VBA Training and Performance Support System (TPSS)

Basic Ratings—Prerequisite Training

Trainee Workbook

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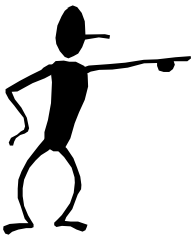
Responsibility

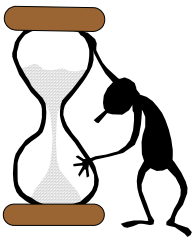


Rating Specialists are tasked with deciding eligibility for many benefits, including disability compensation, special monthly compensation (SMC), pension, special monthly pension (SMP), as well as various ancillary and other benefit entitlements.

Rating Specialist decisions acutely affect the lives and fortunes of millions of beneficiaries and involve billions of dollars of federal funds. This kind of responsibility demands persons of intelligence and compassion, gifted with the ability to rationalize complex issues and arrive at balanced and equitable conclusions.

Rating specialists are required to apply the provisions of numerous laws, regulations, procedures, precedential decisions of the U.S. Court of Appeals for Veterans Claims, General Counsel Opinions, and other legal precedents governing the benefits administered by the Department of Veterans Affairs (VA). Today, we're going to focus on two goals: establishing a familiarity with medical terminology and developing an understanding of the use of the Rating Schedule.

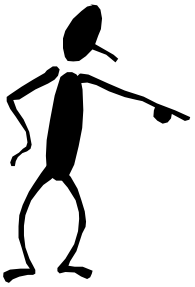
Conduct and Attitude



The mission of the Veterans Benefits Administration, in partnership with the Veterans Health Administration and the National Cemetery System, is to provide benefits and services to veterans and their families in a *responsive, timely* and *compassionate manner* in recognition of our veterans' service to the Nation. The VA's vision is to become an organization that:

- is easily accessible by veteran customers for all benefits and services;
- rapidly and accurately processes requests for benefits;
- provides clear, understandable, timely and informative communications;
- serves as a good steward of the resources entrusted for our use;
- provides employees with training opportunities and job satisfaction.

Conduct and Attitude (cont.)

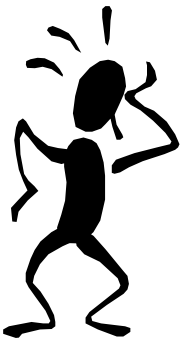


In keeping with the mission and vision of the VA, Rating Specialists are obligated to present and view each claim in a compassionate and responsive manner. Rating Specialists should recognize that each claim folder represents a veteran, or veteran's dependent, seeking benefits to which they may be entitled by law. Rating Specialists owe these persons the fundamental obligation of giving credence to their contentions, respecting their rights, and treating them with the dignity and compassion they deserve.

You should never allow personal feelings to enter into the rating process, no matter what the attitude on the part of the claimant. The Rating Specialist should make certain that fairness and courtesy are shown to the claimants, and should maintain objectivity in evaluating evidence and making decisions.

Lesson 1: Medical Terminology

Origins and History



There is a wealth of evidence you'll be expected to review in making a rating decision. It is therefore imperative to have a basic understanding of the fundamentals of medical terminology in order to comprehend exam and treatment reports, and apply the provisions of the Rating Schedule.

Learning the language of medicine is very much like learning a foreign language, and in many aspects, is a foreign language, as the majority of medical terms have their origin in ancient Greek and Latin. Medical terms are often comprised of word parts. This lesson will discuss some of the more common word roots, suffixes and prefixes found in medical terminology.

This lesson is not meant to be all inclusive, but should provide a general familiarity with medical terminology and an understanding of word structure to provide the Rating Specialist with the tools needed to understand evidence submitted in support of a claim and apply provisions of current laws and regulations.

Origins and History (cont.)

Most medical terms have their origins in ancient Greek and Latin. This is because many of these word parts were developed by Aristotle, a Greek philosopher and scientist (c. 384-322 B.C.) and by Hippocrates, (c. 460-375 B.C.), a Greek physician and teacher of medicine, known for the Hippocratic Oath. In later years, the works of these early scientists were translated into Latin, the basis of much of our language. A background in ancient Greek or Latin is not essential for an understanding of medical terminology, but those who have studied these languages will recognize many of the word parts.

Some examples:

Cirrhosis, a condition of the liver, from the Greek *kirrhos* meaning orange-yellow. This disease in later stages may be characterized by a jaundice, or yellowing of the skin.

Maxilla, upper jaw bone, from the Latin *maxillaris* meaning jaw bone.

Mandible, or lower jaw bone, from the Latin *mandere*, meaning to chew.

Myopia, or nearsightedness, from the Greek *myein* meaning to shut and the Greek *ops* meaning eye.

Porphyria Cutanea Tarda, a skin condition characterized by photosensitivity, causing scarring hyperpigmentation, originates from both Greek and Latin. The Greek *porphyra* meaning purple, the Latin *cutis* means skin and *tardus* means late.

Venogram, study of the veins, from the Latin *vena* meaning vein, and the Greek *graphein* meaning to write.

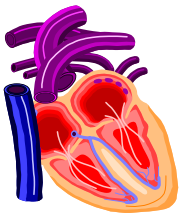
Zygoma, the cheekbone, originates from the Greek *zugoun*, meaning bolt or bar.

Medical terms may also be based on personal names, such as **Alzheimer's Disease** (a degenerative disease of the brain) which is named for a German neurologist, Alois Alzheimer (1864-1915). These are called eponyms. Another example would be **Hodgkin's Disease**, a malignant lymphoma (cancer of lymph nodes), named after Thomas Hodgkin, an English physician (1798-1866).

Word Parts

As previously stated, medical terms are often comprised of word parts. Word parts are classified as word roots, suffixes and prefixes. Word roots contain the basic meaning of the word. Suffixes and prefixes modify the word; with prefixes attached to the beginning of the word root and suffixes attached to the end of a word root. Sometimes, a medical term will have more than one word root.

A combining vowel may be used to connect the various word parts together, usually connecting word roots and suffixes and to connect two word roots together. Usually, if the suffix begins with a vowel, a combining vowel is not needed. The combining vowel serves to ease pronunciation of the word.



Examples:

CARDIAC pertaining to the heart
card/i/ac
The word root **card** means **heart**
The suffix -**ac** means **pertaining to**
The combining vowel **i** is used to join the suffix with the word root

HEPATITIS an inflammation of the liver
hepat/itis
The word root **hepat** means **liver**
The suffix **-itis** means **inflammation of**

PULMONOLOGIST an individual skilled in the study of the lungs
pulmon/o/logist
The word root **pulmon** means **lung**
The suffix **-logist** means **one who studies**
The combining vowel **o** is used to join the word parts

TACHYCARDIA a rapid heart rate
tachy/card/ia
The word root **card** means heart
The prefix **tachy** means **rapid**
The suffix **ia** means **abnormal state**

Word Parts (cont.)

The Rating Specialist should note that not all medical terms will have a suffix, prefix, and/or combining vowel. Usually, if the suffix begins with a vowel, a combining vowel is not needed, except when connecting two word roots. For example:

OSTEOARTHRITIS a degenerative joint disease
oste/o/arthr/itis
The word root **oste** means **bone**
The word root **arthr** means **joint**
The suffix **-itis** means **inflammation of**
The combining vowel is **o**

The Rating Specialist may begin building medical terminology vocabulary by learning word parts listed below and by reading treatment and examination reports.

The word parts presented here are in their combining form, which includes the usual combining vowel which will be inserted when the word root is combined with a suffix or with another word root. Note that some word roots may also be used as suffixes.

Table 1 — Word Parts Related to Body Structure and Systems:

Word Part	Definition	Example
acr/o	*limbs*	acromegaly, enlargement of hands and feet
aden/o	*gland*	adenocarcinoma, cancer derived from glandular tissue
-al, ar, -ic, -ous	*pertaining to*	psychosomatic, pertaining to the interaction of mind and body
-algia	*pain*	arthralgia, painful joints
an-, a-	*without, not*	anemia, lack of red blood cells; asymptomatic, without symptoms; atrophy-decrease in size, as opposed to hypertrophy-over developed; arrhythmia, variation from normal heart rhythm
ang/i, ang/io	*vessel*	angiogram, an x-ray study of blood vessels
-angio	*vessel*	angioplasty, procedure that dilates blood vessel to eliminate areas of narrowing
ankylo-	*crooked, stiff or bent*	ankylosis, inability of motion
anti-	*against*	antitoxin, an agent against a poison
arteri/o	*artery*	polyarteritis, inflammation of many sites in the arteries
arthr/o	*joint*	arthroscopy, a visual study of a joint
ather/o	*yellowish, fatty plaque*	atherosclerosis, hardening of the arteris due to deposits of fatty plaque on arterial wall
ather/o	*fatty plaque*	atherosclerosis, deposits of plaques (atheromas) on inner walls of arteries
aud/i, aud/io	*hearing*	audiometry, a measurement of hearing
bi-	*both, two*	bilateral, both sides
blasto/o	*developing cell*	blastoma, a growth (osteoblastic)
blephar/o	*eyelid*	blepharitis, an inflammation of the eyelid
brady-	*slow*	bradycardia, slowness of heart beat
carcin/o, cancer/o	*cancer*	carcinoma, cancerous growth

