This is a **copy** of `3-1-21_Key Changes_M21-1III_iv_3_SecD.docx` except that I removed "track changes", "comments", and the right-side vertical Viewing Pane. The original document is available on the VA website for the *M21-1 Adjudication Procedures Manual*. → M21-1, Part III, Subpart iv, Chapter 3, Section D - Examination Reports (Article ID: 554400000015812). ***Scroll down*** to near the bottom of the page » look for the heading, **Attachments** » near the bottom of that list of attachments, you will see the link for `3-1-21_Key Changes_M21-1III_iv_3_SecD.docx` – Mark D Worthen PsyD

Department of Veterans Affairs
Veterans Benefits Administration
Washington, DC 20420

M21-1, Part III, Subpart iv
March 1, 2021

Key Changes

Changes Included in This Revision

The table below describes the changes included in this revision of Veterans Benefits Manual M21-1, Part III, "General Claims Process," Subpart iv, "General Rating Process."

Notes:

- The term "regional office" (RO) also includes pension management center (PMC) and decision review operations center (DROC), where appropriate.
- Unless otherwise noted, the term "claims folder" refers to the official, numbered, Department of Veterans Affairs (VA) repository – whether paper or electronic – for all documentation relating to claims that a Veteran and/or his/her survivors file with VA.
- Minor editorial changes have also been made to
  – improve clarity and readability
  – add references
  – update/remove incorrect or obsolete references
  – update the labels of individual blocks to more accurately reflect their content, and
  – bring the document into conformance with M21-1 standards.

Reason(s) for Notable Change	Citation
To add signature requirements for privately completed disability benefits questionnaires (DBQs).	M21-1, Part III, Subpart iv, Chapter 3, Section D, Topic 2, Block b (III.iv.3.D.2.b)
• To add a note indicating that DBQs or medical/examination reports completed by private, non-VA providers must be individually assessed in accordance with certain evidentiary review principles to determine adequacy for rating purposes. • To delete a note indicating that a telehealth/telemental health examination report is only acceptable and actionable for rating purposes when completed by a Veterans Health Administration or Veterans Benefits Administration-contracted examiner.	III.iv.3.D.2.c
To delete old III.iv.3.D.2.e on the discontinuance of publicly available DBQs, as its content is no longer applicable.	--

• To add a new Block e on assessing sufficiency of DBQs completed by non-VA providers. • To incorporate guidance previously located in old III.iv.3.D.2.e, which remains applicable to the assessment of DBQs completed by non-VA providers.	III.iv.3.D.2.e
To update guidance on reviewing DBQs for authenticity.	III.iv.3.D.2.f
To delete a note encouraging invitation of a claim for earlier effective date, as it is inconsistent with the *Veterans Appeals Improvement and Modernization Act of 2017* and *Rudd v. Nicholson*.	III.iv.3.D.5.b

Authority By Direction of the Under Secretary for Benefits

Signature

Beth Murphy, Executive Director
Compensation Service

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Section D. Examination Reports

Overview

In This Section This section contains the following topics:

Topic	Topic Title
1	Obtaining Examination Reports
2	Examination Report Requirements
3	Handling Examination Reports That Are Insufficient for Rating Purposes
4	Reviewing Examination Reports for Rating Criteria
5	Taking Rating Action on Routine Future Examination (RFE) Results

1. Obtaining Examination Reports

Introduction

This topic contains information about obtaining reports, including

- Veterans Health Administration (VHA) examination reports, and
- contract examination reports.

Change Date

October 19, 2020

a. VHA Examination Reports

Examination reports completed by Veterans Health Administration (VHA) examination facilities are located in the Compensation and Pension Record Interchange (CAPRI). These reports are automatically uploaded into the Veterans Benefits Management System (VBMS).

Note: Print VHA examination reports on *yellow* paper when association with a paper claims folder is warranted.

b. Contract Examination Reports

Examination reports completed by Department of Veterans Affairs (VA) contract examiners are automatically uploaded into VBMS.

Use the table below to obtain from appropriate vendor portals any outstanding contract examination reports that are not immediately associated with the electronic claims folder (eFolder).

If the contract examination was conducted by ...	Then obtain its report by visiting ...
QTC Service	QTC Exam Track.
Veterans Evaluation Services (VES)	VES Exams.
Logistics Health, Incorporated (LHI)	LHI Customer Portal.

Important:

- Instructions for registering with and gaining access to contract vendor customer service portals are available on the *Exam Liaison Resource* page.
- A designated regional office (RO) contract examination coordinator or liaison may be assigned to monitor contract examinations.

Note: Contract examination reports obtained through the means described above must be

- uploaded to the appropriate eFolder, as detailed in the VBMS Job Aid – Adding Documents in VBMS eFolders, or
- printed on *yellow* paper when association with a paper claims folder is warranted.

Reference: For more information on VBMS Exam Management functionality, see the *VBMS Core User Guide*.

2. Examination Report Requirements

Introduction

This topic contains information about reviewing examination reports, including

- who must sign examination reports
- examiner qualifications and signature requirements
- TeleCompensation and Pension (Tele-C&P) and telemental health examinations
- review of disability benefits questionnaires (DBQs)
- assessing sufficiency of DBQs completed by non-VA providers
- authenticity of DBQs
- DBQs completed by Veterans who are physicians/health care providers
- qualification requirements of examiners –
  – initial mental disorder examinations
  – review or increased evaluation mental disorder examinations
  – traumatic brain injury (TBI) examinations, and
  – hearing loss and tinnitus
- requirements for
  – examination reports, and
  – acceptable clinical evidence (ACE) examination reports
- evaluating disability diagnoses
- questions about competency and/or validity of examinations
- handling unusual cases
- accepting a fee-based examiner's report, and
- examiner statements that an opinion would be speculative.

Change Date

March 1, 2021

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a. Who Must Sign Examination Reports

All examination reports *must* be signed by the examining health care provider.

Notes:

- Examination reports transmitted electronically by either a VA medical center or by a contract examination provider must be digitally signed.
- Generally, examination reports and the required signatures are documented on disability benefits questionnaires (DBQs) specific to the body system or disability being examined.

Reference: For more information on DBQs, see M21-1, Part III, Subpart iv, 3.A.3.

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b. Examiner Qualifications and Signature Requirements

VA medical facilities (or the medical examination contractor) are responsible for ensuring that examiners are adequately qualified.

RO employees are *not* expected to routinely scrutinize or question the credentials of clinical personnel to determine the acceptability of their reports unless there is contradictory evidence of record. However, examination reports (and DBQs, if they are to be used in lieu of examination) *must* include a valid signature by the certifying professional.

