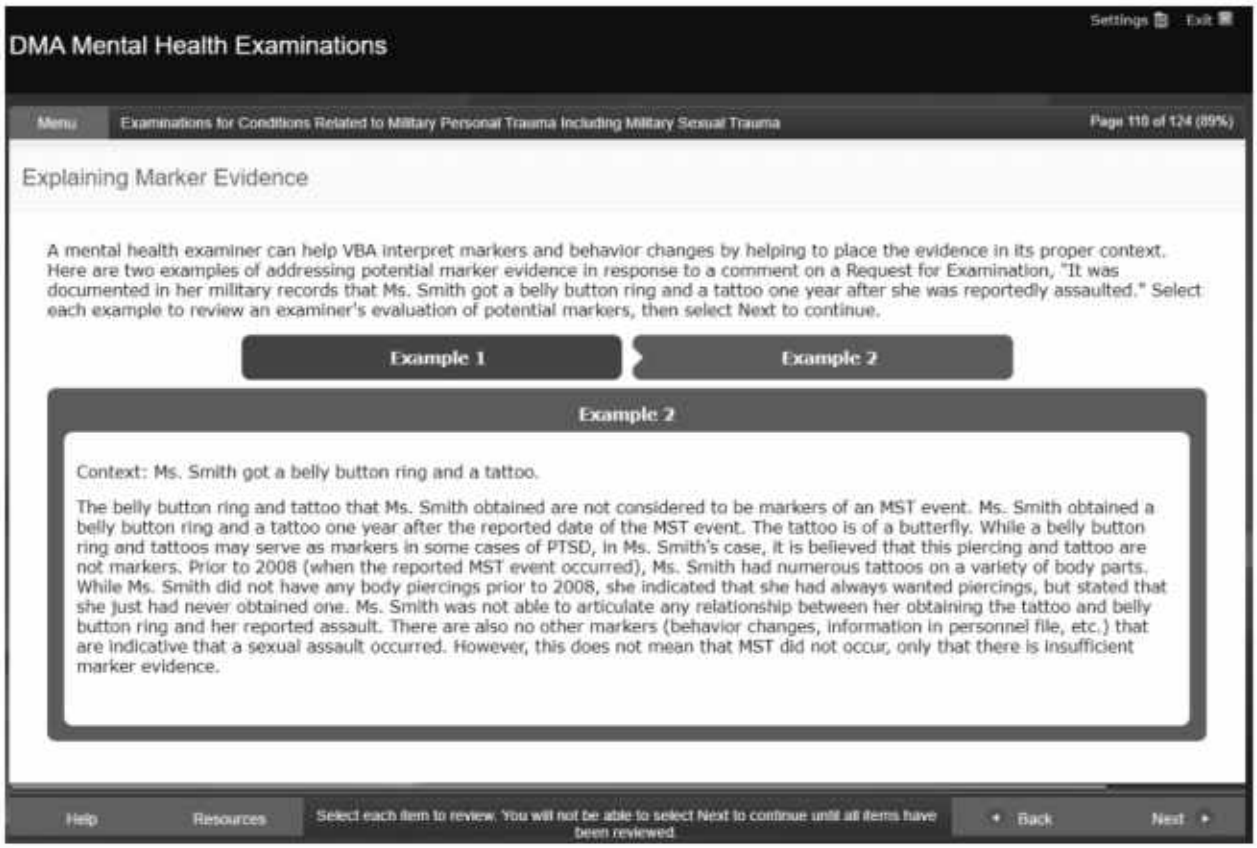
When VBA requests an opinion for PTSD related to military personal trauma including MST, the Request for Examination may include potential markers identified by VBA during development of the claim; they also will ask you to identify relevant markers. This will require you to review the claims file, paying special attention to signs, events, or circumstances that may represent markers for the personal trauma described by the Veteran. VBA will also remind you that your review is not limited to the evidence identified on the request form or tabbed in the eFolder, but to any pertinent evidence in the eFolder.

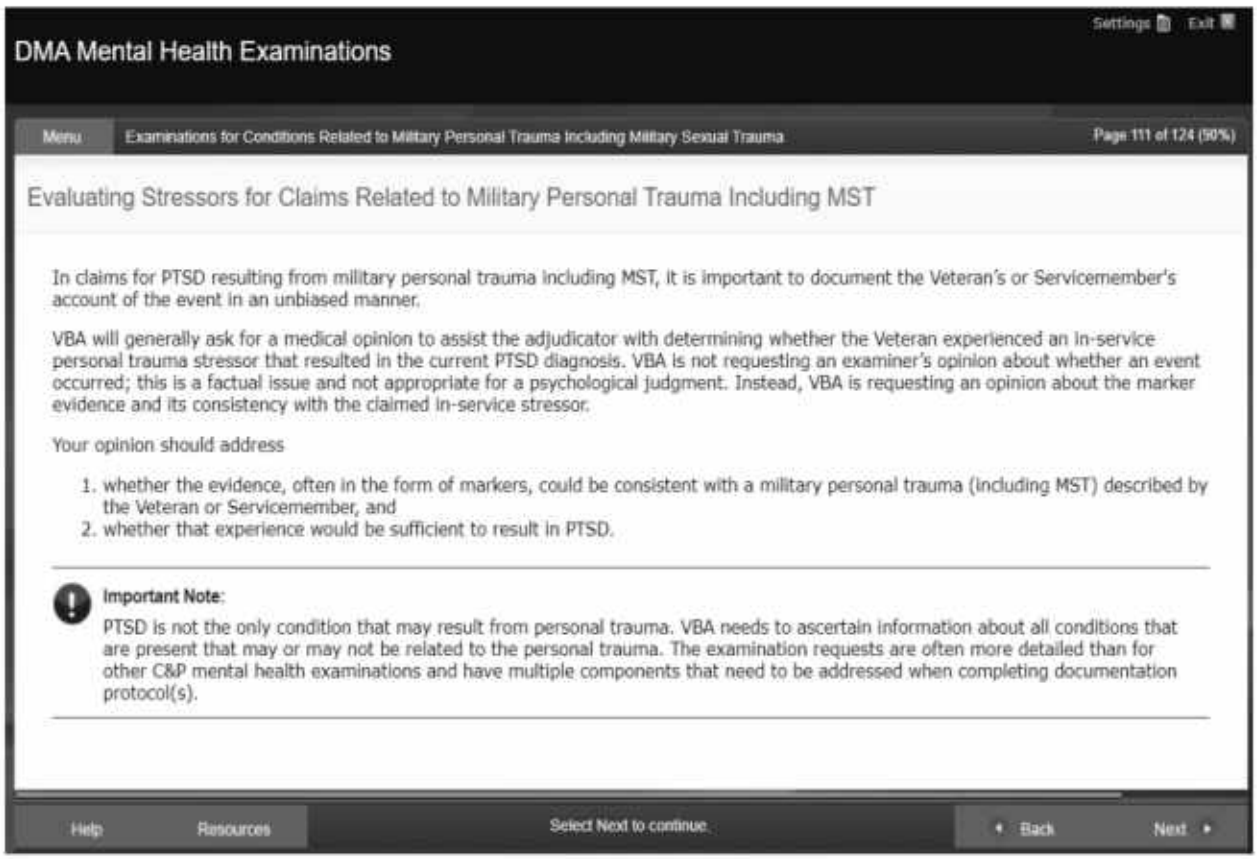
As an examiner, your clinical training and experience may enable you to discover alternative marker evidence in the Veteran's records to support a claim. This can be especially helpful when you determine that marker evidence provided by VBA does not support the possibility that a stressor event occurred, but you've found marker evidence that does support the possibility.

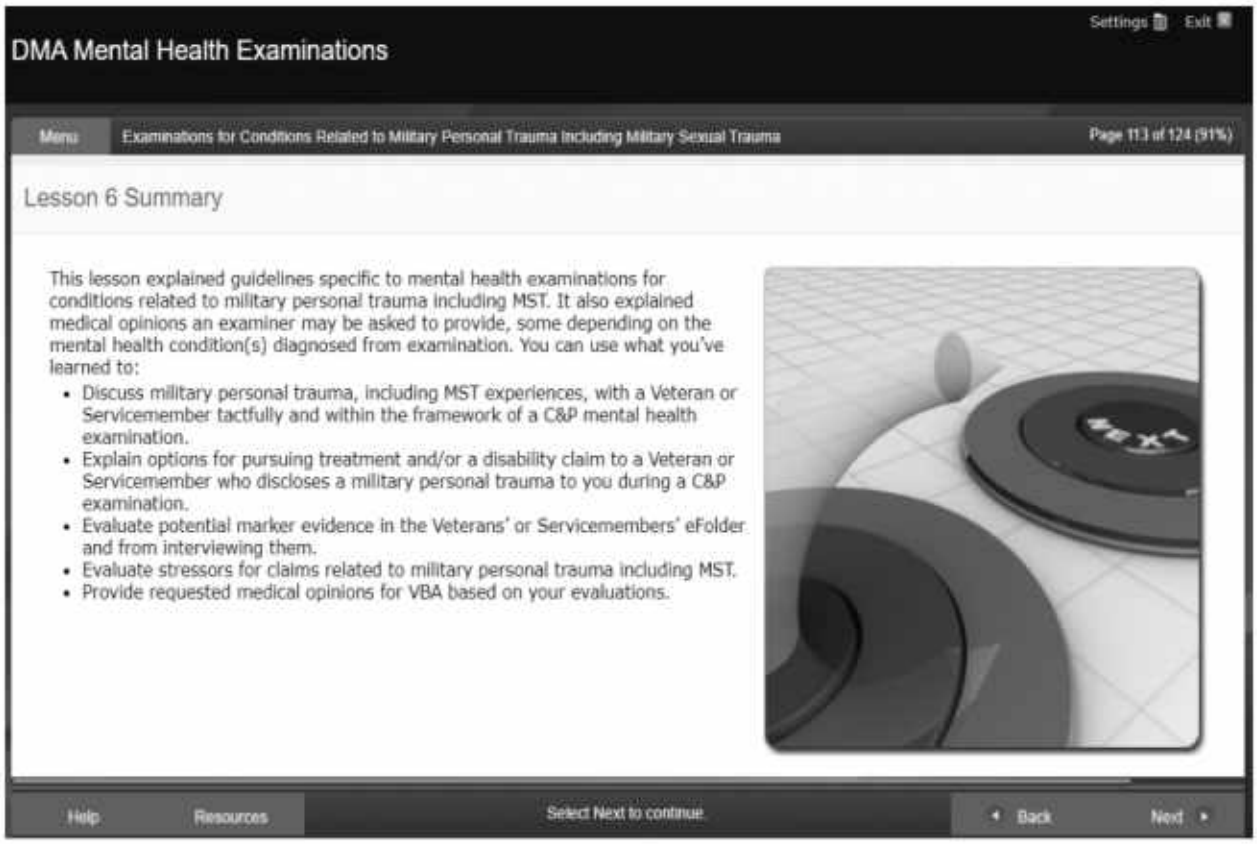
Help | Resources | Select Next to continue | Back | Next


DMA Mental Health Examinations
Settings
Exit
Menu
Examinations for Conditions Related to Military Personal Trauma Including Military Sexual Trauma
Page 110 of 124 (89%)
Explaining Marker Evidence
A mental health examiner can help VBA interpret markers and behavior changes by helping to place the evidence in its proper context. Here are two examples of addressing potential marker evidence in response to a comment on a Request for Examination, "It was documented in her military records that Ms. Smith got a belly button ring and a tattoo one year after she was reportedly assaulted." Select each example to review an examiner's evaluation of potential markers, then select Next to continue.
Example 1
Example 2
Please make a selection.
Help
Resources
Select each item to review. You will not be able to select Next to continue until all items have been reviewed.
Back
Next


DMA Mental Health Examinations
Settings
Exit
Menu
Examinations for Conditions Related to Military Personal Trauma Including Military Sexual Trauma
Page 110 of 124 (89%)
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Example 1
Example 2
Example 1
Context: Ms. Smith got a belly button ring and a tattoo.
The belly button ring and tattoo that Ms. Smith obtained may be considered to be markers of an MST event. Ms. Smith obtained a belly button ring and a tattoo one year after the reported date of the MST event. The tattoo is of the word "strong." While a belly button ring and tattoos would not serve as markers in all cases of PTSD, in Ms. Smith's case, it is believed that these are markers. Prior to 2012 (when the reported MST event occurred), Ms. Smith presented herself in a very conservative fashion. She did not have any body piercings or any tattoos. She indicated that she was raised in a strict, conservative home and indicated that none of her family members had any piercings or tattoos. Ms. Smith indicated that after she was assaulted, her feelings regarding body art began to change, and stated that she obtained both a tattoo and a belly button ring to "prove" to her attacker (and to other men) that she was strong and that she can be overtly desirable (which she interprets as having a belly button ring) without inviting unwanted sexual overtures. Ms. Smith indicated that she does not wish to obtain other tattoos or piercings but stated that her tattoo and her piercing serve to remind her that she is a strong woman. Ms. Smith obtained the belly button ring and tattoo at the time of the one-year anniversary of the MST event.
Help
Resources
Select each item to review. You will not be able to select Next to continue until all items have been reviewed.
Back
Next


DMA Mental Health Examinations
Settings
Exit
Menu
Examinations for Conditions Related to Military Personal Trauma Including Military Sexual Trauma
Page 110 of 124 (89%)
Explaining Marker Evidence
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Example 1
Example 2
Example 2
Context: Ms. Smith got a belly button ring and a tattoo.
The belly button ring and tattoo that Ms. Smith obtained are not considered to be markers of an MST event. Ms. Smith obtained a belly button ring and a tattoo one year after the reported date of the MST event. The tattoo is of a butterfly. While a belly button ring and tattoos may serve as markers in some cases of PTSD, in Ms. Smith's case, it is believed that this piercing and tattoo are not markers. Prior to 2008 (when the reported MST event occurred), Ms. Smith had numerous tattoos on a variety of body parts. While Ms. Smith did not have any body piercings prior to 2008, she indicated that she had always wanted piercings, but stated that she just had never obtained one. Ms. Smith was not able to articulate any relationship between her obtaining the tattoo and belly button ring and her reported assault. There are also no other markers (behavior changes, information in personnel file, etc.) that are indicative that a sexual assault occurred. However, this does not mean that MST did not occur, only that there is insufficient marker evidence.
Help
Resources
Select each item to review. You will not be able to select Next to continue until all items have been reviewed.
Back
Next


DMA Mental Health Examinations
Settings
Exit
Menu
Examinations for Conditions Related to Military Personal Trauma Including Military Sexual Trauma
Page 111 of 124 (90%)
Evaluating Stressors for Claims Related to Military Personal Trauma Including MST
In claims for PTSD resulting from military personal trauma including MST, it is important to document the Veteran's or Servicemember's account of the event in an unbiased manner.
VBA will generally ask for a medical opinion to assist the adjudicator with determining whether the Veteran experienced an in-service personal trauma stressor that resulted in the current PTSD diagnosis. VBA is not requesting an examiner's opinion about whether an event occurred; this is a factual issue and not appropriate for a psychological judgment. Instead, VBA is requesting an opinion about the marker evidence and its consistency with the claimed in-service stressor.
Your opinion should address
1. whether the evidence, often in the form of markers, could be consistent with a military personal trauma (including MST) described by the Veteran or Servicemember, and
2. whether that experience would be sufficient to result in PTSD.
Important Note:
PTSD is not the only condition that may result from personal trauma. VBA needs to ascertain information about all conditions that are present that may or may not be related to the personal trauma. The examination requests are often more detailed than for other C&P mental health examinations and have multiple components that need to be addressed when completing documentation protocol(s).
Help
Resources
Select Next to continue.
Back
Next


Settings
Exit
DMA Mental Health Examinations
Menu
Examinations for Conditions Related to Military Personal Trauma Including Military Sexual Trauma
Page 113 of 124 (91%)
Lesson 6 Summary
This lesson explained guidelines specific to mental health examinations for conditions related to military personal trauma including MST. It also explained medical opinions an examiner may be asked to provide, some depending on the mental health condition(s) diagnosed from examination. You can use what you've learned to:
• Discuss military personal trauma, including MST experiences, with a Veteran or Servicemember tactfully and within the framework of a C&P mental health examination.
• Explain options for pursuing treatment and/or a disability claim to a Veteran or Servicemember who discloses a military personal trauma to you during a C&P examination.
• Evaluate potential marker evidence in the Veterans' or Servicemembers' eFolder and from interviewing them.
• Evaluate stressors for claims related to military personal trauma including MST.
• Provide requested medical opinions for VBA based on your evaluations.
Help
Resources
Select Next to continue
Back
Next

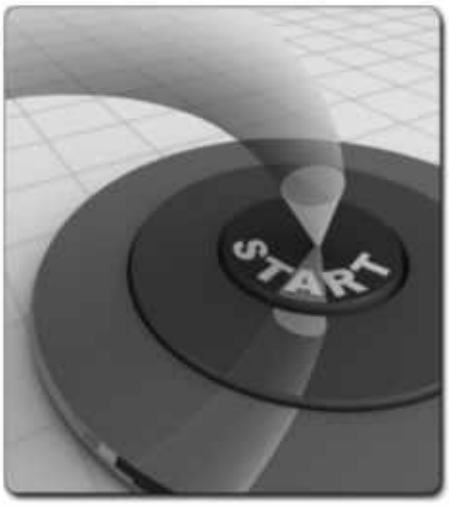
Settings Exit

DMA Mental Health Examinations

Menu | C&P Eating Disorders Examinations | Page 114 of 124 (92%)

Lesson 7 Overview

This lesson will explain the purpose and goals of a C&P eating disorders examination as presented in the Eating Disorders documentation protocol. In addition, this lesson will present data about co-occurring mental health conditions because C&P eating disorders examinations are often requested with other C&P mental health examinations.



Help | Resources | Select Next to continue | Back | Next

Settings Exit

DMA Mental Health Examinations

Menu | C&P Eating Disorders Examinations | Page 115 of 124 (93%)

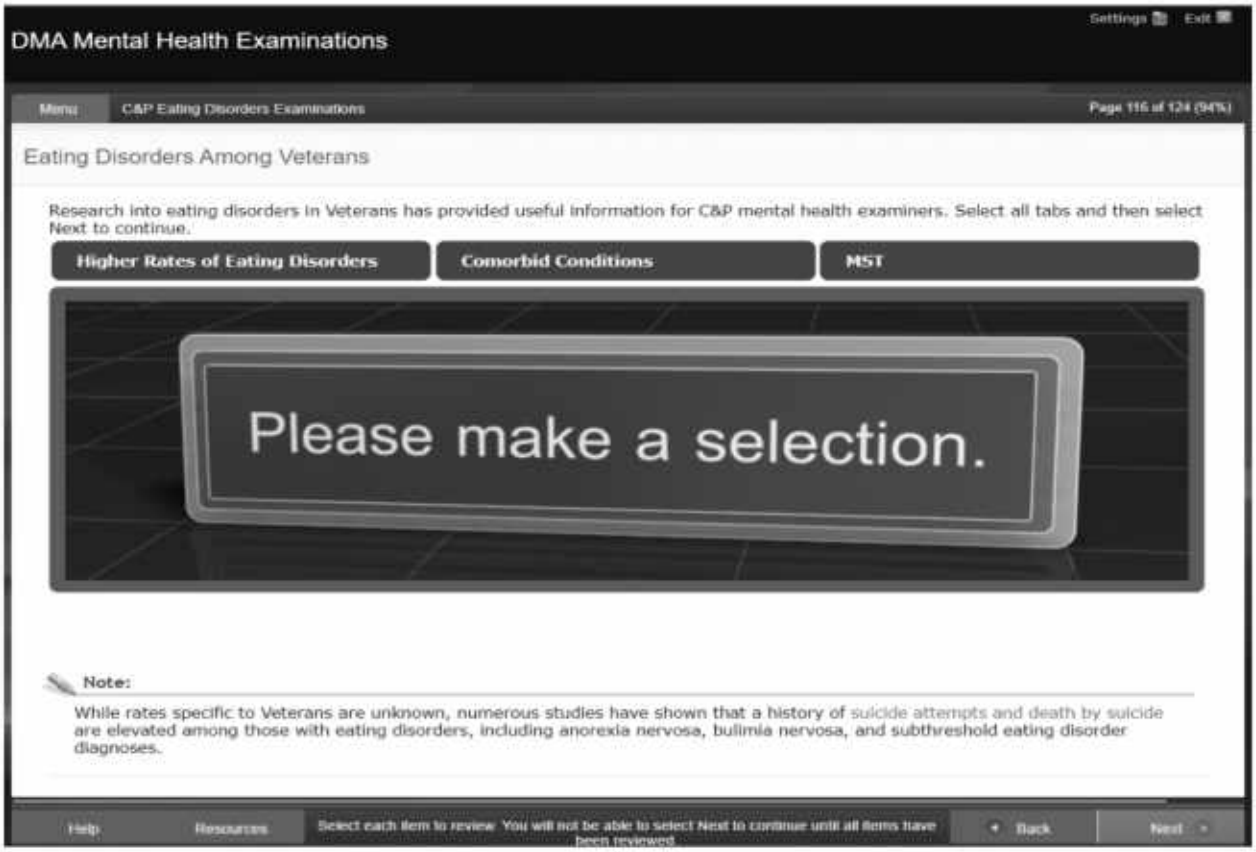
The Purpose of C&P Eating Disorders Examinations

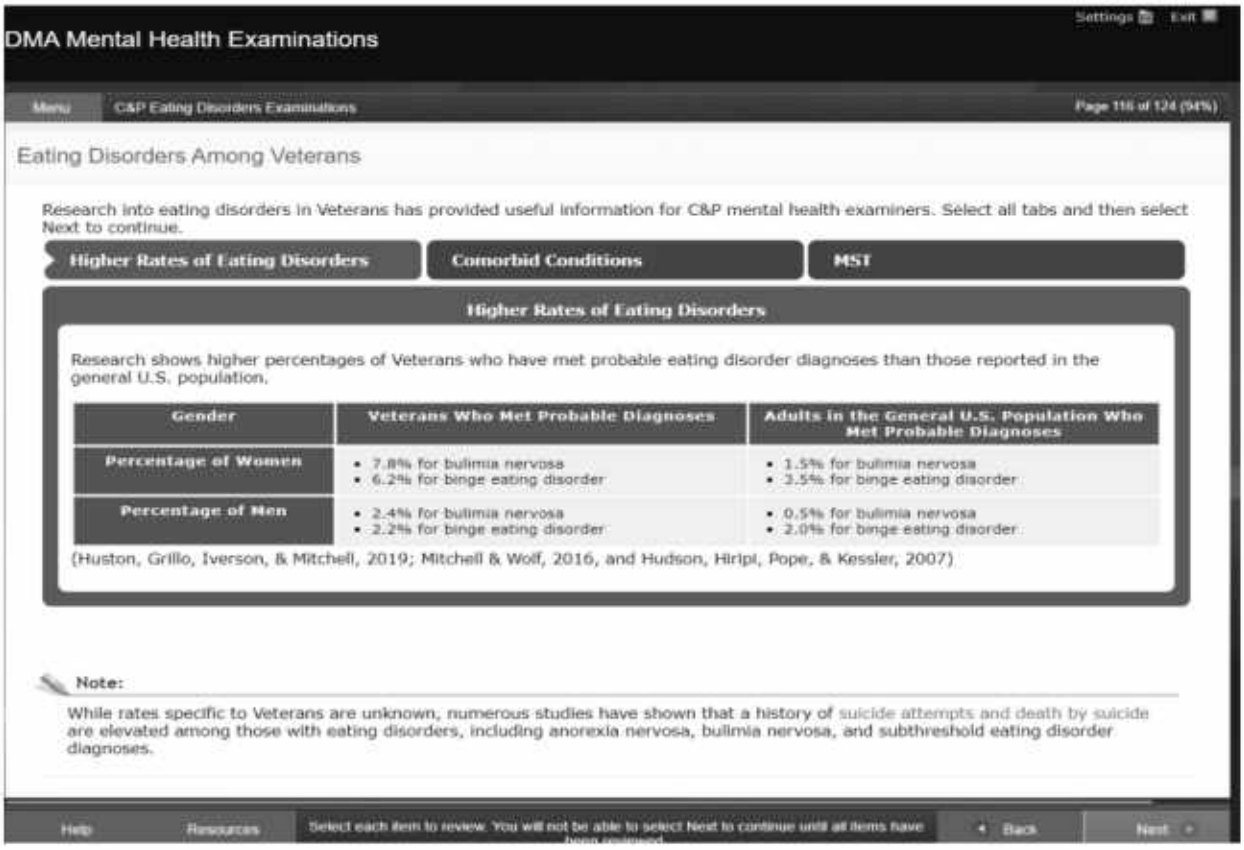
A C&P Eating Disorders examination is used to evaluate anorexia, bulimia, and other eating disorders.

C&P Eating Disorders evaluations are often requested along with another mental disorder evaluation due to the frequency with which they co-occur. The relationship between an eating disorder and another mental disorder – if there is one – can vary on a case-by-case basis. For example, a Veteran could have obsessive behavior such as overeating or undereating due to another mental disorder such as an anxiety disorder or PTSD, but the behavior could also reflect a stand-alone condition. The examiner may determine a relationship between co-occurring eating and mental disorder(s) through a synthesis of reviewing the Veteran's or Servicemember's eFolder, findings from an Eating Disorders evaluation, or both.

The Eating Disorders documentation protocol is closely aligned with the VA Schedule for Rating Disabilities (VASRD) rather than with current clinical diagnostic criteria. As a result, examiners will benefit from reviewing the documentation protocol before the examination to see how examination findings are documented and what information will be needed to complete a report that is sufficient for VBA adjudication.

Help | Resources | Select Next to continue | Back | Next


DMA Mental Health Examinations
Settings
Exit
Menu
C&P Eating Disorders Examinations
Page 116 of 124 (94%)
Eating Disorders Among Veterans
Research into eating disorders in Veterans has provided useful information for C&P mental health examiners. Select all tabs and then select Next to continue.
Higher Rates of Eating Disorders
Comorbid Conditions
MST
Please make a selection.
Note:
While rates specific to Veterans are unknown, numerous studies have shown that a history of suicide attempts and death by suicide are elevated among those with eating disorders, including anorexia nervosa, bulimia nervosa, and subthreshold eating disorder diagnoses.
Help
Resources
Select each item to review. You will not be able to select Next to continue until all items have been reviewed.
Back
Next


DMA Mental Health Examinations
Settings
Exit
Menu
C&P Eating Disorders Examinations
Page 116 of 124 (94%)
Eating Disorders Among Veterans
Research into eating disorders in Veterans has provided useful information for C&P mental health examiners. Select all tabs and then select Next to continue.
Higher Rates of Eating Disorders
Comorbid Conditions
MST
Higher Rates of Eating Disorders
Research shows higher percentages of Veterans who have met probable eating disorder diagnoses than those reported in the general U.S. population.
Gender
Veterans Who Met Probable Diagnoses
Adults in the General U.S. Population Who Met Probable Diagnoses
Percentage of Women
• 7.8% for bulimia nervosa
• 6.2% for binge eating disorder
• 1.5% for bulimia nervosa
• 3.5% for binge eating disorder
Percentage of Men
• 2.4% for bulimia nervosa
• 2.2% for binge eating disorder
• 0.5% for bulimia nervosa
• 2.0% for binge eating disorder
(Huston, Grillo, Iverson, & Mitchell, 2019; Mitchell & Wolf, 2016, and Hudson, Hiripi, Pope, & Kessler, 2007)
Note:
While rates specific to Veterans are unknown, numerous studies have shown that a history of suicide attempts and death by suicide are elevated among those with eating disorders, including anorexia nervosa, bulimia nervosa, and subthreshold eating disorder diagnoses.
Help
Resources
Select each item to review. You will not be able to select Next to continue until all items have been reviewed.
Back
Next

DMA Mental Health Examinations

Settings Exit

Menu | C&P Eating Disorders Examinations | Page 116 of 124 (94%)

Eating Disorders Among Veterans

Research into eating disorders in Veterans has provided useful information for C&P mental health examiners. Select all tabs and then select Next to continue.

Higher Rates of Eating Disorders | **Comorbid Conditions** | **MST**

Comorbid Conditions

Research has also demonstrated that Veterans who have been diagnosed with depressive and anxiety disorders, PTSD, or who have experienced MST are more likely to also have an eating disorder as compared to those without these diagnoses.

Depressive and Anxiety Disorders	PTSD
• Post-9/11 VHA patients with depressive disorders were 5.3 to 6.9 times more likely to have an eating disorder diagnosis compared to those without depressive disorders (Blais, et al., 2017). • Among VHA MOVE! patients diagnosed as overweight or obese, 82.7% with depressive disorders and 83.1% with anxiety disorders had higher rates of twice-weekly binge eating episodes compared to the total sample (78.2%) (Higgins, et al., 2013).	• Post-9/11 VHA patients with PTSD were 1.3 to 1.5 times more likely to have an eating disorder diagnosis compared to those without PTSD (Blais, et al., 2017). • Among VHA MOVE! patients diagnosed as overweight or obese, 81.1% of patients with PTSD reported binge eating at least twice weekly (Higgins, et al., 2013). • In a sample of 1004 female VHA patients, 7.3% of women with PTSD reported a probable eating disorder compared to 3.8% of those without PTSD (Forman-Hoffman, et al., 2012).

(Mitchell & Garovoy, 2019)

Note:

While rates specific to Veterans are unknown, numerous studies have shown that a history of suicide attempts and death by suicide are elevated among those with eating disorders, including anorexia nervosa, bulimia nervosa, and subthreshold eating disorder diagnoses.

Help | Resources | Select each item to review. You will not be able to select Next to continue until all items have been reviewed. | Back | Next

DMA Mental Health Examinations

Settings Exit

Menu | C&P Eating Disorders Examinations | Page 116 of 124 (94%)

Eating Disorders Among Veterans

Research into eating disorders in Veterans has provided useful information for C&P mental health examiners. Select all tabs and then select Next to continue.

Higher Rates of Eating Disorders | Comorbid Conditions | MST

MST

Several studies have shown increased rates of eating disorders among Veterans who screened positive for military sexual trauma (MST):

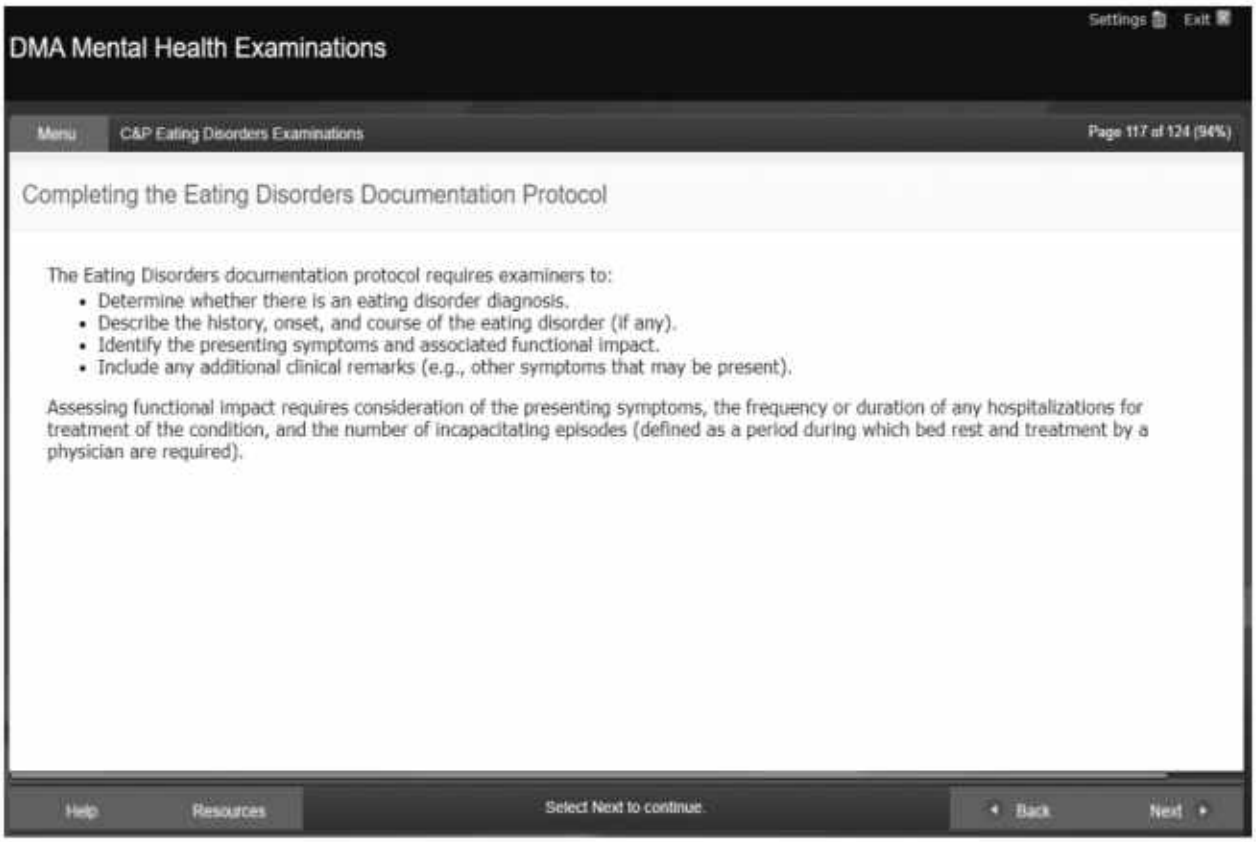
- A study by Blais, et al. (2017) showed that a positive screen for MST was associated with higher probability of an eating disorder diagnosis in one-year and five-year follow-ups among both male and female post-9/11 VHA patients. Individuals with MST were approximately twice as likely to have an eating disorder compared to those without histories of MST.
- In a study of 1004 female VHA patients, rates of eating disorders ranged from 7.6% to 8.1% among women who reported MST, compared to a rate of 3.1% for women who did not report MST (Forman-Hoffman, Mengeling, Booth, Torner, & Sadler, 2012).



Note:

While rates specific to Veterans are unknown, numerous studies have shown that a history of suicide attempts and death by suicide are elevated among those with eating disorders, including anorexia nervosa, bulimia nervosa, and subthreshold eating disorder diagnoses.

Help | Resources | Select each item to review. You will not be able to select Next to continue until all items have been reviewed. | Back | Next


DMA Mental Health Examinations
Settings
Exit
Menu
C&P Eating Disorders Examinations
Page 117 of 124 (94%)
Completing the Eating Disorders Documentation Protocol
The Eating Disorders documentation protocol requires examiners to:
• Determine whether there is an eating disorder diagnosis.
• Describe the history, onset, and course of the eating disorder (if any).
• Identify the presenting symptoms and associated functional impact.
• Include any additional clinical remarks (e.g., other symptoms that may be present).
Assessing functional impact requires consideration of the presenting symptoms, the frequency or duration of any hospitalizations for treatment of the condition, and the number of incapacitating episodes (defined as a period during which bed rest and treatment by a physician are required).
Help
Resources
Select Next to continue.
Back
Next

DMA Mental Health Examinations

Settings Exit

Menu | C&P Eating Disorders Examinations | Page 118 of 124 (95%)

Assessing Eating Disorder Symptoms and History

When assessing current and historic eating disorder symptoms, examiners should:

- Display a high degree of sensitivity when assessing individuals who struggle with Eating Disorders, which can be accompanied by shame and secrecy.
- Remember that specific inquiries about weight may result in increased distress. Sometimes this information can be obtained from recent medical records.

Tip

Eating disorders information resources for clinicians can be accessed here and in course Resources: Disorders: Frequently Asked Questions for Healthcare Providers, Medical Comorbidities in Eating Disorders, and Eating Disorders: Screening and Diagnosis.

