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INDEPENDENT MEDICAL EXPERT (IME) NEXUS OPINION 1 March 2013

To: Veterans Administration (VA)

Re:

C# 595-14-8682

HPI-

As a specialist in the fields of IMOs and diagnoses I have been asked to evaluate this patient's medical records on longitudinal view to determine if his current rating is correct concerning his **hearing loss, sinusitis-sleep apnea (CPAP), lumbar strain, left knee, left infected toe(ingrown) and left ankle** as these problems relate to his service from 2000 to 2006.

I have looked for any new/first time/secondary conditions as they relate to his service time and I utilize the concept of reasonable doubt in accordance with the three-judge VA Court case [case Polovick v. Shinseki (Kasold, Hagel and Davis--22 April 2009)] concerning credible evidence. (Please note that legally inextricably intertwined medical problems are medical problems that have significant impact on each other as these are known as secondary conditions in the medical lexicon)

I have reviewed this patient's relevant and critical medical facts contained in patient's medical records/testimony/lay statements/personnel records, conducted a 60-120 minute patient clinical interview/exam and history to document the effects of his disabilities upon his ordinary activities, imaging based medical examination (see below medical examination sections) and an in-person history/clinical interview. Thus I have had access to the critical relevant medical facts and have reviewed the pertinent relevant medical literature. I have advanced training as I completed a 3-year Neuroradiology fellowship (2 fellowship years at NIH) following my 4-year radiology residency.

I shred all records after this report is produced which is in line with Federal/VA policy on duplicative historical medical records.

facts/data:

Patient entered service fit for duty without any doctor-diagnosed illnesses.

Deluca factors for decreased ROM such as pain, fatigue, weakness and decreased endurance on repeat testing were considered and worst case ranges were recorded which is where the pts pain first began.

My physical Exam of 2013-Vital signs-Current meds.

(nrls = normal ranges for ROM- all ranges of motion consider repetitive motion limitations to functional loses [deluca]):

LUMBAR

ROM limited by pain, weakness, fatigue, lack of endurance, incoordination, stiffness and spasms.

Deluca Pain and repetition factors considered and worse case scenario limitations are listed below.

	EXAM
Flexion/extension (nrls = 90/30)	20/5
L/R rotation (nrls = 30)	20/20
L/R lateral bending (nrls = 30)	15/15

Muscle SPASM guarding and tenderness.

Sensory---- patchy numbness/pins and needles left lower extremity

Abnormal gait – pt walks with a limp.
He is not able to walk on uneven surfaces without left foot giving way.
His left foot often goes completely numb.

Left knee

Swollen **tender** along joint lines.
Skin **break** down
Crepitus on motion.

Medical Diagnostic Codes-OPINIONS:

Hearing loss/tinnitus

The patient worked around loud noise in service as he was assigned to flight line. His ear hurt from the noise and he experienced constant ringing during his service work and since. He is assigned 10% for **his** tinnitus **which** I agree with but he should also be assigned a **0**% code for his **hearing** losses as his service time records show worsening over time decibel losses.

It is my opinion[1] considering every possible sound medical etiology/principle, to at least the 50% level of probability that his current hearing loss problems (0%) are due to his experiences/trauma that the patient had during military service for the following reasons:

1. Per his military records he entered the service fit for duty without any doctor-diagnosed hearing problems.
2. He had exposure to loud noise and acoustic trauma while in the service.
3. The patient has significant hearing loss as I was not able to converse easily with him during normal conversation.
4. He complains of ringing in his ears.
5. He likely falls below the normal thresholds below for decibel loss vs age depicted below.

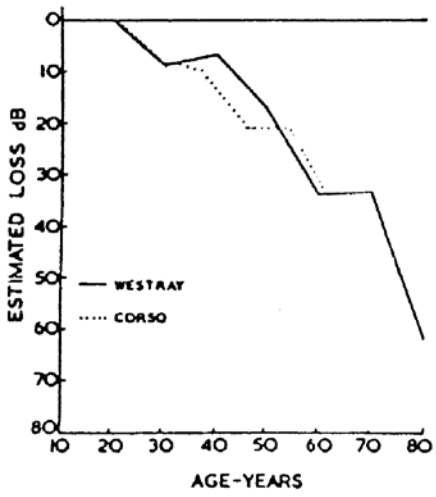

FIG. 10. Comparison of presbycusis values at 4,000 Hz for males, based upon data from island of Westray (53) and United States (41). (After ref. 53.)