Use the table below to determine what certification elements are required to authenticate an examination provider's signature and qualifications.

If the DBQ or examination report was prepared by a ...	**Then the certification and signature block must contain his/her ...**
VHA clinician	• signature, and • printed name and credentials.
Veterans Benefits Administration (VBA)-contracted examination provider	• signature • credentials, and • specialty.
non-VA health care provider	• signature • printed name and credentials • phone and/or fax number, and • medical license number. ***Exception***: The inclusion of a phone and/or fax number is *not* required if the • DBQ is otherwise satisfactorily completed, and • provider's contact information can be verified via internet search.

Notes:

- The specialty of the examination provider must be indicated if a specialist examination is required or requested, as in traumatic brain injury (TBI) examinations.
- Health care providers participating in the Clinicians in Residence program at ROs must be registered and certified VHA clinicians.

References: For more information on

- who must sign examination reports, see M21-1, Part III, Subpart iv, 3.D.2.a
- the review of DBQs, see M21-1, Part III, Subpart iv, 3.D.2.d, and
- insufficient examination reports, see M21-1, Part III, Subpart iv, 3.D.3.a.

c. Tele-C&P and Telemental Health Examinations

TeleCompensation and Pension (Tele-C&P) disability evaluations can provide accurate and fully descriptive face-to-face evaluations for VBA rating purposes through use of telehealth video technologies.

When an examiner elects to conduct a Tele-C&P (or telemental health) examination utilizing telehealth video technologies in lieu of performing an in-person examination, assess the report for sufficiency under the same standards applicable to in-person examinations.

Important: When reviewing DBQs or medical/examination reports prepared *by private, non-VA providers* via means of telehealth/telemental health, for the purposes of determining adequacy for rating purposes, exercise prudent judgment by

- applying the general assessment principles discussed in M21-1, Part III, Subpart iv, 3.D.2.e, and
- considering the
  - credibility and probative value associated with variables disclosed in the DBQ/report, to include the
    - clinician's knowledge of the claimant's relevant history
    - length of time the clinician has treated the Veteran, and
    - extent to which medical records and/or other records were reviewed and considered, and
  - compatibility of the DBQ/report submitted with the types identified as suitable for performance via telehealth technology in the *Office of Disability and Medical Assessment (DMA) Fact Sheet 20-002, Telehealth for Compensation and Pension (C&P) Examinations*.

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d. Review of DBQs

Review DBQs to ensure

- the health care provider meets any specialty requirement for the examination conducted, and
- the DBQ is sufficient for rating purposes.

Note: DBQs completed by a licensed health care provider, to include a nurse practitioner or physician's assistant, are acceptable for VA examinations.

References: For more information on

- DBQs approved for public use, see the *Private Medical Evidence* page
- requirements for examination reports, see M21-1, Part III, Subpart iv, 3.D.2.l
- examiner qualifications and signature requirements, see M21-1, Part III, Subpart iv, 3.D.2.b
- use and acceptance of DBQs for VA examinations and opinions, see M21-1, Part III, Subpart iv, 3.A.3.b
- specialty requirements for mental examination providers, see M21-1, Part III, Subpart iv, 3.D.2.h and i

- specialty requirements for TBI examinations, see M21-1, Part III, Subpart iv, 3.D.2.j, and
- specialty requirements for audiology examinations, see M21-1, Part III, Subpart iv, 3.D.2.k.

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e. Assessing Sufficiency of DBQs Completed by Non-VA Providers

If the evidentiary record contains a privately completed DBQ, generally, claims processors must

- confirm the authenticity of the information reported, as described in M21-1, Part III, Subpart iv, 3.D.2.f
- evaluate it under the evidentiary principles discussed in M21-1, Part III, Subpart iv, 5.A, and
- determine if a VA examination is still warranted in accordance with
  – M21-1, Part III, Subpart iv, 3.D.2.d
  – M21-1, Part III, Subpart iv, 3.A.3.b, and
  – M21-1, Part I, 1.C.3.

Use the table below to determine what action must be taken after receiving a DBQ that has been

- completed by a private, non-VA provider, and
- deemed insufficient for rating purposes for the reasons described in the table.

If the DBQ ...	**Then ...**
is missing information or contains blank or contradictory values in fields that are relevant to the rating activity	• attempt to contact the certifying provider by telephone to resolve insufficiencies, and • document any successful effort at telephone contact on *VA Form 27-0820, Report of General Information*. ***Note***: If the provider cannot be reached by telephone, document any unsuccessful attempt at contact as a permanent note in VBMS, including the • date, time, and purpose of the call, and • provider's – name, and – telephone number.

was completed by a non-VA provider whose records the Veteran has requested be considered in connection with the claim via submission of • *VA Form 21-4142, Authorization to Disclose Information to the Department of Veterans Affairs (VA)*, and • *VA Form 21-4142a, General Release for Medical Provider Information to the Department of Veterans Affairs (VA)*	ensure that all necessary developmental efforts to secure relevant private medical records have been undertaken. ***Reference***: For more information on requesting evidence from private health care providers, see M21-1, Part III, Subpart iii, 1.D.1.
requires additional examination components, such as • a review of service treatment records • performance of specific confirmatory or laboratory testing, and/or • rendition of a medical opinion	ask a VA examiner to perform only those missing requirements.

Note: No action to develop an insufficient DBQ need be taken if the facts of the case would not otherwise necessitate providing an examination and/or opinion.

Reference: For more information on a Veteran's submission of evidence and refusal to attend a VA examination, see *Kowalski v. Nicholson*, 19 Vet.App. 171 (2005).

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f. Authenticity of DBQs

In general, as with other items of evidence, DBQs from treatment providers should be taken at face value.

However, all DBQs completed by treatment providers are subject to validation to confirm the authenticity of the information provided.

DBQs released for public use inform the provider

• that the patient is applying for VA benefits and VA will consider the information provided in processing the claim
• that the physician's signature constitutes a certification that the information provided on the form is accurate, complete, and current, and

that VA may request medical information, including additional examinations, if necessary to complete VA's review of a claimant's application.

Where a review of the DBQ raises questions of authenticity or improper alteration, determine whether additional development is necessary. This may include

- validation of results by the treatment provider
- obtaining medical records, and/or
- a VA examination.

Informal contact with the Office of Inspector General or a fraud referral may also be appropriate.

