



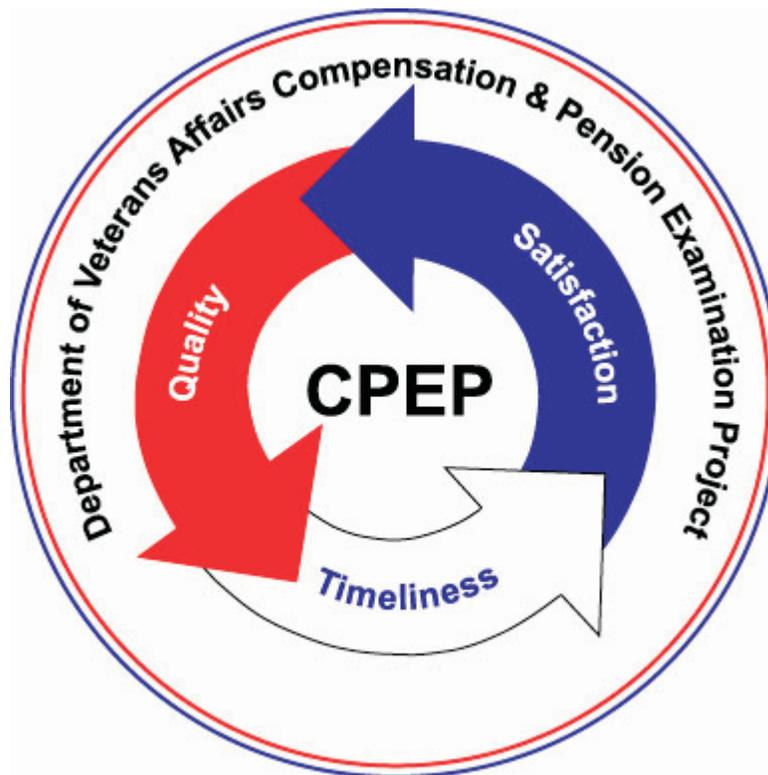
# Department of Veterans Affairs

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## Quality Measurement of Compensation and Pension Examinations

National Baseline Performance  
Ten Most Common Exam Types



July 10, 2002

Compensation and Pension  
Examination Project Office  
CPEP

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DEPARTMENT OF VETERANS AFFAIRS  
WASHINGTON DC 20420

July 3, 2002

MEMORANDUM FOR VISN DIRECTORS, VA MEDICAL CENTER DIRECTORS, AND VA REGIONAL OFFICE DIRECTORS

SUBJECT: Compensation and Pension Examination Project Office Report - Quality Measurement of Compensation and Pension Examinations

The accompanying Compensation and Pension Examination Project (CPEP) report on the baseline quality of compensation and pension (C&P) examinations is a necessary, constructive, and important stride on a fast track of improvement. It identifies our initial challenges, and we welcome them as an opportunity to deliver breakthrough improvements in the quality of our service to America's veterans.

We endorse this report, strongly support CPEP's ongoing quality improvement efforts, and require your support of these efforts as well. Please review the report carefully and use the information to research and implement performance improvement measures at your facilities. CPEP will continue to track your performance in regular future analyses in support of our goal of complete, high-quality, and timely C&P exam reports.

Many participants in the Collaborative Breakthrough Series on Improving Exam Quality have already begun to improve their C&P exam processes and reports. We have seen data on some of the early successes and we commend your effort. We strongly encourage full support by leadership at every level for these quality initiatives.

We now challenge each of you to accept responsibility for your portion of the claims decision process and for the cooperative pursuit, within and across organizational boundaries, of the excellent C&P service veterans deserve.

Let us be clear: C&P claims processing is a VA problem, not just a VBA problem. By the same token, C&P exam reporting is also a VA problem, and not just a VHA problem. The C&P examination process is a key factor in our ability to deliver on this priority. We are taking systematic measures to assure that this process – from the initial exam request to the signed exam report received by the rating decision maker – can and will consistently provide complete, high-quality, responsive, and timely C&P exam reports.

Daniel L. Cooper  
Under Secretary for Benefits

Robert H. Roswell, M.D.  
Under Secretary for Health

Anthony J. Principi  
Secretary

Attachment





July 10, 2002

The Veterans Benefits Administration (VBA) and Veterans Health Administration (VHA) are taking steps to improve veterans' claims processing. On February 20, 2001, the Under Secretaries for Benefits and Health executed a Memorandum of Agreement, which established a joint initiative between VBA and VHA. As a result, the Compensation and Pension Examination Project (CPEP) Office was chartered in April 2001. The purpose of the agreement was to improve the compensation and pension (C&P) examination process. Under this agreement, VHA and VBA united in a collaborative initiative to measure the quality of compensation and pension examinations; improve the compensation and pension examination process; identify and develop best practices; and subsequently export best practices to field facilities. Staffed and funded by both administrations, the CPEP Office was charged with carrying out these activities.

The Compensation and Pension Examination Project (CPEP) Office began operations in June 2001 as a national office. Our overall mission has many components: measuring exam quality in a manner that is meaningful, reliable, and improvement-oriented; guiding exam quality improvement via education; best practice determination and dissemination; focused quality improvement initiatives; performance standards; and information technology.

We share with you the initial results of our work regarding the quality of compensation and pension examination reports produced by VHA and opportunities for improvement of the examination process. This initial report addresses national performance on the ten most commonly requested examinations. Subsequent reports will provide Veterans Integrated Service Network (VISN-specific) performance data and cover the thirty-one most commonly performed examinations. Ongoing quality measurement will be reported to track performance changes over time.

If you would like additional information, please feel free to contact me.

A handwritten signature in black ink, appearing to read 'S. H. Brown'.

Steven H. Brown, M.D.  
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Examination Project Office (CPEP)  
VA Tennessee Valley Healthcare System  
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## Executive Summary

**Introduction:** The Compensation and Pension Examination Project (CPEP) Office was established by VBA and VHA to measure and improve the quality and timeliness of compensation and pension (C&P) examinations and customer satisfaction with the C&P examination process. CPEP's first step was to measure baseline C&P examination report quality in a valid, actionable way. This report documents VHA baseline performance on the ten most commonly requested C&P examination types.

**Methods:** Quality indicators for the ten most commonly requested exams were developed via extensive point-counterpoint discussion among two expert panels: the VBA Systematic Technical Accuracy Review (STAR) staff, and the CPEP Clinical Advisory Board (CAB). The CAB is composed of VHA and VBA clinician experts of national stature. Core quality indicators that apply to all exam types and exam-specific quality indicators were developed and vetted. A database containing all VHA C&P exams finalized in AMIE in the 4<sup>th</sup> quarter of FY 2001 was created (n = 121,087). Double independent reviews were conducted on 110 randomly assigned exams of each type; a third tiebreaking review was conducted if there was disagreement on any indicator.

**Caveats:** The results reported in this document **CANNOT** be compared to other measures of C&P examination quality (e.g., AMIS insufficiency rates) due to methodological differences. The results **CAN** and **SHOULD** be used to guide quality improvement efforts.

**Results:** Performance on the core quality indicators for all exam types was 96.7% +/- 0.33%. Exam-specific indicator performance was 85.4% +/- 0.51%. The overall quality indicator score for the top ten C&P examinations was 89.3% +/- 0.39%. The exam types with the greatest opportunity for improvement were Joints (71.5% +/- 1.88%) and Feet (75.1% +/- 2.22%). Exam types showing the best baseline performance were Mental Disorders (94.3% +/- 0.83%), Review PTSD (93.0% +/- 0.80%) and Audio (93.0% +/- 1.04%). Overall, 58.5% of exams scored 90% or better and 37.4% of exams scored 100%.

**Discussion:** VHA C&P examination quality is variable for the ten most commonly performed exam types. The issue of exam quality is greater than reflected in the "AMIS insufficiency rate." Opportunities for improvement are most apparent for Joints, Feet, Spine, and General Medical exams. Performance on the other exam types was better, but improvements could still be made. Ongoing measurement at the Veterans Integrated Service Network (VISN) level is critical to monitor and guide improvement efforts.

## Introduction

VA is responsible for the administration of programs to benefit those who have “borne the battle.” In 2001 appropriations for carrying out this responsibility included approximately \$23.4 billion for compensation and pension benefits, and \$21.3 billion for healthcare programs.

Quality is the number one issue surrounding VHA compensation and pension (C&P) exams. In fact, the Under Secretaries for Health and Benefits signed a Memorandum of Agreement (MOA) in February 2001 that states:

“If performance measures are not achieved, a mechanism will be developed that will allow VBA to control the funding for compensation and pension examinations by administratively fencing off funds currently expended on compensation and pension examinations performed by VHA.”

The MOA also established the Compensation and Pension Examination Project (CPEP) Office. This national office is chartered to improve the quality and timeliness of C&P exams and customer satisfaction with the C&P examination process. CPEP responsibilities include baseline and continuous assessment of C&P exam quality and communication of results to provide feedback for performance improvement.

## Background

Disability compensation is a monetary benefit paid to veterans with service-connected disabilities. “Service-connected” means that the disability was a result of disease or injury incurred or aggravated during active military service. Disability compensation is graduated according to the degree of the veteran’s disability on a scale from 0% disabling to 100% disabling, in increments of 10%. The benefit payment amount corresponds to the degree of disability. In addition to the 100% disability rate, special monthly compensation benefits are payable to veterans with extremely severe disabilities, such as the anatomical loss or loss of use of a hand or foot, blindness, deafness, or various combinations of serious disabilities. The most seriously disabled veterans receive the highest benefit amounts, and less severely disabled veterans receive lower benefits.

VA pension programs are designed to provide income support to veterans (with wartime service) who become permanently and totally disabled or die as the result of non service-connected conditions, and their families. These programs

serve veterans and survivors who are experiencing financial hardship. Wartime veterans who are determined by VBA to be permanently and totally disabled by a non service-connected disability may be eligible for a disability pension.

The purpose of C&P examinations is to provide the medical information needed to reach a legal decision about a veteran's entitlement (or non-entitlement) to VA monetary benefits based on disability. A C&P examination report must provide specific information about numerous medical and social aspects of the disabling condition(s) to meet the medical/legal criteria contained in the VA rating schedule (38 CFR Part 4) for assigning and supporting a disability rating.

The Veterans Health Administration (VHA) performs 300,000 to 400,000 disability exams per year, or approximately 90% of all those performed. Exams are requested by (or on behalf of) Rating Veterans Service Representatives (RSVRs) working at Veterans Benefits Administration (VBA) regional offices across the country. Clinicians at VHA medical centers and clinics perform exams and return reports to the requesting rating specialist. To guide collection and reporting of the required information by the examiner, disability-rating criteria are summarized as elements of examination protocols (Automated Medical Information Exchange [AMIE] worksheets) for each of 56 categories of disability. Examiners are expected to use the AMIE worksheets as a guide in conducting and completing the disability examination and the examination report.

Exam report quality has been measured as the percentage of reports returned by the requesting rating specialist to the examining site as "insufficient." The exam insufficiency rate typically reported is between 1% and 2%. Because of widespread discontent with existing practice, CPEP has been charged with implementing a more objective quality assessment procedure.

The measurement of compensation and pension examination quality in a credible, actionable way is a top priority for the CPEP Office. This includes determination of baseline performance and ongoing performance measurement. We have developed reliable and valid methodologies for measuring examination quality as determined by the criteria stated in the examination worksheets and the rating regulations. This included elucidation and vetting of specific quality criteria; conducting a pilot study; developing data collection and management tools; and designing methods for acquiring examinations and requests for review.

In November 2001 we began a quality review of recently completed compensation and pension examinations from VHA facilities nationwide that conduct compensation and pension examinations. This initial review—the baseline evaluation of the ten most frequently requested exams—is the second step in a phased approach to objectively describe and actively improve compensation and pension examination quality. CPEP's work does not end

there, however. The current national-level evaluation of the ten most commonly requested exams will soon be extended to provide VISN-level data. In addition, work is already underway to review the next 21 most frequently requested examinations. Together, the 31 most frequently requested examinations account for 95% of all examination requests. Finally, ongoing review to guide quality improvement efforts is being planned.

In this report, CPEP presents the results of its first Compensation and Pension Examination Quality Review of the ten most commonly requested exams.

## Methods

### Exam Type Selection

The ten most frequently requested exams were selected for CPEP's first quality measurement effort. These exams cover two-thirds of all exams requested. We will subsequently examine the next 21 most commonly requested exams. Overall, the top 31 exam types account for 95% of all exams requested, as shown in Table 1 on page 10.

**Table 1**  
**31 Most Commonly Requested C&P Exams**

<b>Rank</b>	<b>Exam Type</b>	<b>Percent of Total</b>	<b>Cumulative Percent</b>
1	General Medical Examination	18.87	18.87
2	Joints	11.70	30.57
3	Hearing	8.67	39.24
4	Spine	8.35	47.58
5	Mental Disorders	5.65	53.24
6	Eye Examination	3.52	56.76
7	Post-Traumatic Stress Disorder (Initial)	2.77	59.53
8	Feet	2.72	62.25
9	Post-Traumatic Stress Disorder (Review)	2.69	64.94
10	Skin Diseases	2.22	67.16
11	Miscellaneous Neurological Disorders	2.14	69.29
12	Hypertension	2.13	71.42
13	Genitourinary Examination	2.00	73.42
14	Heart Disease	1.93	75.35
15	Ear Disease	1.71	77.07
16	Scars	1.69	78.76
17	Hand, Thumb, & Fingers	1.68	80.44
18	Respiratory	1.62	82.06
19	Muscles	1.53	83.59
20	Peripheral Nerves	1.47	85.06
21	Bones	1.46	86.52
22	Nose, Sinus, Larynx, & Pharynx	1.33	87.85
23	Stomach, Duodenum, & Peritoneal Adhesions	1.00	88.85
24	Arteries & Veins	0.93	89.78
25	Rectum & Anus	0.83	90.61
26	Dental & Oral	0.83	91.43
27	Aid & Attendance or Housebound Examination	0.79	92.23
28	Miscellaneous Respiratory Diseases	0.77	92.99
29	Brain & Spinal Cord	0.76	93.75
30	Diabetes Mellitus	0.66	94.42
31	Gynecological Conditions	0.62	95.03

## Quality Indicator Approach

The goal of the CPEP Office was to formulate and implement an instrument to reliably and accurately rate C&P examination report quality. Quality indicators provide an estimate of overall examination quality by focusing on a well-defined, relevant set of objective criteria that represents the performance of the examining clinicians. The quality indicator approach efficiently evaluates a report process by assessing a sample of reviews and reporting on the group performance rates. It differs from the audit approach, which places emphasis on individual, unique cases. In an audit, a thorough, exhaustive and expensive review assesses case-specific issues and judges each examination's adequacy in the context of all other information related to the case. The quality indicator approach assesses systemic issues and provides users with tools for quality improvement.

CPEP developed a set of guiding principles for quality indicators in general before developing specific quality indicators. The initial set of principles for building the quality indicators include the following:

1. **Logical** – The measure must make sense to stakeholders and process owners; it should be easily understood.
2. **Important** – Stakeholders must generally agree that the measure is important. Quality measures should link to an organization's aims and action plans.
3. **Useful** – A quality measure must permit data-driven action. Measures that cannot be acted upon should not be collected.
4. **Valid** – Measures must meet the criteria for good science: precise and reproducible (reliable), accurate (valid), meaningful, and sensitive across time.
5. **Feasible** – It must be possible to implement, collect and display the measure within acceptable time frames, level of effort and resource utilization.
6. **Current** – The measure must be capable of providing timely, and not delayed, feedback.
7. **Process and Outcomes** – Measures are linked to the key features of what is done (process) to bring about impact on the key outcomes.

Four additional guidelines were developed for selecting and framing examination quality indicators:

1. **Common** – Indicators must be common. Situations that apply rarely (e.g., estimated less than 5%) or where performance is already high (e.g., estimated greater than 95%) would not provide the statistical variation needed for a useful indicator.

2. **Relevant** – Indicators must be clearly referenced on the AMIE worksheet and in the rating regulations. Each indicator selected from the AMIE worksheet should also be a key rating schedule requirement.
3. **Objective** – An indicator must have clear, practical instructions for implementation to improve reliability and validity.
4. **Side Effects** – Indicators should not have side effects that could bring about a negative impact on the exam process (e.g., delay exams or increase costs unduly).

## Quality Indicator Development

Two expert panels were convened to write the quality indicators.

The CPEP Clinical Advisory Board (CAB) was formed to provide guidance and clinical oversight for the clinical activities of CPEP. Its members were chosen from around the country for their well-recognized expertise and represent both VBA and VHA.

The CPEP Technical Expert Panel is composed of the VBA Compensation and Pension Service's Systematic Technical Accuracy Review (STAR) staff in Nashville, Tennessee. The STAR staff review claims processing accuracy for VBA nationally. Staff were competitively selected to work for STAR from a national pool based on expertise and experience. In addition to being experienced disability claim reviewers, STAR staff have also taught the rating process and regulations to other VBA employees, served as decision review officers, and functioned as liaisons with examining clinicians.

## CPEP Clinical Advisory Board

Lewis Coulson, M.D., VHA Chicago  
Stephen Hunt, M.D., VHA Puget Sound  
Diane Johnston, M.D., VBA Muskogee  
Caroll McBrine, M.D., VBA VACO  
Steven Oboler, M.D., VHA Denver  
Audrey Tomlinson, D.O., J.D., VHA N. Florida/S. Georgia

**CPEP Technical Expert Panel: VBA STAR Staff**

Bill Bauer, Chief  
Paul Comstock  
Elizabeth Gregory  
Earl Hutchinson  
Dale Hyche  
Edna MacDonald  
Frank Smith

The CPEP Office worked with the STAR staff, the Clinical Advisory Board, and other experts in VBA, VHA, and the Board of Veterans Appeals (BVA) to carefully select representative quality indicators. The technical expert panel (STAR staff) reviewed the AMIE worksheets and rating schedules for the ten most frequently requested examinations. Tentative quality indicators were written, and a point-counterpoint discussion was held on whether the content and phrasing of the indicators met CPEP measurement principles and indicator guidelines. The proposed set of indicators was then sent to the Clinical Advisory Board for critique. An iterative process between panels continued until consensus was reached. The process often involved revisiting and re-evaluating items to be sure the indicators were crafted carefully. The development of the indicators was accomplished by individual and group work through extensive communication via e-mail, written documentation, group meetings and teleconferences. After considerable discussion, the expert panels endorsed the final set of quality indicators.

CPEP has created two categories of quality indicators: core quality indicators that apply to all exam types, and exam-specific indicators. The entire set of quality indicators and implementation instructions employed in the current study of the ten most commonly requested exams are presented in Appendix A. An example quality indicator follows.

**Quality Indicator:** Does report provide the active range of motion in degrees?

**Citations:** AMIE Joint Exam Section C1; 38 CFR 4.40, 4.45, 4.59

**Instructions to Reviewers:** Answer YES if the report states active range of motion in degrees OR explains why these measurements could not be done. Otherwise answer NO. Do not use NA.

## **CPEP Database and Electronic Tools**

CPEP's evaluation of compensation and pension examination quality nationwide required the collection, storage, and analysis of large data sets. To support this extensive information management process, an infrastructure consisting of a data repository and a set of specialized software tools was built, tested, and implemented. Tools were developed to acquire C&P exam data from around the country, to process and store the data, to implement and manage an electronic review process, and to output the resulting quality ratings for formal statistical analysis.

The data acquisition tools queried the VistA system at each medical center nationwide and transferred a detailed set of demographic information, examination requests, examination results, and examination tracking data to CPEP for processing. The initial data processing steps included filtering through the data to correct inconsistencies in data representation (e.g., inconsistencies in coding schemes across stations); rectifying data omissions or duplications; and reorganizing the data into a format compatible with the CPEP database. After processing, the data were loaded into a relational database system (Microsoft SQL Server) that served as the CPEP data repository. In addition to the nationally acquired claim and examination data, all of the quality ratings and review tracking data generated from within CPEP's quality review process were stored in the CPEP data repository to provide a comprehensive data source for subsequent analyses.

The CPEP quality review process was electronically supported by the development of several in-house software programs to streamline workflow and provide administrative data management functions. The CPEP reviewer program integrates quality-rating forms with exam reports, requests, and the appropriate AMIE worksheet. (See example on page 15.)