Help | Resources | Select Next to continue | Back | Next

DMA Mental Health Examinations

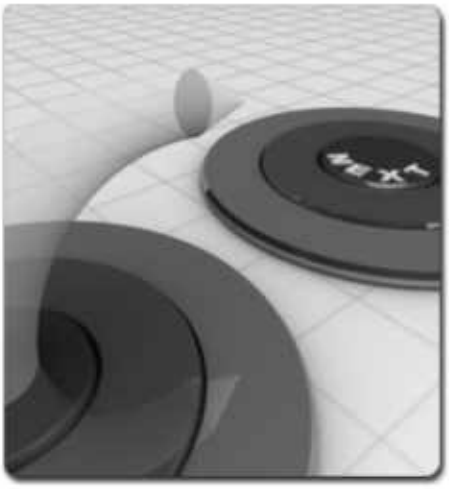
Settings Exit

Menu | C&P Eating Disorders Examinations | Page 120 of 124 (97%)

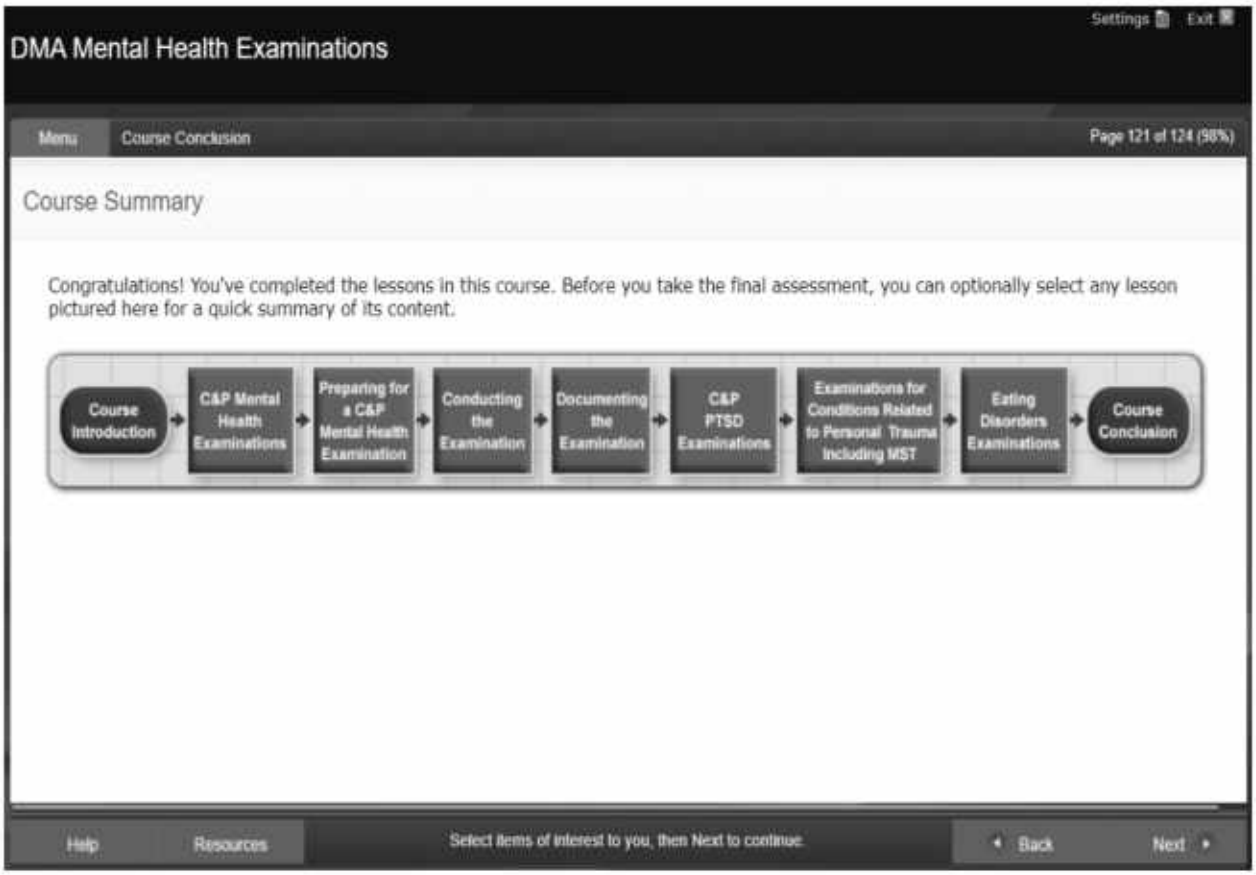
Lesson 7 Summary

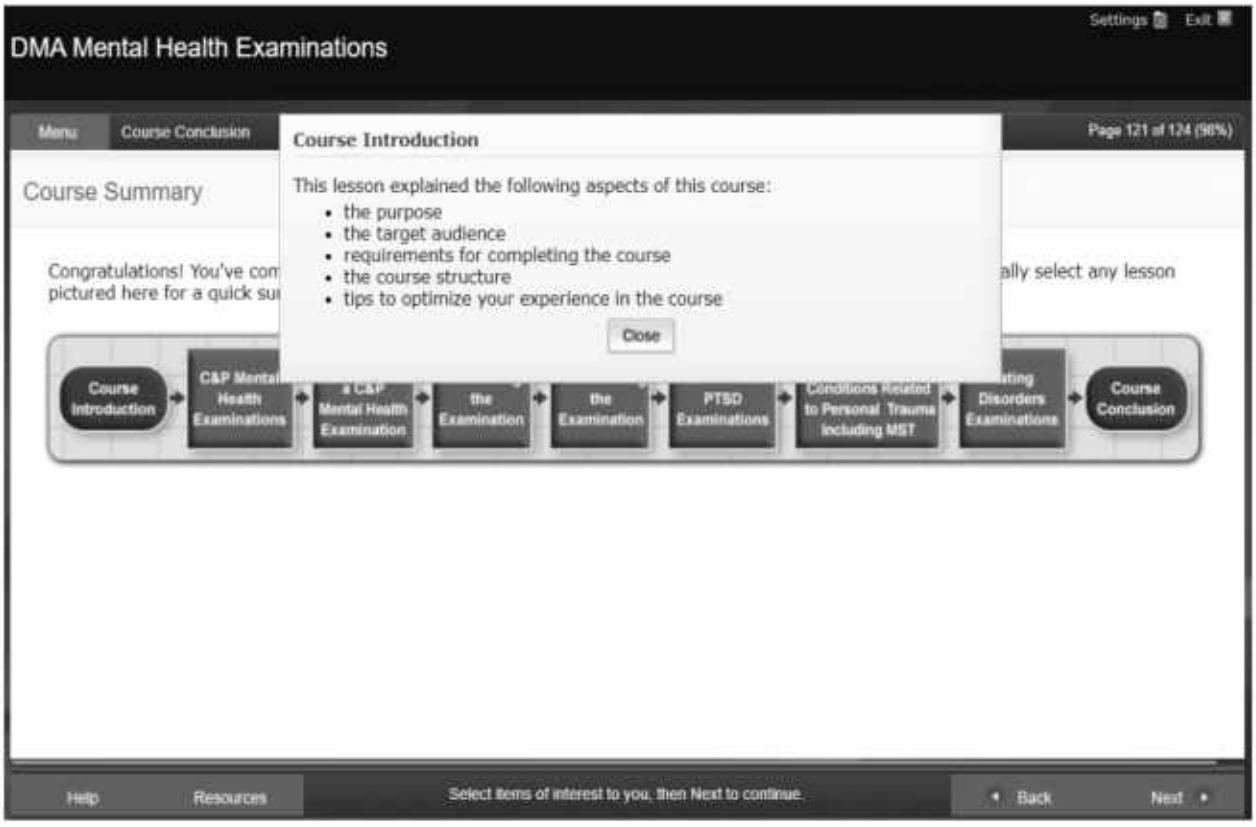
This lesson presented content to help you conduct C&P eating disorders evaluations. You can use what you've learned to

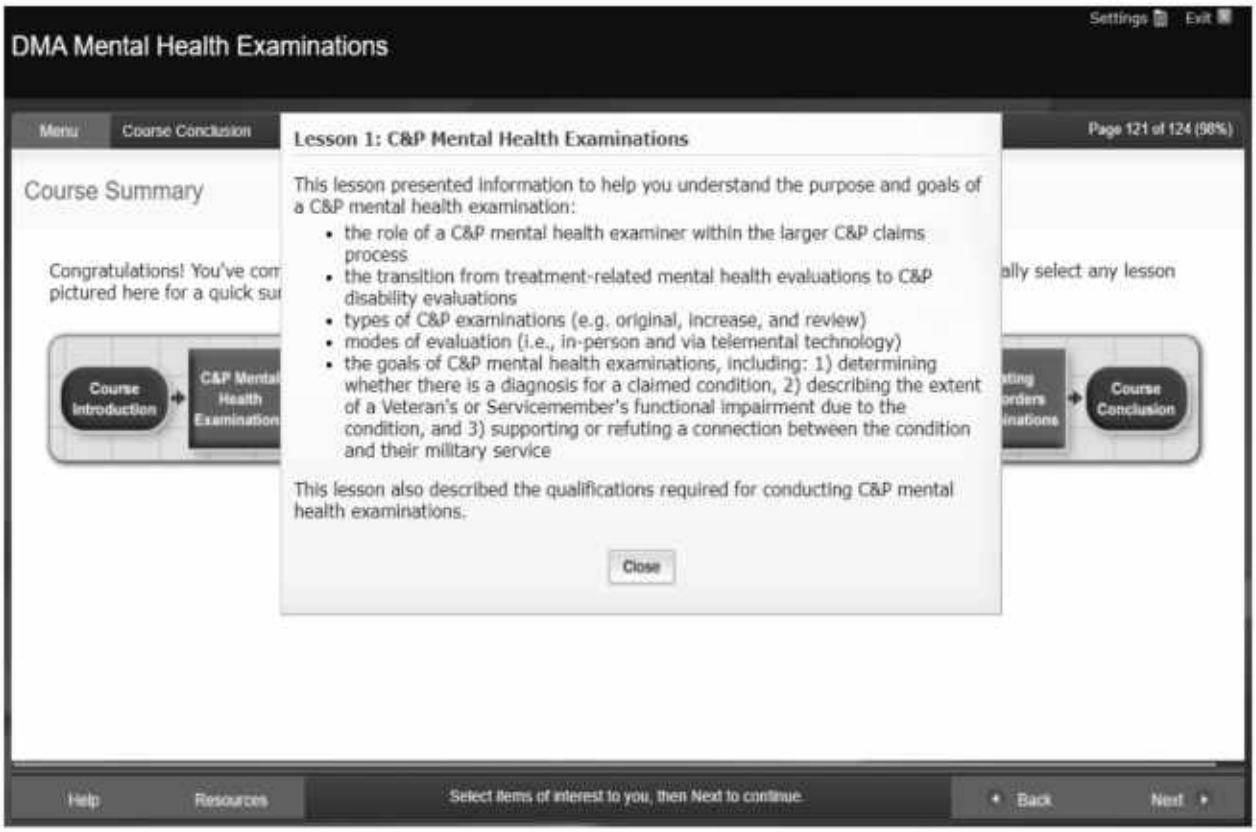
- achieve the purpose and goals of a C&P eating disorders examination, and
- recognize mental health conditions that co-occur with eating disorders.

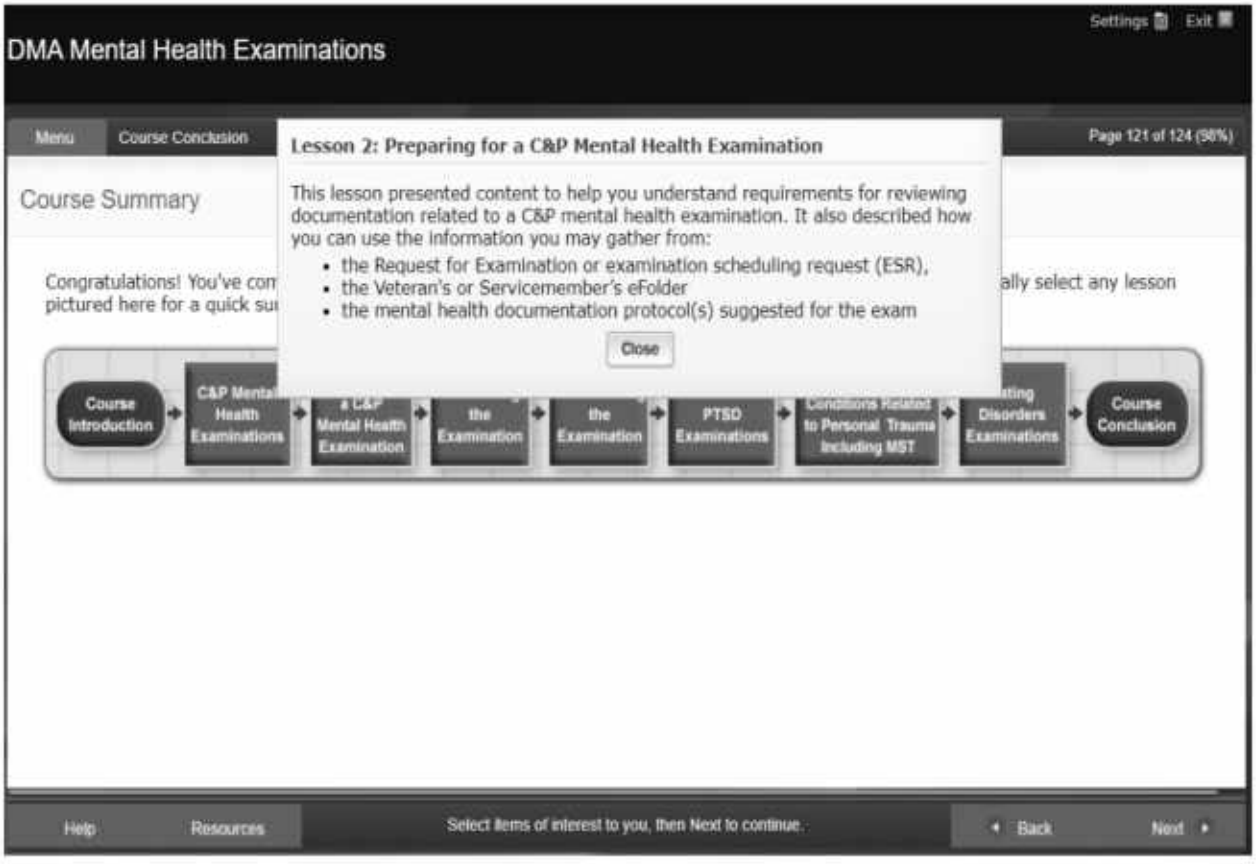


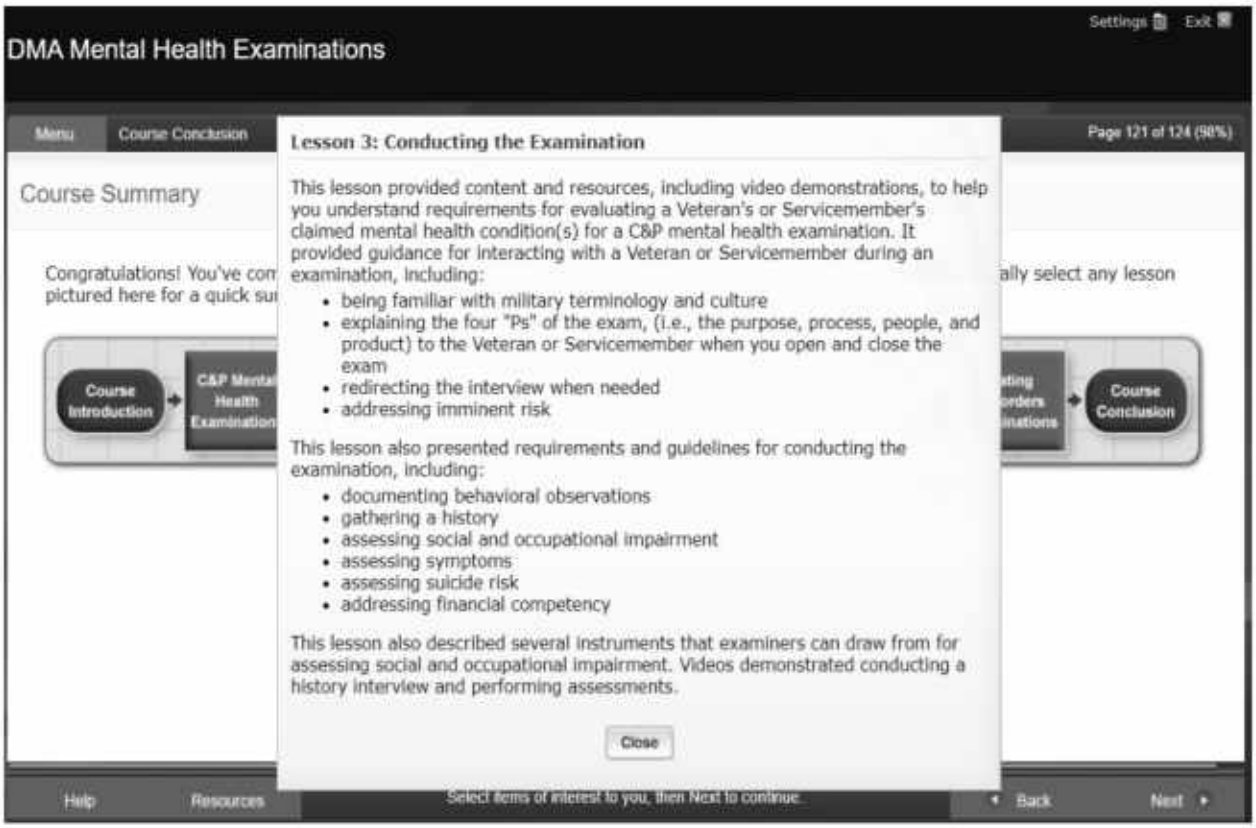
Help | Resources | Select Next to continue | Back | Next

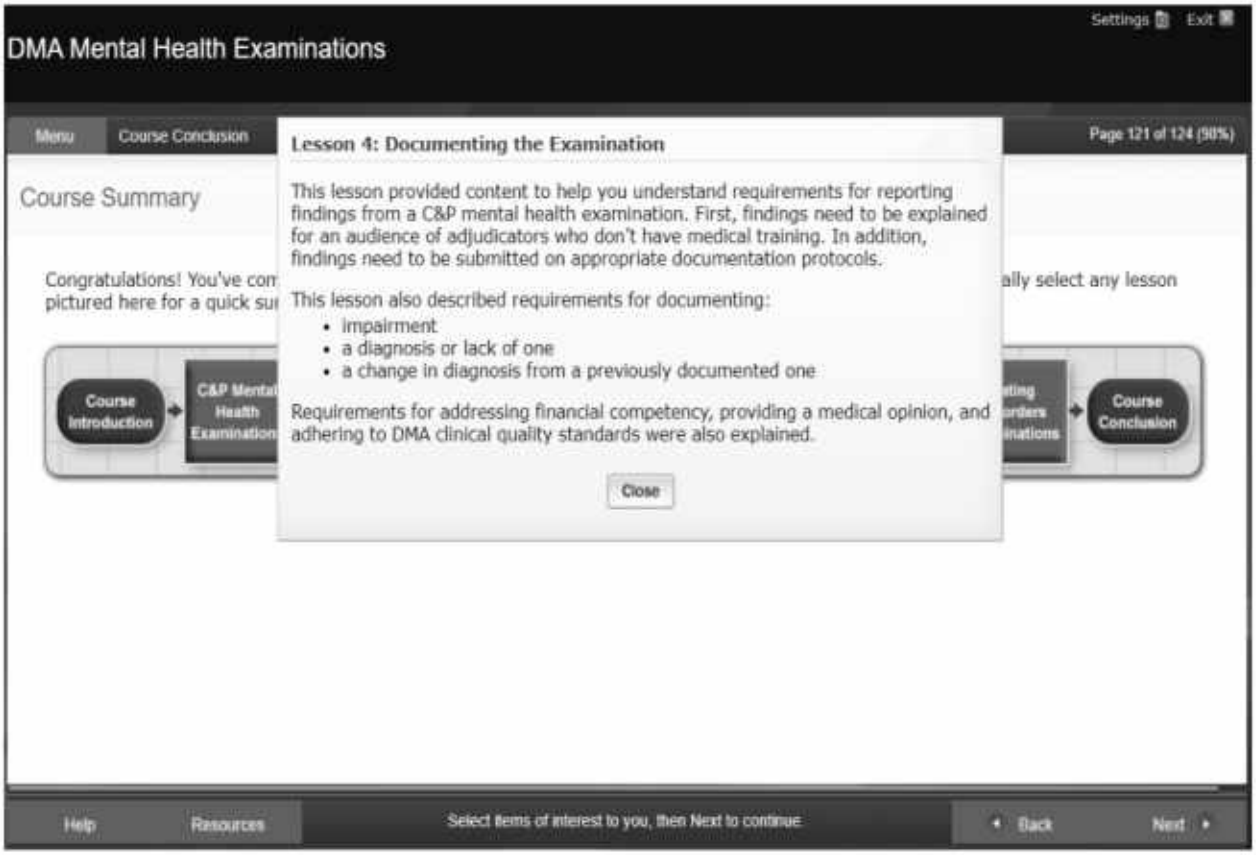

DMA Mental Health Examinations
Settings
Exit
Menu
Course Conclusion
Page 121 of 124 (98%)
Course Summary
Congratulations! You've completed the lessons in this course. Before you take the final assessment, you can optionally select any lesson pictured here for a quick summary of its content.
Course Introduction
C&P Mental Health Examinations
Preparing for a C&P Mental Health Examination
Conducting the Examination
Documenting the Examination
C&P PTSD Examinations
Examinations for Conditions Related to Personal Trauma Including MST
Eating Disorders Examinations
Course Conclusion
Help
Resources
Select items of interest to you, then Next to continue.
Back
Next

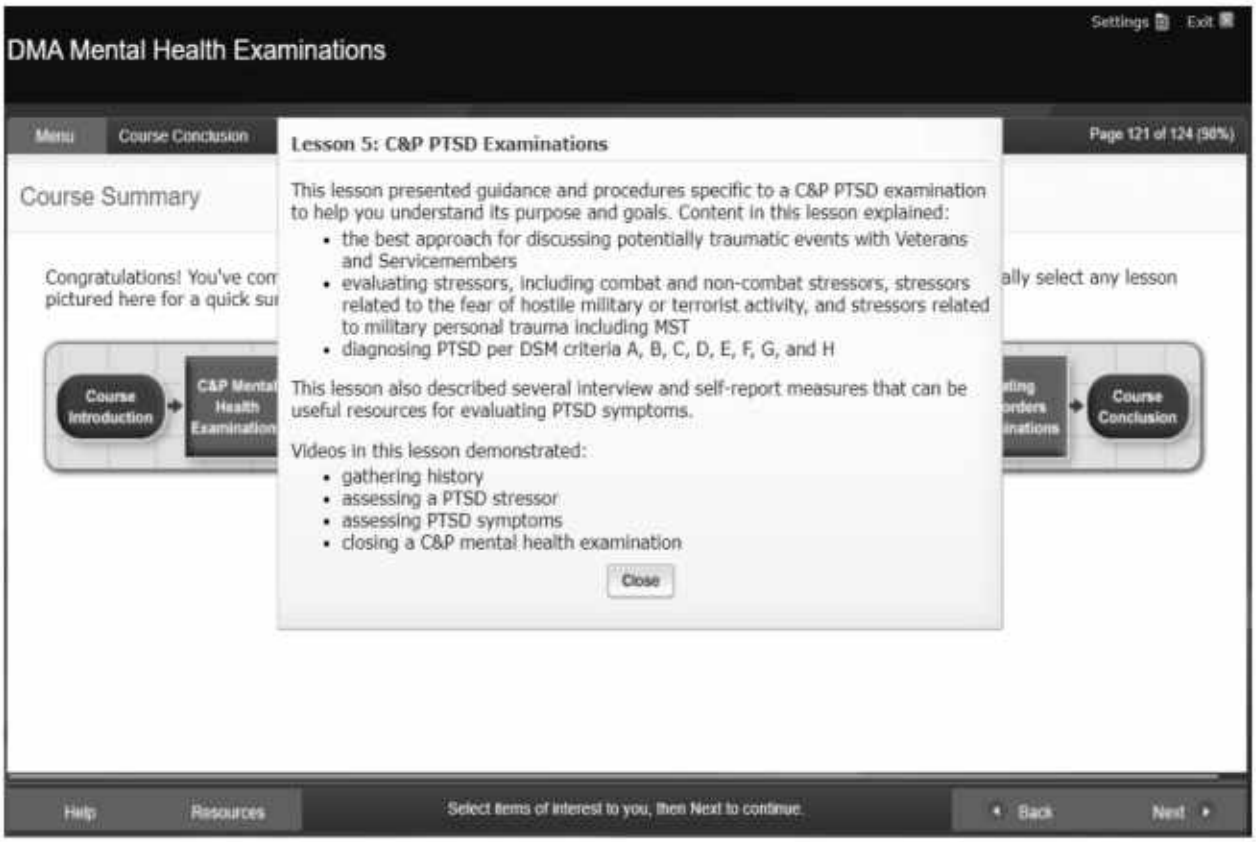

DMA Mental Health Examinations
Settings
Exit
Menu
Course Conclusion
Page 121 of 124 (98%)
Course Summary
Course Introduction
This lesson explained the following aspects of this course:
• the purpose
• the target audience
• requirements for completing the course
• the course structure
• tips to optimize your experience in the course
Close
Course Introduction
Course Conclusion
Help
Resources
Select items of interest to you, then Next to continue.
Back
Next

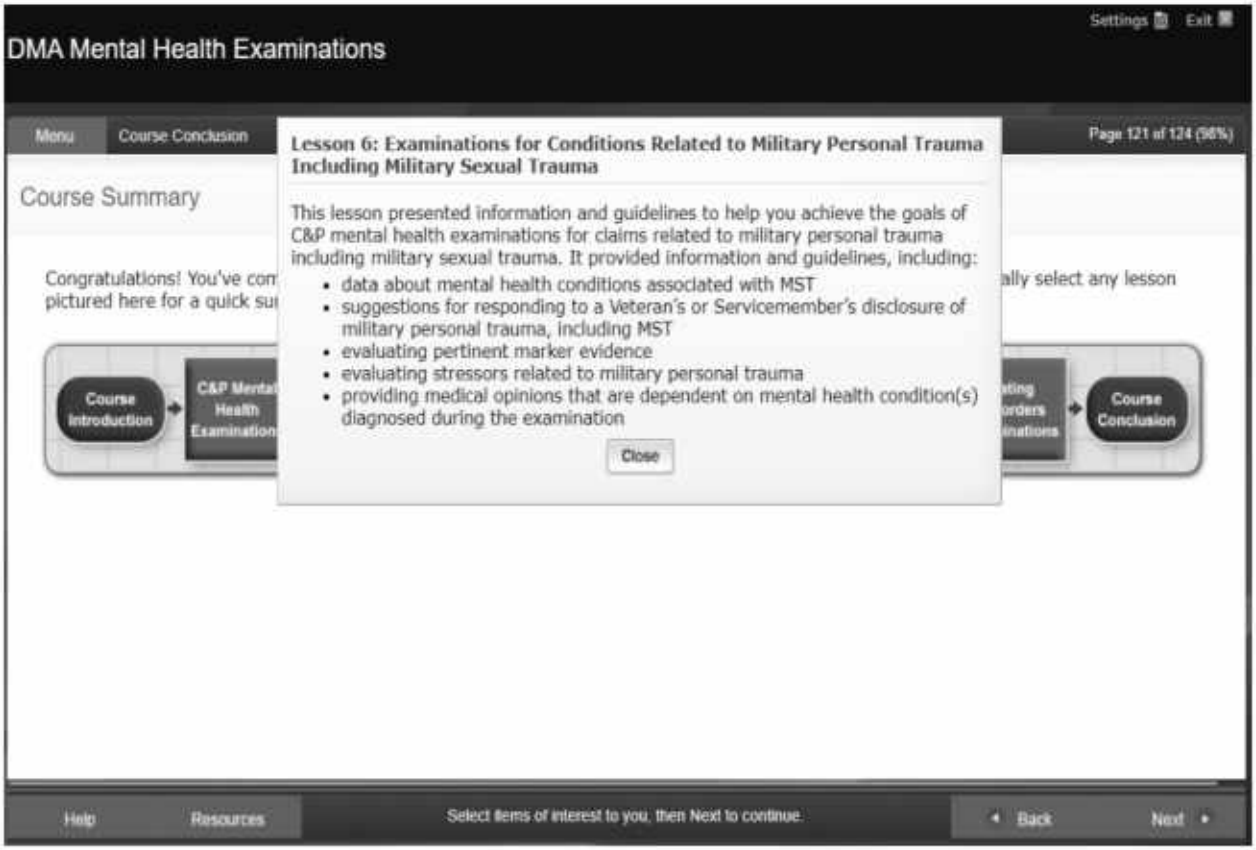

DMA Mental Health Examinations
Settings
Exit
Menu
Course Conclusion
Page 121 of 124 (98%)
Course Summary
Lesson 1: C&P Mental Health Examinations
This lesson presented information to help you understand the purpose and goals of a C&P mental health examination:
the role of a C&P mental health examiner within the larger C&P claims process
the transition from treatment-related mental health evaluations to C&P disability evaluations
types of C&P examinations (e.g. original, increase, and review)
modes of evaluation (i.e., in-person and via telemental technology)
the goals of C&P mental health examinations, including: 1) determining whether there is a diagnosis for a claimed condition, 2) describing the extent of a Veteran's or Servicemember's functional impairment due to the condition, and 3) supporting or refuting a connection between the condition and their military service
This lesson also described the qualifications required for conducting C&P mental health examinations.
Close
Course Introduction
Course Conclusion
Help
Resources
Select items of interest to you, then Next to continue.
Back
Next

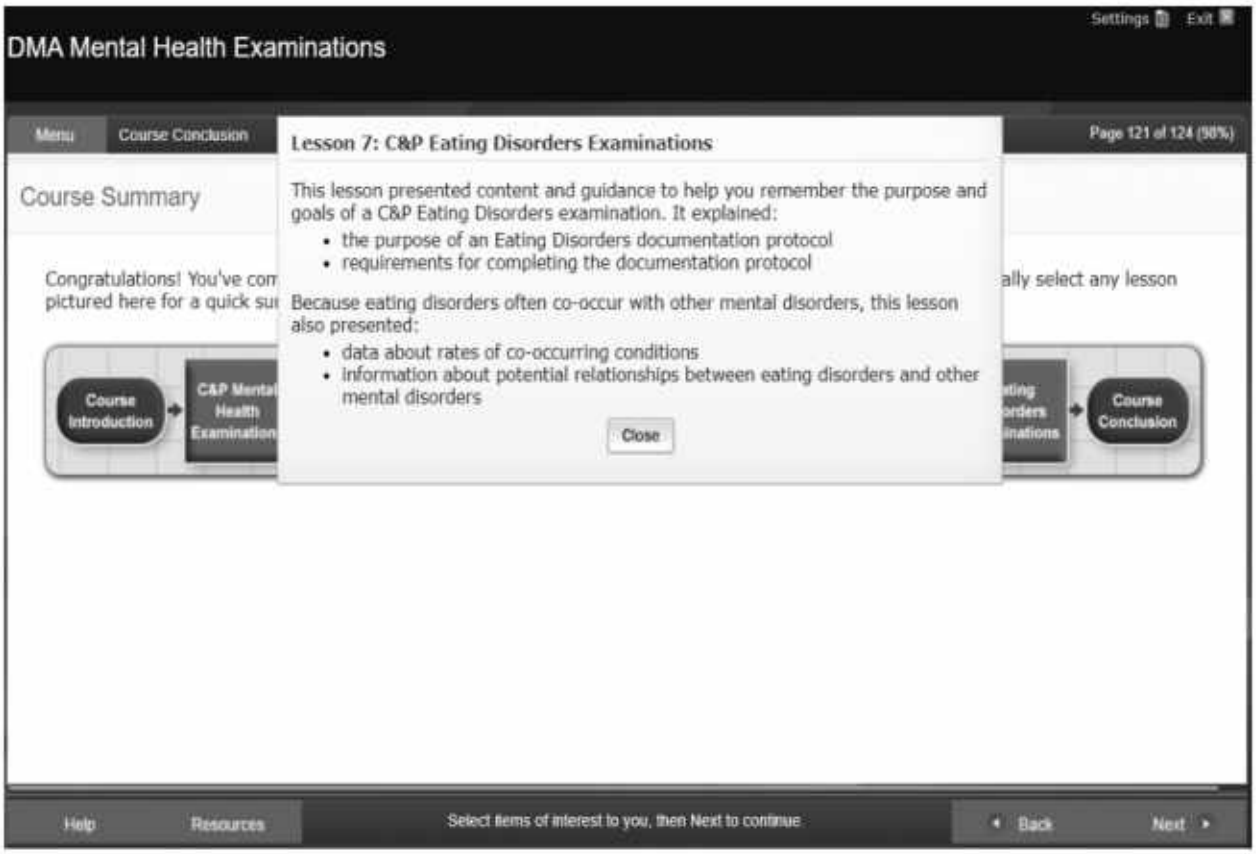

DMA Mental Health Examinations
Settings
Exit
Menu
Course Conclusion
Page 121 of 124 (98%)
Course Summary
Lesson 2: Preparing for a C&P Mental Health Examination
This lesson presented content to help you understand requirements for reviewing documentation related to a C&P mental health examination. It also described how you can use the information you may gather from:
the Request for Examination or examination scheduling request (ESR),
the Veteran's or Servicemember's eFolder
the mental health documentation protocol(s) suggested for the exam
Close
Course Introduction
Course Conclusion
Help
Resources
Select items of interest to you, then Next to continue.
Back
Next

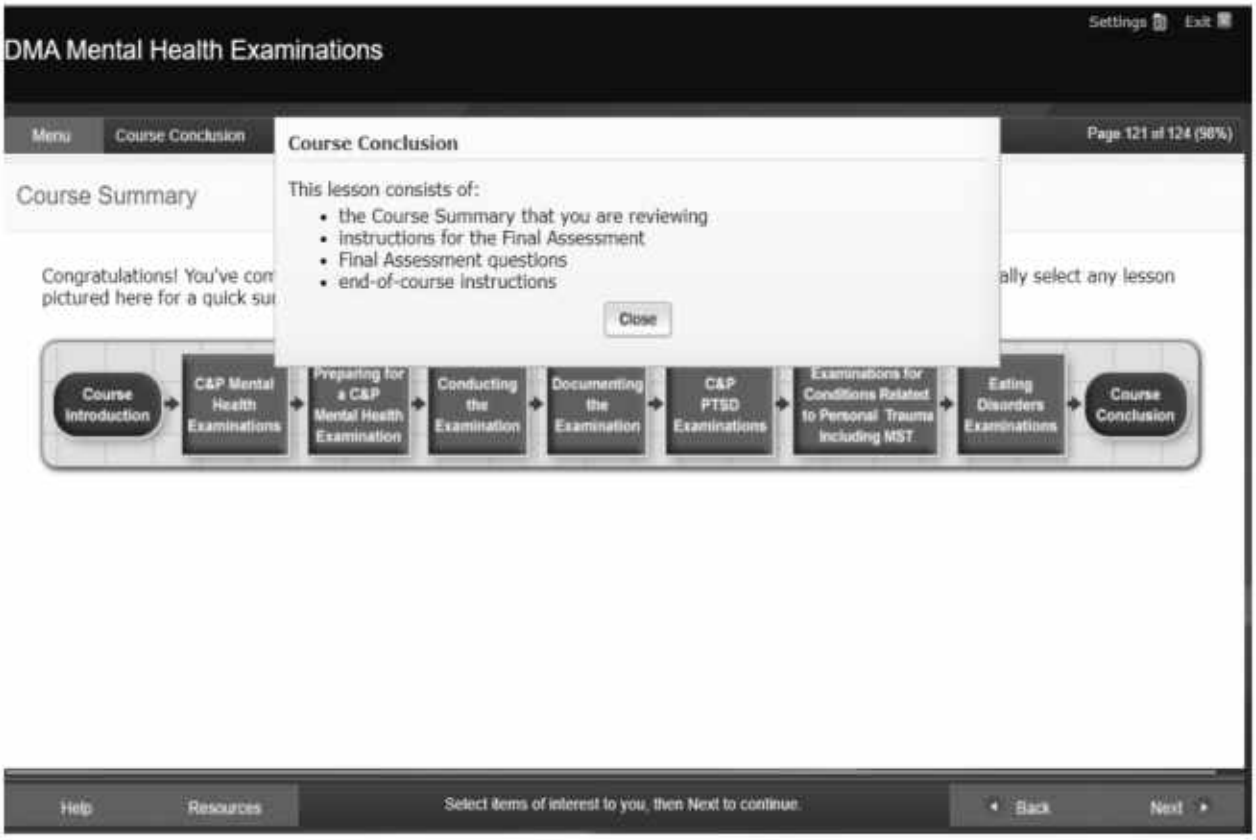

DMA Mental Health Examinations
Settings
Exit
Menu
Course Conclusion
Page 121 of 124 (98%)
Course Summary
Lesson 3: Conducting the Examination
This lesson provided content and resources, including video demonstrations, to help you understand requirements for evaluating a Veteran's or Servicemember's claimed mental health condition(s) for a C&P mental health examination. It provided guidance for interacting with a Veteran or Servicemember during an examination, including:
• being familiar with military terminology and culture
• explaining the four "Ps" of the exam, (i.e., the purpose, process, people, and product) to the Veteran or Servicemember when you open and close the exam
• redirecting the interview when needed
• addressing imminent risk
This lesson also presented requirements and guidelines for conducting the examination, including:
• documenting behavioral observations
• gathering a history
• assessing social and occupational impairment
• assessing symptoms
• assessing suicide risk
• addressing financial competency
This lesson also described several instruments that examiners can draw from for assessing social and occupational impairment. Videos demonstrated conducting a history interview and performing assessments.
Close
Course Introduction
Course Conclusion
Help
Resources
Select items of interest to you, then Next to continue
Back
Next

