VETERANS EVALUATION SERVICES
A Maximus Company

Veterans Evaluation Services

QUARTERLY PROVIDER NEWSLETTER

Summer 2022

Greetings, VES Network Providers!
We hope this issue finds you all doing well and staying comfortable despite the all-too common three digit temperatures across the globe!

VES continues to see a high volume of exam requests for our Veterans and Service Members. We're always appreciative when providers are able to carve out an extra hour or two on their weekly calendars to evaluate even more of our nation's heroes!

Don't forget to play our "I read the provider newsletter!" contest. Congratulations to Oregon Physiatrist, Dr. Thomas Lieb, 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 Provider Help link in your portal (or e-mail VESProviderHelp@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 19 and awarded $200.

VES Medical Advisory Board

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

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From Our **Medical Director**

Hello VES Examiners.

I hope you all had a nice Fourth of July weekend.

This issue of the Newsletter will continue to focus on the quality issues the VA has brought to our attention. I apologize if some of this appears redundant, but with new examiners coming on board each month, and recurrent errors being noted, I felt it important to share this information with you.

In our monthly meetings with the VA, there continues to be a series of errors being made that we want to try to stop. This will save everyone time and help expedite Veterans' benefits.

What the VA has pointed out is most of the errors continue to be in the musculoskeletal examinations and, within that group, the Back DBQ continues to lead within this category as having the most errors.

Issues that continue to surface are as follows:

1. Stating there are no diagnostics, when in fact the medical records file contains diagnostics. This question pertains to any relevant diagnostics. When there are diagnostics in the file and we say there are not, it of course suggests we did not look at the records. We need to state the date, type (x-ray, CT, MRI, etc.), and summary of relevant findings.

2. Internal inconsistencies continue to surface. As an example, stating the Veteran has sciatic radiculopathy based on a decreased patellar reflex and decreased sensation in the femoral nerve dermatome. Some examiners appear to only be comfortable with the more common sciatic radiculopathy. We have to make the distinction between the two named radiculopathies.

3. Another issue pertains to atrophy. We have some examiners who state the Veteran's ankle dorsiflexors and plantar flexors are 1/5 and yet state there is no atrophy. That is not possible. When there is profound weakness the VA will expect there to be atrophy.

4. Another issue pertains to the neurological examination. Some examiners note profound weakness (0-2/5) and reflex changes, yet normal sensation. This is not how the typical radiculopathy or neuropathy behaves. The VA will expect to see sensory changes in this scenario.

5. We continue to have some confusion around IVDS. We still see examiners who diagnose degenerative disc disease, back pain, and radiculopathy, and yet state there is no IVDS. This is basically the definition of IVDS. When we see this trio, we must diagnose IVDS.

6. One issue pertains to the diagnosis of a nerve condition. If this is a new claimed condition, diagnosing foot drop is not acceptable. That is a clinical exam observation, much like shortness of breath. The VA wants the cause (diagnosis) of the foot drop, such as a peroneal neuropathy.

7. Finally, we need to make sure if things do not make sense that we "reconcile" the problem. One example I recently saw involved a Back DBQ and Peripheral Nerve DBQ. On the Back DBQ, a lumbar strain was diagnosed. The exam found weak (3/5) ankle dorsiflexors, ankle plantar flexors and weakness of the great toe extensor. There was decreased sensation in the distal leg and foot and yet no radiculopathy was diagnosed, and there was no explanation. If someone only had this DBQ to read, they would be left confused and think the exam was in error. It would have been appropriate to state the neurological findings related to a peroneal nerve injury as discussed in the peripheral nerve exam, not a radiculopathy.

Thanks for all your hard work serving our Veterans and Service Members. As always, please feel free to contact me with any questions.

