Applying DeLuca Handout

Trainee Handout

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Objectives

* Identify manual references for joints, functional loss and painful motion
* Define functional loss
* Know how to apply the requirements of 38 CFR 4.40, 4.45 and 4.59
* Identify court decisions concerning 38 CFR 4.40, 4.45 and 4.59

References

* [38 CFR 4.21, Application of rating schedule](http://www.ecfr.gov/cgi-bin/text-idx?SID=ad275643432556b9dda942343fb89296&mc=true&node=pt38.1.4&rgn=div5" \l "se38.1.4_121)
* [38 CFR 4.40, Functional loss](http://www.ecfr.gov/cgi-bin/text-idx?SID=ad275643432556b9dda942343fb89296&mc=true&node=pt38.1.4&rgn=div5#se38.1.4_121)
* [38 CFR 4.45, The joints](http://www.ecfr.gov/cgi-bin/text-idx?SID=ad275643432556b9dda942343fb89296&mc=true&node=pt38.1.4&rgn=div5#se38.1.4_121)
* [38 CFR 4.59, Painful motion](http://www.ecfr.gov/cgi-bin/text-idx?SID=ad275643432556b9dda942343fb89296&mc=true&node=pt38.1.4&rgn=div5#se38.1.4_121)
* [38 CFR 4.71, Measurement of ankylosis and joint motion](http://www.ecfr.gov/cgi-bin/text-idx?SID=ad275643432556b9dda942343fb89296&mc=true&node=pt38.1.4&rgn=div5#se38.1.4_121)
* [M21-1, Part III, Subpart iv, Chapter 4, Section A, Musculoskeletal conditions](https://ssologon.iam.va.gov/CentralLogin/Default.aspx?appname=core&URL=https://ssologon.iam.va.gov/CentralLogin/core/redirect.aspx&TYPE=33619969&REALMOID=06-d403f59d-c057-477f-9c49-c0d2a2d13e2b&GUID=&SMAUTHREASON=0&METHOD=GET&SMAGENTNAME=$SM$Dc1iJnfj0EDnZgoGbQhY8pxQ5cSvKdwMq%2fM4NhznJAhElAp4fDXcFkTew7jYCcYk&TARGET=$SM$HTTPS%3a%2f%2fvaww%2ecompensation%2epension%2ekm%2eva%2egov%2fsystem%2ftemplates%2fselfservice%2fva_ka%2fportal%2ehtml%3fportalid%3d554400000001034)
* [*Schafrath v. Derwinski*, 1 Vet App 589, 592](http://vbaw.vba.va.gov/bl/21/advisory/CAVCDAD.htm)
* [*Hicks v. Brown*, 8 Vet App 417, 421](http://vbaw.vba.va.gov/bl/21/advisory/CAVCDAD.htm)
* [*DeLuca v. Brown*, 8 Vet App 202](http://vbaw.vba.va.gov/bl/21/advisory/CAVCDAD.htm)
* [VBN Broadcast, “Considering *DeLuca*”, March 29, 2005](http://vbaw.vba.va.gov/bl/21/Calendar/vbn/transcripts.htm#2005)
* [FAQ on *DeLuca*, April 7, 2005](http://vbaw.vba.va.gov/bl/21/FAQ/faq.htm)
* [FAQ on Painful Motion, September 17, 2008](http://vbaw.vba.va.gov/bl/21/FAQ/faq.htm)
* [Medical EPSS](http://cptraining.vba.va.gov/C%26P_Training/Job_Aids/Medical_EPSS.htm)

Topic 1: Applying DeLuca Laws and Regulations

|  |
| --- |
| **38 CFR 4.40. Functional Loss**What role does functional loss play in evaluating disabilities of the musculoskeletal system?* Disability of the musculoskeletal system is primarily the inability, due to damage or infection in parts of the system, to perform the normal working movements of the body with normal excursion, strength, speed, coordination and endurance.
* It is essential that VA examinations adequately portray the anatomical damage and functional loss, with respect to all these elements.
* Functional loss may be due to the absence of part, or all, of the necessary bones, joints and muscles, or associated structures in the body. It may also be the result of deformity, adhesions, defective innervation, or other pathology. In certain instances, functional loss may be due to pain, when supported by adequate pathology and evidenced by the visible behavior of the claimant undertaking the motion.
* Weakness is as important as limitation of motion. A body part, which becomes painful on use, must be regarded as seriously disabled. A little used part of the musculoskeletal system may show evidence of disuse, either through atrophy, or a skin condition (such as absence of normal callosity).

