18-2136

UNITED STATES COURT OF APPEALS FOR THE FEDERAL CIRCUIT

ERNEST L. FRANCWAY, JR.

Claimant-Appellant

v.

ROBERT WILKIE, Secretary of Veterans Affairs,

Respondent-Appellee

Appeal from the United States Court of Appeals
for Veterans Claims, Case No. 16-3738

JOINT APPENDIX

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UNITED STATES COURT OF APPEALS FOR VETERANS CLAIMS

No. 16-3738

ERNEST L. FRANCWAY, JR., APPELLANT,

V.

DAVID J. SHULKIN, M.D.,
SECRETARY OF VETERANS AFFAIRS, APPELLEE.

Before MEREDITH, *Judge*.

MEMORANDUM DECISION

Note: Pursuant to U.S. Vet. App. R. 30(a), this action may not be cited as precedent.

MEREDITH, *Judge*: The appellant, Ernest L. Francway, Jr., through counsel appeals an October 13, 2016, Board of Veterans' Appeals (Board) decision that denied entitlement to disability compensation for a low back disability. Record (R.) at 1-16. This appeal is timely, and the Court has jurisdiction to review the Board's decision pursuant to 38 U.S.C. §§ 7252(a) and 7266(a). Single-judge disposition is appropriate. *See Frankel v. Derwinski*, 1 Vet.App. 23, 25-26 (1990). For the following reasons, the Court will affirm the Board's October 13, 2016, decision.

I. BACKGROUND

The appellant served on active duty in the U.S. Navy from August 1968 to May 1970. R. at 213. Service treatment records show that the appellant received medical treatment during service, including for back pain. In November 1969, the appellant was seen for a painful, swollen wrist, following a motorcycle accident. R. at 91. On December 9, 1969, the appellant was seen for low back pain on the right side; he was given medication for pain relief, instructed to treat his back with warm soaks, and asked to return to sick call later that morning. *Id.* Later that day, the appellant returned with the same complaint of low back pain, and examination revealed limited range of motion without pain, no deformity, negative test for fracture, and some pain on rotation. *Id.* On

December 10, 1969, the appellant was seen again for low back pain, and he reported that symptoms first began on November 19 when he was involved in a motor vehicle accident and that the "present episode" began on December 8. R. at 92. Examination revealed symptoms at L5-S1 without radiation and on the right sacroiliac joint, and the appellant was placed on light duty. *Id.*

A March 1978 report of medical examination for the U.S. Naval Reserve revealed a normal back. R. at 94-95. In a contemporaneous report of medical history, the appellant reported that he was in good condition and denied currently having or having had any recurrent back pain, but he disclosed currently having or having had "[s]wollen or painful joints" and a "'[t]rick' or locked knee." R. at 96-97. He also reported that he had been hospitalized after a motorcycle accident in 1976 for surgical removal of cartilage from his left knee and a bone fragment from his right shoulder. R. at 97.

A March 1995 non-VA medical record reflects the appellant's complaint of back pain which started after he lifted weights. R. at 2078.

An October 2002 VA treatment record reflects the appellant's complaint of arthritis in his shoulders and hands and his denial of any other physical complaints. R. at 1989-90. The record also noted the 1976 motor vehicle accident that resulted in a left ankle sprain and surgical repair of a right shoulder injury as well as a left knee injury. R. at 1989.

In April 2003, the appellant filed multiple claims for VA benefits, including entitlement to disability compensation for a "back injury on [his] left side dated 5/69. . . . [sustained o]n the U.S.S. Oriskany." R. at 1995. In May 2003, a VA regional office (RO), among other things, denied entitlement to disability compensation for a back condition. R. at 1927-29. In June 2003, the appellant filed a request "to reopen" his prior claims, including for a back condition. R. at 1921. In January 2004, the RO "confirmed [the] previous decision" denying the appellant's claim. R. at 1883. The appellant timely perfected his appeal of the denial. R. at 1855-57 (Mar. 2004 Substantive Appeal), 1863-81 (Feb. 2004 Statement of the Case), 1882 (Feb. 2004 Notice of Disagreement).

In October 2005, the appellant testified at a hearing before the Board, during which he stated that he had injured his back on a flight deck when a gust of wind knocked him over and he fell onto the wheel chocks that he was carrying. R. at 1821. He explained that he fell onto the chocks and injured his abdomen, after which he was carried on a stretcher to sickbay where he stayed for a couple of weeks. *Id*. The appellant stated that he was diagnosed in service with a muscle strain and that he was also assigned to light duty for 3 months. R. at 1821-22. The appellant

denied receiving any treatment for his back after service until he got a muscle cramp in 2004, which was treated with muscle relaxants. R. at 1822. Before 2004, the appellant stated that he would treat his back pain by taking over-the-counter medication and sick leave. R. at 1823-24. In January 2006, the Board remanded the claim for further development. R. at 1800-05.

In May 2006, the appellant underwent a VA examination, during which the appellant reported that he had strained his back in 1969, which "took about three months to go away," after which he experienced intermittent back pain that "got worse" in 2004, when he was told that he may have arthritis. R. at 1617. The examiner, an orthopedist, diagnosed the appellant with lumbosacral strain, concluding that it is not likely that his current back symptoms are related to "a simple strain back in 1969, but rather a natural[ly] occurring phenomenon." *Id.* Contemporaneous diagnostic testing revealed "[m]inimal arthritis" of the lumbosacral spine. R. at 1618. In July 2007, the appellant underwent another VA examination with the same examiner, who diagnosed the appellant with lumbosacral strain with minimal arthritis and reiterated his opinion that this condition was not related to service. R. at 1582. In August 2007, the appellant sought medical treatment and disclosed that he had been rear-ended in a motor vehicle accident, after which he began to experience a stiff neck and headache. R. at 1351.

In May 2009, the Board denied the appellant's claim of entitlement to disability compensation for a low back disorder. R. at 1428-44. In September 2009, the appellant appealed the Board's decision to the Court. R. at 1113. In December 2010, the parties filed a joint motion for partial remand (JMPR), in which they agreed that "it did not appear that [the May 2006 and July 2007 VA] medical opinions provided an adequate rationale for a fully-informed decision by the Board" and that it was "unclear whether the Board properly considered the adequacy of . . . [these] examination reports." R. at 1155, 1158. Later that month, the Court granted the parties' motion. R. at 1115. In May 2011, the Board remanded the claim for further development. R. at 1073-79.

In December 2011, the same examiner who provided the May 2006 and July 2007 VA medical opinions, upon review of the claims file, diagnosed the appellant with spinal stenosis and opined that it was "less likely than not related to service but natural age progression." R. at 1051. In January 2012, a different examiner, a VA internist, reviewed the record and interviewed, but did not examine, the appellant. R. at 1026, 1029. She noted that neither the appellant's narrative of his in-service back injury nor his complaint of recurrent back pain after that injury was reflected

in his service treatment records. R. at 1028. She also observed that the appellant had made "various orthopedic complaints (knee, shoulder) [in October 2002] but expressed no complaint of back pain" until 2005, when he claimed to have a history of chronic back pain, which she further observed was not noted in his VA treatment records or claims file. R. at 1028-29. Upon review of the record and interview of the appellant, the examiner diagnosed him with degenerative disk disease (DDD), opining that spinal stenosis and DDD are less likely than not related to "an acute back strain that occurred more than 30 years prior to his next back complaint and even further from the time of a diagnosis of spinal stenosis." R. at 1029.

In April 2012, the appellant underwent a VA examination by a physician's assistant. R. at 997-1010. The examiner noted the appellant's history of motor vehicle accidents, both prior to service in 1964 and after service in 1976, as well his denial of any back pain after those accidents. R. at 997. The appellant reported that he had low back pain in 1995 secondary to bending over to pick up a 10-pound weight. *Id*. He further stated that he has had chronic and constant low back pain since injuring his back in service but, as observed by the examiner, he did not report having received any medical treatment from the time of his discharge from service until 1995; he stated that his back pain was not formally addressed until 2004 when he received VA treatment for his back. R. at 998. The examiner opined:

> There are no medical records of evidence from 1970-2004 to establish a nexus therefore it would be less likely than not that the [appellant's] spinal stenosis is related to the injury he describes . . . . It would be more likely than not [that] his spinal stenosis is related to natural age progression with consideration [of] wear and tear throughout his life.

R. at 1009-10.

In January 2013, the appellant submitted a statement dated November 2012 from a person, G.P., whom he had known since the 1970s. R. at 960-61. G.P. stated that the appellant had told him he had injured his back in service, that he had "seen [the appellant] in some really bad pain," that the appellant had treated his back pain with over-the-counter medicine, and that the appellant has had back pain since G.P. has known him. R. at 960. In March 2013, the Board remanded the claim for further development, to include a directive that the appellant's claims file "should be reviewed by an appropriate medical specialist for an opinion," who, among other things, "should reconcile any opinion provided with the statements from the [appellant] and G.P. as to reported episodes of back pain since active service." R. at 958.

In September 2014, the appellant underwent another VA medical examination with the same examiner who provided the May 2006, July 2007, and December 2011 VA medical opinions. R. at 376-84. The examiner diagnosed the appellant with lumbosacral strain and spinal stenosis, concluding that "it is less likely that his current [spinal] stenosis is related to one eve[n]t over 40 years ago but rather natural age progression." R. at 377, 383-84.

In March 2015, a VA addendum opinion was provided by the same examiner who wrote the January 2012 VA opinion. R. at 347-48. After reviewing the appellant's claims file, VA treatment records, and the lay statement of G.P., the examiner opined:

> While it is possible that the [appellant] injured or developed disease in his spine after his military service, it's not possible to relate post-service conditions to the self-limited back strain documented in service without resorting to speculation. It is a rare service member or civilian who does not, at one time or another, experience a self-limited musculoskeletal back strain. However, one such event does not qualify as a chronic condition or cause spinal stenosis or any other disease. [G.P.'s] [] statement confirming back pain during the 1970s and thereafter is insufficient to establish the existence of an initial in-service condition that would cause the symptoms and findings occu[r]ring after the service.

R. at 347-48.

On October 13, 2016, the Board denied the appellant's claim for disability compensation for a low back disability. R. at 1-16. This appeal followed.

II. ANALYSIS

The appellant argues, essentially, that the Board erred in (1) relying upon medical opinions that are inadequate and failed to substantially comply with the Board's prior remand directives, and (2) failing to provide adequate reasons or bases in support of its finding that lay statements by the appellant and G.P. carried less probative value than other evidence of record. Appellant's Brief (Br.) at 11-19; Reply Br. at 5-11. The Secretary contends that the Board properly relied upon adequate medical opinions, which substantially complied with prior remands, and that it provided sufficient reasons or bases in assigning less probative value to the lay statements of the appellant and G.P. Secretary's Br. at 8-24.

A. Duty To Assist

"[O]nce the Secretary undertakes the effort to provide an examination [or opinion] when developing a service-connection claim, . . . he must provide an adequate one." *Barr v. Nicholson*, 21 Vet.App. 303, 311 (2007). A medical examination or opinion is adequate "where it is based

upon consideration of the veteran's prior medical history and examinations," *Stefl v. Nicholson*, 21 Vet.App. 120, 123 (2007), "describes the disability, if any, in sufficient detail so that the Board's 'evaluation of the claimed disability will be a fully informed one,'" *id*. (quoting *Ardison v. Brown*, 6 Vet.App. 405, 407 (1994)) (internal quotation marks omitted), and "sufficiently inform[s] the Board of a medical expert's judgment on a medical question and the essential rationale for that opinion," *Monzingo v. Shinseki*, 26 Vet.App. 97, 105 (2012) (per curiam). The law does not impose any reasons-or-bases requirements on medical examiners and the adequacy of medical reports must be based upon a reading of the report as a whole. *Id*. at 105-06.

Additionally, a remand by the Board or this Court "confers on the [appellant] . . . , as a matter of law, the right to compliance with the remand orders," and the Board errs when it fails to ensure compliance with the terms of such a remand. *Stegall v. West*, 11 Vet.App. 268, 271 (1998). Although the Secretary is required to comply with remand orders, it is substantial compliance, not strict compliance, that is required. *See Dyment v. West*, 13 Vet.App. 141, 146-47 (1999) (holding that there was no *Stegall* violation when the examiner made the ultimate determination required by the Board's remand, because such determination "more than substantially complied with the Board's remand order"), *aff'd sub nom. Dyment v. Principi*, 287 F.3d 1377 (Fed. Cir. 2002); *Evans v. West*, 12 Vet.App. 22, 31 (1998) (holding that remand was not warranted because the Secretary substantially complied with the Board's remand order).

The Board's determination of whether there was substantial compliance with a remand and "[w]hether a medical [examination] or opinion is adequate [are] finding[s] of fact, which the Court reviews under the 'clearly erroneous' standard." *D'Aries v. Peake*, 22 Vet.App. 97, 104 (2008) (per curiam); *see Gill v. Shinseki*, 26 Vet.App. 386, 391-92 (2013) (reviewing the Board's finding of substantial compliance for clear error), *aff'd per curiam sub nom. Gill v. McDonald*, 589 F. App'x 535 (Fed. Cir. 2015). A finding of fact is clearly erroneous when the Court, after reviewing the entire evidence, "is left with the definite and firm conviction that a mistake has been committed." *United States v. U.S. Gypsum Co.*, 333 U.S. 364, 395 (1948); *see Gilbert v. Derwinski*, 1 Vet.App. 49, 52 (1990). As with any material issue of fact or law, the Board must provide a statement of the reasons or bases for its determination "adequate to enable a claimant to understand the precise basis for the Board's decision, as well as to facilitate review in this Court." *Allday v. Brown*, 7 Vet.App. 517, 527 (1995); *see* 38 U.S.C. § 7104(d)(1); *Gilbert*, 1 Vet.App. at 56-57.

The Board found that VA had satisfied its duty to assist. The Board concluded that the VA opinions it relied upon were adequate in all respects:

> The April 2012 examiner provided a complete rationale based upon a review of the claims file and a physical examination. The March 2015 examiner conducted an additional review of the claims file, including lay statements and medical records, and provided a detailed medical opinion based on the history and findings. The VA examiners provided detailed rationales and cited supporting data for their conclusions.

R. at 4-5. In addition, the Board determined that "the development ordered in the May 2011 and March 2013 remands has been completed, and no further action is necessary to comply with the remand directives" under *Stegall*, 11 Vet.App. at 271. R. at 3.

Ultimately, the Board denied the appellant's claim based, in part, on the opinions of the "April 2012 and March 2015 VA examiners [who] opined that the [appellant's] current low back disability is not likely related to service." R. at 11. The Board observed again that the opinions were supported by review of the appellant's claims file, specifically finding that their medical opinions were "competent and highly probative, and based on adequate rationales." *Id.* The Board further observed: "The April 2012 examiner found that it was unlikely that spinal stenosis is related to the [appellant's] described in-service injuries. The March 2015 examiner concluded that back strain in service does not qualify as a chronic condition and would not cause spinal stenosis." *Id.* Based upon the foregoing, the Board concluded that there was "no competent evidence of a medical nexus between the current low back disability and an incident of service." *Id.*

The appellant has submitted various arguments in support of his position that the April 2012 VA examination report and the March 2015 VA addendum opinion are each separately inadequate and that they failed to substantially comply with the Board's March 2013 remand. However, as shown above, the Board relied on these opinions collectively, not individually, to determine that VA had satisfied its duty to assist and to find "no competent evidence of a medical nexus between the current low back disability and an incident in service." R. at 11; *see* R. at 4-5.

The appellant first argues that the April 2012 VA examination report and the March 2015 VA addendum opinion are not supported by adequate rationales. With respect to the April 2012 VA examination, the appellant asserts that the opinion was not supported by an adequate rationale in compliance with "the terms of the prior remand in which the parties agreed that future medical examinations or opinions must *provide more clarity . . . and a more robust rationale* than a simple statement that a nexus is unlikely because a particular diagnosed back condition is a naturally

occurring phenomenon." Appellant's Br. at 13 (emphasis added); Reply Br. at 2. With respect to the March 2015 VA addendum, the appellant argues that the opinion "is nonsensical and unresponsive to the medical questions presented," Appellant's Br. at 14-15, and that "the . . . examiner's rationale did not make any sense," Reply Br. at 3. In particular, the appellant appears to take issue with the March 2015 examiner's rationale that (1) the appellant's in-service back strain does not qualify as a chronic condition or cause spinal stenosis or any other disease and (2) G.P.'s statements concerning the appellant's back pain are "insufficient to establish the existence" of a condition that would cause any current low back disability. Reply Br. at 3; *see* Appellant's Br. at 14-15.

The appellant's arguments that the VA medical opinions in question lacked sufficient rationale are not persuasive. Although the Board did not provide an extensive explanation for its finding that the examiners provided detailed rationales, the appellant provides no specific analysis in support of his general contention that the April 2012 examiner did not provide a robust rationale that complied with the terms of the JMPR. Appellant's Br. at 13. Without more, his argument amounts to a disagreement with the Board's assessment of the evidence, which is insufficient to demonstrate that the Board's findings were clearly erroneous. *See D'Aries*, 22 Vet.App. at 104. Similarly, with respect to the March 2015 VA opinion, it is clear from the Board's decision that the Board understood the basis for the examiner's negative nexus opinion—the appellant's in-service "self-limited back strain . . . . does not qualify as a chronic condition or cause spinal stenosis or any other disease" and G.P.'s "statement confirming back pain in the 1970[s] and thereafter is insufficient to establish the existence of an initial in-service condition that would cause the symptoms and findings occurring after service." R. at 10. The Board found that the examiner supported her conclusion with a "detailed rationale" and "data," R. at 5, and the Court finds that the appellant's arguments to the contrary amount to no more than a disagreement with the opinion as well as the Board's reliance upon it to find no evidence of a nexus between the appellant's current low back disability and an in-service incident. *See D'Aries*, 22 Vet.App. at 104.

The appellant next argues that the April 2012 examiner failed to consistently diagnose the appellant with lumbar strain or DDD and provide a nexus opinion for those disabilities, Appellant's Br. at 13; Reply Br. at 2, 7. However, the appellant fails to cite any legal authority supporting the argument that VA examiners must provide consistent diagnoses. Moreover, the Court is not convinced that any error in this regard is prejudicial in light of the Court's determination that the

Board did not err in relying on the March 2015 opinion that it is "not possible to relate post-service conditions to the self-limited back strain documented in service without resorting to speculation. . . . [because] one such event does not qualify as a chronic condition or cause spinal stenosis or any other disease," R. at 347-48.

Additionally, the appellant maintains that the April 2012 examiner could not have substantially complied with the March 2013 remand directive that the examiner address a January 2013 statement by G.P., because the examination predated G.P.'s statement. Appellant's Br. at 14. As a result, he contends that the opinion was "not based on all pertinent evidence" and lacks all probative value. Reply Br. at 3, 7-8. However, the Board's March 2013 remand was directed at obtaining a new opinion to address the appellant's and G.P.'s statements regarding episodes of back pain since service, *see* R. at 958, which the Board in the decision on appeal found was accomplished by the March 2015 VA addendum opinion. R. at 3; *see* R. at 5 (noting that the March 2015 examiner reviewed "lay statements"), 10 (noting that the examiner addressed the January 2013 statement). Moreover, the appellant fails to provide legal support for his contention that the April 2012 opinion would lack all probative value on this basis alone, especially considering that, as the Board noted, the appellant had directly reported to the examiner that he experienced chronic and constant low back pain since discharge. *See* R. at 998; *see also Monzingo*, 26 Vet.App. at 107 (noting, "even if a medical opinion is inadequate to decide a claim," it may be entitled to some probative weight "based upon the amount of information and analysis it contains").

Finally, the appellant asserts that the Board failed to ensure substantial compliance with the March 2013 remand directive that an opinion "should be [obtained] by an appropriate medical specialist" because the March 2015 examiner, a VA internist, is "not an appropriate medical specialist to provide an opinion on a back disorder like an orthopedic surgeon." Appellant's Br. at 14; Reply Br. at 6. Although the Board found substantial compliance with the March 2011 and March 2013 remands, R. at 3 (citing *Stegall*, 11 Vet.App. at 271), it did not specifically address whether the March 2015 examiner was an appropriate medical specialist.

Initially, the Court notes that "VA benefits from a presumption that it has properly chosen a person who is qualified to provide a medical opinion in a particular case," *Parks v. Shinseki*, 716 F.3d 581, 585 (Fed. Cir. 2013) (citing *Sickels v. Shinseki*, 643 F.3d 1362, 1366 (Fed. Cir. 2011)), and the appellant does not argue, nor does the record reflect, that he raised this issue below. Additionally, the appellant does not assert that the record itself reasonably raises some irregularity

in VA's selection process. *Cf. Wise v. Shinseki*, 26 Vet.App. 517, 525-27 (2014) (holding that the presumption of competence does not attach where the face of the examination report reveals some irregularity in the selection of the examiner). Thus, the Board was not required to provide a statement of reasons or bases establishing the medical examiner's competence before relying on her opinion. *See Rizzo v. Shinseki*, 580 F.3d 1288, 1291-92 (Fed. Cir. 2009) (holding that the Board is not required to affirmatively establish the competence of a medical examiner, unless the veteran raises the issue); *see also Parks*, 716 F.3d at 585-86 (holding that the appellant waived his right to rebut the presumption that a nurse practitioner selected by VA was competent because the appellant never challenged the examiner's competence before the Board).

However, even assuming the appellant is not precluded from raising this issue for the first time on appeal, the appellant fails to demonstrate prejudicial error because he fails to explain why an internal medicine specialist may not qualify as "an appropriate medical specialist," given the Board's broad and nonspecific request for an "appropriate medical specialist," and thus fails to explain how or why the March 2015 opinion does not substantially comply with the Board's request. *See Dyment*, 13 Vet.App. at 146-47; *see also D'Aries*, 22 Vet.App. at 104-05 (noting that *Stegall* requires substantial "not strict compliance," and affirming the Board's determination that obtaining an expert opinion from a neurologist substantially complied with VA's request for an opinion by an "'internal medicine specialist'").

For the reasons stated above, the Court is not persuaded by the appellant's arguments on appeal.[1] *Berger v. Brown*, 10 Vet.App. 166, 169 (1997) (the appellant "always bears the burden of persuasion"); *see Hilkert v. West*, 12 Vet.App. 145, 151 (1999) (en banc), *aff'd per curiam*, 232 F.3d 908 (Fed. Cir. 2000) (table). The Court finds that the appellant's arguments are undeveloped or lacking support in legal authority and therefore do not satisfy his burden of persuasion on appeal to show Board error. *See Coker v. Nicholson*, 19 Vet.App. 439, 442 (2006) (per curiam) ("The Court requires that an appellant plead with some particularity the allegation of error so that the Court is able to review and assess the validity of the appellant's arguments."),

[1] The Court declines to address the appellant's additional arguments—raised for the first time in his reply brief—challenging the adequacy of the March 2015 examiner's opinion. *See* Reply Br. at 8. The Court has consistently discouraged parties from raising new arguments after the initial briefing. *See Carbino v. West*, 168 F.3d 32, 34 (Fed. Cir. 1999) ("[I]mproper or late presentation of an issue or argument . . . ordinarily should not be considered."), *aff'g sub nom. Carbino v. Gober*, 10 Vet.App. 507, 511 (1997) (declining to review argument first raised in appellant's reply brief); *Untalan v. Nicholson*, 20 Vet.App. 467, 471 (2006); *Fugere v. Derwinski*, 1 Vet.App. 103, 105 (1990).

vacated on other grounds sub nom. Coker v. Peake, 310 F. App'x. 371 (Fed. Cir. 2008) (per curiam order); *see also Locklear v. Nicholson*, 20 Vet.App. 410, 416 (2006) (holding that the Court is unable to find error when arguments are undeveloped); U.S. VET. APP. R. 28(a)(5).

Additionally, the appellant has failed to meet his burden of demonstrating that the Board committed prejudicial error. *See Shinseki v. Sanders*, 556 U.S. 396, 409 (2009) (holding that harmless-error analysis applies to the Court's review of Board decisions and that the burden is on the appellant to show that he suffered prejudice as a result of VA error); *see also Coker*, 19 Vet.App. at 442.

B. Evidentiary Findings

It is the Board's duty, as factfinder, to determine the credibility and weight to be given to the evidence. *Washington v. Nicholson*, 19 Vet.App. 362, 367-68 (2005); *Owens v. Brown*, 7 Vet.App. 429, 433 (1995) (holding that the Board is responsible for assessing the credibility and weight of evidence and that the Court may overturn the Board's decision only if it is clearly erroneous). This duty includes assessing the probative value of medical evidence. *See Nieves-Rodriguez v. Peake*, 22 Vet.App. 295, 302 (2008) ("Part of the Board's consideration of how much weight to assign [a medical opinion] is the foundation upon which the medical opinion is based."). As with any material issue of fact or law, the Board must provide a statement of the reasons or bases for its determination "adequate to enable a claimant to understand the precise basis for the Board's decision, as well as to facilitate review in this Court." *Allday*, 7 Vet.App. at 527; *see* 38 U.S.C. § 7104(d)(1); *Gilbert*, 1 Vet.App. at 56-57.

In its decision, the Board found the following:

> [T]he [appellant's] statements made in connection with a claim for VA compensation benefits [are] to be of lesser probative value than his more contemporaneous history, including medical records showing that he sought treatment for other complaints but did not report back pain and the absence of complaints or treatment for many years after service. The lay statement of G.P. regarding the [appellant's] complaints of back pain symptoms since the 1970's is likewise considered less probative than the contemporaneous medical records which indicate that the [appellant] denied recurrent back pain.

R. at 11-12.

The appellant argues that the Board provided insufficient reasons or bases for finding that the lay statements of the appellant and G.P. were outweighed by other evidence. Appellant's Br. at 17-18; Reply Br. at 9-10. Specifically, the appellant maintains that the Board "considered and rejected favorable evidence" from the appellant and G.P. and relied upon the "absence of medical

evidence of treatment or complaints of a back disorder since service . . . .[, although n]one of these factors relate in any way to the observations in the certified statement made by [G.P.]." Appellant's Br. at 17. The appellant also contends that "the Board did not cite to any other contemporaneous medical record in which [the appellant] denied recurrent back pain." Reply Br. at 9-10.

The Court is not persuaded by the appellant's arguments on appeal. *Berger*, 10 Vet.App. at 169; *see Hilkert*, 12 Vet.App. at 151. As shown above, the Board, in assigning the lay statements lesser probative value concerning continuity of symptomatology, did not "reject" the contested lay statements. Rather, the Board's analysis reflects that it deemed the appellant's statements less probative because the "more contemporaneous history, *including* medical records" did not reflect continuous complaints, reports, or treatment for back pain for many years after service. R. at 11 (emphasis added). *See Buchanan v. Nicholson*, 451 F.3d 1331, 1337 (Fed. Cir. 2006) (noting it was not ruling out that the Board may "weigh the absence of contemporaneous medical evidence against the lay evidence of record"). Additionally, the Board ascribed lesser probative value to G.P.'s statements concerning the appellant's back symptoms because contemporaneous medical records, i.e., the 1978 examination, showed that the appellant denied recurrent back pain after discharge from service. *See id*. The appellant cites no legal authority requiring the Board to cite to additional contemporaneous medical evidence, other than the March 1978 report of medical history and report of medical examination, in order to find G.P.'s statements of lower probative value. The Court finds that the reasons or bases provided by the Board are sufficient and clearly explain its findings. *See Allday*, 7 Vet.App. at 527; *see* 38 U.S.C. § 7104(d)(1); *Gilbert*, 1 Vet.App. at 56-57. Moreover, as maintained by the Secretary, the appellant's arguments amount to mere disagreement with how the Board weighed the evidence. Secretary's Br. at 23.

III. CONCLUSION

After consideration of the parties' pleadings and a review of the record, the Board's October 13, 2016, decision is AFFIRMED.

DATED: February 6, 2018

Copies to:

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NON-PRECEDENTIAL

UNITED STATES COURT OF APPEALS FOR VETERANS CLAIMS

NO. 16-3738

ERNEST L. FRANCWAY, JR. APPELLANT,

V.

ROBERT L. WILKIE,
ACTING SECRETARY OF VETERANS AFFAIRS, APPELLEE.

Before ALLEN, MEREDITH, and TOTH, *Judges.*

O R D E R

Note: Pursuant to U.S. Vet. App. R. 30(a), this action may not be cited as precedent.

On February 6, 2018, the Court issued a memorandum decision that affirmed the October 13, 2016, Board of Veterans' Appeals (Board) decision that denied entitlement to disability compensation for a low back disability. On February 27, 2018, the appellant filed a motion for panel decision pursuant to Rule 35 of the Court's Rules of Practice and Procedure. The motion for a panel decision will be granted.

Based on review of the pleadings and the record of proceedings, it is the decision of the panel that the appellant fails to demonstrate that 1) the single-judge memorandum decision overlooked or misunderstood a fact or point of law prejudicial to the outcome of the appeal, 2) there is any conflict with precedential decisions of the Court, or 3) the appeal otherwise raises an issue warranting a precedential decision. U.S. VET. APP. R. 35(e); *see also Frankel v. Derwinski*, 1 Vet.App. 23, 25-26 (1990).

Absent further motion by the parties or order by the Court, judgment will enter on the underlying single-judge decision in accordance with Rules 35 and 36 of the Court's Rules of Practice and Procedure.