Jeffrey Middeldorf, D.O.
VES National Medical Director
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Neurology/TBI Perspectives, Pitfalls and Pearls:

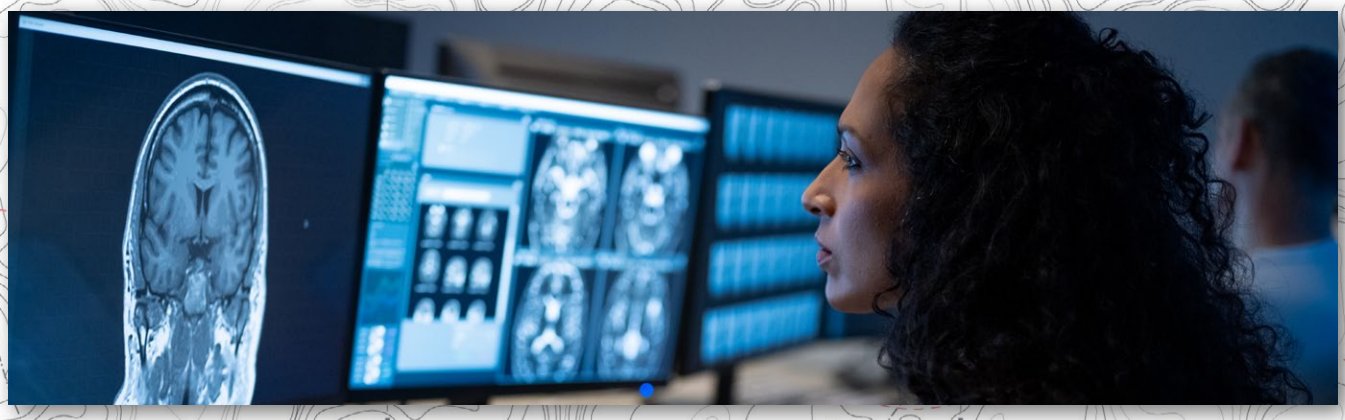
Benign Paroxysmal Positional Vertigo (BPPV)

In this newsletter, I will briefly review the anatomy, pathophysiology, and diagnostic hallmarks of Benign Paroxysmal Positional Vertigo (BPPV). Additionally, I will highlight recommendations for completing the Ear Conditions and TBI DBQs relative to this condition.

Background

BPPV is the most common peripheral vestibular disorder, most often arising acutely following head trauma, or may be delayed following prior viral labyrinthitis. Nearly 50% of cases are idiopathic. The condition often lasts for weeks, though invariably remits and often recurs. It is a treatable condition, hence it is an important diagnosis from a clinical perspective, though accurate diagnosis is also important from a disability rating perspective.

BPPV is often misdiagnosed, as there are frequent misconceptions regarding the expected clinical history and exam findings. While the classic presentation of BPPV may be easy to recognize, knowledge and clinical skill is required to differentiate from other causes of dizziness and positional vertigo. Not all positional vertigo is



BPPV. It is equally important to recognize when the condition is present and when it is not. An incorrect clinical diagnosis of BPPV results in delay in accurate clinical diagnosis and management, in addition to incorrect disability ratings, both of which negatively impacts Service Members and veterans.

As highlighted in the Spring 2022 newsletter, many of the vestibular symptoms and conditions often attributed to brain injury are otologic complications more accurately attributable to head injury. BPPV is a specific example of an otologic condition often resulting from head injury. It is important to understand not all head injuries cause brain injuries, and while most brain injuries are associated with head injury, consequences of head injury such as BPPV should not be considered a residual effect of TBI.

Anatomy and Pathophysiology of BPPV

Benign Paroxysmal Positional Vertigo (BPPV) is a peripheral vestibular disorder resulting from abnormal small crystals of calcium or canalithic debris in the inner ear semicircular canals often resulting from head trauma or prior viral labyrinthitis or neuronitis. While there are three paired semicircular canals, the condition most often involves debris within the posterior canal which causes characteristic brief vertigo sensation when triggered by characteristic position changes.