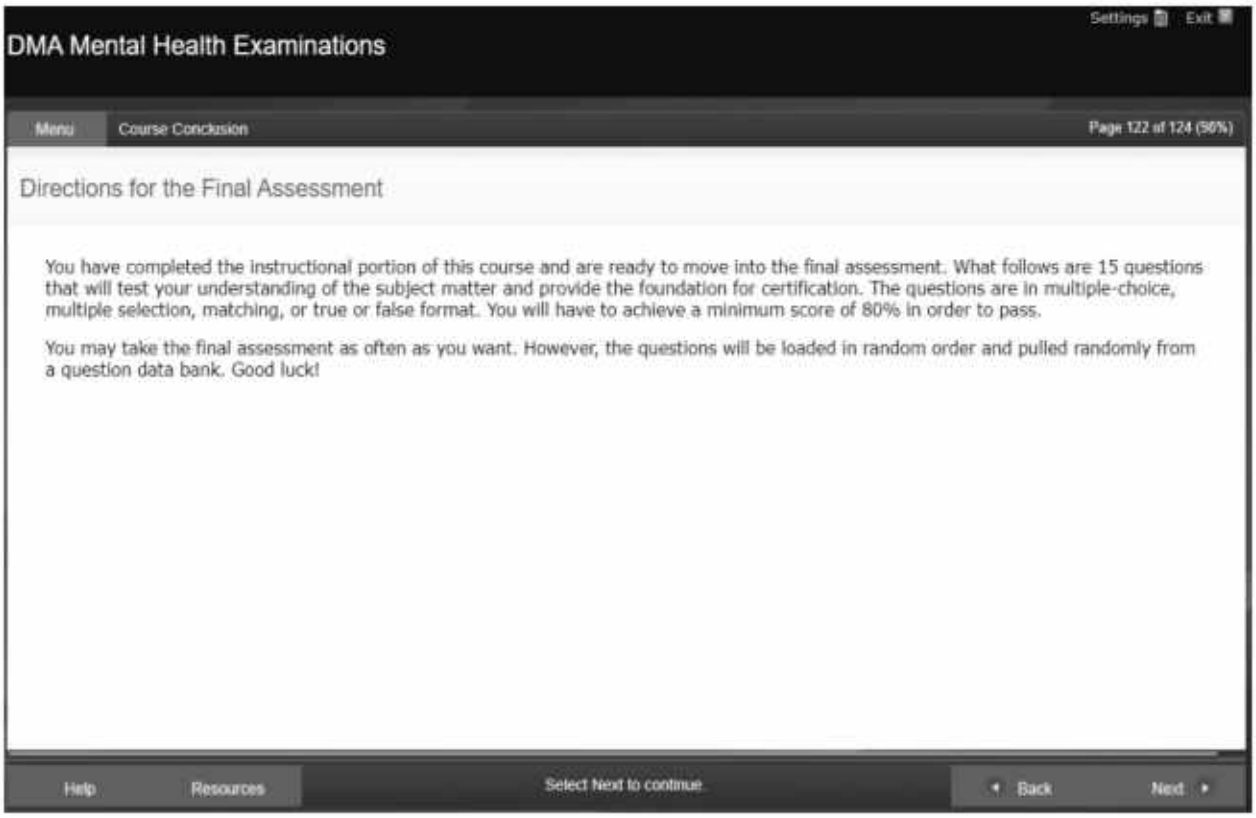

DMA Mental Health Examinations
Settings
Exit
Menu
Course Conclusion
Page 121 of 124 (98%)
Course Summary
Lesson 4: Documenting the Examination
This lesson provided content to help you understand requirements for reporting findings from a C&P mental health examination. First, findings need to be explained for an audience of adjudicators who don't have medical training. In addition, findings need to be submitted on appropriate documentation protocols.
This lesson also described requirements for documenting:
• impairment
• a diagnosis or lack of one
• a change in diagnosis from a previously documented one
Requirements for addressing financial competency, providing a medical opinion, and adhering to DMA clinical quality standards were also explained.
Close
Course Introduction
Course Conclusion
Help
Resources
Select items of interest to you, then Next to continue
Back
Next

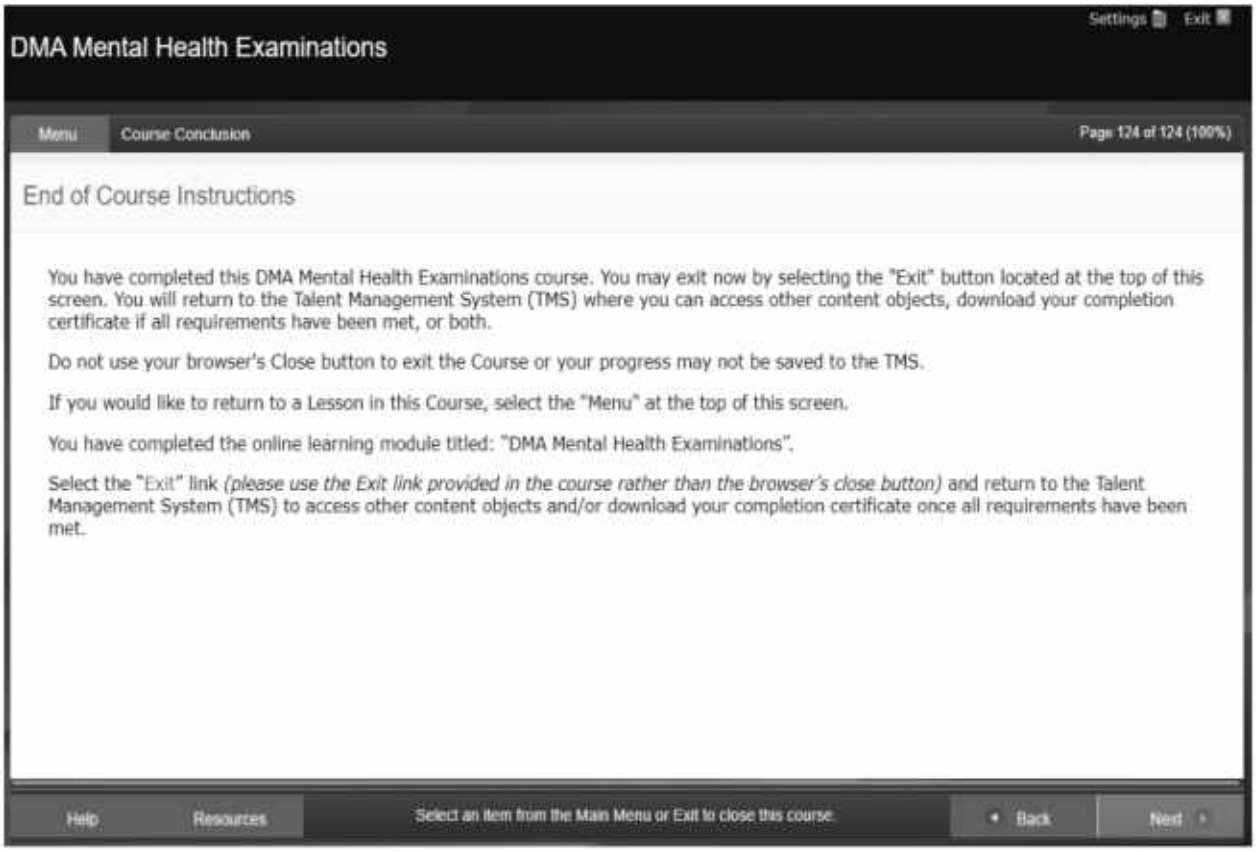

DMA Mental Health Examinations
Settings
Exit
Menu
Course Conclusion
Page 121 of 124 (98%)
Course Summary
Lesson 5: C&P PTSD Examinations
This lesson presented guidance and procedures specific to a C&P PTSD examination to help you understand its purpose and goals. Content in this lesson explained:
• the best approach for discussing potentially traumatic events with Veterans and Servicemembers
• evaluating stressors, including combat and non-combat stressors, stressors related to the fear of hostile military or terrorist activity, and stressors related to military personal trauma including MST
• diagnosing PTSD per DSM criteria A, B, C, D, E, F, G, and H
This lesson also described several interview and self-report measures that can be useful resources for evaluating PTSD symptoms.
Videos in this lesson demonstrated:
• gathering history
• assessing a PTSD stressor
• assessing PTSD symptoms
• closing a C&P mental health examination
Close
Course Introduction
Course Conclusion
Help
Resources
Select items of interest to you, then Next to continue.
Back
Next


DMA Mental Health Examinations
Settings
Exit
Menu
Course Conclusion
Page 121 of 124 (98%)
Course Summary
Lesson 6: Examinations for Conditions Related to Military Personal Trauma Including Military Sexual Trauma
This lesson presented information and guidelines to help you achieve the goals of C&P mental health examinations for claims related to military personal trauma including military sexual trauma. It provided information and guidelines, including:
• data about mental health conditions associated with MST
• suggestions for responding to a Veteran's or Servicemember's disclosure of military personal trauma, including MST
• evaluating pertinent marker evidence
• evaluating stressors related to military personal trauma
• providing medical opinions that are dependent on mental health condition(s) diagnosed during the examination
Close
Course Introduction
Course Conclusion
Help
Resources
Select items of interest to you, then Next to continue.
Back
Next


DMA Mental Health Examinations
Settings
Exit
Menu
Course Conclusion
Page 121 of 124 (98%)
Course Summary
Lesson 7: C&P Eating Disorders Examinations
This lesson presented content and guidance to help you remember the purpose and goals of a C&P Eating Disorders examination. It explained:
• the purpose of an Eating Disorders documentation protocol
• requirements for completing the documentation protocol
Because eating disorders often co-occur with other mental disorders, this lesson also presented:
• data about rates of co-occurring conditions
• information about potential relationships between eating disorders and other mental disorders
Close
Congratulations! You've com
pictured here for a quick su
ally select any lesson
Course Introduction
C&P Mental Health Examination
Course Conclusion
Help
Resources
Select items of interest to you, then Next to continue
Back
Next


DMA Mental Health Examinations
Settings
Exit
Menu
Course Conclusion
Page 121 of 124 (98%)
Course Summary
Course Conclusion
This lesson consists of:
• the Course Summary that you are reviewing
• instructions for the Final Assessment
• Final Assessment questions
• end-of-course instructions
Close
Congratulations! You've com
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ally select any lesson
Course Introduction
C&P Mental Health Examinations
Preparing for a C&P Mental Health Examination
Conducting the Examination
Documenting the Examination
C&P PTSD Examinations
Examinations for Conditions Related to Personal Trauma Including MST
Eating Disorders Examinations
Course Conclusion
Help
Resources
Select items of interest to you, then Next to continue
Back
Next


Settings
Exit
DMA Mental Health Examinations
Menu
Course Conclusion
Page 122 of 124 (98%)
Directions for the Final Assessment
You have completed the instructional portion of this course and are ready to move into the final assessment. What follows are 15 questions that will test your understanding of the subject matter and provide the foundation for certification. The questions are in multiple-choice, multiple selection, matching, or true or false format. You will have to achieve a minimum score of 80% in order to pass.
You may take the final assessment as often as you want. However, the questions will be loaded in random order and pulled randomly from a question data bank. Good luck!
Help
Resources
Select Next to continue
Back
Next


Settings
Exit
DMA Mental Health Examinations
Menu
Course Conclusion
Page 124 of 124 (100%)
End of Course Instructions
You have completed this DMA Mental Health Examinations course. You may exit now by selecting the "Exit" button located at the top of this screen. You will return to the Talent Management System (TMS) where you can access other content objects, download your completion certificate if all requirements have been met, or both.
Do not use your browser's Close button to exit the Course or your progress may not be saved to the TMS.
If you would like to return to a Lesson in this Course, select the "Menu" at the top of this screen.
You have completed the online learning module titled: "DMA Mental Health Examinations".
Select the "Exit" link (please use the Exit link provided in the course rather than the browser's close button) and return to the Talent Management System (TMS) to access other content objects and/or download your completion certificate once all requirements have been met.
Help
Resources
Select an item from the Main Menu or Exit to close this course
Back
Next

Gulf War General Medical Examinations Final Assessment

Question 1 of 15

Which of the following are considered environmental hazards experienced by Veterans who served in Southwest Asia after 1990?

- A. Smoke and particulate matter from oil well fires and burn pits.
- B. Nerve gas antidotes
- C. Agent Orange
- D. A and B only

Correct Feedback

That is correct! Hazards determined by the VA to be commonly exposed to Veterans in Southwest Asia after 1990 include smoke and particulate matter, oil well fires, pesticides and insecticides, infectious diseases, pyridostigmine bromide tablets used as nerve gas antidotes, as well as multiple vaccines and fine grain sand particles.

Incorrect Feedback

That is incorrect. Hazards determined by the VA to be commonly exposed to Veterans in Southwest Asia after 1990 include smoke and particulate matter, oil well fires, pesticides and insecticides, infectious diseases, pyridostigmine bromide tablets used as nerve gas antidotes, as well as multiple vaccines and fine grain sand particles. Agent Orange was used in Vietnam in the 1960s-1970s.

Question 2 of 15

Which of the following is considered an unexplained symptom that does not fit into a recognizable category of disease reported in approximately 25% of Veterans returning from the first Gulf War?

- A. Heart attacks
- B. GI cancer
- C. Ankle sprains
- D. Fatigue

Correct Feedback

That is correct! Unexplained symptoms such as headaches, cognitive difficulties, widespread body pain, and unexplained fatigue were reported by approximately 25% of Veterans.

Incorrect Feedback

That is not correct. Unexplained symptoms such as headaches, cognitive difficulties, widespread body pain, and unexplained fatigue were reported by approximately 25% of Veterans.

Question 3 of 15

Which of the following is the correct acronym that the VA uses for 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. AUI
- B. MUCMI
- C. CFS
- D. ILER

Correct Feedback

That is correct! The VA uses the acronym MUCMI: medically unexplained chronic multi-symptom illness, to describe 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.

Incorrect Feedback

That is not correct. The VA uses the acronym MUCMI: medically unexplained chronic multi-symptom illness, to describe 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.

Question 4 of 15

Which of the following is the true statement regarding the PACT Act and its relation to the Gulf War General Medical Exam?

- A. PACT Act has an added requirement: if the disability does not fall into the disability pattern (1) undiagnosed illness or (2) MUCMI category, then a Toxic Exposure Risk Activity (TERA) medical opinion with rationale must also be provided.
- B. The PACT Act made the entire Gulf War exam obsolete.
- C. The PACT Act did not change eligibility for compensation for Gulf War Veterans.
- D. The PACT Act reduced the number of locations related to burn pits, compared to the Gulf War General Medical Exam.

Correct Feedback

That is correct! The PACT Act has an added requirement: if the disability does not fall into the category (1) undiagnosed illness or (2) MUCMI category, then a Toxic Exposure Risk Activity (TERA) medical opinion with rationale must also be provided.

Incorrect Feedback

That is not correct. The PACT Act has an added requirement: if the disability does not fall into the undiagnosed illness or MUCMI category, then a Toxic Exposure Risk Activity (TERA) medical opinion with rationale must also be provided.

Question 5 of 15

True or false? If the Veterans claim symptoms due to any potential Gulf War exposure, the examiner may document the symptoms on the Gulf War General Medical DBQ and add any relevant DBQs to cover those added symptoms, as long as they are not already service connected for diagnoses related to those symptoms.

- True
- False

Correct Feedback

That is correct! If Veterans claim symptoms due to any potential Gulf War exposure, the examiner may document the symptoms on the Gulf War General Medical DBQ and add any relevant DBQs to cover those added symptoms, as long as they are not already service connected for diagnoses related to those symptoms.

Incorrect Feedback

That is not correct. If Veterans claim symptoms due to any potential Gulf War exposure, the examiner may document the symptoms on the Gulf War General Medical DBQ and add any

relevant DBQs to cover those added symptoms, as long as they are not already service connected for diagnoses related to those symptoms.

Question 6 of 15

Which of the following includes the best directions for examiners to follow when reviewing the ESR?

- A. Any DBQs listed anywhere on the ESR must be related to the Gulf War General Medical exam since they are located on the same ESR.
- B. The ESR must be carefully read as other conditions may also be claimed that are not included as part of the evaluation for the Gulf War General Medical examination (such as increases in already service-connected conditions).
- C. If the DBQ is not listed on the ESR, examiners cannot add anything extra during a Gulf War General Medical DBQ.
- D. Examiners can add any DBQ they want if they receive a Gulf War DBQ, even if it's for a joint injury.

Correct Feedback

That is correct! The ESR must be carefully read as other conditions may also be claimed that are not included as part of the evaluation for the Gulf War General Medical examination (such as increases in already service-connected conditions).

Incorrect Feedback

That is not correct. The ESR must be carefully read as other conditions may also be claimed that are not included as part of the evaluation for the Gulf War General Medical examination (such as increases in already service-connected conditions).

Question 7 of 15

Please choose the statement below that is not reflective of a PDHA (post deployment health assessment):

- A. PDHA is a voluntary assessment completed to report any physical or behavioral concerns after deployment outside the United States
- B. The PDHA becomes part of the service treatment records (STRs)
- C. The PDHA is completed within 30 days of returning home
- D. PDHA only focuses on respiratory disorders

Correct Feedback

That is correct! All of the above statements are representative of a PDHA except D, as the PDHA focuses on more than respiratory disorders and exposures, including TBI screening, PTSD screening, and more.

Incorrect Feedback

That is not correct. All of the above statements are representative of a PDHA except D, as the PDHA focuses on more than respiratory disorders and exposures, including TBI screening, PTSD screening, and more.

Question 8 of 15

Which of the following is most representative of what examiners should do during the history portion of a Gulf War DBQ?

- A. Only look at the DD214
- B. Disregard any statements from family
- C. Use the TERA memorandum and ILER as guides while taking the history
- D. Only ask about breathing problems, as that's the only body system the VA believes is related to Gulf War.

Correct Feedback

That is correct! Examiners should use the TERA memorandum and ILER as guides while taking the history for a Gulf War exam.

Incorrect Feedback

That is not correct. Examiners should use the TERA memorandum and ILER as guides while taking the history for a Gulf War exam.

Question 9 of 15

True or false: 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) medically unexplained chronic multi-symptom illness disability pattern, as categories (3) partially explained etiology or (4) clear etiology would require opinions with nexus statements regarding the cause of the diagnosis.

- True
- False

Correct Feedback

That is correct! Gulf War General Medical examinations are to determine if a Veteran reported illness falls into categories 1 or 2. Categories 3 and 4 require opinions regarding the cause of the diagnosis, even if only partially explainable.

Incorrect Feedback

That is not correct. Gulf War General Medical examinations are to determine if a Veteran reported illness falls into categories 1 or 2. Categories 3 and 4 require opinions regarding the cause of the diagnosis, even if only partially explainable.

Question 10 of 15

Which of the following does the VA consider a STRUCTURAL, not functional GI disorder?

- A. IBS
- B. Chronic diarrhea
- C. GERD
- D. Chronic abdominal pain

Correct Feedback

That is correct! GERD is considered a structural GI disorder due to anatomic/explainable pathology such as sphincter dysfunction.

Incorrect Feedback

That is not correct. IBS is considered a functional GI disorder, or a diagnosis of exclusion, characterized by chronic or recurrent symptoms that are unexplained by structural, endoscopic, laboratory, or other objective signs of disease or injury.

Question 11 of 15

True or False? If a Veteran reports fibromyalgia symptoms for the past 3 years but has not had a workup, the examiner is expected to order a complete diagnostic workup to properly diagnose this condition.

- True
- False

Correct Feedback

That is correct! It is not necessary to request or conduct a vast array of tests. Only limited or specific diagnostic workup should be ordered.

Incorrect Feedback

That is not correct. It is not necessary to request or conduct a vast array of tests. Only limited or specific diagnostic workup 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 evaluations.

Question 12 of 15

A Navy Seal developed a chronic ankle sprain after repeatedly twisting his ankles while training. Please choose the correct disability type from the following choices:

- A) Disability Pattern (1) An undiagnosed illness
- B) Disability Pattern (2) A diagnosable but medically unexplained, chronic multisystem illness of unknown etiology (MUCMI)
- C) Disability Pattern (3) A diagnosable condition with a partially explained etiology
- D) Disability Pattern (4) A diagnosable condition with a clear and specific etiology

Correct Feedback

That is correct! This would be (4), a disease with a clear and specific etiology

Incorrect Feedback

That is not correct. This would be (4), a disease with a clear and specific etiology.

Question 13 of 15

An Army Sergeant developed chronic migratory joint pain after deploying to Iraq for a year. She reported symptoms have been present for the past 2 years and started suddenly at the end of her deployment. She denied fatigue or any muscle involvement. Workup completed by her PCP did not find any underlying autoimmune conditions or infections, nor could the PCP find any explainable condition to represent the Veteran's complaints. Please choose the correct disability type from the following choices:

- A) Disability Pattern (1) An undiagnosed illness
- B) Disability Pattern (2) A diagnosable but medically unexplained, chronic multisystem illness of unknown etiology (MUCMI)
- C) Disability Pattern (3) A diagnosable condition with a partially explained etiology

- D) Disability Pattern (4) A diagnosable condition with a clear and specific etiology

Correct Feedback

That is correct! This would be (1), an undiagnosed illness.

Incorrect Feedback

That is not correct. This would be (1), an undiagnosed illness.

Question 14 of 15

An Air Force officer developed Multiple Sclerosis after deploying to Afghanistan for a year. Please choose the correct disability type from the following choices:

- A) Disability Pattern (1) An undiagnosed illness
- B) Disability Pattern (2) A diagnosable but medically unexplained, chronic multisystem illness of unknown etiology (MUCMI)
- C) Disability Pattern (3) A diagnosable condition with a partially explained etiology
- D) Disability Pattern (4) A diagnosable condition with a clear and specific etiology

Correct Feedback

That is correct! This would be (3), a diagnosable condition with a partially explained etiology.

Incorrect Feedback

That is not correct. This would be (3), a diagnosable chronic multi-symptom illness with a partially explained etiology.

Question 15 of 15

An Army Medic developed Fibromyalgia and Chronic Fatigue Syndrome after a nine-month deployment to Iraq during the First Gulf War. He ETS'd (ended his time in service) only 4 months after returning from deployment. Symptoms had sudden onset, but he was not diagnosed with Fibromyalgia/CFS for another 5 years after ETS. Please choose the correct disability type from the following choices:

- A) Disability Pattern (1) An undiagnosed illness
- B) Disability Pattern (2) A diagnosable but medically unexplained, chronic multisystem illness of unknown etiology (MUCMI)
- C) Disability Pattern (3) A diagnosable condition with a partially explained etiology

- D) Disability Pattern (4) A diagnosable condition with a clear and specific etiology

Correct Feedback

That is correct! This is (2), a MUCMI.

Incorrect Feedback

That is not correct. This is (2), a MUCMI.

Individual Longitudinal Exposure Record (ILER)
Examiner Job Aid

Purpose

This Job Aid provides an overview to contract examiners of information that can be found in the ILER summary, when one is provided within the Veteran's eFolder.

Audience

Examiners responsible for providing medical opinions regarding PACT Act-related conditions due to TERA participation.

Background

The Individual Longitudinal Exposure Record (ILER) is a joint Department of Defense (DoD) and VA web-based application that provides the ability to link a Veteran to military exposures and/or deployments to improve the efficiency, effectiveness, and quality of care.

ILER currently provides access to over two million unique Veteran records and acts as a single access point to deployment history; including time, location, and military occupational specialty (MOS), occupational hazard data, environmental hazards known or later found, monitoring performance in the area(s), diagnosis, treatment, and laboratory data.

Guidance

Required Exposure Resources for Examiner Review

When the Veteran's *TERA Memorandum* shows *Yes* for questions 2A, 2B, or 2C, then the examiner is required to consider the exposure information provided in the ILER Individual Exposure Summary.

The exposure information related to the individual is grouped and displayed in one of the following tiles. **Note that if a tile is not present on a particular report, there is no data to report in that area.**

Individual Deployment History

The Individual Deployment History data is provided by DMDC and encompasses a complete history of a Veteran's military career: geographic location/country, start/end date of deployment, unit name/organization/unit number, and description of duty/work assignment.

Exposure Pathways

Exposure Pathways are based on a collection of site-specific data to identify potential or actual exposure for an individual. Exposure Pathways contain the potential health hazard/exposure route, threat source, environment media, priority, exposure pathway start/end date, personnel assigned to exposure pathway, location, and number of samples.

Table 1: Interpreting "Personnel Assigned to Exposure Pathway"

If	Then
"Yes" is marked	The Veteran was located in the general vicinity of the exposure.
"No" is marked	The Veteran was at the location and may have been exposed and could possibly experience symptoms of exposure.

Periodic Occupational and Environmental Monitoring Summary (POEMS)

POEMS is a DoD provider-focused, technical document that describes Occupational and Environmental Health (OEH) exposures and associated health implications for a deployment location during a specific timeframe. POEMS describes the types of OEH hazards identified during that time and provides a characterization of the base camp population's exposures and potentially associated health effects. The documents provide a description of the risk estimates for short and long-term medical implications and any recommendations for medical action, follow-up, or surveillance. POEMS is based on all available site-specific OEH data, surveys, and reports, and is reviewed by Combatant and Command (COCOM) Force Health Protection (FHP) personnel.

Industrial Hygiene

Industrial Hygiene displays exposure information from the industrial hygiene assessments that were performed on each of the Similar Exposure Groups (SEG) to which the Veteran was assigned. Text in the Industrial Hygiene header will be displayed in red if any of the entries exceed the recommended exposure level.

Registry

The registry contains general information about the event, a listing of locations, any associated incident reports, and a listing of hazards tracked by the registry. Text in the Registry tile header will be displayed in red if any of the entries exceed the recommended exposure level. You will see a Registry tile for all individuals who have been associated to a Registry via an Individual Exposure Profile, Population Exposure Profile, or Potentially Exposed Population (PEP) through an Incident Report.

Incidents

Incidents are a comprehensive form to document all aspects of an incident and whether potentially exposed personnel exhibited signs or symptoms of exposure.

Accessibility Report

Filename:
iler_examiner_job_aid_508v2.pdf

Report created by:

Organization:

[Enter personal and organization information through the Preferences > Identity dialog.]

Summary

The checker found no problems in this document.

- Needs manual check: 5
- Passed manually: 0
- Failed manually: 0
- Skipped: 1
- Passed: 26
- Failed: 0

Detailed Report

Document

Rule Name	Status	Description
Accessibility permission flag	Passed	Accessibility permission flag must be set
Image-only PDF	Passed	Document is not image-only PDF
Tagged PDF	Passed	Document is tagged PDF
Logical Reading Order	Needs manual check	Document structure provides a logical reading order
Primary language	Passed	Text language is specified
Title	Passed	Document title is showing in title bar
Bookmarks	Passed	Bookmarks are present in large documents
Color contrast	Needs manual check	Document has appropriate color contrast

Page Content

Rule Name	Status	Description
Tagged content	Passed	All page content is tagged
Tagged annotations	Passed	All annotations are tagged
Tab order	Passed	Tab order is consistent with structure order
Character encoding	Passed	Reliable character encoding is provided
Tagged multimedia	Passed	All multimedia objects are tagged
Screen flicker	Needs manual check	Page will not cause screen flicker
Scripts	Needs manual check	No inaccessible scripts
Timed responses	Needs manual check	Page does not require timed responses
Navigation links	Passed	Navigation links are not repetitive

Forms

Rule Name	Status	Description

Tagged form fields	Passed	All form fields are tagged
Field descriptions	Passed	All form fields have description

Alternate Text

Rule Name	Status	Description
Figures alternate text	Passed	Figures require alternate text
Nested alternate text	Passed	Alternate text that will never be read
Associated with content	Passed	Alternate text must be associated with some content
Hides annotation	Passed	Alternate text should not hide annotation
Other elements alternate text	Passed	Other elements that require alternate text

Tables

Rule Name	Status	Description
Rows	Passed	TR must be a child of Table, THead, TBody, or TFoot
TH and TD	Passed	TH and TD must be children of TR
Headers	Passed	Tables should have headers
Regularity	Passed	Tables must contain the same number of columns in each row and rows in each column
Summary	Skipped	Tables must have a summary

Lists

Rule Name	Status	Description
List items	Passed	LI must be a child of L
Lbl and LBody	Passed	Lbl and LBody must be children of LI

Headings

Rule Name	Status	Description
Appropriate nesting	Passed	Appropriate nesting

Back to Top

Medication Considerations for Musculoskeletal Conditions Job Aid

Purpose

The purpose of this job aid is to provide guidance on completing Musculoskeletal Disability Benefits Questionnaires (DBQ). As a result of the court decision Ingram v. Collins, VA must consider the severity of the disability in an unmedicated state when the relevant musculoskeletal rating criterion does not already account for medication use.

Audience

This job aid is for all Compensation and Pension examiners who complete musculoskeletal disability examinations and medical opinions for the VA.

Guidance

The following questions will be added to examination scheduling requests (ESR) by claims processors for all types of musculoskeletal DBQs. Examiners are expected to answer these additional questions and provide information on the ameliorative effects of only medication, prescription or non-prescription, if applicable. This information is to be documented in the Remarks section of the relevant musculoskeletal DBQ until these questions have been added to the affected DBQs.

Important: Any other forms of treatment, which may have an ameliorative effect on the musculoskeletal condition being examined, **should not** be used or considered for the questions below. Some examples of other types of treatments that could provide ameliorative effects, but **should not** be considered for these additional questions, are TENS units, canes, acupuncture, physical therapy, etc.

1. At the time of the examination, does the Veteran report taking any medication(s), prescription or non-prescription, to treat the disability being evaluated?
   [ ] Yes
   [ ] No ***(If No, do not answer the remaining questions.)***

2. If Yes, does the medication(s) relieve or reduce the severity of the disability symptoms being evaluated?
   [ ] Yes
   [ ] No ***(If No, do not answer the remaining questions.)***

3. Is it possible to evaluate the severity of the Veteran's disability as if not taking medication(s) (i.e., in an unmedicated state), without resorting to mere speculation?
   [ ] Yes
   [ ] No

   If No, the examiner should explain why it is not possible to do so without resorting to mere speculation in the Remarks Section. The explanation should not be based on an examiner's shortcomings or a general aversion to offering an estimate on issues not directly observed.

If Yes, check all functional losses that apply. For each item checked below, provide the estimated additional functional loss of the disability. If possible, provide this estimate as additional loss of motion of the disability in the Remarks section.

[ ] Pain
[ ] Active ROM
[ ] Passive ROM
[ ] Repetitive use
[ ] Repeated use over time
[ ] Flare-ups
[ ] Additional factors contributing to disability (e.g., interfering with standing or sitting, disturbance of locomotion, more or less movement than normal, weakened movement, instability of station, swelling, deformity, atrophy of disuse)
[ ] Ankylosis
[ ] Flail joints
[ ] Other (specify) _____

Important: If the ESR does not contain this additional language when a musculoskeletal condition is examined, the examiner must still provide this information. *A clarification request **should not** be sent to add this language to the ESR.*

To assist examiners with responses that require further clarification, please see the examples provided below.

Examples to Answer Question 3

To assist examiners with responses that require further clarification or opinions, please see the examples below.

Example 1 – No Response: *At the time of the examination, Veteran XYZ was [taking ABC medication]. It is not possible to calculate the impact of the [medication] on the Veteran's functioning, and it is medically contraindicated to discontinue or alter [medication] for the purposes of this examination; therefore, it is not possible to determine the severity of functional impact in the absence of [ABC medication] without resorting to mere speculation.*

Example 2 – Yes Response: *A Veteran's service-connected lumbosacral strain demonstrates forward flexion limited to 65 degrees. The Veteran reports he has constant lumbar pain, which he treats with Motrin twice daily and uses Tramadol approximately once weekly during periods of increased severity. The Veteran states that the Motrin mildly reduces the severity of pain and improves his mobility such that he is able to put his shoes on and bend over more easily. He can provide a description of the improvement with medication. The examiner finds that **without** the use of such medication, the*

Veteran's lumbar mobility would be more restricted, with flexion limited to 50 degrees. All other ROM findings were the same as reported above.

Important Reminders

- Examiners must ensure all applicable questions are answered thoroughly to avoid returned examinations based on inadequate information.
- When providing a medical opinion, the rationale should be consistent and supportive.
- Examiners should carefully read each question before answering, as a "No" response may not require further action.

References

Ingram v. Collins https://www.uscourts.cavc.gov/documents/IngramCH_23-1798.pdf

Job Aid for Providing Medical Opinions

Purpose

Medical opinions are vital to the disability examination process. The Medical Disability Examination Office (MDEO) has created this Job Aid to assist C&P examiners through the process of writing high quality medical opinions with sound rationales. Serving as a supplement to the trainings listed in the References section, this Job Aid offers important reminders and provides a checklist for examiners to prevent insufficient medical opinions.

Audience

All C&P examiners providing VA disability examinations and medical opinions, and vendor quality assurance staff.

Important Reminders

A medical opinion and rationale should only be provided in the following situations:

- VBA or Board of Veteran's Appeals (BVA) asks for an opinion on an examination request.
- A medical opinion is required by a Disability Benefits Questionnaire (DBQ) (e.g., the Former POW DBQ, and Mental Health DBQ).
- When the medical opinion is within the scope of the claim and the evidence of record requires it. The scope of a claim is determined by the Veteran's description of their disability and symptoms, along with supporting information from both the Veteran and the VA, and it encompasses any reasonably related conditions, not just how the Veteran claimed it (e.g., Veteran claimed knee strain, but the diagnosis is knee arthritis).

Common errors that result in insufficient opinions:

- The requested medical opinion is not provided.
- Examination request instructions are not followed.
- The rationale is either inconsistent, incomplete, or not provided.

Tips to avoid insufficient opinions:

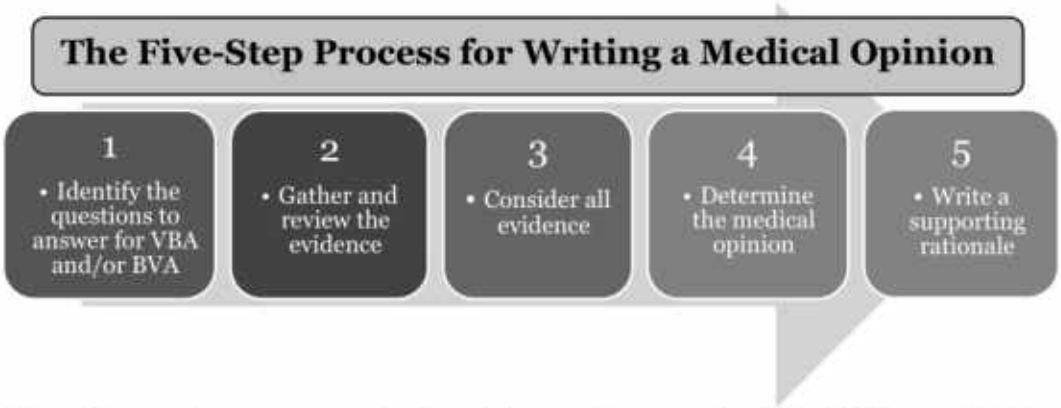
- Ensure that any specific information noted in the ESR, especially lay statements, is reviewed and addressed.
- Provide a thoughtful conclusion based on all available evidence, including peer-reviewed medical research if appropriate, and supported by a logical, clearly stated rationale. Evidence utilized in support of reaching your conclusion should be appropriately included and cited within the rationale to provide consistent support for reaching the medical opinion rendered.
- Avoid using VA regulations to support a negative opinion (e.g., stating that arthritis isn't related to herbicide exposure since VA has not conceded arthritis as a presumptive condition). Instead, examiners should support opinions with their clinical analysis and synthesis of available evidence.

- Be cautious when using absolute terminology in a rationale (e.g., the Veteran has "never" had any complaints or treatment for headaches). A single piece of contradictory evidence may lead to an opinion being discrepant if supported by an incorrect absolute statement.
- Ensure information provided is specific to the Veteran's case being evaluated (e.g., if the Veteran is claiming COPD and a risk factor is smoking but the Veteran never smoked, do not list that amongst risk factors in this case).

Case Studies

Select this link: Medical Opinion Case Studies, to review examples of sufficient medical opinions and rationales.

Checklist for Providing Sufficient Medical Opinions



1. Identify all opinions requested and questions asked by VBA or BVA.

☐ Carefully read and follow the examination request.

* Remember, a remanded medical opinion must precisely follow all BVA's remand instructions on the examination request. This may require use of specific phrasing and information beyond what is requested on the Disability Benefits Questionnaire(s). **All questions and requests in the remand instructions must be addressed.**

2. Gather and review the evidence.

☐ **eFolder Review**: Review all relevant eFolder documentation, such as Service Treatment Records (STRs), Military Personnel Records, private treatment and VA medical records, previous C&P examinations and/or medical opinions, previous VBA or BVA decisions, Veteran's statement of claim, and lay testimony.

☐ **Examination Findings**: Review your examination findings, including diagnosis, test results, and/or statements made by the claimant during the clinical interview.

☐ **From the Claimant:** Review any evidence brought by the Veteran or Service member and document it on the DBQ, and direct them to send the records to the VA.