Workflow review was streamlined by providing immediate electronic access to all necessary documentation. CPEP administrative software provides tools for exam review assignment, tracking and management, quality rating form creation and maintenance, user account administration and access security.

### Example of Computer-based Review Tools

The screenshot displays two overlapping windows from a software application. The 'Exam Review' window on the left contains a checklist of review criteria and a rating scale. The 'Claim Information' window on the right displays details for a specific claim, including the date, diagnosis, and a detailed medical impression.

**Exam Review Window:**

Claim# [redacted] Reviewer 14 35 Mental (Initial Evaluat  
 Claim Date 8/15/2001 Review Itr 1

Yes	No	N/A	Element
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Post-military stressors and description of psychosocial consequer
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does the report address problematic alcohol or substance abuse?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Effects on employment functioning?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Is impairment of thought process or communication addressed an
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Is the diagnosis consistent with DSM-IV and supported by the ex
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does report describe multiple mental disorders and symptoms?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does report address veteran's ability to manage VA benefits?

Yes	No	N/A	Element
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Is each diagnosis stated precisely?
<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Was the lack of a diagnosis justified?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Was functional impairment information provided?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Did the examiner address all issues in the remarks section of the
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Was the requested medical opinion properly stated?

Rate the quality of this examination report in meeting all the AMIE worksheet criteria al  
 deficiency-competency scale

Deficient  1  2  3  4  5  6  Compe

OPTIONAL - enter comments about the exam

[Text input field]

**Claim Information Window:**

Claim# [redacted] Mental (Initial Evaluation PTSD)  
 Claim Date 8/15/2001

stated abstinence from alcohol and drugs.

IMPRESSION:  
 AXIS I: 1. PTSD, severe. 309.81 Note that this was secondary to combat/traumatic exposure in Vietnam.  
 2. Major depressive disorder, moderate, recurrent, without psychotic features.  
 3. History of alcohol abuse and dependence, sober since 1983 or 1985.  
 AXIS II: No diagnosis.  
 AXIS III: 1. Multiple nonserious medical problems, including:  
 a. GERD.  
 b. Hypercholesterolemia.  
 c. Angina.  
 d. History of kidney stones.  
 e. COPD.  
 f. Chronic gastritis.  
 AXIS IV: Psychosocial stressors; moderately severe, including financial hardship, estrangement from his natural family, markedly impaired interpersonal relationships, lack of adequate support system, and treatment resistant PTSD symptoms.  
 AXIS V: GAF: Current 40.

COMPETENCY: The patient is competent to manage any benefits to which he is entitled.

COMMENT: This patient has multi-dimensional impairments which arise following exposure to trauma/combat in Vietnam. There appears to have

use cr/ff

Exam Report Amie Worksheet Exam Request

## **CPEP Quality Review: Sampling and Assignment Strategy**

The CPEP quality review began with the collection of all electronically available records from each medical center within the time frame of the 4<sup>th</sup> quarter of fiscal year 2001 (July-September), yielding a resulting set of 59,009 compensation and pension claims. Attached to these claims were 121,087 examination requests, from which 106,665 actual examination results were obtained. The remaining 13,422 examination results were not available electronically. Data were acquired from almost all medical centers and 20 of 22 VISNs. Data were not gathered from the two VISNS with integrated databases (VISNs 2 and 15) because of recently changed network address information. The data repository will be updated on an ongoing basis.

The 10 most frequently requested examination types constituted 62,335 examination results out of the total 106,665 examination results in the CPEP database. A total of 1,100 examinations were sampled for review, 110 from each of the 10 examination types. The sample size of 110 was selected to ensure that the 95% confidence interval range was less than 5%.

## **CPEP Quality Review Process**

Examinations were assigned at random to a technical expert panel of six STAR staff reviewers who conducted quality assessments using the electronic review process. Each examination was assigned to two reviewers, who independently completed quality assessments online using the exam-specific and core quality indicators. At the end of the survey of indicators, reviewers were able, but not required, to enter comments. Reviewers occasionally encountered instances in which the review could not be completed. These “unreviewable” examination reports were tracked and the reasons for non-review documented. A substitute examination report of the same type was randomly assigned to meet the goal of 110 assessments per type of examination. A qualitative analysis of the unreviewable C&P exam reports may be found on page 53 of this report.

Reviewers were unaware of whether their scoring of an exam report matched that done by any other reviewer. Each pair of independent assessments was electronically compared. If the paired assessments disagreed on any of the exam-specific or core indicators, the examination was assigned to a third reviewer for an independent, tiebreaking review. Whenever a third reviewer was needed, the reviewer was not told which indicators were discrepant in the first two reviews, and was asked to provide a fully independent review. In all cases that were reviewed three times, the majority assessment was designated as the consensus indicator score.

## Analysis

The response to each exam-specific and core indicator was converted into a binary score. The score was equal to 1 if the indicator was met (response of “yes” or “not applicable”) and equal to 0 if the indicator was not met (response of “no,” i.e., the indicator was not addressed by the report). The exam-specific quality indicator score is the percentage of exam-specific indicators met. The core quality indicator score is the percentage of core indicators met. The overall quality indicator score is the percentage of exam-specific and core indicators met. In addition, each indicator from each exam report was scored separately. The score for each individual indicator is the percentage of exam reports in which the indicator was met.

Where relevant, indicator scores are also reported, excluding “not applicable” responses. Thus, the percentage is calculated from the number of “yes” responses divided by the number of “yes” and “no” responses. Various descriptive statistics are displayed for overall results and results stratified by type of examination, including mean percentage, standard error of measurement, and percentiles. The mean percentages are computed to comprise the national core quality score, national exam-specific quality score and overall quality score. Inter-rater reliability was examined using pair-wise percentage agreement and kappa coefficients for the first two reviewers.

Simple descriptive statistics and qualitative analysis of reviewers’ comments and reasons for “unreviewable” exam results are also presented.

## Critical Caveats for the Appropriate Use of Results

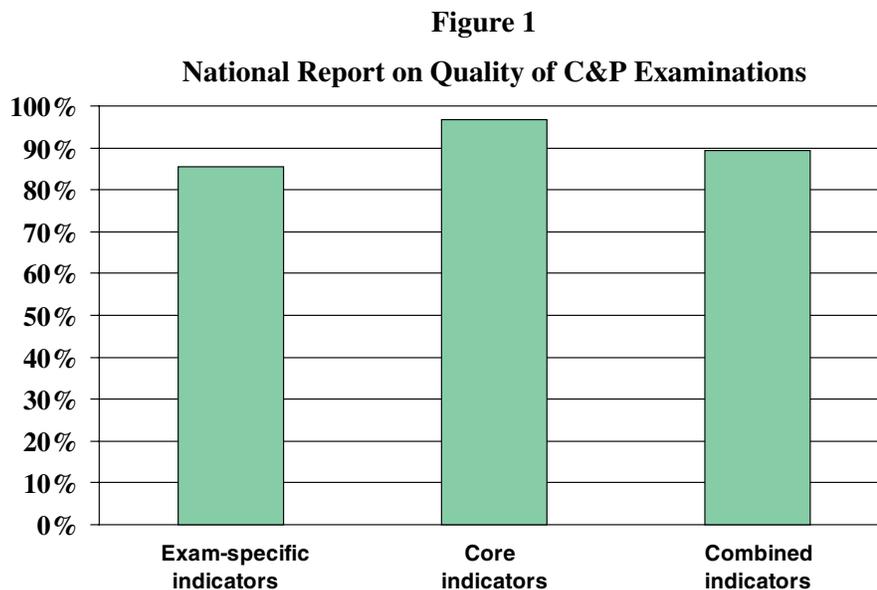
1. *CPEP Baseline Results **CAN NOT** be compared to “insufficiency” measures because different methodologies are employed.*
2. *CPEP Baseline Results **SHOULD** be used for constructive quality improvement efforts; they **SHOULD NOT** be used to punish sites or examiners.*
3. *CPEP Baseline Results **DO NOT** say if an exam was acceptable for rating purposes for a particular case. Other evidence not available to CPEP reviewers influences this determination on a case-by-case basis*

CPEP’s quality indicator approach was designed to produce concrete data to focus and support quality improvement efforts. CPEP’s charge was not to assure ratability of exceptional cases, but rather to improve the overall quality of compensation and pension examinations. To do so, CPEP chose to focus its baseline quality review on an important and frequent sample of specific items of medical information needed to support rating decisions. In future phases, CPEP’s examination quality monitoring activity will “drill down” to investigate examination report issues (and their causes) that occur less frequently than those addressed in this review. This will put us on a sure course of continuous quality improvement that, we believe, will best serve veterans and other stakeholders of the compensation and pension examination process.

## Results

### National Results on Quality Indicators

The national quality scores are 85.4% for exam-specific indicators and 96.7% for core indicators, yielding an overall quality score of 89.3% (Table 2). These scores are accurate within plus or minus 1.5% at the 99% level of confidence. The exam-specific, core, and overall quality indicator scores and standard error of measurement for each type of examination are shown in Table 2.

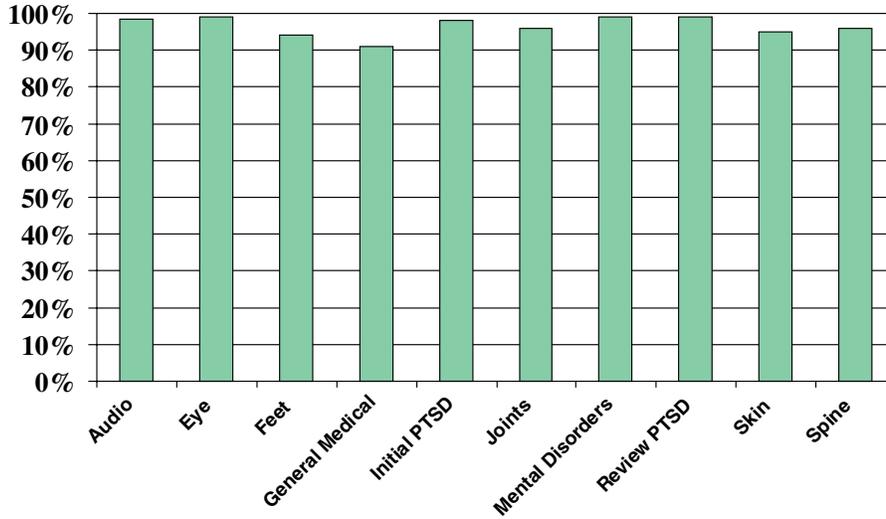


**Table 2**  
**National Quality Indicator Scores for the Top Ten Examinations\***

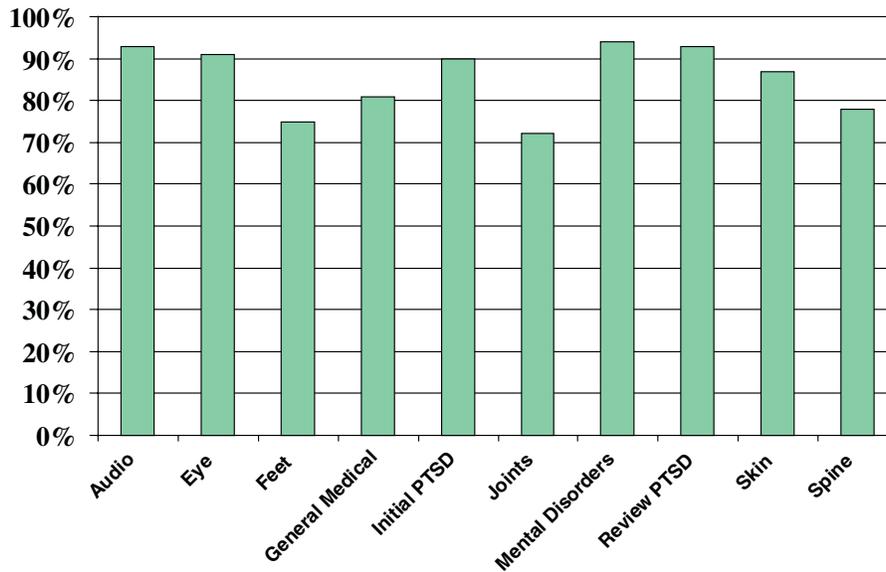
Baseline Period	July 2001 to September 2001
Number of C&P Examinations Reviewed	1,100
Exam-Specific Quality Indicator Score	85.40% ± 0.51%
Core Quality Indicator Score	96.70% ± 0.33 %
Overall Quality Score	89.30% ± 0.39 %

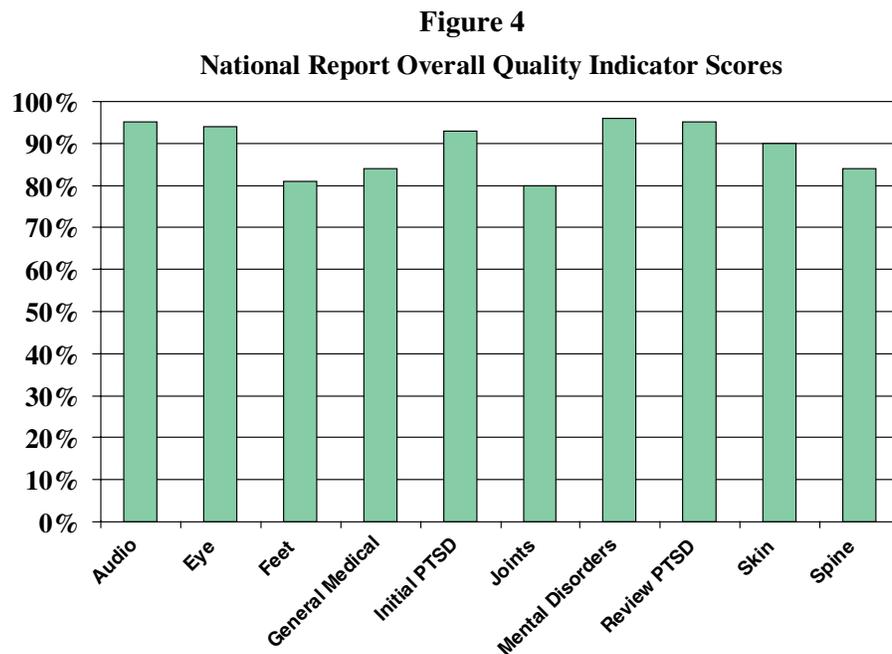
\*Score ± Standard Error of Measurement

**Figure 2**  
National Report Core Quality Indicator Scores



**Figure 3**  
National Report Exam-Specific Quality Indicator Scores





**Table 3**  
**National Quality Indicator Scores for Each of the Top Ten Examinations\***

Examination	Number Reviewed	Exam-Specific Quality Indicator Scores	Core Quality Indicator Scores	Overall Quality Scores
Audio	110	93.0% ± 1.04%	98.6% ± 1.13%	95.0% ± 0.93%
Eye	110	91.3% ± 1.25%	99.1% ± 0.86%	94.1% ± 0.89%
Feet	110	75.1% ± 2.22%	94.0% ± 1.40%	81.4% ± 1.74%
General Medical	110	80.8% ± 1.59%	91.3% ± 1.72%	84.4% ± 1.30%
Initial PTSD	110	89.9% ± 1.21%	98.0% ± 0.89%	92.6% ± 0.93%
Joints	110	71.5% ± 1.88%	96.4% ± 1.07%	79.8% ± 1.41%
Mental Disorders	110	94.3% ± 0.83%	99.5% ± 0.31%	96.0% ± 0.59%
Review PTSD	110	93.0% ± 0.80%	99.3% ± 0.36%	95.1% ± 0.57%
Skin	110	86.8% ± 1.23%	94.9% ± 1.28%	89.7% ± 1.10%
Spine	110	78.1% ± 1.58%	96.0% ± 1.09%	84.5% ± 1.19%
<b>Top Ten Exams</b>	<b>1,100</b>	<b>85.4% ± 0.51%</b>	<b>96.7% ± 0.34%</b>	<b>89.3% ± 0.39%</b>

\*Score ± Standard Error of Measurement

## Results on Core Indicators

The score for each core indicator is shown by exam type in Table 4. Precisely stating a diagnosis and justification for lack of diagnosis is met over 90% of the time for all examinations, except General Medical. Approximately 1 in 5 General Medical examination reports (18.2%) did not meet the criteria for stating precise diagnoses.

The baseline national scoring for the justification of diagnosis and requested medical opinion indicators gave credit for “not applicable (NA)” responses. Consequently, the average scores for core indicators that had a high proportion of “NA” responses go down when we consider only those exam reports with a “yes” or “no” response to the indicator. For example, among the 61 examinations lacking diagnoses, 59% provided no justification. This yields an adjusted score of 41% for this indicator. Among the 93 examinations requesting a medical opinion, 10% did not provide an opinion, producing an adjusted score of 90%.

Study results show that an overall picture of functional impairment was met 89.7% of the time. High scores for this indicator were obtained in the Initial PTSD, Review PTSD, and Mental Disorders examinations. The General Medical, Spine, and Joints examinations scored in the low 90s, and the lowest scores (mid to low 80s) for this indicator were on the Feet and Skin examinations. All examinations scored very high on the core indicator related to addressing the issues in the "remarks" section of the examination request. The scores ranged from 98.2% to 100%.

**Table 4**  
**Core Indicator Scores for Each of the Top Ten Examinations\***

Core Quality Indicator	Top Ten Exams	Audio	Eye	Feet	General Medical	Initial PTSD	Joints	Mental Disorders	Review PTSD	Skin	Spine
Diagnosis stated precisely	95.4% ± 0.63%	98.2% ± 1.3%	99.1% ± 0.9%	93.6% ± 2.3%	81.8% ± 3.7%	98.2% ± 1.3%	94.6% ± 2.2%	99.1% ± 0.9%	99.1% ± 0.9%	94.6% ± 2.2%	96.4% ± 1.8%
Lack of diagnosis justified	96.7% ± 0.54%	98.2% ± 1.3%	99.1% ± 0.9%	96.4% ± 1.8%	84.6% ± 3.5%	98.2% ± 1.3%	97.3% ± 1.6%	100.0%	100.0%	96.4% ± 1.8%	97.3% ± 1.6%
Functional impairment provided	89.7% ± 0.92%	NA	NA	83.6% ± 3.5%	91.8% ± 2.6%	95.5% ± 2.0%	92.7% ± 2.5%	98.2% ± 1.3%	97.3% ± 1.6%	85.4% ± 3.4%	90.0% ± 2.9%
Issues in remarks section	98.9% ± 0.31%	100.0%	99.1% ± 0.9%	97.3% ± 1.6%	98.2% ± 1.3%	99.1% ± 0.9%	98.2% ± 1.3%	100.0%	100.0%	99.1% ± 0.9%	98.2% ± 1.3%
Requested medical opinion	99.2% ± 0.27%	98.2% ± 1.3%	99.1% ± 0.9%	99.1% ± 0.9%	100.0%	99.1% ± 0.9%	99.1% ± 0.9%	100.0%	100.0%	99.1% ± 0.9%	98.2% ± 1.3%
<b>Total Core Quality</b>	<b>96.7%</b> <b>± 0.33%</b>	<b>98.6%</b> <b>± 1.1%</b>	<b>99.1%</b> <b>± .55%</b>	<b>94.0%</b> <b>± 1.40%</b>	<b>91.3%</b> <b>± 1.72%</b>	<b>98.0%</b> <b>± 0.89%</b>	<b>96.4%</b> <b>± 1.07%</b>	<b>99.5%</b> <b>± 0.31%</b>	<b>99.3%</b> <b>± 0.36%</b>	<b>94.9%</b> <b>± 1.28%</b>	<b>96.0%</b> <b>± 1.09%</b>

\*Score ± Standard Error of Measurement

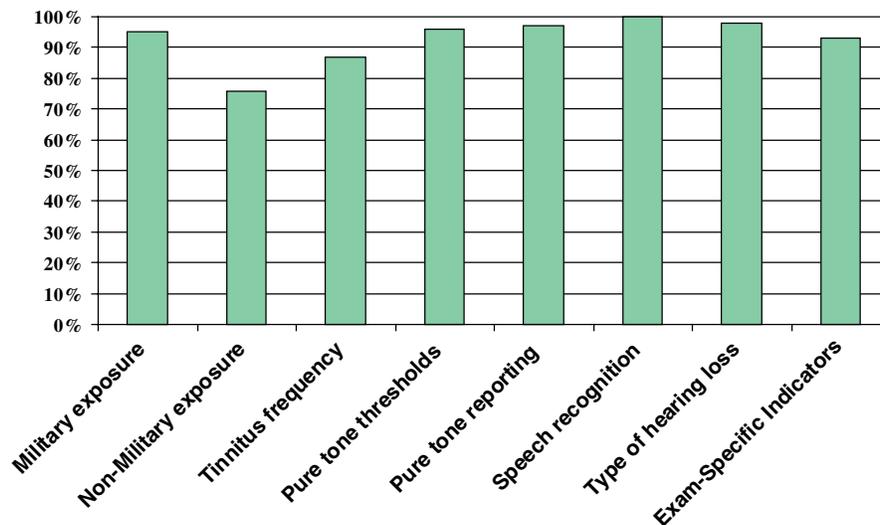
## **Results on Exam-Specific Indicators**

The value of the quality indicator approach is exam-specific feedback on key features that point to targets for improvement. The results of the exam-specific indicators are presented for each of the top ten examinations beginning on page 24.

