IV. Medical Evidence – The Key to a Successful Result in the VA Disability Process

// Prepared by Howard E. Frasier, Jr., Soldiers' Medical Evaluation Board Counsel (SMEBC) at Fort Campbell, Kentucky

A. VASRD – the VA Bible for Ratings - 38 CFR Part 4

1. History – written in late 1940's, some more recent partial updates, not like any of the more modern disability rating codes such as codes used for workers compensation.

2. https://www.ecfr.gov/cgi-bin/text-idx?rgn=div5&node=38:1.0.1.1.5

3. §4.20 Analogous Ratings.

   "When an unlisted condition is encountered it will be permissible to rate under a closely related disease or injury in which not only the functions affected, but the anatomical localization and symptomatology are closely analogous."

4. Combined Ratings Table

   Similar to other disability systems such as workers compensation, the VA has a Combined Ratings Table to insure that no Veteran has more than a 100% disability. I tell my clients that VA math is not the same math that you learn in elementary school, 2 + 2 may not equal 4. Under VA math 10 + 10 equals 19 and it goes downhill from that point. (Enclosure 1).

   Let's take an example of 4 ratings; 10%, 20%, 30% and 40%. One would expect that these 4 ratings mean the Veteran has reached the magic level of 100%, maximum VA disability. You would be wrong. Under the Table, 10 and 20 is actually 28, then you take 28 and match it with 30 to get 50. Finally, you take 50 and match it with the 4th column (40) to obtain a final number of 70. In other words, you have a combined rating of 70% instead of 100%.

   If this is not frustrating enough, in order to move from 70% to 100%, the next rating would have to be 90% or a combination of additional ratings to raise the total combined number to 95 or higher.

   The one bit of good news with VA disability is that if a Veteran qualifies for a 100% combined rating, the Veteran is not prohibited from having a full time civilian job. However, if the Veteran's disability does prevent him or her from performing any full time civilian position, such Veteran may be entitled to additional VA benefits and may be able to apply for social security disability. This is also different from workers compensation that would reduce any permanent and total disability if a claimant returned to the workforce.

B. Objective Medical Evidence – Most Effective for Ratings Changes

1. The strongest evidence to obtain rating changes is through new objective medical evidence that has NOT yet been reviewed by the VA.

2. Because of some who lie and exaggerate for money, the Veteran must understand that his legitimate and significant disabling medical symptoms will only count for purposes of VA disability if sufficient objective medical evidence exists for distinguishing between the Veteran and those few who are trying to defraud the system.

3. The best medical professionals to obtain this information from are the medical providers, particularly specialists, who have provided the most treatment to the Veteran. Moreover, when a Veteran is not being appropriately rated for a severe medical condition, you need to obtain "righteous indignation" from the caring medical providers who truly know how unfair the current rating decision is for the Veteran. I often ask my clients to provide a copy of the relevant VASRD section code (usually only a few pages) to the treating specialist so they will understand what accurate documentation the client needs to support a ratings change.

C. The Necessary Change in Attitude Toward Medical Treatment

1. Most Service Members during their military careers have the following attitude toward medical treatment: "grin and bear it and do not go to the doctor unless I am dying."

2. As SMEBC, during my first contact with Soldiers in the Medical Evaluation Board process, I tell them that for purposes of medical treatment, they need to take off their military cap, put on a civilian cap, and ask themselves: "If I was a civilian, and had these symptoms or significant pain, would I go to the doctor. If the answer is 'yes,' then I need to go to the doctor."

3. I suspect that many Veterans still today have their former military attitude toward medical treatment. As their attorney, the most important advice you can give them is to seek active medical treatment for legitimate and ongoing medical issues.

4. Beyond the scope of this presentation is the related need to convince the VA that the Veteran's worsening medical condition is a service-related or at least a service aggravated condition. This nexus evidence might be in the form of witness statements or military treatment records. The best evidence is from a medic or former military provider. However, it can include evidence in the form of statements from officers, NCO's, and

fellow service members who may have observed service-related injuries or symptoms. Other evidence might include newer studies tying certain diseases and conditions to combat or service-related activities. A physician at Vanderbilt University performed a study establishing that Soldiers who were exposed to sulfur fumes in 2003 in Iraq from a factory intentionally set on fire by terrorists had contracted a specific lung disease. Now these Soldiers not only receive service-related compensation, such injuries are deemed as directly combat-related.