☐ **Peer-Reviewed Medical Literature:** You do not need to cite medical research for every medical opinion, but you should consider it. Consider peer-reviewed medical literature that supports your opinion or can help VA understand your rationale. Be sure to review any cited literature and provide enough information so that the source can be located. When citing materials remember the following:

- Any literature cited should be peer-reviewed
- Cited research must be discussed in the context of a claimant's specific circumstances, as group-level data may or may not apply to any given individual
- Remember: correlation does not equal causation; many studies only discuss association, but the rationale must be based upon causation
- Include enough information to allow adjudicators to access materials
- Best to use when specialized medical knowledge is needed that is not understood easily by lay people

3. Consider all evidence.

☐ Carefully review all pertinent evidence in the eFolder. Do not ignore any relevant documentation, including specific information noted in the ESR to consider, such as lay statements. When formulating your medical opinion, explain in an unbiased, impartial manner any inconsistencies between evidence and the role in determining your opinion.

4. Determine the medical opinion.

☐ On the Medical Opinion DBQ, find the section that corresponds with the requested opinion (e.g., direct service connection, secondary service connection, etc.). Then select the checkbox that corresponds to either a positive or negative opinion for that section.

- **Positive Opinion Language:** A selection will be made from a choice affirming that a condition is due to a type of service connection, most often seen as "as least as likely as not".

- **Negative Opinion Language:** A selection will be made from a choice refuting that a condition is due to a type of service connection, most often seen as "less likely as not".

5. Write the supporting rationale.

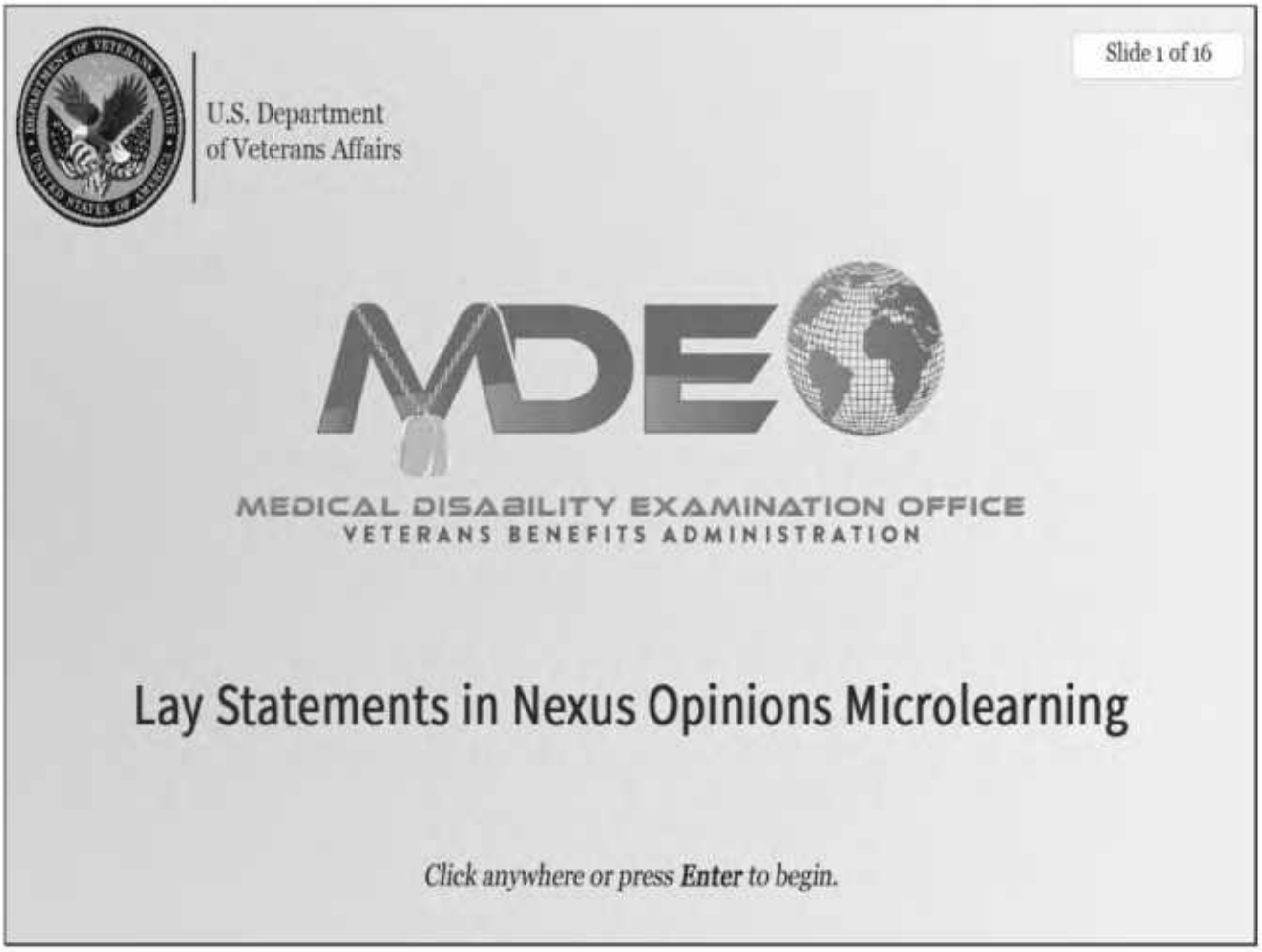
☐ Make sure the medical opinion is supported by a well-written rationale.

- **Rationale may include**:
  - A reference to reviewing the eFolder and specific pertinent records, as well as including review of medical literature/treatises, and other relevant supporting evidence or principles, and/or Remand instructions from the BVA when applicable
  - Specific facts from the evidence
  - Established timeline from service to current disability
  - Nexus between claimed disability and service if applicable

References

- MDE Medical Opinions (DMA Medical Opinions – Update 2022)
- MDE Recertification Part 1 – General Certification Training
- MDE Lay Statements in Nexus Opinions
- Medical Opinion Case Studies

Slide 1 - Lay Statements in Nexus Opinions Microlearning



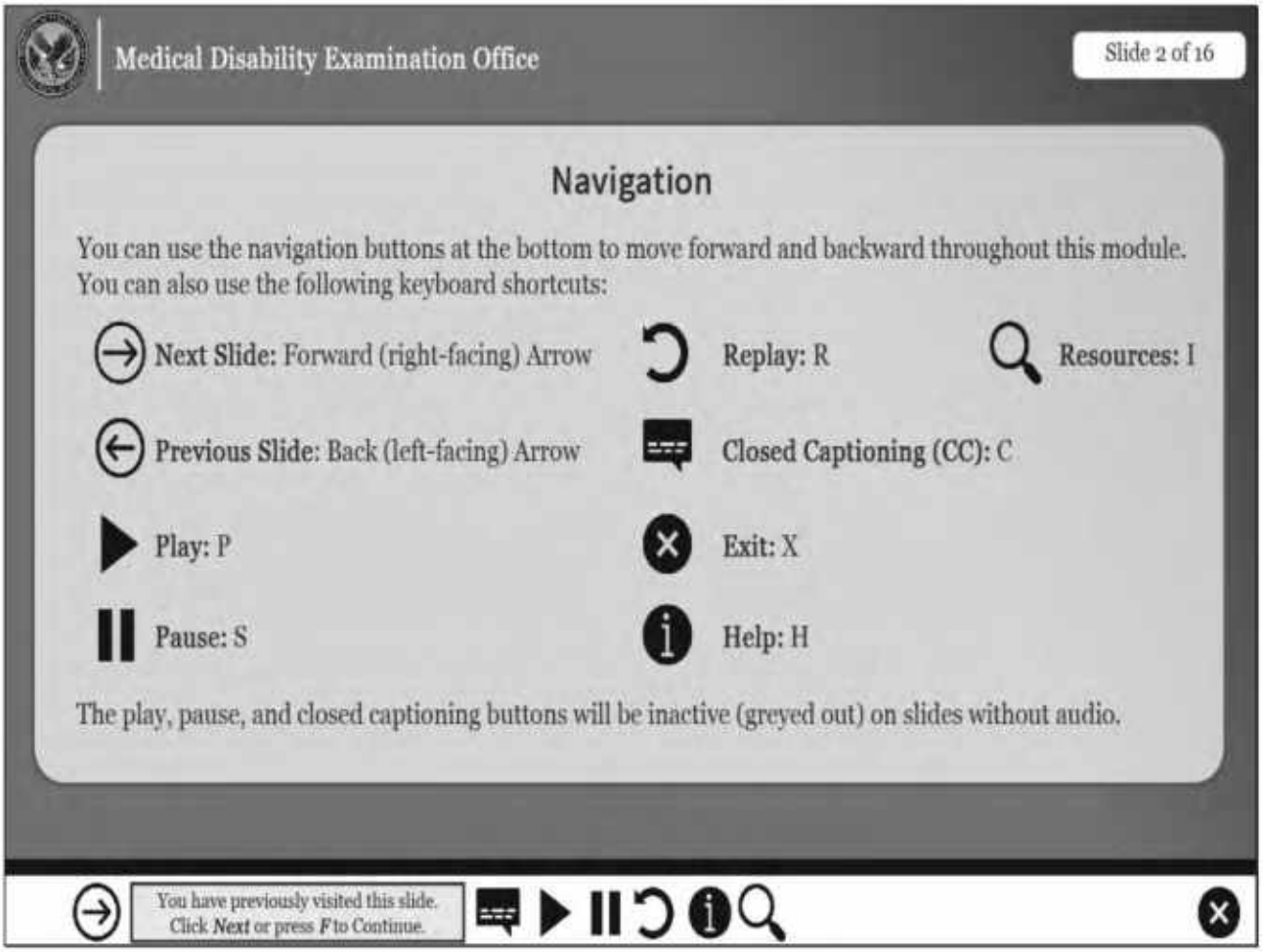
Course Length: .25 Hours

Assessment and Test Out: N/a

Description:

Lay Statements in Nexus Opinions is a course for VBA Vendor Examiners to increase recognition of frequent errors in medical opinions involving lay statements. This course will help examiners recognize where to document evidence involving lay statements within the medical opinion DBQ and recognize VA guidelines regarding what may be utilized as a lay statement.

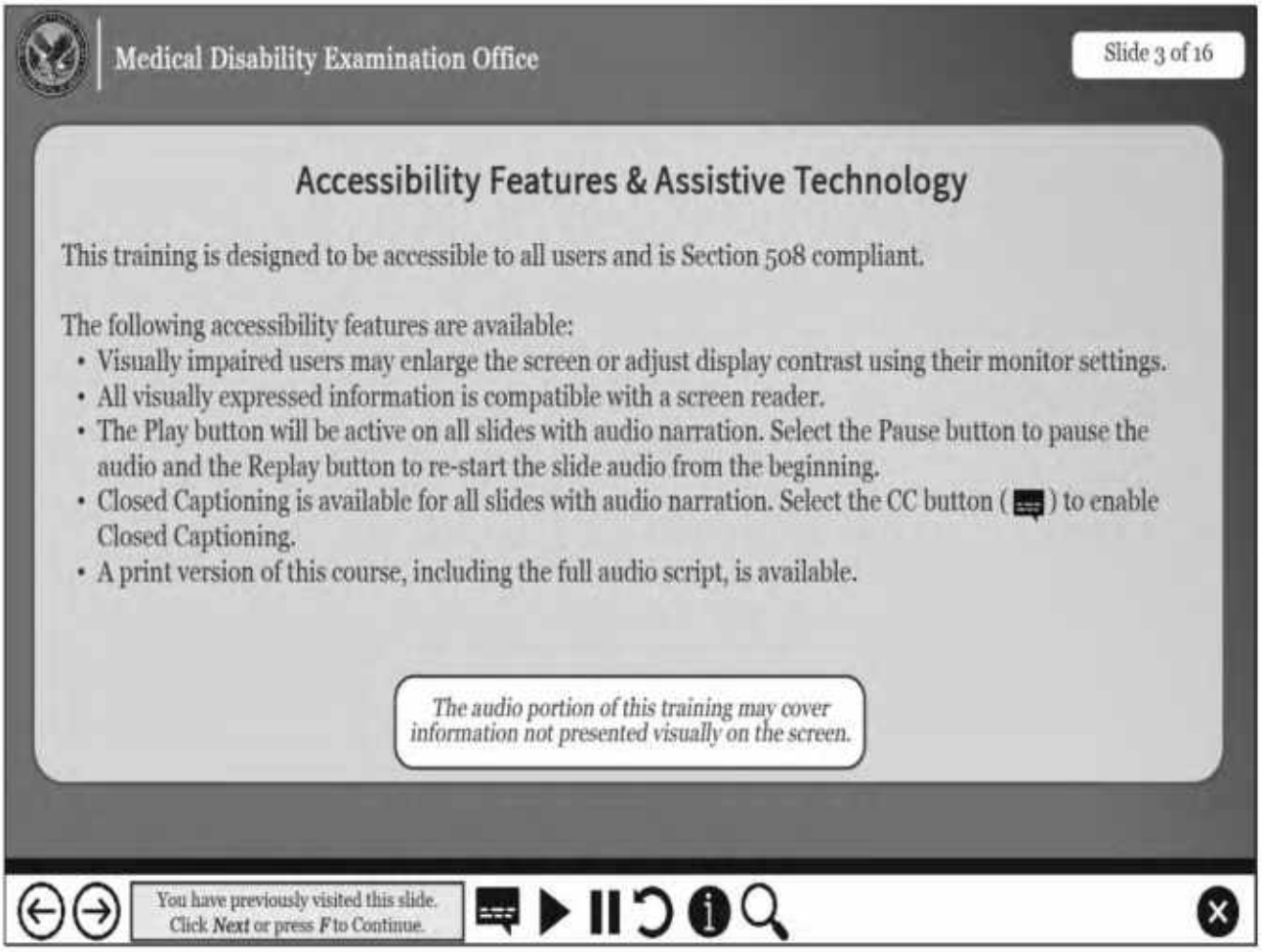
Slide 2 - Navigation



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.

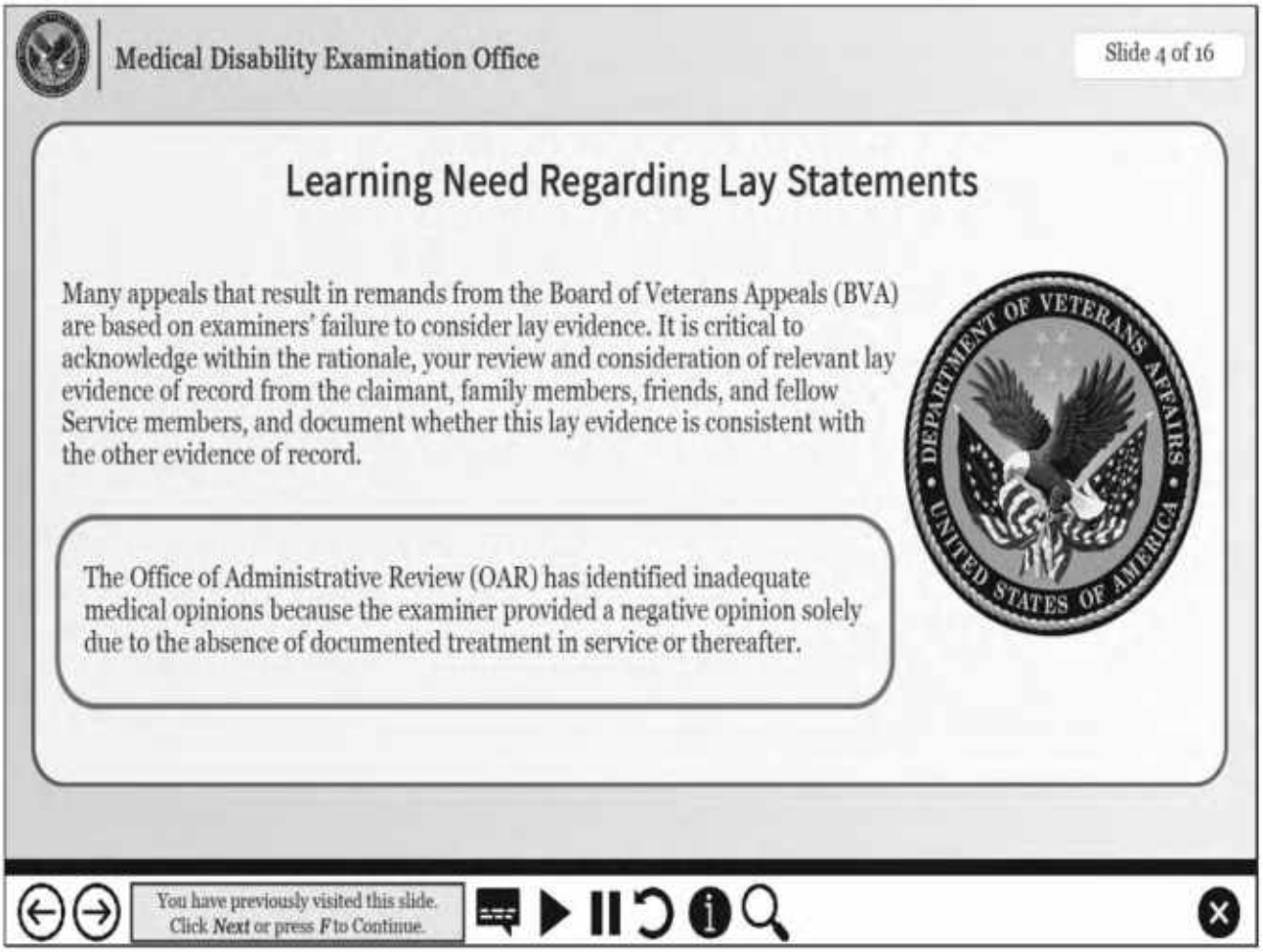
Slide 3 - Accessibility Features & Assistive Technology



Transcript

This presentation is designed to be accessible to all users and is 508 compliant. The screen can be enlarged, and all materials support the use of a screen reader. Closed captions are available for all audio. The audio in the training may cover information that is not presented visually on the screen. A print version is available, including the full audio script. Please select the next button on the bottom left of each screen (or the right-facing arrow) to progress through the presentation.

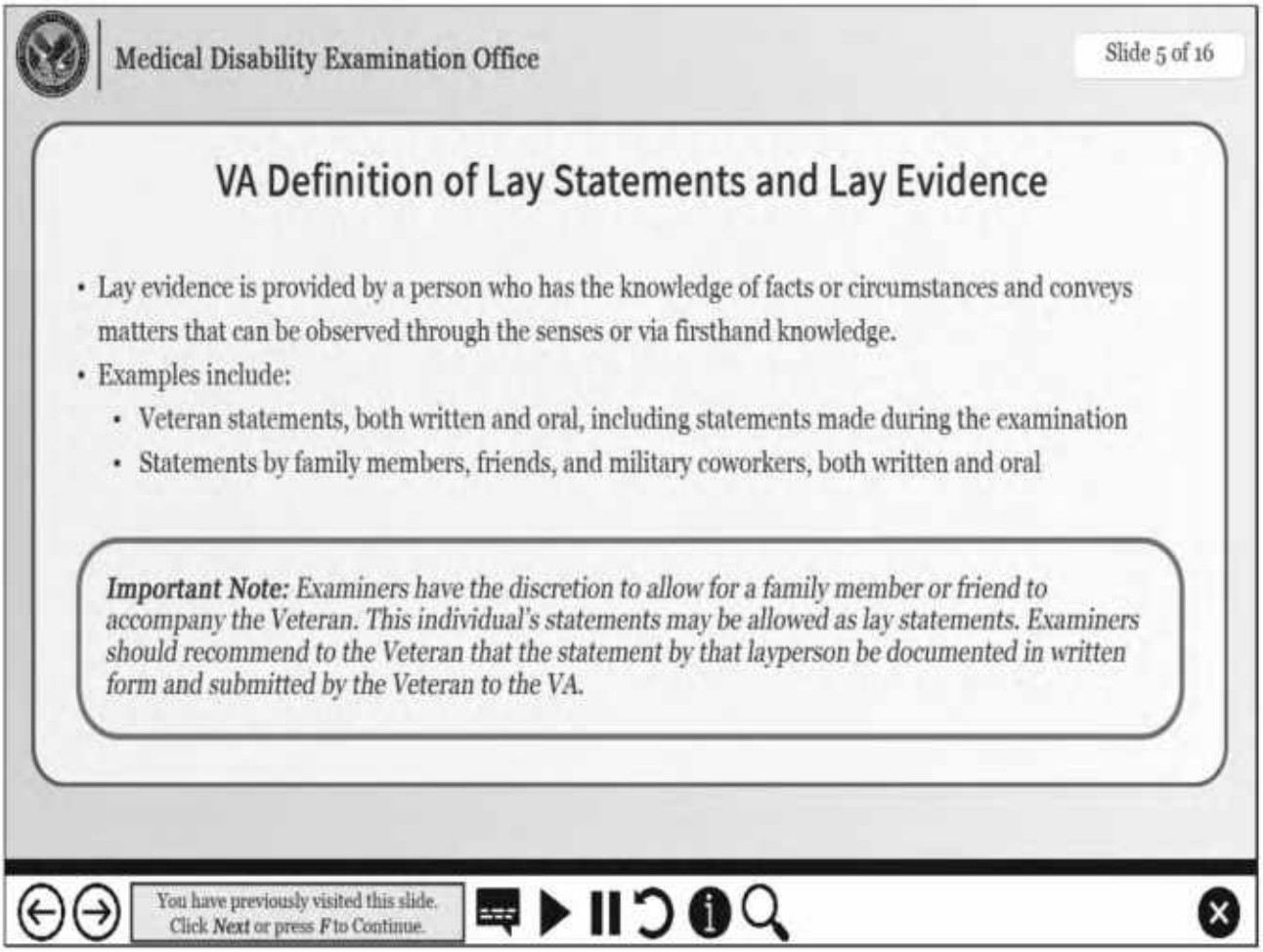
Slide 4 - Learning Need Regarding Lay Statements



Transcript

Welcome to the Medical Disability Examination Office, or MDEO, training on Lay Statements in Nexus Opinions Microlearning. MDEO has prepared this training to reinforce the importance of reviewing and considering lay evidence when forming nexus opinions and completing Medical Opinion Disability Benefits Questionnaires, or DBQs, and other DBQs with embedded nexus opinions such as the Hearing Loss and Tinnitus DBQ. Many remands from the BVA are based on the examiner's failure to consider or properly document lay evidence when completing Disability Benefits Questionnaires, or DBQs. 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.

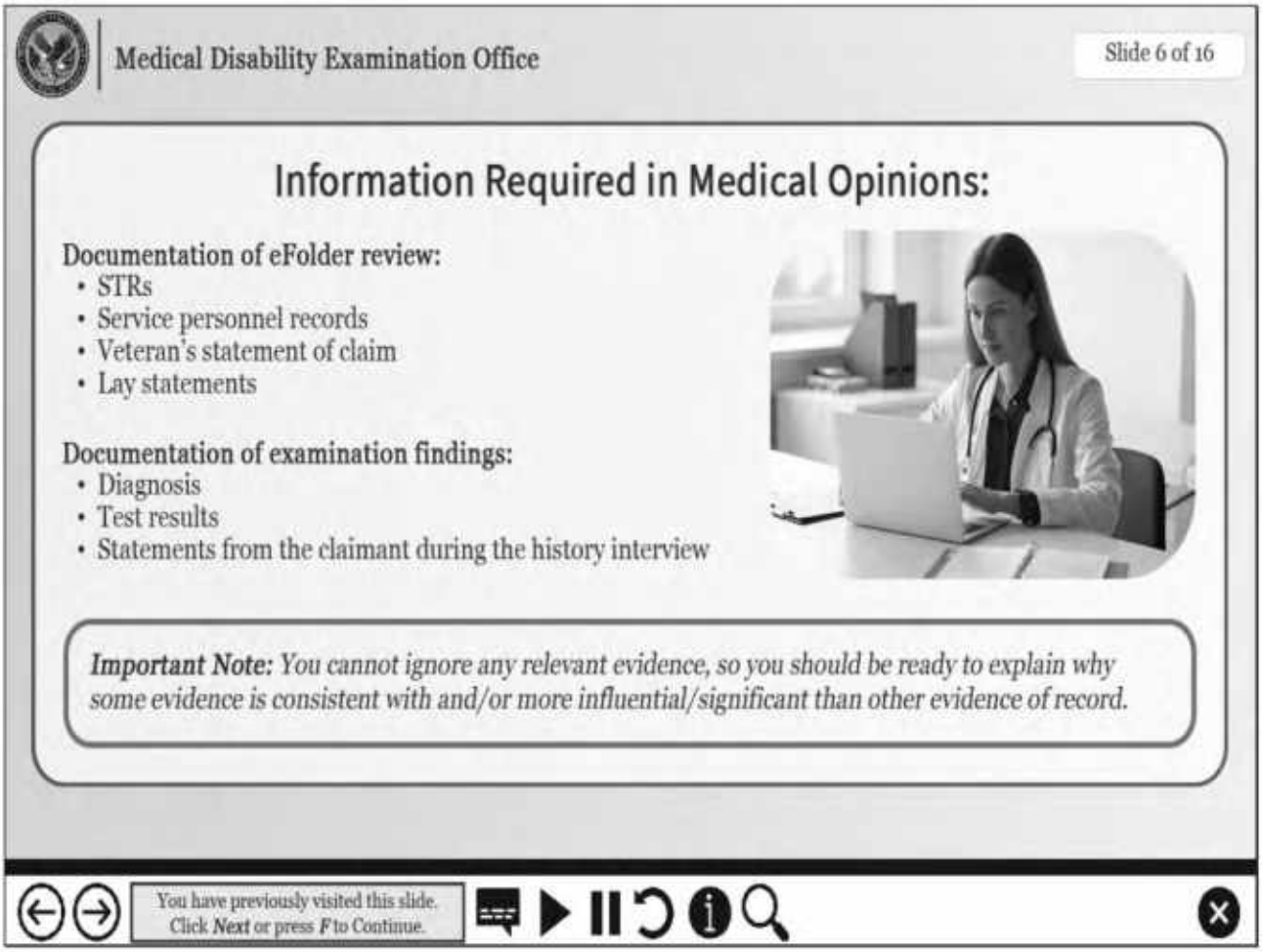
Slide 5 - VA Definition of a Lay Statement and Lay Evidence for C&P Exams



Transcript

You may recall from the Disability Medical Assessment, or 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."

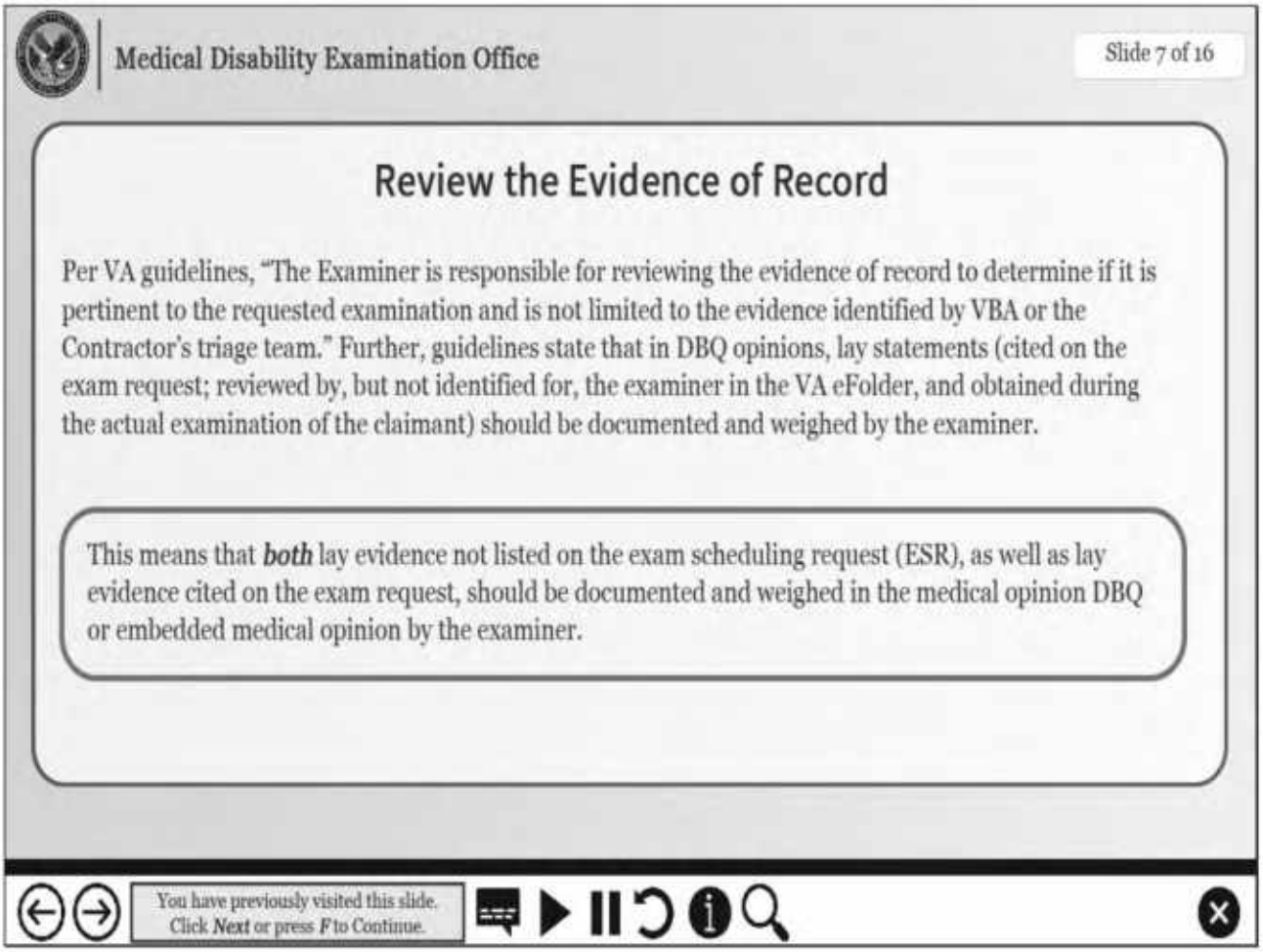
Slide 6 - Information Required in Medical Opinions



Transcript

Examiners are required to weigh the evidence found both in the eFolder and during their actual examination of the Claimant. Carefully weigh both supporting and conflicting evidence for your opinion. Your rationale should cite essential evidence to help VBA make a determination on the claim. In the Medical Opinion DBQ, a lay statement that is relevant to the claim should be documented in the evidence section and referenced in the rationale. This is also true when providing an etiology opinion in the Hearing Loss and Tinnitus DBQ, as well as other DBQs with embedded opinions. It is important to remember that you cannot ignore any relevant evidence. You should be ready to explain why some evidence is more influential or significant than other evidence.

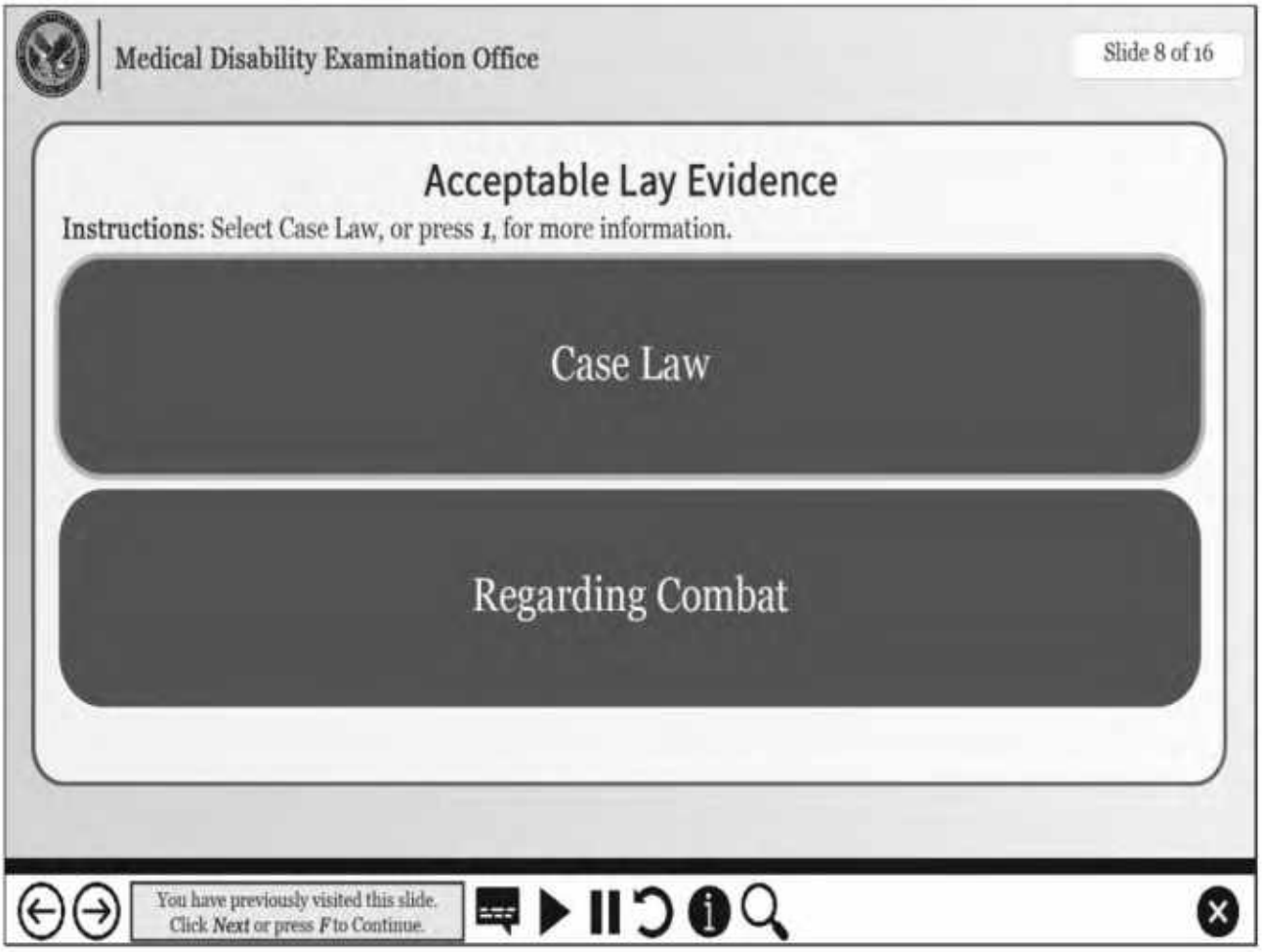
Slide 7 - Review the Evidence of Record



Transcript

When considering lay evidence, there are times when the submitted lay statements may not be clearly tabbed or referenced by either the claims processor or the Vendor. Examiners are still required to include consideration of the lay statement in their medical opinions. When providing medical opinions and etiology opinions, lay statements (cited on the exam request; reviewed by, but not identified for, the examiner in the VA eFolder; and obtained during the actual examination of the Claimant) should be documented and weighed by the examiner.

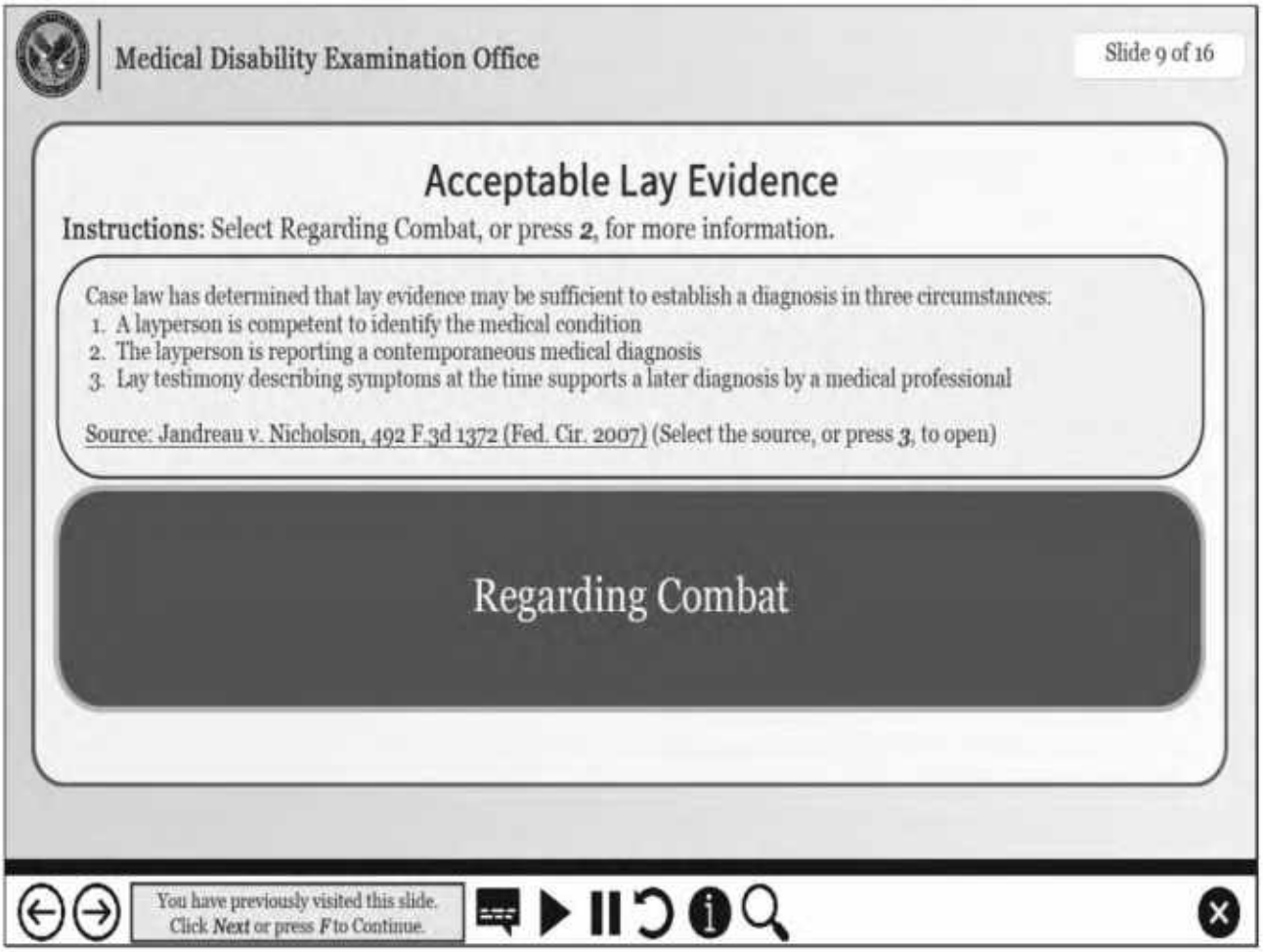
Slide 8 - Acceptable Lay Evidence



Transcript

Lay evidence documented in a Medical Opinion DBQ must be satisfactory, consistent with the circumstances regarding the claim, and must be able to prevail despite the absence of official records.