## Audio Examination

Generally, the Audio examination reports scored well on the exam-specific quality indicators. Audio examination reports received high scores on most of the quality indicators: in the high 90s for describing noise exposure during the military (95.4%), reporting the findings of pure tone thresholds for both ears (96.4%), reporting speech recognition for both ears (100%), and reporting the type of hearing loss (98.2%).

**Figure 5A**  
**Audio Exam-Specific Indicators**



Opportunities for improvement are in describing non-military noise exposure (76.4%; when excluding the 15 NA responses for veterans already service-connected for ear conditions, the score was 72.6%), and addressing the frequency or repetitiveness of tinnitus episodes (87.3%). The exam-specific quality indicator score was 93%, and the core indicator score was 98.6%, yielding an overall quality score of 94.15%. These quality scores indicate that the audiologists who perform audio examinations are producing high quality reports and can further improve with attention to patient history of non-military exposure and frequency of tinnitus episodes. (See Table 5A.)

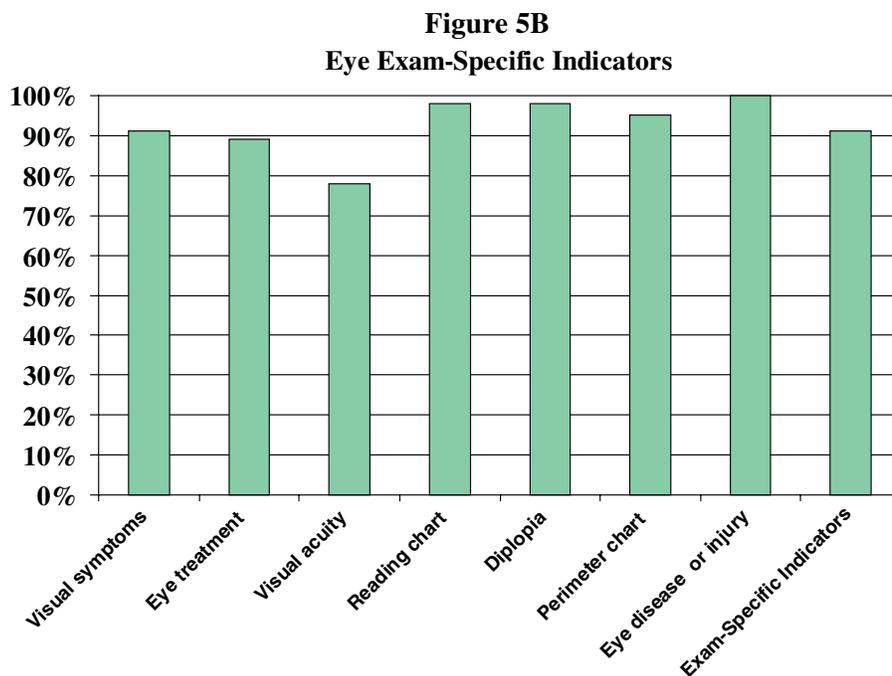
**Table 5A**  
**Audio Exam-Specific Indicator Scores\***

<b>Audio Exam-Specific Indicators</b>	<b>Score</b>
Describes noise exposure during military?	95.4% ± 2.0%
Describes non-military exposure?	76.4% ± 4.1%
Frequency of tinnitus episodes addressed?	87.3% ± 3.2%
Findings of pure tone thresholds for both ears?	96.4% ± 1.8%
Average of pure ton thresholds recorded properly?	97.3% ± 1.6%
Findings of speech recognition for both ears?	100.0%
Diagnosis reports type of hearing loss?	98.2% ± 1.3%
<b>Audio Exam-Specific Quality Indicator Score</b>	<b>93.0% ± 1.04%</b>

\*Score ± Standard Error of Measurement

## Eye Examination

Like the Audio examination report scores, Eye exam-specific quality indicator results are useful for purposes of targeting improvement efforts. Most of the eye exam-specific indicators related to the physical examination score in the high 90s, including findings on the reading chart (98.2%), the Goldmann Perimeter Chart (94.6%), and reporting eye disease (100%). The diplopia indicator score was 98.2%, primarily because this indicator is NA for most examinations. When required to report on diplopia (8 cases), the indicator score was 75%. Excluding NA responses, the indicator performance for reporting findings on the reading chart was 93% for the 28 examinations with visual acuity worse than 5/200, and the Goldmann Perimeter Chart score was 75% for veterans with diplopia and/or visual field deficit.



Indicators show the greatest opportunities for improvement are in reporting corrected visual acuity (78.2%), history of subjective symptoms (80.9%), and ophthalmologic treatment (89.1%). The exam-specific quality indicator score was 91.3%, and the core indicator score was 99.1%, yielding an overall quality score of 95%. These quality scores indicate that the ophthalmology specialists who

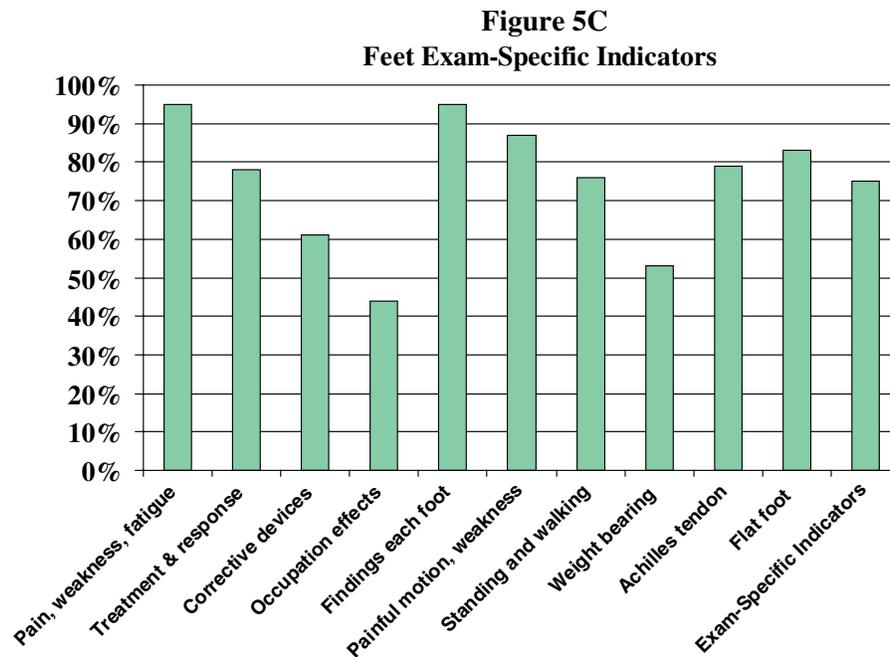
perform Eye examinations are producing high quality reports and can further improve the reports with attention to corrected visual acuity, patient history of symptoms and treatment, and attending to the additional requirements when diplopia and visual field deficits are present.

**Table 5B**  
**Eye Exam-Specific Indicator Scores\***

Eye Exam-Specific Indicators	Score
Subjective complaints of visual symptoms?	80.9% ± 3.7%
Description of ophthalmologic treatment?	89.1% ± 2.9%
Findings provide the best corrected visual acuity for each eye?	78.2% ± 4.0%
Findings on reading chart, counting fingers, hand motion and/or light perception?	98.2% ± 1.3%
If diplopia, constant or intermittent?	98.2% ± 1.3%
Does the report include the Goldmann Perimeter Chart?	94.6% ± 2.2%
Do the objective findings report on eye disease or injury?	100.0%
<b>Eye Exam-Specific Quality Indicator Score</b>	<b>91.3% ± 1.3%</b>

\*Score ± Standard Error of Measurement

## Feet Examination



The exam-specific quality indicator score was 75.1%, and the core indicator score was 94.0%, yielding an overall quality score of 81.4%. Scores are above 95% for 2 of the 10 indicators: description of subjective complaints (95.4%) and physical findings reported for each foot (95.4%).

Scores for the other Feet exam quality indicators shown in Table 5C identify opportunities for improvement. Note that the indicator scores for flat foot conditions, 79.1% and 82.7%, benefit from credit for a large number of “not applicable” responses. If we look only at the applicable cases (those involving the 39 veterans who actually had flat foot), the scores drop to 41% for alignment of the Achilles tendon and 51% for addressing pain on manipulation. (See Table 5C.)

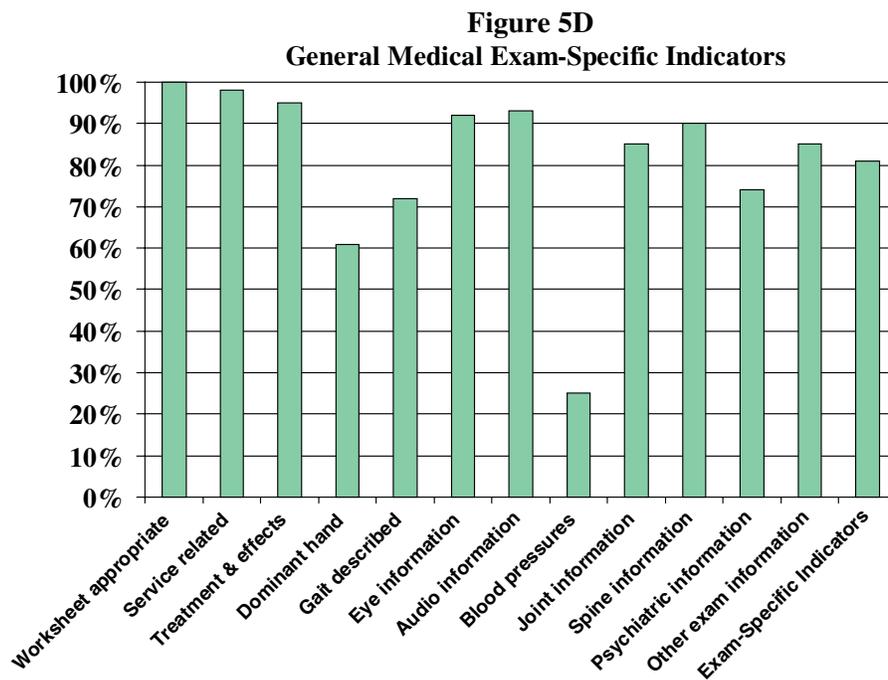
**Table 5C**  
**Feet Exam-Specific Indicator Scores\***

<b>Feet Exam-Specific Indicators</b>	<b>Score</b>
Subjective complaints of pain, weakness, or fatigability?	95.4% ± 2.0%
Description of treatment and response?	78.2% ± 3.9%
Efficacy of corrective devices described?	60.9% ± 4.7%
Effects of condition on usual occupation?	43.6% ± 4.8%
Findings describe each foot?	95.4% ± 2.0%
Evidence of painful motion, edema, weakness, instability, or tenderness?	87.3% ± 3.2%
Functional limitations on standing and walking?	75.4% ± 4.1%
Evidence of abnormal weight bearing?	52.7% ± 4.8%
Describes alignment of Achilles tendon for flat foot condition?	79.1% ± 3.9%
Pain on manipulation is addressed for flat foot condition?	82.7% ± 3.6%
<b>Feet Exam-Specific Quality Indicator Score</b>	<b>75.1% ± 2.2%</b>

\*Score ± Standard Error of Measurement

## General Medical Examination

The General Medical examination worksheet is distinctly different from all other C&P examination worksheets. This examination is used to assess the status of all body systems and to pursue further detail on any abnormal findings. General medical examinations received high scores for description of complaints related to service (98.2%) and treatment effects (94.6%).



A striking result was the 24.6% performance for the criterion of taking three blood pressure measurements for hypertension screening.

Dominant hand was described in 60.9% of the examination reports, and gait was described 71.8% of the time. Follow-up by referring to the examination worksheet appropriate to abnormal findings varies from 73.6% for Mental Disorders exam issues to 92.7% for Audio exam issues. The exam-specific quality indicator score was 80.8% (see Table 5D), and the core indicator score was 91.3%, yielding an overall quality score of 84.4%.

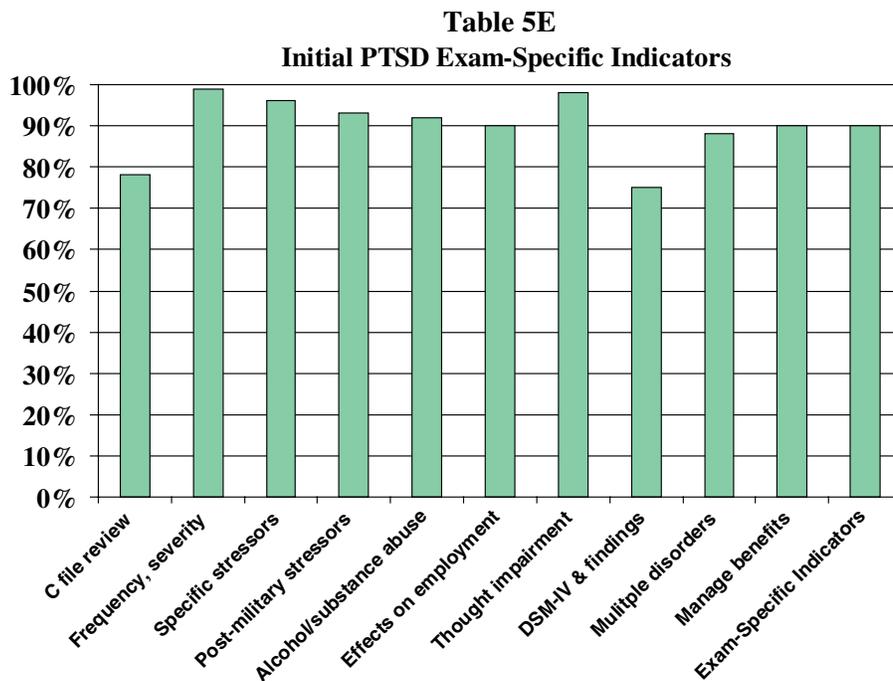
**Table 5D**  
**General Medical Exam-Specific Indicator Scores\***

General Medical Exam-Specific Indicators	Score
Was the General Medical exam request form used?	NA
Report notes complaints and relationship to service?	98.2% ± 1.3%
Current treatment and effects are described?	94.6% ± 2.2%
Dominant hand described?	60.9% ± 4.7%
Gait described?	71.8% ± 4.3%
Does report include Eye exam worksheet information, if indicated?	91.8% ± 2.6%
Does report include Audio exam worksheet information, if indicated?	92.7% ± 2.5%
At least three blood pressure measurements reported?	24.6% ± 4.1%
Does report include Joint exam worksheet information, if indicated?	85.4% ± 3.4%
Does report include Spine exam worksheet information, if indicated?	90.0% ± 2.9%
Does report include Mental Disorders exam worksheet information, if indicated?	73.6% ± 4.2%
Were all other worksheets followed as appropriate?	85.4% ± 3.3%
<b>General Medical Exam-Specific Quality Indicator Score</b>	<b>80.8% ± 1.6%</b>

\*Score ± Standard Error of Measurement

## Initial PTSD Examination

Exam-specific scores for Initial PTSD examination reports were generally quite high. Seven of the ten quality indicators for this exam were above 90%; thus, the psychologists and psychiatrists conducting these examinations tend to meet most of the quality indicators.



The greatest opportunities for improvement are in review of the C-file<sup>1</sup> (78.2%), and consistency of the diagnosis with DSM-IV and exam findings (74.6%). Other areas for improvement are discussion of multiple mental disorders (88.2%), effects on occupation (90%), and ability to manage benefits (90%). The exam-specific quality indicator score was 89.9% (see Table 5E), and the core indicator score was 98.0%, yielding an overall quality score of 92.6%.

<sup>1</sup> Note: Examiners were given credit for meeting this indicator either if they reviewed the C-file **or** if they addressed the availability of the C-file for review by indicating the C-file was unavailable.

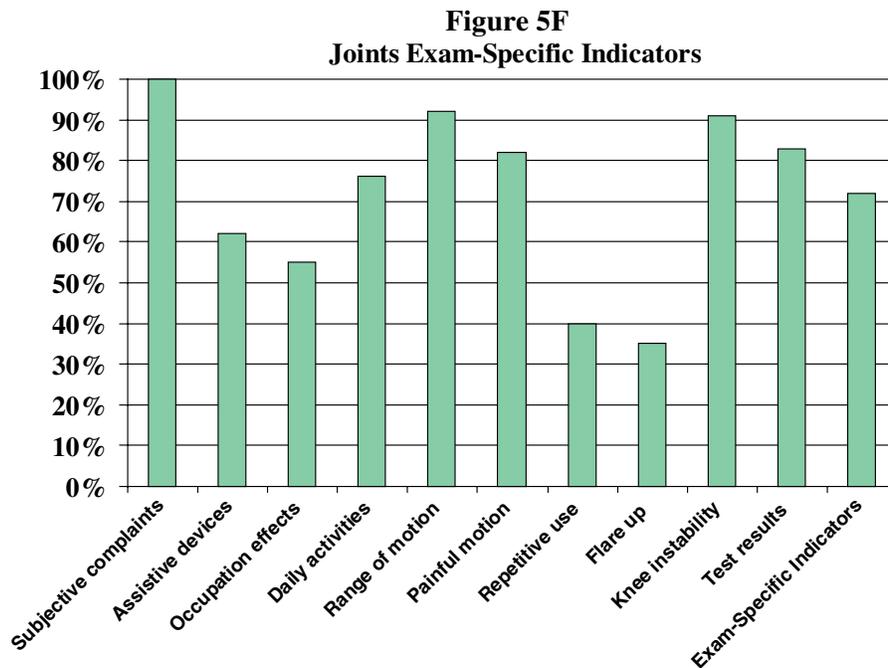
**Table 5E**  
**Initial PTSD Exam-Specific Indicator Scores\***

Initial PTSD Exam-Specific Indicators	Score
C-file reviewed?	78.2% ± 3.9%
Frequency, severity and duration of symptoms?	99.1% ± 0.9%
Specific stressors during service and link to current condition?	96.4% ± 1.8%
Post-military stressors and description of psychosocial consequences?	92.7% ± 1.8%
Does the report address problematic alcohol or substance abuse?	91.8% ± 2.6%
Effects on employment functioning?	90.0% ± 2.9%
Is impairment of thought process or communication addressed and described?	98.2% ± 1.3%
Is the diagnosis consistent with DSM-IV and supported by the exam findings?	74.6% ± 4.2%
Does report describe multiple mental disorders and symptoms?	88.2% ± 3.1%
Does report address veteran's ability to manage VA benefits?	90.0% ± 2.9%
<b>Initial PTSD Exam-Specific Quality Indicator Score</b>	<b>88.9% ± 1.2%</b>

\*Score ± Standard Error of Measurement

## Joins Examination

Results for Joints exam-specific indicators show a relatively broad opportunity for improvement. However, the data clearly indicate that the greatest quality gains can be made in reporting of the “DeLuca” criteria.



These examination reports are proficient in reporting subjective complaints (100%) and in providing active range of motion in degrees (91.8%). Reporting instability of the knee scored 90.1% when “not applicable” responses were considered. Looking only at applicable exam reports (i.e., the 68 cases that involved the knee) produced a score of 85.3% for this indicator.