**Simply put, functional loss occurs when the joints are either damaged or infected and the range of movement that can normally be repeated when performing a function is impeded.**  |
| **38 CFR 4.45. The Joints****Considerations for evaluating the joints.**With regard for the joints, the factors of disability reside in the reduction of the normal excursion of movement in different planes. Inquiry will be directed to these considerations: 1. Less movement than normal (due to ankylosis, limitation or blocking, adhesions, tendon-tie-up, contracted scars, etc.).
2. More movement than normal (from flail joint, resections, nonunion of fracture, relaxation of ligaments, etc.).
3. Weakened movement (due to muscle injury, disease or injury of peripheral nerves, divided or lengthened tendons, etc.).
4. Excess fatigability.
5. Incoordination, impaired ability to execute skilled movements smoothly.
6. Pain on movement, swelling, deformity or atrophy from disuse. Instability of station, disturbance of locomotion, interference with sitting, standing and weight-bearing are related considerations. For the purpose of rating disability from arthritis, the shoulder, elbow, wrist, hip, knee, and ankle are considered major joints; multiple involvements of the interphalangeal, metacarpal and carpal joints of the upper extremities, the interphalangeal, metatarsal and tarsal joints of the lower extremities, the cervical vertebrae, the dorsal vertebrae, and the lumbar vertebrae, are considered groups of minor joints, ratable on a parity with major joints. The lumbosacral articulation and both sacroiliac joints are considered to be a group of minor joints, ratable on disturbance of lumbar spine functions.
 |
| **38 CFR 4.59 Painful Motion****Considerations for evaluating painful motion of the joints.*** With any form of arthritis, painful motion is an important factor of disability. The facial expression (wincing, etc.), on pressure or manipulation, should be carefully noted and definitely related to the affected joint(s). Muscle spasm greatly assists with identifying painful motion. Sciatic neuritis is commonly caused by arthritis of the spine.
* The intent of the schedule is to recognize painful motion in a joint, or periarticular pathology that is productive of disability. *It is the intention to* *recognize that, actually painful, unstable, or malaligned joints, due to healed injury are entitled to at least the minimum compensable rating for the joint*. Crepitation, either in the soft tissues (such as the tendons or ligaments), or within the joint structures, should be noted carefully as areas that are diseased. Flexion elicits such manifestations. The joints involved should be tested for pain on both active and passive motion, in weight-bearing and nonweight-bearing and, if possible, compared to the range of the opposite, undamaged joint.

Note: Pain, in and of itself, is not a disability for compensation purposes; however, for evaluation consideration under 38 CFR 4.59, we must consider pain when evaluating the joints. |
| ***DeLuca v. Brown***How does this court decision affect the way we evaluate disabilities of the joints? * In *DeLuca v. Brown* the Court required that we consider evidence showing not only limitation of motion, but also any evidence demonstrating weakened movement, excess fatigability, in coordination, and pain in evaluating disabilities.
* The Court held that the Rating Schedule does not prohibit consideration of a higher evaluation based on a greater limitation of motion due to pain on use including during flare-ups. The medical examiner must provide an opinion as to whether pain could significantly limit functional ability during flare-ups, or when used repeatedly over time. The examiner must express any additional limitation **in degrees of range of motion lost**, due to pain on use or during flare-ups. If the examiner cannot provide this opinion without resorting to speculation, he/she is to express that, rather than guess whether or not any additional limitation of motion occurs on repetitive movement.
* The Rating Schedule provides that in evaluating the joints, a complete medical examination is required to understand the nature and extent of the claimant’s disabilities. Examiners should provide information not only on the history and objective findings on exam, but also furnish findings of any of the following factors discussed above under 38 CFR 4.45.