6. His current symptoms are per the attached lay statements, which show chronicity of symptoms.
7. His records do not support another more plausible etiology for his current hearing loss pathology or other risk factors (in or out of service) to explain his problems other than his service time experiences.
8. The time lag between loud noise in service and his current acoustic pathology is consistent with known medical principles and the natural history of this disease.
9. No other physician has made a controverting opinion.
10. This opinion is consistent with the patient's subjective lay statements, the objective findings/imaging tests/diagnoses.
11. The literature supports a relationship between loud noise exposure and hearing loss (see Flint: Cummings Otolaryngology: Head & Neck Surgery, 5th ed. below:

Noise-Induced Hearing Loss and Acoustic Trauma

The fact that excessive noise exposure could cause hearing loss was first recognized in the 18th century. In the early 20th century, NIHL was termed "boilermaker's deafness." Careful descriptions of the hearing loss sustained in industry would await development of the audiometer and were first published in the 1930s.[90] NIHL is now recognized as one of the most common occupationally induced disabilities, and noise exposure is now regulated by the Occupational Health and Safety Administration.[91]

Noise can be defined loosely as "unwanted sound," and subdivided by intensity, time course (continuous, fluctuating, intermittent, impact, impulse), and spectral content (pure-tone, narrow-band, broad-band). Impact noise is noise caused by collision of two objects and is common in industry. Impulse noise is noise resulting from sudden release of energy, such as an explosion or weapon fire.

Hearing loss caused by noise is sensorineural in nature. Rarely, extremely intense impulse exposures can result in tympanic membrane perforations, causing a conductive component. Most hazardous noise exposure produces a temporary SNHL that recovers over the next 24 to 48 hours. This reversible loss is termed a *temporary threshold shift*

(TTS). If the noise is of high enough intensity or is repeated often enough, a permanent loss of hearing results, and is referred to as a *permanent threshold shift* (PTS). Two distinct types of hearing loss are caused by excessive noise exposure: NIHL versus acoustic trauma. NIHL is caused by repeated exposures to sound that is too intense or too long in duration. Each exposure is followed by a TTS, which recovers, but eventually a PTS develops. Acoustic trauma consists of a single exposure to a hazardous level of noise, resulting in a PTS without an intercurrent TTS.

12. These disabilities and his total VA medical disabilities clinical problems affect his ability to be gainfully employed.
13. This illness is permanent in nature and thus is not expected to improve with time.

Sinusitis-sleep apnea (CPAP)

Pt is assigned a code for rhinitis but he more likely has sinusitis. His service records document chronic congestion. He needs antibiotics frequently each year to control his chronic sinusitis.

It is my opinion[1] considering every possible sound medical etiology/principle, to at least the 90% level of probability that his current sinus problems-sleep apnea are due to his experiences/trauma that the patient had during military service for the following reasons.

1. Per his military records he entered the service fit for duty without any doctor-diagnosed illnesses.
2. Per his records he had visit to medical professionals for sinus and nose congestion in service. He was evaluated for insomnia and daytime hypersomnolence by Dr. Smith on 28 July 2006. At that time he was referred to the Sleep disorders clinic at Walter Reed but this evaluation at the sleep clinic was never completed.
3. He has had snoring problems since service.
4. It is my opinion that his rhinitis, sinus congestion and sinusitis contributed significantly to Sleep apnea as this is well described in the literature. For example, the blow article supports my opinion:

Effect of improved nasal breathing on obstructive sleep apnea ☆☆☆

Presented at the Annual Meeting of the American Academy of Otolaryngology–Head and Neck Surgery, San Antonio, TX, September 13-16, 1998.

- MICHAEL FRIEDMAN, MD,
- HASAN TANYERI, MD,
- JESSICA W. LIM, MD,
- ROY LANDSBERG, MD,
- KRISHNA VAIDYANATHAN, BS,
- DAVID CALDARELLI, MD