Clinical Hallmarks and Diagnosis of BPPV

The classical clinical features of BPPV include brief episodes of vertigo and specific patterns of nystagmus (usually lasting < 30 seconds) typically only provoked by specific position changes, such as turning in bed or extending the neck, i.e. 'top shelf vertigo.' Diagnosis is confirmed by the provocative positioning test called the Hallpike maneuver when a specific pattern of nystagmus is observed. The condition is often 'cured' at the bedside by the canalith repositioning procedure (CRP), also called the Epley maneuver.

The first diagnostic step is to determine if vestibular disorder is present based upon careful clinical history. It is sometimes difficult to confidently determine if a vestibular condition is present by history alone, as a wide variety of terms are often used by individuals to explain their symptoms. The true vertigo of BPPV is most often described as a brief sensation or illusion of spinning, which may be followed by a longer duration of vague dizziness or motion sickness.

The static exam does not typically reveal nystagmus in BPPV. A specific pattern of nystagmus is required to confirm BPPV following the provocative Hallpike maneuver, which must be performed correctly to increase yield of diagnosis. A positive diagnostic test for posterior canal BPPV requires finding a mixed vertical-

torsional upbeating nystagmus, which beats toward the ground (geotropic) when the patient is held in 'head hanging position' during Hallpike testing. Positive testing is often accompanied by severe vertigo, with associated prominent autonomic symptoms if vertigo severe. Vertigo without the expected pattern of nystagmus is NOT a positive Hallpike test for posterior canal BPPV, nor are other patterns of positioning nystagmus. While it is beyond the scope of this article to further describe the diagnostic testing and expected findings, it is imperative for examiners to understand the requirements for accurate testing and interpretation of clinical findings.

Pearls for Completing the TBI and/or Ear Condition DBQs Evidence Review

Medical record review with summary of pertinent clinical notes supporting the diagnosis should be documented in the Evidence Review section of the DBQ. It is generally insufficient to simply state 'All available records were reviewed and findings considered when completing this DBQ.'

Ear Condition DBQ

Section IB Diagnosis

Render diagnosis of BPPV if supported

Section II Medical History

- ***DETAILS OF ONSET*** with description and duration of the typical vertigo episodes and associated symptoms with clarification of the temporal relation to head trauma. It is helpful to clarify and document the specific triggers and positional features, associated symptoms, and duration of spells. Additionally, clarify and document vertigo history prior to trauma if present.
- ***COURSE OF CONDITION SINCE ONSET*** should include pertinent chronologic history of episodes over time to present to show evidence of chronicity or recurrence, if supported by history. These details are often best recorded in the Other text field.

TBI DBQ

Section I Diagnosis and Medical History

- ***DETAILS OF ONSET and COURSE of CONDITION***: Vertigo history may be appropriate to include in the TBI DBQ if temporally associated with brain trauma incident; however, if the history supports BPPV, that diagnosis should be discussed in the REMARKS section since the condition is not directly attributable to TBI.

Section II. Assessment of Facet-Related Cognitive Impairment and Subjective Symptoms of TBI

Only Neither dizziness nor vertigo should be listed as a physical symptom of TBI if clinical history and diagnostic features support BPPV.

Section III. Additional Residuals, Other Findings, Diagnostic Testing, Functional Impacts and Remarks.

While BPPV is a common complication of head trauma, it is not a residual effect of brain trauma, and hence should not be considered a residual condition of TBI on the TBI DBQ.

Future Topics

Hopefully this is helpful information. Please let me know if you have specific questions about BPPV. Also, please let me know other neurologic or TBI topics you would like me to address in future newsletters.

— Beverly R. Scott, MD
VES Medical Advisory Board,
TBI and Neurology
beverly.rice.scott@gmail.com

Tips for Searching Through Medical Records

We all hate to go through the medical records. Here are some suggestions to make record review more palatable:

1. Know the Veteran's service dates. This may be obvious, but I have seen many reports that required correction because the examiner based an opinion on something that occurred outside the service period.

2. Start with the latest Rating Decision. Look for the rating form that lists all the ratings and their percentages without explanation. This will allow you to find any additional conditions not mentioned in the claim. If you find there is a rating for the unclaimed extremity, for example, you can already eliminate the exam for it because it is considered damaged. If you find radiculopathy is also an established diagnosis, you will look for it and avoid a later clarification. Don't count on the Veteran knowing these details.

