THE C&P EXAM: ISSUES AND SOLUTIONS
A NEUROSURGEON’S PERSPECTIVE

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VETERAN’S EVALUATION SERVICES
**Figure 1.**

**Trends in the Number of Veterans Receiving VA Disability Payments and in Spending on VA Disability Compensation**

*Index, 2000 = 1.0*

- **Veterans Receiving Disability Payments**
- **Spending on VA Disability Compensation**

**Source:** Congressional Budget Office based on data from various years of the Department of Veterans Affairs' Budget Submission and Annual Benefit Report.
Figure 3.
Veterans Receiving VA Disability Compensation, by Era of Service

Source: Congressional Budget Office based on data from various years of the Department of Veterans Affairs' Annual Benefit Report.

Notes: Veteran recipients are counted as of the beginning of each fiscal year.
Average Annualized Payments for VA Disability Compensation, by Era of Service

Source: Congressional Budget Office based on data from various years of the Department of Veterans Affairs’ Annual Benefit Report.
### MEDICAL CONDITIONS CLAIMED, FY 2015-2016

<table>
<thead>
<tr>
<th>Disability</th>
<th>FY2016</th>
<th>FY 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tinnitus</td>
<td>1,610,911</td>
<td>1,450,462</td>
</tr>
<tr>
<td>Hearing loss</td>
<td>1,084,069</td>
<td>1,015,305</td>
</tr>
<tr>
<td>Post-traumatic stress disorder</td>
<td>887,899</td>
<td>813,277</td>
</tr>
<tr>
<td>Lumbosacral or cervical strain</td>
<td>844,353</td>
<td>773,741</td>
</tr>
<tr>
<td>Scars, general</td>
<td>827,459</td>
<td>745,779</td>
</tr>
<tr>
<td>Limitation of flexion, knee</td>
<td>755,204</td>
<td>657,998</td>
</tr>
<tr>
<td>Paralysis of the sciatic nerve</td>
<td>580,986</td>
<td>499,402</td>
</tr>
<tr>
<td>Limitation of motion of the ankle</td>
<td>511,300</td>
<td>455,396</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>438,572</td>
<td>431,166</td>
</tr>
<tr>
<td>Migraine</td>
<td>436,339</td>
<td>395,327</td>
</tr>
<tr>
<td><strong>Total number of most prevalent disabilities</strong></td>
<td><strong>7,977,092</strong></td>
<td><strong>7,237,853</strong></td>
</tr>
<tr>
<td><strong>Total number of disabilities</strong></td>
<td><strong>21,382,399</strong></td>
<td><strong>19,683,391</strong></td>
</tr>
</tbody>
</table>
## INDEPENDENT MEDICAL EVALUATION AND C&P EXAMS
### V. TRADITIONAL CLINICAL EVALUATION

<table>
<thead>
<tr>
<th>Aspects (Usual)</th>
<th>Independent Medical Evaluation (&quot;IME&quot;)</th>
<th>Compensation &amp; Pension Exam (&quot;C&amp;P&quot;)</th>
<th>Traditional Clinical Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goal</strong></td>
<td>Case management &amp; evaluation</td>
<td>Case management &amp; evaluation</td>
<td>Clinical care</td>
</tr>
<tr>
<td><strong>Examiner</strong></td>
<td>Independent physician</td>
<td>Physician, physician’s assistant, nurse practitioner, or clinician in residence</td>
<td>Treating or consulting physician</td>
</tr>
<tr>
<td><strong>Future Visits</strong></td>
<td>No</td>
<td>No</td>
<td>Yes, possible</td>
</tr>
<tr>
<td><strong>Examiner-Patient Relationship</strong></td>
<td>No (or limited)</td>
<td>No (or limited)</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Visits</strong></td>
<td>One</td>
<td>One</td>
<td>Multiple possible</td>
</tr>
<tr>
<td><strong>Reader</strong></td>
<td>Claims professionals, attorneys, fact finder</td>
<td>Claims professionals, attorneys, fact finder</td>
<td>Health care providers</td>
</tr>
<tr>
<td><strong>History</strong></td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>Focused on chief complaints</td>
</tr>
<tr>
<td><strong>Physical Exam</strong></td>
<td>Detailed w/ documentation</td>
<td>Detailed w/ documentation</td>
<td>Focused on chief complaints</td>
</tr>
<tr>
<td><strong>Issues</strong></td>
<td>Multiple potential</td>
<td>Multiple potential</td>
<td>Clinical assessment, evaluation, and treatment</td>
</tr>
<tr>
<td><strong>Report</strong></td>
<td>Detailed, written</td>
<td>Detailed, written</td>
<td>Concise, often e-record</td>
</tr>
</tbody>
</table>
GENERAL OUTLINE

Individual
Diagnosis or condition
Confirmed by Attending Physician
Claims inability to do activity
Limitations or restrictions
Occupational impact
Specified amount of time
Are you willing to exaggerate clinical data to help a patient you think deserves disability benefits?