5. Compensation may also be paid for post-service disabilities that are considered related or secondary to disabilities occurring in service and for disabilities presumed to be related to circumstances of military service, even though they may arise after service.

D. Review of Medical Records

1. Every Veteran should request a complete copy of his military and civilian medical records. He needs to know what they say and what they do not say in order to determine whether witness statements need to be obtained from medics or other service members to verify legitimate service-related and service-aggravated conditions.

2. Some of the most important records are diagnostic tests results and the initial intake examinations of a medical specialist. However, even regular treatment records can be helpful because they might reference ongoing medications or note daily symptoms not noted in specialist records. Only a part of the interaction between provider and service member/veteran is captured in medical records so the patient may need to follow up with the provider to try to get better documentation in the future or sometimes even a corrected medical note.

3. Of course, a signed medical release will be necessary for the attorney to obtain medical records. To the extent the Veteran is encouraged to obtain his records, and to continue to obtain any new records, this will assist the attorney in more quickly being able to advise the Veteran on potential courses of action.

E. VA Medical Examinations

1. The good news is that the VA now uses a system for recording medical examination results that is more detailed than past examination systems. (The older form used by the VA did not always require detailed findings.) The most common form is the C&P (Compensation & Pension) form. Another optional type sometimes used by VA physicians and private doctors is a DBQ (Disability Benefits Questionnaire). Both forms require the answering of a lot of questions and fairly detailed physical

examinations. They generally follow the requirements noted in the VASRD so the Veteran can at least have the ability to determine what findings were not made that could support a higher rating.

2. Because a separate series of questions and examinations is required for every single medical diagnosis, such examinations can become an assembly line procedure without the specific findings required for determining accurate ratings. Even more problematic is the fact that some examiners express doubt about the accuracy of findings favorable to a service member or Veteran and their comments might result in a lower rating or no rating.

3. Generally, all successful appeals of VA rating decisions will require new objective medical evidence not reviewed by the VA examiner. Many successful appeals also provide evidence that the VA examination findings are in error or are inconsistent with preexisting medical records. However, the problem with relying solely upon pre-exam records is the argument that the Veteran has simply had a miraculous recovery and the VA exam findings are more accurate.

4. The Veteran should have been supplied with copies of all VA examination reports as well as any ratings decision report. These reports should definitely be obtained and reviewed by the attorney in order to best assist the Veteran with any appeal.

F. Objective and Subjective Pain With Movement

1. For many body parts including the neck, back, shoulders, hips, knees, feet, ankles, and elbows, a minimal rating can be provided for objective pain with movement (and now even subjective pain in some cases). The "pain" rating for these body parts is generally 10%. However, this has now changed to a minimum 20% for shoulders. The rating was changed to 20% for shoulders because the minimum rating for range of motion limitations is 20% for shoulders and 10% for all other body parts. As a result, it was determined that the minimum "pain" rating for shoulders, through case law, should be 20%.

2. The key to obtaining at least a minimal "pain" rating is the existence of enough evidence to show a service-related diagnosis or at least an aggravation of service-related diagnosis. This may mean diagnostic tests such as MRI or x-ray reports showing structural issues or more extensive physical findings showing objective evidence of at least some type of ongoing diagnosis. Even though "subjective" pain complaints might support a minimal pain rating, such complaints are unlikely to result in a rating if not accompanied by evidence of an actual diagnosis. Because

"pain" is something that can be faked or exaggerated, having documentation from a caring treating provider may make the difference in obtaining or not obtaining a rating.

3. Generally, "pain" ratings are those provided by case law interpretation of the VASRD and are not specifically mentioned in the VASRD unless "pain" is just one of several symptoms listed for a specific diagnosis. For example, under diagnostic code 5055, for knee replacements, if a symptom of chronic severe pain exists after a knee replacement, instead of a minimum 30% rating, the Veteran may be entitled to a 60% rating for chronic residual symptoms.