Upon consideration of the foregoing, it is

ORDERED that the motion for panel decision is granted. It is further

ORDERED that the single-judge memorandum decision remains the decision of the Court.

DATED: May 3, 2018 PER CURIAM.

Copies to:

Sean A. Ravin, Esq.

VA General Counsel (027)

Not Published

UNITED STATES COURT OF APPEALS FOR VETERANS CLAIMS

NO: 16-3738

ERNEST L. FRANCWAY, JR., APPELLANT,

V.

ROBERT L. WILKIE,
ACTING SECRETARY OF VETERANS AFFAIRS, APPELLEE.

JUDGMENT

The Court has issued a decision in this case, and has acted on a motion under Rule 35 of the Court's Rules of Practice and Procedure.

Under Rule 36, judgment is entered and effective this date.

Dated: May 25, 2018

FOR THE COURT:

GREGORY O. BLOCK
Clerk of the Court

By: /s/ Michael V. Leonard
Deputy Clerk

Copies to:

Sean A. Ravin, Esq.

VA General Counsel (027)

General Docket
United States Court of Appeals for Veterans Claims

Case Number:16-3738 **Docketed:** 11/07/2016
Ernest L. Francway, Jr. v. Robert L. Wilkie
Appeal From: Department of Veteran Affairs
Fee Status: dfh

Case Type Information:
1) NOA - Veterans Appeal
2) -
3) -

Prior Cases:
None

Current Cases:
None

Ernest L. Francway, Jr. Appellant	Ernest L. Francway, Jr. [NTC] [redacted] Westlake, OH 44145
v.	
Robert L. Wilkie, Secretary of Veterans Affairs Appellee	Robert Schneider, Esq., Attorney [COR LD NTC] Firm: 202-632-6988 Department of Veterans Affairs, OGC (027) 810 Vermont Ave., NW Washington, DC 20420 OGC-ICM8, Non-Attorney [COR NTC] Department of Veterans Affairs, OGC (027) 810 Vermont Avenue, N.W. Washington, DC 20420

Ernest L. Francway, Jr.,

Appellant

v.

Robert L. Wilkie, Secretary of Veterans Affairs,

Appellee

11/07/2016	0 pg, 0 KB	Notice of Appeal (SEB)
11/07/2016	1 pg, 178.49 KB	Declaration of Financial Hardship (SEB)
11/07/2016	1 pg, 57.89 KB	Appearance of Sean A. Ravin, Esq., as lead counsel for the appellant (SEB)
11/07/2016	0 pg, 0 KB	Fee Agreement (SEB)
11/08/2016	0 pg, 0 KB	Notice of Docketing for BVA's decision w/in 30 days; RBA w/in 60 days (SEB)
11/21/2016	0 pg, 0 KB	BVA Decision transmittal (O)
11/21/2016	15 pg, 267.53 KB	Copy of BVA Decision (O)
12/22/2016	1 pg, 6.83 KB	Appearance of Attorney(s) Robert Schneider for party(s) Appellee Robert A. McDonald, in case 16-3738 as lead counsel (RS)
01/05/2017	1 pg, 31.3 KB	Record Before the Agency notice (O)
01/24/2017	1 pg, 56.36 KB	Mot of Appellant to extend time to respond to the Record Before the Agency. 03/10/2017 (SAR)
01/25/2017		Clerk's stamp ord granting nunc pro tunc to 01/24/2017, appellant's motion to extend time to respond to the Record Before the Agency until 03/10/2017 (AMN)
03/13/2017	1 pg, 38.46 KB	Notice to file Appellant's Brief w/in 60 days (AMN)
03/21/2017	2 pg, 11.67 KB	ORDERED that the Court will initiate a telephonic briefing conference on April 19, 2017, at 9:30 AM (ET). It will be conducted by Andrew P. Reynolds, Esq., of the Court's Central Legal Staff (CLS), and this conference may be rescheduled by the Court only upon a showing of good cause. It is further ORDERED that not later than 14 days prior to the scheduled conference, the appellant's counsel or representative shall submit to the Secretary and the Central Legal Staff (by e-mail or fax), a summary of the issues that the appellant intends to raise in the appeal before the Court, to include citations to the relevant authorities and the pertinent documents in the record. (CLS). (AMN)
04/05/2017	1 pg, 69.38 KB	Rule 33 Certificate of Service (SAR)
04/19/2017		Conference held (APR)
04/27/2017	1 pg, 63.35 KB	Mot of Appellant to extend time to file appellant brief. Requested date 07/03/2017. (SAR)
04/28/2017		Clerk's stamp ord granting appellant's motion to extend time to file appellant's brief until 7/3/2017 (MVL)
06/23/2017	1 pg, 102.1 KB	Appearance of Attorney(s) Manuel Guanipa for party(s) Appellant Ernest L. Francway Jr., in case 16-3738 as attorney (MG)
06/23/2017	1 pg, 102.1 KB	Appearance of Attorney(s) Manuel Guanipa for party(s) Appellant Ernest L. Francway Jr., in case 16-3738 as non-attorney practitioner (MG)
07/05/2017	23 pg, 149.44 KB	Appellant's Brief (SAR)
08/30/2017	2 pg, 9.43 KB	Mot of Appellee to extend time to file appellee brief. Requested date 10/20/2017. (RS)
08/30/2017		Clerk's stamp ord granting appellee's motion to extend time to file appellee's brief until 10/20/2017 (MVL)
10/10/2017	30 pg, 73.43 KB	Appellee's Brief (RS)
10/10/2017	1 pg, 113.11 KB	Mot of Appellant to extend time to file appellant's reply brief. Requested date 12/08/2017. (MG)
10/10/2017		Clerk's stamp ord granting appellant's motion to extend time to file appellant's reply brief until 12/08/2017

		(AMN)
12/09/2017	14 pg, 158.33 KB	RECEIVED: Appellant's reply brief--[Edited 12/12/2017 by AMN] (SAR)
12/11/2017	1 pg, 53.81 KB	Mot of Appellant for leave to file *his reply brief out of time.* (SAR)
12/12/2017	1 pg, 81.22 KB	Judge's stamp order granting appellant's motion for leave to file reply brief out of time (ALLEN) (AMN)
12/12/2017	14 pg, 155.64 KB	Appellant's reply brief (AMN)
12/22/2017	0 pg, 0 KB	Record of Proceedings (RS)
01/10/2018		Assigned case to Judge Meredith (KEM)
02/06/2018	13 pg, 171.4 KB	Memorandum Decision that the BVA decision is affirmed (MEREDITH) (AMN)
02/27/2018	5 pg, 105.57 KB	RECEIVED: Mot of Appellant for reconsideration and in the alternative by Panel--[Edited 02/28/2018 by AMN] (SAR)
02/27/2018	5 pg, 105.56 KB	Corrected Mot of Appellant for reconsideration and in the alternative by Panel--[Edited 02/28/2018 by AMN] (SAR)
05/03/2018	2 pg, 10.88 KB	PER CURIAM ORDERED that the motion for panel decision is granted. It is further ORDERED that the single-judge memorandum decision remains the decision of the Court. (ALLEN, MEREDITH and TOTH) (AMN)
05/25/2018	1 pg, 8.44 KB	Judgment (MVL)
05/25/2018	1 pg, 62.58 KB	Mot of Appellant (Sean A. Ravin) to withdraw as counsel (SAR)
05/29/2018	1 pg, 8.84 KB	ORDERED that the motion is granted. The appellant is treated as self-represented until a qualified representative enters an appearance. The Court does not appoint counsel.(CPS) (AMN)
06/25/2018	2 pg, 36.85 KB	Appellant's Notice of Appeal to the U.S. Court of Appeals for the Federal Circuit (AMN)
07/05/2018	2 pg, 36.85 KB	Appellant's Notice of Appeal transmitted to U.S. Court of Appeals for the Federal Circuit (AMN)
07/09/2018	1 pg, 87.35 KB	RECEIVED: Notice of Docketing from the U.S. Court of Appeals for the Federal Circuit dated 07/09/2018; case number [18-2136] (AMN)

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APPELLANT'S BRIEF

UNITED STATES COURT OF APPEALS
FOR VETERANS CLAIMS

16-3738

ERNEST L. FRANCWAY, JR.,

Appellant,

v.

DAVID J. SHULKIN, M.D.,
SECRETARY OF VETERANS AFFAIRS

Appellee.

SEAN A. RAVIN, ESQ.
COUNSEL FOR APPELLANT

1550 MADRUGA AVENUE, SUITE 414
CORAL GABLES, FLORIDA 33146
PHONE: (202) 607-5731
FAX: (202) 318-0205

Further, A remand order by the Board "confers on the veteran. . . , as a matter of law, the right to compliance with the remand orders". *Stegall v. West*, 11 Vet. App. 268, 271 (1998). The Court has also held that where "the remand orders of the Board or this Court are not complied with, the Board itself errs in failing to insure compliance." Id.

The Court has held that a remand is meant to "entail a critical examination of the justification for the decision." *Fletcher v. Derwniski,* 1 Vet.App. 394, 397 (1991). The Court wrote, in pertinent part:

> We do not mean to imply that a remand, such as is done here, is merely for the purpose of rewriting the opinion so that it will superficially comply with the "reasons or bases" requirement of 38 U.S.C. §7104(d)(1) []. A remand is meant to entail a critical examination of the justification for the decision. The Court expects that the BVA will reexamine the evidence of record, seek any other evidence the Board feels is necessary, and issue a timely, well-supported decision in this case.

Fletcher at 397. Finally, the terms of a prior remand are complied with when there is substantial compliance. *D'Aries v. Peake,* 22 Vet.App. 97, 105 (2008); *see also Dyment v. West*, 13 Vet.App. 141, 146-47 (1999).

In support of its finding that Mr. Francway did not have a currently diagnosed back condition related to any injuries suffered in service, the Board relied upon a VA examination in April 2012 and an addendum opinion from March 2015. R. 4-5 (1-16). Consequently, the Board found that the Secretary's duty to assist with respect to obtaining a VA examination or opinion was met. R. 5 (1-16). Neither the April 2012 examination report nor the March 2015 medical opinion addendum satisfies the duty to assist because: (1) examiners failed to provide a sufficient rationale for their opinions; (2) examiners failed to provide consistent

diagnoses of Mr. Francway's low back disorder; and (3) they did not comply with the terms of prior remands.

The April 2012 examination was conducted by a physician's assistant (PA) who diagnosed moderate to severe spinal stenosis at L4-L5 secondary to disc bulge. R. 1007 (997-1010).). PA Hopperton provided an unfavorable opinion and wrote, in pertinent part:

> There are no medical records of evidence from 1970-2004 to establish a nexus therefore it would be less likely than not that the veteran's spinal stenosis is related to the injury he describes above. It would be more likely than not his spinal stenosis is related to natural age progression with consideration wear and tear throughout his life.

R. 1009-1010 (997-1010). PA Hopperton did not diagnose lumbar strain or degenerative disc disease; two conditions which have been consistently diagnosed throughout while the claim was pending Id. Since PA Hopperton did not identify or diagnose lumbar strain or degenerative disc disease, he failed to provide an opinion as to any link between currently diagnosed lumbar strain and lumbar strain diagnosed in service or degenerative disc disease and the back injuries suffered in service.

Additionally, PA Hopperton's rationale is inadequate to satisfy the terms of the prior remand in which the parties agreed that future medical examinations or opinions must provide more clarity in light of Mr. Francway's diagnosed back strain in service and a more robust rationale than a simple statement that a nexus is unlikely because a particular diagnosed back condition is a naturally occurring phenomenon. R. 1155-56 (1154-59).

Further, the April 2012 examination by PA Hopperton cannot satisfy the terms of the Board's March 2013 remand directive. R. 958 (950-59). The Board explicitly ordered a medical opinion by an "appropriate medical specialist" to specifically "reconcile any opinion

provided with the statements from the Veteran and G.P. as to reported episodes of back pain since active service." Id. PA Hopperton is not a medical specialist such as an orthopedic surgeon, and his opinion predates the November 2012 statement from Mr. Petrry, in which he certified that that he was Mr. Francway's friend since the 1970's; that he has personally observed Mr. Francway suffer from debilitating back pain; that Mr. Francway described his back pain as originating since his injury in service aboard a ship; that Mr. Francway used over the counter medicine to treat his back pain; and that Mr. Francway has had back pain ever since he knew him. R. 960 (960-965). In its remand directive, the Board specifically ordered an opinion to take into consideration Mr. Petrry's profoundly favorable observations and statement.

Likewise, the March 2015 addendum opinion is similarly inadequate. In a March 2015 report, Dr. Amy Schecter, an internist, wrote that she could not provide an opinion without resorting to speculation. Dr. Schecter wrote, in pertinent part:

> While it is possible that the veteran injured or developed disease in his spine after his military service, it's not possible to relate post-service conditions to the self-limited back strain documented in service without resorting to speculation. … A buddy statement confirming back pain during the 1970s and thereafter is insufficient to establish the existence of an initial in-service condition that would cause the symptoms and findings occurring after the service.

R. 348-49 (348-49). Dr. Schecter is not an appropriate medical specialist to provide an opinion on a back disorder like an orthopedic surgeon. Presumably, the Board desired an appropriate medical specialist and not simply any doctor when it directed an opinion by an appropriate medical specialist. Further, Dr. Schecter's opinion is nonsensical and unresponsive to the medical questions presented. Namely, is it as likely as not that currently

diagnosed back disorders such as lumbar strain are at least as likely as not etiologically related to the injuries Mr. Francway suffered in service, to include the diagnosis of a back strain? For these reasons, the March 2015 addendum opinion similarly fails to comply with the parties prior remand regarding clarity of opinions and a sufficient supporting rationale.

The Board's failure to ensure compliance with the duty to assist as well as compliance with the terms of prior remands is prejudicial error. Mr. Francway is entitled to compliance with the duty to assist as well as compliance with the terms of all prior remands. The failure to ensure compliance precludes statutory development of his claim for veterans' disability compensation.

B. The Board failed to provide an adequate statement of reasons or bases to support its finding that pertinent favorable evidence was outweighed by the probative value of other evidence.

The Board must include in its decision a written statement of the reasons or bases for its findings and conclusions, adequate to enable an appellant to understand the precise basis for the Board's decision as well as to facilitate review in this Court. *See* 38 U.S.C. § 7104(d)(1); *Allday v. Brown*, 7 Vet.App. 517, 527 (1995); *Gilbert*, 1 Vet.App. 49, 56-57. To comply with this requirement, the Board must analyze the credibility and probative value of the evidence, account for the evidence that it finds persuasive or unpersuasive, and provide the reasons for its rejection of any material evidence favorable to the claimant. *See Caluza v. Brown*, 7 Vet.App. 498, 506 (1995), *aff'd per curiam*, 78 F.3d 604 (Fed.Cir. 1996) (table); *Gilbert*, 1 Vet.App. at 57.

Additionally, the Board's reasons or bases must include the Board's response to the various arguments advanced by the claimant. *Moore v. Derwinski,* 1 Vet. App. 401, 404 (1991). In *Moore*, the Court wrote, in pertinent part:

> In making its statement of findings, 'the Board must identify those findings it deems crucial to its decision and account for the evidence which it finds to be persuasive or unpersuasive' ... In providing its 'reasons or bases,' the Board must include in its decision 'the precise basis for that decision ...[and] the Board's response to the various arguments advanced by the claimant.' ... This must include 'an analysis of the credibility or probative value of the evidence submitted by and on behalf of the veteran in support of [his or her] claim [and] a statement of the reasons or bases for the implicit rejection of this evidence by the Board'.

Moore at 404. *(emphasis added).*

IN THE UNITED STATES COURT OF APPEALS FOR VETERANS CLAIMS

No. 16-3738

ERNEST L. FRANCWAY, JR.,

Appellant,

v.

DAVID J. SHULKIN, M.D.,
Secretary of Veterans Affairs,

Appellee.

APPELLANT'S REPLY BRIEF

REPLY ARGUMENT

A. The Court should find the Secretary's arguments to be unpersuasive.

In his brief, Mr. Francway argued that the Board failed to ensure compliance with the Secretary's statutory duty to assist. Appellant's Brief (App.Br. at 11-15). In particular, Mr. Francway argued that the Board failed to ensure that the Secretary provided a thorough medical examination consistent with the terms of prior remands. Id. Notably, while the Board relied upon findings and conclusions in an April 2012 examination and a March 2015 medical opinion, neither the examination nor the opinion complied with the terms of prior remands. Id. A prior remand obligated the Secretary to provide examination by an "appropriate medical specialist[1]" to include a reconciliation of lay statements pertaining to

[1] A "specialist" is "one who specializes in a particular occupation, practice, or field of study", i.e. "a specialist in disorders of the immune system". Merriam-Webster.com,

continuous symptoms of back pain since a documented back injury in service. R. 958 (950-59)

As previously argued, neither VA examiner was qualified to examine and render an opinion consistent with the prior remand directives. App.Br. at 13-14. To wit, the April 2012 examination was conducted by a physician's assistant and the March 2015 medical opinion was provided by an internist. App.Br. at 13-14. While a physician's assistant and internist are qualified health care professionals presumed competent to conduct examinations and render medical opinions, neither can be considered an "appropriate medical specialist" for an orthopedic matter. Presumably, the Board's directive that Mr. Francway be examined by an "appropriate medical specialist" did not broadly encompass examination by any medical professional regardless of qualification. To hold as such would render the Board's directive meaningless.

Mr. Francway argued further that the April 2012 examination was inadequate because the examiner did not render an opinion regarding the likelihood that a back strain diagnosed after service was not at least as likely as not due to the back strain diagnosed in service. App.Br. at 13. Further, the April 2012 examiner also did not offer any opinion regarding the relationship of Mr. Francway's diagnosed degenerative disc disease to his recorded injuries to his back in service. Id. Mr. Francway also argued that the April 2012 examination report was inadequate because the opinion was not supported by a robust rationale. Id. Finally, Mr.

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https://www.merriam-webster.com/dictionary/specialist. Dorland's Medical Dictionary Online defines, "specialist" as "a physician whose practice is limited to a particular branch of medicine or surgery, especially one who, by virtue of advanced training, is certified by a specialty board as being qualified to so limit his practice."
https://www.dorlandsonline.com/dorland/definition?id=100098903&searchterm=specialist

Francway argued that it was error for the Board to rely upon the April 2012 examination report because that examiner had not reviewed pertinent favorable evidence which was developed and submitted after that report had been written. Specifically, the April 2012 report did not take into consideration Mr. Petrry's November 2012 statement which served as the basis for a remand for a new medical examination and opinion. R. 958 (950-59).

With specific regard to the March 2015 report and opinion, Mr. Francway argued that the March 2015 examiner's rationale did not make any sense. App.Br. at 14-15. In essence, Dr. Schecter opined that it was not possible to relate post-service conditions to Mr. Francway's diagnosis of back strain in service without resorting to speculation because a single event of back strain: (a) does not qualify as a chronic condition; (b) does not cause spinal stenosis; and (c) does not cause any other disease. Further, Dr. Schecter wrote that a buddy statement confirming the consistency of back pain since service is insufficient to establish the existence of an initial in-service condition that would cause the symptoms and findings occurring after service. In his brief, Mr. Francway argued that Dr. Schecter misunderstood the relevant inquiry; to wit, whether any diagnosed lumbar disorder is at least as likely as not due to any diagnosed condition, incident, or injuries (plural) that Mr. Francway suffered in service.

Mr. Francway further argued that the Board did not provide an adequate statement of reasons or bases to support its finding that the probative value of a sworn statement by Mr. Petrry, his friend of over 40 years, was outweighed by the probative value of other evidence. App.Br. at 16-18.

Further, the Secretary appeared to imply that because another doctor electronically signed the March 2015 opinion by Dr. Schecter,, the opinion met the Board's remand directives. Sec.Br. at 20. Last, the Secretary argued that the March 2015 opinion was adequate and supported by a complete rationale. Sec.Br. at 20-21.

Finally, the Secretary argued that the Board provided an adequate statement of reasons or bases to support its finding assigning little probative weight to Mr. Petrry's lay statement regarding his observations of Mr. Francway's complaints of symptoms of a back disability over the course of their forty plus year friendship. Sec.Br. at 21-23.

1. The April 2012 examination and March 2015 opinion relied upon by the Board did not satisfy the duty to assist and did not substantially comply with terms of prior remands.

The Secretary is precluded from correcting an inadequate statement of reasons or bases. *Smith v. Nicholson*, 19 Vet.App. 63, 73 (2005)(rejecting the Secretary's rationale for decision because "the Board did not set forth any such rationale; it is not the task of the Secretary to rewrite the Board's decision through his pleadings filed in this Court."); *Wanless v. Principi*, 18 Vet.App. 337, 343 (2004)(Steinberg, J. concurring)(noting that "Court's role is to review whether the Board in its decision, rather than the Secretary in his brief, provided an adequate statement of reasons or bases").*See Martin v. Occupational Safety & Health Review Comm'n*, 499 U.S. 144, 156 (1991) ("'[L]itigating positions' are not entitled to deference when they are merely appellate counsel's 'post hoc rationalizations' for agency action, advanced for the first time in the reviewing court.").

At the outset, the Court should note that the parties disagree significantly over whether the terms of a prior remand obligated the Secretary to provide an examination to Mr. Francway by an "appropriate medical specialist". While the Board did not elaborate on the type of medical specialty that would be appropriate to examine Mr. Francway, this claim clearly involves an orthopedic disability. R. 958 (950-959). Mr. Francway is not arguing that a physician's assistant and an internist are not competent to offer medical evidence, but rather when the Board directs the Secretary to provide an examination by an appropriate medical specialist, the Secretary is obligated to comply with the Board's directive. In other words, when the Board explicitly dictates an examination by an appropriate medical specialist, the Secretary does not substantially comply with the terms of a prior remand if a subsequent examination or opinion is provided by a health care professional that is not an appropriate medical specialist.

Thereafter, the question becomes whether a physician's assistant or an internist is an appropriate medical specialist to provide medical evidence in this matter. Mr. Francway asserts that neither a physician's assistant nor an internist is an appropriate medical specialist to diagnose and opine on the etiology of orthopedic disabilities.

In his response, the Secretary acknowledged that the April 2012 VA examiner failed to diagnose lumbar strain or degenerative disc disease, and as such failed to provide any opinion regarding a nexus between those disorders and injuries suffered in service. Sec.Br. at 13-14. In other words, the Secretary argued that the April 2012 VA examination by a physician's assistant was adequate insofar as he provided an opinion concerning spinal stenosis. Id. The Secretary did not address how the April 2012 examiner could have

provided an adequate rationale for *any* finding or conclusion in light of the fact that that he did not address the other significant, pertinent orthopedic diagnoses, including those made by prior VA examiners.

With regard to the Secretary's argument that subsequent examinations and opinions corrected any purported error in the April 2012 examination report, the Court should note that this is not a reason or basis provided by the Board in support of its finding or conclusion. R. 1-16 (1-16). It is telling that the Secretary did not cite to any page in the Board's decision for the proposition that the Board relied upon either the September 2014 examination report or the October 2014 addendum. Indeed, the regional office noted that the September 2014 examination report and October 2014 addendum did not satisfy the terms of the Board's remand order. R. 351-52 (351-52).

With regard to the Secretary's argument that the April 2012 examiner could not have complied with the subsequent remand order to consider, discuss, or reconcile the pertinent favorable evidence received by VA in January 2013, the Secretary misses the point. The Board ordered a remand for a new opinion because Mr. Petrry's statement was pertinent, favorable evidence that indicated that Mr. Fancway's disability symptoms were present for a significant period of time prior to the date he filed his initial claim. R. 958 (950-59). To wit, the Board wrote, in pertinent part:

> The Veteran claims file should be reviewed by an appropriate medical specialist for an opinion as to whether there is at least a 50 percent probability or greater (*at least as likely as not*) that he has a low back disorder as a result of active service. … <u>The examiner should reconcile any opinion provided with the statement from the Vetearn and G.P. as to reported episodes of back pain since active service. An explanation should be provided identifying the reasons if any item of evidence is considered to be not credible.</u>

BOARD OF VETERANS' APPEALS
DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON, DC 20420

IN THE APPEAL OF
ERNEST L. FRANCWAY, JR.

[redacted]

DOCKET NO. 04-09 153) DATE OCT 13 2016
)
)

On appeal from the
Department of Veterans Affairs Regional Office in Cleveland, Ohio

THE ISSUE

Entitlement to service connection for a low back disability.

REPRESENTATION

Veteran represented by: Sean A. Ravin, Attorney

WITNESS AT HEARING ON APPEAL

Veteran

ATTORNEY FOR THE BOARD

Catherine Cykowski, Counsel

IN THE APPEAL OF
ERNEST L. FRANCWAY, JR.

[redacted]

INTRODUCTION

The Veteran had active service from August 1968 to May 1970.

This matter comes before the Board of Veterans' Appeals (Board) on appeal from May 2003 rating decision of the Department of Veterans (VA) Regional Office (RO) in Cleveland, Ohio.

In October 2005, the Veteran testified at a videoconference hearing before the undersigned Veterans Law Judge. A transcript of the hearing is of record.

In a May 2009 decision, the Board denied service connection for lumbosacral strain. The Veteran appealed the Board's decision to the United States Court of Appeals for Veterans' Claims. In December 2010, the Court granted a Joint Motion for Partial Remand and remanded the case to the Board for action consistent with the Joint Motion.

The case was previously remanded in May 2011 and March 2013. In May 2011, the Board remanded the case to obtain a VA examination. A VA examination was obtained in April 2012. The claim was remanded in March 2013 to obtain an addendum medical opinion. A medical opinion was obtained in March 2015. The Board finds that the development ordered in the May 2011 and March 2013 remands has been completed, and no further action is necessary to comply with the remand directives. *Stegall v. West,* 11 Vet. App. 268, 271 (1998).

FINDING OF FACT

A chronic low back disorder to include arthritis of the lumbar spine did not manifest during service or within one year of separation from service, and a current low back disability is not causally related to any disease, injury or event in active service.

IN THE APPEAL OF
ERNEST L. FRANCWAY, JR. [redacted]

CONCLUSION OF LAW

The criteria for service connection for a low back disability have not been met. 38 U.S.C.A. §§ 1110, 1112, 1113, 5103, 5103A, 5107 (West 2014); 38 C.F.R. §§ 3.303, 3.307, 3.309 (2015).

REASONS AND BASES FOR FINDING AND CONCLUSION

Duties to Notify and Assist

As provided for by the Veterans Claims Assistance Act (VCAA), VA has a duty to notify and assist claimants in substantiating a claim for VA benefits. 38 U.S.C.A. §§ 5100, 5102, 5103, 5103A, 5107, 5126 (West 2014); 38 C.F.R. §§ 3.102, 3.156(a), 3.159 and 3.326(a) (2015). A VCAA letter was sent to the Veteran in July 2003 and in July 2006.

VA also has a duty to assist the Veteran in the development of the claim. This duty includes assisting the Veteran in the procurement of service medical records and pertinent treatment records and providing an examination when necessary. 38 U.S.C.A. § 5103A; 38 C.F.R. § 3.159. The record indicates that the RO obtained all information relevant to the Veteran's claim. The service treatment records have been obtained, as well as post-service VA and private treatment records. The RO requested medical records from the Social Security Administration. A negative response was received in June 2011. In October 2011, the RO issued a formal finding of unavailability for records from the Social Security Administration. No additional effort is warranted to try and obtain Social Security records, as it appears that any such additional efforts would be futile. 38 C.F.R. § 3.159(c)(2).

The Veteran had a VA examination in April 2012, and an addendum opinion was obtained in March 2015. When VA undertakes to provide a VA examination or obtain a VA opinion, it must ensure that the opinion is adequate. *Barr v. Nicholson,* 21 Vet. App. 303, 312 (2007). The April 2012 examiner provided a complete rationale based upon a review of the claims file and a physical examination. The

[redacted]

March 2015 examiner conducted an additional review of the claims file, including lay statements and medical records, and provided a detailed medical opinion based on the history and findings. The VA examiners provided detailed rationales and cited supporting data for their conclusions. Accordingly, the Board finds that VA's duty to assist with respect to obtaining a VA examination or opinion has been met. 38 C.F.R. § 3.159(c)(4).

Furthermore, as noted, the Veteran was afforded a Board hearing in October 2005. The Veterans Law Judge and the Veteran's representative outlined the issues on appeal, and the Veteran and representative engaged in a colloquy as to substantiation of the claims, including identifying relevant types of evidence. Overall, the hearing was legally sufficient and the duty to assist has been met. 38 U.S.C.A. § 5103A (West 2014); *Bryant v. Shinseki,* 23 Vet. App. 488 (2010).

The Board finds that all necessary development has been accomplished, and therefore appellate review may proceed without prejudice to the Veteran. No further notice or assistance to the Veteran is required to fulfill VA's duty to assist the Veteran in the development of the claim. *Smith v. Gober,* 14 Vet. App. 227 (2000), *aff'd* 281 F.3d 1384 (Fed. Cir. 2002); *Dela Cruz v. Principi,* 15 Vet. App. 143 (2001); *see also Quartuccio v. Principi,* 16 Vet. App. 183 (2002).