3. For ESTABLISHED diagnoses look at the latest primary care and ortho records. This will give you a clue as to why the Vet likely filed for an increase. Maybe the arthritic knee was replaced or maybe x-rays were done and now there is a new diagnosis of arthritis. This will also give you an idea of how much the condition has been affecting the Veteran. Example: No mention of knee symptoms over the last few years makes the claim of worsening difficult to justify.

4. For NEW CLAIMS first look at records to figure out what the CURRENT diagnosis is, not the claimed condition name or the in-service condition name. Example: Claim is for "Left knee condition." You find x-rays of the left knee in 2018 showed osteoarthritis & Veteran is being treated for arthritis. Your diagnosis is made. Or, claim is for "Left knee strain," but you find another diagnosis, like arthritis or meniscus tear with treatment for same. You now know you should include those diagnoses to avoid a later clarification and that you may not be dealing with a knee strain at all.

5. After determining the current treating diagnoses, THEN examine the service records to determine if that diagnosis could reasonably have resulted from the in-service injury or condition. Example: Claim is for knee strain, there was a knee strain in service 20 years ago, but now the 70-year-old Veteran has knee arthritis.
6. Look at the last Report of Medical History and Exam (separation exam) to see if the in-service condition was persistent.
7. Look at the ENTRY exam for claimed conditions like pes planus to be sure they were not preexisting.
8. For all claimed conditions that require specialized testing for identification and diagnosis, such as ulcer, gastritis, endometriosis, search records for that specialized testing. If it does not exist then there can be no pathology to render a diagnosis for that condition.
9. To find records related to RECENT service try typing in "Contents" to get the contents of the records which will list almost everything the Veteran was seen for in service with names of providers so you can find the actual note.
10. For older claims you can search "Report of Med" or "Dental" to get in the general area where the hand-written records are located, though unfortunately the hand-written records will still require a page-by-page search. These are typically near the end of the medical records file.

I hope these tips are helpful! Thanks for reading.

— Barbara Dubiel, M.D.
VES Medical Advisory Board,
Internal Medicine Member

Mental Health Guidance: Updates & Reminders

We would like to review a few important pieces of VA guidance from our previous newsletters and disclaimer notices which may have been missed, forgotten, or in need of an update. We hope our newer providers will take special care to review this list, as many of you may have joined us well after this information was originally disseminated. We also hope our seasoned providers take notice as well, as these items continue to be the topic of frequently asked questions and addendum requests.

Tele C&P

Our Telehealth Manual (available in the Provider Portal) has been recently updated to reflect

current nationwide scheduling practices per House Rule 7105, which allows psychologists and other providers to conduct VA disability exams across state lines notwithstanding state or local laws. With such allowances, please be aware of how state and local mandated reporting and practice requirements may vary based on the location of the Veteran.

Suicide Risk Assessment

VA has provided us with updated risk assessment procedures to which we are contractually obligated to follow. Please review "Determining Level of Risk for Suicide" (also called Attachment N), located in the Provider Portal, for the updated requirements. Psychologists should take special care to update their informed consents to account for the disclosures required by VA's risk assessment procedures, as they may differ from various state mandated reporting requirements. Please note that we follow the risk assessment procedures in Attachment N in addition to our state mandated reporting requirements.

Neuropsychological Testing

We have been given specific guidance for when neuropsychological testing should and should not be pursued. In most cases, VA expects to see support for neurocognitive diagnoses in the form of either newly obtained neuropsychological testing or recent/relevant testing as located in the medical record. For those of you who conduct neuropsychological testing for VES, please be advised that our testing requirements have been updated (see Dr. Kunchandy's Newsletter Article from Fall 2021).