G. Back and Neck Ratings

1. The Spine diagnostic codes are found at 5235 to 5243. This can be a frustrating section because one of the primary factors in rating spine diagnoses is range of motion testing which often varies with the examiner and is something that is not always accurately recorded by examiners or even treating providers. Generally, the existence of significant structural deficiencies in diagnostic testing, fusion surgery, significant spine injuries, and other objective reasons for limited motion makes the VA examiners less suspicious about Veterans who exhibit significant reduced range of motion findings.

2. Successful appeals of inaccurate VA range of motion testing can include finding examples of ROM tests done both before and after the VA examination that show more significant reduced motion. In particular, a treating orthopedic specialist or physical therapist who has seen the Veteran on multiple occasions and clearly knows the VA examination finding is incorrect may have some "righteous indignation" and may be more than willing to track down older ROM tests and to perform new ROM tests, all of which cumulatively helps to overcome the inaccurate VA tests.

   One important caveat is to make sure the treating provider records the type of device used to make the measurement. Generally, the VA uses a goniometer that is similar to a mechanical compass. Many treating physicians and physical therapists view this as a Stone Age device and use more modern electronic tools such as a bubble goniometer. Most of these more modern devices are even more accurate and their use should not be a problem if mentioned in the record. A problem does exist if the instrument used is not mentioned in a record. In that case, the VA rater may simply determine that the VA examiner's findings are more accurate because they used a goniometer.

3. One related diagnosis involving neck and back conditions is radiculopathy. This occurs when herniated or bulging discs, narrowed nerve openings, or other structural injury or degenerative change causes a bone to push on a nerve or the nerve sac to cause pain and numbness. If in the neck, this might result in pain or numbness in the arms. If in the back, this might cause pain or numbness in the legs. When radiculopathy is present, the Veteran is entitled to a separate rating for nerve involvement in addition to the rating provided for the other symptoms involving the neck or back. These diagnostic codes are found at 8510, 8511 and 8520.

   For neck radiculopathy, a minimum rating is 20% for "mild" to up to 50% for "severe." For back radiculopathy, a minimum rating is 10% for "mild" and up to 60% for "severe." For a better understanding of the differences in "mild," "moderate," "moderately severe," and "severe," a review of the attached Nerve Matrix Chart used by VA raters can be helpful. This is a chart taken out of a manual provided to VA raters for informal guidance on rating decisions. (Enclosure 2).

   While a "mild" rating can be provided for even "subjective" symptoms of an existing radiculopathy diagnosis, objective evidence is required for higher ratings under "moderate," "moderately severe," or "severe" categories. Such evidence can include MRI evidence of nerve impingement, physical findings of sensory loss, atrophy, and positive electrodiagnostic testing (EMG). One qualification is that EMG tests, usually performed by a neurologist, are not always "positive" and strong MRI and physical symptoms of radiculopathy can sometimes overcome a "normal" or "negative" EMG test.

H. Mental Health Ratings

1. One of the most publically criticized areas of VA disability involves mental health. The general criticism is that those who seek disabilities for mental health are largely faking or exaggerating. However, as SMEBC counsel, I can assure you that most of those service members and Veterans who have mental health diagnoses are not faking or exaggerating as shown by the increasing number of suicides. Certainly, every mental health diagnosis is not severe and may not prevent the holding of many types of civilian jobs. I usually begin my discussion of mental health ratings with my clients by pointing out that if every service member with a mental health diagnosis should be medically discharged, who would remain to fight the wars? The answer is "no one" or at least "not many." If a service member is being medically discharged for a mental health diagnosis, this usually means such diagnosis is much more severe than most service members. However, even those service members and Veterans with less severe mental health symptoms may still qualify for a mental health rating.