Abstract

Objectives: The goal was to compare the effect of an improved nasal airway on obstructive sleep apnea (OSA) by use of subjective and objective measures. **Methods:** A prospective study of 50 consecutive patients with nasal airway

obstruction and OSA was carried out. **Results:** Subjectively, nasal breathing improved in 49 (98%) patients, whereas snoring decreased or disappeared in 17 (34%); the remaining 33 (66%) patients did not notice any significant change in their snoring. Daytime energy levels increased in 39 (78%) patients and remained unchanged or worsened in 11 (22%). In review of the polysomnographic data, the group overall did not have significant changes in respiratory disturbance index (RDI) or lowest oxygen saturation levels ($LSaO_2$). Continuous positive airway pressure (CPAP) levels required to correct OSA decreased after nasal surgery ($P < 0.01$). Patients with mild OSA showed significant worsening in RDI ($P < 0.05$), whereas $LSaO_2$ levels were improved in the group with moderate OSA ($P < 0.05$). In patients with severe OSA neither the RDI levels nor the $LSaO_2$ changed, but CPAP levels required to alleviate the obstruction after surgery were reduced ($P < 0.01$). **Conclusions:** Most patients report improvement in nasal and sleep symptoms after correction of nasal airway obstruction. However, nasal surgery alone does not consistently improve OSA when measured objectively. Depending on the severity of OSA, nasal airway reconstruction may contribute to a decrease in CPAP level and improvement in oxygen saturation. Correction of the obstructed nasal airway should certainly be included in the overall treatment plan for OSA. (Otolaryngol Head Neck Surg 2000;122:71-4.)

5. His current symptoms are per the attached lay statements, which show chronicity of symptoms.
6. He currently uses CPAP with some relief.
7. His records do not support another more plausible etiology for his current rhinitis, sinusitis and sleep apnea pathology or other risk factors (in or out of service) to explain his problems other than his service time rhinitis, sinusitis and sleep problem/somnolence experiences.
8. The time lag between service rhinitis, sinusitis and sleep somnolenceand current pathology is consistent with known medical principles and the natural history of this disease.
9. No other physician has made a controverting opinion.
10. This opinion is consistent with the patient's subjective lay statements, the objective findings/imaging tests/diagnoses.
11. These disabilities and his total VA medical disabilities clinical problems affect his ability to be gainfully employed.
12. This opinion represents sufficient and competent medical data and is comprehensive enough for the VA to establish a rating and MDC for this organ system problem without the need for additional work-ups or development.
13. This illness is permanent in nature and thus is not expected to improve with time.

lumbar strain (10%)

The patient had injuries to his lumbar spine during service as per his service time records. He currently likely has spinal/foraminal stenosis in his lumbar spine and he is thus underrated at the 10% level. His range of motion is limited as per my exam today and he has intermittent numbness/weakness of this left lower extremity to the point where he is unable to walk.

It is my opinion[1] considering every possible sound medical etiology/principle, (to at least the 90% level of probability considering any new signs and symptoms to elevate his MDC to the next higher level for muscle, nerve and joint damage) that his current lumbar spine/left leg problems are due to his experiences/trauma that the patient had during military service and he should be rated at the 20% level for his lumbar spine and 20% (nerve) for his left leg as secondary to his lumbar spine for the following reasons.

1. Per his military records he entered the service fit for duty without any doctor-diagnosed illnesses.
2. The cumulative effect of his military service likely injured his lumbar spine.
3. He has limited range of motion in his lumbar spine and left leg weakness numbness both of which should be rated at the 20% level.
4. On longitudinal view his current symptoms are per the attached lay statements, which are valid documentation of observable symptomatology and which show chronicity and continuity of symptomatology.
5. In my opinion this patient's symptoms specifically show direct relationship and connection to his service time injury.
6. The time lag interval between his service time injury/illness and his development of signs and symptoms is consistent with known medical principles and the natural history of this disease.
7. No other physician has opined to the contrary.
8. He likely has sciatic nerve damage which would account for his left leg weakness/numbness

Sciatic nerve	
8520 Paralysis of:	
Complete; the foot dangles and drops, no active movement possible of muscles below the knee, flexion of knee weakened or (very rarely) lost	80
Incomplete:	
Severe, with marked muscular atrophy	60
Moderately severe	40
Moderate	20
Mild	10

9. This opinion is consistent with the medical data, patient's subjective lay statements, the objective findings/imaging tests/diagnoses and is consistent with the reasonable doubt doctrine and it is not speculative nor only at the level of possibility but rather is offered at the very likely level of probability.
10. This opinion represents sufficient and competent medical data and is comprehensive enough for the VA to establish a rating and MDC for this organ system problem without the need for additional work-ups or development.
11. This illness is permanent in nature and thus is not expected to improve with time.

Left Knee (10%)

He has pain and swelling and grinding in his left knee. These problems limit his ability to stand or walk for extend period of time.

On my exam he has crepitus and joint line tenderness consistent with osteoarthritis.