Word Part	Definition	Example
cardi/o	*heart*	cardiomyopathy, disease of the heart muscle
-cele	*protrusion or swelling, hernia*	varicocele, varicose condition of veins forming a swelling; hydrocele, collection of fluid, especially in the testicle
cephal/o	*head*	cephalalgia, headache
cervic/o	*neck*	cervical, pertaining to the neck or cervical spine
chol-	*bile*	cholemia, excess bile in the blood
cholecyst/o	*gallbladder*	cholecystectomy, removal of gallbladder
chondr/o	*cartilage*	costochondritis, inflammation of junction of rib and cartilage
chondr/o	*cartilage*	chondromalacia, softening of the (usually knee) cartilage
col/o	*colon*	colostomy, create an artificial opening to the colon
cost/o	*ribs*	costal, pertaining to the ribs
crani/o-	*skull bones*	craniotomy, surgical opening into the skull
-crit	*to separate*	hematocrit, blood count
cutane/o	*skin*	subcutaneous, below the skin
cyst/o	*urinary bladder*	cystitis, inflammation of the urinary bladder
cyt/o	*cell*	leukocyte, white blood cell
derm/o, dermat/o	*skin*	dermatophytosis, fungal infection of the skin
dia-	*through*	diarrhea, a flowing through
duoden/o	*duodenum*	duodenitis, inflammation of duodenal mucosa
dys-	*difficult, abnormal, painful*	dysphagia, difficulty swallowing
-ectomy	*excision, cut out*	gastrectomy, removal of part of the stomach
-emia	*blood condition*	hypoproteinemia, abnormally low level of protein in the blood

Word Part	Definition	Example
encephal/o	*brain*	encephalopathy, degenerative disease of the brain
endo-	*within*	endocarditis, inflammation of lining membranes of the heart
enter/o	*intestines*	gastroenteritis, acute inflammation of stomach and intestines
esophag/o	*esophagus*	esophagitis, inflammation of the esophagus
eti/o	*cause of disease or injury*	etiology, study of causes of disease
ex-, exo-	*out of*	exostosis, a bony growth projecting outward from the surface of a bone
gastr/o	*stomach*	gastritis, inflammation of the stomach
glyc/o	*relationship to sugars*	glycemia, presence of glucose in the blood
gno/o	*knowledge*	prognosis, prediction of outcome of a disease (pro- before)
-gram, -graphy	*record, x-ray, recording*	electromyography, process of recording electrical properties of muscles
gyn/o, gynec/o	*woman*	gynecology, study of diseases of women
hemat/o, hem/i, hem/a	*blood*	hematocrit, blood count
hemi-	*half*	hemisphere, half of a spherical structure
hepat	*liver*	hepatectomy, removal of the liver
hernio	*hernia*	herniography, radiographic exam of a hernia
hist/o	*tissue*	histology, study of tissues, including cellular composition
hydro-	*water, fluid*	hydrothorax, fluid in the pleural cavity hydronephrosis, distention of the kidney caused by accumulation of urine
hyper-	*above, excessive*	hyperacidity, excessive acidity hyperthyroidism, excessive secretions of thyroid gland

Word Part	Definition	Example
hypo-	*below, lack of, deficiency*	hypotension, low blood pressure
hyster/o	*uterus*	hysterectomy, removal of uterus
-iasis	*disease producing characteristics*	psoriasis, chronic skin disorder with psoriatic lesions
-iatr	*physician, medicine*	psychiatrist, one who studies mental disorders
inter-	*between*	intercellular, between cells
intra-	*within*	intracellular, within cells
isch/o	*blockage, deficiency*	ischemia, deficiency of blood due to constriction or obstruction of blood vessel
-itis	*inflammation; inflammation of*	pancreatitis, inflammation of the pancreas; gastritis, inflammation of stomach
kyph/o	*vertebra, vertebral column*	kyphosis, abnormal condition of vertebral column - an increased convexity in the curvature of the thoracic spine
labyrinth-	*channel of the inner ear*	labyrinthitis, inflammation of the inner ear
lapar/o	*abdomen*	laparoscopy, visual examination into the abdomen
laryng/o	*larynx*	laryngitis, inflammation of larynx
ligament/o	*ligaments (connect bones to other bones)*	ligamentous injury, an injury related to the ligaments
lip/o	*fat*	lipoma, benign tumor of fat cells
lith/o	*stone*	cholelithiasis, gallstones
-logist, -logy	*one who studies, the study of*	gastroenterologist, specialist in digestive system
-logos, logy	*study of*	oncology, study of tumors
lumb/o	*lower back*	lumbar, pertaining to low back
-lysis	*loosening, dissolution*	hemolysis, breakdown of red blood cells dialysis, method used to separate smaller

Word Part	Definition	Example
		particles from larger ones
-lytic	*destroy, reduce*	osteolytic process, destruction of bone
malacia-	*softening*	osteomalacia, softening of the bones
mamm/o, mast/o	*breast*	gynecomastia, excessive development of male mammary glands
-megaly	*enlargement; large*	hepatomegaly, enlargement of the liver; splenomegaly, enlarged spleen
men/o	*menstruation*	dysmenorrhea, painful menstruation
meta-	*after, beyond*	metamorphosis, change in shape or structure from one type to another
metr/o	*uterus*	endometrium, mucous membrane lining the uterus
-metry	*measurement*	audiometry, measurement of hearing
morph/o-	*form, shape*	metamorphosis, change in shape or structure from one type to another
my/o	*muscle*	fibromyalgia, painful fibromuscular tissue
myel/o	*bone marrow, or spinal cord*	osteomyelitis, inflammation of bone and bone marrow, myeloma, malignant neoplasm of bone marrow
nas/o	*nose*	nasoscope, an instrument for viewing nasal cavity
necr-	*death*	necrosis, death of cells or organs
neo-	*new*	neoplasm, new growth
nephr/o	*kidney*	hydronephrosis, distention of kidney with urine
neur/o	*nerve*	neurosis, mental disorder characterized by anxiety, obsession, phobias, with unimpaired reality testing
-oid	*resembling*	mucoid, resembling mucous
-ologist	*one who studies*	psychologist, one who studies human and animal behavior, and related mental

Word Part	Definition	Example
		processes
-oma, onc/o	*tumor*	neuroma, tumor of nerves oncologist, specialist in study of tumors;
onych/o	*nail*	onychomycosis, fungal infection of nails
oophor/o	*ovary*	oophorectomy, removal of ovary
-opia	*vision*	hypertropia, upward deviation of the eye
orch/o	*testis, testicle*	orchiectomy, removal of testis
organ/o	*organ*	organomegaly, enlarged internal organs
-orrhagia,	*rapid flow of blood*	hemorrhage, excessive bleeding
-orrhaphy	*suturing, repairing*	herniorrhaphy, surgical repair of hernia
-osis	*abnormal condition, a disorder*	ankylosis, inability of motion; asbestosis, abnormal condition involving asbestos
oste/o	*bone*	osteopathic, pertaining to any disease of a bone
-ostomy	*create an artificial opening*	colostomy, surgical creation of opening out of the colon
ot/o	*ear*	otopathy, any disease of the ear
-otomy, -tomy	*cut into, incision*	tracheotomy, incision of the trachea
para-	*near, beside*	paraspinal muscles, muscles next to the spine
-paresis	*incomplete paralysis*	hemiparesis, partial paralysis affecting one side of the body
patell/o	*kneecap*	patellofemoral, pertaining to the kneecap and femur
path/o-, pathy	*disease*	pathology, study of diseases
-penia	*deficiency*	erythropenia, deficiency of red blood cells
peri-	*around*	pericarditis, inflammation of the pericardium (lining around the heart)

Word Part	Definition	Example
phage-	*to eat*	dysphagia, difficulty swallowing
phalang/o	*phalanx (finger or toe bone)*	interphalangeal, between the phalanges
pharyng/o	*pharynx*	nasopharyngitis, inflammation of nose and pharynx
phleb/o	*vein*	phlebitis, inflammation of a vein
phono-	*sound*	aphonia, loss of voice
photo-	*light*	photophobia, fear of light
-plasia	*growth, formation*	dysplasia, abnormal growth
plasma	*formation*	neoplasm, new growth
plasty-	*surgical repair*	thoracoplasty, surgical resection of the ribs
-plegia	*paralysis*	paraplegic, paralysis of legs and lower part of the body
pneum/o	*lung, air*	pneumothorax, accumulation of air in pleural space, pneumonia, pertaining to lungs (infection)
post-	*after*	post-operative, after operation, following surgery
proct/o	*rectum*	proctologist, specialist in diseases of the rectum
pseud/o	*false*	pseudoarthrosis, a false joint
psycho, psych, psyche	*the mind, mental*	psychosis, a mental and behavioral disorder
-ptosis	*drooping, downward displacement*	nephroptosis, abnormal downward placement of kidney
pulmon/o	*lung*	pulmonologist, one who studies disabilities of the lung
py/o	*pus, infection*	pyoderma, infection of the skin (such as impetigo)
ren/o	*kidney*	renal, pertaining to the kidney