Areas for improvement include reporting additional functional limitation during flare-ups (35.5%) and following repetitive use (40%); effects on occupation (54.6%); description of need for assistive devices (61.8%); effect on daily activities (76.4%); and findings on painful motion (81.8%). Another opportunity for improvement is in providing results from diagnostic and clinical tests (82.7%). The exam-specific quality indicator score was 71.5% (see Table 5F), and the core indicator score was 96.4%, yielding an overall quality score of 79.8%.

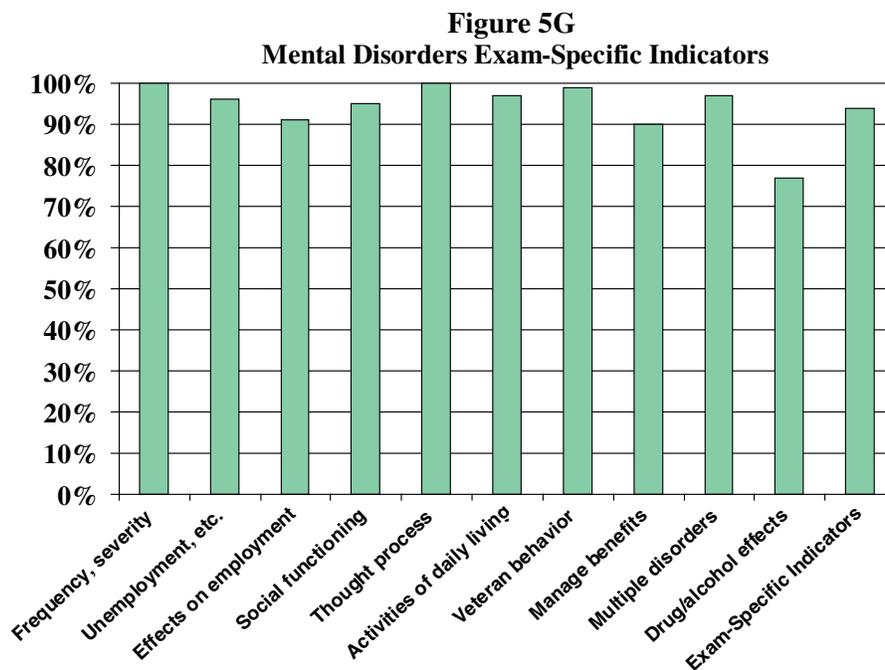
**Table 5F**  
**Joints Exam-Specific Indicator Scores\***

Joints Exam-Specific Indicators	Score
Does report note subjective complaints?	100.0%
Does report describe need for assistive devices?	61.8% ± 4.7%
Does the report describe the effects of the condition on the veteran's usual occupation?	54.6% ± 4.8%
Does the report describe the effects of the condition on the veteran's daily activities?	76.4% ± 4.1%
Does report provide the active range of motion in degrees?	91.8% ± 2.6%
Do the objective findings state whether the joint is painful on motion?	81.8% ± 3.7%
Does the report address additional limitation following repetitive use?	40.0% ± 4.7%
Do findings address additional limitation during flare-ups?	35.5% ± 4.6%
Does report address instability of knee?	90.1% ± 2.8%
Do the objective findings include results of all conducted diagnostic and clinical tests?	82.7% ± 3.6%
<b>Joints Exam-Specific Quality Indicator Score</b>	<b>71.5% ± 1.9%</b>

\*Score ± Standard Error of Measurement

## Mental Disorders Examination

The specialists who perform the Mental Disorders (except PTSD and Eating Disorders) examinations scored well on the exam-specific quality indicators. The exam reports of psychologists and psychiatrists scored above 90% on most of the exam-specific quality indicators. Reports did best at describing symptoms (100%), activities of daily living (99.1%), veteran behavior (97.3%), multiple disorders (97.3%), time lost from work (96.4%), and effects on social functioning (94.6%). The scores on describing effects of symptoms on employment and ability to manage benefits were about 90%, leaving some room for improvement.



The major opportunity for improvement is in addressing the effects of drug and alcohol abuse (77.3%). The exam-specific quality indicator score was 94.3% (see Table 5G), and the core indicator score was 99.5%, yielding an overall quality score of 96.0%.

**Table 5G**  
**Mental Disorders Exam-Specific Indicator Scores\***

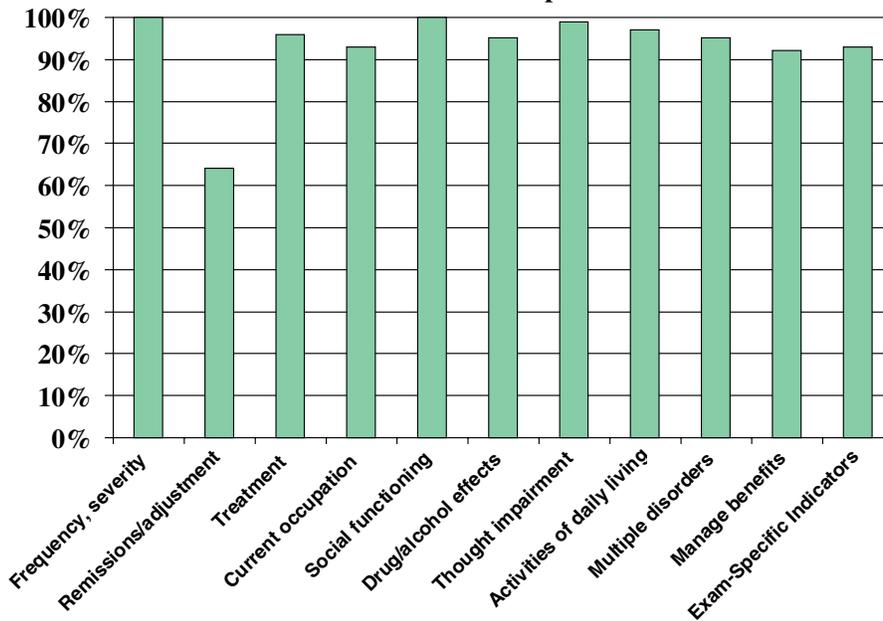
Mental Disorders Exam-Specific Indicators	Score
Frequency, severity and duration of symptoms?	100.0%
Report addresses unemployment or time lost from work?	96.4% ± 1.8%
Examiner reports effects of symptoms on employment?	90.9% ± 2.8%
Effects on social functioning?	94.6% ± 2.2%
Thought process or communication impairment described?	100.0%
Does report address veteran's behavior?	97.3% ± 1.6%
Describes activities of daily living?	99.1% ± 0.9%
Does the report address veteran's ability to manage VA benefits?	90.0% ± 2.9%
Multiple mental disorders and symptoms discussed?	97.3% ± 1.6%
Effects of drug or alcohol abuse addressed, when appropriate?	77.3% ± 4.0%
<b>Mental Disorders Exam-Specific Quality Indicator Score</b>	<b>94.3% ± 0.8%</b>

\*Score ± Standard Error of Measurement

**Review PTSD Examination**

Like the other mental health exam reports, the Review PTSD reports generally received high scores. Performance exceeded 90% on all exam-specific quality indicators, except reporting on remissions and capacity for adjustment (63.6%). Reporting on ability to manage benefits scored 91.8% and describing current work situation scored 92.7%. The exam-specific quality indicator score was 93.0% (see Table 5H), and the core indicator score was 99.3%, yielding an overall quality score of 95.1%.

**Figure 5H**  
**Review PTSD Exam-Specific Indicators**



**Table 5H**  
**Review PTSD Exam-Specific Indicator Scores\***

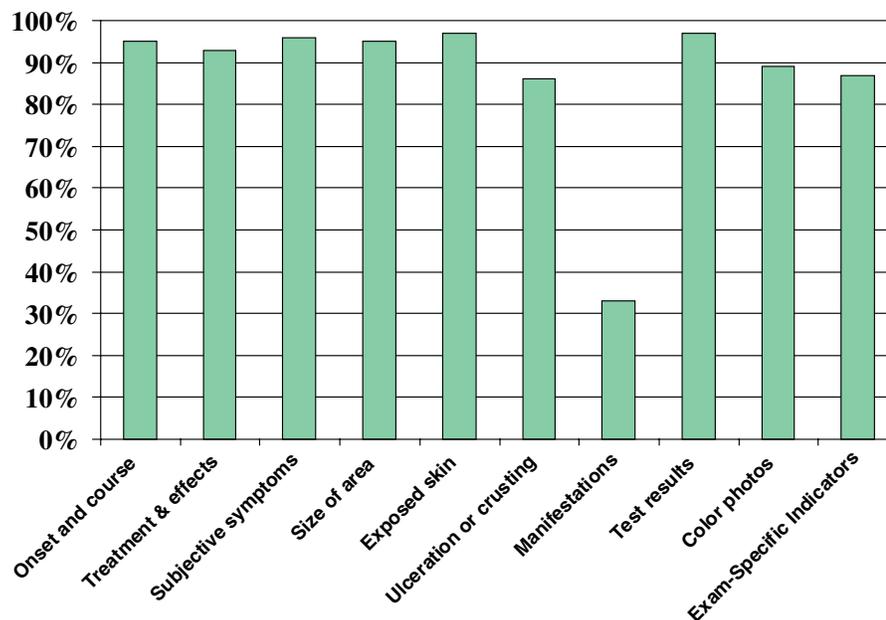
<b>Review PTSD Exam-Specific Indicators</b>	<b>Score</b>
Frequency, severity, and duration of symptoms since last exam reported?	100.0%
Does report comment on remissions and capacity for adjustment?	63.6% ± 4.6%
Does the report comment on type of treatment?	96.4% ± 1.8%
Does the report describe veteran's current occupation and time lost from work?	92.7% ± 2.5%
Does the report describe social functioning since the last exam?	100.0%
Does the report address problematic alcohol or substance abuse?	94.6% ± 2.2%
Is impairment of thought process or communication addressed and described?	99.1% ± 0.9%
Describes activities of daily living?	97.3% ± 1.6%
Does report describe multiple mental disorders and symptoms?	94.6% ± 2.2%
Does the report address veteran's ability to manage VA benefits?	91.8% ± 2.6%
<b>Review PTSD Exam-Specific Quality Indicator Score</b>	<b>93.0% ± 0.8%</b>

\*Score ± Standard Error of Measurement

## Skin Examination

The Skin (not Scars) exam-specific scores were quite high overall (generally in the high 90s). Quality indicators for the Skin examination are generally above 90%: describing the onset and course of the skin condition (94.6%); treatment effects (92.7%); subjective symptoms (96.4%); objective findings on size (94.6%) and exposure (97.3%); and inclusion of diagnostic and clinical test results (97.3%).

**Figure 5I**  
**Skin Exam-Specific Indicators**



The major opportunity for improvement is found in reporting on systemic or nervous manifestations (32.7%). Other areas to improve are inclusion of color photos (89.1%) and findings of ulceration, exfoliation or crusting (86.4%). The exam-specific quality indicator score was 86.8% (see Table 5I), and the core indicator score was 94.9%, yielding an overall quality score of 89.7%.

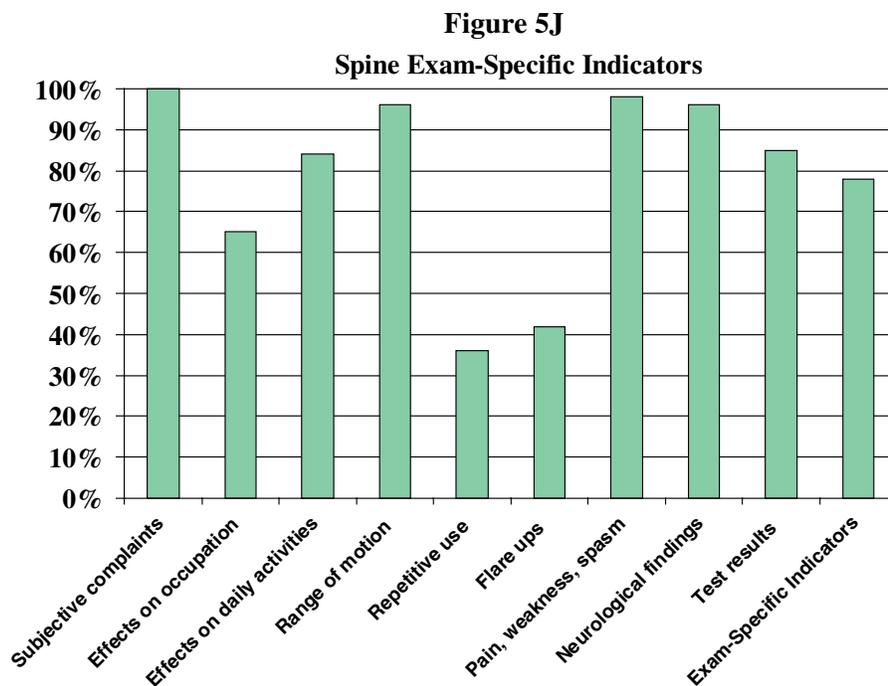
**Table 5I**  
**Skin Exam-Specific Indicator Scores\***

Skin Exam-Specific Indicators	Score
Comment on onset and course of the skin condition?	94.6% ± 2.2%
Does report comment on treatment type and effects?	92.7% ± 2.5%
Does report note subjective symptoms?	96.4% ± 1.8%
Do objective findings report the size of the disease area?	94.6% ± 2.2%
Do objective findings indicate whether the involved skin is exposed?	97.3% ± 1.6%
Do objective findings report on ulceration, exfoliation or crusting?	86.4% ± 3.3%
Do objective findings report on systemic or nervous manifestations?	32.7% ± 4.5%
Do the objective findings include results of all diagnostic and clinical tests conducted?	97.3% ± 1.6%
Does report include color photos?	89.1% ± 3.0%
<b>Skin Exam-Specific Quality Indicator Score</b>	<b>86.8% ± 1.3%</b>

\*Score ± Standard Error of Measurement

## Spine Examination

Exam-specific indicator scores for Spine examination reports showed a pattern similar to those for the Feet and Joints examinations. Like the Joints examination, these examination reports are proficient in reporting subjective complaints (100%) and range of motion (96.4%). Spine examination reports also scored high in meeting the quality indicators for providing objective evidence of painful motion, spasm, weakness, and/or tenderness (98.2%); and reporting neurological abnormalities (98.2%).



Areas for improvement include reporting additional functional limitation following repetitive use (36.4%) and during flare-ups (41.8%); describing effects on occupation (64.6%); and providing the results of diagnostic and clinical tests (85.5%). The exam-specific quality indicator score was 78.1% (see Table 5J), and the core indicator score was 96.0%, yielding an overall quality score of 84.5%.

**Table 5J**  
**Spine Exam-Specific Indicator Scores\***

Spine Exam-Specific Indicators	Score
Does report note veteran's subjective complaints?	100.0%
Does report describe effects of the condition on the veteran's usual occupation?	64.6% ± 4.6%
Does report describe effects of the condition on the veteran's daily activities?	83.6% ± 3.5%
Does report provide each range of motion separately and in degrees?	96.4% ± 1.8%
Does the report address additional limitation following repetitive use?	36.4% ± 4.6%
Do the findings address additional limitation during flare-ups?	41.8% ± 4.7%
Does report address objective evidence of painful motion, spasm, weakness, and/or tenderness?	98.2% ± 1.3%
If neurological abnormalities are noted, is appropriate worksheet followed?	96.4% ± 1.8%
Do the objective findings include results of all conducted diagnostic and clinical tests?	85.5% ± 3.4%
<b>Spine Exam-Specific Quality Indicator Score</b>	<b>78.1% ± 1.6%</b>

\*Score ± Standard Error of Measurement

### Distribution of the Overall Quality Indicator Scores by Examination Type

Table 6 shows the distribution of the overall quality indicator scores (combined score of both core and exam-specific indicators) for each examination type. The table shows the percentage of examination reports that received a perfect score of 100%. Also shown is the percentage of reports that scored less than 90%, less than 75%, and less than 50%. For example, 35.5% of the Audio examination reports scored less than 90%, 2.7% scored less than 75%, and .9% scored less than 50%.

The percentage of examination reports that received perfect quality scores (i.e., each exam report “passed” every quality indicator) ranged from 14.5% (Joints examination) to 61.8% (Audio examination). Almost 10% of the Feet examinations failed to meet over half of the quality indicators. Joints examination (5.5%), Spine examination (3.6%) and General Medical examination (3.6%) reports also failed to meet half of the quality indicators. Across the 1,100 examinations reviewed, 37.4% achieved perfect scores and 58.5% had a quality indicator score above 90%.

**Table 6**  
**Distribution of the Quality Indicator Scores for the Top Ten C&P Examinations**

Top Ten C&P Examinations	% of reports with score = 100%	% of reports with score < 90%	% of reports with score < 75%	% of reports with score < 50%
Audio	61.8	35.5	2.7	0.9
Eye	60.9	39.1	15.5	0.0
Feet	24.5	60.0	39.1	9.8
General Medical	15.5	55.5	23.6	3.6
Initial PTSD	44.5	26.4	8.2	0.9
Joints	14.5	72.7	39.1	5.5
Mental Disorders	58.2	11.8	1.8	0.0
Review PTSD	48.2	16.4	0.9	0.0
Skin	25.5	33.6	7.3	1.8
Spine	20.0	63.6	18.2	3.6
Total	37.4	41.5	15.6	2.5

## **“Inter-rater Reliability”**

To better understand the review process, agreement of the reviewers for evaluating the quality indicators was examined by calculating the percentage agreement and pair-wise kappa coefficients for the first two reviews. In general, inter-rater agreement ranged from fair to excellent. With a scale consisting of 12 to 17 items, even a high rate of inter-rater percentage agreement accumulates a substantial likelihood of less than perfect matching between reviewers over the total scale. We anticipated this statistical phenomenon and arranged for a third complete review when the first two reviewers disagreed on any one indicator for an exam report. The tiebreaking review process resulted in consensus scoring for 99.9% of the indicators. In the remaining 1 in 1000 instances, there was one “yes”, one “no,” and one “NA” response from the three reviewers. This was not a scoring issue, however, because “NA” and “yes” responses were both scored in favor of the examiner (i.e., considered to comply with the indicator).

For the core indicators (see Table 7 on page 46), the inter-rater agreement was in the mid-80s for precisely stating the diagnosis (87.5%) and providing justification when lacking a diagnosis (85.2%). Inter-rater agreement was 78% for describing functional impairment, almost 89% for the indicator regarding medical opinion, and over 94% for addressing remarks. The kappa coefficients (>.70) were excellent for the precise diagnosis, functional impairment and remarks core indicators; and fair (.20 to .40) for the diagnosis justified and medical opinion core indicators.

Kappa coefficients are used to verify that reviewer (or rater) agreement on scoring quality indicators exceeds the agreement one would expect to occur by chance. It is well documented in the literature that the potential value of the kappa coefficient is affected when distribution of the data is asymmetric. High percentage agreement can reduce the maximum attainable kappa to well below 1.0 and produce artificially low kappas. For example, the core indicator for “diagnosis stated precisely” has a lower percentage agreement (87.5% versus 89%) but higher kappa (.79 versus .19) than the medical opinion core indicator. Thus, both percentage agreement and kappa must be considered when examining inter-rater reliability. (See Table 7 on page 46.)

**Table 7**  
**Percentage Agreement and Kappa Coefficients**  
**on the Core Indicators**

Core Quality Indicator	Percent Agreement	Kappa Coefficient
Diagnosis stated precisely	87.5	.79
Lack of diagnosis justified	85.2	.20
Functional impairment provided	78.3	.70
Issues in the remarks section	94.5	.91
Requested medical opinion	89.0	.19

The percentage agreement also varied across examination types from a low of 59.8% to a high of 99.2% (Table 8). The agreement on the functional impairment indicator was lowest on the Feet examination (59.8%). Agreement on functional impairment was approximately 69% on the Joints and Skin examinations. The mid to upper 80 percentage agreement on the functional impairment indicator for the Audio and Eye examinations is moot because the degree of sensory impairment, not functional limitation, determines the rating for disabilities of this nature. On the General Medical examination, agreement for the core indicators of “precisely stated diagnosis” and “justification for lack of diagnosis” were 74.7% and 72.5%, respectively. The percentage agreement was above 90% across all examinations for the remarks indicator and above 80% for the medical opinion indicator.