44% YES

56% NO
PHYSICIANS AND DISABILITY DETERMINATIONS

• Physicians may lack knowledge of the patient’s work duties and rely on the patient’s description of job functions and employer expectations.
• Physicians prefer the advocate role and perceive that time away from work is in the patient’s best interest.
• Physicians perceive that the doctor patient relationship may suffer.
• Physicians lack formal training, education and experience in disability evaluations.
• Physicians do not want to fill out lengthy administrative forms, especially when not compensated for their time.
FROM A CONTRACTOR’S PERSPECTIVE: PROCESS

- Clinic days are scheduled based on physician’s availability.
- Based on the VA requests, dates and locations are scheduled.
- Evaluation time based on number of DBQ’s to be completed.
- Claims file made available/”pertinent medical records” in a separate folder
- Report turn around time: 48 hours.
- QA Addenda sent/ reply time: 48 hours.
- Delays: incomplete testing, incomplete records, difficulty reaching the veteran.
- Rescheduling: C&P exam, ancillary testing, additional C&P evaluations
CLINICAL CHALLENGE OF THE C&P PROCESS

• Veterans file claims months ahead of C&P exam. Rarely do veterans know why they are being seen and for what claim.

• Veterans do not have an opportunity to prepare for the exam. Appointments are made for the veteran.

• Veterans do not bring lists of medications or medications, for example.

• Once the C&P exam is finished, there is no mechanism to make available records, lists of medications or other evidence to the examiner.

• Veterans may hand carry records that are not available on VBMS.

• “Chart dumping”.
CLINICAL CHALLENGES OF THE C&P PROCESS

• Material records not available on the day of the evaluation.
• Veterans who hand carry records/getting the information to VBMS.
• Evaluation and testing done at facilities outside the VA are not available by the time of the evaluation.
• Being careful not to “do the wrong thing faster” as inefficiency can lead to resentment.
• No known mechanism for veterans to make records available to the examiner prior to the visit or after the visit.
• “VA Kickbacks” are anathema to contractors: fear of losing contracts, perception of low quality work.
CLINICAL CHALLENGES AT THE REPORT WRITING LEVEL

• Expectation of report writing in 48 hours irrespective of how long the exam is and how many claims need to be evaluated.

• DBQ/medical condition claimed discrepancy: no efficient mechanism to communicate/improve this at the clinic level. “This is what the VA sent”.

• Example: leg numbness ongoing after a fall from a truck: DBQ Peripheral Nerve instead of a DBQ Back Tspine to address radiculopathy. Veteran would not have a diagnosable condition in the former, but would in the latter. Comments made on the Remarks section but no diagnosis rendered.
CLINICAL CHALLENGES AT THE REPORT WRITING LEVEL

• Instructions for medical opinions can be confusing or even contradictory: “It is more likely than not that the claimed leg numbness is due to an in service illness, injury or event.”

• Redundancy in terms of the information being asked: narrative asks for a summary of testing done, then again testing is asked at the bottom of the DBQ. Which one has more relevance to the adjudicators?

• Availability of remand letters: BIG ISSUE!! Without instructions of what the issues are and the background on the controversy, expert evaluation is meaningless. No way to reconcile conflicting information.

• How to make information available to the VA AFTER report submission? Veteran stops by and brings their new MRI, for example.

• Making prior C&P exams available: exam comparison, evaluate what records were used and assess thoroughness of prior exam (was information missed that should have been included in the prior rating?)
MEDICAL OPINION WRITING

• State the actual premise in detail with special attention to what happened in service (include dates the adjudicator can verify, as well as including follow up notes with dates).

• The current diagnosis should be clear and unequivocal: clear narrative that includes signs and symptoms, diagnostic testing (if applicable), past and current treatment.

• It also presents an opportunity to clarify and apportion what signs and symptoms may belong to a different condition (if needed).

• Elaborate on how the illness, event or injury is service connected including ongoing symptoms and rejecting alternative reasons: CAUSATION!!

• If not clear, the provider has an opportunity to document sources such as research studies. Be careful that correlation is not confused with causation.
MEDICAL OPINION WRITING

• For some conditions there is a presumption based on service: AO, DD 214 data, imminent danger pay scale, for example.

• Secondary conditions: diabetic peripheral neuropathy can be triggered from the DBQ Diabetes Mellitus.

• Aggravation due to service: identify baseline exam data (entrance exam for example), then find clinic notes that support exam findings, symptom complaints and follow them over time.

• Documentation is of the essence. However, it also does not hurt to elaborate on the natural history of a medical condition: ACL tear that leads to degenerative arthritis.

• References from textbooks and well known medical journals and databases. Use EndNote if needed.

• Make it clear for a lay person to follow the logic of the argument: pretend you are testifying in court and that multiple stakeholders are evaluating the strength of your argument.
PROBLEM: ADEQUACY OF MEDICAL EXAMS

Physicians lack formal training regarding VA standards for evaluating disabilities for veterans benefits purposes.

During a 6-month period, the VA relied on approximately 10,400 inadequate or incomplete C&P exams when determining a veteran's benefits.