Word Part	Definition	Example
rhin/o	*nose*	rhinitis, inflammation of nasal mucous membrane
-rrhea	*flow, discharge*	rhinorrhea, discharge from the nose
salping/o	*fallopian tube*	salpingectomy, removal of fallopian tube
sarc/o	*connective tissue, flesh*	sarcoma, tumor made of connective tissue
scler/o, -sclerosis	*hardening*	arteriosclerosis, hardening of the arteries
scoli/o	*crooked, curved*	scoliosis, abnormal curvature of spine
-scopy	*visual exam*	duodenoscopy, visual examination of duodenum
somat/o	*body*	somatic, pertaining to the body
spir/o	*breath*	spirometry, measurement of breathing capacity of lungs
splen	*spleen*	splenomalacia, softening of the spleen
spondyl/o	*vertebra, vertebral column*	spondylosis, abnormal condition of the vertebral column
-stasis	*control, stop*	metastasis, beyond control, spread of a tumor beyond its original site
sub	*below, beneath*	subpulmonary, below the lungs
synovi/o, synovia	*fluid, secreted by the synovial membrane, which lubricates joints*	synovitis, inflammation of synovial membrane
system/o	*system, body*	systemic, pertaining to the body as a whole
tachy-	*fast, rapid*	tachycardia, rapid heart rate
ten/o, tend/o	*tendons (a fibrous cord which connects muscles to bones)*	tendonitis, inflammation of tendons
thorac/o-	*chest*	thoracotomy, surgical incision into chest wall

Word Part	Definition	Example
thromb/o	*blood clot*	thrombectomy, removal of a thrombus (clot)
trans	*through, across*	transcortical, across or through the cortex of the brain
-trophy	*nourishment, development*	atrophy, a wasting away (of muscle, tissues or organs)
tropia-	*turning*	exotropia, outward turning of one eye
uni-	*one*	unilateral, one sided
vas/o	*vessel, duct*	vasoconstriction, constriction of blood vessels

Table 2 – Word Roots Related to Color:

Word Part	Definition	Example
cyan/o	*blue*	cyanosis, abnormal blue condition
erythr/o	*red*	erythema, redness, erythrocyte, red blood cell
leuk/o	*white*	leukocyte, white blood cell
melan/o	*black*	melena, dark stools
ecchym/o	*purple*	ecchymosis, a bruise, purplish discoloration
xanth/o	*yellow*	xanthosis, abnormal condition of yellow

Exercise 1 

Medical Terminology

Task
In a learning pair, correctly determine the meaning of various medical terms/conditions by breaking the term into its word parts.

Materials
List of 12 medical terms of the following two pages.

Criteria for Success
Trainees correctly break the medical terms into their word parts and determine their definitions.

Cooperative Goal
The mutual goal is to ensure that both partners understand the strategy of breaking medical terms into word parts to determine the meaning of the terms.

Individual Accountability
Instructor will randomly choose trainees to give an answer and explanation for selected problems.

Roles
Explainer: Explains step by step how to determine the meaning of the medical term by breaking it up into word parts.

Accuracy Checker: Verifies that the explanation is accurate and provides encouragement.

Procedure
1. **Person A (the explainer)** reads question 1 and determines the answer. You will divide the medical term into word parts by inserting lines in the correct place, define each word part, determine the definition to the entire term, and write this on your worksheet. **Person B (the accuracy checker)** either agrees or disagrees to determine the accuracy of the answer, and provides encouragement. Once you both agree, you will write the solution on your worksheet as well.

2. **Person B (now the explainer)** will explain the strategy to determine question 2, while **Person A (now the accuracy checker)** checks for accuracy and provides encouragement.

3. Continue to alternate these roles until all the medical terms are defined.

Time Allotted: 30 minutes

Exercise 1

Medical Terms Worksheet

1. A d e n o p a t h y

Word parts:

Definition:

2. E n d o m e t r i o s i s

Word parts:

Definition:

3. E n t e r o c o l i t i s

Word parts:

Definition:

4. H y p e r c h o l e s t e r o l e m i a

Word parts:

Definition:

5. H y d r a r t h r o s i s

Word parts:

Definition:

6. H y p e r l i p i d e m i a

Word parts:

Definition:

7. Intravascular

Word parts:

Definition:

8. Myocardial

Word parts:

Definition:

9. Nephrolithiasis

Word parts:

Definition:

10. Osteoporosis

Word parts:

Definition:

11. Salpingectomy

Word parts:

Definition:

12. Tenosynovitis

Word parts:

Definition:

Planes of Movement

In applying the provisions of the Rating Schedule, it will be necessary to understand basic planes of movement of affected joints and muscles. Range of motion studies will be requested of examiners in evaluating specific disabilities. These studies provide, expressed in terms of degrees, the capability of the affected joint or muscle, and such information is required in determining the level of disability (that is, the percentage evaluation assigned).

Table 3 – Medical Terms Related to Planes of Movement

Word	Definition
Abduction	(ab- away from) to bring away from the center or medial line of the body
Active Motion	Movement of a limb caused by its own muscle action
Adduction	(ad- toward) bring toward the center or medial line of the body
Ankylosis	the immobility (no motion occurs) of a joint due to disease, injury, or surgical procedure
Dorsiflexion	the backward bending of the hand or foot, that is, the upward movement of the hand or foot (for these joints only, this may also be called extension)
Eversion	turning outward (used in evaluating the ankle)
Extension	the straightening of a flexed extremity. The movement of separating bone more widely (except for the ankle and hand, where downward movement of the foot or hand is referred to as plantar flexion)
Flexion	the act of bending, or decreasing the angle at the joint between bones by bringing the bones closer together
Inversion	turning inward (used in evaluating the ankle)
Passive Motion	Motion caused by an outside force. The examiner will usually furnish the claimant's range of motion abilities in both passive and active testing
Plantar Flexion	the downward motion of the foot or hand toward the ground
Pronation	the turning of the palm or hand so the palm faces downward
Subluxation	an incomplete or partial dislocation
Supination	Turning the palm upward
Valgus	Bending outward, an angulation away from the midline of the body
Varus	Bending inward, turning toward the midline of the body

Positional and Directional Terms

In identifying location of various body organs, structures, diseases and injuries, it is important to have a general knowledge of positional and directional terms as they apply to the body:

Table 4 – Words Related to Position and Direction as they apply to the body

Word	Definition
Anterior	toward the front of the body
Deep	away from the surface of the body, toward the interior of the body
Distal	away from the medial axis, or the area farthest away from the beginning of a structure, or point of origin
Dorsal	pertaining to the back or posterior aspect (the back of the hand or top of the foot)
Inferior	situated below another structure
Lateral	pertaining to the side, on the outer side of the body
Medial	pertaining to the middle of the body. If you were to divide the body in half lengthwise, to a left and right side, the middle dividing line would be the medial axis
Plantar	pertaining to the undersurface (sole of the foot)
Posterior	toward the back of the body
Proximal	is the area closest to the center midline of the body, or the area closest to the beginning of the structure, or point of origin
Superficial	near the surface, as in a superficial flesh wound
Superior	situated above another structure

Table 5 – Positional Terms Used to Describe Certain Body Areas

Word	Definition
Abdominal Cavity	contains the stomach, intestines, kidneys, liver, gallbladder, pancreas, spleen
Cranial Cavity	area inside the skull (cranium)
Femoral	thigh area
Hallux	the large or great toe
Pelvic Cavity	contains the bladder, certain reproductive organs, parts of the large intestine, rectum
Peroneal	side of the leg
Popliteal	back of the knee
Sacral	that area beneath the low back, between the hips
Spinal Cavity	area inside the spinal column
Tarsal	the ankle
Thoracic Cavity	also known as the chest cavity, containing heart, lungs, esophagus, trachea

Exercise 2 

Medical Jeopardy!

Task

In teams of 3, play Medical Terminology Jeopardy!
Given answers to questions pertaining to medical terms, positional and directional terms, terms related to planes of movement, and terms to describe certain body areas, provide the correct question.

Materials

Jeopardy! game paper (regular lined paper), pencil, PowerPoint slides with answers.

Criteria for Success

Trainee correctly presents the question that goes with the answer. Points are awarded for each correct question.

Cooperative Goal

The goal is for each team to accumulate as many points as possible. The team with the highest point value wins.

Individual Accountability

Instructor randomly selects a "Contestant" to provide the class with the correct question.

Roles

Contestant: Records question on game paper and responds with the question if called upon. (The 1st Contestant is the person in the group whose birthday is chronologically first in the year; the 2nd Contestant's birthday is chronologically second; and so on.)

Researchers: Look up information as directed by the "Contestant."