He is under-rated and thus should be assigned a 20% code for this worsening knee arthritis with crepitus as his records do not contain another more likely cause for his worsening degenerative arthritis .

left infected toe(ingrown) 0%

His left toe is chronically infected. The toe is swollen and painful to touch. The toe nail on a yearly basis causing the skin to breakdown and become infected.

This toe problem is under-rated at 0% as he needs yearly surgery and antibiotics to help maintain his toe function. When the skin breaks down the pt is unable to walk and his convalesce form surgery last about 3 week ever year.

He should be considered for 100% following each of his last surgeries as he has had limitations in movement and this restricts his ability to earn money (work).

left ankle (NR)-heel spur 10%

It is my opinion[1] considering every possible sound medical etiology/principle, to at least the 90% level of probability that his current left ankle problems are due to his experiences/trauma that the patient had during military service for the following reasons.

1. Per his military records he entered the service fit for duty without any doctor-diagnosed illnesses.
2. He is rated for his left heel spur but he should also be rated for his left ankle as he has had left ankle pain since service.
3. His left ankle on my exam today demonstrates pain and crepitus on motion.
4. His current symptoms are per the attached lay statements, which show chronicity of symptoms.
5. His records do not support another more plausible etiology for his current left ankle pathology or other risk factors (in or out of service) to explain his problems other than his service time experiences.
6. The time lag between injury in service and current pathology is consistent with known medical principles and the natural history of this disease.
7. No other physician has made a controverting opinion.
8. This opinion is consistent with the patient's subjective lay statements, the objective findings/imaging tests/diagnoses.
9. This illness is permanent in nature and thus is not expected to improve with time.

Respectfully submitted,

ELECTRONICALLY SIGNED
Craig N. Bash M.D. '86, M.B.A. '81, G.M.E. '95
Medical Director
Board Certified-Associate Professor of Radiology and Nuclear Medicine
Uniformed Services School of Medicine

*****Please note that this opinion is academic in nature and as such is not meant to reflect negatively on any other professional who might hold an alternative professional opinion. The purpose of this report is not meant for medical care or treatment and my opinions do not explicitly or implicitly guarantee that the VA will award any particular rating or benefit to the patient.*****

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SUPPLEMENT

TERMS:

Probability: The VA administrative rules for causation are liberal because often soldiers have lost records and or are not able to access the entire primary, secondary and tertiary spectrum of medical care. The VA administrative rules for legal purposes do not adhere to the routine medical/scientific level of causation set at the 95% level of confidence. The VA will grant VA benefits if the probability of an association between two events or causation of an event it at the as likely as not level of confidence (50%). See below :

"is due to/caused by" = 100% sure/caused by
"more likely than not" = greater than 50%
"much more likely than not" = greater than 75% level of certainty
"very likely" = greater than 90% level of certainty
"at least as likely as not" consistent with beyond a reasonable doubt = equal to or greater than 50%
"not at least as likely as not" = less than 50%
"is not due to" = 0%

Ref: VA's Clinician's Guide for Disability Examination, and BVA case reports.

Aggravation= worsening of the underlying condition versus a temporary flare-up of symptoms--disability increased in severity beyond its natural progression.

Lay evidence Jandreau v. Nicholson

http://scholar.google.com/scholar_case?case=48971277446175552 91&q=Jandreau+v.+Nicholson&hl=en&as_sdt=2,21&as_vis=1 … Lay evidence can be competent and sufficient to establish a diagnosis of a condition when (1) a layperson is competent to identify the medical condition,[4] (2) the layperson is reporting a contemporaneous medical diagnosis, or (3) lay testimony describing symptoms at the time supports a later diagnosis by a medical professional…"

I have been asked to provide the following information by way of multiple formal opinions from the Board of Veterans Appeals (BVA) in Washington D.C.; therefore, the following paragraphs are meant to provide credentialing information for the benefit of the 1400+ VA raters at the 57 Regional Offices and/or external VA Physician experts who are lay/medical personnel who are located in Washington D.C. or regional offices and therefore would not and often do not have first hand information about my background or experience but need this information to accurately determine the probative value of my opinions. This information is not routinely provided in standard clinical medical opinions but should be required of all physician evaluators who provide medical opinions for veterans as this is a nationwide service and the background credentialing information on physicians is often only known to the local/regional university, hospital, or clinic
I am very highly qualified to analyze these medical cases as I have 11 years of Post Graduate professional medical training, I have worked as an accredited veteran service representative for 9 years, I have been an appeals consultant to the BVA's co-located veteran service organizations appeals divisions for over 14 years and in this role I have attended several RO, DRO and BVA administrative Law Judge hearings as an expert witness both locally and in regional centers. Furthermore, I have been a MRI imaging research consultant to the National Institutes of Health (NIH) for over a decade and as such reviewed several thousands Brain and Spine MRI scans of MS patient's who were in our clinical research trails. Germane to the non-MS veteran's IMEs is the fact that I have performed over 3000 IMEs/second medical opinions for disabled veterans and I have interpreted 100,000+ imaging studies. Thus, I have likely performed and reviewed more professional IMEs for American soldiers/veterans than any other US sub-specialty trained solo practice physician.

