VETERANS EVALUATION SERVICES
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Veterans Evaluation Services

QUARTERLY PROVIDER NEWSLETTER

Summer 2021

Greetings, VES Network Providers! We hope this newsletter finds you all having an enjoyable summer so far. Cooler weather and school buses are just around the corner!

We're pleased to announce some important updates to our Medical Advisory Board roster. We recently added two new board members:

- **Elizabeth Kunchandy, PsyD**. A graduate of Loyola University, Dr. Kunchandy formerly worked with the VHA in both Puget Sound, WA and Hines, IL for several years and currently serves as a board member on the state of Washington's Board of Psychology Examiners. In addition to being an active VES examiner since 2014, Dr. Kunchandy is an adjunct faculty member at Antioch University and also brings a wealth of expertise on neuropsychological testing to our Medical Advisory Board.
- **Beverly Scott, M.D.** Dr. Scott is a retired Colonel who served in the U.S. Army for 32 years and specializes in both neurology and neuro-ophthalmology. Though she is retired, she remains passionate about interacting with and helping Veterans, currently doing so through both her VES exams and her involvement with the Madigan Traumatic Brain Injury program at Madigan Army Medical Center in Washington State. Dr. Scott brings significant expertise on TBI evaluations to our board.

We're thrilled to have Drs. Kunchandy and Scott on our Medical Advisory Board to serve as additional resources for our staff and providers. As always, feel free to contact any of our board members with VES-related questions or concerns.

IN THIS ISSUE

Don't forget to play our "I read the provider newsletter!" contest

Congratulations to Ohio Audiologist, Dr. Joseph Baker, who won the contest in May. The next winner could be YOU. There are only two steps to win: 1) Read the newsletter and 2) Send a message to the Physician Help link in your portal (or e-mail vesphysicianshelp@vesservices.com) with your name and mention something you learned by reading the newsletter. That's it! One lucky provider's name will be drawn **on Friday, August 20th and awarded $200.**

VES Medical Advisory Board

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

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

Internal Medicine: Barbara Dubiel, M.D. btdubiel@hotmail.com

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

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

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

Psychology: Elizabeth Kunchandy, PsyD. pnps. kunchandy@gmail.com

From Our **Medical Director**

In this newsletter I wanted touch on a few ongoing areas of concern that have been brought to our attention by the VA.

The first has to do with muscle testing and amputations. If, for instance, the Veteran has a below-knee amputation, then clearly ankle dorsiflexors and plantarflexors cannot be tested. These should be left blank with an explanation in the Remarks as to why there was no score. Many of you put in a "0" instead of leaving it blank. This implies the muscle is able to be tested and the nerve supply was totally paralyzed. This makes for needless confusion. Note that guidance in the portal is to indicate CNT (Could Not Test) instead of leaving it blank.

Another area of concern has to do with joint stability. Some of you are making a diagnosis of instability, though your exam shows the tests for stability were all normal. This type of internal inconsistency is always noted to be our fault when seen by the VA. Please make sure your exam findings are supportive of your diagnosis.

The final area of concern is etiology, specifically as relates to the heart exam. One very common error we see often pertains to the etiology of coronary artery disease. Some of you say the etiology is due to atherosclerosis. Note that is like saying the etiology of high blood pressure is hypertension. The VA is interested in specifics for the Veteran. They do not want you to list a series of potential causes either, as some of you do. For example, some of you put in "lifestyle" and leave it at that. This is not acceptable. Some of you say it is due to "plaque buildup." That is the definition, not etiology. The VA wants things listed such as smoking, hypertension, hyperlipidemia, diabetes, etc. Please make certain that your etiologies make sense and are specific to the veteran you are examining.

As always, please feel free to contact me with any questions.

Jeffrey Middeldorf, D.O.
VES National Medical Director
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The Broad Spectrum of Traumatic Brain Injury:

(TBI) Impact on Disability Determinations – A Neurologist's Perspective

During my 32 years in the Army as a Neurologist and Neuro-Ophthalmologist, I had the opportunity to care for many Service Members and Veterans with concussion or more severe traumatic brain injuries. I am especially grateful for the experiences I gained while serving as the Theater Neurology Consultant, Afghanistan in 2010 and the Director, TBI/Intrepid Spirit Center at Madigan Army Medical Center. Following my military retirement in 2018, I proudly continue to serve our Veterans as a VES Examiner and am grateful for the opportunity to bring my years of TBI experience to the VES Medical Advisory Board.