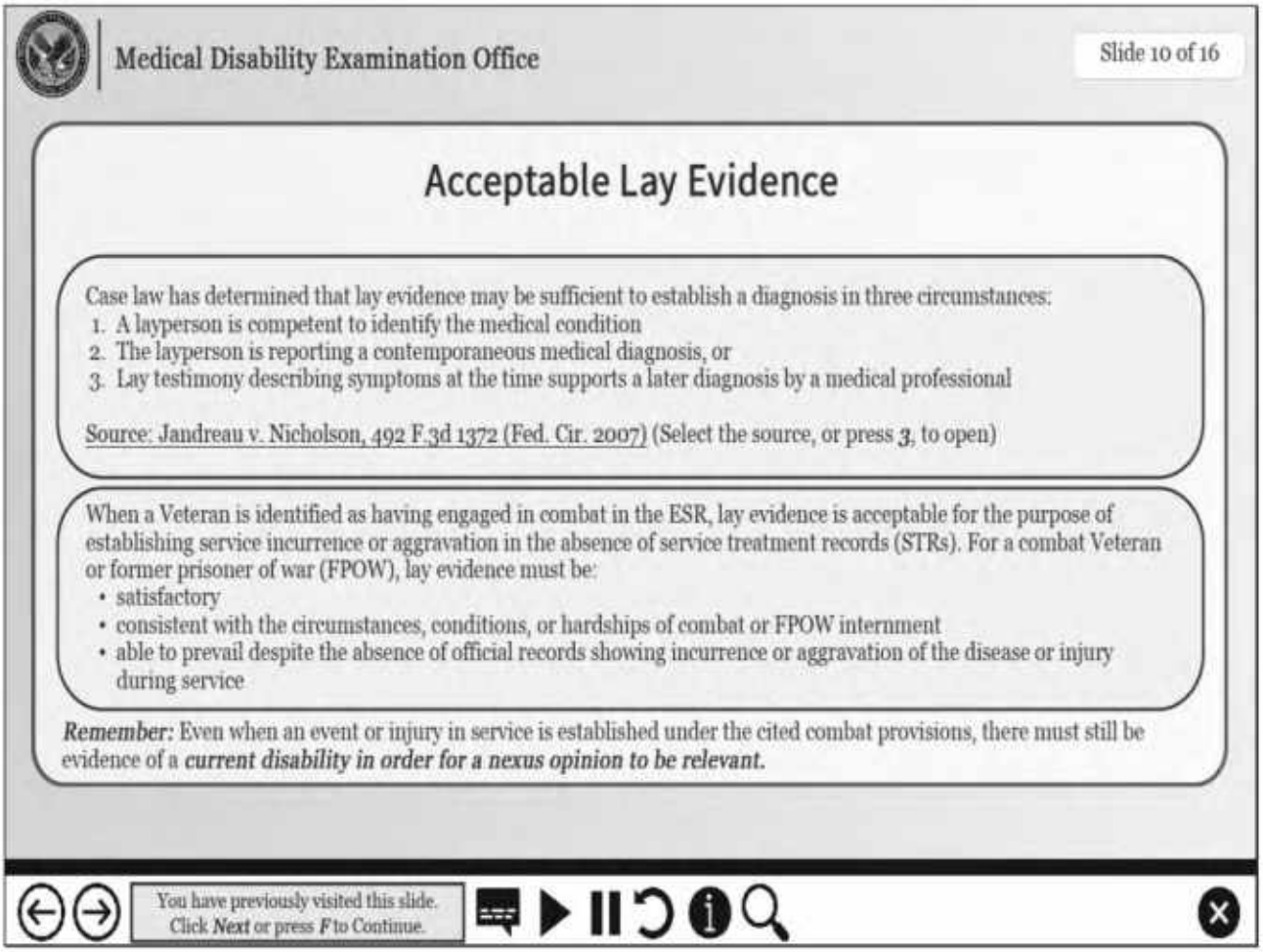
Slide 9 - Acceptable Lay Evidence: Case Law



Transcript

The VA cannot deny a claim solely because the eFolder does not contain evidence supporting an in-service event. VA is required to seek and weigh all sources of evidence. As a result, you may be required to address the absence of evidence where there are no service records (i.e. destroyed or missing) or there are STRs, but the Veteran's in-service symptoms or complaints were not documented. In these circumstances, you must consider lay evidence concerning the type and duration of the symptoms the Veteran experienced in service. Example 1: A lay statement from the spouse of an Airborne soldier confirmed that the soldier came home and reported hitting his head during a jump. The spouse stated that the soldier reported feeling dazed for the next 2 days but did not report the injury to their chain of command. The spouse's statement would be considered lay evidence, and in the Medical Opinion DBQ, a lay statement that is relevant to the claim should be documented in the evidence section and referenced in the rationale.

Slide 10 - Acceptable Lay Evidence: Regarding Combat



Transcript

When the injury reported was due to combat, a Veteran's lay statements may be acceptable for establishing service connection but must be weighed against other evidence in the claims folder, including the presence or absence of military records that would support the claim. Example 2: An Army medic wrote a letter regarding an injury that the Claimant/Veteran sustained in combat and was not recorded in the STRs. Examiners must still find medical evidence of that injury on the C&P physical exam of a current claimed condition that can be linked to service, such as an abnormal joint examination.

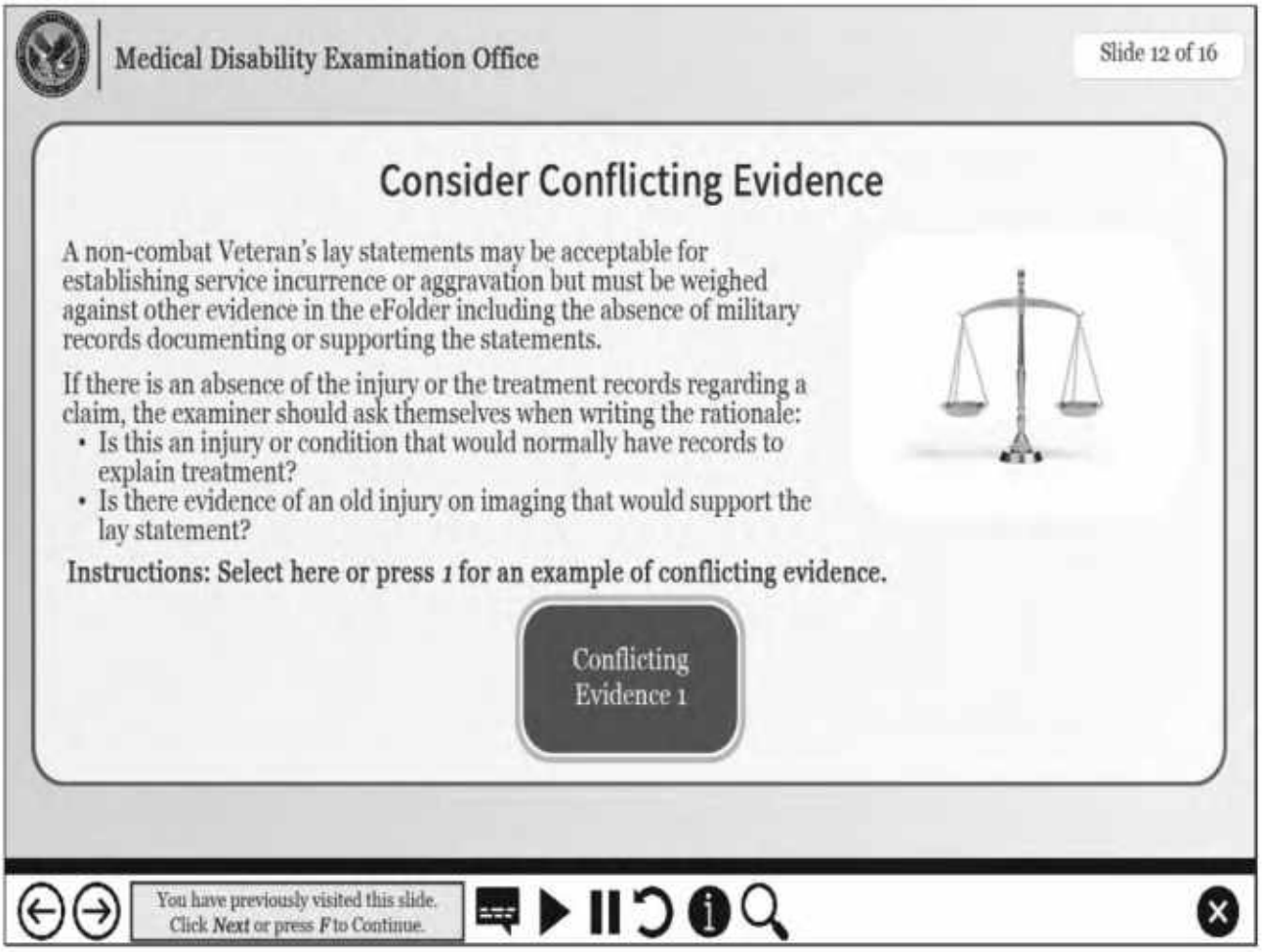
Slide 11 - Addressing Missing Service Treatment Records



Transcript

Remember, the absence of documentation of a condition in the STRs is not a reason to opine against the relationship of a claimed condition to service.

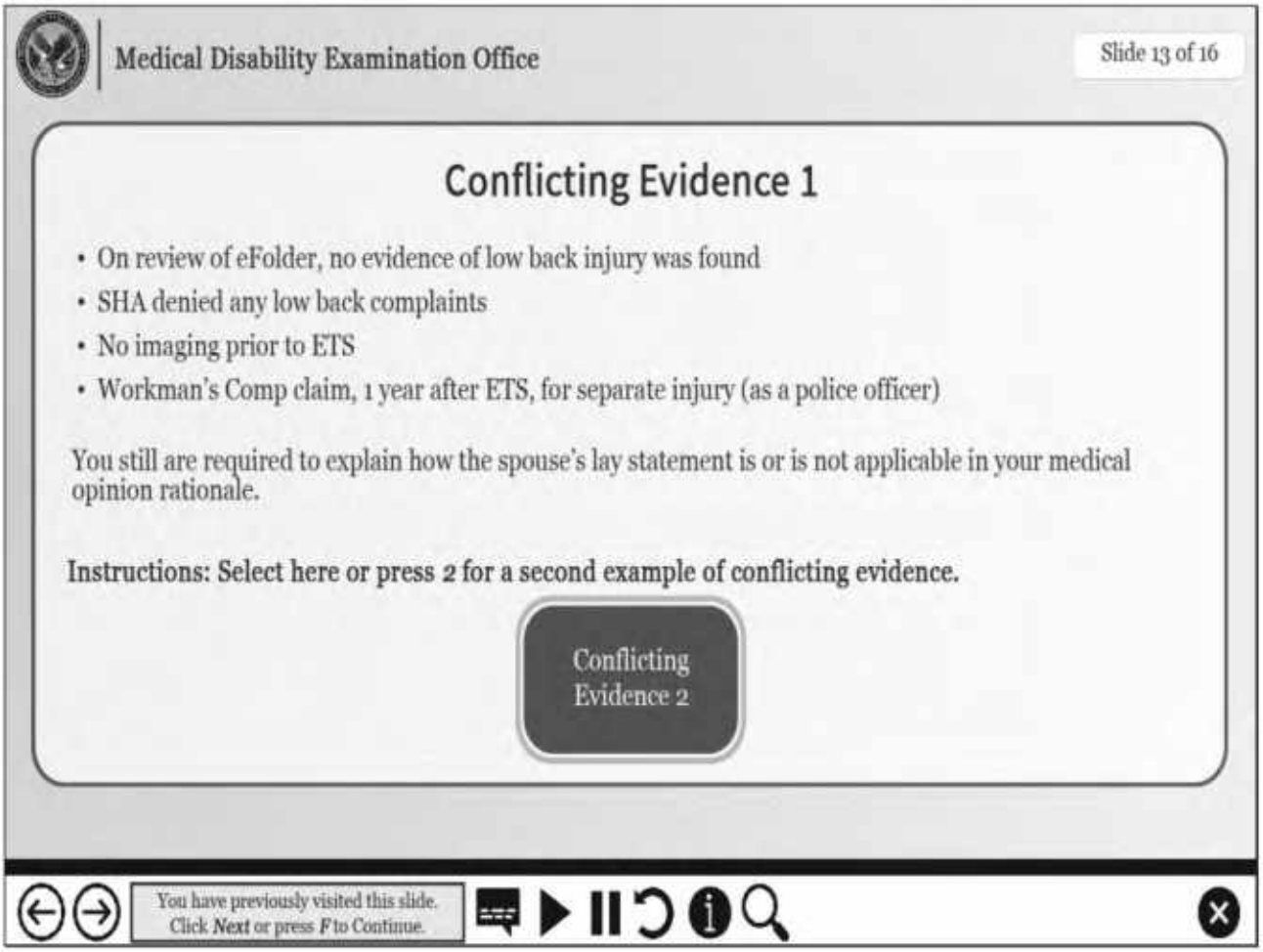
Slide 12 - Consider Conflicting Evidence



Transcript

Lay statements must be considered, and if other medical evidence in the eFolder contradicts the lay statement, these would need to be documented in the evidence section as well as the rationale, with part of the rationale addressing the conflicting evidence. 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. 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.

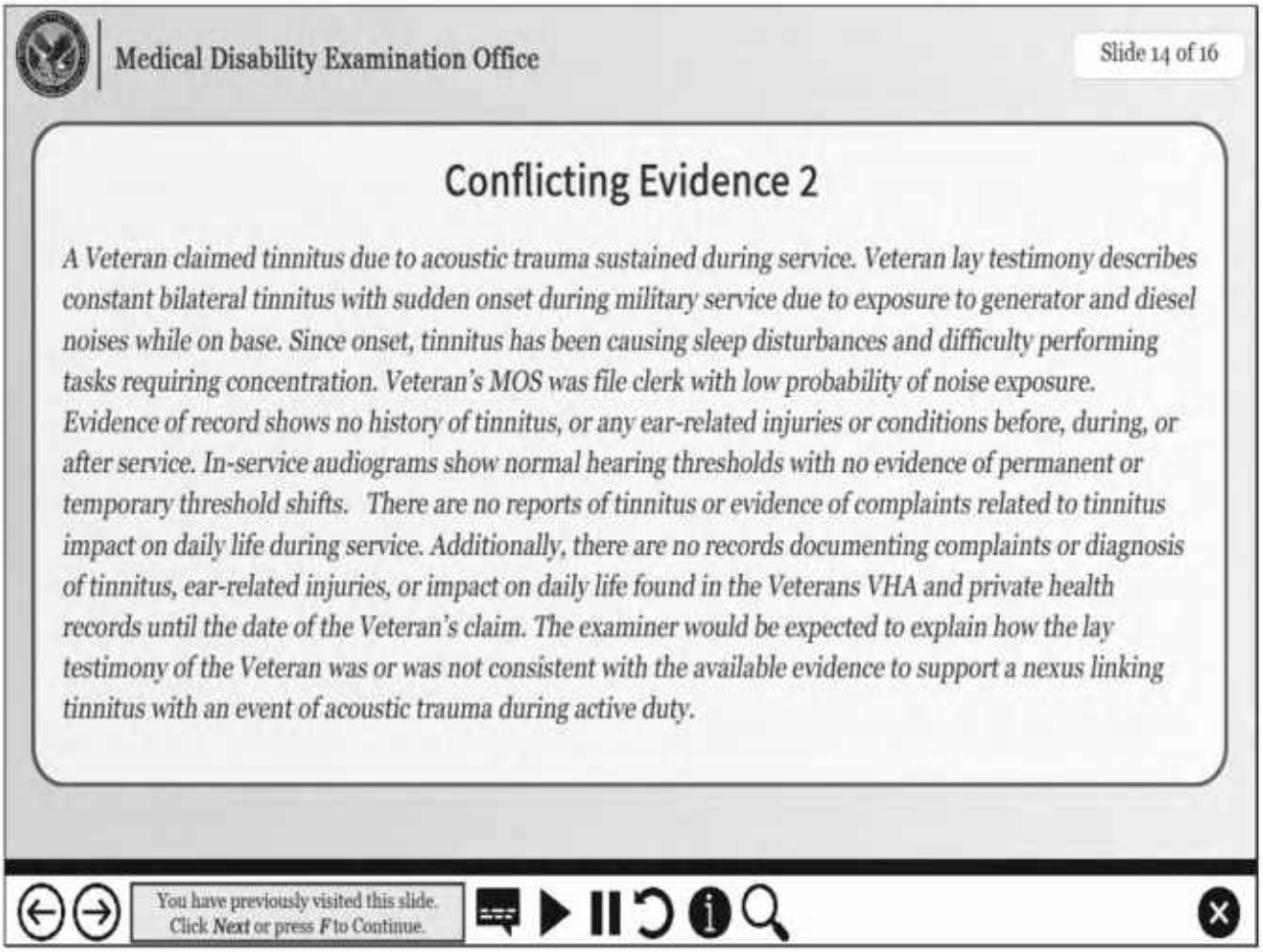
Slide 13 - Conflicting Evidence 1



Transcript

A Veteran claimed a low back injury that was not documented in service. On VA eFolder review, the exit physical or Separation Health Assessment, also referred to as a SHA, denied any low back complaints. No imaging was found prior to imaging completed years after the Veterans Expiration Term of Service, or ETS. The Veteran submitted a lay statement from their spouse claiming that the back pain started shortly after ETS. On review of the VA eFolder, evidence was found documenting a back injury while the Veteran was working as a police officer one year after ETS, with evidence of a Workman's Comp claim at that time. The examiner would be expected to explain how the spouse's lay statement is or is not applicable in this case in the rationale section of the medical opinion.

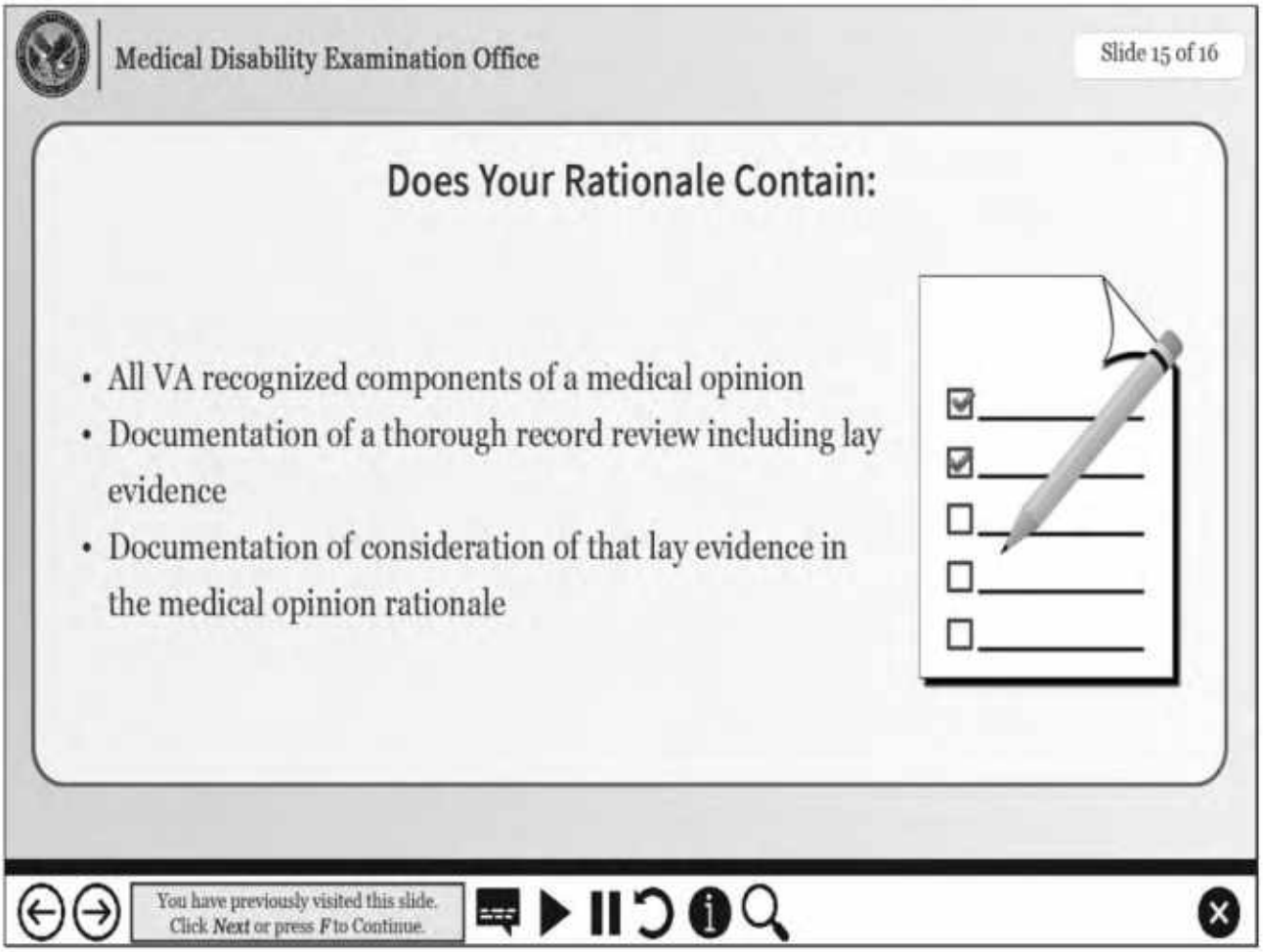
Slide 14 - Conflicting Evidence 2



Transcript

Hearing loss and tinnitus examinations often require consideration of lay evidence. Determining tinnitus diagnosis and etiology relies heavily on lay testimony. However, this testimony must still be weighed with other available evidence. The examiner must also apply clinical knowledge and expertise to determine the consistency of the lay statements with other available evidence when used to support diagnosis and a nexus opinion.

Slide 15 - Does your rationale contain



Transcript

In conclusion, lay statements can be written statements contained in the eFolder from the Veteran or other non-medical persons, Veteran or Claimant statements provided during the exam, and oral or written statements provided during the exam by a friend or family member, if present. A lay statement that is relevant to the medical opinion for the claimed condition should be documented in the evidence section and addressed in the medical opinion rationale. Failure to consider lay testimony can result in need for clarification and or remand.

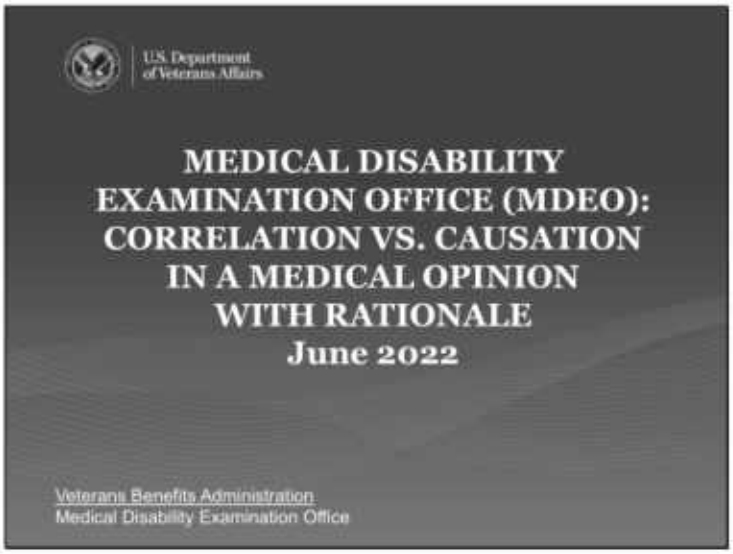
Slide 16 - Congratulations



Transcript

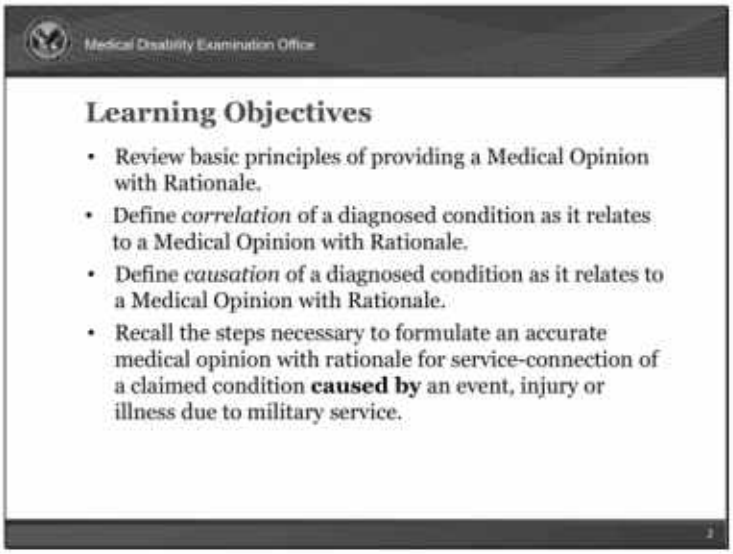
Congratulations, you have completed the training for Lay Statements in Nexus Opinions. Please select the "exit" button or press "X" to close out the course and return to the learning management system.

Slide 1



Examiners are frequently asked to provide a medical opinion with a supporting rationale that is based on the likely causative relationship between one event or circumstance and another. Misinterpretation of correlation and causation contribute to quality errors within examiner rationales. The Medical Disability Examination Office, or MDEO, has developed this brief training module to provide examiners with a better understanding of the critical differences between causation and correlation, how to utilize that knowledge when looking at evidence and formulating a medical opinion with well-reasoned rationale, ultimately leading to a better written discussion that appropriately discusses the evidence AND satisfies all contractual quality aspects.

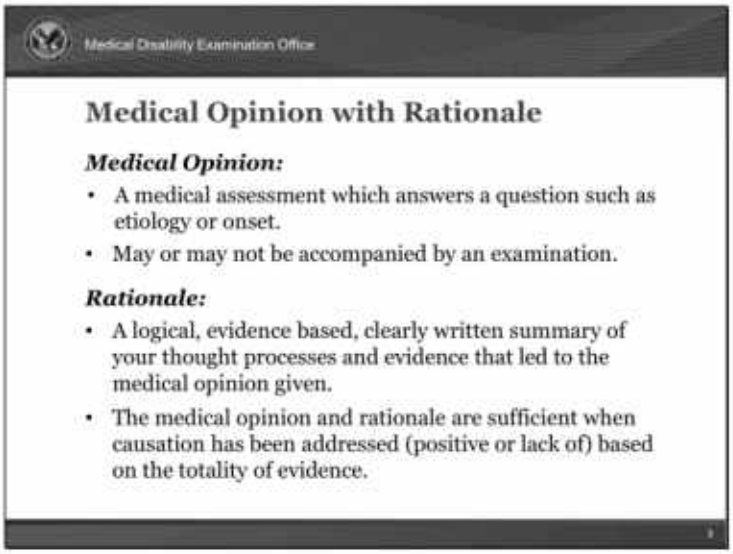
Slide 2



Learning Objectives for this training:

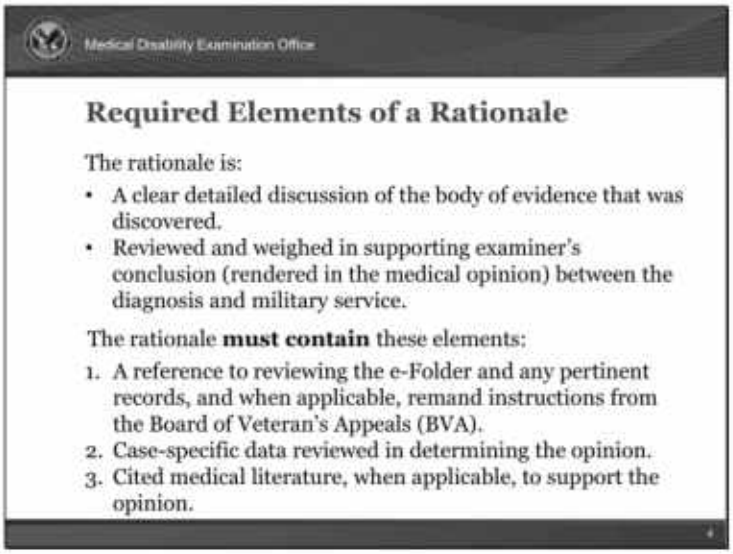
- Review basic principles of providing a Medical Opinion with Rationale.
- Define correlation of a diagnosed condition as it relates to a Medical Opinion with Rationale.
- Define causation of a diagnosed condition as it relates to a Medical Opinion with Rationale.
- Review the steps necessary to formulate an accurate medical opinion with rationale for service-connection of a claimed condition caused by an event, injury or illness due to military service.

Slide 3



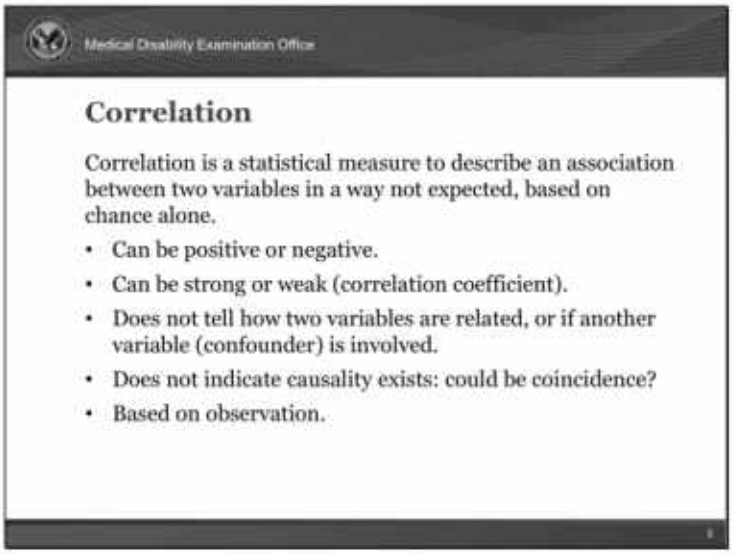
We will begin by reviewing the basic principles of a medical opinion with rationale. A medical opinion is a medical assessment that answers a specific question - such as the relationship between the etiology or onset of a condition and an event, illness or injury during military service. A medical opinion may or may not be accompanied by an examination. However, an opinion does involve the application of an examiner's knowledge, experience, and judgment to a set of facts, and requires a thorough review of the evidence of record to be used to formulate a well supported, accurate opinion. A rationale is a summary of the examiner's thought process that led to the conclusion expressed in the opinion. A medical opinion is only sufficient when supported by a clear, understandable, comprehensive rationale that addresses causation.

Slide 4



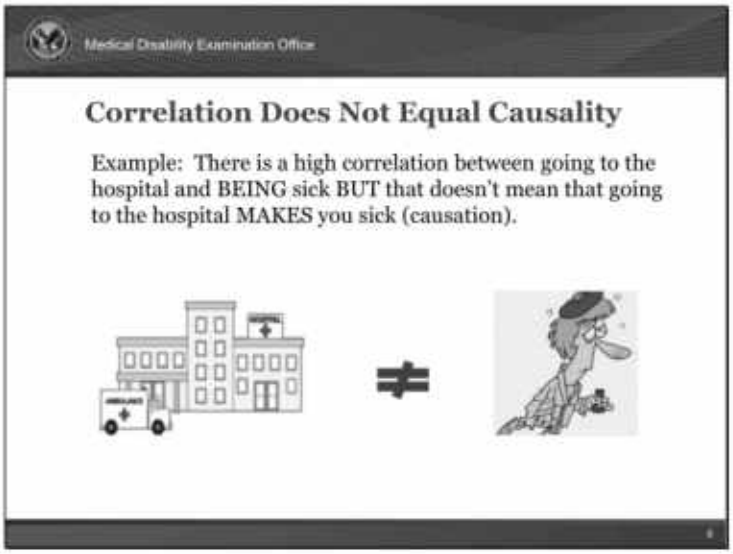
A well-written, adequate rationale is a clear, reasoned medical explanation which supports the opinion given by the examiner. The rationale is extremely important to help adjudicators and others reading the report understand the basis for an examiner's medical opinion. There are three critical elements that must be contained in a well-supported rationale. First, documentation that a thorough review of the evidence of record was performed, including findings of an in-person examination, if conducted, and any specific instructions that are pertinent to this case which are to be addressed. Next, examiners must document case-specific information found in the Veteran's eFolder that is of particular pertinence in their decision relevant to the medical opinion, whether positive or negative. Lastly, examiners must also cite medical literature reviewed to support the medical opinion rendered when applicable, which we will discuss in more detail later in this training.

Slide 5



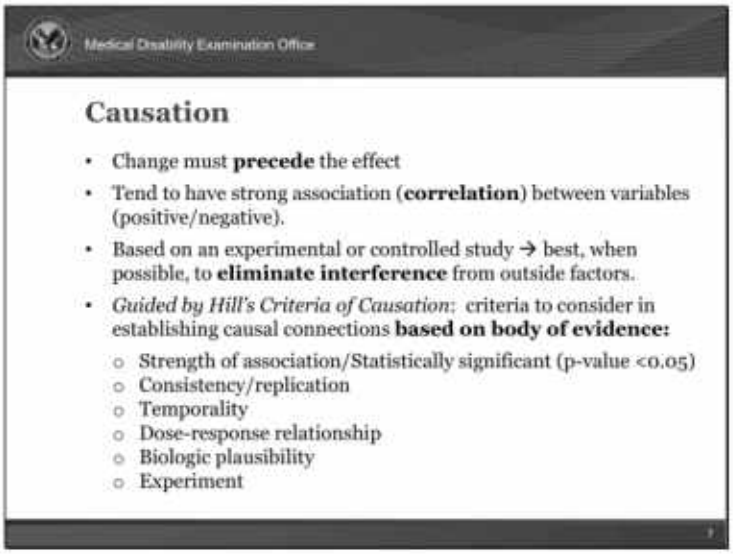
Now, on to reviewing some terminology that has very important implications when examining data, and specifically the kind that is commonly referenced in medical literature that you may run across. Correlation is a statistical measure to describe an association or relationship between two variables that seem to move together in a way not expected by chance alone. Correlation can be positive, where both variables move in the same direction, negative, where they move in opposite directions, or no correlation can be found to exist at all, and the movement was random. There can be a strong or weak correlation between two variables which is determined by using a method to calculate the correlation coefficient. The correlation coefficient can vary from -1 to +1; the closer it is to either end, the stronger the association. This can confuse some people, because correlation does NOT tell how the two variables are associated with each other or if there is another factor, known as a confounder or unexplained bias, affecting the relationship, and making it appear stronger or weaker, than it really is. Correlation is based on observational information, so it cannot establish causality. There may be another explanation for the correlation, such as coincidence. However, if there is a strong correlation, it does give us an area to look at further with an experimental study to try to determine any causal variables.

Slide 6



Correlation is *not t*he same as causation – sometimes two things can share a relationship without one causing the other. Here is an example when correlation does not equal causality; there is a high correlation between going to the hospital and BEING sick but that doesn't mean that going to the hospital MAKES you sick (causation).