Service Connection Criteria

Service connection will be granted if it is shown that the veteran suffers from disability resulting from an injury suffered or disease contracted in line of duty, or for aggravation of a preexisting injury suffered or disease contracted in line of duty, in the active military, naval, or air service. 38 U.S.C.A. § 1110; 38 C.F.R. § 3.303(a). Service connection may also be granted for any disease diagnosed after discharge, when all the evidence, including that pertinent to service, establishes that the disease was incurred in service. 38 C.F.R. § 3.303(d). As a general matter, service connection for a disability requires evidence of: (1) the existence of a current disability; (2) the existence of the disease or injury in service, and; (3) a relationship or nexus between the current disability and any injury or disease during service. *Shedden v. Principi,* 381 F.3d 1163 (Fed. Cir. 2004); *see also Hickson v.*

West, 12 Vet. App. 247, 253 (1999), *citing Caluza v. Brown,* 7 Vet. App. 498, 506 (1995), *aff'd,* 78 F.3d 604 (Fed. Cir. 1996).

The Veteran has been diagnosed with degenerative changes of the lumbar spine. Arthritis is a chronic disease listed under 38 C.F.R. § 3.309(a); therefore, the theory of continuity of symptomatology under 38 C.F.R. § 3.303(b) applies to the claim for service connection for a low back disability. *Walker v. Shinseki,* 708 F.3d 1331 (Fed. Cir. 2013).

Where the evidence shows a "chronic disease" in service or "continuity of symptoms" after service, the disease shall be presumed to have been incurred in service. For the showing of "chronic" disease in service, there is required a combination of manifestations sufficient to identify the disease entity, and sufficient observation to establish chronicity at the time. With chronic disease as such in service, subsequent manifestations of the same chronic disease, at any later date, however remote, are service connected, unless clearly attributable to intercurrent causes. If a condition noted during service is not shown to be chronic, then generally a showing of "continuity of symptoms" after service is required for service connection. 38 C.F.R. § 3.303(b).

Additionally, where a veteran served 90 days or more of active service, and certain chronic diseases, such as arthritis, became manifest to a degree of 10 percent or more within one year after the date of separation from such service, such disease shall be presumed to have been incurred in or aggravated by service, even though there is no evidence of such disease during the period of service. 38 U.S.C.A. §§ 1101, 1112, 1113, 1137 (West 2014); 38 C.F.R. §§ 3.307, 3.309(a). While the disease need not be diagnosed within a presumptive period, it must be shown, by acceptable medical or lay evidence, that there were characteristic manifestations of the disease to the required degree during that time. *Id.*

Competency of evidence differs from weight and credibility. The former is a legal concept determining whether testimony may be heard and considered by the trier of fact, while credibility is a factual determination going to the probative value of the evidence to be made after the evidence has been admitted. *Rucker v. Brown,* 10

Vet. App. 67, 74 (1997); *Layno v. Brown,* 6 Vet. App. 465, 469 (1994); *see also Cartright v. Derwinski,* 2 Vet. App. 24, 25 (1991) ("although interest may affect the credibility of testimony, it does not affect competency to testify").

In determining whether service connection is warranted for a disability, VA is responsible for determining whether the evidence supports the claim or is in relative equipoise, with the veteran prevailing in either event, or whether a preponderance of the evidence is against the claim, in which case the claim must be denied. 38 U.S.C.A. § 5107(b); 38 C.F.R. § 3.102, *Gilbert v. Derwinski,* 1 Vet. App. 49 (1990).

The Veteran asserts that his current low back disability is related to incidents in service including motor vehicle accidents and other incidents. In his service connection claim, the Veteran noted a left sided stomach and back injury during service. At the Board hearing, the Veteran testified that he was on the flight deck carrying wheel chocks when he was hit by a gust of wind. The Veteran testified that he had pain in his back and dropped the chocks. He testified that he was treated for a muscle strain and was given pain pills and put on light duty for three months.

Service treatment records reflect complaints of abdominal pain and back pain. The Veteran was seen in April 1969 with a complaint of a pulled muscle in the right side. He was put on light duty for 24 hours. An entry the following day noted that the Veteran was working on the flight deck lifting the pulley when he got sharp pain in the left lower abdomen. The Veteran complained of vomiting dark red-black blood. He was admitted to the ward and was discharged after four days.

Service treatment records show that the Veteran complained of right side low back pain in December 1969. Examination showed no deformity, and a test for fracture was negative. There was some pain on rotation. The Veteran was instructed to return the following day. An entry the next day noted low back pain, with first symptoms in November 1969. The record indicates that the Veteran was placed on light duty. Service treatment records do not include other complaints or findings regarding the low back.

There is no evidence that arthritis of the lumbar spine manifested to a compensable degree within one year of separation from service in May 1970. Therefore, service connection for arthritis may not be presumed. 38 C.F.R. §§ 3.307, 3.309.

A reserve enlistment examination dated in March 1978 reflects that the Veteran denied recurrent back pain.

Initial post-service treatment of back pain is shown in private treatment records dated in March 1995. Those records reflect that the Veteran reported flank and back pain. The record noted that the Veteran was lifting weights before the pain started.

A VA treatment record dated in October 2002 reflects that the Veteran complained of arthritis of his shoulders and his hands. He denied other physical complaints. Such histories reported by the Veteran for treatment purposes are of significant probative value particularly when compared with more recent assertions and histories given for VA disability compensation purposes. *See Rucker v. Brown*, 10 Vet. App. 67, 73 (1997).

VA treatment records dated in May 2004 show that the Veteran reported back pain for years. The Veteran reported that he initially injured his back on the flight deck in 1969. A physician assessed acute on chronic muscular pain, low back. VA treatment records dated in January 2005 and July 2005 reflect assessments of acute on chronic low back pain, ongoing since 1969. An August 2009 VA spine care consultation reflects that the Veteran reported back pain traveling down his legs. The record noted that the Veteran related the onset of the pain to an incident in service.

The Veteran had a VA examination in May 2006. The Veteran reported a strain injury of his back in 1969. He reported intermittent episodes of back pain over the years. The examiner diagnosed back strain. The examiner opined that it is not likely that his current back symptoms are related to a simple strain in 1969, but rather a natural phenomenon.

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At a July 2007 VA examination, the examiner noted that the Veteran had a strain in service and had persistent back pain over the years. The examiner noted that he now had minimal arthritis by x-ray. The examiner noted that he had a chronic back pain problem. The examiner stated that the opinion was not changed from May 2006. The examiner noted that the Veteran's back pain is not likely related but is a naturally occurring phenomenon.

In the December 2010 Joint Motion, the parties found that the May 2006 and July 2007 opinions were inadequate because the examinations did not provide adequate rationales to allow for a fully informed decision by the Board. The May 2006 and July 2007 medical opinions are therefore not probative regarding the issue of a medical nexus to service.

Upon VA examination in April 2012, the Veteran reported that he injured his back in 1969 while walking across a flight deck carrying wheel chocks. He reported that he was hit by wind, causing him to fall. He recalled immediate pain to his low back and his abdomen at the time of the fall. He reported that he was taken off the flight deck by stretcher and remained on bedrest for a week. He reported that he was on light duty for 90 days after that. The Veteran reported that he was later diagnosed with a hernia to the left side of the abdomen. He reported chronic and constant low back pain since his discharge from service in 1970.

The examiner diagnosed spinal stenosis. The examiner noted that records did not describe any treatment until 1995, when the Veteran developed pain in the area of his hernia radiating to his back. The Veteran reported that his pain was constant and chronic in nature. The examiner noted that there are no medical records from 1970 to 2004 to establish a nexus. The examiner opined that it is therefore less likely than not that the Veteran's spinal stenosis is related to the injury described. The examiner opined that it would be more likely that his spinal stenosis is related to natural age progression with consideration of wear and tear throughout his life.

In January 2013, the Veteran submitted a lay statement from G.P. G.P. stated that he has known the Veteran since the 1970's. G.P. stated that the Veteran has had back problems since he has known him. G.P. indicated that he working as a

mechanic at a gas station when the Veteran came and said that he could not work on his car because of his back. G.P. noted that the Veteran stated that he hurt his back in the service. G.P. noted that he has witnessed the Veteran's back pain over the years when the Veteran visited his home.

In March 2013, the Board remanded the claim for an addendum medical opinion to address the lay evidence from the Veteran and G.P. as to the reported episodes of back pain since service.

In March 2015, a physician reviewed the claims file and provided an addendum opinion. The examiner noted that there were two references to back pain in the service treatment records in December 1969. The examiner noted that the Veteran reported one episode of back pain, which was treated as muscle strain. The episode began in November 1969 and reached its peak in December. The examiner stated, in other words, the Veteran had an acute to subacute episode of back pain in service, lasting approximately two to three weeks. The examiner noted that such an event is extremely common in the general population. The examiner opined that the evidence in the service treatment records is consistent with the normal clinical picture of low back pain and strain, which typically resolves within a few weeks. The examiner noted that the Veteran was examined twice in a short period of time, and the diagnosis was confirmed. The examiner stated that, based on this evidence, there was no reason to suspect a severe injury or chronic condition, and there was no evidence of spinal stenosis. The examiner opined that, while it is possible that the Veteran injured or developed disease in his spine after military service, it is not possible to relate post-service conditions to the self-limited back strain documented in service without resorting to speculation. The examiner opined that it is a rare service member or civilian who does not at one time or another experience a self-limited musculoskeletal back strain. The examiner opined, however, that one such event does not qualify as a chronic condition or cause spinal stenosis or any other disease. The examiner opined that a buddy statement confirming back pain in the 1970's and thereafter is insufficient to establish the existence of an initial in-service condition that would cause the symptoms and findings occurring after service.

The April 2012 and March 2015 VA examiners opined that the Veteran's current low back disability is not likely related to service. The examiners provided a detailed rationale for the opinion based on a review of Veteran's claims file, including service treatment records, post-service medical records and lay statements. The April 2012 examiner found that it was unlikely that spinal stenosis is related to the Veteran's described in-service injuries. The March 2015 examiner concluded that back strain in service does not qualify as a chronic condition and would not cause spinal stenosis. The discussion of the underlying rationale is where most of the probative value of an opinion is derived. *See Nieves-Rodriguez v. Peake,* 22 Vet. App. 295, 304 (2008). The probative value of an opinion is dependent, in part, upon the extent to which it reflects "clinical data or other rationale to support [the] opinion." *Bloom v. West,* 12 Vet. App. 185, 187 (1999). The Board finds that the April 2012 and March 2015 medical opinions are competent and highly probative, and based on adequate rationales. There is no competent evidence of a medical nexus between the current low back disability and an incident of service.

The post-service medical evidence does not reflect complaints or treatment related to a low back disability until 1995. *See Maxson v. Gober,* 230 F.3d 1330, 1333 (Fed. Cir. 2000) (lengthy period of absence of medical complaints for condition can be considered as a factor in resolving claim); *see also Mense v. Derwinski,* 1 Vet. App. 354, 356 (1991) (affirming Board's denial of service connection where veteran failed to account for lengthy time period between service and initial symptoms of disability).

The Board has weighed the lay evidence provided by G.P. and the Veteran as to continuity of his low back symptomatology. The Board finds the Veteran's statements made in connection with a claim for VA compensation benefits to be of lesser probative value than his more contemporaneous history, including medical records showing that he sought treatment for other complaints but did not report back pain and the absence of complaints or treatment for many years after service. The lay statement of G.P. regarding the Veteran's complaints of back pain symptoms since the 1970's is likewise considered less probative than the

contemporaneous medical records which indicate that the Veteran denied recurrent back pain.

A Veteran is competent to report symptoms that he experiences at any time because this requires only personal knowledge as it comes to him through his senses. *Layno,* 6 Vet. App. at 470; *Barr v. Nicholson,* 21 Vet. App. 303, 309 (2007) (when a condition may be diagnosed by its unique and readily identifiable features, the presence of the disorder is not a determination "medical in nature" and is capable of lay observation). The Veteran is competent to report experiencing back pain. However, the Board must determine whether the Veteran is credible.

The absence of contemporaneous medical evidence is a factor in determining credibility of lay evidence, but lay evidence does not lack credibility merely because it is unaccompanied by contemporaneous medical evidence. *See Buchanan v. Nicholson,* 451 F.3d 1331, 1337 (Fed. Cir. 2006) (lack of contemporaneous medical records does not serve as an "absolute bar" to the service connection claim); *Barr v. Nicholson,* 21 Vet. App. 303 (2007) ("Board may not reject as not credible any uncorroborated statements merely because the contemporaneous medical evidence is silent as to complaints or treatment for the relevant condition or symptoms"). But in *Buchanan* and other precedent cases, the United States Court of Appeals for the Federal Circuit (Federal Circuit Court) also has recognized the Board's "authority to discount the weight and probity of evidence in light of its own inherent characteristics and its relationship to other items of evidence." *See, e.g., Madden v. Gober,* 125 F.3d 1477, 1481 (Fed. Cir. 1997). Moreover, for non-combat Veterans providing non-medical related lay testimony regarding an event during service and what has occurred during the years since, *Buchanan* is distinguishable; any lack of documentation in service records and/or records since service must be weighed against the Veteran's statements. *See Bardwell v. Shinseki,* 24 Vet. App. 36 (2010).

In determining whether statements submitted by a Veteran are credible, the Board may consider internal consistency, facial plausibility, consistency with other evidence, and statements made during treatment. *Caluza v. Brown,* 7 Vet. App. 498 (1995). *See also Macarubbo v. Gober,* 10 Vet. App. 388 (1997).

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In statements as part of the current VA disability compensation claim, the Veteran has asserted that his symptoms of low back pain began during service and continued since then. However, the March 1978 reserves enlistment examination reflects that he denied recurrent back pain. The Veteran also did not report back pain when he was first seen at the VA in October 2002, despite complaining of several other orthopedic conditions. The Board finds that the Veteran's reported history of continued low back symptoms since active service is inconsistent with the other lay and medical evidence of record. These inconsistencies in the record weigh against the Veteran's credibility as to the assertion of continuity of symptomatology since service. *See Madden, supra.*

The post-service medical evidence does not reflect complaints or treatment related to a low back disability for many years following active service. *See Maxson and Mensa, both supra.* The Board has weighed the lay evidence as to continuity of low back symptomatology and finds his statements made in connection with a claim for VA compensation benefits to be of lesser probative value than his previous more contemporaneous history, and the absence of complaints or treatment for years after service.

The Veteran himself has asserted that his current low back disability is related to events in service. While the Veteran believes that his current low back disability, was incurred in or is etiologically related to his active service, he is not competent to provide a nexus in this case. The issues are medically complex and require specialized knowledge and experience. *Jandreau v. Nicholson,* 492 F.3d 1372 (Fed. Cir. 2007).

Based on a review of the above evidence, the Board finds that service connection for a low back condition is not warranted. The evidence of record does not show that arthritis of the lumbar spine manifested within the one year presumptive period after service separation. The record does not contain competent evidence of a nexus to service, and the lay evidence of continuity of low back symptoms since service is not considered persuasive. Accordingly, the Board finds that the preponderance of the evidence is against the Veteran's claim for service connection for a low back

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disorder. Consequently, the benefit-of-the-doubt rule does not apply, and entitlement to service connection for a low back condition is denied. *See* 38 U.S.C.A. § 5107 (b); 38 C.F.R. §§ 3.102; 4.3; *Gilbert,* 1 Vet. App. at 55.

ORDER

Service connection for a low back disability is denied.

S. L. Kennedy
Veterans Law Judge, Board of Veterans' Appeals

U.S. Department of Veterans Affairs
Board of Veterans' Appeals

Appellant's Informal Brief

In the Appeal of
Ernest L. Francway

[redacted]

Docket No. 04-09 153

Date: March 2, 2016

On appeal from the
Department of Veterans Affairs Regional Office in Cleveland, Ohio

The Issues

1. Entitlement to service-connection for a low back disorder.

Representation

Appellant represented by: Sean A. Ravin, Attorney at Law

Waivers

The appellant hereby waives his right to have all newly submitted evidence referred to the Agency of Original Jurisdiction ("AOJ") for consideration and the promulgation of either a rating decision or supplemental statement of the case.

The appellant hereby waives any remaining time to submit additional evidence and argument in support of the claims on appeal and asks that the Board issue a decision as promptly as possible.

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Questions Presented

1. Whether the September 2014 VA examination report and March 2015 addendum provide a fully informed rationale and are adequate for rating purposes?

2. Whether Mr. Francway has satisfied the three elements necessary for service-connection with the competent lay evidence submitted throughout the pendency of his claim?

Nature of the Case

By decision dated March 13, 2013, the Board remanded Mr. Francway's appeal for the purpose of obtaining a new VA examination and opinion which discusses and considers fully the lay evidence of record of continuity of symptoms, to include the statement provided by Glen Pettry. L. at 88-97.

Mr. Francway was provided with a new VA examination and opinion in September 2014, with an addendum obtained from the same examiner in March 2015. The examiner ultimately opined that Mr. Francway's back disability "was not related to/or caused by the low back problems during military service as the low back problems [Mr. Francway] had during service were 'acute' periods of lumbar pain and strain that fully resolved during military service." FOIA (F.) at 641-651.

By SSOC dated March 2015, the Cleveland Regional Office continued to deny entitlement to service-connection for a low back disability. L. at 122-127. Mr. Francway's appeal was returned to the Board for a new decision.

Statement of Facts

Ernest L. Francway, Jr. served honorably on active duty in the U.S. Navy from August 1968 to May 1970. Record before the Agency 09-3435 (R). 596.

Service medical records document several instances of injuries to the back and complaints of back pain. In April 1969, while aboard the USS Oriskany, Mr. Francway injured his back on the flight deck and was diagnosed with a muscle spasm and a pulled muscle in the right side. R. 628-630. In November 1969, Mr. Francway was involved in a motorcycle accident and injured his back. R. 634. In December 1969, Mr. Francway "complain[ed] of low back pain" in the L5-S1 vertebrae. R. 636.

In March 1995, Mr. Francway reported complaints of back pain. R. 458-459.

In April 2003, Mr. Francway filed an informal claim for entitlement to service connection for a back disorder for an injury he sustained in 1969 while aboard the U.S.S. Oriskany. R. 564.

By rating decision with cover letter dated May 30, 2003, the VA Regional Office (RO), inter alia, denied entitlement to service connection for a back disorder. R. 497-506. In January 2004, the RO issued another rating decision which continued to deny entitlement to service connection for a back disorder. R. 397-402.

Mr. Francway timely filed notice of disagreement (NOD)(R. 396); the RO issued a statement of the case (SOC)(R. 378-395); and Mr. Francway timely filed a substantive appeal on VA Form 9. R. 372-373

In an October 2005 hearing before the Board (R. 328-353), Mr. Francway testified that he injured his back in April 1969 during service (R. 343), that he was told by a doctor at that time that he suffered a back strain (R. 343); that his back has hurt him continuously since service (R. 344); that he never suffered a post-service injury to his back (R. 345); and that in the 22 years of employment

post service, he self medicated or stayed in bed, but that he did not report his back injury to his employer out of fear that he would lose his job if the existence of his disability was discovered. R.345-346.

Mr. Francway recounted his injury on the USS Oriskany and stated, in pertinent part:

> I was up on the flight deck carrying about 4 or 5 chalks at the time, that you lock the wheels on the aircraft, and I was leaning into the wind and it was blowing real hard and I wasn't used to that kind of leaning into the wind like that and all of a sudden went, stopped, and then a big gust hit me sideways, it turned me and I felt this stabbing pain in my back and I went down, dropped the chalks, and I fell down on the chalks and that's what hurt my stomach and back because I had a big, black-and-blue mark on my left side from falling down.

R. 343.

In a January 2006 decision, the Board remanded Mr. Francway's claim for the RO to obtain treatment records and to schedule Mr. Francway for a VA examination to determine the etiology of his claimed back disorder. R. 322-327.

In a May 2006 VA examination report, Dr. Paul Steurer diagnosed Mr. Francway with minimal arthritis by x-ray and lumbosacral strain, but opined that it was unlikely that "his current back symptoms are related to a simple strain back in 1969 …." R. 128.

In a July 2007 VA examination report, Dr. Steurer diagnosed Mr. Francway with "lumbosacral strain with minimal arthritis", but opined that "it is not likely related, but rather a natural occurring phenomenon." R. 95.

By decision dated May 27, 2009, the Board denied entitlement to service connection for a low back disorder. R. 3-16.

Mr. Francway timely filed an appeal to the US Court of Appeals for Veterans Claims (Court). The parties subsequently entered into a Joint Motion for Partial Remand which was granted by the Court in its December 2010 Order. The parties agreed that the Board failed to provide adequate reasons or bases for its determination that the May 2006 and July 2007 VA examination reports were probative negative opinions despite neither examiner providing a rationale for their opinions.

By decision dated May 24, 2011, the Board remanded Mr. Francway's appeal with the provision of a new VA examination and opinion.

Mr. Francway was provided with a new VA opinion in January 2012. Litigation File (L.) at 21-35. Despite receiving clear instructions to provide Mr. Francway with a new examination, the examiner determined that a physical examination was not necessary as Mr. Francway's reported history did not reveal a link between his current back disability and the in-service back injuries.

By SSOC dated February 2012, the Cleveland VA Regional Office (RO) continued to deny entitlement to service-connection for a back disorder. The Cleveland RO based its decision solely on the results of the January 2012 opinion and noted that no physical examination was provided by the examiner. L. at 36-39.

In April 2012, Mr. Francway was provided with another VA examination and opinion. L. at 55-68. It was the examiner's opinion that because "there are no medical records of evidence from 1970-2004 to establish a nexus therefore it would be less likely than not that the veteran's spinal stenosis is related to the injury."

By SSOC dated May 14, 2012, the Cleveland RO continued to deny Mr. Francway's claim for service-connection. The May 2012 SSOC stated that while VA "acknowledges your reports regarding continued back problems since service…you are not competent to self-diagnose a back disability or to render a medical etiology opinion." Further, the SSOC also found that "that neither

chronicity in service nor continuity of symptomatology after service is shown." L. at 46-51.

In December 2012, Mr. Francway, through counsel, submitted legal argument in support of his appeal for service-connection. Included the argument was a statement from Mr. Francway's longtime friend, Glen Pettry, in which Mr. Pettry stated that he has witnessed Mr. Francway deal with and complain of back pain since his discharge in the 1970s. L. at 84-87.

By decision dated March 13, 2013, the Board remanded Mr. Francway's appeal with the provision of providing a new VA examination and opinion which discusses and considers fully the lay evidence of record of continuity of symptoms, to include the statement provided by Glen Pettry. L. at 88-97.

Mr. Francway was provided with a new VA examination and opinion in September 2014, with an addendum obtained from the same examiner in March 2015. The examiner ultimately opined that Mr. Francway's back disability "was not related to/or caused by the low back problems during military service as the low back problems [Mr. Francway] had during service were 'acute' periods of lumbar pain and strain that fully resolved during military service." FOIA (F.) at 641-651.

By SSOC dated March 2015, the Cleveland RO continued to deny entitlement to service-connection for a low back disability. L. at 122-127. Mr. Francway's appeal was returned to the Board for a new decision.

Argument

For the entire pendency of his claim Mr. Francway has consistently asserted that he injured his back in-service, that he has suffered continuously from persistent back pain since discharge from service, and that he now has a diagnosed back disability that it etiologically related to the incident of injury in-service. In that regard, Mr. Francway has consistently submitted competent and credible lay evidence attesting to the continuity of symptoms of a low back disability suffered since discharge from service.

Prior to be being provided the September 2014 examination and March 2015 addendum, Mr. Francway was provided with four separate examinations and opinions by VA, all of which have been deemed inadequate for rating purposes: May 2006, July 2007, January 2012, and April 2012.

Following the Board's May 2009 denial of entitlement to service-connection for a low back disorder, Mr. Francway timely appealed to the Court. At the Court, the parties entered into a joint motion for remand and agreed that the Board failed to properly consider whether the May 2006 and July 2007 examination reports were adequate for rating purposes. Specifically, although both the May 2006 and July 2007 VA examinations came to similar conclusions that Mr. Francway's current lumbosacral disability was the result of "naturally occurring phenomenon," the parties agreed that the examiners failed to adequately qualify these negative opinions with fully reasoned rationales. See *Stefl v. Nicholson*, 21 Vet.App. 120, 123(2007). This error was especially egregious considering that the medical history noted in both of the examination reports reflected 1) low back strain in service, 2) that "over the years" Mr. Francway had had "persistent back pain," and 3) that Mr. Francway now has a "chronic back pain problem." Further, since neither examination reported any incidents or injuries in the period following discharge from service and prior to 2004 which could have resulted in Mr. Francway's current back disability, it was entirely unclear how, given the medical history, the examiners came to the ultimate conclusion that any medical link to service was "unlikely." See *Nieves-Rodriguez v. Peake*, 22 Vet.App. 295, 301(2008). Mr. Francway's appeal was subsequently remanded for a new VA examination.

Mr. Francway was provided with a new opinion in January 2012. The examiner ultimately opined that while "there is clear evidence of a back strain in the service and there is clear evidence of spinal stenosis and arthritis in the back currently," the examiner was "unable to say that the initial

injury noted in 1969 is likely to have caused [Mr. Francway's] current condition" based on a "lack of sufficient evidence." However, notwithstanding that the January 2012 examiner's opinion was similarly unsupported by any meaningful rationale, the examination was returned as inadequate because the examiner chose not to provide Mr. Francway with a physical examination despite receiving clear instructions from the Board to provide one.

Mr. Francway was provided with yet another examination and opinion in April 2012. Following a physical examination, the examiner provided an etiology opinion. The entirety of the opinion provided is as follows:

> There are no medical records of evidence from 1970-2004 to establish a nexus therefore it would be less likely than not that the veteran's spinal stenosis is related to the injury he describes above. It would be more likely than not his spinal stenosis is related to the natural age progression with consideration wear and tear throughout his life.

For the very same reasons that the May 2006 and July 2007 examination reports were inadequate, the April 2012 examination and opinion are likewise inadequate. The rationale for this paltry opinion, based solely upon a lack of contemporaneous medical records from the period after discharge through 200, that Mr. Francway's has not suffered continuously from symptoms of a back disability since service is contradicted by the evidence of record. Not only has analyses of this nature been resoundingly rejected in case law, the April 2012 examiner chose to disregard entirely the plethora of lay evidence provided by Mr. Francway regarding the continued back pain suffered throughout that period. See *Buchanan v. Nicholson*, 451 F.3d 1331, 1334-1337 (Fed. Cir. 2006). Further, the April 2012 examiner states that Mr. Francway's current disability is more likely associated with natural age progression and "wear and tear" but points to no specific incidents following service which have led to the development of his back disability. The Cleveland VA Regional Office based its May 2012 SSOC continued denial on the results of the April 2012 examination report and Mr. Francway's appeal was returned to the Board.

In support of his appeal for entitlement to service-connection for a low back disorder, Mr. Francway, through counsel, submitted a December 2012 legal argument to the Board. Accompanying that argument was a statement from Glen Pettry, a longtime friend of Mr. Francway. In his letter, Mr. Pettry stated that he has known Mr. Francway since the 1970s following his discharge from the service. Mr. Pettry recalled how Mr. Francway first injured his back in service and had been experiencing severe back pain since then. Mr. Pettry also stated that Mr. Francway "has been at my home a number of times when his back was hurting him and have seen him in some really bad pain." Mr. Pettry's statement clearly indicates that Mr. Francway has suffered from continuous symptoms of a low back disability from discharge until present day. Further, both Mr. Francway and Mr. Pettry are competent and credible in their reporting of the observable symptoms of pain suffered by Mr. Francway as well as a report on Mr. Francway's comments regarding pain radiating from his back. See *Layno v. Brown*, 6 Vet. App. 471 (1994). The Board subsequently remanded Mr. Francway's appeal in its March 2013 decision with the provision of providing yet another new examination to Mr. Francway.

Mr. Francway was provided with a VA examination and opinion in September 2014 by Dr. Paul Steurer, MD. Following a physical examination, Dr. Steurer provided his expert opinion on whether Mr. Francway's current diagnosed back disability was related to the in-service back injury. The entirety of Dr. Steurer's opinion consisted of one statement which was not more than a restatement of previous examiner's opinions. Dr. Steurer's opinion and rationale consisted of the following statement:

> It is less likely that [Mr. Francway's] current spoinal (sic) stenosis is related to one evet (sic) over 40 years ago but rather natural age progression.

Realizing that this absurdly curt opinion with no accompanying rationale did not conform with either the terms of the prior remands or with accepted VA standards, VA sought to obtain an addendum. An addendum, completed by Dr. Amy Schechter, was received in March 2015. Dr. Schechter indicated that she reviewed the entirety of Mr. Francway's claims file as well as the statement from Mr. Pettry. It was ultimately the opinion of Dr. Schechter, however, that "while it is possible that the veteran injured or developed disease in his spine after his military service, it's not possible to relate post-service conditions to the self-limited back strain documented in service *without resorting to speculation*." *Emphasis added.* With regard to the statement from Mr. Pettry, Dr. Schechter opined that "a buddy statement confirming back pain during the 1970s and thereafter is insufficient to establish the existence of an initial in-service condition that would cause the symptoms and findings occurring after the service."

Mr. Francway asserts, once again, that VA has yet to provide to him an adequate examination and opinion. The September 2014 and March 2015 opinions, much like the numerous previous opinions provided, are not adequate for rating purposes. In her rationale, Dr. Schechter states that "it is possible that the veteran injured or developed disease in his spine after his military service" but then points to absolutely no incidents or occurrences in which Mr. Francway did in fact suffer an injury to his back following service *other than* the documented in-service injury. With regard to the statement from Mr. Pettry, it appears that Dr. Schechter does not fully understand the purpose of the buddy statement in this instance. Contrary to her opinion that Mr. Pettry's statement is "insufficient to establish the existence of an initial in-service condition," this is not the point. Mr. Pettry's statement served to confirm the continuity of symptoms of a back disability suffered by Mr. Francway following his discharge from service through the present day.