References: For more information on
- requiring further development, see M21-1, Part III, Subpart iv, 5.A.7.a
- taking evidence at face value, see
  – M21-1, Part III, Subpart iv, 5.A.2.b, and
  – M21-1, Part III, Subpart iv, 5.A.8.a, and
- handling fraudulent cases, see M21-1, Part III, Subpart vi, 5.A.

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g. DBQs Completed by Veterans Who Are Physicians/Health Care Providers

VA cannot summarily discount otherwise competent medical evidence from a Veteran who is a physician or health care provider. DBQ reports completed by these individuals will be reviewed under the same criteria for reviewing DBQs submitted by a third-party health care provider.

In effect, VA claims adjudicators must subject the evidence of record to some degree of scrutiny to determine its probative worth. It is improper in VA practice to "exclude" evidence. Decision makers must weigh the probative value of the evidence and discuss its probative value in the decision narrative.

Note: Exercise the same weighing of probative value for internal-use DBQs that are completed by an external non-VA provider.

Important: Ensure the *Disability Benefits Questionnaire (DBQ) – Veteran Provided* DOCUMENT TYPE under VBMS UNSOLICITED EVIDENCE tab has been updated for DBQs submitted from non-VA providers.

References: For more information on
- reviewing DBQs, see M21-1, Part III, Subpart iv, 3.D.2.d
- evidentiary concepts, see M21-1, Part III, Subpart iv, 5.A.2
- competent medical evidence, see
  – 38 CRF 3.159(a)(1), and
  – M21-1, Part III, Subpart iv, 5.A.2.c
- written testimony submitted by the claimant, see 38 CFR 3.200(b), and
- case law supporting adequacy of examination completed by a Veteran-health care provider, see *Pond v. West*, 12 Vet.App. 341 (1999).

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h. Qualification Requirements of Examiners – Initial Mental Disorder Examinations

The following credentialed mental health professionals are qualified to perform *initial* C&P mental disorder examinations:

- board-certified or board-eligible psychiatrists
- licensed doctorate-level psychologists, or
- the following other mental health professionals, under the close supervision of a board-certified or board-eligible psychiatrist or licensed doctorate-level psychologist:
  – doctorate-level mental health providers
  – psychiatry residents, and
  – clinical or counseling psychologists completing a one-year internship or residency.

Note: "Close supervision" means that the supervising psychiatrist or psychologist met with the Veteran and conferred with the examining mental health professional in providing the diagnosis and the final assessment. The supervising psychiatrist or psychologist must co-sign the examination report.

Important: For a claim for service connection (SC) for posttraumatic stress disorder (PTSD) based upon a stressor related to the Veteran's fear of hostile military or terrorist activity, 38 CFR 3.304(f)(3) directs that the examination must be conducted by a VA psychiatrist or psychologist, or a psychiatrist or psychologist with whom VA has contracted.

Reference: For more information on the qualifications of examiners for specific examinations, to include initial mental disorders examinations, PTSD, and eating disorders, see the *DBQ Switchboard*.

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i. Qualification Requirements of Examiners – Review or Increased Evaluation Mental Disorder Examinations

The following credentialed mental health professionals are qualified to perform C&P mental disorder review examinations or examinations in claims for increased evaluations of service-connected (SC) mental disorders:

- mental health professionals qualified to perform initial mental disorder examinations per M21-1, Part III, Subpart iv, 3.D.2.h, or
- other mental health professionals under the close supervision of a board-certified or board-eligible psychiatrist or licensed doctorate-level psychologist, including
  – licensed clinical social workers
  – nurse practitioners
  – clinical nurse specialists, and
  – physician assistants.

Reference: For more information on the qualifications of examiners for review examinations for PTSD, see the *Review Post Traumatic Stress (PTSD) Disability Benefits Questionnaire* in the *DBQ Switchboard*.

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j. Qualification Requirements of Examiners - TBI Examinations

The *initial* diagnosis of TBI must be made by one of the following specialists:

- physiatrists
- psychiatrists
- neurosurgeons, or
- neurologists.

Note: A generalist clinician who has successfully completed the Disability Examination Management Office TBI training module may conduct a TBI examination, if a TBI diagnosis is of record and was established by one of the aforementioned specialty providers.

Reference: For more information on qualifications of examiners for TBI examinations, see the *Initial Evaluation of Residuals of Traumatic Brain Injury (TBI) Disability Benefits Questionnaire* in the *DBQ Switchboard*.

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k. Qualification Requirements of Examiners – Hearing Loss and Tinnitus

Hearing loss examinations must be completed by a state-licensed audiologist. A hearing loss examination is needed for an initial examination for tinnitus.

If only a tinnitus examination is being requested, the examination may be conducted by either an audiologist or non-audiologist clinician, if a hearing loss examination is of record.

References: For more information on

- qualifications for examiners for hearing loss and tinnitus examinations, see the *Hearing Loss and Tinnitus Disability Benefits Questionnaire* in the *DBQ Switchboard*, and
- evaluating hearing loss and tinnitus, see
  – 38 CFR 4.85, and
  – M21-1, Part III, Subpart iv, 4.D.

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l. Requirements for Examination Reports

VA examinations are to be conducted using DBQs which are disease- and condition-specific, organized as a documentation tool to provide the precise medical evidence needed to rate specific disabilities. The examiner is

- asked to complete the form step by step
- answer the questions posed, and
- provide additional information as required by examination findings.

Note: The report must have a definite and unambiguous description of the disability for each complaint or claimed condition.

Common features of DBQs include

- a diagnosis section

- medical history
- objective findings
- results of diagnostic testing performed, and
- a remarks section for any necessary explanation.

Additional sections may be found on some DBQs, depending on the specialty involved.

Reference: For more information on DBQs, see the *DBQ Switchboard*.

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m. Requirements for ACE Examination Reports

When an examination provider uses acceptable clinical evidence (ACE) in lieu of conducting an in-person examination, review the report for sufficiency. The report must

- note use of the ACE Process
- clearly identify the specific evidence material to the report's findings or opinion, with as much detail as necessary, and
- document the rationale for relying on ACE rather than an in-person examination.

Reference: For more information on ACE examinations, see M21-1, Part III, Subpart iv, 3.A.4.

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n. Evaluating Disability Diagnoses

The precise cause of a disability is often difficult to determine. It is important that

- the same disability is not covered by more than one diagnosis, and
- a definite and unambiguous diagnosis is made for each complaint or symptom having a medical cause.

The table below describes various examination scenarios and what is required for a sufficient diagnosis.