**Table 8**  
**Percentage Agreement on the Core Indicators by Type of**  
**the Top Ten Examinations and Overall Summary**

Core Quality Indicator	Top Ten Exams	Audio	Eye	Feet	General Medical	Initial PTSD	Joints	Mental Disorders	Review PTSD	Skin	Spine
Diagnosis stated precisely	87.5%	93.0%	89.5%	81.6%	74.7%	97.3%	83.0%	93.1%	99.2%	85.3%	84.0%
Lack of diagnosis justified	85.2%	84.2%	89.5%	80.8%	72.5%	93.8%	79.7%	94.6%	94.7%	80.6%	83.2%
Functional impairment provided	78.3%	70.2%	65.7%	59.8%	80.7%	94.5%	69.9%	93.9%	97.7%	69.2%	75.6%
Issues in remarks section	94.5%	93.9%	95.6%	92.0%	92.3%	97.9%	90.8%	96.9%	97.7%	93.8%	96.2%
Requested medical opinion	89.0%	85.8%	86.8%	89.6%	99.4%	94.5%	82.4%	86.9%	85.3%	94.6%	82.5%

The inter-rater percentage agreement and kappa coefficient statistics for each exam-specific indicator are shown in Tables 9A through 9J. The percentage agreement varied from 53% (remissions and capacity for adjustment, Review PTSD) to 100% (speech recognition, Ear), while kappa varied from .18 (findings on the reading chart, Eye) to .99 (subjective complaints, Joints). The variation in statistics reveals from fair to excellent inter-rater agreement. Although enormous effort went into careful and specific wording of the indicators and instructions, variance in responses is expected in all such multi-rater processes of evaluation. The expectation of inherent variation motivated the methodological decision for using a third review for building consensus scoring of the indicators. Sixteen percent of the examination reports (176 of 1,110 exams) had complete agreement across the core and exam-specific indicators. A tiebreaking review was required for 924 examinations in which reviewers disagreed on the scoring of one or more indicators. With an overall average percentage agreement of 88%, a rate of 84% for third reviews is in alignment with expectations.

**Table 9A**  
**Inter-rater Agreement for Assessing the Audio Examination Quality Indicators**

<b>Audio Exam-Specific Indicator</b>	<b>Percent Agreement</b>	<b>Kappa Coefficient</b>
Describes noise exposure during military?	79.5	.50
Describes non-military exposure?	70.9	.39
Frequency of tinnitus episodes addressed?	90.6	.75
Findings of pure tone thresholds for both ears?	99.1	.94
Average of pure tone thresholds recorded properly?	92.3	.87
Findings of speech recognition for both ears?	100.0	NA
Diagnosis reports type of hearing loss?	94.1	.93

**Table 9B**  
**Inter-rater Agreement for Assessing the Eye Examination Quality Indicators**

Eye Exam-Specific Indicators	Percent Agreement	Kappa Coefficient
Subjective complaints of visual symptoms?	75.2	.69
Description of ophthalmologic treatment?	84.1	.74
Findings provide the best corrected visual acuity for each eye?	61.0	.61
Findings on reading chart, counting fingers, hand motion and/or light perception?	61.1	.18
If diplopia, constant or intermittent?	88.6	.20
Does the report include the Goldmann Perimeter Chart?	68.1	.20
Do the objective findings report on eye disease or injury?	92.9	.90

**Table 9C**  
**Inter-rater Agreement for Assessing the Feet Examination Quality Indicators**

Feet Exam-Specific Indicators	Percent Agreement	Kappa Coefficient
Subjective complaints of pain, weakness, or fatigability?	93.8	.88
Description of treatment and response?	65.7	.57
Efficacy of corrective devices described?	72.8	.48
Effects of condition on usual occupation?	72.8	.43
Findings describe each foot?	76.4	.60
Evidence of painful motion, edema, weakness, instability, or tenderness?	71.9	.65
Functional limitations on standing and walking?	71.9	.55
Evidence of abnormal weight bearing?	68.4	.42
Describes alignment of Achilles tendon for flat foot condition?	80.6	.23
Pain on manipulation is addressed for flat foot condition?	82.4	.23

**Table 9D**  
**Inter-rater Agreement for Assessing the General Medical Examination Quality Indicators**

General Medical Exam-Specific Indicators	Percent Agreement	Kappa Coefficient
Was the General Medical exam request form used?	98.7	98.00
Report notes complaints and relationship to service?	86.5	.45
Current treatment and effects are described?	70.5	.70
Dominant hand described?	89.8	.54
Gait described?	89.7	.58
Does report include Eye exam worksheet information, if indicated?	84.6	.77
Does report include Audio exam worksheet information, if indicated?	84.0	.79
At least three blood pressure measurements reported?	88.5	.34
Does report include Joint exam worksheet information, if indicated?	73.7	.65
Does report include Spine exam worksheet information, if indicated?	69.3	.63
Does report include Mental Disorders exam worksheet information, if indicated?	67.3	.57
Were all other worksheets followed as appropriate?	70.5	.60

**Table 9E**  
**Inter-rater Agreement for Assessing the Initial PTSD Examination Quality Indicators**

Initial PTSD Exam-Specific Indicators	Percent Agreement	Kappa Coefficient
C-file reviewed?	89.3	.69
Frequency, severity and duration of symptoms?	95.8	.94
Specific stressors during service and link to current condition?	93.4	.90
Post-military stressors and description of psychosocial consequences?	81.0	.75
Does the report address problematic alcohol or substance abuse?	87.6	.80
Effects on employment functioning?	79.4	.71
Is impairment of thought process or communication addressed and described?	91.8	.88
Is the diagnosis consistent with DSM-IV and supported by the exam findings?	66.9	.57
Does report describe multiple mental disorders and symptoms?	67.8	.56
Does report address veteran's ability to manage VA benefits?	92.4	.81

**Table 9F**  
**Inter-rater Agreement for Assessing the Review PTSD Examination Quality Indicators**

<b>Review PTSD Exam-Specific Indicators</b>	<b>Percent Agreement</b>	<b>Kappa Coefficient</b>
Frequency, severity, and duration of symptoms since last exam reported?	96.7	.96
Does report comment on remissions and capacity for adjustment?	53.3	.48
Does the report comment on type of treatment?	80.0	.78
Does the report describe veteran's current occupation and time lost from work?	79.2	.73
Does the report describe social functioning since the last exam?	92.5	.91
Does the report address problematic alcohol or substance abuse?	88.3	.83
Is impairment of thought process or communication addressed and described?	93.3	.92
Describes activities of daily living?	90.9	.89
Does report describe multiple mental disorders and symptoms?	73.3	.67
Does the report address veteran's ability to manage VA benefits?	93.4	.80

**Table 9G**  
**Inter-rater Agreement for Assessing Joints Examination Quality Indicators**

<b>Joints Exam-Specific Indicators</b>	<b>Percent Agreement</b>	<b>Kappa Coefficient</b>
Does report note subjective complaints?	98.6	.99
Does report describe need for assistive devices?	72.3	.51
Does the report describe the effects of the condition on the veteran's usual occupation?	70.3	.47
Does the report describe the effects of the condition on the veteran's daily activities?	74.4	.60
Does report provide the active range of motion in degrees?	82.9	.82
Do the objective findings state whether the joint is painful on motion?	74.1	.66
Does the report address additional limitation following repetitive use?	63.1	.44
Do findings address additional limitation during flare-ups?	55.5	.40
Does report address instability of knee?	83.0	.33
Do the objective findings include results of all conducted diagnostic and clinical tests?	79.4	.66

**Table 9H**  
**Inter-rater Agreement for Assessing the Spine Examination Quality Indicators**

Spine Exam-Specific Indicators	Percent Agreement	Kappa Coefficient
Does report note veteran's subjective complaints?	100.0	NA
Does report describe effects of the condition on the veteran's usual occupation?	71.5	.52
Does report describe effects of the condition on the veteran's daily activities?	73.9	.65
Does report provide each range of motion separately and in degrees?	90.8	.85
Does the report address additional limitation following repetitive use?	57.2	.43
Do the findings address additional limitation during flare-ups?	64.7	.42
Does report address objective evidence of painful motion, spasm, weakness, and/or tenderness?	87.4	.83
If neurological abnormalities are noted, is appropriate worksheet followed?	83.2	.79
Do the objective findings include results of all conducted diagnostic and clinical tests?	84.9	.71

**Table 9I**  
**Inter-rater Agreement for Assessing the Mental Disorders Examination Quality Indicators**

Mental Disorders Exam-Specific Indicators	Percent Agreement	Kappa Coefficient
Frequency, severity and duration of symptoms?	89.3	.95
Report addresses unemployment or time lost from work?	83.5	.78
Examiner reports effects of symptoms on employment?	73.5	.65
Effects on social functioning?	87.7	.82
Thought process or communication impairment described?	96.7	.97
Does report address veteran's behavior?	92.6	.91
Describes activities of daily living?	94.2	.92
Does the report address veteran's ability to manage VA benefits?	92.5	.79
Multiple mental disorders and symptoms discussed?	82.6	.79
Effects of drug or alcohol abuse addressed, when appropriate?	76.8	.65

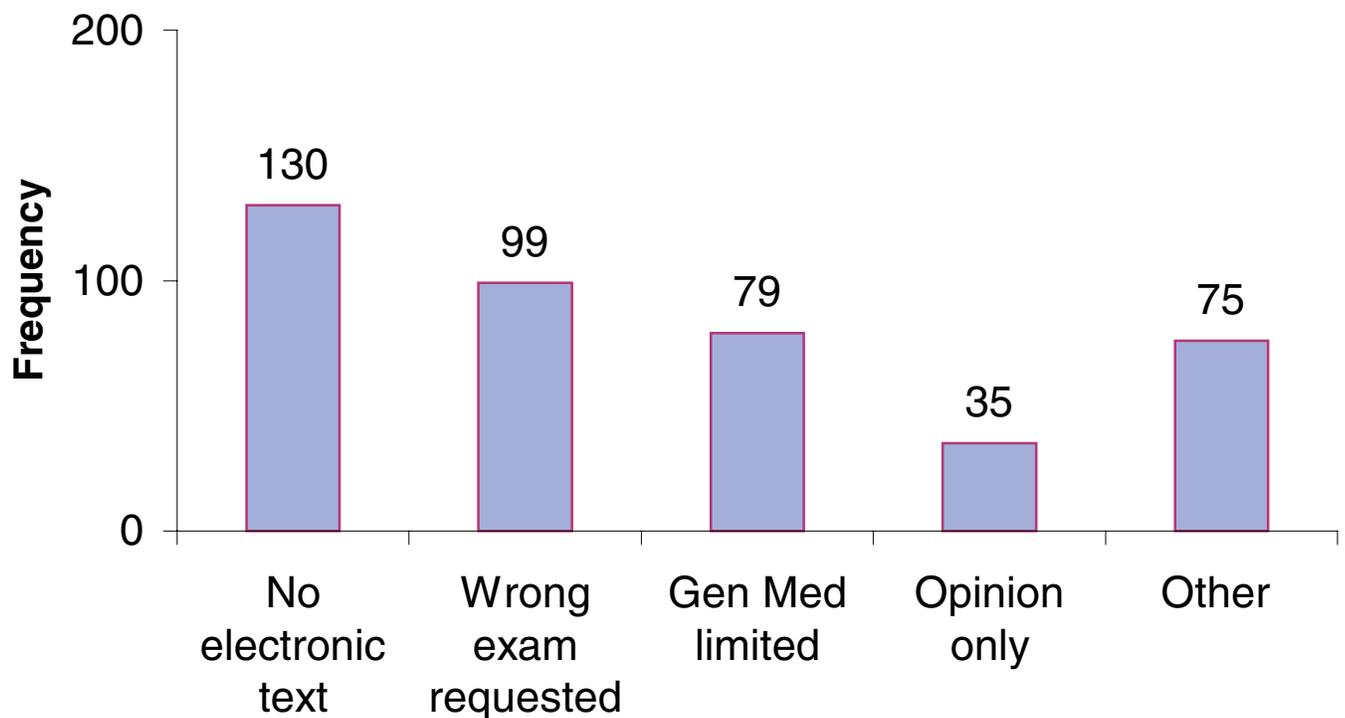
**Table 9J**  
**Inter-rater Agreement for Assessing the Skin Examination Quality Indicators**

Skin Exam-Specific Indicators	Percent Agreement	Kappa Coefficient
Comment on onset and course of the skin condition?	87.5	.83
Does report comment on treatment type and effects?	78.3	.71
Does report note subjective symptoms?	91.7	.87
Do objective findings report the size of the disease area?	80.9	.76
Do objective findings indicate whether the involved skin is exposed?	95.0	.91
Do objective findings report on ulceration, exfoliation or crusting?	71.6	.64
Do objective findings report on systemic or nervous manifestations?	64.2	.40
Do the objective findings include results of all diagnostic and clinical tests conducted?	95.0	.91
Does report include color photos?	69.1	.64

## Unreviewable C&P Examination Reports

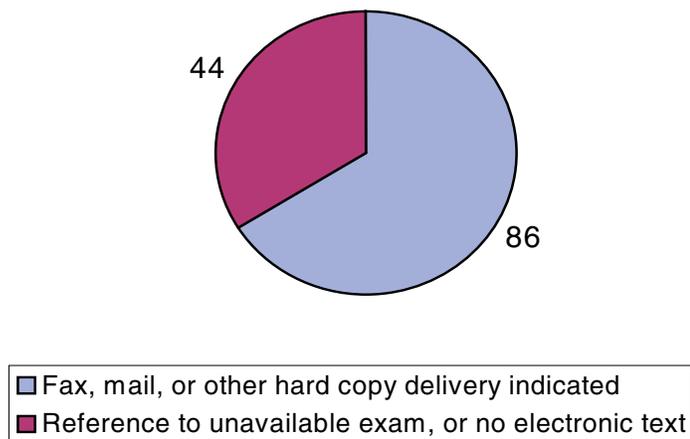
We documented 418 unreviewable examination reports, after excluding duplicate notices from more than one reviewer. As indicated in Graph 1, we found four main reasons reports were unreviewable. The following discussion addresses these reasons in the order of the frequency with which reviewers found them.

**Graph 1**  
**Reasons Exam Reports Were Unreviewable**



**1. No electronic results text (130 cases):** CPEP’s review of C&P exam report quality was conducted without reviewing claims folders. If the examining facility submitted an exam report by any means other than electronically via AMIE, our reviewers could not access the document. In some cases (86), examiners noted in the AMIE system that they were faxing, mailing, or otherwise transmitting a hard copy report to the regional office (RO). In other cases (44), we were unable to determine whether or not a report was sent by any means. Many of these 44 reports contained text stating, for example, “exam completed (date)” or “see (other) exam report of (date).” However, the referenced reports were not available in the CPEP database.

**Graph 2**  
**No Electronic Text Available for Review**  
**130 Cases**

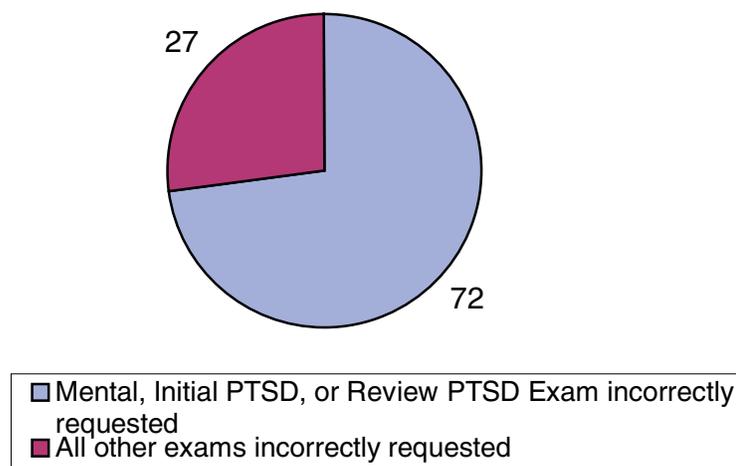


**2. Wrong exam requested by the RO (99 cases):** CPEP's quality review program was designed to evaluate the quality of exam reports based on the exam type requested by the RO. If the RO requested the wrong exam type and the examining facility noticed the error and performed the correct exam type, we could not evaluate the report. In the 99 total cases of incorrect exam requests, 72 involved psychiatric exam requests.

Our quality review included three different types of psychiatric exams: Initial PTSD exam, Review PTSD exam, and Mental Disorders (not PTSD or Eating Disorders) exam. In 45 of the 72 psychiatric exam request errors, Initial PTSD exams were requested instead of Review PTSD exams for veterans who were already service-connected for PTSD. In many of these cases the examiner recognized the exam request error and performed the appropriate exam in spite of the erroneous request.

An exam report for one type of psychiatric exam would not be expected to contain the same type of information ordinarily gathered for another type. As a result, applying CPEP's quality review criteria for the requested exam would be unfair, and we removed those reports from the review sample.

**Graph 3**  
**99 Incorrect Exam Requests**



**3. General Medical exam worksheet used to request limited exams (79 cases):** For various reasons, ROs used the General Medical exam worksheet to request exams for a limited purpose or as a proxy for one or more specific specialty exams. CPEP did not classify this use of General Medical exam worksheets as erroneous because many local facilities have agreed to this use for operational purposes. However, an exam report that answers a limited, specific request that happened to be tied to a General Medical exam cannot be fairly evaluated using the full set of General Medical exam criteria. In addition, an exam report for a General Medical exam would not be expected to contain the same type of information ordinarily gathered for a specialty exam. As a result, applying CPEP's quality review criteria for the requested General Medical exam would be unfair, and we removed those reports from the review sample.

As an example of an operational purpose for using the General Medical exam worksheet for a specific exam: CPEP was told that, for a period of time, problems associated with the VBA-VHA interface using the AMIE system did not allow ROs to place a second request for an exam within nine months of the first request for the same type of exam for the same veteran. This could produce an operational difficulty in instances such as the following: a veteran may have submitted a claim for disability benefits for a right knee condition (Joints exam required), then six months later submitted a separate claim for a disability of the left hip (another Joints exam required). Because the RO could not request a second Joints exam (due to the problems with the AMIE interface), RO staff may have improvised the request, using the General Medical exam worksheet and instructing the examiner to limit the exam to the veteran's left hip.

ROs may not be aware that this problem has been resolved and, therefore, are continuing to use the General Medical exam worksheet for second requests. Currently, the only situation in which the RO cannot request a second exam of the same type for a veteran is when the first exam is still active (open) in the AMIE system (i.e., has been neither cancelled nor released).

**4. Medical opinion requested only (35 cases):** In some cases, ROs do not need a full exam report to rate a veteran's disability claim. Instead, they require only a medical opinion, typically pertaining to the relationship, if any, between a current disability and a veteran's military service. In these cases, the medical professional may not need to examine the veteran to formulate and report the opinion. CPEP removed from the quality review sample those cases in which the RO requested a medical opinion and no examination was performed.

**5. Other reasons for unreviewable exam reports (75 cases):** In addition to the four main reasons exam reports were unreviewable, CPEP identified seven other reasons for unreviewable reports. Seventy-five reports were assigned to these categories as follows:

- a. The scope of the exam was limited by the “remarks” section of the AMIE worksheet (6 cases).
- b. The report was an addendum to clarify or augment a prior exam report (8 cases).
- c. The report referred to another exam worksheet, which either was not available or did not contain the information needed for the requested exam (19 cases).
- d. The report was written in response to specific instructions in a BVA remand (2 two cases).
- e. The veteran refused the exam or did not cooperate during the exam (5 cases).
- f. The veteran failed to report for the exam (16 cases).
- g. Miscellaneous issues prevented review (19 cases).

## Reviewer Comments on Exam Reports

As part of their review of the quality of C&P exam reports, reviewers were asked to provide comments addressing noteworthy issues, concerns, or observations encountered in their review of any exam report. CPEP looked at reviewer comments recorded in exam reports that received three independent reviews. Nine hundred twenty-four (924) exam reports received three reviews (for a total of 2,772 reviews), and 176 received two reviews (for a total of 352 reviews). The overall total of independent reviews of the 1,100 exam reports was 3,124 (i.e., 2,772 plus 352). Thus, we looked at reviewer comments in approximately 89% of the 3,124 total reviews.