2. As an attorney, you have an ethical obligation not to pursue an appeal if no good faith basis exists for such an appeal. In the mental health area, a Veteran with a mental health diagnosis generally has a fairly long history of mental health treatment and copies of all mental health treatment records should be obtained. Much like the Vietnam War, the more recent wars in the Middle East are fought with an enemy who does not wear an enemy uniform and distinguishing between non-combatants and combatants is difficult. Now add IED's and suicide vests and the traumatic effects of combat are magnified. Often the combat experiences I read in medical records or hear from the lips of service members makes the hair on the back of my neck stand up. While I have refused to pursue some appeals based on an absence of good faith, generally service members are very tight-lipped about their combat experiences and the full stories of what happened does not come to light until the service member has months, or even years, of treatment with a trusted mental health provider.

3. If a service member does not have a contemporaneous medical record of events which may have triggered significant mental health symptoms, I generally ask the service member to draft a personal statement identifying the triggering events of significant symptoms and to obtain witness statements from those fellow service members who may have observed combat or training stressors and the observed their effects upon the service member. At some point, a service member may later open up to a treating provider and these later records may be helpful to show service connection. Finally, statements from family members who have observed significant symptoms can be helpful.

4. Unlike physical diagnoses, no procedure exists for hooking up a machine to the brain of a Veteran and reaching a diagnosis of severe PTSD. One can line up 5 psychiatrists in one room, give them the same fact situation, and they might come up with 5 different diagnoses. A lot of wiggle room exists in this area and the Veteran is largely dependent upon the opinions of mental health professionals.

5. Moreover, the main purpose of mental health treatment is NOT to document how severe the mental health diagnosis may be, but to try to improve the mental health status of service members and Veterans. Thus, for those clients who identify significant mental health symptoms, and have not yet had much mental health treatment, they should be encouraged to obtain such treatment for the purpose of improving their mental health. For those who do not improve, the mental health treatment may at least identify the symptoms that qualify for a particular rating.

6. Mental health ratings are based on symptoms and not on a specific mental health diagnosis. (Enclosure 3). The ratings for mental health are 0%, 10%, 30%, 50%, 70%, and 100%. The diagnostic codes for mental health are found at 9201 to 9440. However, even with evidence of symptoms, a mental health provider or a VA psychiatrist must also have rendered an opinion of any actual and chronic mental health diagnosis. Medically discharged service members having stress-related mental health diagnoses such as PTSD or Other Stressor Disorder may be placed on temporary disability and must go back for another evaluation after becoming a Veteran before they obtain a permanent rating. The VA may also independently determine that a mental health diagnosis has improved and lower the rating for such diagnosis. Thus, the Veterans who choose to discontinue mental health treatment after becoming a Veteran, even if symptoms continue, may find that their VA mental health rating is reduced or eliminated.

7. As a final matter to consider, a Veteran seeking assistance with worsening mental health symptoms may have real and continued symptoms of suicide or homicide ideation. If there is any question that a client may act on such thoughts, you should encourage the Veteran to seek emergency treatment. I have had instances where I have had to contact a physician trusted by a service member to obtain assistance in avoiding possible suicide. Generally, if a service member or Veteran already has a trusted mental health provider, or even a physician of any type who they really trust, such medical professionals are willing to intervene. The client may even give you permission to contact such professional if you ask them.

I. Diagnostics Codes Requiring Proof of Frequency

1. A number of VASRD diagnostic codes are dependent upon an accurate log or other documentation of the frequency and severity of episodic events for purposes of ratings. These can include prostrating migraines, seizures, and narcolepsy found at 8100, 8108, 8911, and 8914.

2. For example, if a Veteran has at least one prostrating migraine per month over the last several months, then he may be entitled to a 30% rating under diagnostic code 8100. Less frequent prostrating migraines may only justify a 10% or 0% rating while extremely severe migraines might justify a 50% rating. The best evidence of such frequency is determined by looking at notations in medical records. However, because a Veteran with migraines usually has a combination of some non-ratable tension headaches and some prostrating migraines, and does not always have his migraines adequately documented in medical records, the preparation of detailed and contemporaneous migraines or headaches logs can be helpful. The attached sample log is not sufficient in itself to obtain a rating, but if a copy of such completed log is regularly provided to treating physicians

who are aware of such a diagnosis, and such numbers are incorporated in medical records, this may assist in obtaining a more accurate rating. (Enclosure 4).