If ...	**Then ...**
there are no findings on examination	a diagnosis of a disability should not be rendered by the examiner. ***Example***: Examiner states "normal left knee" and examination shows normal range of motion (ROM), normal stability, and no complaints of pain or other symptoms.
there are findings on examination	a definitive diagnosis of a disability *should* be rendered by the examiner.

	Example: Examiner diagnoses "left knee patellofemoral syndrome" and examination shows limited ROM with pain. ***Important***: • Non-committal diagnoses, such as those including the terms "rule-out" and/or "differential," are not sufficient for rating purposes. • As discussed in M21-1, Part III, Subpart iv, 5.B.1 and 2, symptoms, even in the absence of a specific diagnosis, may constitute a disability sufficient for rating purposes if they produce functional impairment of earning capacity.
a disability exists but a definite name cannot be given	the examiner should describe the disability and indicate that it is of unknown etiology. ***Example***: "Respiratory insufficiency of unknown etiology."
the examiner states further studies, evaluations, or laboratory tests are needed	the additional studies, evaluations, or testing must be performed before the diagnosis on examination can be considered final.
a previously established diagnosis is changed by the examiner	the examiner must state whether the current diagnosis represents • a new disability, or • a progression of the former disability.

Reference: For more information on handling examinations insufficient for rating purposes, see M21-1, Part III, Subpart iv, 3.D.3.

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o. Questions About Competency and/or Validity of Examinations

Duly consider concerns raised by the claimant or his/her recognized representative about a completed examination or opinion. Communications raising concerns may take the form of (but are not necessarily limited to)

- complaints about the examiner
- requests for information about the examiner's qualifications
- assertions that records or other relevant information or evidence was not considered, and/or
- requests for another examination or opinion.

The mere fact that such a communication is received does *not* mean that the examination is insufficient or in need of clarification, or that there is a further duty to assist to obtain records or another examination. However, consideration must be given to whether one or more of those remedies is appropriate.

The table below provides guidance on interpreting communications from claimants or a representative raising concerns about examinations and what action to take, as applicable.

If the substance of the communication is ...	**Then ...**
that the examiner was not qualified to perform the examination or issue the opinion	• review M21-1, Part III, Subpart iv, 3.D.2.b and additional blocks in this topic on qualifications for specific types of examinations, and • consider the guidance on competency of medical evidence in M21-1, Part III, Subpart iv, 5.A.2. When that review leads to a conclusion that the examiner did *not* have the appropriate qualifications, or that the conclusions of the examination or opinion were not otherwise competent, another examination is required. However, where an examiner is basically competent, matters like specialty, board certification, experience, and other related considerations will merely be considerations in determining probative value of the examination report or opinion. ***Note***: There is a presumption that a selected medical examiner is competent.
that the examination was not sufficient or requires clarification	review M21-1, Part III, Subpart iv, 3.D.3 and 4 and take any action required by those topics.
that additional material evidence must be obtained to substantiate the claim	review M21-1, Part I, 1.C on the duty to assist.

Note: VA's C&P claim adjudication system does not have a procedure for completion of interrogatories by VA personnel. ***Interrogatories*** are written questions that, in some court proceedings, must be answered under oath. If the claimant or representative submits a communication characterized as an interrogatory

- ***do not***
  – complete and return the document, and
  – refer it to the examiner, ***but***
- ***do***
  – look at the substance of the communication as indicated above in this block, and

– determine if it is raising questions about examiner competency, adequacy of the examination, or satisfaction of the duty to assist.

References: For more information on

- a claimant's request for information, or complaints, about a VA examination or opinion, see *Nohr v. McDonald*, 27 Vet.App. 124 (2014), and
- challenging the expertise of a VA examiner, see *Bastien v. Shinseki*, 599 F.3d 1301,1307.(Fed.Cir.2010).

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p. Handling Unusual Cases

If necessary, the Veterans Service Center Manager or Pension Management Center Manager should discuss unusual cases with health care officials to ensure proper understanding of the issue or issues at hand.

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q. Accepting a Fee-Based Examiner's Report

There is no prohibition against acceptance of a VA examination report for rating purposes from a fee-based medical examiner who has previously submitted a statement on the claimant's behalf.

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r. Examiner Statements That an Opinion Would Be Speculative

Pay careful attention to any conclusion by the examiner that an opinion could not be provided without resorting to mere speculation (or any similar language to that effect).

VA may only accept a medical examiner's conclusion that an opinion would be speculative if

- the examiner has
  - explained the basis for such an opinion, identifying what facts cannot be determined, and
  - demonstrated consideration of all procurable and relevant information (to include medical treatment records and/or lay testimony), or
- the basis for the opinion is otherwise apparent in VA's review of the evidence.

The medical opinion may be insufficient for rating purposes if an examiner's conclusion

- is not adequately justified, or
- implies a general lack of knowledge or an aversion to opining on matters beyond direct observation.

In such instances, seek clarification of the conclusion.

Note: If the examiner specifically states that a medical opinion cannot be provided unless specific evidence is made available, VA's duty to assist requires that VA determine whether that evidence may be reasonably

obtained. If so, VA is to make efforts to obtain it and then seek an additional medical opinion which considers the relevant information.

Reference: For more information on speculative opinions, see

- *Daves v. Nicholson*, 21 Vet.App. 46 (2007)
- *Jones (Michael H.) v. Shinseki*, 23 Vet.App. 382 (2010), and
- *Sharp v. Shulkin*, 29 Vet.App. 26 (2017).

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3. Handling Examination Reports That Are Insufficient for Rating Purposes

Introduction

This topic contains information about returning insufficient examination reports, including

- insufficient examination reports
- handling insufficient examination reports that were erroneously requested
- clarification of examination reports
- resolving inconsistencies, and
- returning examination reports requested through
  – CAPRI, and
  – VBMS.

Change Date

February 19, 2019

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a. Insufficient Examination Reports

A VA examination report submitted to the rating activity must be as complete as possible.

Any missing, required information on the report makes the examination report insufficient for rating purposes. The following are examples of deficiencies that would render an examination report insufficient:

- The examination report is unsigned.
- The examination report does not address all disabilities for which an examination was requested.
- The required question(s) on the DBQ is/are unanswered.
- The required review of the claims folder was not accomplished.
- The report is missing information pertinent to the specific disability under review, such as the impact of musculoskeletal pain on the functional loss of an affected joint.
- A medical opinion is not properly supported by a valid rationale and/or by the evidence of record.
- A requested medical opinion was not furnished.

Note: If the rating activity determines that a necessary examination was canceled without a valid reason, it must submit a new examination request to the examining facility and specify why the previous cancellation was inappropriate.