One of the most important things I've learned through my various clinical roles is the broad clinical spectrum of TBI. Not only are the clinical presentations following TBI highly varied due to injury location, severity, and mechanism, but also significantly impacted by the presence of co-morbid and premorbid clinical conditions prevalent in our Service Members and Veterans. Hence, symptom attribution and diagnosis are often difficult for our Veteran population following trauma, further complicated by the various nonspecific symptoms deemed associated with TBI often caused by other conditions. While diagnostic accuracy is invaluable to successful clinical care, it is equally important to disability determinations.

As a team member on the VES Medical Advisory Board, I hope to collaborate with our Medical Director, providers, and Quality Analysts, and provide useful clinical perspective on issues related to TBI and Neurology. As a VES provider, I recognize challenges in the disability evaluations, especially as it relates to the symptom attribution and diagnosis following TBI. I continue to learn from our excellent QA team specific ways to improve clarity and accuracy of the DBQ reports for the Veterans we serve.

In the quarterly newsletters, I will share "perspectives, pitfalls, and pearls" predominantly related to TBI evaluations in an effort to improve diagnostic accuracy in disability determinations. The importance of a comprehensive chronologic clinical interview and medical record review to better clarify "the whole story" for our Veterans is critical to accurate diagnosis and symptom attribution. Common neurologic conditions associated with head trauma such as post-traumatic headache, migraine, Benign Paroxysmal Positional Vertigo (BPPV), and other causes for post-traumatic vertigo will also be addressed in future newsletters due to their specific impact on disability determinations.

I look forward to working with all of you and welcome questions, feedback, specific challenges, and educational requests. Please feel free to contact me at beverly.rice.scott@gmail.com if you think I can help you in the evaluation of our Veterans.

— Beverly R. Scott, MD
Medical Advisory Board, TBI and Neurology

Efficient Medical Record Review

Several of you have inquired about efficient medical record review. VES helps greatly by selecting pertinent records, but there still may be hundreds of pages. For established conditions I like to start the search with the old rating decisions. This will usually require some review of the complete C-file. The rating decision gives information about when the condition was established and evidence used for the diagnosis. Review of the rating decision does several things: first, it allows one to be sure the established diagnosis given for the exam does not have added established conditions, like radiculopathy for back conditions and instability with knee conditions. Knowing the add-ons allows one to address the additional established diagnoses at the time of the exam and avoids an addendum later. Second, it gives information about the previous Compensation & Pension (C&P) exam (and when that exam was done) which is helpful if it is necessary to change an established diagnosis. Lastly, the rating decision gives the active duty dates if those are in doubt. Good search words to use are "rating decision" and "granted."

For exam of an established condition I try to find the last primary care encounter. Good key words are "primary care" or "primary care annual." Usually if the established condition is symptomatic there will be some mention in the primary care note. This allows one to get an idea of the treatment plan, symptoms, medications, & whether recent imaging was done. Orthopedic notes are often helpful, especially after joint replacement, key word "ortho." Sometimes searching for "operative" will bring up old operative reports, which are very helpful in trying to determine exactly what was done in an operation (was it a meniscus debridement or a plica excision, for example).

For IMOs requiring review of very old records, good key words are "Report of Med" which brings up the old medical histories and exams. If that does not work, try "trick" as in "trick knee" which should do the same. This generally moves one to the general area of the records containing the old, hand written service records. For newer records, try the helpful key words "Post deployment" which should bring up the post deployment questionnaires that often have information about the claimed condition, and again gets one in the general area of search.

"Contents" is very helpful for the more recent service records and can find all radiology, lab, and treatment records in order. For sleep apnea, try searching "sleep med," "polysomnogram," "Epworth," or "StopBang."

To efficiently see the Veteran in the office, it is helpful to have the record review done ahead of time so you have an idea of at least the recent history and can concentrate more on the current symptoms and exam.

Also, don't be fooled by the claimed condition. Even a specifically claimed condition like "Knee Strain" is not a definitive diagnosis and only a starting point for the claim. For example, a Veteran may file a claim for a knee strain referring to an in-service diagnosis from years ago while all the recent treatment has been directed at a diagnosis of knee arthritis. Unless there is truly some element of the symptom history and exam that is not explained by the knee arthritis, the claimed diagnosis of knee strain does not need to be included just because it is claimed. By the way, speaking of arthritis, a good record search word is "impression" as it helps locate past imaging which is required to confirm a diagnosis of arthritis.