The examination report should note the factors of 38 CFR 4.45, either by objective findings, or by absence of them. Further, the examiner should further furnish the limitation of motion (in degrees), resulting from these factors; and ask the claimant for information on flare-ups and the frequency of symptoms that are intermittent, or experienced only after a period of use or time. |
| ***Schafrath v. Derwinski*****BVA routinely employs the following analysis:**Functional loss due to pain is to be rated at the same level as functional loss where the motion is impeded. ***Schafrath v. Derwinski*, 1 Vet. App. 589, 592 (1991)**. Under 38 CFR 4.59, painful motion is considered limited motion even though range of motion is possible beyond the point when pain sets in. *Hicks v. Brown*, 8 Vet. App. 417, 421 (1995); See also *DeLuca v. Brown*, 8 Vet. App. 202 (1995). **Note**: The definition of “impede” is to interfere with or slow the progress of to retard or obstruct the progress of. *Merriam Webster Online Dictionary.*  |
| * The *DeLuca* decision requires us to consider the provisions of 38 CFR 4.40 and 4.45 when evaluating disabilities of a joint.s. *In DeLuca*, the Court discussed provisions of 38 CFR 4.40 and 4.45, but not 38 CFR 4.59 specifically
* Examiners must state whether joints are limited by range of motion, weakness, fatigue, incoordination, or pain.
* Examiner must state (in degrees) whether there is any additional functional loss shown in any of these areas.
* The provisions of 38 CFR 4.59 specify that we consider pain when evaluating the joints.

Review the training material concerning *DeLuca’s* VBN broadcast (March 29, 2005): * Transcripts
* Scenarios
* [CDN Broadcast](http://vaww.vakncdn.lrn.va.gov/)
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Attachment A: FAQ – *DeLuca* Question, April 7, 2005

**Issue:** ***DeLuca* Question**

**Question**

I don't understand the result in the first *DeLuca* broadcast scenario. The Veteran had pain at 30 degrees extension on repetitive motion. There was wincing, crepitus and swelling supporting the complaint of pain. The examiner stated that additional loss due to functional impairment would be 10 degrees loss of extension. Why don't we assign a 40 percent evaluation? Don't we treat motion as limited where it becomes painful?

**Case Scenario #1:** This is a Veteran with right knee patellofemoral syndrome rated at 0% under diagnostic code (DC) 5261, limitation of leg extension. She filed for an increased evaluation.

In the examination report, the examiner reported that the Veteran had normal range of motion from 0-140. Also, that she winced and complained of pain during extension against resistance. The examiner reported that the Veteran complained of pain with repetitive motion while wearing a weight and that this pain began at 30 degrees extension. The examiner reported crepitus and mild swelling of the right knee. The examiner reported that there was no instability, weakness, fatigability, or incoordination. The x-ray of the knee was normal.

The examiner provided the following statement: "The Veteran has patellofemoral syndrome. Her pain is mild; however, she has pain with walking sometimes, and needs to take OTC meds. She is unable to kneel on her knees because they are sore. She has pain on extension, though this pain is mild, and she is able to move through it. Therefore, in my opinion, her additional loss of range of motion due to pain, weakness, fatigability, incoordination and flare-ups, and considering flare-ups and pain on repeated use, is 10 degrees (in extension)."

**Answer**

In the first scenario, actual limitation of motion was 0 degrees. Range of motion was measured to be from 0 to 140 degrees. Additional limitation of motion due to functional impairment (including painful motion) was to 10 degrees extension in the opinion of the examiner. Therefore total loss of motion was 10 degrees extension and this would warrant a 10 percent evaluation under DC 5261.

The point of this fact pattern was to illustrate that the rating specialist *must rely on medical evidence* to quantify functional impairment. We stated in the broadcast that separate consideration of additional functional loss must be based on the medical examiner's findings. Only a VA examiner, or another medical expert, is competent to offer an opinion on how various findings pertaining to functional impairment equate to limitation of motion (note though that a VA examiner may decline to offer an opinion if doing so would require him to resort to mere speculation). The rating specialist may not simply substitute her judgment for that of the examiner. See *Colvin v. Derwinski*, 1 Vet. App. 171(1991). We would not, in this case, automatically treat motion as additionally limited by pain at 30 degrees extension. If the rating specialist does not understand the rationale for the examiner's opinion on additional loss of motion due to functional impairment or has some reason to doubt the examiner's opinion she retains the prerogative to ask for clarification of the opinion.

As an aside, it is important to be critical of the evidence obtained. The key is to determine which findings are *sufficiently characteristic* to identify the disability from the service connected condition and to *coordinate rating with impairment of function*. 38 CFR §[4.21](http://vbaw.vba.va.gov/bl/21/publicat/Regs/Part4/4_21.htm). The rating schedule compensates for average impairment of earning capacity and ratings presume considerable loss of working time due from exacerbations proportionate to the grade of disability. 38 CFR §4.1. In view of the exam findings in scenario one, a conclusion that functional impairment in this case would be equivalent to loss of extension to 30 degrees would be suspect. Loss of extension to 30 degrees represents fairly significant impairment. Although the Veteran reported some pain starting at 30 degrees of extension on repeated use against resistance and although there were some objective indications to support the complaint of pain, overall the findings were minor. The Veteran reported only occasional pain with walking and pain was mild enough that the Veteran could move the knee despite it. There was no instability, weakness, fatigability or incoordination.