As such, and because for over ten years VA has failed to provide any sort of meaningful examination and etiology opinion for Mr. Francway's diagnosed back disorder, Mr. Francway is entitled to service-connection for his currently diagnosed low back disability. In particular, Mr. Francway is entitled to the benefit of the doubt. *See* 38 U.S.C. § 5107(b).

Prior case law has found that "depending on the evidence and contentions of record in a particular case, lay evidence can be competent and sufficient to establish a diagnosis and medical etiology of a condition." See *Davidson v. Shinseki*, 581 F.3d 1313 (Fed. Cir. 2009), *Jandreau v. Nicholson*, 492 F.3d 1372, 1377 (Fed. Cir. 2007). In this instance, Mr. Francway has (1) the existence of a present disability; (2) in-service incurrence or aggravation of a disease or injury; and (3) a causal relationship between the present disability and the disease or injury incurred or aggravated during service. See *Shedden v. Principi*, 381 F.3d 1163, 1167 (Fed. Cir. 2004); See also 38 C.F.R. § 3.307(b). The record is replete with lay evidence that Mr. Francway has suffered from symptoms of his back disability from the time of the occurrence of the injury through to the present day.

Mr. Francway has been granted enough remands during the 13 years in which he has fought for service-connection of his diagnosed back disability. Mr. Francway prays that the Board find in favor of a grant of service-connection.

Prayer

Mr. Francway prays that given the evidence of a current diagnosis and continued symptoms following service that the Board finds there is competent and credible evidence sufficient to establish a medical nexus between the Mr. Francway's injuries sustained in service and his current back disability.

In the alternative, and only if the Board is disinclined to grant service-connection, Mr. Francway prays that the Board remands his appeal with the provision of providing an adequate examination which fully discusses and considers the medical and lay evidence of record consistent with the terms of prior remand orders.

Respectfully submitted,

Sean A. Ravin

Sean A. Ravin, Esq.,
1550 Madruga Ave., Suite 414
Coral Gables, FL. 33146

Phone: (202) 607-5731
Fax: (202) 318-0205
ravinesq@earthlink.net

Date: March 2, 2016

1206671

THIS IS AN IMPORTANT RECORD
SAFEGUARD IT

VOL 202 PAGE 490

[redacted]

PERSONAL DATA

1. LAST NAME - FIRST NAME - MIDDLE NAME: FRANCWAY, Ernest Leroy, Jr.
2. SERVICE NUMBER: B45 18 15
4. DEPARTMENT, COMPONENT AND BRANCH OR CLASS: NAVY / USN
5a. GRADE, RATE OR RANK: AN
5b. PAY GRADE: E-3
6. DATE OF RANK: 16 JUN 69
7. U.S. CITIZEN: [X] YES [ ] NO
8. PLACE OF BIRTH (City and State or Country): Atlanta, Georgia
9. DATE OF BIRTH: [redacted] 50

SELECTIVE SERVICE DATA

a. SELECTIVE SERVICE NUMBER: 3 32 65 070
b. SELECTIVE SERVICE LOCAL BOARD NUMBER, CITY, COUNTY, STATE AND ZIP CODE: #26, Cleveland, Ohio
c. DATE INDUCTED: DAY NA / MONTH / YEAR

TRANSFER OR DISCHARGE DATA

11a. TYPE OF TRANSFER OR DISCHARGE: Released to inactive duty and transferred to Naval Reserve
b. STATION OR INSTALLATION AT WHICH EFFECTED: USS ORISKANY (CVA-34) at Alameda, California
c. REASON AND AUTHORITY: Reduction in authorized strength BUPERS Manual Art. 3840220 & NAVOP 05/70 -21G-
d. EFFECTIVE DATE: 13 MAY 70
12. LAST DUTY ASSIGNMENT AND MAJOR COMMAND: USS ORISKANY (CVA-34)
13a. CHARACTER OF SERVICE: HONORABLE
b. TYPE OF CERTIFICATE ISSUED: *See Remarks
14. DISTRICT, AREA COMMAND OR CORPS TO WHICH RESERVIST TRANSFERRED: Naval Reserve Manpower Center, Bainbridge, Maryland
15. REENLISTMENT CODE: RE-3R

SERVICE DATA

16. TERMINAL DATE OF RESERVE UMT&S OBLIGATION: DAY 22 / MONTH AUG / YEAR 74
17. CURRENT ACTIVE SERVICE OTHER THAN BY INDUCTION
a. SOURCE OF ENTRY: [X] ENLISTED (First Enlistment) [ ] ENLISTED (Prior Service) [ ] REENLISTED [ ] OTHER
b. TERM OF SERVICE (Years): Two
c. DATE OF ENTRY: DAY 23 / MONTH AUG / YEAR 68
18. PRIOR REGULAR ENLISTMENTS: NONE
19. GRADE, RATE OR RANK AT TIME OF ENTRY INTO CURRENT ACTIVE SVC: AR SQ
20. PLACE OF ENTRY INTO CURRENT ACTIVE SERVICE (City and State): Cleveland, Ohio
21. HOME OF RECORD AT TIME OF ENTRY INTO ACTIVE SERVICE (City and State or ZIP Code): [redacted] Cleveland, Ohio 44102
23a. SPECIALTY NUMBER & TITLE: ABH - 7040
b. RELATED CIVILIAN OCCUPATION AND D.O.T. NUMBER:

22. STATEMENT OF SERVICE		YEARS	MONTHS	DAYS
a. CREDITABLE FOR BASIC PAY PURPOSES	(1) NET SERVICE THIS PERIOD	01	09	20
	(2) OTHER SERVICE	00	00	00
	(3) TOTAL (Line (1) plus Line (2))	01	09	20
b. TOTAL ACTIVE SERVICE		01	09	20
c. FOREIGN AND/OR SEA SERVICE		01	01	18

24. DECORATIONS, MEDALS, BADGES, COMMENDATIONS, CITATIONS AND CAMPAIGN RIBBONS AWARDED OR AUTHORIZED

National Defense Service Medal	X
Vietnam Service Medal/One Bronze Star	X
Republic of Vietnam Campaign Medal	X
Armed Forces Expeditionary Medal/Korea	X

25. EDUCATION AND TRAINING COMPLETED: BMR, AN

VA AND EMP. SERVICE DATA

26a. NON-PAY PERIODS/TIME LOST (Preceding Two Years): TL - NONE; EXLV - NONE
b. DAYS ACCRUED LEAVE PAID: 8
27a. INSURANCE IN FORCE (NSLI or USGLI): [ ] YES [X] NO
b. AMOUNT OF ALLOTMENT: $ NA
c. MONTH ALLOTMENT DISCONTINUED: NA
28. VA CLAIM NUMBER: C- NA
29. SERVICEMEN'S GROUP LIFE INSURANCE COVERAGE: [X] $10,000 [ ] $5,000 [ ] NONE

REMARKS

30. REMARKS: High School - 01
*NO DISCHARGE CERTIFICATE ISSUED AT TIME OF SEPARATION

RECEIVED FOR RECORD
JAN 23 1970
MARK McELROY
COUNTY RECORDER
CUYAHOGA COUNTY, OHIO

AUTHENTICATION

31. PERMANENT ADDRESS FOR MAILING PURPOSES AFTER TRANSFER OR DISCHARGE (City and State or ZIP Code): [redacted] Cleveland, Ohio 44102
32. SIGNATURE OF PERSON BEING TRANSFERRED OR DISCHARGED: Ernest Leroy Francway Jr.
33. TYPED NAME, GRADE AND TITLE OF AUTHORIZING OFFICER: R. E. ALKIRE, SHPCLK, USN
PERS OFF BY DIR OF THE C.O.
34. SIGNATURE OF OFFICER AUTHORIZED TO SIGN: R E Alkire

DD FORM 1 JUL 66 214N PREVIOUS EDITIONS OF THIS FORM ARE OBSOLETE. S/N-0101-800-4301

ARMED FORCES OF THE UNITED STATES
REPORT OF TRANSFER OR DISCHARGE 1

Please note: The Following page is the

BEST

Available

COPY

Do not delete this page. The defects of the following documents are actually in the original document received in the Veteran's C-File

SICK CALL TREATMENT RECORD
NAVMED 10 (REV. 3-58) FRONT

(TYPE OR PRINT BELOW IDENTIFICATION DATA)

(LAST NAME)	(FIRST NAME)	(MIDDLE NAME)	FILE/SERVICE NUMBER	DATE OF BIRTH	USN / USMC
FRANCWAY	ERNEST	E.	B4_18(5		

DATE	NAME OF TREATING FACILITY, COMPLAINT, TREATMENT ADMINISTERED, SIGNATURE AND RANK/RATE OF PERSON ADMINISTERING TREATMENT
JAN 1 0 196_	...al Air Station, North Island San Diego, California 92135 Burn ® arm ① clean and ② Furacin gauze ③ dressing RTC PRN [signature]
JAN 1 1 1969	Naval Air Station, North Island San Diego, California 92135 Cleans Burn (Rt) arm, dressing of Furacin gauze applied. [signature]
1 5 APR 1969	USS ORISKANY (CVA 34) C/o "Pulled muscle in ® side Light duty 24 hrs. ASA 10 gr. q4h [signature]
16 Apr.	CBC & UA — wnl Flat. Plate Abd. ~~10cc Robaxin IM ? 8 hours (5cc in each gluteal region)~~ Montgomery
1500	10 cc ROBAXIN IM GIVEN.

BEST IMAGE AVAILABLE

(Over)

NAVMED 10 (REV. 3-58) BACK

DATE	NAME OF TREATING FACILITY, COMPLAINT, TREATMENT ADMINISTERED, SIGNATURE AND RANK/RATE OF PERSON ADMINISTERING TREATMENT
17 April 69	0730 – Pt. Vomitted ~~[illegible]~~ Approx 30 cc of white solution @ this time – D. A. Boyd [illegible]
	0800 – T-98°
	Release from ward. [signature]
18 APR 1969	USS ORISKANY (CVA 34) c/o sea sickness ① Compazine IM given ② TD Duty [signature]
18 APRIL 1969	Pt brought to sick bay via stretcher from flight deck. AS ABOVE ① COMPAZINE IM GIVEN ② NON DUTY RETURN AM 19 APR ~~4. BED REST~~ ADMIT TO WARD
19 APR 69	DISCHARGED FROM WARD – TO DUTY [signature]

SICK CALL TREATMENT RECORD
NAVMED 10 (REV. 3-58) FRONT

(TYPE OR PRINT BELOW IDENTIFICATION DATA)

(LAST NAME)	(FIRST NAME)	(MIDDLE NAME)	FILE/SERVICE NUMBER	DATE OF BIRTH	☐ USN ☐ USNC
FRANCWAY	Ernest		B 457815		

DATE	NAME OF TREATING FACILITY, COMPLAINT, TREATMENT ADMINISTERED, SIGNATURE AND RANK/RATE OF PERSON ADMINISTERING TREATMENT
15SEP1969	USS ORISKANY (CVA-34) Rash Heat Rash, Refer to Station for Heat Rash Lotion, Etc. Medo
30Sept.69	CVA-34 2nd° Burn ⓛ elbow 1) cleaned + Phisohex 2) Furacin Ointment 3) Dry Sterile Dressing R.J. Ferguson HM2
OCT 1969	USS ORISKANY (CVA-34) burn ⓛ elbow Burn healing well, Clean 4X4 dressing to keep it Clean J.L. Tullis
7 NOV 1969	USS ORISKANY (CVA-34) Pt was struck in nose. Nose was bleeding ~~Pt~~ has stopped. ① X-Ray - neg for Fx. - Dr. HOFFMAN ② Cold packs ③ ASA gr X q 4h prn Pain J.L. Tullis HM2

(Over)

NAVMED 10 (REV. 3-58) BACK

DATE	NAME OF TREATING FACILITY, COMPLAINT, TREATMENT ADMINISTERED, SIGNATURE AND RANK/RATE OF PERSON ADMINISTERING TREATMENT
20 Nov 69	USS Oriskany CVA-34
	Pt was seen last P.M. at Fort Ord by
	MO. following motorcycle accident.
	Pt now c/o swelling c much pain
	(L) wrist.
	~~No MO aboard at this time. Please~~
	~~evaluate & advise Rx.~~ JM Speer HM2
	X-Ray - Neg. Read by Dr. Boorstin
	Rx (1) ace wrap
	(2) warm soaks. AD JM Speer HM2
21 Nov 69.	CVA-34 Recheck / See above.
	Rx (1) continue above Rx JM Speer
26-NOV-69	USS ORISKANY CVA-34
	c/o Remove sutures
	From (R) Foot
	JM Speer HM2
9 Dec. 69	PATIENT COMPLAINS OF LOW BACK PAIN (R) SIDE. GIVEN
(1)	DARVON 65 MG.
(2)	WARM SOAKS TO BACK.
(3)	RETURN TO SICK CALL A.M. 9 DEC 69.
	DONALD F. SARVER, H.N.
9 DEC 1969	USS ORISKANY (CVA-34)
	c/o Same as above / low back pain
	PE ROM limited c Pain, No deformity, Test for fx Neg.
	~~[illegible]~~ some pain upon Rotations.
	Rx Darafon Forte (2) Rtn in AM. JM Speer HM2

SICK CALL TREATMENT RECORD
NAVMED 6150/3 (REV. 12-67) FRONT
(Formerly NAVMED 10) S/N-0105-209-5030

(TYPE OR PRINT BELOW IDENTIFICATION DATA)

(LAST NAME)	(FIRST NAME)	(MIDDLE NAME)	SERVICE/SOCIAL SECURITY NO.	DATE OF BIRTH	USN	USMC
FRANCWAY,	FORREST		845/815		☐	☐

DATE	NAME OF TREATING FACILITY, COMPLAINT, TREATMENT ADMINISTERED, SIGNATURE AND GRADE/RATE OF PERSON ADMINISTERING TREATMENT
10 DEC 1969	USS ORISKANY (CVA-34) Low BACK PAIN
	First sx Nov-19 - in auto when
	clutch slipped —
	Present episode 12-8 →
	Sxs L5-S1 ō radiation also Ⓡ S-I
	jt —
	Disp: Light duty chit
	Darthem q.d.
	A-P + lat lumbar spine
	A-P + lat pelvis
	RV [illegible] days for re-exam
	[signature]
22 DEC 1969	USS ORISKANY (CVA-34) Cold x 3 days
	Temp 98.6
	Imp URI
	Rx ~~[illegible]~~ ASA
	CTM
	Robitussin DM
	[signature]
30 JAN 1970	USS ORISKANY (CVA-34) Cold Stomach Ache
	Vomiting, diarrhea.
	Temp. 99°, No Rebound, Normal Bowel sounds
	1) [illegible] Force fluids 2) [illegible] diet 3) kaopectate
	4) [illegible] combid [illegible]

(Over)

NAVMED 6150/3 (REV. 12-67) BACK

DATE	NAME OF TREATING FACILITY, COMPLAINT, TREATMENT ADMINISTERED, SIGNATURE AND GRADE/RATE OF PERSON ADMINISTERING TREATMENT

Standard Form 88
Revised April 1968
General Services Administration
Interagency Comm. on Medical Records
FPMR 101-11.809-3

REPORT OF MEDICAL EXAMINATION

1. LAST NAME—FIRST NAME—MIDDLE NAME: FRANCWAY, ERNEST LEROY JR.
2. GRADE AND COMPONENT OR POSITION: AN
3. [redacted]
4. HOME ADDRESS (Number, street or RFD, city or town, State and ZIP Code): [redacted] CLEVE OHIO 44102
5. PURPOSE OF EXAMINATION: USNR
6. DATE OF EXAMINATION: 3-4-78
7. SEX: M
8. RACE: W
9. TOTAL YEARS GOVERNMENT SERVICE: MILITARY 2 CIVILIAN
10. AGENCY: USN
11. ORGANIZATION UNIT: ~~VAL 4~~ VP-93
12. DATE OF BIRTH: [redacted] 50
13. PLACE OF BIRTH: ATLANTA, GEORGIA
14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN: WIFE ROBERTA FRANCWAY
15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS
16. OTHER INFORMATION
17. RATING OR SPECIALTY
TIME IN THIS CAPACITY (Total)
LAST SIX MONTHS

CLINICAL EVALUATION

NORMAL	(Check each item in appropriate column; enter "NE" if not evaluated.)	ABNORMAL
✓	18. HEAD, FACE, NECK, AND SCALP	
✓	19. NOSE	
✓	20. SINUSES	
✓	21. MOUTH AND THROAT	
✓	22. EARS—GENERAL (Int. & ext. canals) (Auditory acuity under items 70 and 71)	
✓	23. DRUMS (Perforation)	
✓	24. EYES—GENERAL (Visual acuity and refraction under items 59, 60 and 67)	
✓	25. OPHTHALMOSCOPIC	
✓	26. PUPILS (Equality and reaction)	
✓	27. OCULAR MOTILITY (Associated parallel movements, nystagmus)	
✓	28. LUNGS AND CHEST (Include breasts)	
✓	29. HEART (Thrust, size, rhythm, sounds)	
✓	30. VASCULAR SYSTEM (Varicosities, etc.)	
✓	31. ABDOMEN AND VISCERA (Include hernia)	
✓	32. ANUS AND RECTUM (Hemorrhoids, fistulae) (Prostate, if indicated)	
✓	33. ENDOCRINE SYSTEM	
✓	34. G-U SYSTEM	
✓	35. UPPER EXTREMITIES (Strength, range of motion)	
✓	36. FEET	
✓	37. LOWER EXTREMITIES (Except feet) (Strength, range of motion)	
✓	38. SPINE, OTHER MUSCULOSKELETAL	
	39. IDENTIFYING BODY MARKS, SCARS, TATTOOS	✓
✓	40. SKIN, LYMPHATICS	
✓	41. NEUROLOGIC (Equilibrium tests under item 72)	
✓	42. PSYCHIATRIC (Specify any personality deviation)	
	43. PELVIC (Females only) (Check how done) ☐ VAGINAL ☐ RECTAL	

NOTES. (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary.)

#37
OPS 6" RT Shoulder (Bone fragment
OPS 4" LT Knee (cartilige Removal

(Continue in item 73)

44. DENTAL (Place appropriate symbols, shown in examples, above or below number of upper and lower teeth.)

Restorable teeth / Non-restorable teeth / Missing teeth / Replaced by dentures / Fixed Partial dentures

R I G H T	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	L E F T
	O	X	O				O										
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	
	X															X	

REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES
Type I Exam
Class III
Dentally Qualified

LABORATORY FINDINGS

45. URINALYSIS: A. SPECIFIC GRAVITY
B. ALBUMIN: Neg
C. SUGAR: Neg
D. MICROSCOPIC: Neg
46. CHEST X-RAY (Place, date, film number and result): NFD
47. SEROLOGY (Specify test used and result): RPR NON-REACTIVE DATE: 4 Mar 78
48. EKG: NA
49. BLOOD TYPE AND RH FACTOR: A POS
50. OTHER TESTS: NA

88-116

INTERDISCIPLINARY PROGRESS NOTES

Date & Time	Document significant events during clients course of treatment; implementation of treatment plan and response to treatment. Sign and title all notes.	Dept. or Discipline
4/12/95 1800	Xray (dated (?)) Report 3/31/95:- Advanced [illegible] arthritis Lt knee. See Report. Rampura.	
5/5/95 1715	ER 3/18/95 Report for Nephrolithiasis. NO prescriptions are given. Rampura.	
5/11/95	TO CMC/ORTHO — [signature]	
5/30/95	7A NSC – c/o wart on bottom (L) foot. Told to [illegible] podiatrist. Tyl. [illegible] for discomfort. Referred to NSC for c/o chronic (L) knee pain. — [signature]	
6/6/95 1315	S (L) Lt knee pain had surgery. Rt knee also hurts. O. Both knees ROM not restricted. Rampura	
6/15/95	TO CMC ORTHO — [signature]	
6-15-95	Seen in Ortho clinic @ CMC. — S. [signature]	
6/20/95 1530	Ortho consult 6/15/95 – (L) knee Degen. O.A. (2) (R) knee synovitis given @ CMC. Plan: (L) knee Neoprene sleeve, Knee extension exercises. Rampura	
7/7/95	[illegible] [signature]	

FRANCWAY
294-743

(continue on reverse side)

INTERDISCIPLINARY PROGRESS NOTES

Date & Time	Document significant events during clients course of treatment; implementation of treatment plan and response to treatment. Sign and title all notes.	Dept. or Discipline
3/21/95	12:30pm Resting quietly. Respirations easy. — C Keller	
3/21/95	1:00pm - ate 100% of Lunch. Resting quietly @ present. Respirations easy. — C Keller	
3/21/95	4:00 pm I/M quiet but awake — [illegible]	
	6:00 pm Ate supper all of it but veggies — [illegible]	
	6:00 pm Amie Baitrun DS — [illegible]	
	9:00 pm Stated he has had no pain this shift. [illegible]	
3/21/95	1040pm (I) has 0% discomfort since medication has started (no) problems urinating — [illegible]	
3/22/95	1AM BP 120/80-72-18 Resting quietly on bed. [illegible]	
3/22/95	3:30AM Resting quietly [illegible]	
3/22/95	5:30am Resting quietly [illegible]	
3/22/95	6:50Am - V S 60-16-112/72-98.0(10) Alert, oriented x 3 No complaints this AM Cooperative — C Keller	
3/22/95	9:30Am - Resting quietly @ present in Bed. Respirations easy. — C Keller	
3/22/95	Reg. to leave infirmary [illegible]	
3/22/95 12:00	Pt feels good no pain. As per Pt he had lifted weight before back pain started this [illegible] given to me at this time will release more information [illegible]	
	3/28/95 L Knee X Ray Done by LMR RT.	
3/28/95	NSC - 8:20 Am - c/o pain (L) knee + pain (L) ankle + Wart noted Bottom of (L) foot - noted appx. 3cm in length. No Redness or edema noted (L) knee + (L) ankle. Received Tylenol x 10 for pain. Doctor notified — C Keller	
4/4/95	No show in DSC [illegible]	

INTERDISCIPLINARY PROGRESS NOTES

Date & Time	Document significant events during clients course of treatment; implementation of treatment plan and response to treatment. Sign and title all notes.	Dept. or Discipline
3/21/95 6³⁰A	TO Tx. Rm ē c/o Rt. flank pain radiating to Rt. testicle area. States burning on urination. B/P 128/80 P80 R16 T97.° Abd. soft flat ē active B.S. x4. ø Blood in urine. Urinated 30 cc of Bright yellow urine. —— [signature]	
3/21/95 7⁰⁰	Pt back in (NCC I) clinic for Rt. flank and back pain radiating Rt groin. Pt. came back from OSU ER s̄ any Dx.. Burning urination he say he is not moving his bowel regularly. O/E Pt in pain Abd soft, RLQ palpation NO rebound tenderness, Perineal Region Tender Bowel Sounds NOT hyperactive. [signature]	
3/21/95 7³⁰A	Toradol 60mg IM given Rt gluteal area —— [signature]	
3/21/95 8⁰⁰A	Admitted to Rm 4A in Infirmary Bactrim DS ii P.O. issued —— [signature]	
3/21/95 8¹⁵A	(I) states pain is subsiding + resting quietly. —— [signature]	
3/21/95 - 10¹⁵AM	appears Resting quietly. Respirations easy — [signature]	

Francway 294-743

(continue on reverse)

-0086

NURSING NOTES

GCS—Glasgow Coma Scale. (For purposes of injury stratification, the Glasgow Coma Scale is measured at or after 24 hours.)

(ii) The determination of the severity level under this paragraph is based on the TBI symptoms at the time of injury or shortly thereafter, rather than the current level of functioning. VA will not require that the TBI meet all the criteria listed under a certain severity level in order to classify the TBI at that severity level. If a TBI meets the criteria in more than one category of severity, then VA will rank the TBI at the highest level in which a criterion is met, except where the qualifying criterion is the same at both levels. (Authority: 38 U.S.C. 501, 1110 and 1131)

[44 FR 50340, Aug. 28, 1979, as amended at 66 FR 18198, Apr. 6, 2001; 71 FR 52747, Sept. 7, 2006; 78 FR 76208, Dec. 17, 2013]

Supplement Highlights references: 45(2), 73(3), 106(2).

(Continued Next Page)

Supplemental Statement of the Case	***Department of Veterans Affairs Cleveland Regional Office***		Page 21 03/19/2015
NAME OF VETERAN FRANCWAY, Ernest L.	VA FILE NUMBER [redacted]	SOCIAL SECURITY NR	POA Mr. Sean A. Ravin, Esq.

The following decision has been made based on review of the evidence listed above. While all the evidence listed above has been reviewed and considered, only the most pertinent evidence is specifically discussed below.

DECISION:

Entitlement to service connection for a low back disability is denied.

REASONS AND BASES:

Service connection for your current low back disability is denied as the evidence still does not show that this disability is related to/or was caused by the low back problems you had during military service.

In accordance with the Board of Veterans' Appeals (Remand) Decision instructions of March 13, 2013, you were sent a VA Notification and Development Letter that requested you to provide medical releases (VA Forms 21-4142) for the medical providers who have treated your low back disability. In response, you submitted a Statement in Support of Claim (VA Form 21-4138) and several VA Release of Medical Information Forms (VA Form 21-4142), received July 21, 2014, stating that all your medical treatment with through the VA Health Care System.

Your most recent VA treatment reports from the VA Medical Center, Cleveland, Ohio, were obtained (dated April 28, 2012 to February 12, 2015) and continue to show you with diagnosis and treatment for a current low back disability; but, review of these additional VA treatment reports still did not show by medical opinion or otherwise that your current low back disability is related to/or was caused by the low back problems you had during military service.

Thereafter, pursuant to the Board of Veterans' Appeals (Remand) Decision instructions of March 13, 2013, a VA Examination was ordered, to include review of your VA Claims File and a medical opinion regarding any causal relationship between your current chronic low back disability and the low back problems you had during military service. The request for this examination included the specific language and instructions as ordered by the Board of Veterans' Appeals (Remand) Decision of March 13, 2013, including instructions to the examiner to reconcile any opinion provided with your statements and the "buddy" statement from "G.P." as to reported episodes of back pain since active service; and, that an explanation should be provided identifying the reasons if any item of evidence is considered to be not credible.

In response, your VA Examination Results of September 29, 2014 and Addendum of March 18, 2015, show the examiner(s) diagnosing your current low back disability as lumbosacral strain with spinal stenosis. The examiner(s) opined that your current low back disability was not related to/or caused by the low back problems you had during military service as the low back problems

you had during military service were “acute” periods of lumbar pain and strain that fully resolved during military service without any residuals.

Rather, the examiner(s) of September 29, 2014 and March 18, 2015 indicated that your current low back disability was the result of natural age progression and/or post-service injuries. The examiner(s) further stated that your statements and the statement from G.P., indicating that you had symptoms of back pain during the 1970s and thereafter (while credible) are insufficient to establish the existence of an initial in-service condition that would cause the symptoms and findings occurring after service.

Therefore, service connection for your current low back disability is denied as the evidence still does not show that this disability is related to/or was caused by the low back problems you had during military service.

PREPARED BY

Marc T. Catanzarite 254014

Digitally signed by Marc T. Catanzarite 254014
DN: dc=gov, dc=va, o=internal, ou=people, 0.9.2342.19200300.100.1.1=marc.catanzarite@va.gov, cn=Marc T. Catanzarite 254014
Date: 2015.03.19 14:01:52 -04'00'

Marc T. Catanzarite - Decision Review Officer

Appellant Name: MR. ERNEST L. FRANCWAY

File Number [redacted]

SSOC NOTICE RESPONSE

We have provided you with a Supplemental Statement of the Case (SSOC) about the evidence considered in your appeal. You have 30 days from the date of the SSOC within which to submit additional information or evidence. At this time, if you choose to, you may indicate whether you intend to submit additional information or evidence you know about that would help support your appeal.

Your signature on this response will not affect whether or not you are entitled to VA benefits. It will not affect the amount of benefits to which you may be entitled. It will not affect the assistance VA will provide you in obtaining evidence to support your appeal. It also will not affect the date any benefits will begin if your appeal is granted. Your response will let us know whether to return your case to the Board of Veterans' Appeals without waiting the full 30 days.

RESPONSE

I elect *one* of the following:

____ I have no other information or evidence to submit. Please return my case to the Board of Veterans' Appeals for further appellate consideration as soon as possible.

____ I have more information or evidence to submit in support of my appeal. VA will wait the full 30-day period to give me a chance to submit this information or evidence. I understand that if this evidence is not submitted within the 30-day period, my case will be returned to the Board of Veterans' Appeals.

_____ _____

Appellant/Representative Signature Date

** PROGRESS NOTES **********

LOCAL TITLE: C&P EXAMINATION NOTE
STANDARD TITLE: C & P EXAMINATION NOTE
DATE OF NOTE: MAR 18, 2015@13:30 ENTRY DATE: MAR 18, 2015@13:30:34
AUTHOR: SCHECHTER,AMY B EXP COSIGNER:
INSTITUTION: PARMA CBOC
DIVISION: PARMA CBOC
URGENCY: STATUS: COMPLETED

The C file, VBMS, and Capri records were reviewed with attention to the buddy statement from Mr. Glen Pettry who notes that since the time he met Mr. Francway and through the present time, Mr. Pettry has had back pain and back trouble. He states: "I have known Ernest since the 70's." Mr. Francway served from 8-23-1968 through May 13,1970. It is not clear from the statement whether Mr. Pettry met Mr. Francway before or after his service.