Slide 7

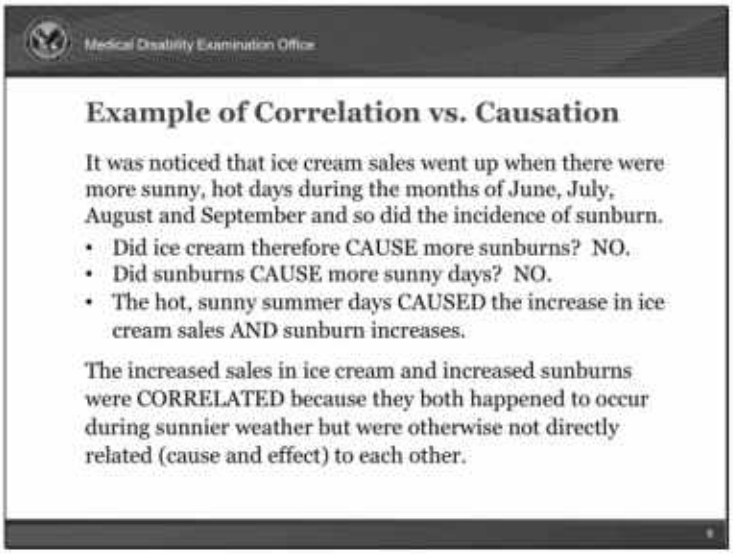


Causation is defined as one variable producing a change in another, what is commonly referred to as the cause-and-effect relationship. We can see that the variable that causes the change MUST precede the effect to be CAUSAL. These relationships are also strongly correlated, in either a positive or negative manner. This relates back to how you use the body of evidence that YOU review as the rationale to form your medical opinion. The rationale must support your medical opinion by compiling the evidence to make a case for cause and effect of the diagnosis to military service, not just a correlation. The best way to determine causation is by performing a randomized controlled trial so that one variable's potential effects can be well controlled to eliminate interference. However, those are not always practical. In trying to develop a way to approach determining whether a causal relationship exists **based on analyzing the body of available evidence**, Sir Austin Bradford Hill, a medical statistician, proposed a set of criteria in 1965 that became a guiding standard in epidemiology. The most important points to consider are:

- The stronger the relationship, especially in the context of one that is measurable and **statistically significant,** the more likely it is to be causal. (Tip: look at the p-values, remember < 0.05 is statistically significant, and the smaller the p-value, the stronger the significance.)
- The study should be able to be **replicated** with similar results by other researchers in different locations, so that **consistency** is demonstrated.
- **Temporality** refers to the cause preceding the effect in time. The amount or intensity of exposure should affect the outcome in a **dose-response relationship.**

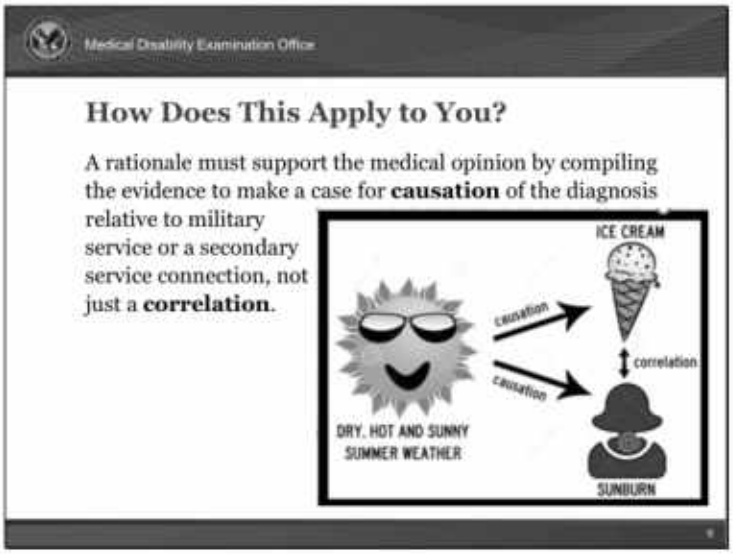
- If there is already a plausible mechanism that explains the causal nature of such a relationship, then it satisfies **biologic plausibility,** however, there may not be the thorough scope of scientific knowledge yet to account for this.
- Lastly, if you were to **experiment** and remove the proposed cause, it would alter the frequency of the effect. That means, when considering causality, would B (the effect) still be present if A (the cause) was removed?

Slide 8



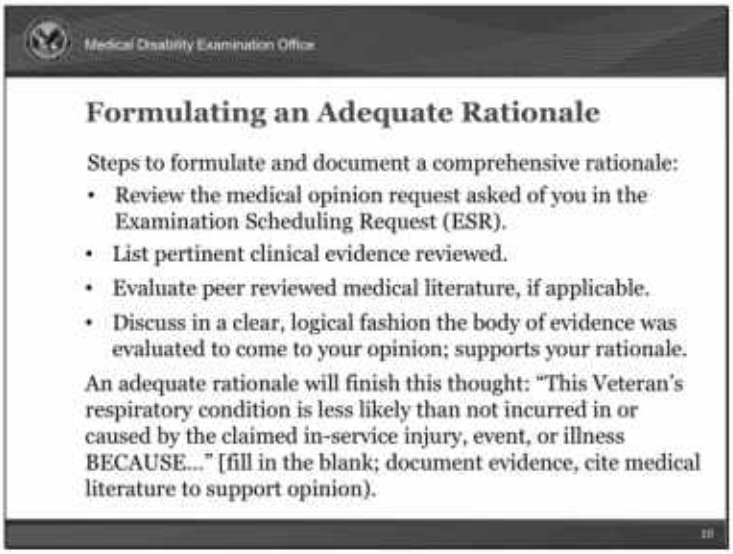
See example on slide.

Slide 9



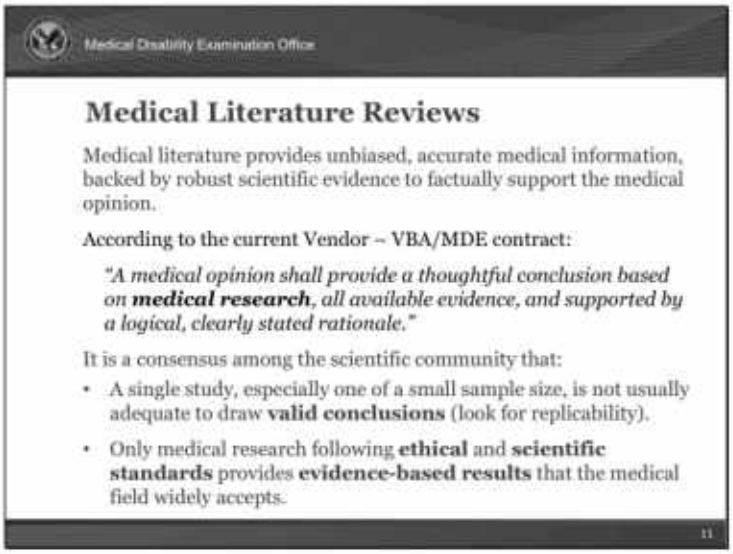
This is a great example to put these concepts into perspective: the data shows that in Long Island there are a LOT more people getting sunburned in June, July and August over the past 15 years and sales of ice cream are much higher in those months as well. Does that mean that getting sunburned caused people to eat more ice cream? Or that as people eat more ice cream, they get sunburned? Even though there is a strong correlation, there is no true relationship between these two variables affecting each other. The causal relationship exists between the sunny, hot weather and the two separate outcomes of sunburn and people buying more ice cream, which can be seen to move in one direction only (in other words, increased sunburns don't CAUSE more hot, sunny weather). A rationale must support the medical opinion by compiling the evidence to make a case for **causation** of the diagnosis relative to military service or a secondary service connection, not just a **correlation.**

Slide 10



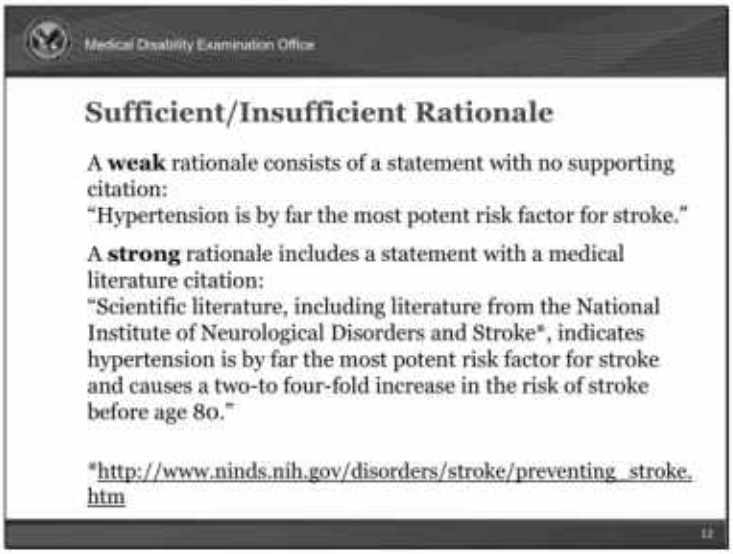
There are several steps in formulating and documenting an adequate rationale. First, review the requested medical opinion and any specific instructions provided on the ESR to ensure a correct and complete answer is provided. Then objectively weigh the evidence to determine if a causal relationship exists between the diagnosed condition and military service, or not. Next, conduct and cite the pertinent evidence and literature review findings which support your opinion. And finally, explain how the evidence, clinical data, and applicable medical literature supports cause and effect; Is the diagnosis caused by military service? An adequate rationale will finish this thought "This Veteran's respiratory condition is less likely than not incurred in or caused by the claimed in-service injury, event, or illness BECAUSE…" by documenting evidence, clinical data and citation of medical literature which supports this opinion.

Slide 11



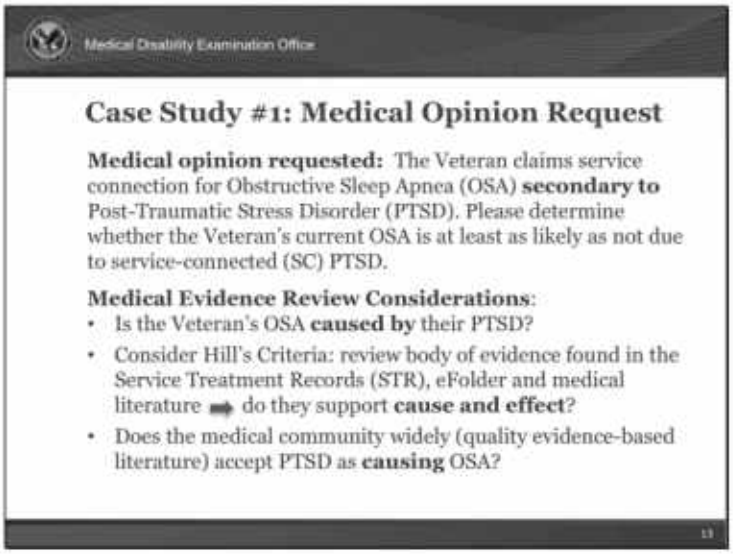
Rationales often rely on medical literature to substantiate and support positive or negative medical opinions. Utilizing and citing high quality medical literature in the DBQ provides unbiased, factually accurate opinions and prevents anecdotal rationales such as "My 25 years experience in the field supports my opinion". Rationales rely on researching current medical literature to substantiate and support positive or negative medical opinions. There are many free sources for locating credible, peer reviewed literature on the internet to assist with your research, such as Google Scholar or Pub Med, or your vendor may provide you access through a paid resource such as UpToDate. When deciding on what types of sites or sources to look at for information, or even a study or site that you have found, it is important to keep in mind the concepts of how evidence-based medicine and validity affect the results. If there is only one study you could find, especially if that study is based on a small sample size, (for instance it only had 100 people), it is difficult to say that it is replicable, nor that it has validity for any conclusions it may state (remember Hill's principles!). Only when medical research provides quality, reproducible, abundance of evidence does the medical field widely accept the outcome of research. NOTE: You will find multiple peer-reviewed articles in journals or other sites that discuss aspects of this topic and have a consensus (see Reference slides at end of presentation).

Slide 12



This and additional slides will provide case study examples of a medical opinion with rationale.

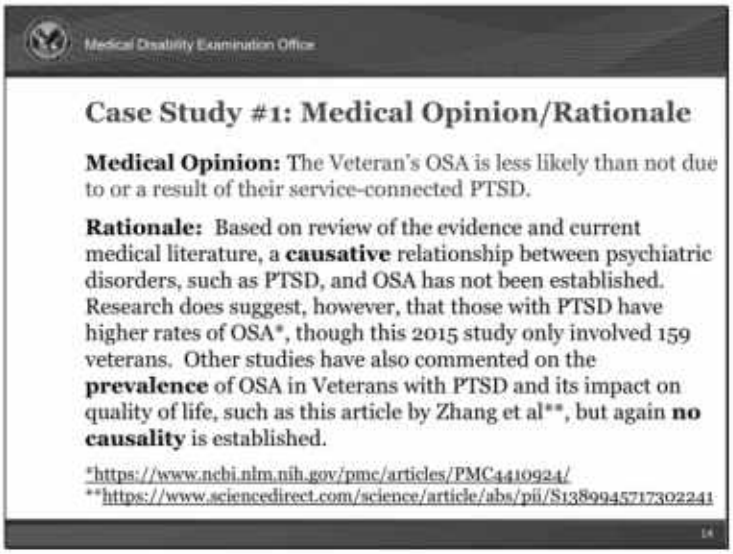
Slide 13



Case study #1: After reading the medical opinion requested (see slide), conduct medical evidence review and consider:

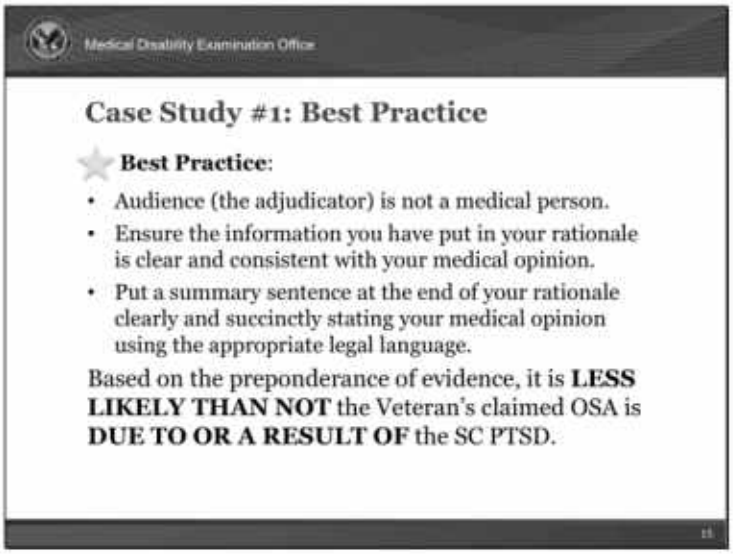
- Is the Veteran's OSA **caused by** their PTSD?
- Is there an abundance of evidence found in the Service Treatment Records (STR), eFolder or medical literature to support a **cause and effect**, not just an association? This is where it is important to remember the difference and consider Hill's Criteria!
- Does the medical community widely accept Post-Traumatic Stress Disorder (PTSD) as causing (supported by high quality, evidenced-based literature) Obstructive Sleep Apnea (OSA)? If so, remember, there should be a multitude of studies throughout peer reviewed literature that should have general concurrence on the outcome.

Slide 14



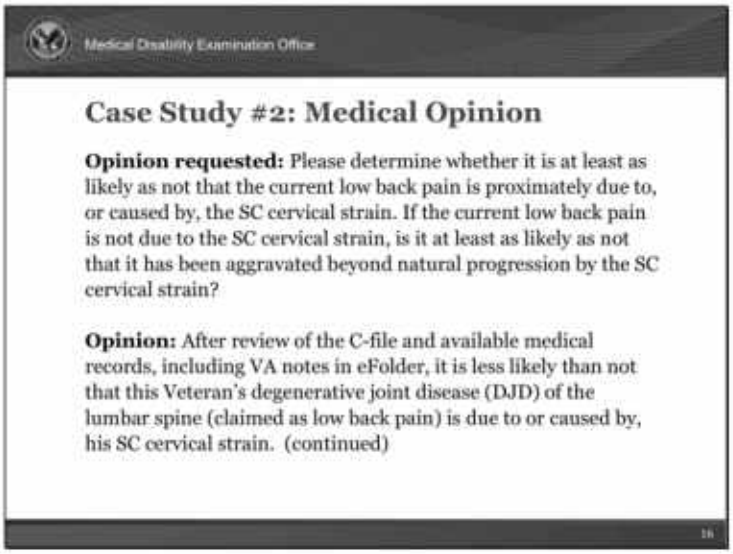
As we read through this brief excerpt from the Rationale of this claim, you can see the examiner looks at the current scientific literature and provides two examples from reputable sources, specifically comments that there is NO CAUSATIVE relationship between the claimed condition of obstructive sleep apnea and the service-connected condition of PTSD but acknowledges that there is much literature about an association of the two conditions.

Slide 15



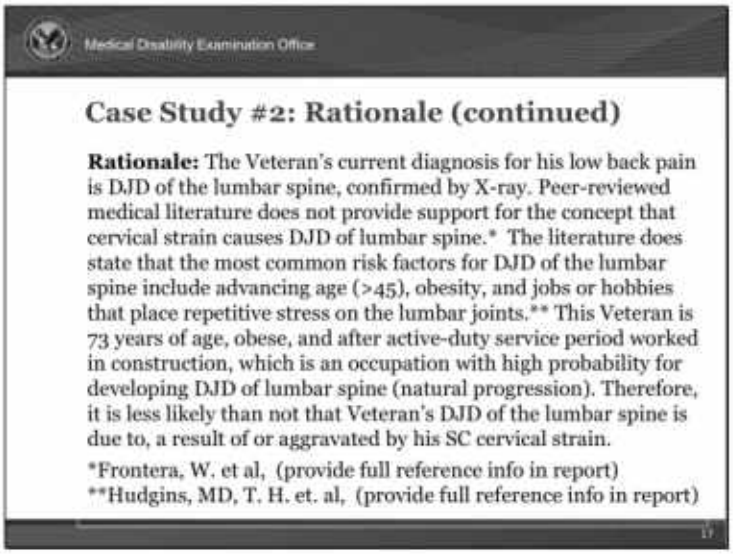
Remembering your audience, (the adjudicator), is not a medical person, and to make sure that YOU have made the information you have put in your rationale clear and consistent with your medical opinion, it is a Best Practice to put a summary sentence at the end of your rationale, again stating clearly and succinctly what the information you put in your rationale supports using the legal language that is the basis for opinions. Remember that the phrase "due to/a result of" is the causation portion that we have been discussing. The final medical opinion states: Based on the preponderance of evidence, it is LESS LIKELY THAN NOT the Veteran's claimed OSA is DUE TO OR THE RESULT OF the SC PTSD.

Slide 16



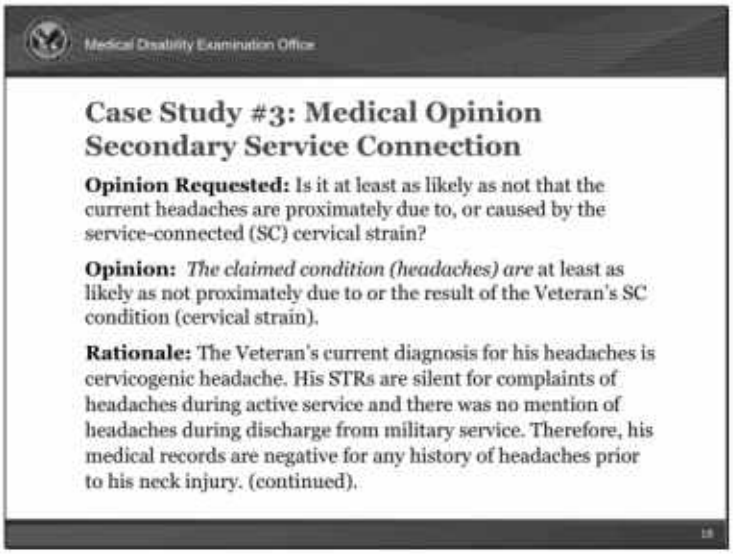
Read case study #2 – Medical Opinion.

Slide 17

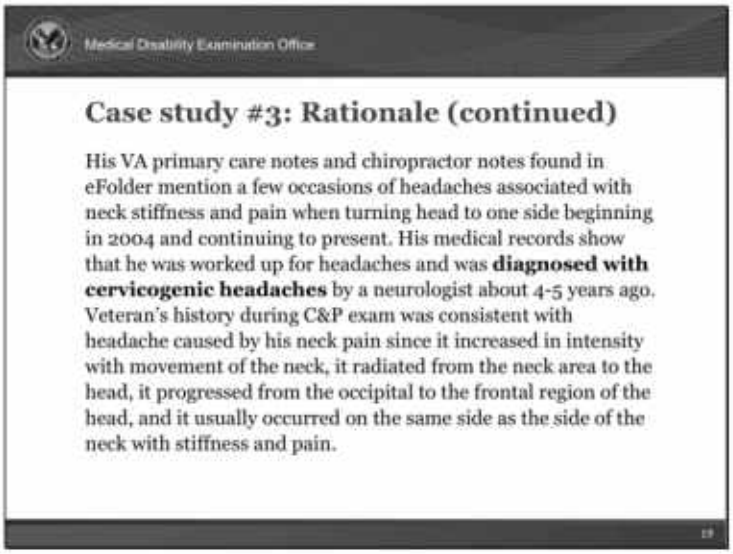


Read case study #2 - Rationale

Slide 18

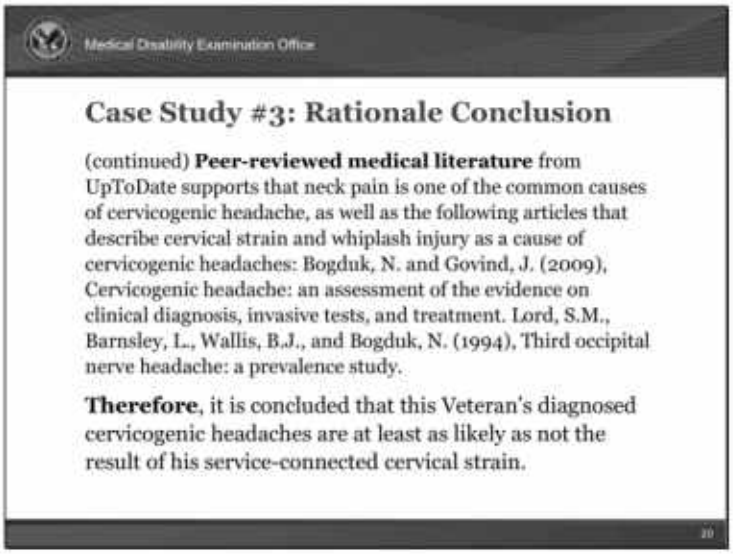

Medical Disability Examination Office
Case Study #3: Medical Opinion
Secondary Service Connection
Opinion Requested: Is it at least as likely as not that the current headaches are proximately due to, or caused by the service-connected (SC) cervical strain?
Opinion: The claimed condition (headaches) are at least as likely as not proximately due to or the result of the Veteran's SC condition (cervical strain).
Rationale: The Veteran's current diagnosis for his headaches is cervicogenic headache. His STRs are silent for complaints of headaches during active service and there was no mention of headaches during discharge from military service. Therefore, his medical records are negative for any history of headaches prior to his neck injury. (continued).

Slide 19



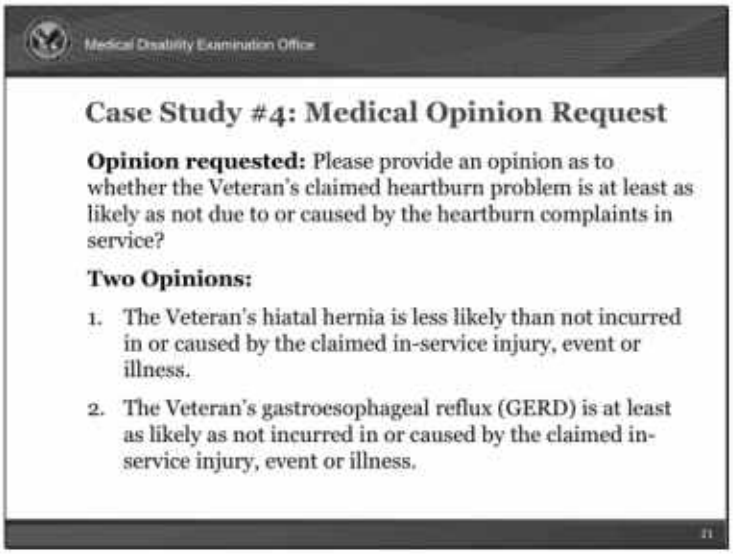
Review of pertinent evidence from his current medical treatment records establish onset, chronicity, as well as diagnosis and support relationship to the service-connected neck condition. Read case study #3 – Rationale.

Slide 20



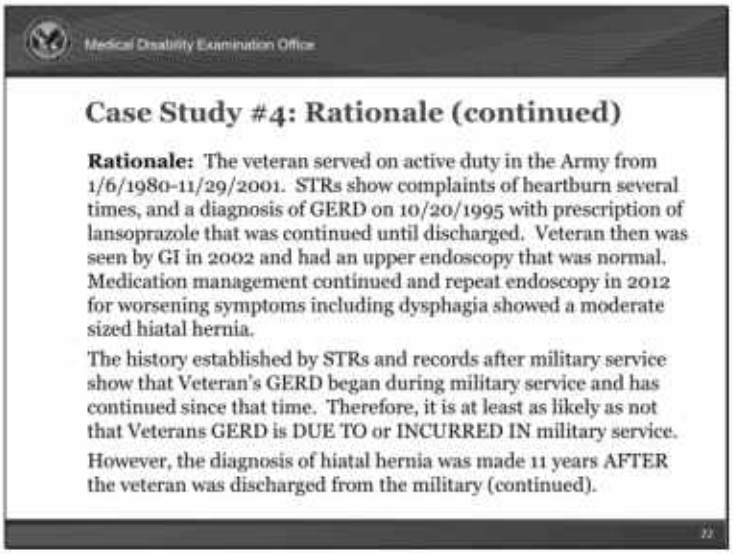
Read case study #3 – Rationale
References may be embedded within the Rationale or documented after the Medical Opinion with Rationale, as seen on previous slides.

Slide 21



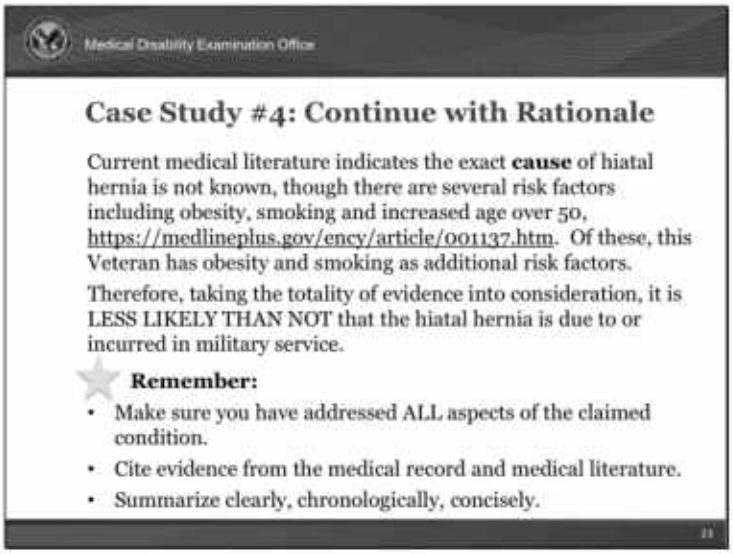
Read case study #4 – Medical Opinion with Rationale

Slide 22



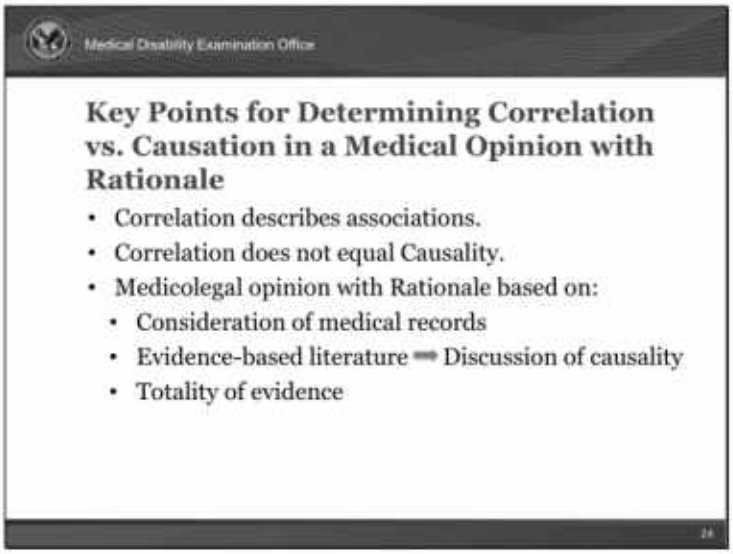
Read case study #4 – Rationale

Slide 23



Read case study #4 - Rationale

Slide 24



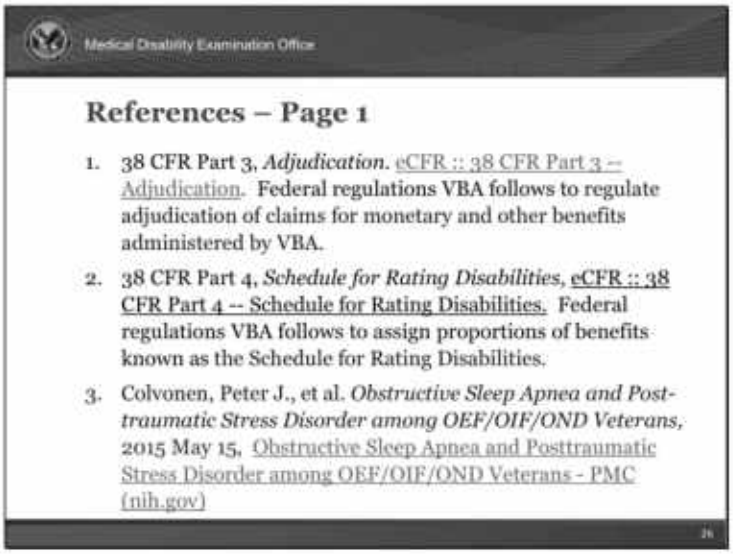
Read Key Points for Determining Correlation vs. Causation in a Medical Opinion with Rationale.

Slide 25

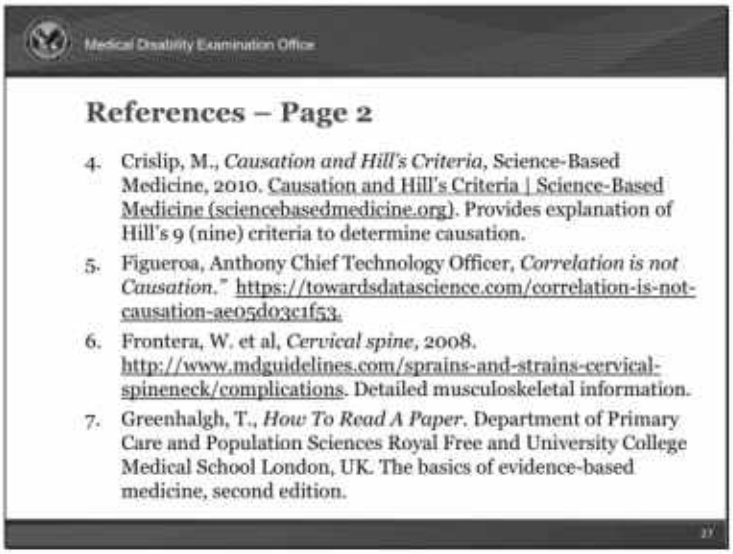


Please see the information on this slide of credible medical literature websites to assist examiners in locating and reviewing research studies. This is just a sample of websites, not an all-inclusive list.

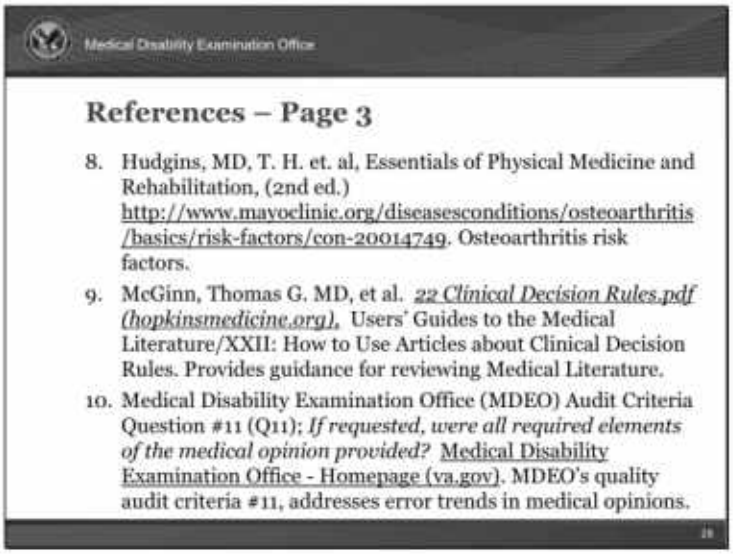
Slide 26


Medical Disability Examination Office
References – Page 1
1. 38 CFR Part 3, *Adjudication*. eCFR :: 38 CFR Part 3 -- Adjudication. Federal regulations VBA follows to regulate adjudication of claims for monetary and other benefits administered by VBA.
2. 38 CFR Part 4, *Schedule for Rating Disabilities*, eCFR :: 38 CFR Part 4 -- Schedule for Rating Disabilities. Federal regulations VBA follows to assign proportions of benefits known as the Schedule for Rating Disabilities.
3. Colvonen, Peter J., et al. *Obstructive Sleep Apnea and Post-traumatic Stress Disorder among OEF/OIF/OND Veterans*, 2015 May 15. Obstructive Sleep Apnea and Posttraumatic Stress Disorder among OEF/OIF/OND Veterans - PMC (nih.gov)

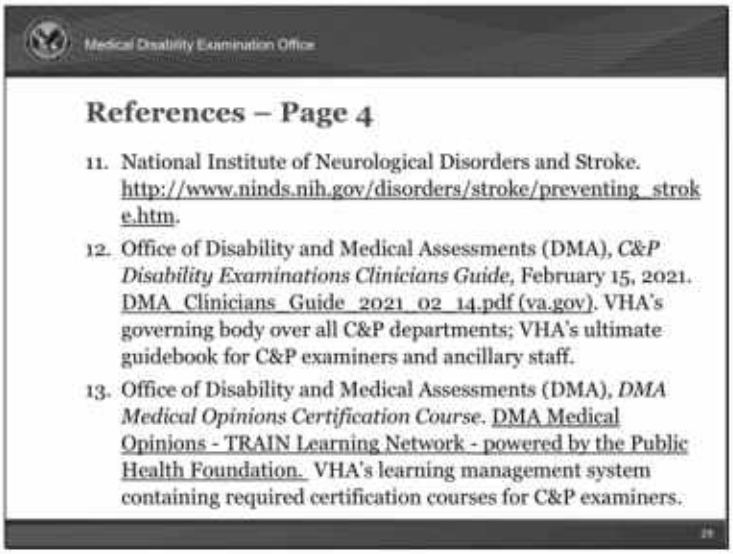
Slide 27


Medical Disability Examination Office
References – Page 2
4. Crislip, M., Causation and Hill's Criteria, Science-Based Medicine, 2010. Causation and Hill's Criteria | Science-Based Medicine (sciencebasedmedicine.org). Provides explanation of Hill's 9 (nine) criteria to determine causation.
5. Figueroa, Anthony Chief Technology Officer, Correlation is not Causation." https://towardsdatascience.com/correlation-is-not-causation-ae05d03c1f53.
6. Frontera, W. et al, Cervical spine, 2008. http://www.mdguidelines.com/sprains-and-strains-cervical-spineneck/complications. Detailed musculoskeletal information.
7. Greenhalgh, T., How To Read A Paper. Department of Primary Care and Population Sciences Royal Free and University College Medical School London, UK. The basics of evidence-based medicine, second edition.

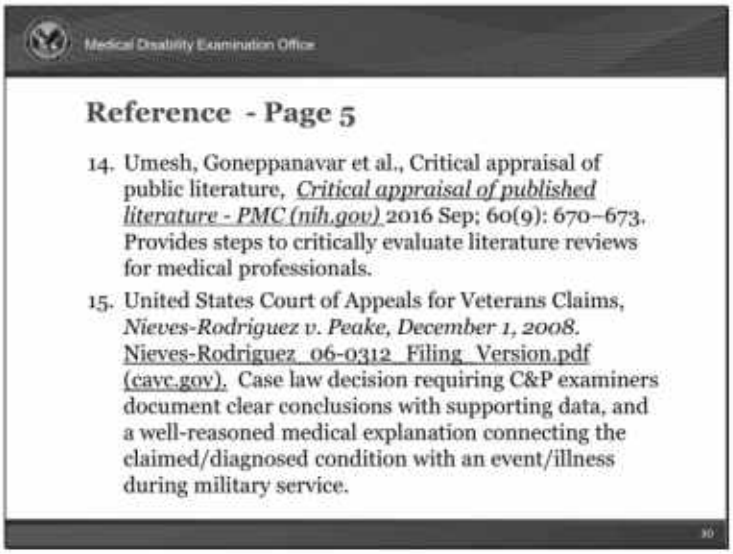
Slide 28


Medical Disability Examination Office
References – Page 3
8. Hudgins, MD, T. H. et. al, Essentials of Physical Medicine and Rehabilitation, (2nd ed.) http://www.mayoclinic.org/diseasesconditions/osteoarthritis/basics/risk-factors/con-20014749. Osteoarthritis risk factors.
9. McGinn, Thomas G. MD, et al. 22 Clinical Decision Rules.pdf (hopkinsmedicine.org), Users' Guides to the Medical Literature/XXII: How to Use Articles about Clinical Decision Rules. Provides guidance for reviewing Medical Literature.
10. Medical Disability Examination Office (MDEO) Audit Criteria Question #11 (Q11); If requested, were all required elements of the medical opinion provided? Medical Disability Examination Office - Homepage (va.gov). MDEO's quality audit criteria #11, addresses error trends in medical opinions.