Example: An examination requested in connection with a claim for a knee condition was not completed because "the claimed condition was not documented and diagnosed in the service treatment records on examiner review." If the rating activity determines that such examination is needed,

the existing report or cancellation notice should be returned to the examining facility as insufficient for rating purposes.

Important: There are instances where missing information in an examination report does not make the examination itself insufficient. However, claims processors must seek and obtain the missing information via communication with and clarification by the examiner, as discussed in M21-1, Part III, Subpart iv, 3.D.3.c, before issuing a final decision on the underlying claim.

References: For more information on

- inadequate examinations, see
  – 38 CFR 4.2, and
  – 38 CFR 4.70
- circumstances under which further development may be needed, see M21-1, Part III, Subpart iv, 5.A.7
- weighing evidence, see M21-1, Part III, Subpart iv, 5.A.9
- partial rating decisions and deferred issues, see M21-1, Part III, Subpart iv, 6.A.1
- resolving inconsistencies, see M21-1, Part III, Subpart iv, 3.D.3.d, and
- descriptions of pain affecting functional loss, see *Floyd v. Brown*, 9 Vet.App. 88 (1996).

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b. Handling Insufficient Examination Reports That Were Erroneously Requested

In *Barr v. Nicholson*, 21 Vet.App. 303 (2007), the Court of Appeals for Veterans Claims (CAVC) held that if VA provides an examination when developing a claim for SC, even if not statutorily obligated to do so,

- the examination must be adequate, or
- the Veteran must be notified as to why one will not or cannot be provided.

Exception: The above requirement for adequacy does not apply to examination reports initiated by VHA that do not

- relate to the contentions under consideration in the pending claim, or
- potentially impact existing benefit entitlement.

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c. Clarification of Examination Reports

An examination report which needs clarification must be discussed with or returned to the examiner. Such instances include, but are not limited to, the following:

- The same disability is diagnosed differently by different examiners.
- Conclusions or findings have been expressed in ambiguous or equivocal terms.
- An examination report shows a change in the diagnosis or etiology for a disability previously recognized as SC.
- An examination was conducted prior to the issuance of an amendment to the rating schedule, and additional information is needed to fully consider

and properly evaluate the disability at issue in light of newly implemented criteria.

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d. Resolving Inconsistencies

Resolve any inconsistency or conflicting findings of various medical examiners by requesting a medical opinion by a different examiner.

References: For more information on requesting

- independent medical opinions, see
  – 38 CFR 3.328, and
  – M21-1, Part III, Subpart iv, 3.F.6, and
- medical opinions, see M21-1, Part III, Subpart iv, 3.A.7.

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e. Returning Examination Reports Requested Through CAPRI

Refer to the table below to determine how to return an insufficient or inadequate examination report to the appropriate provider when the examination was originally requested through ***CAPRI***.

If the examination report ...	**Then ...**
is deemed insufficient *within 45 days* of its receipt	return the examination as insufficient through CAPRI.
is deemed insufficient *more than 45 days* following its receipt	prepare and submit a new examination request using CAPRI.
requires additional clarification	• call or e-mail the examiner or point of contact at the examination facility to try to resolve the issue(s), or • input a medical opinion DBQ request for the necessary supplemental information in CAPRI if the issue(s) is/are complex or cannot be resolved by telephone or e-mail.
needs resolution of a conflicting opinion or diagnosis	input a medical opinion DBQ request in CAPRI.

Important:

- Avoid using language that can be construed as adversarial when returning reports for clarification. Use the term *insufficient for rating purposes* rather than *inadequate examination*.
- Clearly describe the issue(s) needing clarification or resolution.

Notes:

- For VHA examinations, try to resolve any questions or need for clarification with RO resident clinicians as often as possible in order to promote timely claims processing and efficient customer service.

- When the best interest of the Veteran will be advanced by a personal conference or e-mail with the examiner, such measures should always be considered.

References: For more information on
- navigation of and data entry in CAPRI, see the *CAPRI User Manual*, and
- returning examination reports requested through VBMS, see M21-1, Part III, Subpart iv, 3.D.3.f.

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f. Returning Examination Reports Requested Through VBMS

Refer to the table below to determine how to return an insufficient or inadequate examination report to the appropriate provider when the examination was originally requested through ***VBMS***.

If the examination report ...	**Then ...**
is deemed insufficient	return the examination report by • accessing the EXAMS chevron in VBMS, and • selecting – *Rework* from the ACTIONS menu – each contention requiring additional attention – *Insufficiency* as the rework type, and – one or more bases for the report's return from the AVAILABLE REWORK REASONS drop-down menu, and • entering a clear description of the issue(s) needing clarification or resolution in the DETAILED RATIONALE FOR REWORK field. ***Important***: When a VBA-contracted examination report is found to be insufficient, it should *not* be resolved by VHA examiners.
requires clarification	return the examination report by • accessing the EXAMS chevron in VBMS, and • selecting – *Rework* from the ACTIONS menu – each contention requiring additional attention – *Clarification* as the rework type, and – one or more bases for the report's return from the AVAILABLE REWORK REASONS drop-down menu, and

	• entering a clear description of the issue(s) needing clarification or resolution in the DETAILED RATIONALE FOR REWORK field.
needs resolution of a conflicting opinion or diagnosis	input a medical opinion DBQ request in VBMS.

Important: Avoid using language that can be construed as adversarial when returning reports for clarification. Use the term *insufficient for rating purposes* rather than *inadequate examination*.

Notes:

- VBA contract examination providers have a maximum of 14 days to clarify any insufficiency to avoid an insufficiency call. If the insufficiency or need for clarification is not rectified within the time allotted, the examination will be deemed *insufficient*.
- When the best interest of the Veteran will be advanced by a personal conference or e-mail with the examiner, such measures should always be considered. Do not, however, contact the contract examiner directly. Instead, refer to the *Contract Examination Inquiry Guidelines* to initiate contact.

References: For more information on

- navigation of and data entry in VBMS, see the *VBMS Core User Guide*, and
- returning examination reports requested through CAPRI, see M21-1, Part III, Subpart iv, 3.D.3.e.

4. Reviewing Examination Reports for Rating Criteria

Introduction

This topic contains information about examination considerations specific to certain disabilities and body systems, including

- eye examination report review
- headache examination report review
- hearing loss and tinnitus examination report review
- mental health examination report review
- heart conditions examination report review for metabolic equivalents of task (METs)
- musculoskeletal examination report review for
  – ROM
  – functional loss, and
  – X-rays
- nerves examination report review
- respiratory examination report review for pulmonary function tests (PFTs)
- skin and scars examination report review
- sleep disorders examination report review
- temporomandibular disorder (TMD) examination report review, and
- TBI examination report review.