  [Thursday, April 07, 2005]

Attachment B: FAQ – Painful Motion, September 17, 2008

**Issue:** ***Painful Motion***

**Question**

Service connection of arthritis of the right knee has been established and the Veteran is requesting an increased evaluation. Examination findings show full range of normal motion for the joint (0-140 degrees) with pain elicited at the end points of each movement. No additional limitation of motion due to pain during use or functional impairment during flare-ups has been reported.

Questions:

1. Do these findings constitute painful motion warranting a compensable evaluation as contemplated in 38 CFR [4.59](http://vbaw.vba.va.gov/bl/21/publicat/Regs/Part4/4_59.htm)?

2. Are the findings in the DeLuca decision (DeLuca v. Brown, 8 Vet App 202 1995) applicable in this scenario?

**Answer**

**1.** Yes, in the scenario provided for example, a diagnosis of arthritis has been rendered and objective evidence of pain has been documented during the examination.

38 CFR [4.59](http://vbaw.vba.va.gov/bl/21/publicat/Regs/Part4/4_59.htm) states in part: "With any form of arthritis, painful motion is an important factor of disability… The intent of the schedule is to recognize painful motion with joint or periarticular pathology as productive of disability. It is the intention to recognize actually painful, unstable, or malaligned joints, due to healed injury, as entitled to at least the minimum compensable rating for the joint…"

It is important to note that 38 CFR [4.59](http://vbaw.vba.va.gov/bl/21/publicat/Regs/Part4/4_59.htm) is not limited in application to arthritis. The term "joint or periarticular pathology" must be interpreted to include other forms of joint disease or injury. Additionally, this does not allow for a compensable evaluation for both extension and flexion, absent compensable levels of limitation of motion in each plane.

38 CFR 4[.71a](http://vbaw.vba.va.gov/bl/21/publicat/Regs/Part4/4_71a.htm), (See note under DC 5002 and 5003), affirms the mandate of 38 CFR [4.59](http://vbaw.vba.va.gov/bl/21/publicat/Regs/Part4/4_59.htm) as follows: "Where, however, the limitation of motion of the specific joint or joints involved is non- compensable under the codes a rating of 10 percent is for application for each such major joint or group of minor joints affected by limitation of motion…"

Consequently "…even where no compensable limitation of motion is demonstrated per the Schedule, it is the intention to recognize actually painful, unstable, or misaligned joints as at least minimally compensable." Thus, if a Veteran has arthritis, or other joint pathology, and his/her complaints of pain, functional loss, etc. are objectively supported, a minimum compensable evaluation under 38 CFR [4.59](http://vbaw.vba.va.gov/bl/21/publicat/Regs/Part4/4_59.htm) may be assigned.

**2.** No. In this scenario presented for the purpose of this discussion, the Veteran is shown to have full range of motion of the knee and no additional limitation of motion due to pain or during flare-ups has been reported. In the DeLuca decision, the court found additional range of motion loss due to pain or during flare-ups of pain must be considered as indicative of a higher rating. Where there is no additional loss of motion, application of the DeLuca criteria do not result in assignment of a higher rating.

  [Wednesday, September 17, 2008]

Attachment C: Inter-Rater Reliability Case Fact Pattern

Bilateral Knee Condition

The Veteran filed an original claim for service connection for knees on August 11, 2008. Veteran claims “Both Knees” on his VA Form 21-526 – started in service.

**Service information is verified as follow:**

* EOD: September 20, 2004
* RAD: September 19, 2008
* Branch: Marine Corps
* Discharge: Honorable
* Rank: E-3

**Evidence considered in granting service connection for bilateral knees:**

* VA Form 21-526
* Service treatment records (STR) for active duty for September 20, 2004, through September 19, 2008
* VA examination by QTC dated August 19, 2008

**Service Treatment Records**

* Service treatment records show complaints of intermittent bilateral knee pain while on active duty without a confirmed diagnosis
* Service treatment records show on May 8, 2008, as well as during the separation examination dated June 9, 2008 that pain was noted on left knee joint during long hikes
* Service treatment records show treatment for right knee pain in March 2005 and May 8, 2008. A diagnosis of a chronic right knee condition was not noted.