Slide 29


Medical Disability Examination Office
References – Page 4
11. National Institute of Neurological Disorders and Stroke. http://www.ninds.nih.gov/disorders/stroke/preventing_stroke.htm.
12. Office of Disability and Medical Assessments (DMA), C&P Disability Examinations Clinicians Guide, February 15, 2021. DMA_Clinicians_Guide_2021_02_14.pdf (va.gov). VHA's governing body over all C&P departments; VHA's ultimate guidebook for C&P examiners and ancillary staff.
13. Office of Disability and Medical Assessments (DMA), DMA Medical Opinions Certification Course. DMA Medical Opinions - TRAIN Learning Network - powered by the Public Health Foundation. VHA's learning management system containing required certification courses for C&P examiners.

Slide 30


Medical Disability Examination Office
Reference - Page 5
14. Umesh, Goneppanavar et al., Critical appraisal of public literature, Critical appraisal of published literature - PMC (nih.gov) 2016 Sep; 60(9): 670–673. Provides steps to critically evaluate literature reviews for medical professionals.
15. United States Court of Appeals for Veterans Claims, Nieves-Rodriguez v. Peake, December 1, 2008. Nieves-Rodriguez_06-0312_Filing_Version.pdf (cavc.gov). Case law decision requiring C&P examiners document clear conclusions with supporting data, and a well-reasoned medical explanation connecting the claimed/diagnosed condition with an event/illness during military service.

MEDICAL DISABILITY EXAMINATION OFFICE
VETERANS BENEFITS ADMINISTRATION



Direct Service Connection



This is Mr. Dale Willow, a Vietnam Era Veteran who served as a clerk in the U.S. Army from 1968 to 1970, including one deployment to Vietnam. After service, he worked in construction until he retired. He is experiencing neck pain and stiffness that he believes is a result of his military service. Is it?

Exam Scheduling Request (ESR) for Direct Service Connection:

Does the Veteran have a diagnosis of neck pain and stiffness that is at least as likely as not (likelihood is at least approximately balanced or nearly equal, if not higher) incurred in or caused by the treatment for a neck "pop" during service?

Your review is not limited to the evidence identified on this request form or tabbed in the claims folder if an examination or additional testing is required, obtain them prior to rendering your opinion. Rationale must be provided in the appropriate section.

Examiner Reviewed the Following Evidence:

- **Application for Disability Compensation and Related Compensation Benefits (VA Form 526EZ):** Received on December 30, 2020, for claimed condition of cervical strain
- **VA Form 4138 Statement in Support of Claim:** Statement from the Veteran, "I served in the US Army in Vietnam. While riding in a truck, it stopped suddenly, and my neck was wrenched. Since then, it has gotten worse."
- **DD214:** Service from August 6, 1968 to September 30, 1970

- **Service Treatment Records (STRs):**
    - Entrance Exam: Dated August 6, 1968, showed no neck issues documented
    - Treatment Notes: Annotation for treatment on June 2, 1969, with complaints that a truck stopped suddenly and the Veteran felt his neck "pop," upon evaluation the neck had decreased range of motion, and the x- ray was negative for any fracture
    - Separation Exam: Dated September 30, 1970, showed neck was documented to have decreased range of motion and muscle spasm
- **Lay Statement:** Statement from Veteran's wife, "To whom it may concern, I have been married to Dale Willow for 40 years. As long as I can remember he has had trouble turning his head to look behind him. Especially when driving."
- **Physical Examination Findings -** Neck (Cervical Spine) Conditions DBQ
    - Diagnosis: Confirmed a diagnosis of cervical strain, with decreased range of motion
    - Xrays: Normal cervical X-ray.

Medical Opinion with Rationale Provided:

SECTION III - MEDICAL OPINION FOR DIRECT SERVICE CONNECTION
Choose the statement that most closely approximates the etiology of the claimed condition.
☒ 3A. The claimed condition was at least as likely as not (likelihood is at least approximately balanced or nearly equal, if not higher) incurred in or caused by the claimed in-service injury, event, or illness. Provide rationale in Section C.
☐ 3B. The claimed condition was less likely than not (likelihood is less than approximately balanced or nearly equal) incurred in or caused by the claimed in-service injury, event, or illness. Provide rationale in Section C.

3C. Rationale:

Based on the evidence provided , the Veteran's cervical strain, manifesting as neck pain and stiffness, is at least as likely as not caused by an in-service event. The service treatment records (STRs) document an incident where the Veteran's neck was injured due to a sudden stop of a truck, resulting in a "pop" sound and reduced range of motion, with an x-ray ruling out fractures. The separation examination corroborates ongoing neck issues, describing decreased range of motion and muscle spasms. Consistent with these in-service findings, the Veteran and his wife both report a long history of difficulty in neck movement, beginning during his military service and persisting without any subsequent injuries. Recent medical evaluation and findings align with these accounts, showing a diagnosis of cervical strain with decreased range of motion and normal spinal x-rays, confirming the continuity and progression of the initial injury.

MEDICAL DISABILITY EXAMINATION OFFICE
VETERANS BENEFITS ADMINISTRATION



Secondary Service Connection



This is Mr. Dale Willow, a Vietnam Era Veteran who served as a clerk in the U.S. Army from 1968 to 1970, including one deployment to Vietnam. After service, he worked in construction until he retired. He has been service connected for cervical strain resulting from his military service and is now experiencing headaches, which he believes are due to his cervical strain. Are they?

Exam Scheduling Request (ESR) for Secondary Service Connection:

Is the Veteran's headaches 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 the Veteran's service connected cervical strain.

Your review is not limited to the evidence identified on this request form or tabbed in the claims folder. If an examination or additional testing is required, obtain them prior to rendering your opinion. Rationale must be provided in the appropriate section.

Examiner Reviewed the Following Evidence:

- **Application for Disability Compensation and Related Compensation Benefits (VA Form 526EZ):** Received on August 23, 2021, for claimed condition of headaches caused by neck strain
- **Rating Decision:** Dated June 20, 2021, service connection granted for Cervical Strain
- **DD214:** Service from August 6, 1968 to September 30, 1970
- **Service Treatment Records (STRs):**

- Entrance Exam: Dated August 6, 1968, showed no headache complaints documented
- Treatment Notes: No relevant medical records from service
- Separation Exam: Dated September 30, 1970, showed no headache complaints documented

- **Lay Statement:** Statement from Veteran's wife: "To whom it may concern, ever since I have been married to Dale Willow he has complained about headaches and a stiff neck. His headaches can get so bad while driving that I have to drive for him. When at a stop sign he tries to turn his head to see side to side but is unable to turn his head normal. When backing up he cannot look over his shoulder, but he needs to turn his whole upper body to look backward. These movements cause his neck to tighten and then he complains of headaches."
- **Post-Service Treatment Records:**
  - VA medical center treatment notes dated March 3, 2018 and December 20, 2019 showing treatment and complaints for headaches
  - Statement from Veteran's primary care doctor dated January 10, 2020 showing Veteran sought treatment for neck and headache pain
- **Physical Examination Findings -** Headaches (including migraine headaches) DBQ **:**
  - Diagnosis: Exam diagnosed the Veteran with chronic cervicogenic muscle tension headaches.
  - Medical History: Increases in intensity with movement of the neck and it progresses from the occipital to the frontal region of the head, which usually occurs on the same side as the neck stiffness with pain.
- **Medical Literature:** Two peer-reviewed articles showing a connection between neck injuries and the diagnosis of cervicogenic headaches
  - Lord, S. M., Barnsley, L., Wallis, B. J., & Bogduk, N. (1994). Third occipital nerve headache: a prevalence study. *Journal of Neurology, Neurosurgery, and Psychiatry*, 57(10), 1187-1190. https://doi.org/10.1136/jnnp.57.10.1187
  - Bogduk, N., & Govind, J. (2009). Cervicogenic headache: an assessment of the evidence on clinical diagnosis, invasive tests, and treatment. *The Lancet Neurology, 8*(10), 959-968. https://doi.org/10.1016/S1474-4422(09)70209-1

Medical Opinion with Rationale Provided:

SECTION IV - MEDICAL OPINION FOR SECONDARY SERVICE CONNECTION
☒ 4A. The claimed condition is 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 the Veteran's service connected condition. Provide rationale in Section C.
☐ 4B. The claimed condition is less likely than not (likelihood is less than approximately balanced or nearly equal) proximately due to or the result of the Veteran's service connected condition. Provide rationale in Section C.

4C. Rationale:

Based on the evidence , it is concluded that the Veteran's diagnosed cervicogenic headaches are at least as likely as not caused by his service-connected cervical strain. The service treatment records (STRs) are silent on complaints of headaches during active service and at the time of discharge, indicating no history of headaches prior to the neck injury. However, post-service treatment records from the VA and statements from the Veteran's primary care doctor and his wife indicate consistent reports of headaches associated with neck stiffness and pain. The Veteran was diagnosed with cervicogenic headaches, which is supported by the examination findings and consistent with his history of increased headache intensity with neck movement. Additionally, peer-reviewed medical literature supports the connection between neck pain and cervicogenic headaches, specifically noting that involvement of the C2-3 zygapophyseal joint is a common source (Lord et al., 1994) and (Bogduk & Govind, 2009). Therefore, the evidence sufficiently supports that the Veteran's cervicogenic headaches are proximately due to or the result of his service-connected cervical strain.

MEDICAL DISABILITY EXAMINATION OFFICE
VETERANS BENEFITS ADMINISTRATION



Secondary Service Connection



This Mr. Dale Willow, a Vietnam Era Veteran who served as a clerk in the U.S. Army from 1968 to 1970, including one deployment to Vietnam. After service, he worked in construction until he retired. He is service connected for cervical strain and he believes that it has caused his low back pain. Has it?

Exam Scheduling Request (ESR) for Secondary Service Connection:

Is the Veteran's low back pain 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 service connected cervical strain.

Your review is not limited to the evidence identified on this request form or tabbed in the claims folder. If an examination or additional testing is required, obtain them prior to rendering your opinion. Rationale must be provided in the appropriate section.

Examiner Reviewed the Following Evidence:

- **Application for Disability Compensation and Related Compensation Benefits (VA Form 526EZ):** Received on May 15, 2022, for claimed condition of low back pain caused by neck strain
- **Rating Decision:** Dated June 20, 2021 service connection granted for Cervical Strain
- **DD214:** Service from August 6, 1968 to September 30, 1970
- **Service Treatment Records (STRs):**
    - Entrance Exam: Dated August 6, 1968 showed no low back complaints documented
    - Treatment Notes: No relevant medical records from service

- Separation Exam: Dated September 30, 1970 showed no low back complaints documented

- **Post-Service Treatment Records:**
  - Chiropractic records in April and May 2011 documents low back pain for several years, has mild tenderness over lower lumbar spine, with pain at extremes of motion. Mildly limited motion. X-rays show degenerative joint disease at L5-S1 with disc space narrowing and minor osteophytes of other lumbar vertebrae.
  - Treatment provider diagnosis: Lumbar spondylosis with facet joint dysfunction. Treatment: Spinal adjustments L5, with moderate relief noted.
- **Physical Examination Findings -** Back (Thoracolumbar Spine) Conditions DBQ:
  - Diagnosis: Exam diagnosed the Veteran with degenerative joint disease (DJD) of the lumbar spine
  - Medical history: Veteran states that he has had more or less steady low back pain, with gradual worsening, over the past 12 years. The pain is worse after heavy lifting or with other back exertion. Pain does not radiate. He feels that his service- connected cervical condition is related to his low back pain and makes it worse. His first medical visit for low back pain was to a chiropractor in 2011. He received several spinal adjustments, resulting in some relief of pain. However, the low back pain did continue and is now worse than it has ever been. He has no leg pain.
  - Physical examination: The Veteran was noted to have pain during the extreme range of flexion, extension, and rotation of thoracolumbar spine, which worsens slightly on repetitive use. ROM examination shows forward flexion of 0 to 80, extension of 0 to 20, left lateral flexion 0 to 30, right lateral flexion 0 to 30, left lateral rotation 0 to 20, and right lateral rotation of 0 to 20. After three repetitions of ROM, all the ranges of motion are about 5 degrees less. There is no tenderness or spasm of the thoracolumbar area. Straight leg raising and reflexes are normal.
  - X-rays: Thoracolumbar spine X-rays show small osteophytes of the lower thoracic vertebrae and all the lumbar vertebrae with mild narrowing of the L5-S1 disc space.
- **Medical Literature:** Peer-reviewed articles discussing the complications of cervical strains and the most common risk factor for osteoarthritis
  - Hudgins, T. H., et al. (2008). Cervical Sprain or Strain. In Frontera, W. R., Silver, J. K., & Rizzo, T. D. (Eds.), Essentials of Physical Medicine and Rehabilitation (2nd ed., pp. 372-376). Philadelphia, PA: Saunders.
  - Mayo Clinic Staff. (2021). Osteoarthritis: Symptoms and causes. Mayo Clinic.

Retrieved from https://www.mayoclinic.org/diseases-conditions/osteoarthritis/symptoms-causes/syc-20351925

Medical Opinion with Rationale Provided:

SECTION IV - MEDICAL OPINION FOR SECONDARY SERVICE CONNECTION
☐ 4A. The claimed condition is 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 the Veteran's service connected condition. Provide rationale in Section C.
☒ 4B. The claimed condition is less likely than not (likelihood is less than approximately balanced or nearly equal) proximately due to or the result of the Veteran's service connected condition. Provide rationale in Section C.

4C. Rationale:

Based on the review of records, the Veteran's low back pain, diagnosed as degenerative joint disease (DJD) of the lumbar spine, is less likely than not related to or caused by his service connected cervical strain. The cited medical literature identifies older age, obesity, and occupations involving repetitive stress on the lumbar joints as common risk factors for DJD of the lumbar spine and does not support a causal relationship between cervical strain and the development of DJD in the lumbar spine (Hudgins et al., 2008) and (Mayo Clinic Staff, 2021). The Veteran possesses multiple risk factors for DJD of the lumbar spine: he is in his 70s, obese, and has a history of working in construction, an occupation that places significant repetitive stress on the lumbar spine. Based on these risk factors, which is supported by the medical literature , it is concluded that the Veteran's DJD of the lumbar spine is less likely attributable to his service-connected cervical strain.

MEDICAL DISABILITY EXAMINATION OFFICE
VETERANS BENEFITS ADMINISTRATION



Aggravation of a Condition That Existed Prior to Service



This is Mr. John Steadman. He is an Army Veteran, who served from 2000 to 2004 and has had one deployment to Iraq. When he enlisted, it was documented on his entrance examination that he had flat feet. Although he clearly had this condition before entering active duty, he believes that it has worsened because of his military service. Has it?

Exam Scheduling Request (ESR) for Aggravation of a Condition That Existed Prior to Service:

Was the Veteran's bilateral flat feet (which clearly and unmistakably existed prior to service), aggravated beyond its natural progression by long marches and training exercises during service?

Your review is not limited to the evidence identified on this request form or tabbed in the claims folder. If an examination or additional testing is required, obtain them prior to rendering your opinion. Rationale must be provided in the appropriate section.

Examiner Reviewed the Following Evidence:

- **Application for Disability Compensation and Related Compensation Benefits (VA Form 526EZ):** Received on January 2, 2020 for claimed condition of bilateral flat feet
- **DD214:** Service from August 6, 2000 to September 30, 2004
- **Service Treatment Records (STRs):**
    - Entrance Exam: Dated August 1, 2000 showing mild bilateral flexible pes planus, normal variant with no functional limitations documented

- Treatment: Complaints of bilateral feet pain which increases following long road marches and field training exercises
- Separation Exam: Dated September 20, 2004 showed moderate bilateral pes planus, mild pronation bilateral and positive for pain in both feet documented

- **Post-Service Treatment Records:** Treatment from a podiatrist for on-going bilateral foot pain since leaving service and was prescribed orthotics, which have not resolved his symptoms of pain
- **Physical Examination Findings -** Foot Conditions, Including Flatfoot (Pes Planus) DBQ
  - Diagnosis: Exam diagnosed the Veteran with bilateral pes planus
  - Physical exam:
    - Loss of longitudinal arch of feet
    - Moderate pronation of feet with bowing of the Achilles tendon
    - Mild pain of feet during manipulation
    - Calluses noted under heels and metatarsal heads bilaterally
    - Bilaterally palpable pedal pulses
  - X-rays: shows positive DJD of first metatarsal joints, Hallux valgus bilaterally and loss of longitudinal arch of feet
- **Medical Literature:** Peer-reviewed article describing the natural progression of flatfeet and activities that could aggravate symptoms related to pes planus
  - Raj, M. A., & Russo, M. (2021). Pes Planus. In StatPearls. StatPearls Publishing. Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK537084/

Medical Opinion with Rationale Provided:

SECTION V - MEDICAL OPINION FOR AGGRAVATION OF A CONDITION THAT EXISTED PRIOR TO SERVICE
☒ 5A. The claimed condition, which clearly and unmistakably existed prior to service, was aggravated beyond its natural progression by an in-service injury, event, or illness. Provide rationale in Section C.
☐ 5B. The claimed condition, which clearly and unmistakably existed prior to service, was clearly and unmistakably not aggravated beyond its natural progression by an in-service injury, event, or illness. Provide rationale in Section C.

5C. Rationale:

Based on the review of records, the Veteran's bilateral flat feet (pes planus) were documented as mild and asymptomatic during the entrance examination in August 2000. Throughout his service, the Veteran experienced and reported increasing pain in his feet following long marches and field training exercises, which were consistently documented in his Service Treatment Records (STRs). His separation examination in September 2004 revealed a progression to moderate pes planus with mild

pronation and significant pain. Post-service records indicate ongoing treatment for persistent foot pain and the use of orthotics, which did not fully alleviate symptoms. Peer-reviewed medical literature supports that pes planus condition can progress beyond its natural course due to physically demanding activities similar to long marches and military training (Raj & Russo, 2021). Consequently, it is determined that the Veteran's bilateral flat feet condition, which clearly and unmistakably existed at the time of military enlistment, was aggravated beyond its natural progression by in-service activities.

MEDICAL DISABILITY EXAMINATION OFFICE
VETERANS BENEFITS ADMINISTRATION



Aggravation of a Condition That Existed Prior to Service



This is Mr. Simon Marcus, a Veteran who served in the Army as a photographer. Before enlisting in the military, Mr. Marcus was diagnosed with aortic stenosis; however, it was not noted on his military entrance exam. He believes that his heart condition worsened as a result of his military service. Has it?

Examination Scheduling Request (ESR) for Aggravation of a Condition That Existed Prior to Service:

Was the Veteran's aortic valve replacement and aortic stenosis (which clearly and unmistakably existed prior to service), aggravated beyond its natural progression by his military duties during service?

Your review is not limited to the evidence identified on this request form or tabbed in the claims folder. If an examination or additional testing is required, obtain them prior to rendering your opinion. Rationale must be provided in the appropriate section.

Examiner Reviewed the Following Evidence:

- **Application for Disability Compensation and Related Compensation Benefits (VA Form 526EZ):** Received on May 10, 2021, for claimed condition of aortic valve replacement and aortic stenosis
- **DD214:** June 17, 1990 to June 16, 1994

- **Pre-Service Treatment Records (received with 526EZ):** Private treatment records, prior to enlistment, showed the Veteran underwent an annual physical by his primary care physician. During this encounter, an echocardiogram was completed on February 1, 1988 showing mild aortic stenosis, normal wall thickness and wall motion of left ventricle, and normal systolic and diastolic function. The aortic valve area was noted as 1.9 square centimeters, and the diagnosis was mild aortic stenosis. His primary care provider recommended him to follow-up with a Cardiologist.
- **Service Treatment Records (STRs):**
    - Entrance Exam: Dated June 17, 1990 showed no heart issues
    - Treatment: Note dated September 12, 1992 showed one incident of shortness of breath and lightheadedness during military service, which was attributed to mild dehydration after being out in the heat for a prolonged time
    - Separation Exam: Dated June 16, 1994 showed no heart issues
- **Post-Service Treatment Records:**
    - Did not develop symptoms until five years after being discharged from his service
    - Started experiencing difficulty breathing with exercise and was found to have progression of his aortic stenosis
    - Subsequently underwent aortic valve replacement in 2013
- **Physical Examination Findings -** Heart Conditions DBQ
    - Diagnosis: Confirmed diagnosis of aortic stenosis treated with aortic valve replacement
    - Physical Examination: Physical exam coincides with the findings of the Cardiologist report from the aortic valve replacement in 2013.
- **Medical Literature:** Peer-reviewed articles describing the natural progression of aortic stenosis, to include causes and onset of disease and activities that could aggravate it
    - Lindman, B. R., & Bonow, R. O. (2019). Aortic valve disease. In D. P. Zipes, P. Libby, R. O. Bonow, D. L. Mann, & G. F. Tomaselli (Eds.), Braunwald's Heart Disease: A Textbook of Cardiovascular Medicine (11th ed., pp. 1389-1414). Elsevier.
    - Brener, S. J., Duffy, C. I., Thomas, J. D., & Stewart, W. J. (1995). Progression of aortic stenosis in 394 patients: Relation to changes in myocardial and mitral valve dysfunction. Journal of the American College of Cardiology, 25(2), 305-310. https://doi.org/10.1016/0735-1097(94)00361-N

Medical Opinion with Rationale Provided:

SECTION V - MEDICAL OPINION FOR AGGRAVATION OF A CONDITION THAT EXISTED PRIOR TO SERVICE
☐ 5A. The claimed condition, which clearly and unmistakably existed prior to service, was aggravated beyond its natural progression by an in-service injury, event, or illness. Provide rationale in Section C.
☒ 5B. The claimed condition, which clearly and unmistakably existed prior to service, was clearly and unmistakably not aggravated beyond its natural progression by an in-service injury, event, or illness. Provide rationale in Section C.

5C. Rationale:

Based on the review of records, the Veteran had no significant recurrence of cardiac/respiratory symptoms during service that would indicate an aggravation of the condition beyond its natural progression. The only complaint during service was likely due to mild dehydration and was not indicative of a worsening heart condition. The timeline and clinical findings all support that the Veteran's aortic valve replacement and aortic stenosis did not result from military-related aggravation of his pre-existing heart condition. The Veteran's heart condition progressed in severity over time at an expected, typical rate according to medical literature on the natural history of aortic stenosis (Brener et al., 1995) and (Lindman & Bonow, 2019). Given the evidence and the medical understanding of aortic stenosis, it can be concluded that the Veteran's condition was not aggravated by his military service and is the expected result of his diagnosed condition.

MEDICAL DISABILITY EXAMINATION OFFICE
VETERANS BENEFITS ADMINISTRATION



Aggravation of a Nonservice Connected Condition by a Service Connected Condition



This is Ms. Mary Hoffman, a Veteran who served in the Air Force from April 1970 to May 1973, including one deployment to Udon Royal Thai Air Base. She was diagnosed with a chronic kidney condition not related to her military service. Later, she developed and was service connected for diabetes, and her previously controlled kidney condition worsened. She believes that her kidney condition has become more severe because of her service connected diabetes. Has it?

Exam Scheduling Request (ESR) for Aggravation of a Nonservice Connected Condition by a Service Connected Condition:

- Can you determine a baseline severity of the chronic kidney condition based upon medical evidence available prior to aggravation or the earliest medical evidence following aggravation by diabetes mellitus?
- Is the current severity of the chronic kidney condition greater than the baseline?
- If yes, was the chronic kidney condition at least as likely as not aggravated beyond its natural progression by the service connected diabetes?

Your review is not limited to the evidence identified on this request form or tabbed in the claims folder. If an examination or additional testing is required, obtain them prior to rendering your opinion. Rationale must be provided in the appropriate section.

Examiner Reviewed the Following Evidence:

- **Application for Disability Compensation and Related Compensation Benefits (VA Form 526EZ):** Received on October 1, 2022, claim for chronic kidney condition
- **Rating decision:** Dated December 18, 2015, service connection granted for Diabetes Mellitus Type II
- **DD214:** Service from April 19, 1970 to May 20, 1973
- **Service Treatment Records (STRs):**
    - Entrance Exam: Dated April 19, 1970 showed no complaints
    - Treatment Notes: No relevant in-service medical records
    - Separation Exam: Dated May 20, 1973 showed no complaints
- **Post-Service Treatment Records:**
    - In 2005 diagnosed with stage one chronic kidney disease BMI 35, BP 120/70. Annual physical at PCP office otherwise normal. Lab work revealed Cr 1.5 mg/dL, BUN 27 mg/dL, eGFR 90 mL/min, and UA with Tr Prot, Tr Blood. Ultrasound of kidneys revealed 2cm cyst in right kidney (benign)
    - From 2007-2012 BP was stable, lost 20 lb. Labs in 2012 were Cr 1.5 mg/dL, BUN 29 mg/dL, eGFR 90mL/min, and UA 1+ Prot, Tr Blood
    - In 2013 BMI 34, BP 122/72. Labs were: Cr 1.5 mg/dL, BUN 32 mg/dL, eGFR 80 mL/min; UA 1+ Prot. Spot urine microalbumin negative. Referred to nephrologist for persistently elevated kidney function
    - In 2015 diagnosed with Diabetes Mellitus Type II and was placed on treatment with liraglutide (GLP-1). BMI 33, BP 124/74. Labs: A1c 7.5, Cr 1.7 mg/dL, BUN 40 mg/dL, eGFR 70 mL/min, UA 1+ Gluc/ 1+Prot/Tr Ket
    - In 2016 labs were: A1c 7.1, Cr 1.6 mg/dL, BUN 30 mg/dL, eGFR 70 mL/min, UA 1+ Protein
    - In 2017 labs were: A1c 7.0, Cr 1.7 mg/dL, BUN 32 mg/dL, eGFR 65 mL/min, UA 1+ Protein
    - In 2018 labs were: A1c 7.1, Cr 1.5 mg/dL, BUN 33 mg/dL, eGFR 65 mL/min, Urine 1+ Protein, Spot Alb/Cr 30mg/g
- **Physical Examination Findings:** - Kidney (Nephrology)Disability Benefit Questionnaire
    - Labs were: A1c 7.1, Cr 1.5 mg/dL, BUN 33 mg/dL, eGFR 60 mL/min, Urine 1+ Protein, Spot Alb/Cr 30mg/g
    - Diagnosis: Veteran diagnosed with Stage 2 chronic kidney disease (CKD)

- **Medical Literature:** Peer-reviewed articles showing that diabetes is a major cause of kidney disease, with nearly a third of diabetics developing diabetic nephropathy.
    - Hall, J. E., Henegar, J. R., Dwyer, T. M., Liu, J., Da Silva, A. A., Kuo, J. J., & Tallam, L. (2004). Is obesity a major cause of chronic kidney disease? Advances in Renal Replacement Therapy, 11(1), 41-54. https://doi.org/10.1053/j.arrt.2003.10.007
    - Mayo Clinic Staff. (2022). Diabetic nephropathy (diabetic kidney disease): Symptoms and causes. Mayo Clinic. Retrieved from https://www.mayoclinic.org/diseases-conditions/diabetic-nephropathy/symptoms-causes/syc-20354556

Medical Opinion with Rationale Provided:

SECTION VI - MEDICAL OPINION FOR AGGRAVATION OF A NONSERVICE CONNECTED CONDITION BY A SERVICE CONNECTED CONDITION

6A. Can you determine a baseline level of severity of (claimed condition/diagnosis) based upon medical evidence available prior to aggravation or the earliest medical evidence following aggravation by (service connected condition)?

(•) Yes ( ) No

If "Yes" to question 6A, answer the following:

I. Describe the baseline level of severity of (claimed condition/diagnosis) based upon medical evidence available prior to aggravation or the earliest medical evidence following aggravation by (service connected condition):

II. Provide the date and nature of the medical evidence used to provide the baseline:

III. Is the current severity of the (claimed condition/diagnosis) greater than the baseline?

(•) Yes ( ) No

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

(•) Yes (provide rationale in Section 6B.)

( ) No (provide rationale in Section 6B.)

I. The baseline severity of the chronic kidney condition can be established from pre-aggravation records. Baseline (pre-DM II) lab results show Cr 1.5-1.7 mg/dL, BUN 27-32 mg/dL, eGFR 70-90 mL/min, UA 1+ Prot with a diagnosis of Stage 1 CKD. Prior to diabetes diagnosis, the Veteran's CKD was stable based on consistent laboratory values and clinical evaluations. Currently (post-DM II) the labs results show Cr 1.5-1.7 mg/dL, BUN 30-33 mg/dL, eGFR 60-70 mL/min, UA 1+ Prot, diagnosis of Stage 2 CKD. With the current eGFR

at 60 mL/min compared to 70 mL/min during the DM II diagnosis year (2015), it suggests a progression in CKD severity. Current lab findings show an increase in CR and BUN levels, and a decrease in eGFR, which indicates a worsening kidney function beyond the naturally expected progression for someone with stable CKD stage 1.

II. Laboratory records from 2005-2015

6B. Provide Rationale:

Medical Literature supports that diabetes is a leading cause of kidney disease, often leading to diabetic nephropathy in nearly a third of diabetic patients (Mayo Clinic Staff, 2022). The abrupt change in CKD status coinciding with the onset of diabetes mellitus, combined with BMI and BP levels that were previously controlled, suggests that diabetes has likely exacerbated the progression of CKD. While obesity is also a risk factor (Hall et al., 2004), the Veteran's CKD was stable prior to diabetes onset, indicating that diabetes played a significant role in aggravation. The renal function decline post-diabetes diagnosis, indicated by significantly worse laboratory results, is consistent with patterns observed due to the progression of kidney disease. Therefore, the claimed condition of chronic kidney disease was at least as likely as not aggravated beyond its natural progression by the service-connected diabetes mellitus type 2.

MEDICAL DISABILITY EXAMINATION OFFICE
VETERANS BENEFITS ADMINISTRATION



Aggravation of a Nonservice Connected Condition by a Service Connected Condition



This is Mr. Dale Willow, a Vietnam Era Veteran who served as a clerk in the U.S. Army from 1968 to 1970, including one deployment to Vietnam. After service, he worked in construction until he retired. He is service connected for a cervical spine condition. He has a diagnosis of degenerative joint disease (DJD) of the lumbar spine that was found not to be related to his military service or secondary to his service connected cervical spine condition. He filed a new claim stating that his lower back pain became more severe because of his cervical spine condition. Has it?

Exam Scheduling Request (ESR) for Aggravation of a Nonservice Connected Condition by a Service Connected Condition:

- Can you determine a baseline severity of the degenerative joint disease (DJD) of the lumbar spine (claimed as lower back pain) based upon medical evidence available prior to aggravation or the earliest medical evidence following aggravation by the cervical spine condition?
- Is the current severity of the degenerative joint disease (DJD) of the lumbar spine (claimed as lower back pain) greater than the baseline?
- If yes, was the Veteran's degenerative joint disease (DJD) of the lumbar spine (claimed as lower back pain) at least as likely as not aggravated beyond its natural progression by the service connected cervical spine strain?

Your review is not limited to the evidence identified on this request form or tabbed in the claims folder. If an examination or additional testing is required, obtain them prior to rendering your opinion. Rationale must be provided in the appropriate section.

Examiner Reviewed the Following Evidence:

- **Application for Disability Compensation and Related Compensation Benefits (VA Form 526EZ):** Received on July 5, 2023, for claimed condition of lower back pain aggravated by service connected cervical spine condition
- **Rating Decision:**
  - Dated June 20, 2021, service connection granted for Cervical Strain
  - Dated September 5, 2021, service connection is denied for degenerative joint disease (DJD) of the lumbar spine (claimed as low back pain secondary to cervical strain) on a secondary and direct basis
- **DD214:** Service from August 6, 1968 to September 30, 1970
- **Service Treatment Records (STRs):**
  - Entrance Exam: Dated August 6, 1968 showed no lower back complaints
  - Treatment Notes: No relevant in-service medical records
  - Separation Exam: Dated September 30, 1970 showed no lower back complaints
- **Post-Service Treatment Records:**
  - Chiropractic records in April and May 2011 documents low back pain for several years. These records show that he has mild tenderness over lower lumbar spine, with pain at extremes of motion. Mildly limited motion. X-rays show degenerative joint disease at L5-S1 with disc space narrowing and minor osteophytes of other lumbar vertebrae.
  - Treatment provider diagnosis: Lumbar spondylosis with facet joint dysfunction. Treatment: Spinal adjustments L5, with moderate relief noted.
- **Physical Examination Findings -** Back (Thoracolumbar Spine) Conditions DBQ**:**
  - Diagnosis: Exam diagnosed the Veteran with degenerative joint disease (DJD) of the lumbar spine
  - Medical history: Veteran states that he has had more or less steady low back pain, with gradual worsening, over the past 12 years. The pain is worse after heavy lifting or with other back exertion. Pain does not radiate. He feels that his service connected cervical condition is related to his low back pain and makes it worse. His first medical visit for low back pain was to a chiropractor in 2011. He received several spinal adjustments,

resulting in some relief of pain. However, the low back pain continued and is now worse than it has ever been. He has no leg pain.

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

- **Medical Literature:** Peer-reviewed articles discussing the complications of cervical strains and the most common risk factor for osteoarthritis
  - Hudgins, T. H., et al. (2008). Cervical Sprain or Strain. In Frontera, W. R., Silver, J. K., & Rizzo, T. D. (Eds.), Essentials of Physical Medicine and Rehabilitation (2nd ed., pp. 372-376). Philadelphia, PA: Saunders.
  - Mayo Clinic Staff. (2021). Osteoarthritis: Symptoms and causes. Mayo Clinic. Retrieved from https://www.mayoclinic.org/diseases-conditions/osteoarthritis/symptoms-causes/syc-20351925

Medical Opinion with Rationale:

SECTION VI - MEDICAL OPINION FOR AGGRAVATION OF A NONSERVICE CONNECTED CONDITION BY A SERVICE CONNECTED CONDITION

6A. Can you determine a baseline level of severity of (claimed condition/diagnosis) based upon medical evidence available prior to aggravation or the earliest medical evidence following aggravation by (service connected condition)?

(•) Yes ( ) No

If "Yes" to question 6A, answer the following:

I. Describe the baseline level of severity of (claimed condition/diagnosis) based upon medical evidence available prior to aggravation or the earliest medical evidence following aggravation by (service connected condition):

II. Provide the date and nature of the medical evidence used to provide the baseline:

III. Is the current severity of the (claimed condition/diagnosis) greater than the baseline?

(•) Yes ( ) No

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

( ) Yes (provide rationale in Section 6B.)

(•) No (provide rationale in Section 6B.)

I. Baseline Severity of Degenerative Joint Disease (DJD) of the Lumbar Spine: The earliest post-service documentation of lower back pain is from Chiropractic records in April and May 2011, where the Veteran was noted to have mild tenderness over the lower lumbar spine, mild limitations in motion, and X-ray evidence of DJD at L5-S1 with disc space narrowing. As per the most recent physical examination findings, the Veteran's back pain has progressively worsened over the past 12 years, with moderately limited ranges of motion and some pain noted during extreme ranges. The Veteran's cervical strain is stable with no arthritic changes.

II. Medical Evidence was used from Chiropractic records dated April and May 2011.

6B. Provide Rationale:

The Veteran's current severity of lumbar spine DJD is not aggravated beyond its natural progression by the service-connected cervical spine strain. There is no evidence or medical literature to substantiate that a cervical strain could worsen lumbar spine DJD. Based on the medical literature, the DJD of the lumbar spine tends to worsen over time due to natural aging and/or repetitive injury (Hudgins et al., 2008) and (Mayo Clinic Staff, 2021). The Veteran's DJD is more likely due to factors such as age, obesity, and occupational history (construction work). Based on review of the entire evidence of record and considering the chronology of symptoms and medical evaluations, the current assessment does not support the claim of aggravation.

'MDE | Military Sexual Trauma (MST) Final Assessment' assessment

Question 1 of 17

Which of the following is a good example of trauma-sensitive documentation for an MST claim exam?

- Use biased and judgmental language.
- Use terms like “alleged”.
- Use judgmental language, like, “The Veteran’s account was not believable.”
- Avoid judgmental statements like, “the service member did not fight off the perpetrator.”

Correct Feedback *(Only on the final attempt)*

That is correct! You should avoid judgmental statements in your documentation of a MST claim exam.