Change Date

May 27, 2020

a. Eye Examination Report Review

When a visual field defect is perceived, examiners must perform any necessary visual field testing using either

- Goldmann kinetic perimetry, or
- automated perimetry using Humphrey Model 750, Octopus Model 101, or later versions of these perimetric devices with simulated kinetic Goldmann testing capability.

If the examination was not performed using the proper testing method, then the examination report should be returned as insufficient. An examination sufficient for rating purposes must include, at minimum,

- documentation of numerical values for all required fields as measured by a perimetric device, ***or***
- results documented on a Goldmann chart.

Important: Irrespective of the eye condition being examined, no visual field testing is required if the examiner indicates that the Veteran does *not* suffer a

visual field defect. The absence of visual field testing results does not, in these instances, render an examination report insufficient for rating purposes.

Reference: For more information about eye conditions, see

- 38 CFR 4.75
- 38 CFR 4.76(b)(3)
- 38 CFR 4.77
- 38 CFR 4.79, and
- M21-1, Part III, Subpart iv, 4.C.

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b. Headache Examination Report Review

A neurological headache examination report will be considered insufficient if it does not indicate the frequency of prostrating headaches and whether the headaches are migraine-type or non-migraine type.

Reference: For more information on rating migraines, see

- 38 CFR 4.124a, and
- M21-1, Part III, Subpart iv, 4.N.7.

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c. Hearing Loss and Tinnitus Examination Report Review

A hearing loss and tinnitus examination report may be considered insufficient if an opinion was requested by the RO and is not provided in the report.

Unusual circumstances may arise during the examination, requiring the examiner to

- identify any audiometric frequencies that could not be tested (CNT) and explain why testing could not be done
- provide an explanation of why speech discrimination testing was not performed on the Veteran, or why a speech discrimination score is not appropriate in his/her case, and/or
- state the functional impact of tinnitus.

Reference: For more information on requesting audiometric examinations and medical opinions, see M21-1, Part III, Subpart iv, 4.D.1.d.

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d. Mental Health Examination Report Review

Mental health examinations can be complex when there are psychological symptoms existing simultaneously with and usually independently of another medical condition, such as PTSD and TBI symptoms of memory loss.

An examination report may be insufficient if

- there is more than one mental disorder diagnosed, and the examiner does not address the criteria for all the diagnoses

- there is a diagnosis of a mental disorder and TBI, and the examiner does not
  – differentiate and list which symptom(s) is/are attributable to each diagnosis, or
  – provide a reason that it is not possible to differentiate what portion of each symptom is attributable to each diagnosis
- the *Occupational and Social Impairment* section of the report is not completed, or
- the examiner fails to address the question of the claimant's competency.

Reference: For more information on considering a change in the diagnosis of a psychiatric disorder, see M21-1, Part III, Subpart iv, 4.O.1.c.

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e. Heart Conditions Examination Report Review for METs

The metabolic equivalents of task (METs) score for heart conditions can be provided as an estimate, as indicated on the DBQs. If the Veteran has co-morbid conditions that prevent the examiner from performing METs testing or providing an interview-based METs estimate, then the

- examiner must indicate why
  – METs testing could not be performed, or
  – a METs estimate could not be provided, and
- RO will evaluate the condition based on the remaining examination results and evidence of record.

Reference: For information on rating heart conditions, see M21-1, Part III, Subpart iv, 4.G.2.

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f. Musculoskeletal Examination Report Review for ROM

In order to address CAVC's interpretation of VA's regulations in *DeLuca* and *Mitchell*, musculoskeletal joint examination reports must address ROM criteria for repetitive motion and flare-ups.

Following the initial assessment of ROM, the examiner must perform repetitive-use testing to the extent permitted by the disability under evaluation. After the initial measurement, the examiner must reassess ROM after three repetitions and report the post-test measurements.

The examination report is insufficient if the examiner does not

- repeat ROM testing during the examination and report any additional functional loss, or
- provide a rational explanation for why repetitive-use testing could not be accomplished, if applicable.

In order to address CAVC's holdings in *Corriea* and ensure adequacy for rating purposes, musculoskeletal examination reports must also reflect testing of

- involved joints for pain
  – on both active and passive motion, and
  – in states of weight-bearing and nonweight-bearing, and
- ROM of the opposite, undamaged joint, if applicable and medically feasible.

Musculoskeletal examination reports containing self-evident contradictory findings, conclusions, and/or terminology will also be rendered insufficient or require additional clarification. Examples of such contradictory examination features include, but are not limited to, the following:

- annotations of "unaffected gait" and "walks with a cane" in the same report
- indication that a joint has required surgery, accompanied by the annotation "scar not addressed", and
- conclusion that a joint warrants no clinical diagnosis, accompanied by coexisting objective findings of unqualified
  – irregular limitation of motion (LOM)
  – pain on ROM testing, and/or
  – degenerative changes or arthritis.

References: For more information on

- rating musculoskeletal conditions, see M21-1, Part III, Subpart iv, 4.A and B
- musculoskeletal review for
  – functional loss, see M21-1, Part III, Subpart iv, 3.D.4.g, and
  – x-rays, see M21-1, Part III, Subpart iv, 3.D.4.h
- additional functional impairment during flare-ups or with repeated use over time, see
  – *DeLuca v. Brown*, 8 Vet.App. 202 (1995), and
  – *Mitchell v. Shinseki*, 25 Vet.App. 32 (2011), and
- required ROM testing, see *Correia v. McDonald*, 28 Vet.App. 158 (2016).

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g. Musculoskeletal Examination Report Review for Functional Loss

The clinician conducting a musculoskeletal examination must address additional functional limitation or LOM during flare-ups or following repeated use over time, based on the Veteran's history and the examiner's clinical judgment.

The examination report must address whether the functional ability of a joint is significantly limited during flare-ups or when the joint is used repeatedly over a period of time due to

- pain
- weakness
- fatigability, and/or
- incoordination.

If such opinion is not feasible, then the examiner must state so and provide an explanation as to why the opinion cannot be rendered.

Example: John Smith reports severe knee pain with repeated use over time when walking back and forth to the store several times a day. During those flare-ups, the capacity for knee flexion is demonstrated/reported to be 0-110 degrees.

Important: The examiner conducting an initial or review musculoskeletal examination must consider all the evidence of record when estimating functional loss due to flare-ups. The examiner must review the claims folder in order to adequately meet this requirement.