Out of the 924 exam reports that were reviewed three times (for a total of 2,772 reviews), 831 exam reports contained comments by the STAR staff reviewer. These 831 comments were distributed among 603 of the 1,100 total exam reports reviewed. We organized the reviewers' comments into the following categories:

1. Good exam report.
2. Multiple diagnoses were provided, but the relationship among them was not discussed, or the symptoms were not delineated.
3. Unsubstantiated diagnosis (diagnosis provided was not supported in the body of the exam).
4. Imprecise or no diagnosis (diagnosis given was not precise [e.g., "history of," "pain," "symptom," etc.] or no diagnosis was provided at all).
5. Incomplete exam.
6. RO requested the wrong exam.
7. "DeLuca criteria" (i.e., additional functional limitation resulting from pain, weakness, fatigue, or lack of endurance during flare-ups or following repetitive use) were either omitted or not covered completely.
8. Range of motion was either omitted or not provided in the proper format.
9. Occupational/daily activities (report did not address effects of disability on veteran's occupation or social activities).
10. RO request was not helpful or informative.
11. Objective testing results were not included in report.
12. Requested opinion was not properly stated (i.e., whether, in the examiner's opinion, a disability was [or was not] "at least as likely as not" to be related to the veteran's service or to another service-connected disability).
13. No annotation regarding review of C-file (for psychiatric exams).

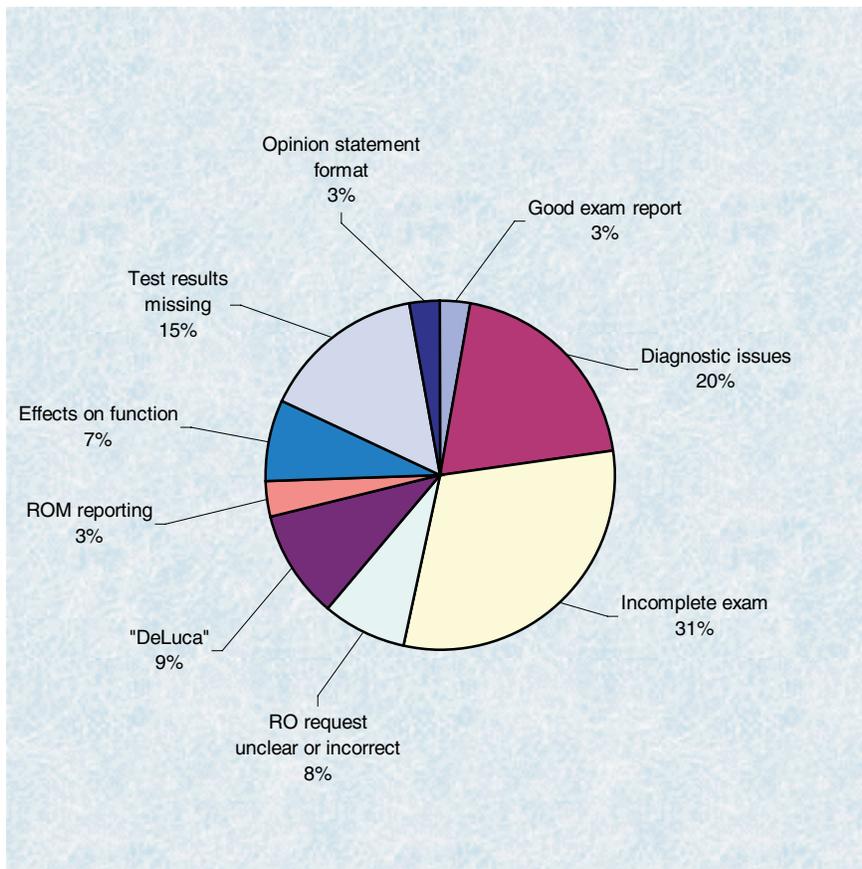
In some cases, the comments in reviews of a single exam report applied to two or more of the categories identified above. Our analysis addresses the comment frequency by category only. Frequency of comment co-occurrences is not evaluated in this study.

Some comments on exam reports were excluded from this analysis. Among the reasons for eliminating comments were that they merely explained a reviewer's recorded findings; they documented the form of the exam report (e.g., Joint exam results were included in a Muscles exam report); their interpretation depended on the exam report context (which would require an additional review); they were duplicative of another remark on the same exam report; or, they addressed an administrative aspect of the study itself. In all, 231 comments were eliminated from review for these reasons.

The remaining 600 comments produced 774 categorizations (again, a single reviewer remark may raise more than one exam issue). On average, each usable reviewer remark applied to approximately 1.3 of the categories identified on page 58.

The following graphic (Chart 4) on page 60 shows the percentage distribution of the 774 categorizations of reviewer comments. Note that the graphic combined categories 2, 3, and 4 into one "diagnostic issues" category, and categories 6 and 10 into "RO request unclear or incorrect." Also, category 13 "no annotation of C-file review," is not represented because only two comments (rounding to 0% of the total) fit in that category.

**Graph 4**  
**Distribution of Review Remarks**



The actual number of comments applicable to the condensed categories are shown in the following table:

**Table 10**  
**Reviewer Comments Breakdown**

Item	Description	Comment Count
1	Good exam report	21
2-4	Diagnostic Issues: 2 – Multiple diagnoses (12) 3 – Unsubstantiated diagnosis (26) 4 – Imprecise or no diagnosis (118)	156
5	Incomplete exam	236
6-7	RO Request Issues: 6 - Wrong exam requested (14) 7 - Request not informative (46)	60
8	"DeLuca"	77
9	ROM reporting	27
10	Effects on function	57
11	Test results missing	118
12	Opinion statement format	22
13	No C-file review annotation	2

The following table shows the frequency of "incomplete exam" comments by exam type:

**Table 11**  
**Frequency of Incomplete Exams**

Exam Type	Number of "Incomplete" Comments
Audio	16
Eye	25
Feet	19
General Medical	73
Initial PTSD	13
Joints	26
Mental Disorders (Except PTSD and Eating Disorders)	4
Review PTSD	19
Skin	27
Spine	14

Table 11 shows that reviewers described the General Medical exam as incomplete almost three times more often than any other exam type.

In the 14 reviews where the RO requested the wrong exam, the examining facility conducted the exam anyway, making the report “scoreable” for quality review purposes. Had the examining facility not conducted the exam or conducted a different exam, the CPEP quality review program would not apply, and reviewers would be unable to score the report. In these 14 cases, then, the results of the exam were judged against the criteria for the exam that was actually requested rather than the exam that should have been requested.

## Discussion

### Summary of Performance

The CPEP national baseline quality measurement of the ten most frequently requested C&P examinations found mixed results. Overall performance on the core quality indicators was 96%, and the core quality indicator performance did not dip below 91% for any exam type. Performance on exam-specific quality indicators was 90% or greater for 5 of 10 exam types: Audio, Eye, Initial PTSD, Review PTSD and Mental Disorders.

Much more room for improvement was found in the remaining five exam types (Feet, General Medical, Joints, Skin and Spine), in which the overall exam-specific quality indicator scores ranged as low as 71.5%.

The quality indicator scores can serve as a yardstick for measuring the aggregate quality of examinations at the level of the VHA site, VISN, or the national VA C&P examination process. The pattern of results should be used by C&P teams to benchmark their performance and to identify the problem areas for their local quality improvement initiatives. The most prominent opportunities for improvement revealed by this national baseline study are described below.

#### Audio

Audiologists can improve the quality of their examination reports by attending to frequency (or constancy) of tinnitus episodes and describing non-military noise exposure.

#### Eye

ENT specialists can improve the quality of their examination reports by reporting both near and far corrected visual acuity for each eye; by doing a more complete history of visual symptoms, and type and dates of treatment; and by attending to the additional requirements when diplopia or visual field deficits are present.

## **Mental Disorders, Initial PTSD and Review PTSD**

Psychologists and psychiatrists can improve the quality of their examination reports by separating the effects of drug or alcohol abuse from other mental disorders, delineating symptoms associated with each of multiple mental disorders, reporting effects of mental disorders on employment, and assessing the veteran's ability to manage VA benefits.

There are instances when mental health examiners are asked to address particularly difficult issues. They need to realize that it can be appropriate to respond with "*I don't know*" (with a brief explanation) in the report. For example, delineating the symptoms of multiple mental disorders and substance abuse and describing their relationship to a veteran's disability may not be possible in all cases. Examiners must recognize that they are not expected to make concrete determinations when science and facts are lacking. They must equally recognize that it is their responsibility to clearly state when this is the case so that the claim can be processed as fairly and expeditiously as possible.

The AMIE worksheet requires the veteran's C-file to be available for review prior to an Initial PTSD examination. Obtaining C-files for review can be difficult and, sometimes an insurmountable problem. In such situations the examination report should state that the C-file was not available for review. The CPEP exam-specific indicator gives credit to reports where the examiner states that either the C-file was reviewed or that it was unavailable for review. Approximately 22% of the Initial PTSD examiners failed to include such a statement in their report.

Examiners can also improve their PTSD examinations by assuring that their diagnoses are consistent with the DSM-IV criteria and that they are supported by the findings in the report. The PTSD examination can also be improved by commenting on the length of remissions (if they occur) and the veteran's capacity for adjustment during remissions.

## **Joints and Spine**

DeLuca criteria reporting (i.e., additional functional limitation resulting from pain, fatigue, weakness, or lack of endurance during flare-ups or following repetitive use) can be improved. The "DeLuca" criteria are so named by reference to a precedent decision by the Court of Appeals for Veterans Claims (*DeLuca vs. Brown*, 8 Vet. App. 202, 206 [1995]), which interpreted VA regulations to require consideration of these factors in rating disabilities involving range of motion.

Scores on the exam-specific indicators related to the DeLuca requirements were low for both Joints and Spine exams. Examiners frequently did not report findings of additional limitation following repetitive use or during flare-ups. Possible explanations include knowledge deficits about the importance and techniques of eliciting these findings; examiner discomfort with performing exam components that cause the veteran pain; the distance between these exam components and 'usual' clinical exam techniques; uncertainty about proper reporting, and others. Whatever the cause, we are optimistic that rapid improvement can be achieved in this area.

Performance on the exam-specific quality indicator regarding the disability's effect on the veteran's usual occupation was poor in the Joints and Spine examinations, which scored 55% and 65%, respectively. Along with the DeLuca criteria, examiners need education regarding the critical importance of this requirement when performing a disability exam. Additional opportunities for improvement include describing the veteran's need for assistive devices and assuring that the objective findings include results of all conducted diagnostic and clinical tests.

## **Feet**

The exam-specific quality indicator score for the Feet examination (75.1%) was in the same neighborhood as Joints (71.5%) and Spine (78.1%). There are substantial opportunities for improvement. Some of the key areas for attention are: describing the effects of the condition on the veteran's usual occupation; reporting on functional limitations and the objective evidence of abnormal weight bearing; assessing the efficacy of corrective devices; and describing treatment and response to treatment. When a veteran has a flat foot condition, the examiner can also improve the report by noting alignment of the Achilles tendon and pain upon manipulation.

## **General Medical**

General Medical exams are qualitatively different from other exam types. This is the only exam type used as a broad screening exam, rather than a focused exam. Providers conducting a general medical exam are expected to follow other worksheets "as appropriate." This requires that they know what other worksheets are needed, know when to use them, and have access to them "just in time." The quality results show a noncompliance rate that range from 10% (Spine exam follow-up) to 25% (Mental Disorders exam follow-up). Examiners

can also improve the quality of their examination reports by identifying the veteran's dominant hand and by reporting at least three blood pressure measurements when screening for hypertension.

Requests for General Medical exams are also qualitatively different. Some RO-MC teams use General Medical exam requests by agreement as substitutes for requesting multiple specific exams. Other ROs use general medical exams to request focused or specialty exams in certain circumstances (see qualitative analysis of Unreviewable C&P Exam Reports on page 53). Some requests for general medical exams may be made because the requestor is uncertain what to ask for. In any event, general medical exams are different from other exam types for both requesting sites and performing sites. Moreover, it is likely that the General Medical exam is not used uniformly system-wide.

## **Skin**

Examiners can improve the quality of Skin examinations by reporting on systemic or nervous manifestations; describing the findings of ulceration, exfoliation or crusting; and providing color photographs in cases of disfigurement.

## **Core Indicators**

Performance on the core quality indicator of the examiner's responsiveness to the issues in the remarks section of the exam request ranged from 98% to 100%. In the exams that were reviewed, examiners were responsive to remarks on the exam requests. If so, the VBA rating specialists may have an opportunity to make better use of the remarks section to solicit more responsive and relevant reports from the examiners.

In cases where opinions cannot be rendered or diagnoses reached, clinicians should indicate the reasons in the text of the exam report. Clinicians may not be aware that lack of a firm diagnosis or opinion is acceptable if a clear, brief explanation for not providing one is reported. Clinicians may also not be aware of how to properly make such a statement. Education may be well received in this area, as it is quite plausible that such situations of uncertainty are uncomfortable for the clinician.

In this baseline report, 8.5% of the examinations requested a medical opinion, and medical opinions were provided for 90% of these requests. Since the number of examinations requesting a medical opinion is relatively small, C&P examination sites might be able to flag these exams as they arrive and conduct quality assurance reviews to correct the 10% of reports missing medical opinions.

## **Specialist vs. Generalist Exams**

Performance on exam-specific quality indicators was better for the five exams performed by specialists than the other five exam types. Those requiring examination by a specialist are Audio, Eye, Initial PTSD, Review PTSD, and Mental Disorders (except PTSD and Eating Disorders). Reasons for this result were not explored in the current study.

## **Effects on Occupational Functioning**

In three exam types (Feet, Joints, and Spine), performance on exam-specific quality criteria regarding the disability's effect on the veteran's usual occupation was poor. Unlike the DeLuca criteria, this requirement should be clear to any clinician performing a disability exam.

In two exam types, core quality measures regarding functional impairment were not applied. Specifically, ratings for eye and hearing disabilities are not linked to occupational, social, or other functional abilities. In these two cases, the ratings are numerically determined from testing results. Nevertheless, CPEP felt that functional disability assessment was critical to the C&P exam process and retained this element as a core quality indicator.

## **Why No "C-folder"**

CPEP elected not to use C-files for the national baseline quality measurement review of the most frequently requested exams for several reasons. First, in most cases the product asked for by VBA is a complete exam that can stand on its own without supplementation by other records. VBA wants a complete exam result product unless otherwise specified. Recognizing this, CPEP excluded from review instances when a more focused exam was specifically requested. Second, in many cases the C-file is not sent to the medical center. For better or worse, the examining clinician is often unaware of existing evidence that might make whole an otherwise insufficient exam. Third, the measurement process was not designed to make a determination of "ratability" for any particular exam. It was designed to discover and estimate the frequency of overall performance deficiencies on important and actionable issues. Given this basic design, the case-specific context offered by the C-file is not necessary. Fourth, CPEP was concerned that sequestering C-files for review purposes could delay claims processing and that the logistics surrounding proper management of the files would delay production of valuable quality review results.

## Setting Target Performance

In concept, each and every C&P examination should satisfy all quality indicators and all AMIE worksheet criteria. In practice, perfection is extremely difficult and may be unrealistic, given the resource consumption needed for each incremental gain in quality. What, then, is a reasonable quality improvement target? Setting a goal will require a good deal of discussion and consensus building. If we were to arbitrarily select as the target meeting at least 80% or 90% of the quality indicators, the base rate for the top ten examination types would be:

**Table 12**  
**Quality Indicator Goal for Top Ten Exam Types**

Top Ten C&P Examinations	% of reports with score of 80% or better	% of reports with score of 90% or better
Audio	93.6	64.5
Eye	80.9	60.9
Feet	55.5	40.0
General Medical	60.9	44.5
Initial PTSD	86.4	73.6
Joints	42.7	27.3
Mental Disorders	93.3	88.2
Review PTSD	96.4	83.8
Skin	83.6	66.4
Spine	61.8	36.4
Total	73.9	58.5

These base rates indicate substantial room for improvement. Setting a goal that 90% of examination reports score 90% or better would result in significant improvement in the quality of the C&P examination reports. In defining such a goal, however, we need to assure that the CPEP quality indicators do not come to be regarded by the examiners as a substitute for the AMIE worksheets. The gold standard for C&P exam report quality continues to be conformity with the AMIE worksheets.

## Future Improvements in Inter-rater Reliability

The reviewers used by the CPEP Office for this quality report are “truly” experts, with many years of experience in reading and interpreting examination reports and rating veteran claims for compensation and pension. The variance in inter-rater agreement reveals the difficulty in assessing the content of the examination

report for objective and operationally defined performance indicators. We intend to use the item analysis and qualitative comments from this initial study to debrief the reviewers and produce the next version of quality indicators with clearer instructions and case examples for scoring. We will develop training materials from this baseline study to educate reviewers on their assessment process and improve inter-rater reliability. As the ambiguities disappear and reviewer consensus improves, we anticipate fewer third reviews and have a long-term goal of producing an instrument that will improve scoring consistency sufficiently to justify single review for producing aggregated quality indicator scores.

## **Unreviewable Exam Results**

Several lessons can be learned from the unreviewable exam analysis. Frequent use of the General Medical exam worksheet to request other types of exams suggests that the number of true General Medical exams conducted is lower than shown in current data. It also suggests that it may not always be appropriate to require that an exam request be linked to one of the 56 AMIE exam types. Possible categories to consider adding include “opinion only” and “focused exam only.”

A relatively high number of exam requests (99) were for the wrong exam type. Some of these were overt errors requiring no medical judgment or data. Examiners often recognized the request error and performed the exam appropriate to the condition claimed. This was particularly true in cases where the RO had requested one type of psychiatric exam when a different type was appropriate. More subtle exam request errors were not evaluated in this study. For example, we did not evaluate exam requests for accuracy in context of C-file data, and recognize that this is important work for future analysis.

The number of exams released without data in AMIE suggests that the system may be under-used as a reporting tool. There may be many reasons that an examining facility would choose to transmit exam reports outside the AMIE system. However, the AMIE system is a cost-effective, efficient, and reliable method for getting exam reports to regional offices (ROs). Disuse of AMIE may contribute to fragmentation of VA’s C&P exam process. CPEP has no evidence to suggest that the quality of exam reports that are delivered to the RO outside AMIE are systematically different from those that are transmitted via AMIE. However, we cannot say for sure that the quality levels of AMIE and non-AMIE reports are equivalent. It is possible that exam reports submitted outside the AMIE system are, on average, significantly better, or worse, than those submitted via AMIE.

Finally, approximately 4% of all unreviewable exams were cases in which the examining facility released a report as “complete” when the only information reported was that the veteran failed to appear for the exam. In such cases, the exam report should not be released as completed—because there was no exam to be reported. Releasing such an exam gives the facility unearned credit for both work and timeliness.

## **Exam Comments**

Comments generally tended to reinforce reviewers’ scoring in the quality indicator portion of the review. Our discussion of the comments highlights qualitative impressions of the reviewers, along with some of the implications for this study and the exam process itself.

Overall, the six areas that were most frequently commented on (diagnostic issues; incomplete exam; RO request unclear or incorrect; “DeLuca;” occupational/daily activities; and test results not included in exam report), reiterate the findings of the quantitative analysis. However, we also find it noteworthy that CPEP reviewers volunteered a number of positive comments.

CPEP did not instruct reviewers to provide narrative comments on exam reports that were especially well done. Nevertheless, some exam reports were of such outstanding quality that reviewers were moved to go beyond merely recording a high score on the review. We were pleased to find such good reports in our sample.

Certain other inferences can be drawn from reviewer comments as well.

The “incomplete exam” category is, in a sense, a catchall. For purposes of this study, the category generally refers to the absence from the exam report of a significant requirement of the AMIE worksheet for the requested exam. The quantitative data and discussion reflect the frequency of such omissions. Beyond that, however, reviewer comments identified the General Medical exam as incomplete particularly often. In its intended use, the General Medical exam is the most comprehensive of all 56-exam types. It requires the examiner to address all major body systems and, if symptoms are present, provide additional information called for by the AMIE worksheet specific to the disease found or suspected.

Elsewhere in this report we have also seen that the General Medical worksheets are often used by ROs as a “proxy” exam to request one or more other specialty C&P exams. Together, these findings suggest that the General Medical exam presents special process issues that may require separate attention.