Incorrect Feedback *(Only on the final attempt)*

That is not correct. A good example of trauma-sensitive documentation for an MST claim is to avoid judgmental statements in your documentation.

Question 2 of 17

Which of the following does the VA recognize as part of a trauma-sensitive exam?

- Good practice is to assume the Claimant has not experienced trauma.
- Good practice is to conduct all VA Compensation and Pension C&P examinations in a trauma-sensitive manner.
- Good practice is to assume that the Claimant reported the MST while in service.
- Good practice is to refuse to address the Claimant directly during the MST exam.

Correct Feedback *(Only on the final attempt)*

That is correct! Good practice is to conduct all VA Compensation and Pension (C&P) examinations in a trauma-sensitive manner.

Incorrect Feedback *(Only on the final attempt)*

That is not correct. Good practice is to conduct all VA Compensation and Pension (C&P) examinations in a trauma-sensitive manner.

Question 3 of 17

Which of the following words does the VA use to describe potential evidence, indirect in nature, that may be found in an e-folder of someone who claims MST?

- Marker
- Label
- Report
- Accusation

Correct Feedback *(Only on the final attempt)*

That is correct! The VA uses the term marker to describe potential evidence, indirect in nature, that may be found in an e-folder of someone who claims MST.

Incorrect Feedback *(Only on the final attempt)*

That is not correct. The VA uses the term marker to describe potential evidence, indirect in nature, that may be found in an e-folder of someone who claims MST.

Question 4 of 17

Which of the following is a possible drawback to seeking service connection for MST?

- Financial assistance
- Having to disclose MST to an unknown examiner
- Potential for validation
- Acknowledgement of the traumatic experience

Correct Feedback *(Only on the final attempt)*

That is correct! Having to disclose MST to a stranger is seen as a possible drawback.

Incorrect Feedback *(Only on the final attempt)*

That is not correct. Financial assistance is seen as a possible benefit to seeking service connection for MST. Having to disclose MST to an unknown examiner (i.e., stranger) is seen as a possible drawback.

Question 5 of 17

Which of the following is a true statement about MST?

- Someone has to be convicted of assault for MST to have occurred.
- MST does not happen to men.
- Sexual assault and chronic sexual harassment occur across all ranks.

- If a person does not fight or refuse their perpetrator, they must have consented.

Correct Feedback *(Only on the final attempt)*

That is correct! Sexual assault and chronic sexual harassment does occur across all ranks.

Incorrect Feedback *(Only on the final attempt)*

That is not correct. In fact, the majority of perpetrators of MST are never reported or convicted. The correct answer is C, sexual assault and chronic sexual harassment occur across all ranks.

Question 6 of 17

MST can have a strong impact on physical health and is associated with higher rates of headaches, gastrointestinal difficulties, sexual dysfunction, chronic pain, and chronic fatigue.

- True
- False

Correct Feedback *(Only on the final attempt)*

True: That is correct! MST can have a strong impact on physical health and is associated with higher rates of headaches, gastrointestinal difficulties, sexual dysfunction, chronic pain, and chronic fatigue.

Incorrect Feedback *(Only on the final attempt)*

False: That is not correct. MST can have a strong impact on physical health, including higher rates of headaches, gastrointestinal difficulties, sexual dysfunction, chronic pain, and chronic fatigue.

Question 7 of 17

True or False: the DoD recognizes MST and uses the same terminology as the VA.

- True
- False

Correct Feedback *(Only on the final attempt)*

False: That is correct! The DoD uses the separate terms sexual assault and/or sexual harassment.

Incorrect Feedback *(Only on the final attempt)*

True: That is not correct. The DoD does not use the term MST and therefore not all Active Duty Service members will recognize the term. The DoD uses the separate terms sexual assault and/or sexual harassment.

Question 8 of 17

If a Service member discloses MST during a SHA exam and agrees with having the incident documented in the SHA, which suggestion is correct for documenting MST in the examination report?

- a. If physical residuals exist, document the residuals and include a statement reflecting how the physical residuals may be related to the MST experience.
- b. If the Service member has not filed a report with the military, be careful how you document the MST incident (do not include specifics) to protect the Service member's privacy such as simply documenting, "Assault happened while stationed at [location], no physical residuals."
- c. Never include direct quotations from the Service member.
- d. a and b only

Correct Feedback *(Only on the final attempt)*

That is correct! If a Service member discloses MST during a SHA exam and agrees with having the incident documented in the SHA, if physical residuals exist, document the residuals and include a statement reflecting how the physical residuals may be related to the MST experience. Also if the Service member has not filed a report with the military, be careful how you document the MST incident (do not include specifics) to protect the Service member's privacy such as simply documenting, "Assault happened while stationed at [location], no physical residuals." C is incorrect as examiners should include direct quotations from the Service member, when possible.

Incorrect Feedback *(Only on the final attempt)*

That is only partially correct. The correct answer is a and b only. If a Service member discloses MST during a SHA exam and agrees with having the incident documented in the SHA, if physical residuals exist, document the residuals and include a statement reflecting how the physical residuals may be related to the MST experience. Also if the Service member has not filed a report with the military, be careful how you document the MST incident (do not include specifics) to protect the Service member's privacy such as simply documenting, "Assault happened while stationed at [location], no physical residuals." C is incorrect as examiners should include direct quotations from the Service member, when possible.

Question 9 of 17

True or False: When reporting a sexual assault to DoD, service members have the option of filing either a restricted report or an unrestricted report. A restricted report is used by Service members who wish to confidentially disclose the incident to specifically identified individuals without triggering the official investigative process or notification to command. An unrestricted report is used by Service members to disclose the incident to DoD authorities who will investigate it and notify those in command.

- True
- False

Correct Feedback *(Only on the final attempt)*

True: That is correct! When reporting a sexual assault to DoD, service members have the option of filing either a restricted report or an unrestricted report. A restricted report is used by Service members who wish to confidentially disclose the incident to specifically identified individuals without triggering the official investigative process or notification to command. An unrestricted report is used by Service members to disclose the incident to DoD authorities who will investigate it and notify those in command.

Incorrect Feedback *(Only on the final attempt)*

False: That is not correct. When reporting a sexual assault to DoD, service members have the option of filing either a restricted report or an unrestricted report. A restricted report is used by Service members who wish to confidentially disclose the incident to specifically identified individuals without triggering the official investigative process or notification to command. An unrestricted report is used by Service members to disclose the incident to DoD authorities who will investigate it and notify those in command.

Question 10 of 17

Although you express concerns for a Service member's confidentiality, a Service member may still choose to disclose MST to you during a SHA exam. When this happens, how should you respond?

- Stop the examination.
- Respond in a way that conveys empathy but gently limit the depth of disclosure.
- Refuse to hear the disclosure in order to protect the Service member's confidentiality.
- Insist that only DoD personnel should hear the disclosure.

Correct Feedback *(Only on the final attempt)*

That is correct! You should respond in a way that conveys empathy but gently limit the depth of the disclosure because giving you a detailed account may distress the Service member. If the Service member prefers not to disclose to DoD or call the Safe Helpline for support, that is not a reason to stop the examination. While you should caution the Service member about confidentiality concerns, you do not need to refuse a disclosure and you should not insist that the Service member disclose to DoD.

Incorrect Feedback *(Only on the final attempt)*

That is not correct. You should respond in a way that conveys empathy but gently limit the depth of the disclosure because giving you a detailed account may distress the Service member. If the Service member prefers not to disclose to DoD or call the Safe Helpline for support, that is not a reason to stop the examination. While you should caution the Service member about confidentiality concerns, you do not need to refuse a disclosure and you should not insist that the Service member disclose to DoD.

Question 11 of 17

True or False: The documentation from a Separation Health Assessment becomes part of a Service member's service treatment records.

- True
- False

Question 12 of 17

An empathetic, supportive response has the power to be tremendously healing. There are many effective things you can say to respond sensitively when a Veteran shares with you that they experienced MST. Which response below should you avoid?

- "I'm very sorry this happened to you."
- "I'm not sure anyone will believe you."
- "There are many services and treatments available to help you in your recovery, if you need them."
- "Thank you for deciding to share this information today."

Correct Feedback *(Only on the final attempt)*

That is correct! "I'm not sure anyone will believe you" is the statement that is not a sensitive response; therefore, it should be avoided. The other three statements are examples of sensitive responses.

Incorrect Feedback *(Only on the final attempt)*

That is not correct. “I’m not sure anyone will believe you” is the statement that is not a sensitive response; therefore, it should be avoided. The other three statements are examples of sensitive responses.

Question 13 of 17

Examiners should follow one of the four suggestions below when conducting a trauma-sensitive exam. Which is correct?

- Avoid eye contact with the Service member or Veteran.
- Don’t explain your reasons for questions you ask.
- Don’t provide the Veteran or Service member options and choices.
- Be transparent, explaining your reasoning for questions.

Correct Feedback *(Only on the final attempt)*

That is correct! Being transparent and explaining your reasoning for questions is one way of reducing the power differential as part of a trauma-sensitive examination. Other trauma-sensitive practices include making eye contact, having conversations while the examinee is fully dressed, and providing the Veteran or Service member with options and choices.

Incorrect Feedback *(Only on the final attempt)*

That is not correct. Being transparent and explaining your reasoning for questions is one way of reducing the power differential as part of a trauma-sensitive examination. Other trauma-sensitive practices include making eye contact, having conversations while the examinee is fully dressed, and providing the Veteran or Service member with options and choices.

Question 14 of 17

Which of the following suggestions applies if a Veteran discloses an MST experience during a VA examination?

- Prevent any disclosure altogether.
- Solicit a detailed account and process the experience.
- Ignore any discomfort.
- Use trauma informed methods.

Correct Feedback *(Only on the final attempt)*

That is correct! A claimant may volunteer basic information during an examination. As a VA examiner, your role is neither to prevent any disclosure altogether, nor to solicit a detailed account and process the experience. You should not ignore discomfort, but rather, you should use trauma-sensitive methods to collect the information needed and reserve discussion and processing the trauma for ongoing treatment with an established mental health provider with expertise in trauma-related issues.

Incorrect Feedback *(Only on the final attempt)*

That is not correct. A claimant may volunteer basic information during an examination. As a VA examiner, your role is neither to prevent any disclosure altogether, nor to solicit a detailed account and process the experience. You should not ignore discomfort, but rather, you should use trauma-sensitive methods to collect the information needed and reserve discussion and processing the trauma for ongoing treatment with an established mental health provider with expertise in trauma-related issues.

Question 15 of 17

Which of the following is false regarding seeking MST-related health care from VA facilities?

- Individuals do not need to have reported their experience of MST to the authorities at the time it occurred.
- There is no required timeframe to initiate MST-related care after their MST experience.
- Individuals must be service connected (VA disability compensation) to receive MST-related care.
- Individuals do not need to have documentation that the MST occurred to receive MST-related care.

Correct Feedback *(Only on the final attempt)*

That is correct! The statement that individuals must be service connected to receive MST-related care is false. Individuals do not need to be service connected in order to receive MST-related care from VHA facilities. The other three statements are true because individuals do not need to have reported their experiences of MST or have documentation that the MST occurred in order to received MST-related care from VHA facilities, and there is no required timeframe to initiate MST-related care after their MST experience.

Incorrect Feedback *(Only on the final attempt)*

That is not correct. The statement that individuals must be service connected to receive MST-related care is false. Individuals do not need to be service connected in order to receive MST-related care from VHA facilities. The other three statements are true because individuals do not need to have reported their experiences of MST or have documentation that the MST occurred in order to received MST-related care from VHA facilities, and there is no required timeframe to initiate MST-related care after their MST experience.

Question 16 of 17

True or False: Military Sexual Trauma (MST) is recognized as a diagnosis by the VA.

- True
- False

Correct Feedback *(Only on the final attempt)*

That is correct! MST is an experience, not a diagnosis.

Incorrect Feedback *(Only on the final attempt)*

That is not correct. MST is an experience, not a diagnosis.

Question 17 of 17

True or False: Current Service members can receive free, confidential MST-related counseling at the Veterans Health Administration (VHA) Vet Centers, regardless of duty status.

- True
- False

Correct Feedback *(Only on the final attempt)*

That is correct! Current Service members can receive free, confidential MST-related counseling at VHA's Vet Centers, regardless of duty status.

Incorrect Feedback *(Only on the final attempt)*

That is not correct. The correct answer is true. Current Service members can receive free, confidential MST-related counseling at VHA's Vet Centers, regardless of duty status.

Military Sexual Trauma Examiner Job Aid

Purpose

The purpose of this Job Aid is to support mental health examiners in the completion of high-quality Disability Benefits Questionnaires (DBQs) and medical opinions related to Military Sexual Trauma (MST) by reviewing current VA definitions, identifying best practices, and providing checklists of important reminders for examiners to consider when completing MST-related examinations.

Audience

This Job Aid is for mental health examiners conducting Compensation and Pension (C&P) disability examinations for conditions claimed as related to MST.

Guidance

For the purposes of disability compensation claims, the Veterans Benefits Administration defines personal trauma and military sexual trauma as follows:

- **Personal trauma** refers broadly to stressor events involving harm perpetrated by a person who is not considered part of an enemy force.
  Examples: assault, battery, robbery, mugging, stalking, harassment

- **Military Sexual Trauma** (MST) is a subset of personal trauma and refers to sexual harassment, sexual assault, or rape that occurs during military service.
  Examples: being pressured into sexual activities, non-consensual sexual contact, being physically forced to have sex, unwelcome comments about a service member's body or sexual activities, unwanted sexual advances, being touched or grabbed in a sexual way (including during hazing)



Completing MST-related DBQs and medical opinions can be complex and challenging. By applying a step-by-step approach, examiners can ensure they provide all necessary information. The process can be divided into sequential steps, each supported by a checklist of important reminders. Utilizing these aids ensures high-quality and effective examination reports. Although these best practices are most relevant for MST-related Initial Post Traumatic Stress Disorder (PTSD) DBQs, examiners may find some elements to be useful across different exam types.

Checklists and Important Reminders

The following checklists can be used to assist in capturing the essential components of an MST-related examination.

Review Exam Request

- ☐ Carefully review the exam request and understand what is needed
- ☐ Identify and analyze all requested opinions
- ☐ Make note of any potentially relevant evidence that is specifically listed in the exam request

Review eFolder

- ☐ To understand the stressor, locate and review the Veteran's personal statement (e.g., VA Form 21-0781, VA Form 21-4138)
- ☐ Find and review all evidence that was specifically noted in the exam request as potential marker evidence (e.g., "STRs, page 65, pregnancy test")
- ☐ Independently review the entire eFolder to locate clinically significant information including any additional potential marker evidence (e.g., post-service VA records, civilian police reports, crisis center records or other private medical reports showing behavioral changes)
- ☐ Make note of contextual information such as chronology of potential marker evidence and timeline of significant case details

Document Stressors and Analyze Potential Markers

- ☐ Document all stressors as described by the Veteran, ensuring that multiple stressors are documented separately
- ☐ To the extent possible, with the understanding that the Veteran may not be able to provide additional details, identify time frames and locations of service when the stressor(s) occurred
- ☐ Analyze and assess the potential marker evidence in the context of case details
- ☐ Determine consistency of marker evidence with the nature of the MST experience (e.g., a pregnancy test cannot be a marker of a stressor event if it preceded that stressor and/or the stressor did not include physical contact)
- ☐ Consider: Is the marker evidence clinically informative when considered in chronological, behavioral, or disciplinary contexts?
- ☐ Document marker evidence that supports the occurrence of MST stressor(s) and explain how the markers are connected to the stressor(s)
- ☐ For any potential markers that were identified in the exam request, explain why each item is or is not a marker for this individual's stressor(s)
- ☐ Ensure that all statements regarding the occurrence of stressor(s) are trauma-informed and use unbiased, non-judgmental language
- ☐ REMEMBER: A stressor can meet VA's definition of MST but not meet the threshold for a Criterion A stressor as defined by DSM-5; in such cases, consider potential alternate diagnoses other than PTSD

Provide Requested Opinions

- ☐ Review the exam request and ensure that each requested opinion is addressed separately and is accompanied by a sound, well-supported rationale
- ☐ Use the appropriate legal language and provide clear, consistent, and unequivocal opinions

☐ Apply clinical expertise to provide opinions that are supported by a *synthesis* of all evidence, including subjective and objective data (i.e., reconciling eFolder documentation with the Veteran's self-report)
☐ If the 4-part MST-specific opinion has been requested, ensure that all applicable components have been provided
☐ NOTE: If there is no diagnosis, no medical opinion should be provided (unless the opinion is requested by the Board of Veteran's Appeals, in which case instructions must be followed precisely)

Finalize the DBQ
Confirm that the DBQ:
☐ Addresses all elements of the exam request
☐ Documents review, consideration, and analysis of each item of potentially relevant evidence specifically listed in the exam request
☐ Documents all efforts taken to identify additional potential marker evidence in the eFolder
☐ Clearly describes a rationale for concluding the clinical significance (or lack of clinical significance) for the specific Veteran's case, based on any marker evidence identified in the exam request or through an independent review of the eFolder
☐ Provides sufficient, relevant history to support diagnoses that fully satisfy DSM-5 criteria or, if no diagnosis is rendered, the lack of diagnosis is explained
☐ Provides all requested opinions with clear, well-supported, clinically sound rationales
☐ Is internally consistent across diagnostic criteria, symptoms, impairment, and medical opinions and that all of these areas are based on current status
☐ Uses trauma-informed, unbiased, and non-judgmental language
Conduct a final review for accuracy

MST-related Medical Opinion Components:

Each component of an MST-related medical opinion requires examiners to provide a slightly different opinion depending on the clinical assessment and diagnostic determinations. Provided below is the Examination Scheduling Request (ESR) 4-part MST Opinion Request Text and the requirements of the examiner's response.

1. The examiner is asked to comment on whether the evidence of record corroborates the occurrence of the MST stressor event. Is the evidence of record at least as likely as not (likelihood is at least approximately balanced or nearly equal, if not higher) consistent with the occurrence of the MST stressor event(s)? Please provide a rationale for the opinion and list any evidence used to arrive at your decision.
Examiner response will: Establish whether the marker evidence is consistent with the MST stressor(s).

2. IF YOUR EXAMINATION DETERMINES THE VETERAN HAS A CURRENT DIAGNOSIS OF PTSD, please provide an opinion as to whether the current PTSD diagnosis 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 MST stressor event(s). Please note that PTSD is the only mental health condition that can be service connected solely based on circumstantial marker evidence.
Examiner response will: Confirm a PTSD diagnosis and indicate a *positive* or *negative* nexus between the MST and the PTSD diagnosis.

3. IF YOUR EXAMINATION DETERMINES THAT, IN ADDITION TO PTSD, THE VETERAN HAS ADDITIONAL MENTAL DISORDERS, please state whether the additional mental disorders are at least as likely as not (likelihood is at least approximately balanced or nearly equal, if not higher) secondary to the PTSD and provide a rationale. For each mental disorder diagnosed, identify, and clearly list which symptoms are attributed to each diagnosis. If one or more symptoms overlap and cannot be separated without speculation, please state so and provide a rationale.
Examiner response will: Confirm diagnoses of PTSD *and* one or more additional mental health diagnoses; indicate whether these additional diagnoses are secondary to the PTSD.

4. IF YOUR EXAMINATION DETERMINES THE VETERAN DOES NOT HAVE PTSD BUT HAS A DIFFERENT MENTAL DISORDER(S), please review the claims folder for supporting in-service evidence of the MST stressor(s). If there is in-service evidence supporting the Veteran's statement regarding the stressor, please provide an opinion as to whether the mental disorder(s) diagnosed on examination 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 MST stressor event(s). Please provide a rationale for the opinion and list the evidence used to arrive at your decision.
Examiner response will: Confirm that *no* diagnosis of PTSD is present, but one or more *non-PTSD* diagnoses *are* present; indicate whether there is in-service evidence that supports the stressor(s) and if there is a *positive* or *negative* nexus between the MST and the *non-PTSD* diagnosis.

Important Reminders:

- ☑ Provide a clear and complete understanding of the stressor(s).
- ☑ Explicitly discuss the tabbed/identified records in the DBQ.
- ☑ Discuss any identified markers, their absence, or document efforts to locate potential markers in the DBQ.
- ☑ Sufficiently describe and/or provide a clinical analysis of the potential markers in the DBQ.
- ☑ Include a clear statement on the connection between potential markers and stressor(s) in the DBQ.
- ☑ Identify and address any additional relevant evidence not in the exam request.
- ☑ Sufficiently address medical/clinical history for the condition at issue.
- ☑ Use trauma-informed practices to minimize distress and prioritize the Veteran's well-being. If a Veteran cannot continue with the exam, follow internal protocol for rescheduling the exam and reporting the incident if applicable.

Resources

- Veterans Crisis Line – DIAL 988 then PRESS 1
- Trauma-Informed Communication with Veterans and Service Members Who Have Experienced Military Sexual Trauma (MST)
- Safe Helpline
- Sexual Assault Prevention and Response Office (SAPRO)
- Information For Current and Former Service Members Who Have Experienced Sexual Trauma
- Mental Health – Military Sexual Trauma Overview
- VHA MST Coordinators

PACT Act key Terms & Medical Opinions for Examiners' Assessment

Question 1 of 6

"Synergistic, combined effect" is found in the Medical Opinion for Toxic Exposure Risk Activities and indicates you should:

- consider all TERAs when opining about the relationship between the claimed disability and the in-service events.
- insert canned language into your rationale.
- provide a mere speculation response because research is time consuming.

Correct Feedback

Correct. In a Medical Opinion for Toxic Exposure Risk Activities, you should consider all TERAs when opining about the relationship between the claimed disability and the in-service events.

Canned responses are not acceptable, as the rationale must be unique to the fact specific to each claimant. A medical opinion is only sufficient when supported by a clear, understandable, comprehensive rationale that addresses causation.

Incorrect Feedback

That's incorrect. In a Medical Opinion for Toxic Exposure Risk Activities, you should consider all TERAs when opining about the relationship between the claimed disability and the in-service events.

Canned responses are not acceptable, as the rationale must be unique to the fact specific to each claimant. A medical opinion is only sufficient when supported by a clear, understandable, comprehensive rationale that addresses causation.

Question 2 of 6

Toxic Exposure Risk Activity:

- is limited to specific geographic locations.
- only applies to certain Military Occupational Specialties (MOS).
- may include herbicide exposure, burn pits and other toxins to include fine particulate matter (BPOT).

Correct Feedback

Correct. TERA is **not** limited to specific geographic locations or MOS. TERA may include herbicide exposure, burn pits and other toxins to include fine particulate matter (BPOT).

Incorrect Feedback

That's incorrect. TERA is **not** limited to specific geographic locations or MOS.
TERA **may** include herbicide exposure, burn pits and other toxins to include fine particulate matter (BPOT).

Question 3 of 6

Individual Longitudinal Exposure Record, or ILER is not _____.

- an exposure tracking database that verifies toxic exposure throughout a service member's military service.
- a system that examiners will access.
- a system that VBA claims processors will access and make the records available in the eFolder for examiner review, when such records exist.
- a system that contains records back to the 1990s.

Correct Feedback

That's correct. ILER is not a system that examiners will access. It is an exposure tracking database that verifies toxic exposure throughout a service member's military service.

Incorrect Feedback

VBA claims processors will access ILER and make the records available in the eFolder for examiner review. Examiners will **not **access the ILER system. ILER contains records back to the 1990s.

Question 4 of 6

Click the link to access a mock TERA Memorandum. Review the memo and then select which TERA has NOT been conceded by VBA.

- Herbicide agent
- Exposure per ILER record
- Toxic Exposure – 38 U.S.C. § 1119

Correct Feedback

That's correct. Herbicide agent was not conceded by VBA. Questions 2A and 2B indicate exposure is shown in the ILER Record. Question 4A indicate the exposure is based on a 38 U.S.C. § 1119 location.

Incorrect Feedback

That's incorrect. Herbicide agent has not been conceded by VBA. Questions 2A, 2B and 4A are marked "Yes" on the TERA Memorandum. Questions 2A and 2B indicate exposure is shown in the ILER Record. Question 4A indicate the exposure is based on a 38 U.S.C. § 1119 location.

Question 5 of 6

Using the same TERA Memorandum as the prior question, select the answer that would NOT be the next step you would take in formulating a medical opinion for non-presumptive PACT Act condition.

- Consult the Toxic Exposure Risk Activity (TERA) Memorandum Examiner Job Aid.
- Locate and review the ILER Individual Exposure Summary in the eFolder for specific exposure information.
- Review and consider the two links provided in the TERA Memorandum Job Aid related to military exposures.
- Review and consider the three links provided in the TERA Memorandum Job Aid related to airborne hazards and burn pits.
- Formulate opinion and rationale without review of additional resources.

Correct Feedback

That's correct. You would not formulate opinion and rationale without review of additional resource. Your next steps include consulting the Toxic Exposure Risk Activity (TERA) Memorandum Examiner Job Aid. Based on the conceded exposure, the job aid directs you to locate and review the ILER record, and consider the links provided related to both military exposures and airborne hazards and burn pits

Incorrect Feedback

That's incorrect. The correct answer is formulate opinion and rationale without review of additional evidence. Your next steps include consulting the Toxic Exposure Risk Activity (TERA) Memorandum Examiner Job Aid. Based on the conceded exposure, the job aid directs you to locate and review the ILER record, and consider the links provided related to both military exposures and airborne hazards and burn pits

Question 6 of 6

You are in receipt of a medical opinion request for Toxic Exposure Risk Activities. The TERA Memorandum and ILER records show exposure to airborne hazards, burn pits and excessive lead dust from weapons firing. In formulating your opinion, which TERA(s) will you consider?

- airborne hazard & burn pits
- lead dust
- herbicide agents
- airborne hazards, burn pits, and lead dust
- all of the above

Correct Feedback

That's correct. Application of the "synergistic, combined effect" leads you to consider both airborne hazards & burn pits, and lead dust when determining whether the claimed condition is related to the in-service exposures.

Incorrect Feedback

That's incorrect. Application of the "synergistic, combined effect" leads you to consider both airborne hazards & burn pits, and lead dust when determining whether the claimed condition is related to the in-service exposures.

To review the questions and answers, select the Review button. Once you have passed the post-assessment, select the Continue button to proceed to the course evaluation.

Radiation Exposure - Examiner Job Aid

Purpose

The purpose of this Job Aid is to improve the overall quality of examinations related to radiation exposure by providing clarification of commonly occurring documentation errors during disability evaluations, as well as additional resources that are available to assist disability examiners. Given the rarity and complexity of radiation-related examinations, it is important to ensure that disability examiners are provided with current guidance and resources to conduct high-quality disability examinations.

Audience

This Job Aid is for all Compensation and Pension (C&P) disability examiners conducting disability evaluations for conditions claimed to be due to radiation exposure while in service.

Guidance

PACT Act and Toxic Exposure Risk Activity (TERA) Medical Opinions:

Examiners must address the total potential exposure through all applicable military deployments of the Veteran, and the synergistic, combined effect of all TERAs of the Veteran, when providing the requested TERA medical opinion.

There is no required minimum level of radiation exposure or duration of participation in a TERA to warrant a TERA examination. If there is evidence of occupational exposure to ionizing radiation in the Veteran's claims file, the examiner must review any dose assessments (if available) when considering the total potential exposure through all applicable military deployments of the Veteran, and the synergistic, combined effect of all TERAs on the Veteran.

Diseases subject to presumptive service connection:

The following diseases are subject to presumptive service connection *if* the Veteran participated in a **radiation risk activity,** as verified by a claims processor. It is important to note that although these diseases are recognized as presumptive, the presumption only applies if the Veteran meets the qualifying service requirements. When there is evidence of a diagnosed presumptive radiogenic disease **and** participation in radiation risk activity, as determined by the claims processor, presumptive service connection may typically be granted without a request for a medical opinion.

Diseases subject to presumptive service connection	
Bronchiolo-alveolar carcinoma	Cancer of the pharynx
Cancer of the bile ducts	Cancer of the salivary gland
Cancer of the bone	Cancer of the small intestine
Cancer of the brain	Cancer of the stomach
Cancer of the breast	Cancer of the thyroid
Cancer of the colon	Cancer of the urinary tract[1]
Cancer of the esophagus	Leukemia (other than chronic lymphocytic leukemia)
Cancer of the gall bladder	Lymphomas (except Hodgkin's disease)
Cancer of the lung	Multiple myeloma
Cancer of the ovary	Primary liver cancer (except if cirrhosis or hepatitis B is indicated)
Cancer of the pancreas	

[1] For the purposes of this section, the term "urinary tract" means the kidneys, renal pelves, ureters, urinary bladder, and urethra (38 CFR 3.309(d)).

When providing medical opinions, examiners should not solely base their rationale on whether or not they perceive a condition to be presumptive. A sound rationale, to include consideration for any identified radiation risk activity, should be discussed fully, paying close attention to address any additional information in the examination request. Claims processors do not typically request medical opinions for presumptive conditions if the Veteran has met eligibility requirements.

Insufficient Example: A 70-year-old Veteran was diagnosed with colon cancer. The Veteran participated in the cleanup of Enewetak Atoll in 1979, which is a radiation risk activity verified by a claims processor. The Veteran meets the eligibility requirements for the presumption; therefore, a medical opinion should not be requested.

Claims related to ionizing radiation:

VA acknowledges that certain diseases are possibly caused by exposure to **ionizing radiation** during service.

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

Claims based on exposure to ionizing radiation are decided on a case-by-case basis. Radiation type, radiation dose and duration as well as timing of the onset of illness are considered when making determinations for service connection. However, it is important to note that VA will consider additional diseases if the Veteran provides competent scientific and/or medical evidence to show the disease is related to radiation exposure.

Example: A 43-year-old Veteran was diagnosed with hypertension. The claims processor determines the Veteran participated in a TERA, which includes exposure to ionizing radiation. Hypertension is not a recognized radiogenic disease. This claim would be decided on a case-by-case basis. If a TERA medical opinion is requested, the examiner is responsible for reviewing the claims file, relevant evidence, and scientific or medical literature. The examiner must consider 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 when providing the opinion.

Important Reminders

Facts:

- Non-ionizing radiation refers to types of electromagnetic radiation that do not carry enough energy to ionize atoms or molecules.
- Ionizing radiation is a type of radiation that has enough energy to remove tightly bound electrons from the orbit of an atom.
- 1 rem = 1,000 millirem (mrem) = 0.01 Gray (Gy) = 10 millisievert (mSv)
- The average American is exposed to 0.62 rem (620 millirem) of radiation each year (cosmic radiation, terrestrial radiation, internal radiation, medical procedures, industrial activities).
- There is no specific radiation DBQ to complete.

Dos:

- Opinions must be provided based on review of the claims file, relevant evidence, and scientific or medical literature.
- Opinions should cite current scientific or medical literature that supports the provided medical opinion and rationale.
- TERA medical opinions must be adequately justified in the supporting rationale and consider the Veteran's occupational and environmental history, including possible exposure to all TERAs, including radiation, during military service.
- Provide the level of probability and certainty in your medical opinion.
- Only provide the opinions that are requested in the Exam Scheduling Request (ESR).
- A rationale must support the medical opinion by compiling the evidence to make a case for causation of the diagnosis relative to military service, not just a correlation.

Don'ts:

- Do not make assumptions about the level of exposure or health effects without data and verified information. If existing information is lacking, explicitly state what is insufficient (e.g. dose to which the Veteran was exposed in service).
- Do not make speculative statements that are not supported by scientific evidence or diagnostic findings.
- Do not make broad generalizations about radiation exposure; each case should be evaluated on its individual merits.
- Do not cite journal articles that are unrelated or do not align/support the provided medical opinion and rationale.
- Do not base rationale on whether a condition is or is not presumptive.
- Do not misinterpret or misrepresent scientific data.
- Do not provide an opinion unless one is requested in the ESR.

References

- TERA Memorandum Examiner Job Aid – Version 3.0
- Diseases specific to radiation-exposed veterans (38 CFR 3.309(d))
- Claims based on exposure to ionizing radiation (38CFR 3.311)
- Public Law 117 – 168
- Public Health – Military Exposure - Radiation
- Report NT-24-2 (Occupational Radiation Exposure from U.S. Naval Nuclear Plants and Their Support Facilities)
- Health Physics Society Specialists in Radiation Safety, "Common Sources of Radiation" (Revised: September 2020)
- Potential Radiation Exposure in Military Operations: Protecting the Soldier Before, During, and After
- US Nuclear Regulatory Commission: Doses in our Daily Lives
- Health Physics Society, "Uncertainty in Risk Assessment"
- Health Physics Society, "Radiation Risk in Perspective"
- UpToDate: Risk Factors for Prostate Cancer

Vendor PACT Act Medical Opinion Guidance Document

This document includes guidance to aid vendors in providing medical opinions for non-presumptive condition(s) due to Toxic Exposure Risk Activities (TERA).

1. **Review claimed condition(s) and Exposure Profile (TERA Memorandum and Examiner Job Aid):** Prior to making TERA medical opinions, it is important to review the Examination Scheduling Request (ESR) and Exposure Profile, as well as any available ILER summaries or other identified documents in the eFolder, to have a thorough understanding of the ask.

   Tip: To demonstrate a thorough understanding of the condition(s) to be opined on, state "The Veteran is claiming service connection for XXXXXXXX based upon exposure(s) to XXXXXXX" within the medical opinion.

2. **Disease/Illness-based Discussion:** Prior to making TERA medical opinions, the presence or absence of the claimed condition(s) and clinically accurate and sound diagnoses must be determined. The TERA medical opinion then serves as a nexus statement identifying the relationship of the claimed condition(s) to TERA.

   Tip: Ensure the DBQ for the claimed condition and/or the medical opinion addresses the following:

   - Differential diagnosis and consideration of relevant non-exposure risk factors
   - Onset and course of claimed condition(s)
     - Diagnosis
     - Date of Diagnosis
     - Progression of Disease/Illness
     - Treatment received for condition(s) specifically claimed as related to the TERA, including outpatient treatment, any hospitalization(s), any evaluations by a specialist

3. **Exposure-based Discussion:** When formulating a TERA medical opinion, the total potential exposure through all applicable military deployments and the synergistic combined effect of all toxic exposure risk activities (TERA) of the Veteran should be considered.

   Tip: Ensure a thorough review of all available records and supporting reference materials. Information from the ESR, as well as identified eFolder records should be reviewed and utilized when formulating the opinion. The applicable military deployments and TERA events will be identified on the ESR and/or the TERA Memorandum.

   - Review of supporting reference material is not limited to the websites included on the Examiner Job Aid.

   Tip: The medical opinion should address all pertinent exposure details related to the claimed condition(s) after reviewing the Exposure Profile to include:

   - Reported place of exposure
   - Reported activity resulting in exposure
   - Duration of exposure(s)
   - Levels of exposure(s) if known, and specifically any noted above acceptable/normal limits in the ILER record or TERA Summary
   - TERA Summary
   - Discuss route of exposure(s) (Inhalation, Oral, Dermal)
   - Provide frequency of exposure(s) (daily, weekly, monthly) if possible
   - Explain if PPE was used or not during exposure(s)
   - List all types of known exposure(s) (chemical, gas, particulate matter etc.)
   - List what is unknown from above

4. **Medical Opinion:**

CHOOSE THE STATEMENT THAT MOST CLOSELY APPROXIMATES THE ETIOLOGY OF THE CLAIMED CONDITION.

- ○ THE CLAIMED CONDITION WAS AT LEAST AS LIKELY AS NOT (LIKELIHOOD IS AT LEAST APPROXIMATELY BALANCED OR NEARLY EQUAL, IF NOT HIGHER) CAUSED BY THE INDICATED TOXIC EXPOSURE RISK ACTIVITY(IES), 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. PROVIDE RATIONALE IN SECTION C.

- ○ THE CLAIMED CONDITION WAS LESS LIKELY THAN NOT (LIKELIHOOD IS LESS THAN APPROXIMATELY BALANCED OR NEARLY EQUAL) CAUSED BY THE INDICATED TOXIC EXPOSURE RISK ACTIVITY(IES), 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. PROVIDE RATIONALE IN SECTION C.

5. **Providing a Rationale:** A sufficient medical opinion must also include a supporting rationale. A rationale is a summary of the examiner's thought process that led to the conclusion expressed in the opinion. A medical opinion is only sufficient when supported by a clear, understandable, comprehensive rationale that addresses causation.

   Reasons for a negative opinion/rationale could include, but are not limited to, the following:

   - there is no medical or scientific evidence available that provides any indication of a relationship between the development of the condition(s) at issue and the TERA
   - there are risk factors outside of military service (hereditary, congenital, smoking history, weight, lab findings, multifactorial, etc…) that far outweigh the factors identified in the TERA

Reason(s) for a positive opinion/rationale could include, but are not limited to, the following:

- there is medical or scientific evidence available that notes a relationship between the development of the condition(s) at issue and the TERA
- there is medical or scientific evidence available that notes a relationship between the development of the condition(s) at issue and the geographical location(s) of service

Tip: Ensure appropriate identification of evidence-based, peer-reviewed scientific literature/medical studies/resources that were searched and considered in formulating the opinion(s) are included in the medical opinion rationale.