Procedure

1. An answer is projected on the screen.
2. The Contestant will direct the Researchers to look up information if necessary.
3. The Contestant will write the question on the game paper and will share his/her question if called upon.
4. The team members will rotate roles for the next answer.

Time Allotted: 90 minutes

Abbreviations

In understanding the Rating Schedule, Service Medical Records, VA and private treatment reports, discharge summaries, and examination reports, it is imperative to have a knowledge of the many abbreviations used in describing and treating various disabilities.

There is a booklet entitled “Medical References” published by Compensation & Pension Service Training Operations, that is available on the VBA Intranet, which contains descriptions of various medical tests, signs and reflexes. It also includes medical symbols, common prefixes and suffixes, and medical abbreviations. This document is available for you to refer to as needed.

Some of the more common abbreviations found in the evidence and documents a Rating Specialist are provided in this document. Please realize that many times there are multiple definitions for the same abbreviation. You will need to refer to the context of the report to determine which definition is best.:

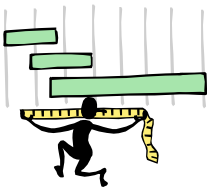
Table 6 – Abbreviations

Abbreviation	Meaning
AC	Acromioclavicular
AROM	Active range of motion
BP	Blood pressure
C/C/E	Clubbing, cyanosis, edema
CHF	Congestive heart failure
CO	Carbon monoxide
COPD	Chronic obstructive pulmonary disease
CTA	Clear to auscultation (lungs)
CTS	Carpal Tunnel Syndrome
CVA	Cerebrovascular accident
DDD	Degenerative disc disease
DJD	Degenerative joint disease
DM	Diabetes Mellitus
DTR	Deep tendon reflex
DX	Diagnosis

Abbreviation	Meaning
ENT	Ear, nose and throat
EOM	Extraocular movement
EPTS	Existed prior to service
FAROM	Full active range of motion
FROM	Full range of motion
FX	Fracture
GI	Gastrointestinal
GSW	Gunshot wound
GU	Genitourinary
HEENT	Head, eyes, ears, nose and throat
HFHL	High frequency hearing loss
H/O	History of
HX	History
JVD	Jugular venous distention
LBP	Low back pain
LT, L	Left
MEB	Medical Evaluation Board
MI	Myocardial infarction
NAD	No acute distress
NCD	Not considered disabling
NEG	Negative
NML / NL	Normal
NVD	Nausea, vomiting, diarrhea
PE	Physical exam
PEB	Physical Evaluation Board
PERRLA(C)	Pupils equal, round, reactive to light and accommodation
PFT	Pulmonary function test
PT	Patient; physical therapy; physician training
PVD	Peripheral vascular disease
RBC	Red blood cell

Abbreviation	Meaning
RFB	Retained foreign body
R/O	Rule Out
ROM	Range of motion
RRR	Regular rate and rhythm (heart)
RT, R	Right
RX	Prescription
SLR	Straight leg raising
SMR	Service Medical Record
SOB	Shortness of breath
S/P	Status post
TDRL	Temporary disability retirement list
TPR	Temperature
TX	Treatment
WBC	White blood cell
WNL	Within normal limits
Y.O.	Years old

Tests, Signs and Reflexes



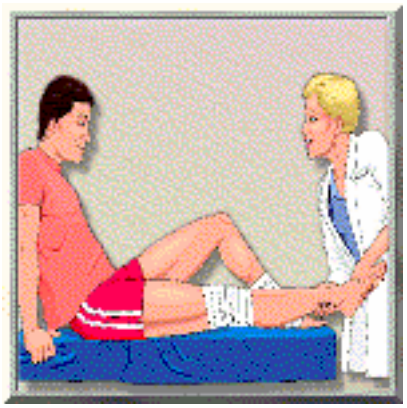
The examiner may conduct certain maneuvers or physical tests on the claimant in examining the disability. You might come across the terms, "Patrick's sign (or test) is negative" or "Positive Anterior Drawer Sign." These refer to certain types of functional tests that are used to help determine the etiology of the complaint, that is, the possible cause of the symptom. When the examiner reports that the test or sign (these terms are often used interchangeably), is positive, this indicates to the examiner the likely cause of the complaint, such as a ligament tear, or spinal lesion.

Some of the more common tests, signs and reflexes include those identified in the following table.

Table 7 – Tests and Signs

Test or Sign	Definition
Babinski's Sign or Test	A test for organic lesions of the nervous system. Stroking the lateral aspect of the sole causes extension of the great toe with fanning of the other toes, often with flexion of the knee and hip. The reflex is of spinal origin, so a positive response indicates possible upper motor neuron lesion.
Drawer Sign	This test measures ligament instability. The knee is flexed and tested by placing both hands behind the upper leg then drawing the tibia forward. Anterior mobility indicates disruption of the anterior cruciate or medial collateral ligament (this would be referred to as positive Anterior Drawer Sign). If the tibia is pushed backward, mobility indicates tear of the posterior cruciate ligament.
Goldthwaite's Sign	This tests for evidence of sprain of sacroiliac ligaments. With the claimant lying supine, the leg is raised by the examiner with one hand, and the other hand is placed under the lower back. Leverage is then applied to the side of the pelvis. If pain is felt before the lumbar spine is moved, the lesion is a sprain of the sacroiliac joint. If pain does not appear until after the lumbar spine moves, the lesion is in the sacroiliac or lumbosacral articulation.
Kernig Sign	A test used as a sign of Meningitis. A positive result is when while lying flat on his/her back, the patient can easily and completely extend the leg, however, while sitting or lying on his/her back with knee raised, the leg cannot be completely extended.

Test or Sign	Definition
Lachmann's Test	A test to measure anterior cruciate ligament insufficiency of the knee by testing the knee at 20 degrees flexion. Excessive forward motion of the tibia indicates anterior cruciate injury either isolated or in association with other collateral or capsular injuries.
McMurray's Test	Measures knee meniscal ligament injury by having the claimant lie supine with the knee fully flexed, then the examiner rotates the claimant's foot fully outward while extending the knee slowly. If a painful "click" is present, this indicates a possible tear of the medial meniscus of the knee joint. If the "click" occurs when the foot is rotated inward, the tear may be in the lateral meniscus.
Patrick's Test	This measures anterior cruciate ligament and lateral ligament insufficiency of the knee. While lying supine, the thigh and knee are flexed and the external malleolus (ankle) is placed over the patella of the opposite leg, then the knee is depressed. If pain is produced, this is indicative of arthritis of the hip. This test is also referred to as Fabere Sign.
Straight Leg Raising	This is a test to determine whether there is a herniated nucleus pulposus (a herniated disc in the back). The claimant lies supine with hip flexed and the examiner extends the knee. A positive test is when sciatic pain is produced. If the pain is felt in the opposite leg, it is strongly presumptive of a herniated nucleus pulposus.



Treatment Reports

Treatment reports or records will include information describing the patient's condition. The information is usually divided by summary/history, objective findings, assessment, and a plan for treatment. You will also notice that many treatment records will use abbreviations to signify each section. Some of these abbreviations are included below:.

S or H	Summary and history of the injury or disease
O	Objective findings on exam
A, I(Imp), or Dx	Assessment (the clinical impression of the diagnosis)
P	Plan for treatment

Summary

This section provides a summary and history of the injury or disease and may include related subjective complaints, such as pain, numbness, limitation of function. This information is important for determining the chronicity of the injury or disease, that is, whether it is acute and transitory, or indicative of a more long standing disability. In the summary and history section, the period of onset of symptoms will be recorded. It will be important to note whether symptoms have been present only a few days or for several weeks or months.

Objective Findings

The physical examination will record the examiner's clinical findings related to the patient's complaint. Sometimes the subjective complaints are listed here, instead of in the summary section. The examiner will report findings such as range of motion, evidence of decreased sensation, tenderness or pain to touch, and other observable objective evidence of abnormality such as swelling or discoloration.

It is important to note that at times there may be no objective findings perceptible to an examiner. This does not necessarily mean there is no disability. Symptoms may only be present after prolonged or repeated use, such as at the end of a work shift. Symptoms might also be present under certain conditions, as is often the case with skin rashes, which may be exacerbated by certain seasons.

Treatment Reports (cont.)

Assessment

In this section, you will find the examiner's opinion of the disease or injury causing the patient's complaint. The examiner may furnish a definite diagnosis, or may be uncertain and report only a "probable" cause or diagnosis. Additional tests or studies may be required before a diagnosis is made. In these cases, you will likely see "rule out" or "R/O" before the diagnosis, for example, "rule out torn meniscus." The examiner may suspect a torn meniscus is causing the patient's knee symptoms but would likely order additional tests to be more definite. Additional tests are not always ordered, especially if the patient has no further complaints following treatment.

Plan for Treatment

Here you will find the course of treatment prescribed such as any medication, limited duty, bed rest, physical therapy, increased fluid intake, etc. You may not always find this section in the treatment report, particularly if the condition is not so severe as to warrant medication or other measures.