References: For more information on

- requirement for claims folder review in a musculoskeletal examination, see
  – *Sharp v. Shulkin*, 29 Vet.App. 26 (2017), and
  – M21-1, Part III, Subpart iv, 3.A.8.b, and
- musculoskeletal examination report review for
  – ROM, see M21-1, Part III, Subpart iv, 3.D.4.f, and
  – x-rays, see M21-1, Part III, Subpart iv, 3.D.4.h.

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h. Musculoskeletal Examination Report Review for X-Rays

During review of musculoskeletal examination reports, check to ensure that x-rays were obtained when necessary.

A diagnosis of arthritis must be confirmed by x-ray or other radiographic testing before SC may be established.

Where there is a claim of *non-specific joint pain* in a joint or multiple joints, x-rays will not be provided prior to the Veteran being seen by the examiner.

- The examiner will determine if x-rays are needed in order to provide a diagnosis consistent with the history and symptomatology.
- If there is a diagnosis other than arthritis or a determination that no diagnosable disability exists, do not return the examination as insufficient merely because x-rays were not provided.

However, when arthritis is *claimed* or *diagnosed*, the examination and/or medical evidence of record *must* include x-rays of the joint at issue. If the examination does not include x-rays, and none are otherwise available for consideration, then return the examination report as insufficient.

Note: Once arthritic changes are shown in a joint, no further x-rays will ever be required for that joint to support a diagnosis of arthritis.

References: For more information on musculoskeletal examination report review for

- ROM, see M21-1, Part III, Subpart iv, 3.D.4.f, and
- functional loss, see M21-1, Part III, Subpart iv, 3.D.4.g.

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i. Nerves Examination Report Review

Examiners must, to the extent possible, identify the nerve that best correlates to the area affected even if the condition is a spinal cord nerve condition.

This information will allow the rating decision to address the functional impairment of the area affected.

Reference: For more information on diseases of the peripheral nerves, see
- 38 CFR 4.120, and
- M21-1, Part III, Subpart iv, 4.N.4.

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j. Respiratory Examination Report Review for PFTs

Pulmonary function tests (PFTs) are required for most respiratory conditions unless

- there is a recent study in the Veteran's records that accurately reflects the Veteran's current condition, or
- the examiner provides an explanation on the special exceptions listed in 38 CFR 4.96(d)(i) through (iv).

Obtaining and reporting the PFT is only half of the requirement. The other half of the requirement is for the examiner to interpret the PFT in relation to the claimed condition.

References: For more information on
- when PFTs are required, see M21-1, Part III, Subpart iv, 4.F.1.e, and
- assigning disability evaluations based on the results of PFTs, see M21-1, Part III, Subpart iv, 4.F.1.f.

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k. Skin and Scars Examination Report Review

Use the table below to ensure a skin or scar examination report is not considered insufficient for rating purposes.

If the disability being assessed is a ...	**Then the ...**
skin condition (e.g. dermatitis, eczema, etc.) whose evaluation criteria involve consideration of its effects on bodily areas	*Skin Diseases Disability Benefits Questionnaire* must identify the total body surface area and exposed body surface area (both expressed as percentages) affected.
scar	*Scars/Disfigurement Disability Benefits Questionnaire* must identify the scar's

	• location (e.g. left lower extremity, right upper extremity, etc.) • type (e.g. linear, superficial non-linear, painful, etc.), and • dimensions of measurement (i.e. length and width). ***Note***: Non-scar DBQs identifying residual scars that are *not* painful/unstable or greater than 39 square centimeters in area are also sufficient for rating purposes.

Notes:
- If color photographs are not included with a skin or scar examination report, do not return the examination report as insufficient to request photographs ***unless*** the report clearly indicates that photographs *were* captured at the time of examination, but fails to provide them. In this instance, the photographs must be obtained for rating consideration.
- If photographs are included, then consider the evidence when evaluating the condition(s) at issue.

Reference: For more information on rating skin conditions and scars, see
- 38 CFR 4.118, and
- M21-1, Part III, Subpart iv, 4.L.

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l. Sleep Disorders Examination Review

Sleep apnea must be diagnosed with a sleep study. Review the sleep study to ensure the condition is interpreted in relationship to the claimed condition.

If there is an SC condition that is co-morbid to the sleep apnea that requires a PFT, like asthma, ensure that such testing was completed.

Sleep disturbances, such as insomnia, may be claimed as secondary manifestations of other primary conditions, including, but not limited to,

- mental health disorders
- pain experienced from an SC disability, and/or
- signs or symptoms of undiagnosed illness and medically unexplained chronic multi-symptom illnesses.

Notes:
- When the *Sleep Apnea Disability Benefits Questionnaire* is negative for a diagnosis of sleep apnea, but the examiner provides information about sleep disturbances, such as insomnia, then review the report in accordance with M21-1, Part III, Subpart iv, 4.O.1.l to determine if any additional medical opinion is required.
- As expressed in M21-1, Part III, Subpart iv, 4.F.5.f, upper airway resistance syndrome is neither synonymous with sleep apnea nor

considered a ratable disability for compensation purposes. As such, its diagnosis does *not* warrant requesting any examination, medical opinion, or clarification of existing examination results.

References: For more information on

- determining when an examination or medical opinion is necessary, see M21-1, Part I, 1.C.3.b
- subthreshold diagnoses, see M21-1, Part III, Subpart iv, 5.B.1.b
- sleep apnea and sleep studies, see M21-1, Part III, Subpart iv, 4.F.5.a
- sleep apnea schedule of ratings, see 38 CFR 4.97, diagnostic code (DC) 6847
- when PFTs are required, see M21-1, Part III, Subpart iv, 4.F.1.e, and
- the *Sleep Apnea Disability Benefits Questionnaire*, see the *DBQ Switchboard*.

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m. TMD Examination Report Review

There is no need to return a temporomandibular disorder (TMD) examination report simply because a dentist did not perform the examination. TMD is musculoskeletal in nature.

Important: As part of the musculoskeletal requirements, the *Temporomandibular Disorders (TMDs) Disability Benefits Questionnaire* requires the examiner to address

- flare-ups that impact the function of the temporomandibular joint
- initial ROM measurements
- ROM measurement after repetitive-use testing
- functional loss and additional limitation in ROM, and
- pain (pain on palpation) and crepitus.

References: For more information about

- rating TMD, see 38 CFR 4.150, DC 9905, and
- the *Temporomandibular Disorders (TMDs) Disability Benefits Questionnaire*, see the *DBQ Switchboard*.

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n. TBI Examination Report Review

Ensure the initial TBI diagnosis is provided by a qualified examiner.