VA Office of Inspector General: Office of Audits & Evaluations findings
PROBLEM: ADEQUACY OF MEDICAL EXAMS

VA conducted C&P exams are often inadequate for purposes of rating a veteran’s conditions

“The adequacy of medical examinations and opinions, such as those with incomplete findings or supporting rationale for an opinion, has remained one of the most frequent reasons for remand.”

113th Cong. 1st Sess. 23 (2013)

(statement of Laura H. Eskenaki, Executive in Charge, BVA)
PAVING THE PATH FOR IMPROVEMENT: ADMINISTRATIVE ISSUES

• Oversight of which DBQ’s are more appropriate to send to evaluate the claim.
• In the event the DBQ is not appropriate, a mechanism to allow to request the appropriate DBQ.
• Allow for an expeditious process of correcting/self-correcting claims due to wrong DBQ being sent.
• Example: DBQ TBI INITIAL sent to evaluate a CNS condition (tumor, mucocoele, cyst) that belongs in the DBQ CNS.
PAVING THE PATH FOR IMPROVEMENT: ADMINISTRATIVE ISSUES

• Veterans and their representatives need to be informed of what condition they are being evaluated for PRIOR to the C&P appointment.
• Reminders to attend the appointment.
• Make veterans aware of the Blue Button initiative: access to their medical records.
• Assist veterans in completing forms, attending diagnostic appointments and the C&P appointment.
• Seek feedback about the quality of the appointment: facility, provider, diagnostic testing facility with veterans reporting bruising, long wait times, inadequate sanitary conditions as examples.
PAVING THE PATH FOR IMPROVEMENT: PROVIDER ISSUES

- VA/contractor collaboration with community providers to participate in C&P evaluations
- Training modules: online, webinars, use professional society meetings to offer training, offer CME for module completion. Educate providers on the “culture and language of the VA.” Trial and error is not effective and is costly.
- Face to face interview desirable: get to know your providers, strengths, weaknesses, personalities.
- Monitor adequacy of C&P evaluations: peer to peer, quality analysts, allow the different providers that are evaluating a veteran to be able to exchange observations and opinions.
- Insure providers have an understanding of issues related to causation including interpreting medical literature (basic knowledge of statistics, evaluating a journal article, causation).
PAVING THE PATH FOR IMPROVEMENT:
PROVIDER ISSUES

• Not all providers are equal: some are more personable, some are more reserved, some write more, some less.

• C&P workforce: interest residents of different specialties in the process. Post graduate six month fellowship with certification, some providers that are on leave from their practices while caring for loved ones or helping raise families, for example.

• Provide frequent feedback to providers: quarterly stats on their performance, address issues of timeliness, report writing including opinion writing, causation.

• Seek provider feedback on issues that arise during the course of the evaluations. Report to VA in quarterly meeting, for example.
PAVING THE PATH FOR IMPROVEMENT: VA ADMINISTRATION

• Eliminate “chart dumping”: table of contents, improve the search function on the platform to allow for multiple search terms.

• The remand letter along with the issues related to the remand needs to be flagged and made available.

• Evaluations that have a remand order should be preferably done by providers who have experience with medical opinion writing. Extra time (96 vs 48 hours, for example).

• Spend time educating physicians who, ultimately, are interested in doing a good job, on what the VA expects: provide feedback on opinion writing (what worked, what was not clear).

• Pilot study for remand cases: communication/conduit between veteran, RO, provider, to insure (a) adequate DBQ, (2) all evidence is evaluated including lay statements if warranted, (3) insure the veteran has an opportunity to have their story heard, validated, (4) provide feedback to provider about veteran’s perception of exam, (5) provide feedback from adjudicators and have a conversation if needed.
PAVING THE PATH FOR IMPROVEMENT: VA ADMINISTRATION

• Veterans find the process onerous: lengthy forms, multiple appointments in different locations.

• Veterans and their representatives can benefit from knowing timeline for their appointments and what their appointments are for.

• Veterans and their representatives should have an opportunity to insure all the necessary evidence is on VBMS or, at least, streamline a process whereby that information can be made accessible to all the stakeholders evaluating the claim: transcripts available, remand letters, prior evaluations, clinical and diagnostic information and records, lay statements.

• Make available a yearly report of how many claims were filed with denials, granting benefits, how many remands, most common conditions, as well as adequacy of exams, why denials.
PAVING THE PATH FOR IMPROVEMENT: VA ADMINISTRATION

• DBQ improvement: revise DBQ content to reflect current medical guidelines. For example: MMSE evaluation on the DBQ TBI INITIAL.

• Educational program for providers: modules, training sessions, mock evaluations, testing, newsletter, provide CME, reach out to specialty societies such as American Association of Neurological Surgeons or the American Board of Internal Medicine.

• AMA has their own guidelines book. The VA should similarly publish a guidelines book. For remand and appeal cases, request physicians who have demonstrated education and experience in medical report writing, understand causation, understand how to evaluate medical literature.

• Consider a “fellowship” option for residents interested in doing disability evaluations from different specialties. Otherwise consider allowing practicing providers to become knowledgeable on VA C&P evaluation processes and provide timely and continuous feedback with the goal of improving report quality.
THANK YOU!