The veteran's service treatment records refer to the veteran's back during only one 2-day period in 1969:

December 9, 1969 "Patient complains of low back pain R side. Given Darvon 65 mg, warm soaks to back, return to sick call a.m. 9 Dec 69. c/o same as above/low back pain: PE ROM limited with pain, no deformity, test for fracture negative, some pain upon rotations Rx. Parafon Forte 2. Return in AM."

December 10, 1969 "First sx Nov 19 in auto when clutch slipped. Present episode 12-8 -->. Symptoms L5-S1 with radiation also right SI joint.
Disp: light duty chit, diathermy daily, A-P and lat lumbar spine, A-P pelvis. Return 2 days for exam"

The veteran was honorably discharged May 13, 1970. There are no records of his following up on 12/12/69, or at any time therafter about his back. And although he did report other medical issues: an URI on 12/22/69, and a stomach ache, vomting and diarrhea on 1/30/70 he does not mention at those visits, nor are there any further records of the back issue prior to his discharge in May of 1970.

To summarize the STRs in his evidence, the veteran reported one episode of back pain which was treated as muscle strain. The episode began in mid November and ended sometime after December 10th, reaching it's peak on December 9th and 10th. In other words, he had an acute to subacute episode of musculoskeletal back pain lasting approximately 2-3 weeks. Such an event is extremely common generally in the population, and even more common in active duty soldiers, sailors, airmen, and marines, due to the physical demands of their jobs. The evidence in the STRs is consistent with the normal clinical picture of low back pain and strain which typically resolves within a few weeks. The veteran is examined twice in this short period of time and the diagnosis is confirmed. Based on the evidence, there is no reason to suspect a severe injury, chronic condition, and there is no evidence of spinal stenosis.

While it is possible that the veteran injured or developed disease in his spine after his military service, it's not possible to relate post-service conditions to the self-limited back strain documented in service without resorting to

speculation. It is a rare [redacted]rvice member or civilian wh[redacted]oes not, at one time or another, experience a self-limited musculoskeletal back strain. However, one such event does not qualify as a chronic condition or cause spinal stenosis or any other disease. A buddy statement confirming back pain during the 1970s and thereafter is insufficient to establish the existence of an initial in-service condition that would cause the symptoms and findings occuring after the service.

/es/ AMY B. SCHECHTER
M.D., INTERNIST
Signed: 03/18/2015 15:05

Receipt Acknowledged By:
03/19/2015 06:38 /es/ PAUL ANTHONY STEURER
ORTHOPEDIST

Catanzarite, Marc, VBACLEV

From:	Catanzarite, Marc, VBACLEV
Sent:	Wednesday, March 18, 2015 10:50 AM
To:	O'Malley, Theresa, VBACLEV
Cc:	Betts, Nicole, VBACLEV
Subject:	HOT CASE - BVA/Court Remand - Additional Medical Opinion needed.
Signed By:	marc.catanzarite@va.gov

FRANCWAY, Ernest L., Jr.
([redacted]L
BVA Remand: March 13, 2013

VA Examination, VA Medical Center, Cleveland, Ohio: September 29, 2014
Examiner: Dr. Paul A. Steurer

As part of the VA examination request for this BVA Remand, the examiner was advised (per BVA examination instructions) that a prior VA Examination (April 2012) showed the examiner opining that the veteran's current low back disability was "less likely than not" related to/caused by the reported thoracolumbar spine injury sustained during military service; but, rather, was caused by natural age progression with consideration of wear and tear throughout his life (after military service).

The examiner was also advised (per BVA examination instructions) that evidence received since the VA Examination of April 2012 indicated that the veteran had chronic back pain/symptoms since military service. Specifically, a buddy statement from "G.P." states he had known the veteran since the 1970's and that they had remained good friends and recalled a time when the veteran came to him with car trouble and that the veteran could not work on it himself because of his back. "G.P." also stated that he recalled the veteran could not even bend over and that that veteran experienced episodes of back pain over the years.

Based on the foregoing, the examiner was requested to review the veteran's claims file and together with the examination results provide a medical opinion as to whether there is at least a 50 percent probability or greater (at least as likely as not) that he has a low back disorder as a result of active service.

In addition, the examiner was specifically requested to reconcile any opinion provided with the statements **from the veteran *and* G.P.** as to reported episodes of back pain since active service; and, that an explanation should be provided identifying the reasons if any item of evidence is considered to be not credible.

In other words, if the examiner determined that the veteran's current low back disability was less likely than not related to military service, the examiner was to specifically state why such an opinion was made in light of the fact the **veteran *and* "G.P."** had stated that the veteran had low back pain/symptoms since military service to the present; and, if the statements from the veteran and/or "G.P." were not considered credible, the examiner was to state why these statements were not credible.

In response, the VA Examination Results of September 29, 2014 show the examiner again determining that the veteran's current low back disability (lumbar strain and spinal stenosis) was less likely than not caused by the reported injury during military service; but, rather was caused by natural age progression. In an Addendum dated October 6, 2014, the examiner added that he'd reviewed the claims file, noting multiple other accidents (presumably involving the thoracolumbar spine), but this did not change his opinion.

However, the examiner DID NOT provide the requested medical opinion/discussion regarding why such an opinion was made in light of the fact the veteran and "G.P." had stated that the veteran had low back pain/symptoms since military service to the present; and, if the statements from the veteran and/or "G.P." were not considered credible, the examiner was to state why these statements were not credible. This requested medical opinion/discussion is a critical element of the examination request by BVA and must be provided.

Based on the foregoing, we need to have the VA examiner of September 29, 2014 (Dr. Paul A. Steurer) provide an addition medical opinion/discussion regarding:

1. Why he determined that the veteran's current low back disability (lumbar strain and spinal stenosis) was less likely than not caused by the reported injury during military service, in light of the fact the veteran and "G.P." had stated that the veteran had low back pain/symptoms since military service to the present; AND

2. If he determined that the statements from the veteran and/or "G.P." were not considered credible, he needs to specifically state why these statements were not credible.

Thanks –

Marc T. Catanzarite
Decision Review Officer
U.S. Department of Veterans Affairs
Cleveland Regional Office (RO 325)
1240 East 9th Street
Cleveland, Ohio 44199
(216) 522-3539 ext. 3052
marc.catanzarite@vba.va.gov

problems/pathologic reflexes)?
[ ] Yes [X] No

15. Intervertebral disc syndrome (IVDS) and incapacitating episodes

a. Does the Veteran have IVDS of the thoracolumbar spine?
[X] Yes [ ] No

b. If yes, has the Veteran had any incapacitating episodes over the past 12 months due to IVDS?
[ ] Yes [X] No

16. Assistive devices

a. Does the Veteran use any assistive device(s) as a normal mode of locomotion, although occasional locomotion by other methods may be possible?
[ ] Yes [X] No

17. Remaining effective function of the extremities

Due to a thoracolumbar spine (back) condition, is there functional impairment of an extremity such that no effective function remains other than that which would be equally well served by an amputation with prosthesis? (Functions of the upper extremity include grasping, manipulation, etc.; functions of the lower extremity include balance and propulsion, etc.)
[X] No

18. Other pertinent physical findings, complications, conditions, signs and/or symptoms

a. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any conditions listed in the Diagnosis section above?
[ ] Yes [X] No

b. Does the Veteran have any other pertinent physical findings, complications, conditions, signs or symptoms?
[ ] Yes [X] No

19. Diagnostic testing

a. Have imaging studies of the thoracolumbar spine been performed and are the results available?
[X] Yes [ ] No

If yes, is arthritis documented?
[X] Yes [ ] No

b. Does the Veteran have a thoracic vertebral fracture with loss of 50 percent or more of height?

Sep 29, 2014 08:00 Prm C&p/Steurer Checked Out

FRANCWAY, ERNEST L JR [redacted] 1950 (64)

*** WORK COPY ONLY *** Printed: Oct 07, 2014 08:20

[ ] Yes [X] No

c. Are there any other significant diagnostic test findings and/or results?
[ ] Yes [X] No

20. Functional impact

Does the Veteran's thoracolumbar spine (back) condition impact on his or her ability to work?
[X] Yes [ ] No

If yes describe the impact of each of the Veteran's thoracolumbar spine (back) conditions providing one or more examples:
limited to sedentary work

21. REMARKS

a. Remarks, if any:
it is less likely that his current spoinal stenosis is related to one evet over 40 years ago but rather natural age progression

b. Mitchell criteria:
It is my medical opinion that it is more likely than not (greater than 50/50 probability) that pain, but not weakness, fatigability or incoordination, could significantly limit functional ability during flare-ups, or when the joint is used repeatedly over a period of time and that there is additional limitation due to pain with change in the baseline range of motion due to "pain on use or during flare-ups." It would be pure speculation to state what additional ROM loss would be present due to pain on use or during flare-ups since the veteran is not examined during flare-up.

/es/ PAUL ANTHONY STEURER
ORTHOPEDIST
Signed: 09/29/2014 08:00

10/06/2014 ADDENDUM STATUS: COMPLETED
c-file reviewed multilple other accidents noted, no change in opinion

/es/ PAUL ANTHONY STEURER
ORTHOPEDIST
Signed: 10/06/2014 09:51

End of report

LOCAL TITLE: COMPENSATION & PENSION EXAMINATION
STANDARD TITLE: C & P EXAMINATION NOTE
DATE OF NOTE: SEP 29, 2014@08:00 ENTRY DATE: SEP 29, 2014@08:00:30
AUTHOR: STEURER,PAUL ANTHON EXP COSIGNER:
URGENCY: STATUS: COMPLETED

Back (Thoracolumbar Spine) Conditions
Disability Benefits Questionnaire

Name of patient/Veteran: ernest francway

Indicate method used to obtain medical information to complete this document:

[ ] Review of available records (without in-person or video telehealth examination) using the Acceptable Clinical Evidence (ACE) process because the existing medical evidence provided sufficient information on which to prepare the DBQ and such an examination will likely provide no additional relevant evidence.
[ ] Review of available records in conjunction with a telephone interview with the Veteran (without in-person or telehealth examination) using the ACE process because the existing medical evidence supplemented with a telephone interview provided sufficient information on which to prepare the DBQ and such an examination would likely provide no additional relevant evidence.
[ ] Examination via approved video telehealth
[X] In-person examination

Evidence review

Was the Veteran's VA claims file reviewed?
[ ] Yes [X] No

If yes, list any records that were reviewed but were not included in the Veteran's VA claims file:

If no, check all records reviewed:

[ ] Military service treatment records
[ ] Military service personnel records
[ ] Military enlistment examination
[ ] Military separation examination
[ ] Military post-deployment questionnaire
[ ] Department of Defense Form 214 Separation Documents
[ ] Veterans Health Administration medical records (VA treatment records)
[ ] Civilian medical records
[ ] Interviews with collateral witnesses (family and others who have known the Veteran before and after military service)
[ ] No records were reviewed
[X] Other:
vbms, summary on 2507

1. Diagnosis

Does the Veteran now have or has he/she ever been diagnosed with a thoracolumbar spine (back) condition?
[X] Yes [ ] No

Thoracolumbar Common Diagnoses:
- [ ] Ankylosing spondylitis
- [X] Lumbosacral strain
- [ ] Degenerative arthritis of the spine
- [ ] Intervertebral disc syndrome
- [ ] Sacroiliac injury
- [ ] Sacroiliac weakness
- [ ] Segmental instability
- [ ] Spinal fusion
- [X] Spinal stenosis
- [ ] Spondylolisthesis
- [ ] Vertebral dislocation
- [ ] Vertebral fracture

2. Medical history

Describe the history (including onset and course) of the Veteran's thoracolumbar spine (back) condition (brief summary):
old injury in 69, now has spinal stenosis, no op done on it, some leg pain with it

3. Flare-ups

Does the Veteran report that flare-ups impact the function of the thoracolumbar spine (back)?
[X] Yes [ ] No

If yes, document the Veteran's description of the impact of flare-ups in his or her own words:
It is my medical opinion that it is more likely than not (greater than 50/50 probability) that pain, but not weakness, fatigability or incoordination, could significantly limit functional ability during flare-ups, or when the joint is used repeatedly over a period of time and that there is additional limitation due to pain with change in the baseline range of motion due to "pain on use or during flare-ups." It would be pure speculation to state what additional ROM loss would be present due to pain on use or during flare-ups since the veteran is not examined during flare-up.

4. Initial range of motion (ROM) measurement

a. Select where forward flexion ends (normal endpoint is 90):

[ ] 0	[ ] 5	[ ] 10	[ ] 15	[ ] 20
[ ] 25	[X] 30	[ ] 35	[ ] 40	[ ] 45
[ ] 50	[ ] 55	[ ] 60	[ ] 65	[ ] 70
[ ] 75	[ ] 80	[ ] 85	[ ] 90 or greater	

Select where objective evidence of painful motion begins:
[ ] No objective evidence of painful motion

[X] 0 [ ] 5 [ ] 10 [ ] 15 [ ] 20
[ ] 25 [ ] 30 [ ] 35 [ ] 40 [ ] 45
[ ] 50 [ ] 55 [ ] 60 [ ] 65 [ ] 70
[ ] 75 [ ] 80 [ ] 85 [ ] 90 or greater

b. Select where extension ends (normal endpoint is 30):
[X] 0 [ ] 5 [ ] 10 [ ] 15 [ ] 20
[ ] 25 [ ] 30 or greater

Select where objective evidence of painful motion begins:
[ ] No objective evidence of painful motion
[X] 0 [ ] 5 [ ] 10 [ ] 15 [ ] 20
[ ] 25 [ ] 30 or greater

c. Select where right lateral flexion ends (normal endpoint is 30):
[ ] 0 [ ] 5 [ ] 10 [X] 15 [ ] 20
[ ] 25 [ ] 30 or greater

Select where objective evidence of painful motion begins:
[ ] No objective evidence of painful motion
[X] 0 [ ] 5 [ ] 10 [ ] 15 [ ] 20
[ ] 25 [ ] 30 or greater

d. Select where left lateral flexion ends (normal endpoint is 30):
[ ] 0 [ ] 5 [ ] 10 [X] 15 [ ] 20
[ ] 25 [ ] 30 or greater

Select where objective evidence of painful motion begins:
[ ] No objective evidence of painful motion
[X] 0 [ ] 5 [ ] 10 [ ] 15 [ ] 20
[ ] 25 [ ] 30 or greater

e. Select where right lateral rotation ends (normal endpoint is 30):
[ ] 0 [ ] 5 [ ] 10 [X] 15 [ ] 20 [ ] 25
[ ] 30 or greater

Select where objective evidence of painful motion begins:
[ ] No objective evidence of painful motion
[X] 0 [ ] 5 [ ] 10 [ ] 15 [ ] 20 [ ] 25
[ ] 30 or greater

f. Select where left lateral rotation ends (normal endpoint is 30):
[ ] 0 [ ] 5 [ ] 10 [X] 15 [ ] 20 [ ] 25
[ ] 30 or greater

Select where objective evidence of painful motion begins:
[ ] No objective evidence of painful motion
[X] 0 [ ] 5 [ ] 10 [ ] 15 [ ] 20 [ ] 25
[ ] 30 or greater

g. If ROM for this Veteran does not conform to the normal range of motion identified above but is normal for this Veteran (for reasons other than a back condition, such as age, body habitus, neurologic disease), explain:
No response provided.

5. ROM measurement after repetitive use testing
---
a. Is the Veteran able to perform repetitive-use testing with 3 repetitions?
[X] Yes [ ] No

b. Select where post-test forward flexion ends:
[ ] 0 [ ] 5 [ ] 10 [ ] 15 [ ] 20 [ ] 25 [X] 30
[ ] 35 [ ] 40 [ ] 45 [ ] 50 [ ] 55 [ ] 60 [ ] 65
[ ] 70 [ ] 75 [ ] 80 [ ] 85 [ ] 90 or greater

c. Select where post-test extension ends:
[X] 0 [ ] 5 [ ] 10 [ ] 15 [ ] 20 [ ] 25 [ ] 30 or greater

d. Select where post-test right lateral flexion ends:
[ ] 0 [ ] 5 [ ] 10 [X] 15 [ ] 20 [ ] 25 [ ] 30 or greater

e. Select where post-test left lateral flexion ends:
[ ] 0 [ ] 5 [ ] 10 [X] 15 [ ] 20 [ ] 25 [ ] 30 or greater

f. Select where post-test right lateral rotation ends:
[ ] 0 [ ] 5 [ ] 10 [X] 15 [ ] 20 [ ] 25 [ ] 30 or greater

g. Select where post-test left lateral rotation ends:
[ ] 0 [ ] 5 [ ] 10 [X] 15 [ ] 20 [ ] 25 [ ] 30 or greater

6. Functional loss and additional limitation in ROM
---
a. Does the Veteran have additional limitation in ROM of the thoracolumbar spine (back) following repetitive-use testing?
[ ] Yes [X] No

b. Does the Veteran have any functional loss and/or functional impairment of the thoracolumbar spine (back)?
[X] Yes [ ] No

c. If the Veteran has functional loss, functional impairment and/or additional limitation of ROM of the thoracolumbar spine (back) after repetitive use, indicate the contributing factors of disability below:
[X] Less movement than normal
[X] Pain on movement
[X] Instability of station
[X] Interference with sitting, standing and/or weight-bearing
[X] Lack of endurance

7. Pain and muscle spasm (pain on palpation, effect of muscle spasm on gait)
---
a. Does the Veteran have localized tenderness or pain to palpation for joints and/or soft tissue of the thoracolumbar spine (back)?

[X] Yes [ ] No

If yes, describe:
tender lumbar spine

b. Does the Veteran have muscle spasm of the thoracolumbar spine resulting in abnormal gait or abnormal spinal countour?
[X] Yes [ ] No

c. Does the Veteran have muscle spasms of the thoracolumbar spine not resulting in abnormal gait or abnormal spinal countour?
[ ] Yes [X] No

d. Does the Veteran have guarding of the thoracolumbar spine resulting in abnormal gait or abnormal spinal countour?
[X] Yes [ ] No

e. Does the Veteran have guarding of the thoracolumbar spine not resulting in abnormal gait or abnormal spinal countour?
[ ] Yes [X] No

8. Muscle strength testing
---
a. Rate strength according to the following scale:

0/5 No muscle movement
1/5 Palpable or visible muscle contraction, but no joint movement
2/5 Active movement with gravity eliminated
3/5 Active movement against gravity
4/5 Active movement against some resistance
5/5 Normal strength

Hip flexion:
Right: [X] 5/5 [ ] 4/5 [ ] 3/5 [ ] 2/5 [ ] 1/5 [ ] 0/5
Left: [X] 5/5 [ ] 4/5 [ ] 3/5 [ ] 2/5 [ ] 1/5 [ ] 0/5

Knee extension:
Right: [X] 5/5 [ ] 4/5 [ ] 3/5 [ ] 2/5 [ ] 1/5 [ ] 0/5
Left: [X] 5/5 [ ] 4/5 [ ] 3/5 [ ] 2/5 [ ] 1/5 [ ] 0/5

Ankle plantar flexion:
Right: [X] 5/5 [ ] 4/5 [ ] 3/5 [ ] 2/5 [ ] 1/5 [ ] 0/5
Left: [X] 5/5 [ ] 4/5 [ ] 3/5 [ ] 2/5 [ ] 1/5 [ ] 0/5

Ankle dorsiflexion:
Right: [X] 5/5 [ ] 4/5 [ ] 3/5 [ ] 2/5 [ ] 1/5 [ ] 0/5
Left: [X] 5/5 [ ] 4/5 [ ] 3/5 [ ] 2/5 [ ] 1/5 [ ] 0/5

Great toe extension:
Right: [X] 5/5 [ ] 4/5 [ ] 3/5 [ ] 2/5 [ ] 1/5 [ ] 0/5
Left: [X] 5/5 [ ] 4/5 [ ] 3/5 [ ] 2/5 [ ] 1/5 [ ] 0/5

b. Does the Veteran have muscle atrophy?
[ ] Yes [X] No

```
9. Reflex exam
--------------
Rate deep tendon reflexes (DTRs) according to the following scale:

   0  Absent
   1+ Hypoactive
   2+ Normal
   3+ Hyperactive without clonus
   4+ Hyperactive with clonus

   Knee:
     Right: [ ] 0   [ ] 1+   [X] 2+   [ ] 3+   [ ] 4+
     Left:  [ ] 0   [ ] 1+   [X] 2+   [ ] 3+   [ ] 4+

   Ankle:
     Right: [ ] 0   [ ] 1+   [X] 2+   [ ] 3+   [ ] 4+
     Left:  [ ] 0   [ ] 1+   [X] 2+   [ ] 3+   [ ] 4+

10. Sensory exam
----------------
Provide results for sensation to light touch (dermatome) testing:

   Upper anterior thigh (L2):
     Right: [X] Normal   [ ] Decreased   [ ] Absent
     Left:  [X] Normal   [ ] Decreased   [ ] Absent

   Thigh/knee (L3/4):
     Right: [X] Normal   [ ] Decreased   [ ] Absent
     Left:  [X] Normal   [ ] Decreased   [ ] Absent

   Lower leg/ankle (L4/L5/S1):
     Right: [X] Normal   [ ] Decreased   [ ] Absent
     Left:  [X] Normal   [ ] Decreased   [ ] Absent

   Foot/toes (L5):
     Right: [X] Normal   [ ] Decreased   [ ] Absent
     Left:  [X] Normal   [ ] Decreased   [ ] Absent

11. Straight leg raising test
-----------------------------
Provide straight leg raising test results:
   Right: [X] Negative   [ ] Positive   [ ] Unable to perform
   Left:  [X] Negative   [ ] Positive   [ ] Unable to perform

12. Radiculopathy
-----------------
Does the Veteran have radicular pain or any other signs or symptoms due to
radiculopathy?
[X] Yes   [ ] No

a. Indicate symptoms' location and severity (check all that apply):

   Constant pain (may be excruciating at times)
```

Right lower extremity: [X] None [ ] Mild [ ] Moderate [ ] Severe
Left lower extremity: [X] None [ ] Mild [ ] Moderate [ ] Severe

Intermittent pain (usually dull)
Right lower extremity: [ ] None [ ] Mild [X] Moderate [ ] Severe
Left lower extremity: [ ] None [ ] Mild [X] Moderate [ ] Severe

Paresthesias and/or dysesthesias
Right lower extremity: [ ] None [X] Mild [ ] Moderate [ ] Severe
Left lower extremity: [ ] None [X] Mild [ ] Moderate [ ] Severe

Numbness
Right lower extremity: [X] None [ ] Mild [ ] Moderate [ ] Severe
Left lower extremity: [X] None [ ] Mild [ ] Moderate [ ] Severe

b. Does the Veteran have any other signs or symptoms of radiculopathy?
No response provided.

c. Indicate nerve roots involved: (check all that apply)

[X] Involvement of L4/L5/S1/S2/S3 nerve roots (sciatic nerve)

If checked, indicate: [ ] Right [ ] Left [X] Both

d. Indicate severity of radiculopathy and side affected:

Right: [ ] Not affected [X] Mild [ ] Moderate [ ] Severe
Left: [ ] Not affected [X] Mild [ ] Moderate [ ] Severe

13. Ankylosis

Is there ankylosis of the spine? [ ] Yes [X] No

14. Other neurologic abnormalities

Does the Veteran have any other neurologic abnormalities or findings related to a thoracolumbar spine (back) condition (such as bowel or bladder problems/pathologic reflexes)?
[ ] Yes [X] No

15. Intervertebral disc syndrome (IVDS) and incapacitating episodes
---
a. Does the Veteran have IVDS of the thoracolumbar spine?
[X] Yes [ ] No

b. If yes, has the Veteran had any incapacitating episodes over the past 12 months due to IVDS?
[ ] Yes [X] No

16. Assistive devices
---
a. Does the Veteran use any assistive device(s) as a normal mode of locomotion, although occasional locomotion by other methods may be

possible?
[ ] Yes [X] No

17. Remaining effective function of the extremities

Due to a thoracolumbar spine (back) condition, is there functional impairment of an extremity such that no effective function remains other than that which would be equally well served by an amputation with prosthesis? (Functions of the upper extremity include grasping, manipulation, etc.; functions of the lower extremity include balance and propulsion, etc.)
[X] No

18. Other pertinent physical findings, complications, conditions, signs and/or symptoms
---
a. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any conditions listed in the Diagnosis section above?
[ ] Yes [X] No

b. Does the Veteran have any other pertinent physical findings, complications, conditions, signs or symptoms?
[ ] Yes [X] No

19. Diagnostic testing
---
a. Have imaging studies of the thoracolumbar spine been performed and are the results available?
[X] Yes [ ] No

If yes, is arthritis documented?
[X] Yes [ ] No

b. Does the Veteran have a thoracic vertebral fracture with loss of 50 percent or more of height?
[ ] Yes [X] No

c. Are there any other significant diagnostic test findings and/or results?
[ ] Yes [X] No

20. Functional impact

Does the Veteran's thoracolumbar spine (back) condition impact on his or her ability to work?
[X] Yes [ ] No

If yes describe the impact of each of the Veteran's thoracolumbar spine (back) conditions providing one or more examples:
limited to sedentary work

21. REMARKS
---
a. Remarks, if any:
it is less likely that his current spoinal stenosis is related to one evet

over 40 years ago but rather natural age progression

b. Mitchell criteria:
It is my medical opinion that it is more likely than not (greater than 50/50 probability) that pain, but not weakness, fatigability or incoordination, could significantly limit functional ability during flare-ups, or when the joint is used repeatedly over a period of time and that there is additional limitation due to pain with change in the baseline range of motion due to "pain on use or during flare-ups." It would be pure speculation to state what additional ROM loss would be present due to pain on use or during flare-ups since the veteran is not examined during flare-up.

/es/ PAUL ANTHONY STEURER
ORTHOPEDIST
Signed: 09/29/2014 08:00

FRANCWAY, Ernest L., Jr.
[redacted]
VA Medical Center, Cleveland, Ohio
October 4, 2002 to August 27, 2014

Vitals:

ACTIVE MEDICATIONS (VA):
BADR - Brief Adv React/All
Allergy/Reaction: No Known Allergies

AMRS - MEDS (REC SUCCINCT)

Active and Recently Expired Inpatient and Outpatient Medications
(including Supplies):

	Active Outpatient Medications	Status
1)	AMMONIUM LACTATE 5% LOTION APPLY A SUFFICIENT AMOUNT EXTERNALLY EVERY DAY TO DRY SKIN	ACTIVE
2)	ARTIFICIAL TEARS POLYVINYL ALCOHOL INSTILL 1 DROP IN EACH EYE THREE TIMES A DAY AS NEEDED FOR DRY EYES	ACTIVE
3)	CHOLECALCIFEROL (VIT D3) 1,000UNIT TAB TAKE ONE TABLET BY MOUTH EVERY DAY FOR LOW VITAMIN D LEVEL	ACTIVE
4)	CYCLOBENZAPRINE HCL 10MG TAB TAKE ONE TABLET BY MOUTH EVERY 8 HOURS AS NEEDED FOR MUSCLE SPASMS	ACTIVE
5)	ETODOLAC 300MG CAP TAKE ONE CAPSULE BY MOUTH EVERY 6 HOURS AS NEEDED FOR PAIN	ACTIVE
6)	MULTIVITS W/MINERALS TAB/CAP (NO VIT K) TAKE 1 TABLET BY MOUTH EVERY DAY	ACTIVE
7)	MUPIROCIN 2% OINT APPLY A SUFFICIENT AMOUNT EXTERNALLY FOUR TIMES A DAY TO THE TREATED AREAS ON THE GENITALS	ACTIVE
8)	SIMVASTATIN 80MG TAB TAKE ONE-HALF TABLET BY MOUTH AT BEDTIME	ACTIVE
9)	TAPE,MICROPORE 2IN 3M #1530-2 USE TAPE SUPPLY ITEM AS DIRECTED	ACTIVE
10)	VARDENAFIL HCL 20MG TAB TAKE ONE TABLET BY MOUTH ONE TIME ONE HOUR BEFORE SEXUAL ACTIVITY (NO MORE THAN 1 DOSE PER 24 HOUR PERIOD)	ACTIVE

	Inactive Outpatient Medications	Status
1)	GAUZE PAD 4IN X 4IN 8-PLY STERILE USE GAUZE SUPPLY ITEM AS DIRECTED	EXPIRED

11 Total Medications

BODY MASS INDEX:
Body Mass Index >27 Nutritional/Exercise Counseling

SocHx (reviewed 6/28/10):
Divorced
Estranged from children; not seen in 22 yrs
Imprisoned for 5 yrs for "menacing"
Currently living in car

Private physisicans:
none; all care through VA

Subjective: 60 y/o man presents for medication renewals, f/u on LBP, knee pain.

Pain worse with rain; wants to know if can.

has some growths in upper groin area. States that some of them started to bleed but wants them gone. Started in January.

ROS reviewed & otherwise negative.