**VA Examination**

**Left Knee:** Examination revealed a normal gait, no edema, effusion, weakness, tenderness, redness, heat, abnormal movement, guarding, subluxation, locking pain or crepitus. There was positive patellofemoral compression test on the left and range of motion was decreased as well. Active flexion is limited at 135 of the normal 140 degrees, with pain at 135 degrees with active extension within normal limits at 0%. Repetitive motion of the left knee increased pain, but did not decrease range of motion. Repetitive motion did not alter fatigability, weakness or lack of endurance. There was no instability noted on the examination and x-rays were negative. The examiner diagnosed patellofemoral syndrome, left knee. Consideration was given to additional loss after repetitive movement.

**Right Knee:** Examination revealed there was no evidence of edema, effusion, weakness, tenderness, redness, heat, abnormal movement, guarding of movement, subluxation, locking pain or crepitus. The patellofemoral compression test was negative on the right side. Range of motion was active flexion to 140 degrees and active extension to 0 degrees. Range of motion was not limited by pain, fatigue, weakness, lack of endurance, or incoordination following repetitive use. Medial and lateral collateral ligaments, anterior and posterior cruciate ligaments and medial and lateral meniscus reveal no instability. McMurray's and drawer tests were normal, bilateral. No additional limitation in degrees after repetitive use was noted. X-ray revealed no significant findings. The examiner noted no evidence of right knee pathology.

**Results:**

**Left Knee**: Service connection for left knee patellofemoral pain syndrome is established as directly related to military service. An evaluation of 10 percent is assigned because the VA examination shows functional impairment from the reports of intermittent pain, as well as the examiner’s findings of a positive patellofemoral compression test, limited flexion to 135 degrees and full extension to 0, with pain after repetitive use which does not additionally limit the joint function. A higher evaluation of 20 percent is not warranted because the VA examination does not show flexion is limited to 30 degrees; or extension is limited to 15 degrees; or there is instability that would warrant a separate evaluation. (DC – 5260; 10% effective 09-20-2008)

**Right Knee**: Service connection for right knee condition is denied because the medical evidence of record fails to show that this disability has been clinically diagnosed. Although there was evidence of right knee pain in service, there is no current evidence of a diagnosis of a chronic condition; therefore, service connection is denied. (DC – 5260; denied service connection)

Attachment D: Inter-Rater Reliability Case Fact Pattern

Low Back Condition

The Veteran filed an original claim for service connection for a low back condition on July 11, 2007. He claimed “back condition” on his VA Form 21-526, which started in service.

**Service information is verified as follow:**

* EOD: November 25, 2002
* RAD: November 24, 2006
* Branch: Army
* Discharge: Honorable
* Rank: E-4

**Evidence considered in granting service connection for back condition:**

* VA Form 21-526, Veteran's Application for Compensation and/or Pension, received July 11, 2007
* Service treatment records (STR) for service from November 25, 2002, to November 24, 2006
* DD 214
* VA Medical Center (VAMC) treatment reports dated June 19, 2007, through February 18, 2008
* VA Form 21-4138, Statement in Support of Claim received August 2, 2007
* Development letter dated August 9, 2007
* VCAA/Duty-to-Assist letter dated July 24, 2007
* VA Form 21-4176, Report of Accidental Injury in Support of Claim for Compensation or Pension, received August 22, 2007
* VCAA/Duty-to-Assist letter dated August 24, 2007
* VA examination dated January 9, 2008

**DD214 –** Veteran earned a Parachute Badge

**Service Treatment Records**

* STRs show multiple complaints of back pain
	+ March 24, 2006 complaint chronic low back pain since last jump with more frequent back spasms and radiating pain to legs. Straight leg raising test and contra lateral straight leg raising tests were positive. Anterior thigh spasm with movement was noted. No tenderness or spasms in the back were noted. Treated with chiropractic manipulation and profile. Normal lumbar spine x-ray on March 28, 2006.
	+ April 21, 2006 – complaint of chronic low back pain with radiation down both legs increased past 3 months. Veteran received profile for lumbago with no PT, jumps, runs or marches. Subsequent MRI showed evidence of minimal multilevel disc desiccation without significant herniation and mild posterior element degeneration in the lower lumbar spine and lumbosacral junction
	+ June 27, 2006 – Post deployment health assessment showed complaint of back pain (midline and lower back). Tenderness on palpation was noted.
	+ July 17, 2006 - complaint of low back pain since February 10 when the Veteran had a bad parachute jump and landed on his canteen. History of five sessions with chiropractor that helped some. Pain is aggravated by lifting and with left rotation and side bending combined. Mechanical low back pain was diagnosed.
	+ August 2006 – continued to have complaints of low back pain with intermittent spasms, although some improvement was noted.
	+ September 5, 2006 (Separation Exam) – complained of recurrent low back pain. Diagnosis was merely low back pain.
	+ November 14, 2006 - complaint of back pain during deployment in Iraq

**VA Medical Records**

* September 2007 – Complaint of low back pain with history noted of low back injury as parajumper in Army and blew over on canteen. Complaint of radiculopathy to legs. Normal x-ray. History of nine months PT profiles in service.