General Information

All of these sections of the treatment report are important for understanding the history, and circumstances surrounding onset of symptoms of a disease or injury, and for determining entitlement to benefits. One instance of treatment for a sprained ankle, for example, does not necessarily mean the patient has a chronic ankle condition. You will need to review the entire evidence of record. You will also need to note the level of severity of the condition as recorded by the examiner.

The type of treatment plan may lead to development for further treatment, operative, or other reports, and will help determine the extent of the injury or disease. You should note that an assessment is not always definitive. For example, the same left knee complaint may variously be assessed left knee strain, torn meniscus, or retro patellar pain syndrome. This does not mean the patient has three different knee conditions, just that the examiners were unable to concur on a diagnosis.

As a Rating Specialist, it is imperative to review **all** of the evidence of record, and all of the component parts of that evidence before making any decision regarding entitlement and evaluation of disabilities.

Sample Treatment Report 1

Gorgas Army Hospital

Wilber C. Fuegot

Past H/O Rt. Knee injury in 1975. Arthroscopic surgery revealed torn medial meniscus. Pt. Underwent medial meniscectomy, followed by a course of physical therapy and limited duty. Symptoms continued. MEB exam completed 9/76. On exam there was marked lateral laxity and some tenderness to medial aspect. No edema or locking. Pt. Discharged from service with disability severance pay.

O: Pt. complained of rt. Knee buckling, pain with prolonged standing, stair climbing, sitting

Flexion to 110°, extension to 5°. Tenderness to patellar compression. Positive varus/valgas stress testing. Marked lateral laxity. Neg. anterior drawer sign. No ecchymosis, edema. X-rays showed slight joint space narrowing, osteoarthritic changes.

DX: S/P rt. Torn medial meniscus, medial meniscectomy with residual limited ROM, lateral laxity.

P: Refer for orthopedic consult, MRI, arthroscopy

Sample Treatment Record 2

Date: Mar 22,1995 Compensation and Pension Exam Report Page 1
Bay Pines, Florida
** FINAL **For AUDIO Exam

==========

Name: Ricker, Tony C.

SSN: 111 03 0000
C-Number: 111 03 0000
DOB: JUL 17, 1927

Address: 812 Pine Hills Way
City, State, Zip+4:
Bradenton, FL12345
Entered active service: APR 6,1945
Released active service: AUG 21,1946
Priority of exam: Original SC

Res phone: 0000
Bus phone:
Last rating exam date:

==========

Examining provider: ADAMS.
Examined on: MAR 15,1995

==========

Examination results:

A. Audiological history: Veteran reported decrease in hearing in left ear since explosion near left ear in 1940. Veteran reported a history of military noise exposure, mines, explosions, and gun fire. Veteran denies otosurgery, middle ear pathology, otalgia, otorrhea, tinnitus, and noise exposure after military service.

B. Pure tone thresholds:

RIGHT EAR	LEFT EAR
500 - 25	500 - 20
1000 - 20	1000 - 20
2000 - 20	2000 - 35
3000 - 30	3000 - 75
4000 - 45	4000 - 75
Average - 29	Average 51

C. Speech recognition score:
1. Maryland CNC word list 96% (R) ear 32% (L) ear

D. Tinnitus:
Veteran denies tinnitus.

E. Note whether audiologic results indicate an ear or hearing problem - N/A

F. Summary: Pure tone audiometry indicated a mild to moderate high frequency sensorineural hearing loss above 2000HZ in the right ear and a severe high frequency sensorineural hearing loss in the left ear. Speech discrimination ability was excellent in the right ear; essentially deaf in the left ear. Impedance measures could not be performed due to an inability to seal the canals bilaterally.

G. Recommendations: This veteran is a candidate for amplification in the left ear due to hearing loss throughout the speech frequency range. All of veteran's responses were reliable.

This exam has been reviewed and approved by the examining provider.
VA Form 2507

Ctest3-05
Sample Treatment Record #3

MEDICAL HISTORY

Cruise David C.

U.S. NAVAL HOSPITAL, SAMPSON, N.Y.

12-14-44: Last night patient became hysterical, was unable to talk, became rigid and had some tremors. There was paresis of the right arm. Patient was hyperventilating. Lumbar puncture revealed clear fluid, protein 15.54 mg%, sugar 68 mg%, chloride 709 mg% Blood chlorides 412 mg%. Blood calcium is 19.7%

Neurological consultation: Couldn't speak because throat is too dry. Got scared.
Examination shows apprehensive but cooperative alert youth with hyperactive DTRs.
Cranial nerves WNL. No muscular weakness or Kernig sign or stiff neck.

During night apparently had cramps from dehydration and hyperventilation on anxiety basis. Paper bag-rebreathing. CO2 should relieve any recurrrence plus reassurance. In view of negative spinal tap can not attach importance to abnormal reflexes.

12-16-44 Patient apparently well and normal in all respects. Throat culture negative for beta hemolytic strep.

12-20-44 TPR Normal. No complaint. HEENT nml. Heart RRR. Lungs CTA. Throat resolved.

12-23-44 Discharge to duty well.

Exercise 3

Treatment Records

Task
In groups of 3, answer questions pertaining to the treatment records.

Materials
Medical Treatment Records #1, #2, and #3 on following pages.
Three sets of questions (A, B, and C) pertaining to certain information on the report.

Criteria for Success
Provide complete and correct answers for each assigned question set.

Cooperative Goal
The goal is for each trainee to fully understand the presentation of information on the treatment records as well as the meaning of various abbreviations found on the report.

Individual Accountability
Trainees will be randomly selected to answer questions in a group setting.

Roles
Each trainee will answer one of the question sets described on the following page. Rotate these question sets for each treatment record. Put your initials next to question set you working on for each record. Answer a different question set for each treatment record. (Note: If there are only two trainees, combine Question Sets A and B.)

Record #1	Record #2	Record #3
_____Question Set A	_____Question Set A	_____Question Set A
_____Question Set B	_____Question Set B	_____Question Set B
_____Question Set C	_____Question Set C	_____Question Set C

Procedure
1. Select a question set for each record.
2. Research the treatment report to answer your assigned questions.
3. Summarize the information found in that section to your group members.
4. Listen carefully as your teammates answer their question set for that record.
5. Repeat these steps until all treatment records have been examined.

Time Allotted: 45 minutes

Exercise 3

Treatment Records

Question Set A:
Define the abbreviations included in the medical report.

Question Set B:
Define the highlighted medical terms relating to disabilities and/or conditions; planes of movement; position and direction; and tests, signs or reflexes in the context of the treatment report.

Break these words into their component parts (word roots, suffix, prefix, combining vowel) when applicable. If you can't break the term into word parts, use any available medical references.

Question Set C:
Identify the sections and the information on the record that correspond to: Summary, Objective Findings, Assessment, and/or Plan.

Describe why this information is important.

Treatment Record #1

Ctest5-32
Exercise 3
Record #1

Last week, working with boards, this 26 y.o. pt hurt his L knee joint. Also hx of reflux after meals and intermittent stomach pain. Some N,D, no vomiting.

PE: skin Mark at the left anterior tibia, effusion in left knee joint, slight ecchymosis. Abdomen soft, non-tender. No organomegaly.

Imp: Contusion of L knee with effusion.
Gastroenteritis, r/o reflux esophagitis.

Rx: elastic bandage 4 inch
Butazolidin
consult gastroenterology for GI series.

Ctest5-05
Exercise 3
Record #2

COMPENSATION AND PENSION EXAMINATION
VAOPC ORLANDO FLORIDA

NEWTON, JACKSON C. 567 03 8901

Mr. Newton was examined on 11/23/93.

His chief complaints are pain in both feet and progressively worsening pain in his right hip and right shoulder.

Pain in his knees has been present since 1961. He was in the Army from 1960 to 1962. He had surgery on his left knee at a hospital when he was in Germany and was told that both knees showed arthritic changes.

He has had progressive difficulty with pain in his knees and in both feet. He also now has pain in his right hip and in his right shoulder.

The pain in his knees is almost constant. He can't walk very far. He used to play golf. He now has so much pain in his right shoulder and left knee when he tries to swing a golf club that he has had to give up playing this game. About 4 or 5 months ago, he had to give up his job as a dry wall hanger. Again because of the pain as described.

He also complains of sob with exertion.

He admits to drinking about a pint of vodka per day to help relieve the pain in his knees. He also smokes about a pack a day of cigarettes.

He is divorced but lives with a girlfriend. She does the cooking. He eats well. He has normal bowel movements. He denies N,V,D. No trouble with nocturia or dysuria.

PHYSICAL EXAMINATION: He is well developed and well nourished, in NAD. He is rather slender. He says his weight however has been constant.

He was able to walk from the reception area to the examining room without any great difficulty although he did limp a little bit trying to keep the weight off of his knees as this is his most painful problem.

Pulse:	114. This was checked twice.
Temperature:	97.3
B/P:	142/84
Height:	71 inches
Weight:	155 1/2 lbs.

SKIN: Appears normal. No lymphadenopathy.

ENT: Appears normal. He has infections of his teeth along the gum lines. This involves mainly his lower jaw. He has a partial plate in the upper part of his mouth. There is some overgrowth visible where the plate pushes up against the teeth. I don't see any open lesions or anything to suggest a serious problem such as a cancer.