I routinely shred the historical VA duplicative records (as is expected per VA and Privacy Act guidelines. N.B. most of these records are very old--- greater than 5 years) because VA maintains the only original copy of the Claims file. Destruction of duplicative records is expected per VA and Federal Privacy Act guidelines, as federal HIPAA rules do not apply. I sent this original letter to the veteran/veteran's spouse/family who will send it on to the VA for entry into the C-file.

In analyzing these issues, I have been advised to use the reasonable doubt concept as per the Board of Veterans Appeals (BVA) in Washington D.C. because often the service member is cared for/treated in an austere environment without the benefit of sophisticated imaging/surgical/medical care or provided treatment solely by board certified/eligible physicians and most of the deployed physicians do not have timely access to the medical literature. For example, recent research shows a significant inability of physicians to access the medical literature/resources as only "… 19% of physicians had daily access to the Internet while deployed…" (Ref: Kane, et. al. Military Medical informatics: Accessing Information in the deployed environment Military Medicine vol.176, no. 3, p. 259 March 2009). Furthermore, often the service time medical records are incomplete or missing due to combat or other strenuous condition (hardship-unusual -exceptional) or record/transfer storage facility losses/fires and these soldiers are exposed to many types of medical dangers while performing hazardous duty in the U.S Armed Forces. Finally, often these patient cases have been pending for decades and thus the interim treating physicians have either retired or destroyed their medical records. Some of these lost record problems are being resolved with the advent of the seamless military/VA records system used now in 2009 and years forward.

The precedent setting 3 judge Court of Veterans Appeals (CVA) case Polovick v. Shinseki (Kasold, Hagel and Davis--22 April 2009) states in part "….presumption of service connection is warranted …when a positive statistical association exists …[and]…. when the credible evidence for the association is equal to or outweighs the credible evidence against the association…[based] …on sound medical and scientific information….[and]… statistical analysis cannot be the sole basis for determination…and a medical professional opinion cannot be rejected simply because the opinion is based in part on statistical analysis. Rather it is the total analysis provided by the medical professional that must be weighted and considered by the board….[rejection of a medical opinion]…because it was not consistent with data in the IOM (Institute of Medicine) …for presumptive disease – is inadequate…[and]….Agent Orange Updates use only general statistical analysis …not the likelihood that an individuals health problem is associated with or caused by the herbicide in question…".

The court recently decided in Shannon v Shinseki (08-1976 Kendall J.D.) in May 2010 "..the denial service connection for a disease on the basis that it is not likely there is any nexus to service solely because the statistical analysis does not support presumptive service connection would, in effect, permit the denial of direct service connection simply because there is no presumptive service connection…vacated… remanded…"

http://search.uscourts.cavc.gov/isysquery/9fe33f62-43c2-4ad2-9872-67c500b89d1e/1/doc/ShannonJL_08-1876.pdf#xml=http://cavc-isys1.cavc.adir/isysquery/9fe33f62-43c2-4ad2-9872-67c500b89d1e/1/hilite/

The above opinions are all to a high degree of medical certainty at least at the "much more likely than not" level which would equate to a greater than 75% level of certainty.

Please note that the VA has special rules concerning medical certainty that have been generously weighted in favor of the veteran (benefit of the doubt) by Congress as often these young patients are deployed or are in war zones where full and complete medical care/records are not possible and these patients are often exposed to significant unknown toxins and extremely stressful environments. Thus I write these reports not at the 95% confidence level used in clinical medicine but rather at the "much as likely as not" or greater than the 75% level of confidence. VA law in the federal code at 38 CFR §3.102 mandates the at least as likely as not level which is set at the 50% level of likelihood**.** I am a National Institutes of Health (NIH) trained researcher and associate professor and I therefore understand the limitations and imperfections of clinical science but at the same time I have written these types of opinions for a couple of decades and have provided thousands of opinions and it is my opinion that in order to be fair to all veterans, any physician writing medical opinions for veterans should have a good working knowledge of the basic VA laws concerning benefit of the doubt covered in the federal code (in addition to medical principles), or the unknowing physician may inadvertently penalize the veteran patient, which means, at the extreme, that that patient may not be eligible for continued or future VA medical care/treatment.