## VA Examination (January 9, 2008)

* Veteran stated he injured his back after a jump when he landed on a canteen
* Veteran reported symptoms of intermittent pain aggravated by standing. He reported flare-ups three to four times per month lasting two to sixteen hours. These are aggravated by lifting > 50 pounds and are relieved with rest.
* Veteran reported complaints of shooting, stabbing, and aching pain in his lower back 3-4 per month and takes Gabapentin for his symptoms
* Veteran reported profiles in service due to back pain
* VA Exam shows Veteran has normal gait; normal neurological exam, with normal sensory and motor exam
* Active (or functional) range of motion shows forward flexion of 87 degrees (normal is 90 degrees), extension of 20 degrees (normal is 30 degrees), right and left lateral flexion of 30 degrees each, right rotation of 18 degrees (normal is 30 degrees) and left rotation of 20 degrees (normal is 30 degrees). There is a total combined range of thoracolumbar motion of 205 degrees, with normal being 240 degrees.
* After repetitive motion, the examiner did not see any objective evidence of additional loss due to pain, fatigue, weakness, lack of endurance, in coordination or loss of motion. X-ray of the lumbar spine September 21, 2007, showed vertebral bodies are normal in stature in alignment and the disc spaces are well maintained.
* Diagnosis is lumbar strain.

**Results:**

* Veteran is entitled to service connection for lumbar strain as evidence showed incurrence in service and chronic residual disability. A 10 percent evaluation is assigned from November 25, 2006, the date after discharge, for the lumbar strain due to the Veteran’s combined active range of motion of the lumbar spine at 205 degrees.
* An evaluation of 10 percent is granted for forward flexion of the thoracolumbar spine greater than 60 degrees but not greater than 85 degrees; or, combined range of motion of the thoracolumbar spine greater than 120 degrees but not greater than 235 degrees. An evaluation of 10 percent is also granted for muscle spasm, guarding, or localized tenderness not resulting in abnormal gait or abnormal spinal contour or for intervertebral disc syndrome with incapacitating episodes having a total duration of at least one week but less than 2 weeks during the past 12 months.
* A higher evaluation of 20 percent is not warranted unless there is forward flexion of the thoracolumbar spine greater than 30 degrees but not greater than 60 degrees; or, the combined range of motion of the thoracolumbar spine is not greater than 120 degrees. A higher evaluation of 20 percent could also be assigned for muscle spasm or guarding severe enough to result in an abnormal gait or abnormal spinal contour such as scoliosis, reversed lordosis, or abnormal kyphosis or for incapacitating episodes of intervertebral disc syndrome having a total duration of at least 2 weeks but less than 4 weeks during the past 12 months

Attachment E: Inter-Rater Reliability Case Fact Pattern

Low Back Condition #2

The Veteran filed an original claim for lower back strain on November 7, 2007, through the pre-discharge program. Veteran claims “low back strain” on his VA Form 21-526 – no date of onset.

**Service information is verified as follow:**

* EOD: March 6, 1986
* RAD: March 31, 2008
* Branch: Air Force
* Discharge: Honorable

**Evidence considered in granting service connection for low back strain:**

* VA Form 21-526
* Service treatment records (STR) for the period March 6, 1986, to March 31, 2008
* VA examinations conducted December 4, 2007, and January 22, 2008

**Service Treatment Records**

STRs indicate the following incidents of treatment for back:

* Initial treatment for low back pain after injury on March 26, 1997 (diagnosed with muscle strain).
* Additional treatment for low back pain secondary to muscle spasm in January 2005.
* Last record of treatment for low back pain in service is dated November 2, 2007 (diagnosed with lower back sprain).