Record #2 cont.

NECK: Normal. No masses. Normal mobility.

LUNGS: Clear and resonant today.

HEART: Sounded normal.

ABDOMEN: Flat and no organs or masses felt.

GENITALIA: Normal.

No herniae.

RECTAL: Nml. Prostate feels normal.

He has normal mobility in almost all of his joints. He can bend over and touch the floor but he says this causes considerable pain in his right hip area. SLR at about 40 degrees caused pain in his right hip.

Both knees have normal range of motion, although there is some clicking in the left knee joint when he bends. There is no swelling or fluid present.

Normal motion of his right shoulder joint. However when he raises his hand above the level of his head, he says there is severe pain in his shoulder.

IMPRESSION:

1) Bunions of both feet with the second toe overlapping the great toe in both feet. He also has some evidence of onychomycosis.

2) Probable arthritis of both knees. Probably related somewhat to the operation he had in 1961.

3) Probable arthritis of his right shoulder and possible arthritis of his hip. Please refer to orthopedic report which should be attached.

4) Abnormal liver function tests probably related to alcohol intake.

Treatment Record #3

Ctest5-04
Exercises 3/5
Record # 3

SMITH, Jack C.
2507 11/30/93

This 58 year old white male was examined on November 30, 1993. He served in the Army from July 7, 1960 until June 13, 1962.

Pt has h/o operative procedure performed in 1961 on his left knee for osteochondritis dissecans. Post operatively, he was placed on a permanent physical profile because of "arthritis in both knees." He states that he has had "pain in both knees for 30 years but I guess I have a tolerance for pain." The left knee has "swelling all the time." He experiences no locking of either knee. His knees buckle when walking on rough terrain.

EXAMINATION: Examination of his knees reveals no swelling, erythema, tenderness or crepitation in either knee. There is a 3 inch well healed scar on the medial aspect of the left knee. The scar is non adherent and non tender. Both knees appear to be stable without any laxness of the collateral or cruciate ligaments. There is no evidence of quadriceps atrophy or weakness in either leg. McMurray and Lachman signs are negative bilaterally as well as the pivot and compression tests.

He extends both knees to 0 degrees. AROM in flexion of left knee is to 153 degrees. Full passive ROM. He actively flexes the rt knee to 135 degrees and passively flexes it to 154 degrees. He completes a full deep knee bend without difficulty.

X-ray examination of both knees show osteoarthritic degenerative changes in the both knee joints with narrowing of the medial knee compartments. Sclerotic changes are also seen in the left medial femoral condyle as well as the proximal tibia. There is narrowing of the left and right femoral patellar articulation.

IMPRESSION:

Osteoarthritis, both knees, with x-ray evidence of bilateral degenerative changes, otherwise nml exam, with no limitation of motion.

Lesson 2: Introduction to the Rating Schedule

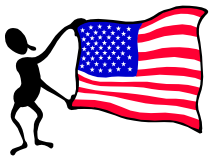
Purpose and Historical Development

The Rating Schedule is primarily a guide to be used by rating personnel. It covers a host of disabilities and suggests a percentage evaluation, in increments of 10 percent, when certain disability criteria are met. For the most part, the Rating Schedule is flexible for the purposes of evaluation; however, it is also quite rigid in such areas as Audio and Visual Acuity. To be effective, Rating Specialists must study and understand the Rating Schedule.

Relief for service-connected disabilities for veterans in the United States dates back to the early American colonial period, with a law passed by the General Assembly of Colonial Virginia in 1624. Individual colonies followed suit, with the enactment of veterans pension laws by Plymouth Colony in 1636, Massachusetts Bay Colony in 1676, Maryland in 1661, New York in 1691 and Rhode Island in 1718. The first national pension law in the United States was adopted by the Continental Congress August 26, 1776. A number of amendments, consolidations and Veterans Acts followed, until 1921, when the Veterans Bureau was established and the first codified Schedule for Rating Disabilities was drafted. This 1921 edition of the Rating Schedule provided for presumption of service-connection for tuberculosis and neuropsychiatric conditions and for creation of local rating boards around the country instead of a single rating board in Washington, D.C.

The World War Veterans' Act of 1924 called for a new Rating Schedule, which was placed into operation January 1, 1926. Known as the 1925 Rating Schedule, it had evaluation percentages in increments of one percent. On the positive side, unlike the current 1945 Rating Schedule presently in effect, it wasn't necessary to jump 10 percent every time an increase occurred. On the minus side, it required considerable arbitrary discrimination to determine the difference between one or two percentage points. This schedule also had an occupational variant. For example, a veteran who had an eye disability would receive a higher disability evaluation if he was an accountant as opposed to a laborer with the same disability.

Purpose and Historical Development (cont.)



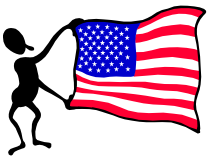
In other words, good eyesight was considered to be more important to someone who dealt in figures than to someone who performed manual tasks. This was the original rationale for having an occupational specialist on the rating board.

The Economy Act of March 30, 1933 authorized the next version of the Rating Schedule. The 1933 Rating Schedule eliminated evaluations in increments of one percent, and substituted multiples of 10 percent. It also eliminated the occupational variance and substituted the concept of average impairment. Veterans with the same disability received the same percentages regardless of occupation. The 1933 Rating Schedule eliminated the difference between temporary and permanent percentage evaluations. Additionally, it provided for the bilateral factor as it is used today.

The next version of the Rating Schedule, the 1945 Rating Schedule, became effective April 1, 1946. This schedule raised the percentages in some disabilities and lowered others. It also provided for a review of all ratings under the prior 1925 and 1933 Schedules. If a higher evaluation could be assigned under the 1945 Schedule, it was, and protection under the prior Rating Schedule was lost. Protection in this sense, means that a disability rating evaluation will not be reduced solely on the basis of a revision to the Rating Schedule (unless medical evidence establishes that the disability to be evaluated has actually improved). If a higher percentage could not be made, the disability evaluation rating under the prior Rating Schedule was retained in a protected status. In other words, the assigned percentage could only increase but would not decrease.

Based on a Government Accounting Office study in 1988, the current Rating Schedule in use is undergoing additional revision in order that it use current medical terminology, provide unambiguous criteria for evaluating disabilities and reflect recent medical advances.

Purpose and Historical Development (cont.)



Precedence Chart of VBA References

This depicts the process by which the VBA references evolve:

The CONSTITUTION of
The UNITED STATES of AMERICA

established

The CONGRESS

which passes bills about veterans which, when signed into law by

The PRESIDENT,

are codified by Congress as

Title 38 United States Code (U.S.C.)

which is interpreted by VA in

38 Code of Federal Regulations (CFR)

from which VBA policy and procedural instructions are given in

DIRECTIVES

in the form of

MANUALS and VBA CIRCULARS

NOTE: The U.S. Court of Appeals for Veterans Claims and the VA General Counsel (in GC opinions) refine the interpretation of Title 38 U.S.C.

The Rating Schedule (38 CFR, Part 4) is a set of regulations that has as its basis of authority the statute, 38 U.S.C. 1155. Parts 3 and 4 of Title 38 CFR deal with issues related to certain veterans' benefits and eligibility and evaluation of disabilities.

Purpose and Historical Development (cont.)

When a change to regulations is needed, VBA proposes regulations to be incorporated into the CFRs, and publishes these proposals in the *Federal Register*. This allows for public review and comment on the proposed implementation of the law through changes or additions to the CFRs. Once a period of time has elapsed to allow sufficient comment and consideration of the proposed changes, the final regulations are then published in the *Federal Register*. The comments received are summarized and discussed, and the final regulation as it will appear in the CFR, is published.

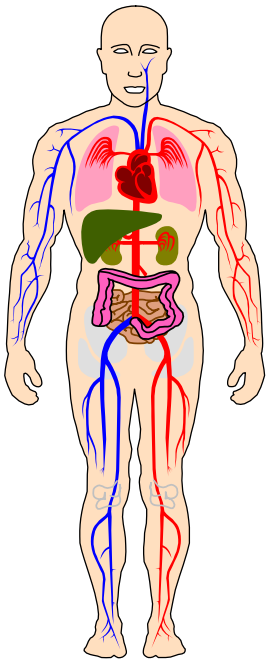
The CFRs are a constantly changing body of regulations. This is due to the current revisions of the Rating Schedule presently underway, as recommended by the GAO, as well as the impact of certain precedential U.S. Court of Appeals for Veterans Claims decisions and General Counsel Opinions which might mandate that a certain regulation is not in compliance with the intent of Congress or somehow misinterpreted the law or is unclear in its interpretation of the law.

As the CFRs are continuously evolving, there is a need for supplements to the published *Code of Federal Regulations.* The Rating Specialists and Claims Examiners are provided with these supplements. The CFR's were most recently published during March 25, 1992, and any changes to that edition are implemented by **Supplements** to the CFRs. For the new Rating Specialists, who will be furnished Part 4 of 38 CFR.