I do not have a vested interest in the assignment of this patient's medical diagnostic codes like all expert witnesses I am paid a flat fee prior to the writing of any of my reports. This payment method is similar to payment arrangements of any second medical opinion consultant-in or outside the VA. (n.b. I do a fair amount of pro-bono cases for veterans) Thus my opinions are based on the judicious application of medical principles/my training/experience unperplexed and unbiased by considerations not connected with the Hippocratic Oath.

I do not know the attending physicians or hospital administrative staff who have cared for this patient and I do not have any commercial or personnel interest in any equipment/devices/prosthetics or pharmaceuticals used in the care of this patient.

This report conforms to the federal guidelines on expert testimony as they apply to medical data/facts, reliable principles/methods (see my attached C.V. and book references), and the application of medical principles/methods to the facts/data and is therefore not in any way speculative.

The concept of reasonable doubt in accordance with the three-judge VA Court case (case Polovick v. Shinseki (Kasold, Hagel and Davis--22 April 2009)) concerning credible evidence has been considered**.** (Please note that a face to face hands-on medical examination is not needed, as that exam would only tell me the current extent of his disease, which is already well documented in his records but I have conducted an extensive history/clinical interview via tele-medicine.)

It is important to note that Tele-medicine has been extensively studied by the VA (and other see Google scholar http://scholar.google.com/scholar?hl=en&q=tele-medicine+va&as_sdt=20000&as_ylo=&as_vis=0) and is well described in the medical literature and thus is being used as a substitute for routine physician visits in order to gather clinical information; therefore, a Tele-medicine clinical interview should not be routinely assumed/considered less probative than a VA/QTC physicians in-person clinical interview, which is currently often done by VA non-physician raters and appeals judges. In fact, according to Girard in the VA's JRRD document, Telemedicine plays a critical role within the …VA… by allowing surveillance and care of patients isolated geographically….In the military settings…being used to identify injury and illness….both domains are transforming the way clinicians provide care…". VA raters/ administrative Law judges should use tele-medicine for C and P exams and should consider Tele-medicine exams by physician's superior to exams done in person by physician assistants and/or nurses/ practitioners due to the higher level of training and experience of the physicians and the literature documented high quality of tele-medicine examinations.

I have analyzed this case in light of the VA's compassionate core value, which states that the VA will "…treat all veterans and their families with the utmost dignity and compassion. We will provide services in a caring manner, with a sympathetic consciousness of others' distress together with a desire to alleviate it…." (All of the VA core values are listed at the end of this report.) Also in line with VA guidelines, I have liberally applied every possible sound medical etiology/principle to at least the 50% level of probability, in order to link all this patent's primary and secondary medical conditions to service and to consider his/her symptoms for the next higher rating and to consider the effect of his/her disabilities on his/her employability, which is consistent with the directives and guidelines provided to me by the VA and Congress concerning service connection/VA medical diagnostic code (MDC) assignment.

In order to make this evaluation, I have carefully reviewed the following available duplicative information:

Patient's historical medical records;
Patient's imaging reports and available imaging studies raw data;
Patient's lay statements;
Other historical medical opinions; and
Medical literature review.

TERMS:

Benefit-of-the-Doubt (BOD): Used by VA physicians and occurs when where is "…an approximate balance of positive and negative evidence…" the veteran shall prevail on the medical issue. [Ashley V Brown 6 vet App. 52. 59 (1993) and Massey v. Brown, 7 Vet App. 204, 206-207 (1994)]. BOD interfaces with the higher evaluation concept which means that the higher evaluation will be applied to the veteran if that level of evaluation has medical sign and symptom/labs that is most accurately represented (closest highest rating) by the two nearly equal MDCs (ratings) apply (38 CFR , 4.7).