**VA Examination**

VA examination indicate the following results:

* VA Pre-discharge Examination dated December 4, 2007, provided a diagnosis of lower back strain. X-rays of the lumbar spine were normal.
* Upon examination there is noted painful and limited motion of the thoracolumbar spine with:
	+ Forward flexion of 54 degrees with pain beginning at 26 degrees
	+ Backward extension of 10 degrees with pain beginning at 6 degrees
	+ Right lateral flexion of 10 degrees with pain
	+ Left lateral flexion of 15 degrees with pain
	+ Right rotation of 15 degrees with pain
	+ Left rotation of 5 degrees with pain
* Upon repetitive use:
	+ There was pain, which did not cause additional limitation of function in degrees.
	+ There was no fatigue, weakness, and lack of endurance or incoordination.
* Examiner stated there was no additional limitation of function after repetitive motion.
* The examination elicited muscle spasm in the paraspinal muscles of the lumbar area.
* There was also no tenderness or ankylosis of the lumbar spine.
* Diagnosis low back strain.

**Veteran Reports**

The Veteran provided the following to the VA examiner:

* History of low back pain for an estimated 7 years, which occurs approximately 20 times per month and lasts for 3 hours.
* Pain described as burning and sharp and is exacerbated with prolonged sitting, standing, running, or walking.
* Report of an incapacitating episode, which lasted for two days during the prior twelve-month period.

**Results:**

The evidence shows lumbar strain, which began in service and has continued throughout service. Therefore, service connection for lumbar strain is warranted.

The evidence shows:

* Forward flexion of the lumbar spine of 54 degrees.
* Combined range of motion of 106 degrees to warrant a 20 percent evaluation.

The evidence does not show:

* Ankylosis of the thoracolumbar spine
* Forward flexion of 30 degrees or less to warrant a higher evaluation.

Therefore, a 20 percent evaluation is assigned effective April 1, 2008, the first day following separation from service.

A higher evaluation of 40% is not warranted unless there is forward flexion of the thoracolumbar spine of 30 degrees or less; or, favorable ankylosis of the entire thoracolumbar spine.

Practical Exercise

Directions: Given the scenarios below, answer the following questions.

# DeLuca Fact Pattern #1

The Veteran is service connected for left knee tendonitis, currently evaluated at 10 percent disabling under DC 5024. He files a claim for an increased evaluation of his left knee disability.

At his VA examination, the Veteran reports the following symptoms: weakness, stiffness and locking. He does not have swelling, heat, redness, giving way, lack of endurance, fatigability or dislocation. Due to the condition, he has had pain located in his left knee for 10 years. The pain occurs 2 times per week and each time lasts for 2 hours. The pain is localized. The characteristic of the pain is aching. From 1 to 10 (with 10 being the worst pain), his pain level is at 7. The pain can be elicited by physical activity. The pain comes by itself. Rest relieves it. At the time of pain, he takes over the counter (OTC) medication. The claimant is not receiving any treatment for his condition. He has not had any prosthetic implants of the joint. He reports the following functional impairments: no long distance running.

Physical examination of the left knee reveals the following: On the left there is tenderness. The left knee shows no sign of edema, effusion, weakness, redness, heat or guarding of movement. There is no subluxation. Examination of the left knee reveals crepitus. There is no genu recurvatum or locking pain.

Range of motion (ROM) of left knee shows flexion is 120 degrees with pain at 120 degrees and extension is 0 degrees with pain at 0 degrees. The joint function is not additionally limited by pain, fatigue, weakness, lack of endurance, or incoordination after repetitive use. The anterior and posterior cruciate ligaments stability test of the left knee is within normal limits. The medial and lateral collateral ligaments stability test is within normal limits. The medial and lateral meniscus test is within normal limits. X-rays are within normal limits.

The examiner provides a diagnosis of left knee tendonitis. The subjective factors are left knee pain. The objective factors are left knee tenderness and pain with ROM. The joint function is not additionally limited by pain, fatigue, weakness, lack of endurance, or incoordination after repetitive use.

Is this examination considered sufficient?

How would you evaluate the Veteran’s left knee disability? Why?

# *DeLuca* Fact Pattern #2

The Veteran files a claim for service connection for a low back condition, due to supply boxes falling on him in service. Service treatment records confirm the accident in service, with treatment for recurrent low back pain. The evidence of record shows that service connection for the claimed disability is warranted. Below are findings from the Veteran’s VA examination.

The Veteran reports he has had low back pain since his accident in service. He has been told that he had degenerative changes in the back. He has stiffness, weakness, and pain on a daily basis. The pain is sticking, cramping, or burning. He rates it a 9/10 in severity. It is increased with physical activity. It comes on by itself. He can function with the use of ibuprofen. He has not been incapacitated.