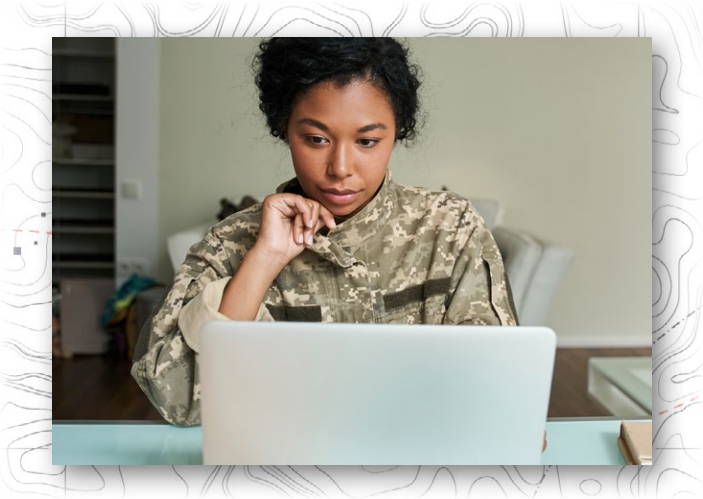
VA does not generally support the pursuit of neurocognitive diagnoses and associated testing when there is no cognitive component to the claim, established condition, medical opinion, or other aspect of the exam request. When cognitive concerns are present during the exam in the absence of a cognitive component to the exam request, we are asked to simply state them in the behavioral observations or medical diagnoses sections as applicable.

DSM 5 Diagnoses

Only DSM 5 diagnoses may be provided on Mental Disorder or PTSD DBQs. We continue to see outdated diagnoses submitted on exams such as Mild Cognitive Impairment and Alcohol Abuse which have not been used since DSM IV. Please ensure that you have completed continuing education or relevant training in utilization of DSM 5 as many diagnoses and diagnostic criteria have changed. Additionally, please be advised that "V" or "Z" codes (bereavement, abuse, partner violence, etc.) are not considered to be diagnoses; they are "other conditions that may be a focus of clinical attention," and, therefore, may not be provided on the DBQ diagnosis line. Last, you are probably aware that DSM 5-TR has recently been published. However, we do not yet have a transition date for when VA contractors will begin utilization of the revised text. For now, please continue to only use DSM 5 diagnoses.

New Claims that Fail To Identify Established Conditions

Please remember to adequately review all previous rating decisions prior to the start of the exam. From time to time, we will see new claims processed as new/initial mental disorder claims, where, in actuality, the Veteran is already service connected for PTSD or another mental disorder. In these cases, the service-connected condition must be addressed on your DBQ, usually as a current diagnosis, or perhaps as subsumed by



a new/corrected diagnosis. In instances of an existing PTSD service connection, providers should address the new claim on a PTSD Review DBQ instead. It is the provider's responsibility to review records prior to the exam so that all established conditions can be addressed and all necessary changes to the DBQ worksheet can be identified. Please do not hesitate to contact Physician Help if you have questions pertaining to updates or changes needed to an exam worksheet!

Thank you for taking the time to review these important updates and reminders. Note, however, that they represent just a few of our more frequently asked questions. If you have not already done so, please consider reviewing the past few years of Newsletter Articles (especially October 2019 and later, as this period represents a number of important VA updates) and relevant entries to the disclaimer page (provider bulletin board) to ensure you have read all recently disseminated VA guidance.

— Maria Baker, PhD.
VES Medical Advisory Board,
Psychology Member

Audiology: Records Reviews and ASA to ISO/ANSI Conversions

Hello, fellow audiologists! Below are a couple of topics to help remind us of best practices in performing C&P examinations for our country's Veterans:

- Records reviews
- ASA to ISO/ANSI conversions

Records Reviews

Issue: At times a significant piece of documentation will be missing from a hearing loss and/or tinnitus opinion. Some documents to heavily consider include the DD 214, any hearing tests, and chart notes re: hearing/ear issues.