Lastly, also realize that an IMO asking if a claimed condition is due to that condition in service does not necessarily mean that the claimed condition was actually present in service. Such phrasing is a shorthand way of asking if the condition is due to some element of service. Thus, you may not find the knee arthritis in the service record when the Veteran was 20, but you may find the meniscus tear that predisposed the knee to the arthritis.

— Barbara Dubiel, M.D.
VES Medical Advisory Board Member
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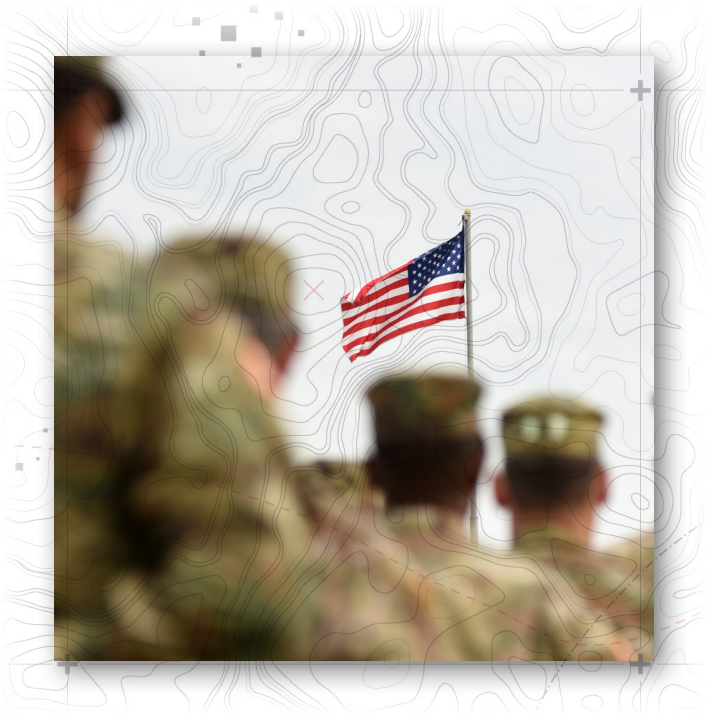
MST Medical Opinion Update



Dear VES Psychologists,

You will notice some minor changes to the wording of MST opinions. However, please note the adjudication of MST claims has not changed. While the wording will appear much clearer, our clinical responsibilities remain the same. Additionally, please note VA commonly reviews our MST exams from a clinical quality perspective. To avoid quality errors, please take note of a few helpful reminders pertaining to MST Stressors and Marker Evidence.

1. Please ensure you have included enough details about the stressor event so that it is clear criterion A for PTSD is or is not met. Do not simply paste the stressor in from the record or exam instructions. We must carefully decide whether or not criterion A is met. Please note that, when MST is claimed but the stressor is pertaining to harassment in the absence of actual assault or threat of assault, criterion A will probably not be met. Carefully review DSM 5 criteria for PTSD Criteria A when making these sometimes difficult determinations.
2. Ensure you have clearly documented the date and location of the claimed MST stressor event so that marker evidence can effectively be identified. Separate stressor events must be listed separately and may require different markers.
3. Make every effort to locate marker evidence from the service treatment records and be sure to explain how the identified evidence is relevant to and supports the occurrence of the claimed stressor. Your clinical judgment is paramount here - both the DBQ and MO should clearly explain how and why the marker evidence is clinically relevant to the stressor. If evidence is present in the service records, we are required to identify it.
4. After identifying and explaining all marker evidence found in the service treatment records, you may also incorporate evidence from the Veteran's stressor statement (Form 0781) and other lay statements that have been provided. You must explain how their claimed behavior changes are relevant to and support the occurrence of the claimed stressor. For example, you may state: "The Veteran's Form 0781 indicates onset of insomnia, nightmares, and anxiety immediately following the claimed 2/2/21 MST stressor event. Symptoms such as insomnia, nightmares, and anxiety are commonly found to onset following sexual assault and are consistent with the behavioral changes and reactions of a person who experienced a sexual assault such as the claimed MST stressor event." Simply listing "insomnia, nightmares, and anxiety" in the Marker Evidence field of the DBQ and in the associated Medical Opinions is insufficient and can lead to returned exams.
5. Next, you may also include marker evidence found in post-discharge records such as VHA treatment records. The VA does not identify any particular time period after discharge during which markers must be present; post-

discharge markers may be identified from any point in time. Again, you must fully explain its relevance to the claimed stressor. If in-service marker evidence is present, it would be incorrect for the examiner to only identify post-discharge evidence.