Each time a new Supplement is provided to the Rating Specialist, there will be instructions on what parts of the CFR are amended or should be replaced. Although the Supplement instructions indicate that removal pages should be discarded, it is highly recommended that Rating Specialists maintain prior copies of their former versions of the CFRs in order to have an historical record of these regulations.

Rating Specialists will be using Parts 3 and 4 of Title 38 of the CFR to make eligibility determinations and assign percentage evaluations. Most often, it will be Part 4 of the CFR to which the Rating Specialist will daily refer for determining percentage evaluations to be assigned disabilities. 38 CFR Part 4 is titled the *Schedule for Rating Disabilities* (and is commonly referred to as the Rating Schedule).

Organization of the Rating Schedule



The Rating Schedule is divided into fifteen body systems:

1. Musculoskeletal System
2. Organs of Special Sense (eyes)
3. Impairment of Auditory Acuity (hearing disabilities)
4. Infectious Diseases, Immune Disorders and Nutritional Deficiencies
5. Respiratory System
6. Cardiovascular System
7. Digestive System
8. Genitourinary System
9. Gynecological Conditions and Disorders of the Breast
10. Hemic and Lymphatic Systems
11. Skin
12. Endocrine System
13. Neurological Conditions and Convulsive Disorders
14. Mental Disorders
15. Dental and Oral Conditions

There is also a chapter, General Policy in Rating, which includes regulations pertaining to such topics as: essentials of evaluative rating (assigning evaluation percentages), interpretation of exam reports, resolution of reasonable doubt, evaluation of evidence, analogous ratings, attitude of rating officers, use of diagnostic code numbers, and assigning a no-percent rating.

The Rating Schedule has a table of contents arranged by chapter, and within each chapter, numerically lists each section number of the regulation. (For example, 38 CFR 4.22 is Part 4, Section 22 of 38 CFR)

There are two indices to the Rating Schedule:

Index 1

This is arranged numerically by the CFR Section number. If you know the Regulation Section number, this will tell the Rating Specialist the subject of that regulation and section. This is not a very helpful tool unless you already know the number of the regulation to which you are referring.

Organization of the Rating Schedule (cont.)

Index 2

This is an alphabetical listing of key words, including disabilities (with diagnostic code numbers), conditions, tables, plates, figures, and other material from Part 4, indexed to the section number in which they appear, and providing the corresponding Diagnostic Code. This should be a *very* helpful tool for the new Rating Specialist when trying to find a diagnostic code which matches a particular disability, or to find which chapter contains evaluation criteria for certain body systems, diseases or injuries.

There is a table of contents listing each chapter of the Rating Schedule, and the regulation section contained therein.

There are also three appendices:

Appendix A

A table of amendments and effective dates since 1946 (remember this is the 1945 Rating Schedule, initially published during April 1946). These are listed by regulation section number (4.16, 4.125, etc.). This appendix is current through Dec. 7, 1987. Thereafter, refer to the citations at the end of each section in the text.

Appendix B

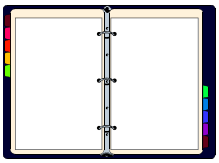
This is a numerical index of disabilities, listed by diagnostic code number, but generally grouped according to body system or part (the shoulder and arm, the elbow and forearm, muscle injuries, diseases of the eye, the heart, etc.)

Appendix C

This is an alphabetical index of disabilities (with some general groupings, such as amputations, arthritis, fever, hernia, injury, etc.), and cross referencing to Diagnostic Code. Index 2 is now replacing this appendix.

It should be noted that new Rating Specialists may not always be provided with a complete copy of the Rating Schedule containing all of these parts .

Page Layout



Each page of the Rating Schedule contains information in six different locations:

The page number appears in both the upper left hand corner and the upper right hand corner of the page. If there is only one section on the page, these numbers will be identical. However, if the page contains two or more short sections (e.g., 4.112 and 4.113), then the number in the upper left hand corner indicates the first section on the page (4.112-1) while the number in the upper right hand corner indicates the last section on the page (e.g. 4.113-1). This is very similar to a dictionary, which may list the first word defined in the upper left hand corner, and the last word presented on the upper right hand corner of the page.

The top center of the page repeats this information, but also includes the title of the sections included on that page. You can glance at the top of the page and therefore see the number and name of the sections you are reading.

The text of the regulation occupies the bulk of the page. The text is as it appears in the annual bound volume of the *Code of Federal Regulations*, as amended by final rules published in the daily *Federal Register*. Relying on the bound volume of *the Code of Federal Regulations* can be hazardous since it is always out of date by the time it is published. Reading the *Federal Register* every day in order to update the CFR can be a time consuming task. We therefore rely on the Supplements to the CFR provided by VA Central Office as well as the Automated Reference Materials System (ARMS) for updates and revisions to the CFRs.

In the lower right hand corner of the page, there is a “Next section is” indicator. The CFRs are not always in exact numerical order, sometimes section numbers are skipped or have subsections (e.g., 4.31followed by 4.40; or 4.86 followed by 4.86a). The Rating Specialist may not know that 4.40 follows 4.31 (there are no sections 4.32, 4.33, 4.34, etc.). Therefore, the Rating Specialist is provided with a means of determining whether their set of regulations is complete. Whenever there is a skip in section numbers, the phrase “Next section is…” followed by the next section number will appear on the lower right hand corner of the page. If there is no “Next section is” reference, this means the next section is in normal ascending numerical sequence.

On the lower left hand corner of the page is a source entry (Original 3/25/92) or (No. 2 10/25/92). The first form was on every page when the book was initially published. The second form indicates there was a replacement page sent due to an amendment to the regulation. It indicates the Supplement number in which it was transmitted and the date of mailing the Supplement.

Supplements

The Supplements are issued when there are changes affecting the CFRs published in the *Federal Register*. The Supplement will contain a title page telling you to which book of the CFR this Supplement applies (Book C is the Rating Schedule: 38 CFR Part 4); there will be a general instructions page explaining the period of *Federal Register* issues covered by that Supplement number, filing instructions telling you which pages to remove and replace and which sections are affected, and highlights which summarize the changes made. The highlights page is particularly important for explaining what specifically was amended in the Rating Schedule.

Exercise 4 

The Rating Schedule

Task

Individually determine the rating code and body system given a disability, and determine the disability and body system given a rating code. In groups of 3, reach consensus and complete a Group Answer Sheet.

Materials

Rating Schedule Scavenger Hunt Worksheet on the following two pages;
Rating Schedule; Group Answer Sheet (Instructor will distribute these)

Criteria for Success

Group correctly locates and identifies the disability or diagnostic code and determines the body system for each of the clues in the "Hunt for" column on the Scavenger Hunt Worksheet.

Cooperative Goal

The goal is for each trainee to become familiar with the Rating Schedule basic format, navigation, and assigning disability codes.

Individual Accountability

Each trainee will sign the group answer sheet to indicate that they agree with the group answer and feel comfortable using the rating schedule.

Instructor randomly selects any member of a group to provide answers from the group answer sheet.

Roles

Researchers: Navigate through the Rating Schedule to identify missing information on the Scavenger Hunt Worksheet. (Each trainee will perform the role of Researcher for the first part of this exercise.)

Recorder: After Rating Schedule Scavenger Hunt group discussion, documents the group's answers in writing on the Group Scavenger Hunt Worksheet. (Each group elects one member to be the Recorder.)

Comprehension Checkers:
Ensure each individual team member understands and agrees with the group's answers. Paraphrase when necessary to clarify any communication challenges. Repeat or rephrase questions, as necessary, to encourage individuals to think about their answers.

Exercise 4 

The Rating Schedule

Procedure

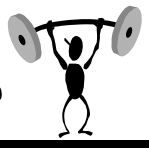
1. Individually complete the Rating Schedule Scavenger Hunt Worksheet.

2. Elect a Recorder to document the group's answer on the Group Answer Sheet. Other groups members perform role of Comprehension Checkers to ensure everyone's understanding and agreement about the group's answers.

3. When all group members have completed the scavenger hunt, compare all answers and reach consensus about one group answer.

4. Sign the Group Answer Sheet to indicate that you agree with the group's answers and feel comfortable using the rating schedule.