Physical examination of the thoracolumbar spine reveals no evidence of radiating pain on movement. Muscle spasm is not present There is tenderness noted on exam. There is negative straight leg raising test bilaterally. There is no ankylosis of the lumbar spine. Range of motion of the thoracolumbar spine is as follows:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Movement | Normal ROM | ROM in degrees | Degree that pain occurs |
|  | Flexion | 0 to 90 degrees | 65 | 55 |
|  | Extension | 0 to 30 degrees | 25 | 25 |
|  | Right Lateral flexion | 0 to 30 degrees | 25 | 25 |
|  | Left Lateral flexion | 0 to 30 degrees | 25 | 25 |
|  | Right rotation | 0 to 30 degrees | 25 | 25 |
|  | Left rotation | 0 to 30 degrees | 25 | 25 |

The Veteran complained of pain with repetitive motion at the degrees noted above.

The joint function of the spine is additionally limited by the following after repetitive use: pain and fatigue, and pain has the major functional impact. It is not additionally limited by the following after repetitive use: weakness, lack of endurance, incoordination. Pain additionally limits the joint function as described above with flexion limited to 55 degrees.

There is symmetry of spinal motion with normal curvatures of the spine. There are no signs of intervertebral disc syndrome. Gait is within normal limits.

X-ray of the lumbar spine reveals degenerative changes of vertebral bodies II, IV, and V consistent with degenerative arthritis, and a final diagnosis of degenerative arthritis of the lumbar spine is provided.

Is this examination considered sufficient?

How would you evaluate the Veteran’s lumbar back disability? Why?

# *DeLuca* Fact Pattern #3

The Veteran files a claim for service connection for cervical strain, due to a motor vehicle accident in service. Service treatment records confirm the accident in service, with treatment for recurrent neck pain. The evidence of record shows that service connection for the claimed disability is warranted. Below are findings from the Veteran’s VA examination:

The Veteran reports being diagnosed with neck strain. The condition has existed since a car accident in service. She reports the following symptoms from the spine condition: stiffness. She has no visual disturbances, weakness, numbness, fevers, bladder complaints, malaise, bowel complaints, or dizziness. She states she has not lost any weight due to the condition. She has had pain located at the neck. The pain occurs 2 times per month and each time lasts for 0.5 days. The pain is localized. The characteristic of the pain is aching, sharp, and cramping. From 1 to 10 (10 being the worst pain) the pain level is at 8. The pain is elicited by physical activity. The pain can come on by itself. It is relieved by rest and OTC medication. She is not receiving any treatment for her condition. She states her condition has not resulted in any incapacitation.

Physical examination reveals no evidence of radiating pain on movement. There is evidence of muscle spasm cervical. There is tenderness cervical. There is no ankylosis of the cervical spine.

Range of motion of the cervical spine is as follows:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Movement | Normal ROM | ROM in degrees | Degree that pain occurs |
|  | Flexion | 0 to 45 degrees | 35 | 15 |
|  | Extension | 0 to 45 degrees | 35 | 15 |
|  | Right Lateral flexion | 0 to 45 degrees | 35 | 35 |
|  | Left Lateral flexion | 0 to 45 degrees | 35 | 35 |
|  | Right rotation | 0 to 80 degrees | 70 | 70 |
|  | Left rotation | 0 to 80 degrees | 70 | 70 |

The Veteran complained of pain with repetitive motion at the degrees noted above.

There is symmetry of spinal motion with normal curvatures of the spine. There are no signs of intervertebral disc syndrome. Neurological examination of the upper extremities is within normal limits. Gait is within normal limits. The cervical spine x-ray findings are within normal limits. Diagnosis is chronic cervical strain.

The examiner provides the following statement, “The Veteran has chronic cervical strain. She has mild pain on in all ranges of motion, however she only describes significant pain twice a month. She is able to function through the pain. There are no neurological abnormalities and her X-rays are normal. Considering pain, fatigue, weakness, lack of endurance, and incoordination on repetitive use and flare-ups, pain has the major functional impact resulting in additional loss of range of motion of 10 degrees in flexion and extension. Therefore, flexion is 25 degrees; extension 25 degrees; right lateral flexion 35 degrees; left lateral flexion 35 degrees; right rotation 70 degrees; left rotation 70 degrees.”

Is this examination considered sufficient?

How would you evaluate the Veteran’s neck disability? Why?