Reasonably Medical Certainty: often used by civil attorneys in instructions to physicians in medical malpractice cases and sometimes incorrectly used by VA leadership in instructions to physicians in VA benefit cases, because the correct threshold standard for VA cases [as per the Code of Federal Regulations

(CFR) and Congress for granting benefits] is the "as likely as not" concept (50-50) which means that the medical evidence/medical principles for and against the association is at least evenly divided. This is a different standard than the one used in clinical medical evidence, which is set at the 95% confidence level because our US citizens have liberally established the VA regulations in favor of the soldier. Our citizens recognize the risks and civil value of service to our country and thus have voted for the development of generous VA system of benefits due to the fact that often servicemen/women records are lost during deployment and that they are often unable to get routine treatment or that the treatment they receive occurs in austere environments which do not always afford the soldier access to specialties or specialized medical technology/equipment.

Reasonable Doubt = "*The Reasonable Doubt rule is one of the most important liberalizing rules that VA uses to grant veterans benefits and is defined under 38 CFR §3.102. The Reasonable Doubt rule means that when there is an equal balance of evidence for and against the claimant [50% to 50%], that the claimant be awarded their claim. This is just like in baseball as the 'tie goes to the runner*.'"
Ref: Theresa Aldrich's Veterans-claims-self-help-guide

Or legally means: ***"*** *When, after careful consideration of all procurable and assembled data, a reasonable doubt arises regarding service origin, the degree of disability, or any other point, such doubt will be resolved in favor of the claimant. By reasonable doubt is meant one that exists because an approximate balance of positive and negative evidence which does satisfactorily prove or disprove the claim*."
Ref: BVA Administrative Law Judge

Duty to assist: Regards outstanding medical information and the VA's responsibility to notify the patient of evidence needed from the patient and which information the VA will attempt to obtain within one year of the VA notice date.

Chronic illness = signs and symptoms that extend for over one year.

MDC = medical diagnostic code

TDIU = total disability individual unemployability (**individual unemployability = form 21-8940)**

Probative Value of medical exam, training, experience and Curriculum Vitae (C.V.):

I have conducted a clinical interview and I have attached my C.V., which outlines my extensive multi-system training, board certifications and experiences. My multi-system training means that I am able to opine on all areas of medicine. My C.V. documents the probative value of my opinions and any comparison between physician opinions should be partially based on their respective C.V.s. (As an aside, I have noted that often the VA physicians who opine on IMEs do not provide their C.V.s or medical board status and this information should be included with every IME so that an analysis of the probative value of the medical opinion can be accomplished by the VA rating team because without the C.V. to look at any analysis of a physician's credentials would be/is arbitrary and biased due to lack of critical information)

Expertise-Special Knowledge:

I have special knowledge in the areas of **neurological-spine, hearing loss, sinusitis-sleep apnea (CPAP), lumbar strain, left Knee, left infected toe(ingrown) and left ankle** diseases, as I have radiology sub-subsection training and testing in these organ system areas as of my comprehensive 1990 boards. I am double board certified specialist (national board of medical examiners and American Board of Radiology with an 4 month internship followed by a 4 year residency and a 3 year Neuroradiology Fellowship (2 years

at NIH) for a post graduate total of year-7+ [PGY-7+] level of training, which is similar to the number of PGYs required for Neurosurgical training, am a Senior Member of the American Society of Neuro-Radiology (ASNR), and am an attending level school of medicine Associate Professor. It is important to note that vast majority physicians in America are trained only at the PGY level of 3. For example, almost all the primary care physicians in internal medicine, neurology, pediatrics and family practice are all trained at the PGY-3 level.

For the benefit of VA raters it is important to note that by comparison for example orthopedic surgeons are trained at the PGY-4 and most general surgeons have PGY 5 levels of training and other specialty-trained surgeons are trained at the PGY 6 and 7 levels. I have completed a fellowship in Neuro-Radiology at the NIH (National Institutes of Health) and as such I am one of about 3000 neuro-radiologists in America at the PGY-7 level of training and one of less than a dozen who have completed a 2 year NIH experimental neuro-imaging research fellowship in the laboratory of diagnostic radiology research (please note that there are about 700,000 physicians in the US).

I am a 100% disabled veteran and I have a Masters degree in Business Administration (MBA--Golden Gate University 1981) and have been employed as a Medical Director of a large ($1-200 million annual revenue) philanthropic disabled veterans organization and part of my duties involved reviewing medical records for the employment of disabled personnel and perform site visits to review quality of care at VA's largest tertiary care hospitals and nursing/domiciliary/state homes. I therefore have both practical and theoretical experience/training in the issues surrounding the employment of disabled workers (TDIU) and needs of patients for long term care. (Please see my attached C.V.)