Also noteworthy was the frequency of comments that RO exam requests were incomplete or unclear. While the primary focus of this baseline study was to assess the overall quality of C&P exam reports, we have an inherent interest in all factors that influence quality outcomes. One critical factor influencing report quality is the clarity and specificity of the request. This is the essence of the axiom “garbage in, garbage out.” CPEP is working with other elements of VA to improve and standardize (to the extent useful) the ways in which ROs request disability exams.

Reviewer comments also provided added dimension to the findings regarding examiner reporting on occupational and/or daily activities. The comments suggest that examiners may overlook explicitly commenting on occupational or daily activities in what some might regard as “obvious” cases: those in which the examiner sees little or no effect of the disability in these arenas. In such cases, however, a comment to that effect would provide medical support for the rating determination.

The rating schedule is conceptually based on average impairment of earning capacity resulting from disability in civil occupations. For most C&P exams, the effects of the veteran’s disability on occupation and/or daily activities are fundamental elements in determining the level of disability.

## **Previous C&P Exam Quality Studies**

The question of C&P exam quality has been asked repeatedly over the last decade. In 1993 the VBA found that approximately 75% of the Navy and Marine Corps' service separation examinations were inadequate for rating purposes. The VBA conducted a large study in 1996 on the adequacy of VA examinations, and then a smaller study in 2000. CPEP carefully reviewed each of these studies and applied the lessons learned to the current effort.

### **AMIS Insufficiency Rate**

The most widely known measure of C&P exam "quality" is the AMIS 290 insufficiency rate. This value is calculated using the number of exam reports returned to the performing site due to "insufficiencies" as the numerator, and the number of released reports as the denominator. It is calculated monthly for each medical center. There is a 13-element list of reasons for insufficiencies implemented in the AMIE II computer system package. The reasons vary considerably in their granularity; some are specific and actionable (failed to perform requested specialist exam), others are too general to provide useful feedback (e.g., eye exam is insufficient). There is a common sentiment within VBA and VHA that exams are not always returned as insufficient, even when significant deficiencies exist. Reasons cited include use of other "repair" mechanisms and pressure to produce ratings quickly.

### **1996 VBA Exam "Adequacy" Survey**

In 1996 VBA conducted a three-month exam adequacy study by surveying staff at regional offices. The survey asked if the exam was adequate for rating purposes, and if not, why not. Respondents selected reasons for exam inadequacy from a 42-element list. Data were collected for 21,600 exam reports and entered onto a spreadsheet. We cannot determine from the report, dated December 17, 1996, how sampling was conducted and the type of instructions and techniques that reviewers were told to follow. The report notes that the Chicago Regional Office did not send in a final data batch because they felt their report was based on faulty information. The study's finding of an exam report inadequacy rate of 12% is substantially higher than the AMIS insufficiency rate of 1%-3% (the percentage of examinations returned to the examining facilities for corrective action).

The most common issues found among inadequate exams were:

- 15% Physician's failure to follow examination instructions
- 9% Diagnosis, symptoms, severity and medications not adequately described
- 7% Functional impairment not adequately described
- 7% Failed to provide requested medical opinion
- 7% Diagnosis lacking
- 6% Range of motion in degrees not specified
- 5% Necessary specialty exams not conducted
- 5% Diagnosis not meaningful
- 1% Three blood pressure readings not provided on hypertension exam

Recommendations from this 1996 study included: (1) improving the AMIE worksheets, (2) revising the Physician's Guide to Disability Evaluation Examinations, and (3) providing a training program for examiners.

### **2000 VBA Review of VHA Disability Examination Reports**

In February 2000 VBA issued a report on VHA C&P exam quality. This study performed an expert review of 160 exams "randomly" selected by examination coordinators at 8 regional offices from 15 VHA examining sites. The study designers requested that specific exam types be represented in similar proportions to the frequencies used for contractor exam analysis. The review process included a list of 24 reasons for inadequate exams. Of these, 12 reasons were exam-specific. An expert reviewer reviewed each exam one time. Random exam selection techniques are not described, multiple independent reviews were not conducted, and sample sizes are too small to draw conclusions about deficiencies present within specific exam types. Nonetheless, 51 of the 160 exams (31.9%) were felt by the expert reviewer to be inadequate for rating purposes. The most common reason for exam inadequacy was the lack of a meaningful diagnosis (e.g., symptom reported rather than diagnosis). Other reasons cited include lack of description of functional disability, no diagnosis provided to address all the veteran's complaints, all claimed or noted disabilities not examined, and diagnosis not supported by findings. A number of other instructive points were presented in the analysis portion of this report. CPEP consulted this report in the design of the current study.

**Comparing Results:** It cannot be stressed strongly enough that the current study uses different methodology than previous efforts and that the results are not directly comparable to previous evaluations. The prior studies required a judgment on the adequacy or sufficiency for “rating” purposes. Raters often extract evidence from medical records in claim files, thus the judgment of whether an examination is adequate for rating purposes is relative to the context of additional information. The CPEP indicators are grounded in the actions specified in the worksheets and rating schedule, separating the quality of the examination from the decision of “ratability” based partially on the examination. In spite of this conceptual difference in approach, there are interesting similarities and differences in results between the VBA and CPEP studies.

The 1996 VBA study reported issues as percentage of inadequacies rather than rates using the 21,600 examinations or the appropriate exam type as the denominator. When converted to rates, the 1.8% failure rate to follow instructions (12% overall inadequacy times the 15% of inadequacy due to failure to follow instructions) is comparable to the 1.1% rate in the CPEP study. The earlier study, however, found a 7% failure rate to respond to medical opinions requested, where the CPEP study found that 10% did not provide a requested opinion. Seven percent of the inadequacies in the VBA study were related to description of functional impairment, whereas the CPEP study found that 10.3% of the examinations did not meet the core indicator quality regarding description of functional impairment in occupation. In brief, these findings from the CPEP study concur with the VBA studies that the issue of exam quality is much greater than reflected in the “insufficiency rate.”

The driving factors for investigating C&P exam quality are to achieve better medical information upon which to evaluate the veteran’s disability and to control the amount of re-work. Returning insufficient examinations to the facility for corrective action achieves the objective of acquiring needed information from the C&P administrative office, but does not assure that the responsible examiners receive feedback conducive to learning. The CPEP indicators not only produce national measures of exam quality, but also can be applied in quality improvement. By separating the issues of exam quality from judgment of ratability, the quality indicators provide relevant feedback to examiners that indicate the type of action required for improving the exam process and clinical examination report. The findings from the CPEP study are currently being used by the VA Collaborative Breakthrough Series on Improving the Quality of Compensation and Pension Examinations to bring about quality improvement and by the CPEP Office to develop and distribute educational materials for C&P examiners.

**Other studies not addressing C&P exam quality per se:**

1999 – Final Report on Study of “Incomplete” C&P Examinations  
(Vince Crawford)

1999 – GAO “Veterans Benefits Claims: Further improvements needed in  
claims processing accuracy”

1997 – VA OIG Review of C&P Medical Examination Services

1997 – VA OIG Summary Report on VA Claims Processing Issues

## Upcoming Evaluations

The baseline evaluation will be extended in two ways. First, performance on the top ten exams will be measured at the VISN level. The same criteria that were used for the national-level review will be applied. Second, a national-level evaluation of the next 21 most commonly requested exams will be conducted. Overall, the top 31-exam types cover 95% of all exams performed nationwide. The criteria are currently undergoing final review by the CPEP Clinical Advisory Board.

# APPENDIX A

## Quality Indicators

### KEY ELEMENTS (QUALITY INDICATORS) FOR THE 10 MOST FREQUENTLY REQUESTED C&P EXAMINATIONS

*The CPEP Office is using these key elements to establish a baseline quality level for C&P examination reports.*

*CPEP Office  
Nashville, Tennessee  
January 15, 2002*

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**Audio**

<b>Key Element</b>	<b>AMIE Ref.</b>	<b>Reviewer Instructions</b>
1. Describes noise exposure during military?	B4 38 CFR 3.303 3.304 3.385	For original service connection: Answer YES if report indicates presence OR absence of noise exposure during military service. Answer NO if report does not address military noise exposure. Answer NA if veteran is already service connected for hearing/ear condition.
2. Describes non-military noise exposure?	B4 38 CFR 3.303 3.304	For original service connection: Answer YES if report indicates presence OR absence of non-military occupational and recreational noise exposure. Answer NO if report does not address non-military noise exposure. Answer NA if veteran is already service connected for hearing/ear condition.
3. Does report address whether tinnitus is recurrent?	B5c Dx code 6260	Answer YES if report indicates no tinnitus was found OR (if tinnitus is present but not constant) indicates how frequently tinnitus episodes occur. Otherwise, answer NO. Do not use NA.
4. Findings of pure tone thresholds for both ears?	C1 Dx code 6100 38 CFR 4.85 3.385	Answer YES if report provides separate thresholds for each ear at the frequencies specified in the AMIE worksheet. Otherwise, answer NO. Do not use NA.
5. Average of pure tone thresholds recorded properly?	C1 38 CFR 3.385 4.85	Answer YES if report contains average pure tone threshold calculated using thresholds at 1000, 2000, 3000, and 4000 Hz for each ear. Answer NO if report does not contain average threshold OR if threshold average is not properly calculated. Do not use NA.
6. Findings of speech recognition for both ears?	C2 38 CFR 3.385 4.85 Dx code 6100	Answer YES if report includes results of the Maryland CNC word list speech recognition test for each ear OR examiner explains why the test could not be administered (e.g., language difficulties). Otherwise, answer NO. Do not use NA.
7. Diagnosis reports type of hearing loss?	E1 38 CFR 3.303 3.385 3.304	Answer YES if report indicates there is no hearing loss OR (if hearing loss is present) identifies the type of loss (normal, conductive, sensorineural, central, or mixed). Otherwise, answer NO. Do not use NA.

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## Eye

Key Element	AMIE Ref.	Reviewer Instructions
1. Subjective complaints of visual symptoms?	B3 38 CFR 4.10 4.40	This item refers to complaints of watering; swelling; blurred vision; distorted or enlarged images; etc. Answer YES if report includes any statement identifying visual symptoms or noting absence of symptoms. Otherwise, answer NO. Do not use NA.
2. Description of ophthalmologic treatment?	B4 & 5 CFR 4.1 4.2	Answer YES if the report indicates the veteran has received no ophthalmologic treatment OR (if treated) describes the type and last date of treatment. Otherwise, answer NO. Do not use NA.
3. Findings provide the best corrected visual acuity for each eye?	C1 38 CFR 4.83 4.75 Dx codes 6061- 6079	Answer YES if report indicates best corrected near and far visual acuity for each eye. Answer NO if best corrected visual acuity information is absent or incomplete. Do not use NA.
4. Findings on reading chart, counting fingers, hand motion and/or light perception?	C1e 38 CFR 4.75 4.83 6061- 6079	This item applies if visual acuity is worse than 5/200 in either or both eyes. Answer YES if the report states the distance at which veteran is able to read chart, count fingers or detect hand motion OR (if unable to detect hand motion) whether or not veteran has light perception. Answer NO if distance and detection information is absent or incomplete. Answer NA if visual acuity is better than 5/200 in both eyes.
5. If diplopia, constant or intermittent?	C2b 38 CFR 4.77 Dx codes 6090- 6092	This item applies when diplopia is present. Answer YES if objective findings report whether diplopia is constant or intermittent. Otherwise, answer NO. Answer NA if diplopia is absent.

6. Does the report include the Goldmann Perimeter Chart?	C2 & C3 38 CFR 4.27 4.77 Dx codes 6080- 6081 6090- 6092	When diplopia and/or visual field deficit is present: Answer YES if the report includes a Goldmann Perimeter Chart illustrating the size and location of each condition present (i.e., diplopia and/or field of vision defect). Answer NA if veteran does not have diplopia and/or visual field deficit. Otherwise, answer NO.
7. Do the objective findings report on eye disease or injury?	C4 Dx codes 6000- 6035	This item refers to details of eye disease or injury (including eyebrows, eyelashes, and eyelids) other than loss of visual acuity, diplopia, or visual field defect. Answer YES if report comments on presence or absence of eye disease or injury. Otherwise, answer NO. Do not use NA.

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**Feet**

<b>Key Element</b>	<b>AMIE Ref.</b>	<b>Reviewer Instructions</b>
1. Subjective complaints of pain, weakness, or fatigability?	B1 38 CFR 4.10 4.59	Answer YES if the report indicates presence or absence of pain, weakness, or fatigability, etc., at rest or on standing or walking. Answer NO if report does not address effects in at least one of these activities. Answer NA if unaddressed AND veteran is not ambulatory (i.e., in a wheelchair).
2. Description of treatment and response?	B2 38 CFR 4.1 4.2	Answer YES if the report indicates that veteran is not treated for the condition OR (if veteran is treated) describes the effects of treatment. Otherwise, answer NO. Do not use NA.
3. Efficacy of corrective devices described?	B6 Dx code 5276 5278	If veteran uses corrective device(s): Answer YES if report states the veteran does not use corrective devices OR describes the effectiveness of corrective shoes, shoe inserts, or braces. Answer NO if the report is silent on use of these items OR does not describe their effectiveness. Answer NA if veteran is not ambulatory (i.e., in a wheelchair).
4. Effects of condition on usual occupation?	B7 38 CFR 4.10 4.40 3.321	Answer YES if report includes any comment on how the foot condition interferes with the veteran's usual occupation. Otherwise, answer NO. Do not use NA.
5. Findings describe each foot?	C1 38 CFR 4.26 Dx code 5276 5277 5279 5280 5281 5284	Answer YES if report describes each foot. Otherwise, answer NO. Answer NA if veteran does not have two feet OR any other circumstance makes the item irrelevant (e.g., exam is for unilateral neuroma, gunshot wound, infection, malignancy, etc.).  NOTE: Each foot is to be described separately if the condition of each is not the same.
6. Evidence of painful motion, edema, weakness, instability, or tenderness?	C5 38 CFR 4.6 4.10 4.59 Dx code 5276	Answer YES if report indicates there is no objective evidence that veteran has painful motion, edema, weakness, instability, or tenderness OR (if any of these is present) describes objective evidence. Otherwise, answer NO. Do not use NA.

7. Functional limitations on standing and walking?	C6 38 CFR 4.10 4.40 Dx code 5276 5283 5284	Answer YES if report states veteran is not ambulatory OR describes functional limitations on standing or walking. Otherwise, answer NO. Do not use NA.
8. Evidence of abnormal weight bearing?	C7 Dx codes 5276 5278 38 CFR 4.10 4.40	Answer YES if examiner reports: 1) veteran is not ambulatory OR 2) there is no evidence of abnormal weight bearing OR 3) indications of abnormal weight bearing (e.g., callosities, breakdown, unusual shoe wear). Otherwise, answer NO. Do not use NA.
9. Describe alignment of Achilles tendon for flat foot condition?	C11a Dx code 5276	This item applies when flat foot is an issue: Answer YES if report describes weight-bearing and non-weight-bearing alignment of the Achilles tendon. Answer NO if description is absent for either weight-bearing or non-weight-bearing alignment of Achilles tendon. Answer NA if veteran does not have flat foot.
10. Pain on manipulation is addressed for flat foot condition?	C11b Dx code 5276 38 CFR 4.59	This item applies when flat foot is an issue. Answer YES if the report describes whether or not the foot is painful on manipulation. Answer NO if pain on manipulation is not addressed. Answer NA if veteran does not have flat foot.

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### General Medical Exam

Key Element	AMIE Ref.	Reviewer Instructions
1. Was the General Medical exam request form used appropriately?		Answer YES if the request actually called for a General Medical examination. Answer NO if the request used the General Medical request template to request one or more specialty exams. Do not use NA. NOTE: If you answer NO, do not review this exam.
2. Report notes complaints and relationship to service?	B1 38 CFR 3.303 3.304 3.306 4.42	If claim is for original service connection: Answer YES if report discusses whether each identified injury or disease occurred before, during, or after active service. Answer NO if report does not address time of onset in relation to the veteran's active service. Answer NA if claim is for pension or individual unemployability.
3. Current treatment and effects are described?	B3 38 CFR 4.1 4.2 4.10	Answer YES if report describes current treatments and effects OR states that there are no current treatments. Answer NO if one or both elements are absent. Do not use NA.
4. Dominant hand described?	C2 38 CFR 4.71A 4.73 4.241a	Answer YES if the dominant hand is noted. Answer NA in the event of bilateral upper extremity amputations. Otherwise answer NO.
5. Gait described?	C3 C19 38 CFR 4.45 4.40 4.10	Answer YES if the report notes gait to be normal OR (if the gait is abnormal) the reason for abnormality. Answer NA if veteran is not ambulatory. Otherwise, answer NO.
6. Does report include eye exam worksheet information, if indicated?	C7 & Narrative 38 CFR 4.75	Answer YES if report states no vision problem was noted OR eye exam information is included. Otherwise, answer NO. Do not use NA.
7. Does report include audio exam worksheet information, if indicated?	C8 & Narrative 38 CFR 4.85	Answer YES if report states no hearing problem was noted OR (if hearing problem noted) audio exam information is included. Otherwise, answer NO. Do not use NA.

8. At least three blood pressure measurements reported?	C13c1, 2, 3, 4, 5 38 CFR 4.104	If veteran has not been diagnosed with hypertension and is not claiming hypertension: Answer YES if at least three blood pressure measurements are recorded. Answer NO if fewer than three measurements are recorded. Answer NA if veteran has been diagnosed with, or is claiming, hypertension.
9. Does report include joint exam worksheet information, if indicated?	C17 & Narrative 38 CFR 4.40 4.59 4.71a 4.26 4.61	Answer YES if the report indicates no joint pathology was noted OR (if joint pathology noted) includes joint exam worksheet information. Otherwise, answer NO. Do not use NA.
10. Does report include spine exam worksheet information, if indicated?	C17 & Narrative 38 CFR 4.40 4.59 4.61 4.66 4.71a	Answer YES if the report indicates no spine pathology was noted OR (if spine pathology noted) includes spine exam worksheet information. Otherwise, answer NO. Do not use NA.
11. Does report include mental exam worksheet information, if indicated?	C20 & Narrative 38 CFR 4.125 4.130	Answer YES if report states no mental disorder is noted or suspected OR (if noted or suspected) includes mental or PTSD exam worksheet information. Otherwise, answer NO. Do not use NA.
12. Were all other worksheets followed as appropriate?	Narrative 38 CFR 4.42 38USC 5103 5107	Answer YES if the appropriate worksheet information for every condition that was either claimed or noted is included in the report OR if absence of the worksheet is explained (e.g., veteran refused). Otherwise, answer NO. Do not use NA.

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**Initial PTSD**

Key Element	AMIE Ref.	Reviewer Instructions
1. C-file reviewed?	B1 C1(c) M21-1 Part VI 11.38	Answer YES if report definitively states that C-file was reviewed OR states that C-file was not provided. Otherwise answer NO. Do not use NA.
2. Frequency, severity and duration of symptoms?	C2 38 CFR 4.126 4.130	Answer YES if report states that no psychiatric symptoms appeared in the past year OR (if symptoms appeared) addresses their frequency, severity, and duration. Otherwise, answer NO. Do not use NA. Symptoms may include: persistent re-experiencing of traumatic events; persistent avoidance of stimuli associated with trauma; numbing of general responsiveness; persistent symptoms of increased arousal (startle); distressing dreams during which the traumatic event is replayed.
3. Specific stressors during service and link to current condition?	D (Mil) 9 and NOTE 38 CFR 3.304(f) M21-1 Part VI 11.38	This item refers to specific traumatic stressors experienced during service and their relationship to current condition. Answer YES if the report clearly describes stressor(s) with details and the relationship to current symptoms OR explains why these cannot be described. Otherwise, answer NO. Do not use NA.
4. Post-military stressors and description of psychosocial consequences?	D (Post-Mil) 2 38 CFR 3.303(d) M21-1 Part VI 11.38	This item refers to post-military traumatic stressors and any psychosocial consequences (e.g., treatment received, disruption to work, or adverse health consequences). Answer YES if report indicates no post-military stressors OR (if present) describes psychosocial consequences. Otherwise, answer NO. Do not use NA.
5. Does the report address problematic alcohol or substance abuse?	D (Post-Mil) 8 38 CFR 4.130 3.301 FL 01-35	Answer YES if report indicates presence or absence of substance abuse AND (if present) makes any reference to presence or absence of associated problems (e.g., legal problems related to substance use, interference with employment, domestic abuse, etc.). Otherwise, answer NO. Do not use NA.
6. Effects on employment functioning?	E 38 CFR 4.130 4.16	Answer YES if report contains any comment on how PTSD signs, symptoms, or impairment interfere with employment. Otherwise, answer NO.