3. Migraines are also a diagnosis that is easy to claim but often difficult to support. Unfortunately, no test of the brain can be made to determine the number of prostrating migraines that have occurred. As a result, VA examiners and raters are often skeptical of service member and Veteran reports of prostrating migraines. While a traumatic brain injury (TBI) might result in a brain damage sufficient to cause prostrating migraines that can be documented with a brain scan, most TBI events do not provide such evidence. High blood pressure, neck injuries, or even mental health stressors may cause migraines. If a treating provider for continuing prostrating migraines can identify some type of cause, then this may offer additional support for a rating. Generally, neurologists are the type of specialists who treat migraines and are in the best position to document their frequency.

4. Epilepsy and similar diagnoses which result in seizures are generally rated according to the frequency of major or minor seizures under diagnostic code 8911. A Veteran with seizures needs to make sure that his treating medical providers are keeping track with the frequency of his seizures and the keeping of a contemporaneous log can also be helpful if regularly provided to the treating physician.

5. Narcolepsy is also rated based upon the frequency of narcoleptic episodes similar to major and minor seizures under 8108. Narcolepsy generally occurs when a service member or Veteran involuntary falls asleep. If it occurs with cataplexy, then this means there is a sudden falling asleep which is most similar to a seizure. Other forms of narcolepsy are without cataplexy that means a less sudden failing asleep similar to a forced nap. Narcolepsy without cataplexy is generally more difficult to establish a rating because a medical provider may simply recommend the taking of two or more naps per day to avoid any narcoleptic episodes.

J. Obstructive Sleep Apnea (OSA)

1. Currently, if a Veteran is diagnosed with service-related OSA, and is provided a CPAP machine, he is entitled to a 50% rating under VA the diagnostic code 6847. The reason for this rating is that in the late 1940's, to treat a condition similar to OSA, the patient was placed in the hospital and hooked to a machine the size of a small room. At that time, no one could predict that a CPAP machine would be invented which was the size of a small box; and, if it resolved the episodes of snoring and permitted a deep sleep, then there would be little if any occupational disability.

2. Some service members with lumbar or neck fusion surgery, and significant occupational disability, are only obtaining a 10% or 20% rating and they ask me how it is fair for another service member/veteran with OSA to get a 50% rating. The answer is that it is one of the few areas of the VASRD that is more favorable from a rating perspective than other areas. (Of course, I had a recent client who had lumber fusion surgery and a separate diagnosis for OSA with a CPAP device, so he was not complaining.) While there is some discussion of lowering the rating for OSA, this has not yet occurred, and any attorney for a Veteran should certainly investigate whether a treating provider has identified any service-related sleep issues with a possible diagnosis for OSA with a CPAP machine.

3. Generally, evidence of OSA with a CPAP machine requires an initial sleep study to determine if OSA is present. If a diagnosis of OSA is made after the initial sleep study, then a second titration sleep study is scheduled with the use of a CPAP machine that may provide a mask covering only the nose or a mask that covers both the nose and the mouth. Finally, if the patient tolerates the use of a CPAP machine and there is an improvement in periods of deep sleep, then a CPAP machine is provided to a patient. The recognition by the VA of an OSA with CPAP diagnosis generally requires the submission of the two sleep studies mentioned above, the order for the CPAP device, and a treating provider diagnosis showing a service-related condition requiring such treatment.

K. "Truth and Justice"

1. Helping Veterans obtain fair VA disability ratings for legitimate and significant occupational disabilities can be personally fulfilling. After years of military service, often in remote locations without a lot of medical documentation, and after years of a treatment attitude of "grinning and bearing it," it can sometimes be challenging to fight for "truth and justice" and obtain a fair rating for service-related occupational disabilities.

2. The vast majority of my clients insist that they only want to be treated "fairly" and they do NOT want anything in excess of fair disability benefits. The mantra that is most effective in this process to obtain objective medical evidence supportive of fair disability determinations is to insist with clients, treating providers, and VA raters that the desired result is only "Truth and Justice" under the law and the evidence presented.