Working resolution: Some electronic medical files, such as the C-files and pertinent files, will be viewable and searchable by keyword without issue. However, at times these files will contain documents that are illegible and/or not searchable by keyword. In these cases, a thorough manual search may be needed to find significant pieces of documentation needed to complete the DBQ.

ASA to ISO/ANSI conversions

Issue: Veterans who served around 1969 or prior will oftentimes have records that utilized the ASA standard for hearing tests. If this is the case, and the Veteran was discharged after the military switched to ISO/ANSI standards (post 1969), then a conversion process will be needed in order to compare hearing tests from different standards eras.

Working resolution: Please use the following conversion table (also viewable in your portal under "training by specialty"). The following values must be ADDED to ASA standard audiograms in order for an accurate comparison to be made and subsequent calculations such as threshold shifts:

- 500Hz: 15dB
- 1000Hz: 10dB
- 2000Hz: 10dB
- 3000Hz: 10dB
- 4000 Hz: 5dB

Thank you again for your continuous attention to detail during these examinations and in your report submissions.

Warm regards,

— Jeffrey D. Cooper, AuD.
VES Medical Advisory Board,
Audiology Member

QC Corner

As you may have noticed in your communications with VES, particularly those in the QA department, we have recently restricted the team and given it a new, more appropriate name: Quality Control, or the QC team. This name more accurately captures the role of the person reviewing providers' reports: controlling the quality before it is sent to VBA for rating purposes.

Lastly, please note we are recycling these two articles from the spring newsletter as they continue to be prominent trends in our reports, and unfortunately errors in our VA report cards.

Yes, you may review records brought in by Veterans.

Attention General Medical Providers

There has been much confusion over the past several years on whether providers may review medical records brought in by the Veteran. We are pleased to clear this confusion up by sharing the following current guidance from VA:

"In cases where a Claimant presents medical records to the Examiner, the Examiner shall review the evidence contained in the medical records, state in the remarks section of the DBQ, 'This evidence was brought in by the Veteran to the examination,' and document the evidence considered. Additionally, the Examiner shall direct the Claimant to send the records to VA."

Please instruct the Veteran to submit his/her medical records to the VA Intake Center:

DEPARTMENT OF VETERANS AFFAIRS
CLAIMS INTAKE CENTER

P.O. BOX 4444

JANESVILLE, WI 53547-4444

Other Helpful Tips/Clarifications on Reviewing Records and Diagnostics

- Only actual diagnostic reports of record should be included as evidence in the DBQ. Another provider's reference in the records to the results of a diagnostic which is not available for confirmation should not be incorporated into the current DBQ.
- Be sure to record accurate dates when citing diagnostics from the records. Use the date of the testing and not the date of the interpretation, follow-up appointment, upload date to VBMS, etc.
- Be sure to summarize relevant diagnostics from the records in your DBQ and MO.

What Our **Veterans are Saying!**

> My visit to the Pflugerville, Texas VES office today was excellent. The Intake Specialists (Raynie, Lyric, Claudia) were professional, polite, kind, and helpful. The intake process was smooth and quick. The COVID check and questions were quickly covered and then I was offered a drink and snacks while I waited for my appointment with David Makia, NP. David called me back on time to the exam room and made sure I was comfortable prior to starting the questioning and physical exam. David was also thorough, professional, and polite. I felt he really cared about my needs and conducted his exam in such a way that I felt comfortable with him from start to finish. I have visited and received care at VA facilities all over the country; they could take a real lesson in veteran care from this VES office. Thank you for your service to our nation's veterans and warfighters.

> Staff was very friendly. Great wait time. They knew exactly what they were doing.

> I wanted to take a brief minute and provide feedback on the Team that helped me this last week. I am in the process of going through my C&P evaluations and knowing how important the process is and never having done it before it can be a little stressful. I would like to thank Dr. Stuart, Ms. Lisa Nina, and Ms. Tanya Kisha with the San Antonio VES center for their professionalism and humor. It was a very good experience which placed me at ease, and the fact that the ladies acknowledged my pending retirement with a congratulatory word was a great touch. Thank you for fostering such a great environment.