7. Is impairment of thought process or communication addressed and described?	E1 38 CFR 4.130	Answer YES if report states there is no impairment of thought process or communication OR (if impairment is found) indicates frequency and extent of impairment and how it interferes with employment or social functioning. Otherwise, answer NO. Do not use NA.
8. Is the diagnosis consistent with DSM-IV and supported by the exam findings?	H1 38 CFR 4.125 4.126 4.130	Answer YES if the report states PTSD diagnosis (or non-diagnosis of PTSD) consistent with DSM-IV AND the diagnosis is supported by exam findings. Otherwise, answer NO. Do not use NA.
9. Does report describe multiple mental disorders and symptoms?	H2 & Note 38 CFR 4.14	When more than one mental disorder is present, examiner should delineate, to the extent possible, symptoms associated with each disorder and discuss their relationship to PTSD, if diagnosed. Answer YES if report states other mental disorders were not found OR delineates symptoms associated with each disorder (or explains why delineation is not possible) and discusses the relationship of other mental disorders to PTSD. Otherwise, answer NO. Answer NA if PTSD was not diagnosed.
10. Does report address veteran's ability to manage VA benefits?	K 38 CFR 3.353	Answer YES if report states veteran is, or is not, able (competent) to manage VA benefits. Otherwise, answer NO. Do not use NA.

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### Joints

Key Element	AMIE Ref.	Reviewer Instructions
1. Does report note subjective complaints?	B1 38 CFR 4.1 4.10 4.41 4.59	Answer YES if the report comments on presence or absence of any subjective complaints (e.g., pain, weakness, swelling, stiffness, instability, etc.). Otherwise, answer NO. Do not use NA.
2. Does report describe need for assistive devices?	B2 38 CFR 4.1 4.2	Answer YES if the report indicates that veteran does not need assistive devices (e.g., crutches, brace, cane, corrective shoes, etc.) OR describes veteran's need for such devices. Otherwise, answer NO. Do not use NA.
3. Does the report describe the effects of the condition on the veteran's usual occupation?	B8 38 CFR 4.1 4.2 4.70 3.321(b)(1)	Answer YES if any comment appears on how joint impairment interferes with the veteran's usual occupation. Otherwise, answer NO. Do not use NA.
4. Does the report describe the effects of the condition on the veteran's daily activities?	B8 38 CFR 4.10	Answer YES if any comment appears on how joint impairment interferes with daily activities. Otherwise, answer NO. Do not use NA.
5. Does report provide the active range of motion in degrees?	C1 38 CFR 4.40 4.45 4.59	Answer YES if the report states active range of motion in degrees OR explains why these measurements could not be done. Otherwise answer NO. Do not use NA.
6. Do the objective findings state whether the joint is painful on motion?	C2 38 CFR 4.59	Answer YES if the report notes presence or absence of pain on motion AND (if painful motion is present) indicates at what point in the range of motion pain begins (or explains why this measurement could not be done). Otherwise answer NO. Do not use NA.
7. Does the report address additional limitation following repetitive use?	C3 38 CFR 4.40 4.45 4.59 (DeLuca)	This item refers to functional status (DeLuca) with repetitive use of joint. Answer YES if comment indicates to what extent (if any) and in which degrees (if possible – or reason this could not be determined) the range of motion or joint function is additionally limited by pain, fatigue, weakness, or lack of endurance following repetitive use. Otherwise answer NO. Do not use NA.

8. Do findings address additional limitation during flare up?	C3 38 CFR 4.45 4.59 (DeLuca)	This item refers to functional status (DeLuca) during flare-ups. Answer YES if the report states there are no flare ups OR indicates to what extent (if any) and in which degrees (if possible – or reason this could not be determined) the range of motion or joint function is additionally limited by pain, fatigue, weakness, or lack of endurance during flare-ups. Otherwise answer NO. Do not use NA.
9. Does report address instability of knee?	D2b Dx codes 5257, 5260, 5261 38 CFR 4.10, 4.14 GC Precedent Opinion 97-23	For exams involving knee conditions: Answer YES if report notes the knee is stable OR (if instability is present) describes knee instability. Otherwise, answer NO. Answer NA if the knee is not an issue in the exam.
10. Do the objective findings include results of all conducted diagnostic and clinical tests?	E2 38 CFR 4.10	Answer YES if no tests were conducted OR (if conducted) results are included in the report. Otherwise, answer NO. Do not use NA.

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**Mental Disorders**  
(Except PTSD and Eating Disorders)

Key Element	AMIE Ref.	Reviewer Instructions
1. Frequency, severity and duration of symptoms?	B2a 38 CFR 3.309 3.304 4.41 4.126	Answer YES if report states no mental disorders or psychiatric symptoms appeared in the past year OR addresses frequency, severity, and duration of documented symptoms. Otherwise, answer NO. Do not use NA.
2. Report addresses unemployment or time lost from work?	B2c 38 CFR 4.126 4.16 Dx code 9440	Answer YES if report indicates veteran has been unemployed over the last 12 months OR indicates current occupation and extent of time lost from work over that period. Otherwise, answer NO. Do not use NA.
3. Examiner reports effects of symptoms on employment?	C2 38 CFR 4.10 4.126 4.16 3.321 Dx code 9440	Answer YES if report contains any comment on how signs, symptoms, or impairment associated with veteran's mental disorder (if diagnosed) interfere with employment. Otherwise, answer NO. Answer NA if no mental disorder is found on exam.
4. Effects on social functioning?	C2 38 CFR 4.126 Dx code 9440	Answer YES if report contains any comment on how signs, symptoms, or impairment associated with veteran's mental disorder (if diagnosed) interfere with social functioning. Otherwise, answer NO. Answer NA if no mental disorder is found on exam.
5. Thought process or communication impairment described?	C2a 38 CFR 4.10 4.126 Dx code 9440	Answer YES if report states there is no impairment of thought process or communication OR (if found) indicates how it interferes with employment or social functioning. Otherwise, answer NO. Do not use NA.
6. Does report address veteran's behavior?	C2c 38 CFR 4.126	Answer YES if report indicates presence or absence of inappropriate behavior AND (if present) provides examples. Otherwise, answer NO. Do not use NA.

7. Describes activities of daily living?	C2e 38 CFR 4.130 Dx code 9440	Answer YES if report describes veteran's ability to maintain any basic activities of daily living in addition to personal hygiene (e.g., dressing, feeding, managing money, etc.). Otherwise, answer NO. Do not use NA.
8. Does the report address veteran's ability to manage VA benefits?	D3a 38 CFR 3.353 3.354 Dx code 9440	Answer YES if report states veteran is, or is not, able (competent) to manage VA benefits. Otherwise, answer NO. Do not use NA.
9. Multiple mental disorders and symptoms discussed?	E3 Dx code 9440	When more than one mental disorder is present, examiner should delineate, to the extent possible, symptoms associated with each disorder and discuss their relationship. Answer YES if report states other mental disorders were not found OR delineates symptoms associated with each disorder (or explains why delineation is not possible) and discusses their relationship. Otherwise, answer NO. Do not use NA.
10. Effects of drug or alcohol abuse addressed, when appropriate?	E NOTE Dx code 9440 38 CFR 3.301 4.130 FL 01- 35	Answer YES if report states drug and/or alcohol abuse are not factors in the veteran's condition OR separates drug/alcohol abuse effects from other mental disorders (or explains why the effects cannot be separated). Otherwise, answer NO. Do not use NA.

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## Review PTSD

Key Element	AMIE Ref.	Reviewer Instructions
1. Frequency, severity, and duration of symptoms since last exam reported?	B2 38 CFR 4.126 Dx code 9411	Answer YES if report states there are no psychiatric symptoms since last exam OR (if symptoms present) addresses frequency, severity, and duration. Otherwise, answer NO. Do not use NA.
2. Does report comment on remissions and capacity for adjustment?	B3 38 CFR 3.327(a) 4.1 4.2	This item refers to length of remissions from psychiatric symptoms, including some indication of veteran's ability to adjust during periods of remissions. Answer YES if report states there are no periods of remission OR (if remissions occur), indicates the veteran's capacity for adjustment. Answer NO if report does not address remissions OR (if remissions occur) does not discuss capacity for adjustment. Do not use NA.
3. Does the report comment on type of treatment?	B4 38 CFR 4.1 4.2	Answer YES if the report indicates that veteran is not treated for the condition OR (if veteran is treated) describes the treatment and its effects. Answer NO if the report does not indicate whether or not veteran receives treatment OR (if treated) does not describe the treatment and effects. Do not use NA.
4. Does the report describe veteran's current occupation and time lost from work?	C3 38 CFR 3.321 Dx code 9411	Answer YES if veteran is employed and report identifies current occupation, length of time at job, and time lost from work during last 12 months OR (if unemployed) states whether veteran attributes unemployment to mental disorder and examiner notes factors and objective findings that support or rebut the veteran's contention. Otherwise, answer NO. Do not use NA.
5. Does the report describe social functioning since the last exam?	C5 38 CFR 3.327(a)	Answer YES if the report comments on social relationships or social functioning. Otherwise, answer NO. Do not use NA.
6. Does the report address problematic alcohol or substance abuse?	C7 38 CFR 3.301 4.130 FL 01-35	Answer YES if report indicates presence or absence of substance abuse AND (if present) makes any reference to presence or absence of associated problems (e.g., legal problems related to substance use, interference with employment, domestic abuse, etc.). Otherwise, answer NO. Do not use NA.

7. Is impairment of thought process or communication addressed and described?	D1 38 CFR 4.130 Dx code 9411	This item refers to social or work effects of impaired thought process or communication: Answer YES if report states there is no impairment of thought process or communication OR (if found) indicates frequency and extent of impairment and how it interferes with employment or social functioning. Otherwise, answer NO. Do not use NA.
8. Describes activities of daily living?	D4 38 CFR 4.130 Dx code 9411	Answer YES if report describes veteran's ability to maintain any basic activities of daily living in addition to personal hygiene (e.g., dressing, feeding, managing money, etc.). Otherwise, answer NO. Do not use NA.
9. Does report describe multiple mental disorders and symptoms?	G2 38 CFR 4.14	When more than one mental disorder is present, examiner should delineate, to the extent possible, symptoms associated with each disorder and discuss their relationship to PTSD, if diagnosed. Answer YES if report states other mental disorders were not found OR delineates symptoms associated with each disorder (or explains why delineation is not possible) and discusses the relationship of other mental disorders to PTSD. Otherwise, answer NO. Answer NA if PTSD was not diagnosed.
10. Does the report address veteran's ability to manage VA benefits?	J 38 CFR 3.852 3.853	Answer YES if report states veteran is, or is not, able (competent) to manage VA benefits. Otherwise, answer NO. Do not use NA.

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**Skin**  
(Not Scars)

Key Element	AMIE Ref.	Reviewer Instructions
1. Comment on onset and course of the skin condition?	B1 38 CFR 3.303, 3.304, 3.306, 4.42 M21-1, Part VI, 1.01d	Answer YES if report comments on disease onset AND course (intermittent or constant). Otherwise, answer NO. Do not use NA.
2. Does report comment on treatment type and effects?	B2 38 CFR 4.1, 4.2	Answer YES if the report indicates that veteran is not treated for the condition OR (if veteran is treated) describes the effects of current treatment. Otherwise, answer NO. Do not use NA.
3. Does report note subjective symptoms?	B3 38 CFR 4.1, 4.2, 4.10	Answer YES if the report addresses the presence or absence of pruritus, pain, etc. Otherwise, answer NO. Do not use NA.
4. Do objective findings report the size of the disease area?	C1 Dx codes 7801- 7802	This item refers to identification of the size of skin areas involved. Answer YES if report states that no active disease is found OR (if found) contains a description of the size of the disease area. Otherwise, answer NO. Do not use NA.
5. Do objective findings indicate whether the involved skin is exposed?	C1 Dx code 7800 7806- 7817	Answer YES if report notes exposure or non-exposure of involved skin (NOTE: Explicit reference to exposure/non-exposure is not necessary if examiner reports location of involved skin). Answer NO if the report does not indicate the exposure (or location) of involved skin. Do not use NA.
6. Do objective findings report on ulceration, exfoliation or crusting?	C2 Dx codes 7803 7806- 7817	Answer YES if report includes any comment on presence or absence of ulceration, exfoliation, or crusting. Otherwise, answer NO. Do not use NA.
7. Do objective findings report on systemic or nervous manifestations?	C3 38 CFR 3.310 Dx code 7806- 7817	Answer YES if report indicates presence or absence of associated systemic or nervous manifestations. Otherwise, answer NO. Do not use NA.

8. Do the objective findings include results of all diagnostic and clinical tests conducted?	D2 38 CFR 4.10	Answer YES if no tests were indicated OR (if tests indicated) report discusses and includes test results. Otherwise, answer NO. Do not use NA.
9. Does report include color photos?	E1 38 CFR 4.118 Dx code 7800	Answer YES if there is no indication of disfiguring skin condition or disfiguring scars OR (if report indicates condition is disfiguring) color photos accompany the exam report. Otherwise, answer NO. Do not use NA.

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## Spine

Key Element	AMIE Ref.	Reviewer Instructions
1. Does report note veteran's subjective complaints?	B1 38 CFR 4.1, 4.2, 4.10, 4.40, 4.41	Answer YES if the report comments on presence or absence of any subjective complaints (e.g., pain, weakness, stiffness, fatigability, lack of endurance, etc.). Otherwise, answer NO. Do not use NA.
2. Does report describe effects of the condition on the veteran's usual occupation?	B6 38 CFR 4.10, 4.45	Answer YES if the report comments on how the condition affects the veteran's performance in his/her usual occupation. Otherwise, answer NO. Do not use NA.
3. Does report describe effects of the condition on the veteran's daily activities?	B6 38 CFR 4.10, 4.45	Answer YES if the report provides any comment on how the condition affects the veteran's daily activities (e.g., walking, driving, housework, etc.). Otherwise, answer NO. Do not use NA.
4. Does report provide each range of motion separately and in degrees?	C1, D 38 CFR 4.40, 4.45, 4.46, 4.59, 4.61, 4.71	Each measured range of motion is to be reported separately rather than as a continuum. Answer YES if the report states range of motion separately and in degrees OR explains why measurement could not be done. Otherwise answer NO. Do not use NA. NOTE: For thoracic spine disorder, examiner should provide cervical or lumbar spine range of motion (or both, if appropriate). Thoracic spine has no independent range of motion.
5. Does the report address additional limitation following repetitive use?	C3 38 CFR 4.40, 4.45 ( <i>DeLuca</i> )	This item refers to functional status (DeLuca) with repetitive use of spine. Answer YES if report indicates to what extent (if any) and in which degrees (if possible – or reason this could not be determined) the range of motion or joint function is additionally limited by pain, fatigue, weakness, or lack of endurance following repetitive use. Otherwise answer NO. Do not use NA.
6. Do the findings address additional limitation during flare-ups?	C3 38 CFR, 4.1, 4.45, 4.71 ( <i>DeLuca</i> )	This item refers to functional status (DeLuca) with flare-ups. Answer YES if the report states there are no flare ups OR indicates to what extent (if any) and in which degrees (if possible – or reason this could not be determined) the range of motion or joint function is additionally limited by pain, fatigue, weakness, or lack of endurance during flare-ups. Otherwise answer NO. Do not use NA.

7. Does report address objective evidence of painful motion, spasm, weakness, and/or tenderness?	C4 38 CFR 4.10 4.45 4.59 4.71	Answer YES if report addresses presence or absence of objective evidence of any of the following: painful motion, spasm, weakness, and/or tenderness, etc. Otherwise, answer NO. Do not use NA.
8. If neurological abnormalities are noted, is appropriate worksheet followed?	C7 38 CFR 4.1, 4.2, 4.66, 4.71a	Answer YES if report indicates no neurological abnormalities were found OR (if found) the appropriate neurological exam worksheet information is provided. Otherwise answer NO. Do not use NA.
9. Do the objective findings include results of all conducted diagnostic and clinical tests?	E1 & E2 38 CFR 4.10	Answer YES if no tests were conducted OR (if conducted) results are included in the report. Otherwise, answer NO. Do not use NA.

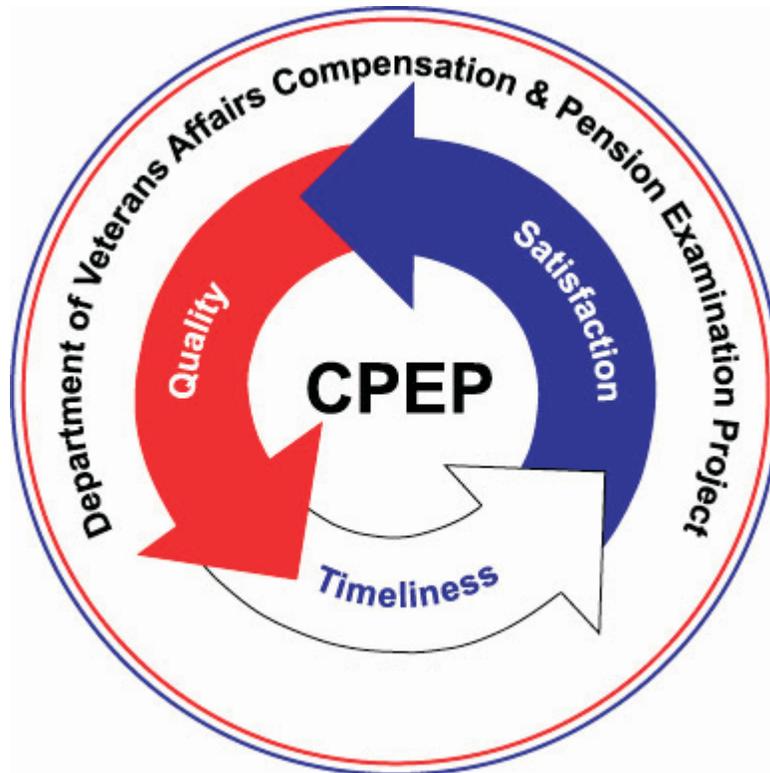
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## Exam Core Questions

Key Element	AMIE Ref.	Reviewer Instructions
1. Is each diagnosis stated precisely?	38 CFR 3.4(b), 4.2, 4.13	Answer YES if each statement that is supposed to be a diagnosis actually is a diagnosis (as opposed to a sign, symptom, rule-out, only historical, etc.). Answer NA if no diagnosis appears. Otherwise, answer NO.
2. Was the lack of a diagnosis justified?	38 CFR 4.2, 4.13	Answer YES if the report indicates why a precisely stated diagnosis was not provided as an explanation for the veteran's signs or symptoms (e.g., "In spite of subjective complaints, there was no evidence to support a diagnosis," veteran interrupted exam, undiagnosed illness, etc.). Answer NO if there was no explanation for the lack of a precisely stated diagnosis. Answer NA if all diagnoses were precisely stated.
3. Was functional impairment information provided?	38 CFR 4.10, 4.40	Answer YES if the report paints a picture of the effect of the veteran's impairment on occupational functioning. Otherwise, answer NO. Do not use NA.
4. Did the examiner address all issues in the remarks section?	38 CFR 4.2 M21-1, Part VI, Para. 1.07	Answer YES if the examiner addressed the issue at all, without regard to completeness. Otherwise, answer NO. Do not use NA.
5. Was the requested medical opinion properly stated?	38 CFR 3.328, 4.13	If a medical opinion was requested: Answer YES if the opinion is expressed using the proper medico-legal threshold of assurance. Answer NA if a medical opinion was not requested. Otherwise, answer NO. Proper phrases include: As likely as not, Not as likely as not, More likely than not, At least as likely as not, etc. Improper words include: Maybe, Could be, Might be, Etc.

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**July 10, 2002**

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