Objective:
Gen: WNWD male, tired-appearing
HEENT: NC/AT PERRLA EOMI
N: Supple; no TM, JVD, bruits noted
H: RRR S1S2 no r/c/g/m
L: CTA, no r/w
Abd: Soft, NT/ND +BS
Ext: No c/c/e
wearing articulated brace,
ambulating with antalgic, slightly splayed gait

FRANCWAY, Ernest L., Jr.
[redacted]
VA Medical Center, Cleveland, Ohio
October 4, 2002 to August 27, 2014

```
Assessment/Plan:

Dyslipidemia:
        Simvastatin 20 mg nightly
        Lipids, LFTs due

Acute on Chronic LBP, OA b/l Knees; right hip pain post-fall:
        Ongoing since 1969 for LBP, OA b/l knees
        Completed PT program in 8/2004; has home program.
        Declines PT for right hip pain.
        Failed ibuprofen, naproxen, lodine, piroxicam, diclofenac
        States tramadol also ineffective (4/09, 5/09)
        Seen by Pain Management, 15Aug2006:
                Declines further PT/AquaTherapy
                Recommended another NSAID if wants PT
                Discharged from Pain Management
        Seen by Pain Management again 28July2009, 07Aug2009:
                Declined further PMC Psychology f/u
                Etodolac 300 mg every 8 hours as needed (8/09); to every 6H prn
        PT w/TENS ordered; pt refused consult when contacted.
        Encouraged to try AquaTherapy for further improvement in ROM; declines.
        Ortho recommended TKR.
        Ortho also recommends NO OPIOIDS due dependence potential and also
difficulty managing post-operative pain in future.  Writer agrees as I do
believe that this would only increase in amount and frequency of use of this
medication. However, would give for sporadic flares.

+PTSD (10%-SC'd); +depression screen:
        Seen by CSR; declined assistance.
        Currently being followed by Dr. Shurell for psychotherapy;
        Per CSR consult 02July2009:
        " CANCELLED 07/17/09 10:12      HROVAT,JOHN M       HROVAT,JOHN M
Treatment team including Dr. Blank met to discuss vet's referral to CSR.
Based on previous assessment of 4/09 and chart review it was decided that
the veteran should remain with Dr. Shurell."
        Appears never rescheduled w/Dr. Shurell
        Trazodone not effective for sleep.

Elevated PSA:
        5.3 (6/11)
        Repeat PSA today
        D/W pt need for possible Urology referral and/or DRE, and/or TRPB.

Erectile Dysfunction, BPH:
        Vardenefil 10 mg renewed
        PSA, u/a

h/o left 3rd digit paronychia (5/11):
        Resolved.

Left Ulnar exostosis:
        No Ortho F/U since 3/2004.
        Isn't certain about surgery -- scared of the procedure.

Nummular eczema:
        Prev. on Camphor/menthol lotion two pumps as needed.
        Previously on triamcinolone 0.1% cream as needed for rash

Folliculitis;
        Following w/Derm.
        Previously on Cleocin soln nightly, benzoyl peroxide daily,
chlorhexidine soap

Left inguinal hernia:
        Declines surgical evaluation.

Cholelithiasis, asymptomatic:
        By CT scan.

Fatty liver, asymptomatic:
        By CT scan.
        Diet, lipid management.

Preventive medicine (reviewed 12/14/11):
        Pneumococcal:   Due 65 yoa
        Tetanus:        TDaP 5/30/11
        Influenza:      11/17/11
```

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        Novel H1N1:     12/16/10
        Zoster:         Revisit per pt request
        Stool cards:    Given 6/23/11
        PSA:            Due
        TSH:            Due
        lipids:         Due
        ECG:            3/2003; due

RTC June 2012

Clinical Reminders Activity
  Pain Assessment:
    Patient indicated that this is an ongoing pain.  The initial pain
    assessment was completed on No Data Available.
      Provider Reassessment:
        Patient is compliant with the pain management plan of care.
          Yes

MEDICATION RECONCILIATION
    MEDICATION RECONCILIATION REPORT reviewed and discussed with patient.
      VA prescription medications:
        Patient reports variations from prescribed regimen; please see the
        Medications Tab.

      Prescription medications from another source:
        Patient reports changes to the non-VA prescriptions; please see
        Medications Tab.

      Over the counter medications, vitamins, herbals, and nutritional
      supplements:
        Patient reports changes to the over the counter medications,
        vitamins, herbals, or nutritional supplements; please see meds
        tab.

PATIENT EDUCATION:
        Medical Diagnosis, Nutrition, Medication (including side effects)



FUTURE CLINIC VISITS:
  DATE     TIME   CLINIC                          STATUS
  ----     ----   ------                          ------
12/14/2011 08:20  B PCM/HOVIS

/es/ JENNIFER C. HOVIS
GERONTOLOGIST
Signed: 12/14/2011 08:35

12/14/2011 ADDENDUM                     STATUS: COMPLETED
PROSTATIC SPECIFIC ANTIGEN,TOTAL    4.9Hng/mL      0.0 - 4.0

---------------------

Please contact Mr. Francway.  His PSA remains increased & at this time I would
prefer for him to see Urology.  If he is in agreement, I will place the consult.

Thank you.

/es/ JENNIFER C. HOVIS
GERONTOLOGIST
Signed: 12/14/2011 15:22

Receipt Acknowledged By:
12/14/2011 15:42        /es/ SHAWN J YUHAS
                             REGISTERED NURSE


 LOCAL TITLE: PARMA PRIMARY CARE (T)
STANDARD TITLE: PRIMARY CARE NOTE
DATE OF NOTE: DEC 14, 2011@07:55     ENTRY DATE: DEC 14, 2011@07:55:56
      AUTHOR: HOVIS,JENNIFER C     EXP COSIGNER:
 INSTITUTION: ZZ-BRECKSVILLE VANPH
    DIVISION: BRECKSVILLE
     URGENCY:                           STATUS: COMPLETED

   *** PARMA PRIMARY CARE (T) Has ADDENDA ***
```

FRANCWAY, Ernest L., Jr.
[redacted]
VA Medical Center, Cleveland, Ohio
October 4, 2002 to August 27, 2014

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FUTURE CLINIC VISITS:
  DATE     TIME   CLINIC                          STATUS
  ----     ----   ------                          ------
12/14/2011 08:20  B PCM/HOVIS

/es/ JENNIFER C. HOVIS
GERONTOLOGIST
Signed: 12/14/2011 08:35

12/14/2011 ADDENDUM                    STATUS: COMPLETED
Veteran agreed to see urology, veteran extremely concerned about prostate exam,
but is willing to hear what they have to say.

/es/ SHAWN J YUHAS
REGISTERED NURSE
Signed: 12/14/2011 15:43

Receipt Acknowledged By:
12/14/2011 15:45        /es/ JENNIFER C. HOVIS
                             GERONTOLOGIST


 LOCAL TITLE: OUTPATIENT NURSING INTAKE NOTE (T)
STANDARD TITLE: PRIMARY CARE NURSING NOTE
DATE OF NOTE: DEC 14, 2011@08:02     ENTRY DATE: DEC 14, 2011@08:02:44
      AUTHOR: PACE,ALPHONSO        EXP COSIGNER:
 INSTITUTION: ZZ-BRECKSVILLE VANPH
    DIVISION: BRECKSVILLE
     URGENCY:                          STATUS: COMPLETED


Review Allergies
  Allergies reviewed and updated per protocol.

  Patient has answered NKA

  Hemoglobin A1C - POC
  No data available


  Hemoglobin A1C
  No data available



MEDICATION LIST REVIEW REPORT
    OTC/Herbal was documented at this visit.

PATIENT EDUCATION
  LEARNING NEEDS ASSESSMENT:


  I. Learning Preference:
    Hands-on


  II. Barriers to Learning:
    No Barriers to Learning


  III. Social Influences Related to Educational Needs:
    No social barriers to learning


  IV. Readiness to Learn:
    Patient
      Appears ready to learn.
  No Change in Learning Assessment

Clinical Reminders Activity
  Pain Scale:
    Pain screening was done at this visit.
      Enter Pain Level: 8
  Pain, Brief Evaluation:
    Type of pain:  Ongoing
```

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[redacted]
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    Location:  Low Back                   Lower back and left knee.
    Intensity:
      Currently:
        8
      Usually:  8
    Description of Pain:  Aching, Burning

    Evaluation:
      Pain will be evaluated by provider today.
       Notified via Encounter Form.
  BMI > 30 or > 24.99 in High Risk:
    "At this visit, the health risks of obesity were reviewed and
    discussed with the patient, and the benefits of a weight management
    treatment program, such as MOVE! was discussed and offered to the
    patient."
    Patient Refuses referral.  After discussing the health risks of
    obesity and offering a referral to MOVE or another weight loss program
    outside the VA, the patient REFUSES REFERRAL to MOVE or other weight
    loss program at this time.

  Alcohol Use Screen (AUDIT-C):
    SCREEN FOR ALCOHOL (AUDIT-C)
      An alcohol screening test (AUDIT-C) was negative (score=0).

      1. How often did you have a drink containing alcohol in the past
      year?
      Never

      2. How many drinks containing alcohol did you have on a typical day
      when you were drinking in the past year?
      Response not required due to responses to other questions.

      3. How often did you have six or more drinks on one occasion in the
      past year?
      Response not required due to responses to other questions.

/es/ ALPHONSO PACE
LICENSED PRACTICAL NURSE
Signed: 12/14/2011 08:09


 LOCAL TITLE: COMPENSATION & PENSION EXAMINATION
STANDARD TITLE: C & P EXAMINATION NOTE
DATE OF NOTE: DEC 05, 2011@07:00     ENTRY DATE: DEC 05, 2011@07:18:40
      AUTHOR: STEURER,PAUL ANTHON  EXP COSIGNER:
 INSTITUTION: ZZ-BRECKSVILLE VANPH
    DIVISION: BRECKSVILLE
     URGENCY:                            STATUS: COMPLETED


                     Back (Thoracolumbar Spine) Conditions
                       Disability Benefits Questionnaire

    Name of patient/Veteran:   Ernest Fancway

    Your patient is applying to the U. S. Department of Veterans Affairs (VA) for
    disability benefits.  VA will consider the information you provide on this
    questionnaire as part of their evaluation in processing the Veteran's claim.

    1. Diagnosis
    ------------
    Does the Veteran now have or has he/she ever been diagnosed with a
    thoracolumbar spine (back) condition? [X] Yes   [ ] No

       If yes, provide only diagnoses that pertain to thoracolumbar spine (back)
       conditions:

          Diagnosis #1:  spinal stenosis
              ICD code:  724.02
              Date of diagnosis:

          Diagnosis #2:
              ICD code:
              Date of diagnosis:

          Diagnosis #3:
              ICD code:
```

FRANCWAY, Ernest L., Jr.
[redacted]
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```
            Date of diagnosis:

         If there are additional diagnoses pertaining to thoracolumbar spine
         (back) conditions, list using above format:

   2. Medical history
   ------------------
   Describe the history (including onset and course) of the Veteran's
   thoracolumbar spine (back) condition (brief summary):
      c-file reviewed, opinion given multiple times. His stenosis is not related
      to a strain in service but natural age progression. No exam is needed.

   3. Flare-ups
   ------------
   Does the Veteran report that flare-ups impact the function of the
   thoracolumbar spine (back)? [ ] Yes   [ ] No

      If yes, document the Veteran's description of the impact of flare-ups in
      his or her own words:

   4. Initial range of motion (ROM) measurements
   ---------------------------------------------
   Measure ROM with a goniometer, rounding each measurement to the nearest 5
   degrees. During the measurements, observe the point at which painful motion
   begins, evidenced by visible behavior such as facial expression, wincing,
   etc. Report initial measurements below.

   Following the initial assessment of ROM, perform repetitive-use testing.  For
   VA purposes, repetitive-use testing must be included in all exams. The VA has
   determined that 3 repetitions of ROM (at minimum) can serve as a
   representative test of the effect of repetitive use. After the initial
   measurement, reassess ROM after 3 repetitions. Report post-test measurements
   in section 5.

   a. Select where forward flexion ends (normal endpoint is 90):
        [ ] 0    [ ] 5    [ ] 10   [ ] 15   [ ] 20   [ ] 25   [ ] 30
        [ ] 35   [ ] 40   [ ] 45   [ ] 50   [ ] 55   [ ] 60   [ ] 65
        [ ] 70   [ ] 75   [ ] 80   [ ] 85   [ ] 90 or greater

      Select where objective evidence of painful motion begins:
        [ ] No objective evidence of painful motion
        [ ] 0    [ ] 5    [ ] 10   [ ] 15   [ ] 20   [ ] 25   [ ] 30
        [ ] 35   [ ] 40   [ ] 45   [ ] 50   [ ] 55   [ ] 60   [ ] 65
        [ ] 70   [ ] 75   [ ] 80   [ ] 85   [ ] 90 or greater

   b. Select where extension ends (normal endpoint is 30):
        [ ] 0    [ ] 5    [ ] 10   [ ] 15   [ ] 20   [ ] 25   [ ] 30 or greater

      Select where objective evidence of painful motion begins:
        [ ] No objective evidence of painful motion
        [ ] 0    [ ] 5    [ ] 10   [ ] 15   [ ] 20   [ ] 25   [ ] 30 or greater

   c. Select where right lateral flexion ends (normal endpoint is 30):
        [ ] 0    [ ] 5    [ ] 10   [ ] 15   [ ] 20   [ ] 25   [ ] 30 or greater

      Select where objective evidence of painful motion begins:
        [ ] No objective evidence of painful motion
        [ ] 0    [ ] 5    [ ] 10   [ ] 15   [ ] 20   [ ] 25   [ ] 30 or greater

   d. Select where left lateral flexion ends (normal endpoint is 30):
        [ ] 0    [ ] 5    [ ] 10   [ ] 15   [ ] 20   [ ] 25   [ ] 30 or greater

      Select where objective evidence of painful motion begins:
        [ ] No objective evidence of painful motion
        [ ] 0    [ ] 5    [ ] 10   [ ] 15   [ ] 20   [ ] 25   [ ] 30 or greater

   e. Select where right lateral rotation ends (normal endpoint is 30):
        [ ] 0    [ ] 5    [ ] 10   [ ] 15   [ ] 20   [ ] 25   [ ] 30 or greater

      Select where objective evidence of painful motion begins:
        [ ] No objective evidence of painful motion
        [ ] 0    [ ] 5    [ ] 10   [ ] 15   [ ] 20   [ ] 25   [ ] 30 or greater

   f. Select where left lateral rotation ends (normal endpoint is 30):
        [ ] 0    [ ] 5    [ ] 10   [ ] 15   [ ] 20   [ ] 25   [ ] 30 or greater

      Select where objective evidence of painful motion begins:
```

FRANCWAY, Ernest L., Jr.
[redacted]
VA Medical Center, Cleveland, Ohio
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I would like to update you on your recent results:

Your recent stool cards were all negative for blood.

As part of the colon cancer screening process, I recommend meeting with the GI (Gastroenterology) clinic to discuss scheduling a colonoscopy. A colonoscopy is when the healthcare provider inserts a scope into the rectum to actually look into your colon to screen for the presence of any polyps, tumors, or other abnormalities. This is the best way to screen for colon cancer. There are two types of endoscopies, one is done under sedation and one is not. The GI provider would discuss which is best for you at the appointment and then schedule the procedure at that time.

Please call our nurse at 440-526-3030, extension 6534, if you would like to have a consult placed to the GI clinic to discuss this further, or if you have any questions about this letter.

Thank you for your prompt attention to your health.

Sincerely,

Dr. Hovis
Your VA Healthcare Team

07/05/2011 ADDENDUM STATUS: COMPLETED
Contact information is correct in patient chart, called patient back at number listed in CPRS and it was working.

/es/ JOHNNY K. HUGHES
REGISTERED NURSE
Signed: 07/05/2011 16:00

Receipt Acknowledged By:
07/07/2011 08:18 /es/ ALPHONSO PACE
LICENSED PRACTICAL NURSE

LOCAL TITLE: PARMA PRIMARY CARE (T)
STANDARD TITLE: PRIMARY CARE NOTE
DATE OF NOTE: JUN 23, 2011@07:45 ENTRY DATE: JUN 23, 2011@07:45:30
AUTHOR: HOVIS,JENNIFER C EXP COSIGNER:
INSTITUTION: ZZ-BRECKSVILLE VANPH
DIVISION: BRECKSVILLE
URGENCY: STATUS: COMPLETED

The patient is a 61 year old MAN.

ALLERGIES: Patient has answered NKA

Vitals:

ACTIVE MEDICATIONS (VA):
BADR - Brief Adv React/All
Allergy/Reaction: No Known Allergies

AMRS - MEDS (REC SUCCINCT)

Active and Recently Expired Inpatient and Outpatient Medications (including Supplies):

	Active Outpatient Medications	Status
1)	AMMONIUM LACTATE 5% LOTION APPLY A SUFFICIENT AMOUNT EXTERNALLY EVERY DAY TO DRY SKIN	ACTIVE
2)	CHOLECALCIFEROL (VIT D3) 1,000UNIT TAB TAKE ONE TABLET BY MOUTH EVERY DAY FOR LOW VITAMIN D LEVEL	ACTIVE
3)	CLINDAMYCIN HCL 150MG CAP TAKE THREE CAPSULES BY MOUTH THREE TIMES A DAY (WITH FOOD)	ACTIVE
4)	CLOTRIMAZOLE 1% TOP CREAM APPLY A SUFFICIENT AMOUNT EXTERNALLY TWICE A DAY TO GROIN	ACTIVE
5)	CYCLOBENZAPRINE HCL 10MG TAB TAKE ONE TABLET BY MOUTH EVERY 8 HOURS AS NEEDED FOR MUSCLE SPASMS	ACTIVE
6)	DIPHTH/PERTUSS/TET (Tdap) (BOOSTRIX) SYR INJECT 0.5ML INTRAMUSCULARLY ONE TIME	ACTIVE
7)	ETODOLAC 300MG CAP TAKE ONE CAPSULE BY MOUTH EVERY 8 HOURS AS NEEDED FOR PAIN	ACTIVE

FRANCWAY, Ernest L., Jr.
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VA Medical Center, Cleveland, Ohio
October 4, 2002 to August 27, 2014

```
8)   MULTIVITS W/MINERALS TAB/CAP (NO VIT K) TAKE 1 TABLET  ACTIVE
       BY MOUTH EVERY DAY
9)   SIMVASTATIN 80MG TAB TAKE ONE-HALF TABLET BY MOUTH AT  ACTIVE
       BEDTIME
10)  VARDENAFIL HCL 20MG TAB TAKE ONE TABLET BY MOUTH ONE   ACTIVE
       TIME ONE HOUR BEFORE SEXUAL ACTIVITY (NO MORE THAN
       1 DOSE PER 24 HOUR PERIOD)

     Inactive Outpatient Medications                       Status
=========================================================================
1)   ARTIFICIAL TEARS POLYVINYL ALCOHOL INSTILL 1 DROP IN   EXPIRED
       EACH EYE THREE TIMES A DAY AS NEEDED FOR DRY EYES
2)   TABLET CUTTER USE THIS    AS DIRECTED TO SPLIT         EXPIRED
       TABLETS IN HALF

12 Total Medications

BODY MASS INDEX:
        Body Mass Index >27 Nutritional/Exercise Counseling


SocHx (reviewed 6/28/10):
        Divorced
        Estranged from children; not seen in 22 yrs
        Imprisoned for 5 yrs for "menacing"
        Currently living in car

Private physisicans:
        none; all care through VA

Subjective:  60 y/o man presents for medication renewals, f/u on LBP, knee pain.

Pain worse with rain; wants to know if can.

has some growths in upper groin area.  States that some of them started to bleed
but wants them gone.  Started in January.

ROS reviewed & otherwise negative.

Objective:
        Gen:    WNWD male, tired-appearing
        HEENT:  NC/AT PERRLA EOMI
        N:      Supple; no TM, JVD, bruits noted
        H:      RRR S1S2 no r/c/g/m
        L:      CTA, no r/w
        Abd:    Soft, NT/ND +BS
        Ext:    No c/c/e
                wearing articulated brace,
                        ambulating with antalgic, slightly splayed gait

Assessment/Plan:

Dyslipidemia:
        Simvastatin 20 mg nightly
        Lipids, LFTs due

Acute on Chronic LBP, OA b/l Knees; right hip pain post-fall:
        Ongoing since 1969 for LBP, OA b/l knees
        Completed PT program in 8/2004; has home program.
        Declines PT for right hip pain.
        Failed ibuprofen, naproxen, lodine, piroxicam, diclofenac
        States tramadol also ineffective (4/09, 5/09)
        Seen by Pain Management, 15Aug2006:
                Declines further PT/AquaTherapy
                Recommended another NSAID if wants PT
                Discharged from Pain Management
        Seen by Pain Management again 28July2009, 07Aug2009:
                Declined further PMC Psychology f/u
                Etodolac 300 mg every 8 hours as needed (8/09); to every 6H prn
        PT w/TENS ordered; pt refused consult when contacted.
        Encouraged to try AquaTherapy for further improvement in ROM; declines.
        Ortho recommended TKR.
        Ortho also recommends NO OPIOIDS due dependence potential and also
difficulty managing post-operative pain in future.  Writer agrees as I do
believe that this would only increase in amount and frequency of use of this
medication. However, would give for sporadic flares.
```

FRANCWAY, Ernest L., Jr.
[redacted]
VA Medical Center, Cleveland, Ohio
October 4, 2002 to August 27, 2014

```
+PTSD (10%-SC'd); +depression screen:
        Seen by CSR; declined assistance.
        Currently being followed by Dr. Shurell for psychotherapy;
        Per CSR consult 02July2009:
        " CANCELLED 07/17/09 10:12      HROVAT,JOHN M       HROVAT,JOHN M
Treatment team including Dr. Blank met to discuss vet's referral to CSR.
Based on previous assessment of 4/09 and chart review it was decided that
the veteran should remain with Dr. Shurell."
        Appears never rescheduled w/Dr. Shurell
        Trazodone not effective for sleep.

Erectile Dysfunction, BPH:
        Vardenefil 10 mg renewed
        PSA, u/a

h/o left 3rd digit paronychia (5/11):
        Resolved.

Left Ulnar exostosis:
        No Ortho F/U since 3/2004.
        Isn't certain about surgery -- scared of the procedure.

Nummular eczema:
        Prev. on Camphor/menthol lotion two pumps as needed.
        Previously on triamcinolone 0.1% cream as needed for rash

Folliculitis;
        Following w/Derm.
        Previously on Cleocin soln nightly, benzoyl peroxide daily,
chlorhexidine soap

Left inguinal hernia:
        Declines surgical evaluation.

Cholelithiasis, asymptomatic:
        By CT scan.

Fatty liver, asymptomatic:
        By CT scan.
        Diet, lipid management.

Preventive medicine (reviewed 6/23/11):
        Pneumococcal:   Due 65 yoa
        Tetanus:        TDaP 5/30/11
        Influenza:      12/16/10
        Novel H1N1:     12/16/10
        Zoster:         Revisit per pt request
        Stool cards:    Given 6/23/11
        PSA:            Due
        TSH:            Due
        lipids:         Due
        ECG:            3/2003; due

RTC December, 2011


Clinical Reminders Activity
  Pain Assessment:
    Patient indicated that this is an ongoing pain.  The initial pain
    assessment was completed on No Data Available.
      Provider Reassessment:
        Patient is compliant with the pain management plan of care.
          Yes



PATIENT EDUCATION:
        Medical Diagnosis, Nutrition, Medication (including side effects)



FUTURE CLINIC VISITS:
  DATE     TIME   CLINIC                          STATUS
  ----     ----   ------                          ------
06/23/2011 08:00  B PCM/HOVIS
```

FRANCWAY, Ernest L., Jr.
[redacted]
VA Medical Center, Cleveland, Ohio
October 4, 2002 to August 27, 2014

/es/ JENNIFER C. HOVIS
GERONTOLOGIST
Signed: 06/23/2011 08:16

LOCAL TITLE: OUTPATIENT NURSING INTAKE NOTE (T)
STANDARD TITLE: PRIMARY CARE NURSING NOTE
DATE OF NOTE: JUN 23, 2011@07:45 ENTRY DATE: JUN 23, 2011@07:45:38
AUTHOR: MIGUEL,AUGUSTO EXP COSIGNER:
INSTITUTION: ZZ-BRECKSVILLE VANPH
DIVISION: BRECKSVILLE
URGENCY: STATUS: COMPLETED

Review Allergies
Allergies reviewed and updated per protocol.

Patient has answered NKA

MEDICATION LIST REVIEW REPORT
Patient's Active Medications were reviewed at this visit.
Patient states not taking any OTC/Herbals at this visit.

Clinical Reminders Activity
Colorectal Cancer Screen FOBT:
Patient has not had a sigmoidoscopy or colonoscopy.
Stool cards given to patient. Patient was educated on the importance of returning the stool cards.
Level of understanding: Good
Depression Screening:
PHQ-2
A PHQ-2 screen was performed. The score was 2 which is a negative screen for depression.

1. Little interest or pleasure in doing things
Several days

2. Feeling down, depressed, or hopeless
Several days
Pain, Brief Evaluation:
Type of pain: Ongoing
Location: Low Back left knee and hernia
Intensity:
Currently:
7
Description of Pain: Aching, Cramping, Dull, Nagging, Sharp, Shooting, Throbbing

Evaluation:
Pain will be evaluated by provider today.
Notified via Router Slip

/es/ AUGUSTO MIGUEL
LICENSED PRACTICAL NURSE
Signed: 06/23/2011 07:54

LOCAL TITLE: PHARMACY MEDICATION EDUCATION (T)
STANDARD TITLE: PHARMACY EDUCATION NOTE
DATE OF NOTE: MAY 30, 2011@22:19 ENTRY DATE: MAY 30, 2011@22:19:55
AUTHOR: BUGAJ,PATRICK S EXP COSIGNER:
INSTITUTION: CLEVELAND VAMC
DIVISION: WADE PARK
URGENCY: STATUS: COMPLETED

PATIENT EDUCATION DOCUMENTATION
Education Topic: Safe and effective use of medications

Patient was educated on the following medications marked with an X:
Active Outpatient Medications (including Supplies):

Active Outpatient Medications	Status

FRANCWAY, Ernest L., Jr.
[redacted]
VA Medical Center, Cleveland, Ohio
October 4, 2002 to August 27, 2014

```
  =
  1)   AMMONIUM LACTATE 5% LOTION APPLY A SUFFICIENT AMOUNT   ACTIVE
         EXTERNALLY EVERY DAY TO DRY SKIN
  2)   CHOLECALCIFEROL (VIT D3) 1,000UNIT TAB TAKE ONE        ACTIVE
         TABLET BY MOUTH EVERY DAY FOR LOW VITAMIN D LEVEL
  X    CLINDAMYCIN HCL 150MG CAP TAKE THREE CAPSULES BY       ACTIVE
         MOUTH THREE TIMES A DAY (WITH FOOD)
  4)   CLOTRIMAZOLE 1% TOP CREAM APPLY A SUFFICIENT AMOUNT    ACTIVE
         EXTERNALLY TWICE A DAY TO GROIN
  5)   CYCLOBENZAPRINE HCL 10MG TAB TAKE ONE TABLET BY MOUTH  ACTIVE
         EVERY 8 HOURS AS NEEDED FOR MUSCLE SPASMS
  6)   DIPHTH/PERTUSS/TET (Tdap) (BOOSTRIX) SYR INJECT 0.5ML  ACTIVE
         INTRAMUSCULARLY ONE TIME
  7)   ETODOLAC 300MG CAP TAKE ONE CAPSULE BY MOUTH EVERY 8   ACTIVE
         HOURS AS NEEDED FOR PAIN
  8)   MULTIVITS W/MINERALS TAB/CAP (NO VIT K) TAKE 1 TABLET  ACTIVE (S)
         BY MOUTH EVERY DAY
  9)   SIMVASTATIN 80MG TAB TAKE ONE-HALF TABLET BY MOUTH AT  ACTIVE
         BEDTIME
  10)  VARDENAFIL HCL 20MG TAB TAKE ONE TABLET BY MOUTH ONE   ACTIVE
         TIME ONE HOUR BEFORE SEXUAL ACTIVITY (NO MORE THAN
         1 DOSE PER 24 HOUR PERIOD)
    Level of Understanding: Good

  Teaching Strategy:
    Verbal discussion

  Patient/Family Response:
    Able to repeat information

/es/ PATRICK S. BUGAJ
PHARMACIST
Signed: 05/30/2011 22:20


 LOCAL TITLE: MEDICATION ADMINISTRATION NOTE (T)
STANDARD TITLE: NURSING MEDICATION MGT NOTE
DATE OF NOTE: MAY 30, 2011@22:18     ENTRY DATE: MAY 30, 2011@22:19:01
      AUTHOR: RUSSELL,VIRGINIA A   EXP COSIGNER:
 INSTITUTION: CLEVELAND VAMC
    DIVISION: WADE PARK
     URGENCY:                            STATUS: COMPLETED



MEDICATION

  Diphtheria/Tetanus Toxoids/Perstussis Vaccines
    Patient received injection per order.
      Patient received the Diphtheria/Tetanus Toxoids/Pertussis vaccine
      (Boostrix) at this visit. The patient does not have an acute febrile
      illness. The patient is not hypersensitive to any component of the
      vaccine, including thimerosal, a mercury derivative.
        Site of Injection: Right deltoid intramuscularly
        Lot #
          : AC52B069BB
        Manufacturer:
          : SmithGlaxoKline
        Amount given:  0.5ml



/es/ VIRGINIA A. RUSSELL
REGISTERED NURSE
Signed: 05/30/2011 22:20


 LOCAL TITLE: EMERGENCY DEPARTMENT MEDICATION ADMINISTRATION NOTE
STANDARD TITLE: NURSING EMERGENCY DEPT NOTE
DATE OF NOTE: MAY 30, 2011@22:17     ENTRY DATE: MAY 30, 2011@22:17:04
      AUTHOR: RUSSELL,VIRGINIA A   EXP COSIGNER:
 INSTITUTION: CLEVELAND VAMC
    DIVISION: WADE PARK
     URGENCY:                            STATUS: COMPLETED
```

FRANCWAY, Ernest L., Jr.
[redacted]
VA Medical Center, Cleveland, Ohio
October 4, 2002 to August 27, 2014

==========

--- Original Document ---

12/29/10 PARMA PRIMARY CARE (C):
The patient is a 60 year old MAN.