6. In cases where in-service marker evidence is not found in the service treatment records, we may still render a positive medical opinions pertaining to MST/Marker Evidence if it is fully supported by well-reasoned clinical judgment and other areas of the medical record such as Form 0781, lay statements, and post-discharge records. In these rare cases, we must take particular care to fully explain our rationale and clearly state how and why the marker evidence we have identified is relevant to and supports the occurrence of the claimed stressor. Again, the explanation of your clinical judgment is the most important asset in these situations.
7. Please ensure you have fully addressed all tabbed evidence and state whether or not it supports the claimed MST stressor. For example, you may have been presented with tabbed evidence that pre-dated the stressor, or was otherwise entirely unrelated. In these cases, please state why the tabbed evidence does not support the claimed stressor's occurrence. For example, exam instructions may indicate "Tab A Herpes." However, upon investigation, the examiner finds that the herpes diagnosis was in 1990 and the claimed MST stressor was in 1992. The examiner should explain in the DBQ "The Veteran's 1990 Herpes diagnosis is noted and considered, but it is not found to be relevant to the claimed MST stressor as it pre-dated the stressor event, which the Veteran reports occurred in 1992." Alternatively, if the tabbed evidence indeed supports the MST event, please explain that as well.

Lastly, please note there is a related new training slideshow which is available in your provider portal under "Training by Specialty" called "VA's Best Practices for MST Exams."

Thank you for taking the extra time and attention to ensure that we are providing the very best clinical quality for these important yet challenging claims. Please feel free to reach out with questions!

— Maria K. Baker, Ph.D.
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Attention VES Psychologists: The VA Wants to Know What, When, and Why!

In providing clinico-legal examinations, a VES psychologist's main purpose is to identify what (diagnosis), when (onset), and why (etiology) for every mental health condition we diagnose so that VA can use our report to adjudicate Veterans' disability claims. VA needs to know what the Veteran is diagnosed with, when it onset, and why it developed - even if there is no current medical opinion attached to the exam. Our goal in every initial exam is to gather as much information and evidence as possible to

answer these three questions. This guidance also applies to review exams, especially if we are providing a new or different diagnosis than the service connected condition. As psychologists are provided with relatively exhaustive guidance pertaining to the what (see DSM 5 diagnostic criteria), we will focus this article on our hunt for the when and the why. But just a brief note on diagnoses to get us started…

Diagnosis

Our VA guidance specifies that every diagnosis provided on a mental health exam should meet full DSM 5 criteria. Diagnoses should not be provisional, by history, or in need of rule out. They should not be a "V" or "Z" code, as these are not actual DSM 5 diagnoses. It is best practice to fully describe the diagnostic criteria that is used to support your diagnoses, especially on mental disorder DBQs where diagnostic check boxes are not present (as they are on initial or review PTSD DBQs). In cases where our diagnoses differ from the diagnoses provided in the record, we must acknowledge and reconcile these differences. However, unlike in many other areas of our practice, our clinico-legal exams require us not only to fully support our diagnostic criteria, but to take our investigation two steps further to identify our impressions as to the time of onset and etiology, to the very best of our clinical judgment and abilities. Without this information, we will inevitably struggle to correctly answer medical opinions and VA may not be able to use our reports to adjudicate claims.

Onset

VES Psychologists should make every attempt to identify the time of onset for every diagnosis that is provided on a DBQ. It is of particular importance to indicate if conditions onset before, during, or after the Veteran's active duty military service.

Helpful Hint: Be sure to accurately identify the Veteran's active duty service period. This does not generally include time spent in the Reserves or Guard. Some Veterans have spent decades in the Reserves or Guard, with only a few months or years of activations, usually for deployments or training. The Medical Opinion instructions (found at the top of the medical opinion worksheet) may provide VA's official active duty dates for the Veteran.