Time Allotted: 50 minutes

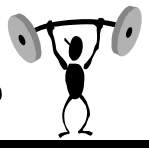
Exercise 4 

Rating Schedule Scavenger Hunt Worksheet

Find the disability or diagnostic code and determine the body system chapter

	Hunt for:	Disability or Code	Body System
1.	7913		
2.	7338		
3.	Nephrolithiasis		
4.	Bipolar Disorder		
5.	Gout		
6.	Cold Injury Residuals		
7.	Hypertensive Vascular Disease		
8.	5055		
9.	7345		
10.	Pneumonoconiosis		
11.	5309		
12.	Total Blindness		
13.	Tinnitus		
14.	7010		
15.	Endometriosis		

Exercise 4

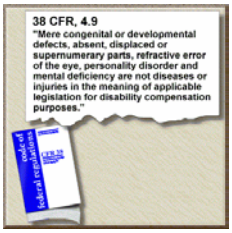


Rating Schedule Scavenger Hunt Worksheet

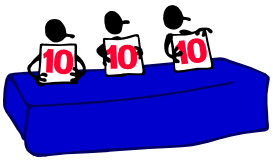
	Hunt for:	Disability or Code	Body System
16.	9411		
17.	Leg, limitation of flexion of		
18.	Tinea Barbae		
19.	Non-Hodgkin's Lymphoma		
20.	9434		
21.	Otosclerosis		
22.	Hypochondriasis		
23.	6833		
24.	Maxilla, loss of half or less		
25.	Multiple Sclerosis		
26.	Chronic Obstructive Pulmonary Disease		
27.	Aphakia		
28.	Hypothyroidism		
29.	8045		
30.	Osteomyelitis, acute, subacute, or chronic		

General Paragraphs of the Rating Schedule

Now it is time to review some of the General Paragraphs found in the Rating Schedule. This will help facilitate your navigation through this volume of regulations.



Assigning Evaluations



The Rating Schedule is a guide to assigning percentage evaluations for certain disabilities. The percentages are in increments of 10. When the disability is service connected and a compensable evaluation (at least 10%) is assigned, the veteran will be entitled to receive a monetary monthly payment of benefits.

The Rating Schedule provides certain criteria which must be met in order to receive a certain percentage evaluation. The Rating Specialist should be aware that not every known diagnosis will be listed in the Rating Schedule, and at times, the percentages recommended will not properly reflect the level of severity of a specific disability.

In exceptional cases, when the Rating Schedule does not adequately evaluate the condition, the case must be referred to Compensation and Pension Services for consideration of an extra-schedular percentage assignment.

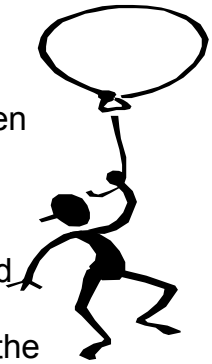
If the disability is not found in the Rating Schedule, it may be necessary to use an analogous condition that is listed in the Rating Schedule for the purpose of evaluating a certain disability. More information on analogous diagnostic codes is discussed later in this document.

When assigning evaluations, the medical evidence must support the diagnosis and the percentage assigned for the condition. When the symptoms shown by the examiner show a disability rate greater than one evaluation, but not high enough to qualify for the next higher evaluation, the higher evaluation must be assigned.

General Paragraphs of the Rating Schedule (cont.)

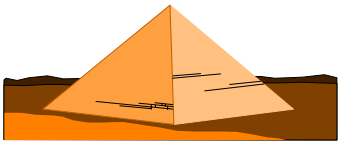
When, after careful consideration of all procurable and assembled data, a reasonable doubt arises regarding the degree of disability, such doubt will always be resolved in favor of the claimant.

The basis of disability evaluations is the ability of the body as a whole, or of the psyche, or of a system or organ of the body to function under the ordinary conditions of daily life, including employment. Evaluations are based upon the lack of usefulness of the body parts or systems, especially in self-support. The examiner is therefore required to furnish a full description of the effects of disability upon the claimant's functional abilities.



When evaluating disabilities, do not be tempted to *"inflate"* evaluations. In pension claims, this is often done in order to qualify a veteran for pension benefits without referring the case to the Adjudication Officer for extraschedular consideration. However, if this has been done and the veteran subsequently establishes service connection for the condition which was *"inflated"*, the evaluation in effect for pension purposes becomes the evaluation for compensation benefits. Evaluations are to be considered equally for compensation and pension purposes.

Remember that in *every instance* where the Rating Schedule does not provide a zero percent evaluation for a diagnostic code, a zero percent evaluation shall be assigned when the requirements for a compensable evaluation have not been met.



Pyramiding

Pyramiding is the evaluation of the same disability under several different diagnostic codes for the same manifestations. The evaluation of the same manifestations for a disability under various diagnoses or diagnostic codes is to be avoided. Each condition must be rated according to the most predominant symptom or symptoms which warrant the highest evaluation.

General Paragraphs of the Rating Schedule (cont.)

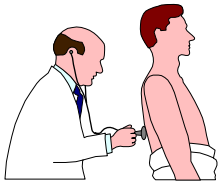
For example, an injury to the ankle may be evaluated under range of motion of the ankle, or, if there is nerve damage, then it may be evaluated based upon neurologic symptoms. Consider the appropriate evaluation to be assigned in each body system, and then assign the percentage which is *most advantageous* to the veteran.

In order to accurately determine the disability evaluation level, medical evidence (usually in the form of treatment and examination reports) must be reviewed. These reports vary in content and detail from examiner to examiner.

The Rating Specialist must interpret such reports in light of the whole recorded history, reconciling the evidence of record into a consistent picture so that the Rating Decision may accurately reflect the elements of disability present, and how such disability impacts the veteran's functional ability.

> Remember that the percentage evaluations represent, as far as practicable, *the average impairment in earning capacity resulting from such diseases and injuries and their residual components.*

Interpretation of Examination Reports



The Rating Specialist must be able to evaluate the adequacy of all medical evidence received. Examination and treatment reports usually (but not always) include:

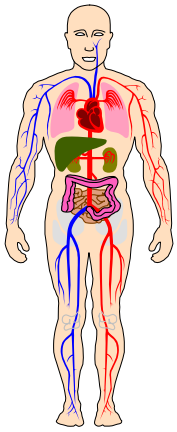
- ☑ Brief history of the disability
- ☑ Description of subjective complaints
- ☑ Complete description of objective (or clinical) findings
- ☑ Diagnosis or clinical impression/assessment

The examiner will usually provide a diagnosis for all described conditions, except for Gulf War claims based on undiagnosed illnesses. These types of cases will be discussed more fully in later modules.

General Paragraphs of the Rating Schedule (cont.)

If a VA examination is inadequate for rating purposes, such as the wrong joint is examined, or no ROM studies are furnished, follow local procedures to correct the problem. An examiner's diagnosis of "history of knee pain" is not really acceptable. Pain is a symptom, not a diagnosis, and any examination which lists this as a diagnosis is insufficient for rating purposes.

Use of Diagnostic Code Numbers



The Rating Schedule lists disabilities under fifteen different body systems, and assigns a Diagnostic Code to each disability categorized.

Diagnostic Codes are four digit numbers assigned to disabilities in the Rating Schedule, ranging from 5000 to 9999. Such codes are entered into the veteran's Master Record and may be used to help determine VAMC treatment eligibility. The codes may also be used for trend analysis and other purposes.

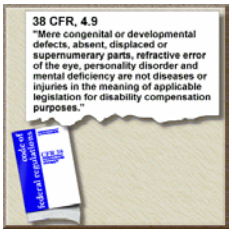
Each disability rated for compensation or non-service connected pension must have a Diagnostic Code assigned.

In identifying Diagnostic Codes, the first two digits are applicable to the body system or disease process involved, such as 5000 series for Arthritis, 5200 for Musculoskeletal disabilities, 5300 for Muscle Damage, 6000 series for Eye diseases, etc. These follow numerically chapter by chapter.

It is important that the most appropriate Diagnostic Code always be used and uniformly applied. Information paragraphs and notes in the Rating Schedule should be read for assistance in selecting a Diagnostic Code.

As noted, the Rating Schedule lists disabilities under fifteen body system chapters. There are also appendices and indices which may be used to help find an appropriate Diagnostic Code.

General Paragraphs of the Rating Schedule (cont.)



In some cases, the diagnosis provided by the examiner may not correspond with any disability listed in the Rating Schedule. When an unlisted disability or condition is encountered it is permissible to rate that disability or condition under a closely related disease or injury. These condition must be closely related not only by the functions affected, but the anatomical location and symptomatology must be closely analogous as well.

For example, Crohn's Disease is not specifically listed in the Rating Schedule. This condition is an inflammatory bowel disease and can be rated as 7323 *(ulcerative colitis)* or 7319 *(irritable colon syndrome)* depending on which provides the closest picture of the disability.

When evaluating by analogy any disability not listed in the Rating Schedule, use a built-up diagnostic code consisting of two Diagnostic Codes separated by a hyphen. The first two digits of the first diagnostic code should be applicable to the body system involved and the second two digits would end with "99." The second diagnostic code is to be taken from the Rating Schedule and identifies the diagnostic criteria used to evaluate the claimed disability.

For example, Crohn's disease, when rated analogous to ulcerative colitis, will have a Diagnostic Code of 7399-7323. Use of Diagnostic Codes and build up of analogous Diagnostic Codes will be discussed in the TPSS *Rate an Original Claim for Disability Compensation* module.

Conclusion

TPSS Basic Ratings Course

This prerequisite training has provided you with a basic foundation on understanding medical terminology and on the use of the Rating Schedule. The information and tools that you have learned are requisite to the first module of the VBA Training and Performance Support System's (TPSS's) Basic Ratings course, *Rate an Original Claim for Disability Compensation*.