ALLERGIES: Patient has answered NKA

Vitals: 97.9 80 20 130/72 198.4 6

ACTIVE MEDICATIONS (VA):
BADR - Brief Adv React/All
Allergy/Reaction: No Known Allergies

AMRS - MEDS (REC SUCCINCT)

Active and Recently Expired Inpatient and Outpatient Medications
(including Supplies):

	Active Outpatient Medications	Status
1)	AMMONIUM LACTATE 5% LOTION APPLY A SUFFICIENT AMOUNT EXTERNALLY EVERY DAY TO DRY SKIN	ACTIVE
2)	ARTIFICIAL TEARS POLYVINYL ALCOHOL INSTILL 1 DROP IN EACH EYE THREE TIMES A DAY AS NEEDED FOR DRY EYES	ACTIVE
3)	CHOLECALCIFEROL (VIT D3) 1,000UNIT TAB TAKE ONE TABLET BY MOUTH EVERY DAY FOR LOW VITAMIN D LEVEL	ACTIVE (S)
4)	CLOTRIMAZOLE 1% TOP CREAM APPLY A SUFFICIENT AMOUNT EXTERNALLY TWICE A DAY TO GROIN	ACTIVE
5)	ETODOLAC 300MG CAP TAKE ONE CAPSULE BY MOUTH EVERY 8 HOURS AS NEEDED FOR PAIN	ACTIVE
6)	OXYCODONE HCL 5MG/ACETAMIN 325MG TABLET TAKE 1 TO 2 TABLETS BY MOUTH EVERY 4 HOURS AS NEEDED WITH FOOD FOR PAIN	ACTIVE
7)	VARDENAFIL HCL 20MG TAB TAKE ONE TABLET BY MOUTH ONE TIME ONE HOUR BEFORE SEXUAL ACTIVITY (NO MORE THAN 1 DOSE PER 24 HOUR PERIOD)	ACTIVE

	Inactive Outpatient Medications	Status
1)	CYCLOBENZAPRINE HCL 10MG TAB TAKE ONE TABLET BY MOUTH EVERY 8 HOURS AS NEEDED FOR MUSCLE SPASMS	EXPIRED
2)	MULTIVITS W/MINERALS TAB/CAP (NO VIT K) TAKE 1 TABLET BY MOUTH EVERY DAY	EXPIRED
3)	SIMVASTATIN 80MG TAB TAKE ONE-HALF TABLET BY MOUTH AT BEDTIME	EXPIRED

	Active Inpatient Medications	Status
1)	INFLUENZA VACCINE `10-11 INJ 0.5ML INTRAMUSCULARLY ONE TIME ** Patient Needs Influenza Vaccine ** Give when patient is afebrile.	ACTIVE

11 Total Medications

BODY MASS INDEX: 29
Body Mass Index >27 Nutritional/Exercise Counseling

SocHx (reviewed 6/28/10):
Divorced
Estranged from children; not seen in 22 yrs
Imprisoned for 5 yrs for "menacing"
Currently living in car

Private physisicans:
none; all care through VA

Subjective: 60 y/o man presents for medication renewals, f/u on LBP, knee pain.

Had back flare during sleep; uncertain what he did. Slowly improving now.
Percocet good for flare. Last flare over 6 months ago.

ROS reviewed & otherwise negative.

Objective:

FRANCWAY, Ernest L., Jr.
[redacted]
VA Medical Center, Cleveland, Ohio
October 4, 2002 to August 27, 2014

```
        Gen:    WNWD male, tired-appearing
        HEENT:  NC/AT PERRLA EOMI
        N:      Supple; no TM, JVD, bruits noted
        H:      RRR S1S2 no r/c/g/m
        L:      CTA, no r/w
        Abd:    Soft, NT/ND +BS
        Ext:    No c/c/e
                wearing articulated brace,
                        ambulating with antalgic, slightly splayed gait

Assessment/Plan:

Dyslipidemia:
        Simvastatin 20 mg nightly
        Lipids, LFTs due

Acute on Chronic LBP, OA b/l Knees; right hip pain post-fall:
        Ongoing since 1969 for LBP, OA b/l knees
        Completed PT program in 8/2004; has home program.
        Declines PT for right hip pain.
        Failed ibuprofen, naproxen, lodine, piroxicam, diclofenac
        States tramadol also ineffective (4/09, 5/09)
        Seen by Pain Management, 15Aug2006:
                Declines further PT/AquaTherapy
                Recommended another NSAID if wants PT
                Discharged from Pain Management
        Seen by Pain Management again 28July2009, 07Aug2009:
                Declined further PMC Psychology f/u
                Started on Etodolac 300 mg every 8 hours as needed to be taken
with food (08Aug2009)
                PT w/TENS ordered; pt refused consult when contacted.
        Encouraged to try AquaTherapy for further improvement in ROM; declines.
        Ortho recommended TKR.
        Ortho also recommends NO OPIOIDS due dependence potential and also
difficulty managing post-operative pain in future.  Writer agrees as I do
believe that this would only increase in amount and frequency of use of this
medication. However, would give for sporadic flares.

+PTSD (10%-SC'd); +depression screen:
        Seen by CSR; declined assistance.
        Currently being followed by Dr. Shurell for psychotherapy;
        Per CSR consult 02July2009:
        " CANCELLED 07/17/09 10:12      HROVAT,JOHN M       HROVAT,JOHN M
Treatment team including Dr. Blank met to discuss vet's referral to CSR.
Based on previous assessment of 4/09 and chart review it was decided that
the veteran should remain with Dr. Shurell."
        Appears never rescheduled w/Dr. Shurell
        Trazodone not effective for sleep.

Erectile Dysfunction, BPH:
        Vardenefil 10 mg renewed
        PSA, u/a

Left Ulnar exostosis:
        No Ortho F/U since 3/2004.
        Isn't certain about surgery -- scared of the procedure.

Nummular eczema:
        Prev. on Camphor/menthol lotion two pumps as needed.
        Previously on triamcinolone 0.1% cream as needed for rash

Folliculitis;
        Following w/Derm.
        Previously on Cleocin soln nightly, benzoyl peroxide daily,
chlorhexidine soap

Left inguinal hernia:
        Declines surgical evaluation.

Cholelithiasis, asymptomatic:
        By CT scan.

Fatty liver, asymptomatic:
        By CT scan.
        Diet, lipid management.

Preventive Medicine (reviewed 12/29/10):
```

FRANCWAY, Ernest L., Jr.
[redacted]
VA Medical Center, Cleveland, Ohio
October 4, 2002 to August 27, 2014

```
        Pneumococcal:   Due 65 yoa
        Tetanus:        2003
        Influenza:      12/16/10
        Novel H1N1:     12/16/10
        Zoster:         Revisit per pt request
        Stool cards:    Negative 7/8/10
        PSA:            Due
        TSH:            Due
        lipids:         Due
        ECG:            3/2003; due

RTC 6 months


Clinical Reminders Activity
  Pain Assessment:
    Patient indicated that this is an ongoing pain.  The initial pain
    assessment was completed on No Data Available.
      Provider Reassessment:
        Patient is compliant with the pain management plan of care.



MEDICATION RECONCILIATION
    MEDICATION RECONCILIATION REPORT reviewed and discussed with patient.
      VA prescription medications:
        Patient reports variations from prescribed regimen; please see the
        Medications Tab.

      Prescription medications from another source:
        Patient reports no non-VA prescription medications

      Over the counter medications, vitamins, herbals, and nutritional
      supplements:
        Patient reports taking no OTC meds, vitamins, herbals, or
        nutritional supplements



PATIENT EDUCATION:
        Medical Diagnosis, Nutrition, Medication (including side effects)



FUTURE CLINIC VISITS:
  DATE     TIME   CLINIC                          STATUS
  ----     ----   ------                          ------
12/29/2010 08:20  B PCM/HOVIS

/es/ JENNIFER C. HOVIS
GERONTOLOGIST
Signed: 12/29/2010 08:14

01/03/2011 ADDENDUM                    STATUS: COMPLETED
Please send CBOC Lab Notification dated 1/3/11.

Thank yuo.

/es/ JENNIFER C. HOVIS
GERONTOLOGIST
Signed: 01/03/2011 16:09

Receipt Acknowledged By:
01/03/2011 16:28        /es/ ALPHONSO PACE
                             LICENSED PRACTICAL NURSE


 LOCAL TITLE: PARMA PRIMARY CARE  (C)
STANDARD TITLE: PRIMARY CARE CONSULT
DATE OF NOTE: DEC 29, 2010@07:47     ENTRY DATE: DEC 29, 2010@07:47:45
      AUTHOR: HOVIS,JENNIFER C     EXP COSIGNER:
 INSTITUTION: ZZ-BRECKSVILLE VANPH
    DIVISION: BRECKSVILLE
     URGENCY:                          STATUS: COMPLETED

   *** PARMA PRIMARY CARE  (C) Has ADDENDA ***
```

FRANCWAY, Ernest L., Jr.
[redacted]
VA Medical Center, Cleveland, Ohio
October 4, 2002 to August 27, 2014

Thank yuo.

/es/ JENNIFER C. HOVIS
GERONTOLOGIST
Signed: 01/03/2011 16:09

Receipt Acknowledged By:
01/03/2011 16:28 /es/ ALPHONSO PACE
LICENSED PRACTICAL NURSE

==========

--- Original Document ---

12/29/10 PARMA PRIMARY CARE (C):
The patient is a 60 year old MAN.

ALLERGIES: Patient has answered NKA

Vitals: 97.9 80 20 130/72 198.4 6

ACTIVE MEDICATIONS (VA):
BADR - Brief Adv React/All
Allergy/Reaction: No Known Allergies

AMRS - MEDS (REC SUCCINCT)

Active and Recently Expired Inpatient and Outpatient Medications
(including Supplies):

	Active Outpatient Medications	Status
1)	AMMONIUM LACTATE 5% LOTION APPLY A SUFFICIENT AMOUNT EXTERNALLY EVERY DAY TO DRY SKIN	ACTIVE
2)	ARTIFICIAL TEARS POLYVINYL ALCOHOL INSTILL 1 DROP IN EACH EYE THREE TIMES A DAY AS NEEDED FOR DRY EYES	ACTIVE
3)	CHOLECALCIFEROL (VIT D3) 1,000UNIT TAB TAKE ONE TABLET BY MOUTH EVERY DAY FOR LOW VITAMIN D LEVEL	ACTIVE (S)
4)	CLOTRIMAZOLE 1% TOP CREAM APPLY A SUFFICIENT AMOUNT EXTERNALLY TWICE A DAY TO GROIN	ACTIVE
5)	ETODOLAC 300MG CAP TAKE ONE CAPSULE BY MOUTH EVERY 8 HOURS AS NEEDED FOR PAIN	ACTIVE
6)	OXYCODONE HCL 5MG/ACETAMIN 325MG TABLET TAKE 1 TO 2 TABLETS BY MOUTH EVERY 4 HOURS AS NEEDED WITH FOOD FOR PAIN	ACTIVE
7)	VARDENAFIL HCL 20MG TAB TAKE ONE TABLET BY MOUTH ONE TIME ONE HOUR BEFORE SEXUAL ACTIVITY (NO MORE THAN 1 DOSE PER 24 HOUR PERIOD)	ACTIVE

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1)	CYCLOBENZAPRINE HCL 10MG TAB TAKE ONE TABLET BY MOUTH EVERY 8 HOURS AS NEEDED FOR MUSCLE SPASMS	EXPIRED
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3)	SIMVASTATIN 80MG TAB TAKE ONE-HALF TABLET BY MOUTH AT BEDTIME	EXPIRED

	Active Inpatient Medications	Status
1)	INFLUENZA VACCINE `10-11 INJ 0.5ML INTRAMUSCULARLY ONE TIME ** Patient Needs Influenza Vaccine ** Give when patient is afebrile.	ACTIVE

11 Total Medications

BODY MASS INDEX: 29
Body Mass Index >27 Nutritional/Exercise Counseling

SocHx (reviewed 6/28/10):
Divorced
Estranged from children; not seen in 22 yrs
Imprisoned for 5 yrs for "menacing"
Currently living in car

Private physisicans:

FRANCWAY, Ernest L., Jr.
[redacted]
VA Medical Center, Cleveland, Ohio
October 4, 2002 to August 27, 2014

```
        none; all care through VA

Subjective:  60 y/o man presents for medication renewals, f/u on LBP, knee pain.

Had back flare during sleep; uncertain what he did.  Slowly improving now.
Percocet good for flare.  Last flare over 6 months ago.

ROS reviewed & otherwise negative.

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        Gen:    WNWD male, tired-appearing
        HEENT:  NC/AT PERRLA EOMI
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        L:      CTA, no r/w
        Abd:    Soft, NT/ND +BS
        Ext:    No c/c/e
                wearing articulated brace,
                        ambulating with antalgic, slightly splayed gait

Assessment/Plan:

Dyslipidemia:
        Simvastatin 20 mg nightly
        Lipids, LFTs due

Acute on Chronic LBP, OA b/l Knees; right hip pain post-fall:
        Ongoing since 1969 for LBP, OA b/l knees
        Completed PT program in 8/2004; has home program.
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        Failed ibuprofen, naproxen, lodine, piroxicam, diclofenac
        States tramadol also ineffective (4/09, 5/09)
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                Declines further PT/AquaTherapy
                Recommended another NSAID if wants PT
                Discharged from Pain Management
        Seen by Pain Management again 28July2009, 07Aug2009:
                Declined further PMC Psychology f/u
                Started on Etodolac 300 mg every 8 hours as needed to be taken
with food (08Aug2009)
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        Ortho recommended TKR.
        Ortho also recommends NO OPIOIDS due dependence potential and also
difficulty managing post-operative pain in future.  Writer agrees as I do
believe that this would only increase in amount and frequency of use of this
medication. However, would give for sporadic flares.

+PTSD (10%-SC'd); +depression screen:
        Seen by CSR; declined assistance.
        Currently being followed by Dr. Shurell for psychotherapy;
        Per CSR consult 02July2009:
        " CANCELLED 07/17/09 10:12      HROVAT,JOHN M       HROVAT,JOHN M
Treatment team including Dr. Blank met to discuss vet's referral to CSR.
Based on previous assessment of 4/09 and chart review it was decided that
the veteran should remain with Dr. Shurell."
        Appears never rescheduled w/Dr. Shurell
        Trazodone not effective for sleep.

Erectile Dysfunction, BPH:
        Vardenefil 10 mg renewed
        PSA, u/a

Left Ulnar exostosis:
        No Ortho F/U since 3/2004.
        Isn't certain about surgery -- scared of the procedure.

Nummular eczema:
        Prev. on Camphor/menthol lotion two pumps as needed.
        Previously on triamcinolone 0.1% cream as needed for rash

Folliculitis;
        Following w/Derm.
        Previously on Cleocin soln nightly, benzoyl peroxide daily,
chlorhexidine soap

Left inguinal hernia:
```

FRANCWAY, Ernest L., Jr.
[redacted]
VA Medical Center, Cleveland, Ohio
October 4, 2002 to August 27, 2014

```
        Declines surgical evaluation.

Cholelithiasis, asymptomatic:
        By CT scan.

Fatty liver, asymptomatic:
        By CT scan.
        Diet, lipid management.

Preventive Medicine (reviewed 12/29/10):
        Pneumococcal:   Due 65 yoa
        Tetanus:        2003
        Influenza:      12/16/10
        Novel H1N1:     12/16/10
        Zoster:         Revisit per pt request
        Stool cards:    Negative 7/8/10
        PSA:            Due
        TSH:            Due
        lipids:         Due
        ECG:            3/2003; due

RTC 6 months


Clinical Reminders Activity
  Pain Assessment:
    Patient indicated that this is an ongoing pain.  The initial pain
    assessment was completed on No Data Available.
      Provider Reassessment:
        Patient is compliant with the pain management plan of care.



MEDICATION RECONCILIATION
    MEDICATION RECONCILIATION REPORT reviewed and discussed with patient.
      VA prescription medications:
        Patient reports variations from prescribed regimen; please see the
        Medications Tab.

      Prescription medications from another source:
        Patient reports no non-VA prescription medications

      Over the counter medications, vitamins, herbals, and nutritional
      supplements:
        Patient reports taking no OTC meds, vitamins, herbals, or
        nutritional supplements



PATIENT EDUCATION:
        Medical Diagnosis, Nutrition, Medication (including side effects)



FUTURE CLINIC VISITS:
  DATE     TIME   CLINIC                          STATUS
  ----     ----   ------                          ------
12/29/2010 08:20  B PCM/HOVIS

/es/ JENNIFER C. HOVIS
GERONTOLOGIST
Signed: 12/29/2010 08:14

01/03/2011 ADDENDUM                     STATUS: COMPLETED
Lab notification placed in outgoing mail.

/es/ ALPHONSO PACE
LICENSED PRACTICAL NURSE
Signed: 01/03/2011 16:29


 LOCAL TITLE: CBOC LAB NOTIFICATION (T)
STANDARD TITLE: PRIMARY CARE OUTPATIENT NOTE
DATE OF NOTE: JAN 03, 2011@16:08     ENTRY DATE: JAN 03, 2011@16:08:54
      AUTHOR: HOVIS,JENNIFER C     EXP COSIGNER:
 INSTITUTION: ZZ-BRECKSVILLE VANPH
    DIVISION: BRECKSVILLE
```

FRANCWAY, Ernest L., Jr.
[redacted]
VA Medical Center, Cleveland, Ohio
October 4, 2002 to August 27, 2014

```
      Ongoing pain:  Yes
      Location:  Low Back
      Intensity:
        Currently:
          8

  CHIEF COMPLAINT:  Pain Issue -  low back pain started an hr ago.

  PERTINENT ASSESSMENT:

   states has hx of low back  injury & here tonight due to c/o of low back
  pain  that  started an hr ago. claims took rx an hr ago but no relief.
    Suicide Screen
      Are you presently having thoughts of harming yourself or others?
        No
    Abuse Screen
      Do you feel safe in  your home?
        Yes

    Patient exhibits signs of gait abnormality.
    Patient is less than 65 yrs old.



  Patient referred to:
    Urgent Care

  Is the patient assigned to the Urgent Care Center fast track?
      Yes
  ALLERGIES:  Patient has answered NKA


Patient was given current medication list upon registration to the
Emergency Department.  The patient will review the medication list with
the Emergency Department provider and discuss any questions.


/es/ EVANGELINE B LUZANO
REGISTERED NURSE
Signed: 12/16/2010 00:09


 LOCAL TITLE: Addendum
STANDARD TITLE: ADDENDUM
DATE OF NOTE: JUL 09, 2010@09:44:16  ENTRY DATE: JUL 09, 2010@09:44:16
      AUTHOR: PACE,ALPHONSO        EXP COSIGNER:
 INSTITUTION: ZZ-BRECKSVILLE VANPH
    DIVISION: BRECKSVILLE
     URGENCY:                            STATUS: COMPLETED


Lab notification placed in outgoing mail.


/es/ ALPHONSO PACE
LICENSED PRACTICAL NURSE
Signed: 07/09/2010 09:44

==============================================================================

 --- Original Document ---

06/28/10 PARMA PRIMARY CARE (T):
The patient is a 60 year old MAN.

ALLERGIES: Patient has answered NKA

Vitals: 72  20  106/68    206


ACTIVE MEDICATIONS (VA):
BADR - Brief Adv React/All
   Allergy/Reaction: No Known Allergies

AMRS - MEDS (REC SUCCINCT)

Active and Recently Expired Inpatient and Outpatient Medications
```

FRANCWAY, Ernest L., Jr.
[redacted]
VA Medical Center, Cleveland, Ohio
October 4, 2002 to August 27, 2014

(including Supplies):

	Active Outpatient Medications	Status
1)	ARTIFICIAL TEARS POLYVINYL ALCOHOL INSTILL 1 DROP IN EACH EYE THREE TIMES A DAY AS NEEDED FOR DRY EYES	ACTIVE
2)	CLOTRIMAZOLE 1% TOP CREAM APPLY A SUFFICIENT AMOUNT EXTERNALLY TWICE A DAY	ACTIVE
3)	CYCLOBENZAPRINE HCL 10MG TAB TAKE ONE TABLET BY MOUTH EVERY 8 HOURS AS NEEDED FOR MUSCLE SPASMS	ACTIVE
4)	ERGOCALCIFEROL (VITAMIN D) 50000 UNT CAP TAKE ONE CAPSULE BY MOUTH EVERY 4 WEEKS	ACTIVE
5)	ETODOLAC 300MG CAP TAKE ONE CAPSULE BY MOUTH EVERY 8 HOURS AS NEEDED FOR PAIN	ACTIVE
6)	MULTIVITS W/MINERALS TAB/CAP (NO VIT K) TAKE 1 TABLET BY MOUTH EVERY DAY	ACTIVE (S)
7)	SIMVASTATIN 80MG TAB TAKE ONE-HALF TABLET BY MOUTH AT BEDTIME	ACTIVE
8)	VARDENAFIL HCL 20MG TAB TAKE ONE TABLET BY MOUTH ONE TIME ONE HOUR BEFORE SEXUAL ACTIVITY (NO MORE THAN 1 DOSE PER 24 HOUR PERIOD)	ACTIVE

	Inactive Outpatient Medications	Status
1)	DERMA CERIN TOP CREAM APPLY A SUFFICIENT AMOUNT TO AFFECTED AREA AS NEEDED FOR DRY SKIN	EXPIRED

9 Total Medications

BODY MASS INDEX: 30
Body Mass Index >27 Nutritional/Exercise Counseling

SocHx (reviewed 6/28/10):
Divorced
Estranged from children; not seen in 22 yrs
Imprisoned for 5 yrs for "menacing"
Currently living in car

Private physisicans:
none; all care through VA

Subjective: 60 y/o man presents for medication renewals, f/u on LBP, knee pain.

Worse pain with storms.

States needs more of cholesterol medication.

Denies recent falls.

ROS reviewed & otherwise negative.

Objective:
Gen: WNWD male, tired-appearing
HEENT: NC/AT PERRLA EOMI
N: Supple; no TM, JVD, bruits noted
H: RRR S1S2 no r/c/g/m
L: CTA, no r/w
Abd: Soft, NT/ND +BS
Ext: No c/c/e
wearing articulated brace,
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Assessment/Plan:

Dyslipidemia:
Simvastatin 20 mg nightly
Lipids, LFTs due

Acute on Chronic LBP, OA b/l Knees; right hip pain post-fall:
Ongoing since 1969 for LBP, OA b/l knees
Completed PT program in 8/2004; has home program.
Declines PT for right hip pain.
Failed ibuprofen, naproxen, lodine, piroxicam, diclofenac
States tramadol also ineffective (4/09, 5/09)
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FRANCWAY, Ernest L., Jr.
[redacted]
VA Medical Center, Cleveland, Ohio
October 4, 2002 to August 27, 2014

```
                Discharged from Pain Management
        Seen by Pain Management again 28July2009, 07Aug2009:
                Declined further PMC Psychology f/u
                Started on Etodolac 300 mg every 8 hours as needed to be taken
with food (08Aug2009)
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        Influenza:      12/17/09
        Novel H1N1:     12/17/09
        Zoster:         Revisit
        Stool cards:    1/2006 -- negative
        PSA:            12/09
        TSH:            12/09
        lipids:         Due next visit
        ECG:            3/2003; due

RTC December, 2010

Clinical Reminders Activity
  Evaluation of + Depression Screen:
    VHA Pocket Card Suicide Risk Questions Are you feeling hopeless about
    the present or future?   NO
    Have you had thoughts about taking your life?   NO
    Have you ever had a suicide attempt?     NO

    PROVIDER EVALUATION The results of the PHQ depression screen have been
    reviewed. I have personally evaluated the patient including inquiry
    about feelings of hopelessness, suicidal thoughts, suicide plan if
    thoughts are present, and prior suicide attempts. Based on the
    evaluation, the following disposition plan will be implemented:
```

FRANCWAY, Ernest L., Jr.
[redacted]
VA Medical Center, Cleveland, Ohio
October 4, 2002 to August 27, 2014

Signed: 12/28/2009 09:02

Receipt Acknowledged By:
12/28/2009 09:05 /es/ JENNIFER C. HOVIS
GERONTOLOGIST

LOCAL TITLE: Addendum
STANDARD TITLE: ADDENDUM
DATE OF NOTE: DEC 21, 2009@14:40:52 ENTRY DATE: DEC 21, 2009@14:40:52
AUTHOR: PACE,ALPHONSO EXP COSIGNER:
INSTITUTION: ZZ-BRECKSVILLE VANPH
DIVISION: BRECKSVILLE
URGENCY: STATUS: COMPLETED

Lab notification placed in outgoing mail.

/es/ ALPHONSO PACE
LICENSED PRACTICAL NURSE
Signed: 12/21/2009 14:41

==========

--- Original Document ---

12/17/09 PARMA PRIMARY CARE (T):
The patient is a 59 year old MAN.

ALLERGIES: Patient has answered NKA

Vitals:
T: NO RESULTS FOR TODAY
P: NO RESULTS FOR TODAY
R: NO RESULTS FOR TODAY
BP: NO RESULTS FOR TODAY
PAIN: 6 (12/17/2009 08:01)
HEIGHT: NO RESULTS FOR TODAY
WEIGHT: NO RESULTS FOR TODAY

ACTIVE MEDICATIONS (VA): BADR - Brief Adv React/All
Allergy/Reaction: No Known Allergies

AMRS - MEDS (REC SUCCINCT)

Active and Recently Expired Inpatient and Outpatient Medications
(including Supplies):

	Active Outpatient Medications	Status
1)	CYCLOBENZAPRINE HCL 10MG TAB TAKE ONE TABLET BY MOUTH EVERY 8 HOURS AS NEEDED	ACTIVE
2)	DERMA CERIN TOP CREAM APPLY A SUFFICIENT AMOUNT TO AFFECTED AREA AS NEEDED FOR DRY SKIN	ACTIVE
3)	ETODOLAC 300MG CAP TAKE ONE CAPSULE BY MOUTH EVERY 8 HOURS AS NEEDED	ACTIVE
4)	TRAMADOL HCL 50MG TAB TAKE ONE TABLET BY MOUTH TWICE A DAY	ACTIVE
5)	VARDENAFIL HCL 20MG TAB TAKE ONE TABLET BY MOUTH ONE TIME ONE HOUR BEFORE SEXUAL ACTIVITY (NO MORE THAN 1 DOSE PER 24 HOUR PERIOD)	ACTIVE

	Inactive Outpatient Medications	Status
1)	SIMVASTATIN 80MG TAB TAKE ONE-HALF TABLET BY MOUTH AT BEDTIME	EXPIRED

	Active Non-VA Medications	Status
1)	Non-VA MULTIVITAMIN 1 TAB/CAP MOUTH EVERY DAY	ACTIVE

7 Total Medications

BODY MASS INDEX:
Body Mass Index >27 Nutritional/Exercise Counseling

SocHx:
Divorced

FRANCWAY, Ernest L., Jr.
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VA Medical Center, Cleveland, Ohio
October 4, 2002 to August 27, 2014

```
        Estranged from children; not seen in 22 yrs
        Imprisoned for 5 yrs for "menacing"
        Currently living in car

Private physisicans:
        none; all care through VA

Subjective:  59 y/o man presents for medication renewals, f/u on LBP, knee pain.

States needs more of cholesterol medication.

ROS otherwise negative.

Objective:
        Gen:    WNWD male, tired-appearing
        HEENT:  NC/AT PERRLA EOMI
        N:      Supple; no TM, JVD, bruits noted
        H:      RRR S1S2 no r/c/g/m
        L:      CTA/P, no r/w
        Abd:    Soft, NT/ND +BS
        Ext:    No c/c/e
        wearing articulated brace, ambulating with antalgic, slightly splayed
gait

Assessment/Plan:

Dyslipidemia:
        Simvastatin 20 mg nightly
        Lipids, LFTs due

Acute on Chronic LBP, OA b/l Knees; right hip pain post-fall:
        Ongoing since 1969 for LBP, OA b/l knees
        Completed PT program in 8/2004; has home program.
        Declines PT for right hip pain.
        Failed ibuprofen, naproxen, lodine, piroxicam, diclofenac
        States tramadol also ineffective (4/09, 5/09)
        Seen by Pain Management, 15Aug2006:
                Declines further PT/AquaTherapy
                Recommended another NSAID if wants PT
                Discharged from Pain Management
        Seen by Pain Management again 28July2009, 07Aug2009:
                Declined further PMC Psychology f/u
                Started on Etodolac 300 mg every 8 hours as needed to be taken
with food (08Aug2009)
                PT w/TENS ordered; pt refused consult when contacted.
        Encouraged to try AquaTherapy for further improvement in ROM; declines.
        Ortho recommended TKR.
        Ortho also recommends NO OPIOIDS due dependence potential and also
difficulty managing post-operative pain in future.  Writer agrees as I do
believe that this would only increase in amount and frequency of use of this
medication.

+PTSD (10%-SC'd):
        Seen by CSR; declined assistance.
        Currently being followed by Dr. Shurell for psychotherapy;
        Per CSR consult 02July2009:
        " CANCELLED 07/17/09 10:12      HROVAT,JOHN M       HROVAT,JOHN M
Treatment team including Dr. Blank met to discuss vet's referral to CSR.
Based on previous assessment of 4/09 and chart review it was decided that
the veteran should remain with Dr. Shurell."
        Appears never rescheduled w/Dr. Shurell
        Trazodone not effective for sleep.

Erectile Dysfunction, BPH:
        Vardenefil 10 mg renewed
        PSA, u/a

Left Ulnar exostosis:
        No Ortho F/U since 3/2004.
        Isn't certain about surgery -- scared of the procedure.

Nummular eczema:
        Camphor/menthol lotion two pumps prn renewed.
        Previously on triamcinolone 0.1% cream as needed for rash

Folliculitis;
        Following w/Derm.
```

FRANCWAY, Ernest L., Jr.
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        Previously on Cleocin soln nightly, benzoyl peroxide daily,
chlorhexidine soap

Left inguinal hernia:
        Declines surgical evaluation.