To identify time of onset, we begin by locating the Veteran's pre-service Enlistment Exam to find out if any mental health concerns were noted at the time of enlistment examination. If the Enlistment Exam is negative for mental health concerns, the Veteran is presumed sound at the start of active duty service (see Presumption of Soundness 38 U.S.Code 1111).

Helpful Hint: You will recall from the recent newsletter on Aggravation Opinions that refuting the presumption of soundness requires a high bar of proof such as original source pre-service mental health treatment records. Self reported pre-service symptoms are insufficient to refute the presumption of soundness.

Given these legal requirements, we often find situations where, while some initial symptoms or traumas may have been present pre-service, the enlistment exam is negative for mental health and the Veteran was first diagnosed and treated in-service. When asked to opine on time of onset for these situations, we are usually providing opinions that the evidence of record supports in-service onset given the combination of a clean enlistment exam and an initial in-service diagnosis.

Once we have located an Enlistment Exam that is negative for pre-service mental health conditions, we usually proceed under the impression that the mental health condition has onset either during or after service. To make these important determinations, we look for a series of clues:

1. Check the medical records for the date of the initial diagnosis, if present.
2. Take note of when the diagnosed condition first required treatment.
3. Examine for when social and occupational impairments first began to present.
4. If the condition is stressor-related, ensure that the date of the stressor is obtained.

Each of these clues will provide important clinical information that, once filtered through your clinical judgment, will lead to a well-reasoned rationale to support the time of onset for each diagnosis you provide. Clearly state your impressions pertaining to time of onset in the mental health section of the DBQ.

Etiology

Determining the cause of mental health conditions is no easy task, and has often been a neglected aspect of our field. But few more important tasks will cross our desks as clinico-legal examiners; mental disorder etiology is one of the most important aspects of VA disability claims adjudication. We will organize our discussion into two classes of etiology: stressor-related and non-stressor related. When approaching etiological impressions, begin by determining if the condition was caused by a stressor event.

Stressor-Related Causes

The majority of mental health claims probably fall under this category in that the diagnosed condition is found to have onset due to a stressor. This encompasses our PTSD claims as well as many of our secondary claims where a condition is claimed to be secondary/due to a medical disorder or, as we will call it here, a medical stressor. We commonly diagnose many stressor-related disorders including PTSD and Adjustment Disorders, as well as unspecified and other specified trauma and stressor related disorders. If any stressor related disorder is diagnosed, we must clearly identify the index stressor: the stressor event that caused the onset of the disorder. This is key to providing clear etiological impressions in the DBQ as well as formulating rationales for medical opinions. Index stressors are clear and obvious for PTSD (as they are required in Criterion A), but should be considered equally important for all other stressor-related disorder diagnosis. Be sure to identify the date of the index stressor/s and discuss the causal relationship between the index stressor and the resulting symptoms and diagnosis.

Helpful Hint: Please note that, unless you are diagnosing PTSD, the index stressor does NOT need to meet criteria A for PTSD. When diagnosing adjustment disorders or other/unspecified trauma and stressor related disorders, the index stressor may be any identifiable stressor that causes an emotional or behavioral response such as injury, divorce, family separation, job loss, medical diagnosis, functional limitations, pain, etc.

Non-Stressor Related

Conditions that lack clear stressor-related origins usually can be described as developmental (early onset and/or congenital disorders), hereditary and/or genetic, pathophysiological (caused by biological or structural changes), or substance induced. DSM 5 does a good job of identifying disorders that tend to have strong leanings toward a particular etiology, such as the likelihood that Schizophrenia is caused by genetic factors whereas ADHD is considered

neurodevelopmental. (Please note schizophrenia, like other genetic conditions, can be attributed to service even though it's genetic, so long as it didn't manifest/present until service.)

Helpful Hint: Psychologists are often faced with issues of scope when dealing with claims regarding pathophysiological etiologies. For example, we may see a new claim for "neurocognitive disorder due to Parkinson's Disease." In these cases, it is important to obtain neuropsychological testing to establish the presence or absence of a neurocognitive disorder, as well as whether or not the pathophysiological changes related to the Parkinson's Disease was the most likely etiology. Psychologists should generally not make statements regarding pathophysiological etiologies without first obtaining diagnostics/testing.

In determining non-stressor related etiologies, we rely heavily on a comprehensive interview and review of the records; be sure to thoroughly investigate the time of onset, environmental factors and social situations present around the time that symptoms first emerged, and gather a full understanding of the Veteran's family mental health history.