Additionally, I have performed and/or interpreted plain x-rays, CT scans, ultrasounds, angiograms, arthrograms, barium studies, contrast studies, PET, nuclear medicine scans, and MRI (basic and research/experimental) scans as appropriate on thousands of patients with this patient's type of primary and secondary disorders, and I have correlated my findings with the clinical record/physical exam. Please note that this patient's claim hinges on the imaging findings.

Competency, credible and professional opinions:

I am highly competent and credible to make the professional medical opinion/s herewith because I am an actively licensed physician (Maryland) with extensive specialized training and experience (22 years of IME production) in the areas of interest (as described above). I have performed several hundred VA IMEs and I am familiar with the VA rating schedule as published in the CFRs/U.S. Codes. In fact, I have worked as a VA accredited Veteran Service Organization (VSO) representative for 8 years with two different VSO groups (PVA and DAV). I have reviewed the medical record and the patient's lay statements, I have conducted a clinical historical interview, I have referenced current applicable publications (explained how they apply to this patient's medical data set), I have examined the patient by way of reviewing his pivotal imaging study reports, I have reviewed pertinent positive and negative medical data, and I have reviewed/referenced other physicians professional medical opinions[1.]

Medical examination:

In this case a face-to-face hands-on medical examination was done. The crux of this issue involves causation and etiology and this involves time line diagnoses for which I am exquisitely well trained as a Diagnostician.

Depth of knowledge:

The VA has recently started to extensively use non-credentialed Nurses/Nurse Practitioners (NPs) and Physician Assistants (PAs), so-called "On-Site Providers" (OSP) or VA examiners, to provide medical opinions in complex cases that often involve the review of medical records that extend over decades. These non-MD's do not have the depth of knowledge needed to accurately evaluate the veteran-patient's primary and secondary medical problems nor diagnose subtle or rare diseases; therefore the quality of these important medical exams is diminished by using these non-licensed practitioners (AKA Dumbing Down). These reviewers provide sub-optimal reviews simply because they do not have extensive training or experience as compared to a physician. The axiom "...You see what you look for and you look for what you know..." applies to these complex veteran cases, which involve multiple organ systems and which involve pathologic processes that extend over decades. These sub-optimally trained reviewers do not know because of limited training many subtle aspects of medicine and therefore are unable to see or look for the linkages necessary to create a fair nexus or analysis of any veterans' medical issues. Thus these supervised only/novice practitioners are not able to consider every possible sound medical etiology/principle as is required by VA mandate for assignment of medical diagnostic codes. MD expertise is required for these complex cases as is well-recognized by the VA, which has recommend specialists analysis for medical diagnostic code assignments via the VA court decision in Hyder v. Derwinski, 1 Vet. App. 221 (1991).

My review on the other hand is based on a deep body of knowledge and training acquired over almost 30 years as is illustrated in my C.V. contained in the file and this CV is compared to the C.V.'s of a standard support staff nurse/PA/health technician (HT)/nurse practitioner (NP) below:

	Dr. Bash	**Support Staff PA/nurse/HT/NP/OSP**
College/University	4 years	2-4 years
Masters degree in Business (2 years)	yes	none
Medical school MD degree	4 years	none
Licensed Physician	Yes	no
Nurse school/PA	none	2-3 years
Internship/OJT	1 year	none-1
Residency	4 years	none
Fellowship clinical	1 year	none
Fellowship-research at NIH	2 years (PGY7)	none
Practice only under supervision	No	Yes- Required limited skill/training
Medical director	3 years	none
Radiology department director	2 years	none
MS/Brain--MRI research	Yes since 1992	none
Associate professor Medical school	yes-10 years	none
Peer reviewed articles	22	none
Paper H-index (14 Oct 2012)	24	none
http://code.google.com/p/citations-gadget/		
Most number of times paper cited	128	none
Number of paper citations	348	none
Spinal Cord MRI research experience	yes	none
NIH Senior Fellow/staff experience	yes-18 years	no
Several thousand VA IME's	yes	no
50+ site visits for VA Quality of Care	yes	no
Years experience as MD	26+	none
Years accredited VA service rep	8	none
Review of C-File if available	yes	+/-
Review x-ray/CT/MRI if available	yes	no

Number of years doing VA cases	26	?
Number of VA Patients done	4000+	?
Number of VA organ system claims	40,000 est.	?
Success rate of cases	80-90%	?
Total Formal Post-Grad training years	13 years	2-3 years