The examiner must address

- all the facets of the TBI diagnosis, and if any facets are left blank, it must be indicated in the *Remarks* section of the DBQ that the symptoms are related to a non-TBI condition, with an explanation provided
- any additional residuals, other findings, diagnostic testing, functional impact of the diagnosis, and an explanation regarding conflicting diagnoses from medical versus mental health clinicians, if applicable
- other pertinent physical findings, scars, complications, conditions, signs and/or symptoms, such as mental, physical, or neurological conditions or

residuals attributable to a TBI (such as migraine headaches or Meniere's disease), and
- the functional impact on the Veteran's ability to work.

A mental health evaluation alone is not sufficient in addressing TBI. A TBI examination completed by a medical clinician, with input from a mental health examiner, needs to be completed when attributable signs and symptoms co-exist.

Objective evidence and neuropsychiatric testing may be required when cognitive impairment symptoms are identified. Some examples of cognitive impairment symptomology include

- memory loss, and
- reduced attention, concentration, and executive functioning.

References: For more information on
- TBI examiner qualifications, see M21-1, Part III, Subpart iv, 3.D.2.j, and
- evaluating TBI, see
  – 38 CFR 4.124a, and
  – M21-1, Part III, Subpart iv, 4.N.2.

5. Taking Rating Action on RFE Results

Introduction

This topic contains information about taking action on the results of RFEs, including when an RFE

- shows worsening symptomatology, and
- demonstrates development of additional residual or secondary disabilities.

Change Date

March 1, 2021

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a. When an RFE Shows Worsening Symptomatology

Use the table below to determine the rating action to take if results of a routine future examination (RFE) demonstrate worsening symptomatology.

If RFE results and/or associated medical evidence demonstrate that an SC disability ...	Then ...
has worsened so as to warrant a higher evaluation under schedular rating criteria	• consider the disability's evaluation an issue raised on VA initiative, and • award entitlement to the appropriate increased evaluation from the date of the examination's performance.
renders the Veteran unemployable	• consider the issue of entitlement to individual unemployability (IU) reasonably raised • follow procedural instructions found in M21-1, Part IV, Subpart ii, 2.F.2 for reasonably raised claims of IU, and • continue end product 310 until all issues are decided.
required hospitalization or observation at VA expense for a period in excess of 21 days	• consider entitlement to a temporary total rating a reasonably raised subordinate issue • award entitlement to a temporary 100-percent evaluation under 38 CFR 4.29 for the duration of the hospitalization or treatment/observation period, and • assign an appropriate schedular evaluation based on current examination results following discontinuance of the temporary 100-percent evaluation.

required surgical or other treatment necessitating at least one month of convalescence • at any point in time, if administered at a VA or military treatment facility, or • within the year prior to the date of the examination's performance, if administered by a private or civilian provider	• consider entitlement to a temporary total rating a reasonably raised subordinate issue • award entitlement to a temporary 100-percent evaluation under 38 CFR 4.30 for the duration of the convalescence period, and • assign an appropriate schedular evaluation based on current examination results following discontinuance of the temporary 100-percent evaluation.

Note: Under the circumstances described above, do ***not*** raise the issue of entitlement to a temporary total rating under 38 CFR 4.29 or 4.30 unless the evidence of record supports a grant of such benefits.

References: For more information on
- effective dates of
  – increased compensation, see M21-1, Part III, Subpart iv, 5.C.5
  – hospitalization ratings, see M21-1, Part IV, Subpart ii, 2.J.2.h, and
  – convalescent ratings, see M21-1, Part IV, Subpart ii, 2.J.4.g
- handling hospitalization reports to adjudicate entitlement to benefits under 38 CFR 4.29 and 4.30, see
  – M21-1, Part III, Subpart ii, 2.B.3.b
  – M21-1, Part IV, Subpart ii, 2.J.2.b, and
  – M21-1, Part IV, Subpart ii, 2.J.4.e
- preparing hospitalization ratings, see M21-1, Part IV, Subpart ii, 2.J.3
- preparing convalescent ratings, see M21-1, Part IV, Subpart ii, 2.J.4, and
- actions to take when an RFE demonstrates development of additional residual or secondary disabilities, see M21-1, Part III, Subpart iv, 3.D.5.b.

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b. When an RFE Demonstrates Development of Additional Residual or Secondary Disabilities

Use the table below to determine the rating action to take if results of an RFE demonstrate that a primary SC disability has progressed to involve the development of one or more additional residual, complications, or secondary disabilities.

If the newly developed disability discovered on RFE is …	**Then ...**
• the residual of a primary SC disease or disability whose DC criteria under 38 CFR Part 4 – required re-examination, and	award entitlement to SC for the newly developed residual or secondary disability(ies), as well as any corresponding ancillary benefits, effective the date of the examination that resulted in discovery.

– instruct that residuals be rated according to the body system involved, *or* • one that 38 CFR Part 4 and/or other sources of official VA guidance identify as an accepted part of the underlying SC disability, such as – complications of systemic disease processes, including diabetes mellitus – scars associated with surgical interventions, or – peripheral nerve involvement associated with spinal pathology	***Example***: A Veteran SC for prostate cancer attends an RFE intended to assess that disability's severity on January 1, 2016, at which time he is diagnosed with residual erectile dysfunction. ***Outcome***: The rating activity will establish SC for erectile dysfunction and entitlement to special monthly compensation under 38 U.S.C. 1114(k) for loss of use of a creative organ effective January 1, 2016, the date of the review examination's performance.
• affirmatively related to the primary SC disability as per the conclusions of a favorable medical opinion, ***but*** • not considered an accepted part of the underlying SC disability, as discussed in the cell above	solicit a claim for benefits in accordance with M21-1, Part III, Subpart iv, 6.B.5.a. ***Example***: A Veteran SC for lumbar spinal stenosis attends an RFE intended to assess that disability's severity, at which time her VA examiner diagnoses right knee patellofemoral pain syndrome and provides a medical opinion that the latter is at least as likely as not related to the former. ***Outcome***: The rating activity will • evaluate the severity of the SC lumbar spinal stenosis based on the facts of the case, and • solicit a claim for SC for right knee patellofemoral pain syndrome. ***Note***: If, during the course of the VA examination, the Veteran expresses intent to seek compensation for the new disability, handle such communication as a request for application in accordance with M21-1, Part III, Subpart ii, 2.C.6.

Reference: For more information on actions to take when an RFE shows worsening symptomatology, see M21-1, Part III, Subpart iv, 3.D.5.a.