Multiple Etiologies

It is not uncommon for mental health conditions to result from multiple etiologies, be it multiple stressor events or a combination of stressor and non-stressor related etiological likelihoods. In these situations, it is important to simply state the multiple etiologies that you have identified in your exam.

Helpful Hint: If you are answering a medical opinion pertaining to whether or not a specific etiology has caused the diagnosed condition, and you have found multiple etiologies, you may continue to provide a positive opinion as long as one of your identified etiologies is the subject of the MO. For example, VA may ask if a depressive disorder is at least as likely as not the result of the service connected back problems. You may have found that the depression is due to multiple

medical stressors including back pain, neck pain, and hip pain. Unless the depression clearly pre-dated the back pain, you can most likely proceed with a positive opinion if, indeed, back pain is one of your identified and supported etiologies. The specific nexus should always be clearly explained.

Presenting your Diagnosis, Onset, and Etiological Impressions

Please utilize the Mental Health History section of the DBQ to fully describe the current symptoms, time of onset, and etiological impressions for each diagnosis that you provide on the DBQ. This is important even if there is no medical opinion currently attached to the exam, as one may be sent at a later date. This explanation need not necessarily be extensive. For example, in some cases, something such as the following may suffice:

Example: "The currently diagnosed Adjustment Disorder with Depressed Mood onset after the Veteran's discharge from active duty service, around 2015, due to his difficulty adjusting to the pain and functional limitations associated with his service connected degenerative disk disease."

As you complete your quest for the symptoms, onset, and etiology of all diagnosed conditions, you may find that you have provided two diagnoses, each with nearly identical symptoms,

onset, and etiology. In these cases, please ensure you do not have redundant or subsumed diagnoses represented on your DBQ.

Helpful Hint: We often see new claims for insomnia, anxiety, or depression in the context of Service Connected PTSD. Upon exam, we often find that the newly claimed condition onset immediately following the index stressor and remains due to and organized around the index stressor. In these cases, we could consider the newly claimed condition to be a symptom of the PTSD and would explain that it is subsumed by the PTSD diagnosis instead of supplying a new and redundant diagnosis.

Lastly, please note there will inevitably be times when, try as we might, identification of onset and etiology remains unclear. These cases may occur when the Veteran is a poor historian or the available records are particularly sparse. We hope, though, that these will be rare exceptions, as this may lead to VA's inability to use our report to adjudicate a claim.

Thank you for your time in reading this guidance, and for making every effort to provide this information in your reports. Taking the time to adhere to these guidelines means you are providing an invaluable service to our Veterans and to the swift adjudication of their claims. As always, please reach out should you have any questions!

— Maria K. Baker, Ph.D.
VES Medical Advisory Board Member
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Audiology: Common Mistakes During Modified Performance Intensity Function

The VA continues to cite a significant amount of errors for the PIF portion of the DBQ. The most cited errors are:

- Not performing initial speech testing 40dB over SRT (if tolerable and not exceeding 100dB).
- Not providing a second ascending/ descending presentation if there is a 6% or greater increase in score.
- Not using a 50 word list for PBMax.

Variable testing interpretations from different providers can yield different scores, which can impact the Veteran's rating. Our Veterans deserve continuity of care regardless of provider. The full protocol can be found on the portal under "Training by Specialty." We appreciate everyone's hard work and diligence with providing our Veterans with the highest standard of care. As always, if you have any questions, comments, or concerns feel free to reach out to Jeffrey Cooper or myself.

Thanks as always for your diligence and hard work in serving our Veterans.

— Lauren Simpkins, AuD.
VES Medical Advisory Board Member
northtxaud@gmail.com

What Our **Veterans are Saying!**

> You have all been more than kind. **Everyone has been so nice and always are available** when I contact you. If everyone was as **courteous and efficient** as your organization in this country it would be a better place.

> I appreciate the hospitality, and most of all **I appreciate the way I felt when I left.** I left the facility thinking, 'Wow, now those were just plain ole genuine good people.' There needs to be more places and people like this!

> An NP conducted my C&P exam on 29 July 21 in Maineville, OH. He was **prompt, thorough, cordial, exceptionally knowledgeable,** and easy to communicate with. He is an **outstanding example of veterans serving veterans.** You should hire many more like him.

> The rep at the front desk and the examiner were both **professional throughout the entire exam**.