Cholelithiasis, asymptomatic:
        By CT scan.

Fatty liver, asymptomatic:
        By CT scan.
        Diet, lipid management.

Preventive Medicine (12/17/09):
        Pneumococcal:   Due 65 yoa
        Tetanus:        2003
        Influenza:      12/17/09
        Novel H1N1:     12/17/09
        Zoster:         Revisit at 60 yoa
        Stool cards:    1/2006 -- negative
        PSA:            4/08
        TSH:            4/08
        lipids:         Due next visit
        ECG:            3/2003; due

RTC June, 2010


Clinical Reminders Activity
  Pain Assessment:
    Patient indicated that this is an ongoing pain.  The initial pain
    assessment was completed on No Data Available.
      Provider Reassessment:
        Pain scores within acceptable range per patient. Continue current
        plan of care.
        Patient is compliant with the pain management plan of care.



PATIENT EDUCATION:
        Medical Diagnosis, Nutrition, Medication (including side effects)

FUTURE CLINIC VISITS:
  DATE     TIME   CLINIC                          STATUS
  ----     ----   ------                          ------
12/17/2009 08:20  B PCM-HOVIS
12/17/2009 08:40  B PCM-HOVIS                     CANCELLED BY PATIENT

/es/ JENNIFER C. HOVIS
GERONTOLOGIST
Signed: 12/17/2009 08:20

12/20/2009 ADDENDUM                     STATUS: COMPLETED
Please send CBOC Lab Notification dated 12/20/09.

Thank you.

/es/ JENNIFER C. HOVIS
GERONTOLOGIST
Signed: 12/20/2009 19:53

Receipt Acknowledged By:
12/21/2009 14:40        /es/ ALPHONSO PACE
                             LICENSED PRACTICAL NURSE


 LOCAL TITLE: PARMA PRIMARY CARE (T)
STANDARD TITLE: PRIMARY CARE NOTE
DATE OF NOTE: DEC 17, 2009@08:09     ENTRY DATE: DEC 17, 2009@08:09:39
      AUTHOR: HOVIS,JENNIFER C     EXP COSIGNER:
 INSTITUTION: ZZ-BRECKSVILLE VANPH
    DIVISION: BRECKSVILLE
     URGENCY:                           STATUS: COMPLETED

   *** PARMA PRIMARY CARE (T) Has ADDENDA ***

The patient is a 59 year old MAN.
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FRANCWAY, Ernest L., Jr.
[redacted]
VA Medical Center, Cleveland, Ohio
October 4, 2002 to August 27, 2014

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      Provider Reassessment:
        Pain scores within acceptable range per patient. Continue current
        plan of care.
        Patient is compliant with the pain management plan of care.



PATIENT EDUCATION:
        Medical Diagnosis, Nutrition, Medication (including side effects)

FUTURE CLINIC VISITS:
  DATE     TIME   CLINIC                          STATUS
  ----     ----   ------                          ------
12/17/2009 08:20  B PCM-HOVIS
12/17/2009 08:40  B PCM-HOVIS                     CANCELLED BY PATIENT

/es/ JENNIFER C. HOVIS
GERONTOLOGIST
Signed: 12/17/2009 08:20

12/21/2009 ADDENDUM                    STATUS: COMPLETED
Lab notification placed in outgoing mail.

/es/ ALPHONSO PACE
LICENSED PRACTICAL NURSE
Signed: 12/21/2009 14:41


 LOCAL TITLE: PARMA NURSING NOTE
STANDARD TITLE: NURSING NOTE
DATE OF NOTE: DEC 17, 2009@08:29     ENTRY DATE: DEC 17, 2009@08:29:48
      AUTHOR: LABODA,JESSICA MARI  EXP COSIGNER:
 INSTITUTION: ZZ-BRECKSVILLE VANPH
    DIVISION: BRECKSVILLE
     URGENCY:                          STATUS: COMPLETED

Clinical Reminders Activity
  Influenza H1N1 Vaccine:
    Influenza H1N1 Novel (Pandemic) Immunization
      The patient received influenza H1N1 immunization 0.5ml IM today in
      the Right Deltoid.
      CSL, lot 00249711A, exp 6/30/2010

         Indication: prophylaxis for pandemic influenza H1N1
         Complications: No signs or symptoms of adverse reaction noted.
      patient received Influenza A (H1N1) Vaccine Information Statement
      dated 10/2/09 from the CDC.
      Temperature:
        Temp: 98 F (36.7 C)


/es/ JESSICA MARIE LABODA
LICENSED PRACTICAL NURSE
Signed: 12/17/2009 08:30


 LOCAL TITLE: PRIMARY CARE NURSING INTAKE NOTE (T)
STANDARD TITLE: PRIMARY CARE NOTE
DATE OF NOTE: DEC 17, 2009@08:01     ENTRY DATE: DEC 17, 2009@08:01:20
      AUTHOR: STRANG,AMY E         EXP COSIGNER:
 INSTITUTION: ZZ-BRECKSVILLE VANPH
    DIVISION: BRECKSVILLE
     URGENCY:                          STATUS: COMPLETED


Review Allergies
  Allergies reviewed and updated per protocol.

  Patient has answered NKA

MEDICATION LIST REVIEW REPORT
    Patient states no change in documented OTC/Herbals at this visit.


Clinical Reminders Activity
  Alcohol Use Screen (AUDIT-C):
    SCREEN FOR ALCOHOL (AUDIT-C)
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VA Medical Center, Cleveland, Ohio
October 4, 2002 to August 27, 2014

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      An alcohol screening test (AUDIT-C) was negative (score=0).

      1. How often did you have a drink containing alcohol in the past
      year?
      Never

      2. How many drinks containing alcohol did you have on a typical day
      when you were drinking in the past year?
      Response not required due to responses to other questions.

      3. How often did you have six or more drinks on one occasion in the
      past year?
      Response not required due to responses to other questions.
  Pain, Brief Evaluation:
    Type of pain:  Ongoing
    Location:  Low Back
    Intensity:
      Currently:
        6
      Usually:  6
    Description of Pain:  Aching|Nagging

    Evaluation:
      Pain will be evaluated by provider today.
       Notified via Encounter Form.
  BMI > 30 or > 24.99 in High Risk:
    "At this visit, the health risks of obesity were reviewed and
    discussed with the patient, and the benefits of a weight management
    treatment program, such as MOVE! was discussed and offered to the
    patient."
    Patient Refuses referral.  After discussing the health risks of
    obesity and offering a referral to MOVE or another weight loss program
    outside the VA, the patient REFUSES REFERRAL to MOVE or other weight
    loss program at this time.
  Influenza H1N1 Vaccine:
    The patient declines to be vaccinated for Influenza H1N1.
      Comment: will discuss with PCP
  Influenza Vaccine:
    Patient received 0.5ml influenza vaccine per order.
      Site of injection:  Left deltoid intramuscularly
      Lot number/manufacturer:  Afluria: CS Biotherapies Lot# 08949111A
      Exp 6/30/10
      Patient received Vaccine Information Statement (VIS) about the
      influenza vaccine, dated 8/11/2009 Centers for Disease Control and
      Prevention.
        Level of Understanding: Good

/es/ AMY E. STRANG
LICENSED PRACTICAL NURSE
Signed: 12/17/2009 08:07


 LOCAL TITLE: SPINE CARE CONSULTATION (C)
STANDARD TITLE: PAIN CONSULT
DATE OF NOTE: AUG 07, 2009@09:45     ENTRY DATE: AUG 11, 2009@07:41:54
      AUTHOR: WOODS,DONALD M       EXP COSIGNER:
 INSTITUTION: CLEVELAND VAMC
    DIVISION: WADE PARK
     URGENCY:                            STATUS: COMPLETED


CHIEF COMPLAINT:  Low back pain with bilateral S1 radiculopathy to knees/severe
lumbar canal stenosis (L4-L5).

HISTORY OF PRESENT ILLNESS:  I saw the patient as initial patient evaluation at
the Cleveland Wade Park VA Hospital, Spine Care Center, on Friday, August 7,
2009.  He was a dual appointment, initially having seen Pain Psychology and then
seeing myself, pain physician.  He was seen by Dr. Cynthia Van Keuren back on
July 28; I have reviewed her note prior to seeing the patient.

The veteran is a 59-year-old white male with a past medical history significant
for severe lumbar canal stenosis (L4-L5), depression, post-traumatic stress
disorder (status post airplane crash while in Navy), and marked diminished black
flexion, among other conditions.  In the past, the veteran has been dissatisfied
with much of the care he has received at the VA and has threatened legal
actions.  The computer also reveals that he feels his pain control has been
inadequate in the past, that he has received "candy-coated aspirin".
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FRANCWAY, Ernest L., Jr.
[redacted]
VA Medical Center, Cleveland, Ohio
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The veteran presents complaining of low back pain which is below the belt and travels down the backs of his legs in the S1 distribution to the knees. He also complains of numbness and tingling bilateral in the S1 distribution to the ankles. He relates the onset of his pain to 1969 when he was working aboard an aircraft carrier while in the Navy. He states he was carrying some chocks and fell to the deck injuring his back. The pain is worse with bending and stooping and better with heat. He has difficulty applying the heat because he is homeless; he has lived in his car for 7 years.

Currently, the veteran is occasionally using Bengay and Icy Hot which help though are short lived. He states he did go to the emergency room and has received Vicodin though he states this was of no benefit. He has also taken anti-inflammatories; he states ibuprofen and states this was of no benefit.

The veteran had a lumbar MRI in July 2009. Per the report, at the L4-L5 level, there is severe canal stenosis and bilateral mild neuroforaminal stenosis. At L3-4 there is right-sided mild neuroforaminal stenosis and in L2-L3 there is moderate canal stenosis.

PAST MEDICAL HISTORY: Severe lumbar canal stenosis (L4-L5), post-traumatic stress disorder (secondary to plane exploding while he worked on the flight deck while in the Navy), depression, history of scabies, elevated lipids, cataracts.

PAST SURGICAL HISTORY: Right shoulder surgery, left knee scope.

ALLERGIES: No know drug allergies.

MEDICATIONS: Veteran denies blood thinners, tramadol 50 mg every 12 hours p.r.n., simvastatin, vardenafil.

SOCIAL HISTORY: The veteran was in the Navy from 1968 through 1970; he was stationed in San Diego and also aboard an aircraft carrier. He worked on the flight deck; he got out as an E3. He does not smoke, he never drank; he denies any history of illegal drugs. Per the computer, the veteran has spent at least 5 years in prison; he states in the past he worked heavy equipment, cranes and such, with Midland Steel for over 21 years. He has also done various other jobs including electrical work and motorcycle mechanic. He states he has been living in his car for the past 7 years, it is a Chevy Cavalier; he sleeps in the front seat with the back reclined, obviously very uncomfortable. He knows that there are resources out there to help change the situation, though he has chosen not to take advantage of them.

The veteran is currently on 10% service-connected disability secondary to his post-traumatic stress disorder. I believe he has a reevaluation for this scheduled this afternoon, at least that is what he states, though it is not in the computer. He is also requesting evaluation for other conditions; he states he has submitted for his back though this was refused. He has also applied for Social Security disability though this too has been refused. I told the veteran we do not get involved in these matters though we will help to facilitate so that he gets a prompt hearing.

PHYSICAL EXAMINATION: General - alert and oriented x3. Pupils are normal. Veteran is wearing a left knee brace outside his jeans. He demonstrates a pain behavior. He is slow moving, he is slow to get up from the chair. Left knee is swollen. Gait - slow, broad based, stooped forward and bowlegged; veteran refuses to attempt to stand on his tiptoes secondary to his knee pain, minimal heel elevation. Back shows significant diminished forward flexion and extension. Lower extremity - sensation is normal. Motor strength is 4 to 5/5; right patellar reflex is 2/4; left patellar reflex, patient refuses to allow me to check secondary to knee pain; right Achilles 0/4, left Achilles 1/4. Straight leg raise was painful as I lowered the legs; there is bilateral lumbar paravertebral tenderness and right-sided sacroiliac joint tenderness.

IMAGING/LABORATORIES: Creatinine 0.9, platelets 192,000; lumbar MRI - July 2009 - specifics dictated above.

ASSESSMENT AND PLAN: A 59-year-old white male with a past medical history significant for severe lumbar canal stenosis (L4-L5), depression, post-traumatic stress disorder (secondary to airplane crash on aircraft carrier) and marked diminished back flexion who presents complaining of low back pain with bilateral S1 radiculopathy to the knees. Patient is also homeless and lives in his car times 7 years.

1. Pain Psychology - veteran was a dual appointment; he was previously seen by Dr. Cynthia Van Keuren. The veteran does not wish to follow up with Pain Psychology.

FRANCWAY, Ernest L., Jr.
[redacted]
VA Medical Center, Cleveland, Ohio
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2. I hope to carbon copy Dr. Van Keuren and John Prentice with this note.

3. Disability - the veteran is currently 10% service connected, disability secondary to post-traumatic stress disorder. He has obvious severe financial difficulty. He is applying for reevaluation; I told him I do not get involved in these matters. He understood this logic.

4. Left knee arthritis - being cared for by Orthopedics. Apparently they want to offer him surgery; he refuses.

5. Non-steroidal anti-inflammatories (NSAIDs) - veteran has failed these in the past; I told him that we would start him on Etodolac 300 milligrams every 8 hours as needed to be taken with food. The veteran was instructed not to take any other non-steroidal anti-inflammatories (NSAIDs) while taking this medication.

6. Flexeril - prescribed 10 milligrams every 8 hours as needed.

7. Physical therapy/transcutaneous electrical nerve stimulator (TENS) unit - A consult will be submitted to have physical therapy and a transcutaneous electrical nerve stimulator (TENS) trial done at the Wade Park location. He has failed physical therapy in the past; I encouraged him to give it another shot. I acknowledged that doing routine physical therapy, home program, will be difficult due to the patient's living situation, living in his car.

8. Opioids - I do not advocate opioids for chronic benign pain and the veteran did not request these.

9. Return to clinic in 2 to 3 months.

10. Future - I will consider starting the veteran on anti-epileptic and/or a low dose antidepressant. He may be a candidate for an injection, though he has refused these in the past with respect to other conditions.

ALPHA2110161(08/07/2009 16:01:07)30249783
$END

/es/ DONALD M. WOODS
PHYSICIAN
Signed: 08/11/2009 21:35

Receipt Acknowledged By:
08/17/2009 08:08 /es/ JOHN A. PRENTISS
PHYSICAL THERAPIST
08/12/2009 09:50 /es/ CYNTHIA P. VANKEUREN
PSYCHOLOGIST

LOCAL TITLE: PAIN MANAGEMENT PSYCHOLOGY EVALUATION NOTE
STANDARD TITLE: PAIN MEDICINE NOTE
DATE OF NOTE: JUL 28, 2009@08:00 ENTRY DATE: JUL 28, 2009@17:03:12
AUTHOR: VANKEUREN,CYNTHIA P EXP COSIGNER:
INSTITUTION: CLEVELAND VAMC
DIVISION: WADE PARK
URGENCY: STATUS: COMPLETED

Identifying information:
Vet's hygiene was extremely poor, likely due to the fact that he has been living in his car. Vet was very preoccupied with expressing his frustration that he is not being compensated for having served his country. This made it difficult to get specific answers to many questions.

Referral question:
Veteran was referred by Dr. Hovis. The referral question reads "analgesic recommendations." Vet was see by pain psychology for 30 minutes as part of a dual appointment process at the Pain Management Center.

Presenting complaint:
Vet complains of pain in his back and bilateral knees. Both problems are equally bothersome to vet. He described the back pain "like somebody's beating me with a baseball bat?sharp, aching, stiff." The pain then shoots pain down the back of both legs to the knees. It is also a stinging pain. The pain is located from his belt down. PT made the pain worse. Sleeping in his car makes the pain worse. Cortisone injections in knees were "worthless." Nothing makes the pain better. He added that "ain't nobody touching my back" when asked about other procedures that he may have had. Per vet, nothing in his life is going

FRANCWAY, Ernest L., Jr.
[redacted]
VA Medical Center, Cleveland, Ohio
October 4, 2002 to August 27, 2014

Signed: 04/18/2008 09:09

04/21/2008 ADDENDUM STATUS: COMPLETED
Lab notification placed in outgoing mail.

/es/ ALPHONSO PACE
LICENSED PRACTICAL NURSE
Signed: 04/21/2008 09:57

LOCAL TITLE: CBOC LAB NOTIFICATION (T)
STANDARD TITLE: PRIMARY CARE OUTPATIENT NOTE
DATE OF NOTE: APR 21, 2008@07:47 ENTRY DATE: APR 21, 2008@07:47:56
AUTHOR: HOVIS,JENNIFER C EXP COSIGNER:
INSTITUTION: ZZ-BRECKSVILLE VANPH
DIVISION: BRECKSVILLE
URGENCY: STATUS: COMPLETED

Apr 21,2008

FRANCWAY,ERNEST L
[redacted]
WESTLAKE, OHIO 44145

Dear FRANCWAY,ERNEST L:

I would like to update you on your recent lab results:

CHOLESTEROL AND TRIGLYCERIDES - YOUR RESULTS WERE:

CHOL:	174	(04/18/08 09:19)	SERUM	NORMAL RANGE:
TRIGLYC:	113	(04/18/08 09:19)	SERUM	HIGH: 200 OR GREATER
HDL CHO:	45	(04/18/08 09:19)	SERUM	NORMAL RANGE: 35-80
LDL-DIR:	112	(04/18/08 09:19)	SERUM	YOUR LDL GOAL IS:

LIVER FUNCTION - YOUR RESULTS WERE:

SGOT:	21	(04/18/08 09:19)	SERUM	NORMAL RANGE: 0-45
SGPT:	34	(04/18/08 09:19)	SERUM	NORMAL RANGE: 3-36

BLOOD COUNT - YOUR RESULTS WERE:

WBC:	7.37	(04/18/08 09:19)	BLOOD	NORMAL RANGE: 3.6-11
HCT:	46.7	(04/18/08 09:19)	BLOOD	NORMAL RANGE: 40-51
PLT:	207	(04/18/08 09:19)	BLOOD	NORMAL RANGE: 150-400

KIDNEY FUNCTION - YOUR RESULTS WERE

NA:	141	(04/18/08 09:19)	SERUM	NORMAL RANGE: 135-148
K:	4.0	(04/18/08 09:19)	SERUM	NORMAL RANGE: 3.7-5
CO2:	26.0	(04/18/08 09:19)	SERUM	NORMAL RANGE: 24-30
BUN:	16	(04/18/08 09:19)	SERUM	NORMAL RANGE: 10-26
T. BIL:	1.0	(04/18/08 09:19)	SERUM	NORMAL RANGE: 0-1.5
CREAT:	1.1	(04/18/08 09:19)	SERUM	NORMAL RANGE: 0.7-1.5

THYROID FUNCTION - YOUR RESULTS WERE:

FRANCWAY, Ernest L., Jr.
[redacted]
VA Medical Center, Cleveland, Ohio
October 4, 2002 to August 27, 2014

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 TSH-SH:   0.695    (04/18/08 09:19)  SERUM   NORMAL RANGE: .35-5.5


------------------------------------------------------------------------
PROSTATE FUNCTION - YOUR RESULTS WERE:

 PSA:      3.0      (04/18/08 09:19)  SERUM   NORMAL RANGE: 0-4

I have reviewed your lab results and they are normal. I look forward to
seeing you at your next scheduled visit.



Sincerely,

/es/ JENNIFER C. HOVIS
GERONTOLOGIST
Signed: 04/21/2008 07:48


 LOCAL TITLE: PRIMARY CARE NURSING INTAKE NOTE (T)
STANDARD TITLE: PRIMARY CARE NOTE
DATE OF NOTE: APR 18, 2008@08:48     ENTRY DATE: APR 18, 2008@08:48:46
      AUTHOR: STRANG,AMY E         EXP COSIGNER:
 INSTITUTION: ZZ-BRECKSVILLE VANPH
    DIVISION: BRECKSVILLE
     URGENCY:                            STATUS: COMPLETED

Reason for visit: Planned or scheduled follow-up

Allergies reviewed and updated per protocol.

Patient has answered NKA

MEDICATION LIST REVIEW REPORT
    OTC/Herbal was documented at this visit.

PATIENT EDUCATION
    Best Methods for Learning:
      Visual
      Hearing
      Hands on
      Written (in native language)
      Group Class
      Individual
    Documentation of Barriers:
      Physical Limitations
        : back pain, knee pain
      Emotional Limitations:
        Comment: depression

Clinical Reminders Activity
  Pain, Brief Evaluation:
    Type of pain:  Ongoing
    Location:  Low Back                    knees
    Intensity:
      Currently:
        3
      Usually:  3
    Description of Pain:  Aching|Nagging

    Evaluation:
      Pain will be evaluated by provider today.
       Notified via Encounter Form.
  Tobacco Use Screen FY07:
      The patient indicated that he/she is a lifetime non-user of tobacco.
  Prostate Counseling:
    Patient advised of the risks and benefits of screening prostate cancer
    with PSA blood test and was provided an opportunity to ask questions
    and or discuss the information.
      Level of Understanding: Good
  Colorectal Cancer Screen FOBT:
    Patient has not had a sigmoidoscopy or colonoscopy.
    Stool cards given to patient. Patient was educated on the importance
    of returning the stool cards.
      : Good
```

FRANCWAY, Ernest L., Jr.
[redacted]
VA Medical Center, Cleveland, Ohio
October 4, 2002 to August 27, 2014

/es/ AMY E. STRANG
LICENSED PRACTICAL NURSE
Signed: 04/18/2008 08:53

LOCAL TITLE: DENTAL IMAGE (C)
STANDARD TITLE: DENTISTRY NOTE
DATE OF NOTE: JAN 22, 2008@08:56 ENTRY DATE: JAN 22, 2008@08:56:52
AUTHOR: BETEN,JAMIE EXP COSIGNER:
INSTITUTION: CLEVELAND VAMC
DIVISION: WADE PARK
URGENCY: STATUS: COMPLETED

*****This consult note is for DENTAL IMAGES only*****

Dental images are attached to this note.
Please see progress note for interpretation.

/es/ JAMIE BETEN
DENTIST
Signed: 01/22/2008 08:56

LOCAL TITLE: DENTAL CONSULTATION NOTE (C)
STANDARD TITLE: DENTISTRY CONSULT
DATE OF NOTE: JAN 22, 2008@08:55 ENTRY DATE: JAN 22, 2008@08:56:40
AUTHOR: BETEN,JAMIE EXP COSIGNER:
INSTITUTION: CLEVELAND VAMC
DIVISION: WADE PARK
URGENCY: STATUS: COMPLETED

Patient Name: FRANCWAY,ERNEST L, DOB: [redacted]1950, Age: 57
Visit: S: Jan 22, 2008@08:05 - W DENTAL/WALK-IN.
Primary PCE Diagnosis: 525.9 (DENTAL DISORDER NOS).
Dental Category: 18-PRIOR 1, EMERGENCY (OPT). Treatment Status: Inactive.

Completed Care:
(D0330) Dental panoramic film. DX: (525.9).
(D0140) Limit oral eval problm focus. DX: (525.9).
(D2940) Dental sedative filling. Tooth: 3. DX: (521.00).

- -
patient presents as walk in.

Active Problems:
Neck Pain
Eczema (ICD-9-CM 692.9)
Bilateral Cataracts
Cholelithiasis (ICD-9-CM 574.20)
Inguinal hernia, without mention of obstruction or gangrene (ICD-9-CM 550.90)
Hyperlipidemia (ICD-9-CM 272.4)
Low Back Pain (ICD-9-CM 724.2)
Exostosis
Scabies (ICD-9-CM 133.0)
Impotence of Psychogenic Origin (ICD-9-CM 302.72)
Arthritis (ICD-9-CM 716.90)
Posttraumatic Stress Disorder
MAJOR DEPRESSIVE, SINGLE EPISODE

---- Outpatient Medication ----
SIMVASTATIN 80MG TAB - (ACTIVE)
DICLOFENAC NA 50MG EC TAB - (ACTIVE)
CYCLOBENZAPRINE HCL 10MG TAB - (ACTIVE)
VARDENAFIL HCL 20MG TAB - (ACTIVE)
CODEINE 30/ACETAMINOPHEN 300MG TAB - (ACTIVE)
ZINC OXIDE 20% OINT - (ACTIVE)

Active Allergies:
No Known Allergies

pan taken.
patient report hx of breaking upper right tooth on sandwich.
had been to er - recieved two days worth of t3 at that visit.

BOARD OF VETERANS' APPEALS
DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON, DC 20420

IN THE APPEAL OF
ERNEST L. FRANCWAY, JR.

[redacted]

DOCKET NO. 04-09 153) DATE MAR 1 3 2013
)
)

On appeal from the
Department of Veterans Affairs Regional Office in Cleveland, Ohio

THE ISSUE

Entitlement to service connection for a low back disorder.

REPRESENTATION

Appellant represented by: Sean A. Ravin, Attorney

WITNESS AT HEARING ON APPEAL

Appellant

ATTORNEY FOR THE BOARD

T. L. Douglas, Counsel

IN THE APPEAL OF [redacted]
ERNEST L. FRANCWAY, JR.

[redacted]

INTRODUCTION

The appellant is a Veteran who served on active duty from August 1968 to May 1970.

This matter comes before the Board of Veterans' Appeals (Board) by order of the United States Court of Appeals for Veterans Claims (hereinafter "the Court") on December 15, 2010, which, in pertinent part, vacated a May 2009 Board decision and remanded the issue on appeal for additional development. The case was remanded to the RO for the requested development in May 2011.

The issue initially arose from a May 2003 rating decision by the Cleveland, Ohio, Regional Office (RO) of the Department of Veterans Affairs (VA). In October 2005, the Veteran testified at a video conference hearing before the undersigned Veterans Law Judge. A copy of the transcript of that hearing is of record.

The Board notes that in correspondence dated in July 2012 the Veteran's attorney requested copies of VA records pursuant to the Privacy Act. VA correspondence dated September 26, 2012, sent to the attorney at his address of record noted the requested copies were provided. In correspondence dated November 1, 2012, the Board notified the attorney at his address of record that good cause had been shown for a requested 60-day extension of time beginning on September 26, 2012, and that he had until November 26, 2012, to submit a response. In correspondence dated December 2012 the attorney, in essence, reiterated the Veteran's claim and provided new evidence without waiver of agency of original jurisdiction (AOJ) consideration.

The appeal is REMANDED to the RO.

IN THE APPEAL OF
ERNEST L. FRANCWAY, JR.

[redacted]

REMAND

The Veterans Claims Assistance Act of 2000 (VCAA) describes VA's duty to notify and assist claimants in substantiating a claim for VA benefits. 38 U.S.C.A. §§ 5100, 5102, 5103, 5103A, 5107, 5126 (West 2002 & Supp. 2012); 38 C.F.R. §§ 3.102, 3.156(a), 3.159, 3.326(a) (2012). The Veteran was notified of the VCAA duties to assist and of the information and evidence necessary to substantiate his claim by correspondence dated in July 2003 and July 2006. The Board notes that the Social Security Administration (SSA) reported in June 2011 that exhaustive and comprehensive efforts revealed no medical records and that further efforts would be futile. The Veteran was notified that SSA could not be obtained and, in essence, that he was ultimately responsible for providing evidence in support of his claim by correspondence dated in October 2011.

The VCAA duty to assist requires that VA make reasonable efforts to assist the claimant in obtaining evidence necessary to substantiate a claim and in claims for disability compensation requires that VA provide medical examinations or obtain medical opinions when necessary for an adequate decision. 38 C.F.R. § 3.159. A medical examination or medical opinion is deemed to be necessary if the record does not contain sufficient competent medical evidence to decide the claim, but includes competent lay or medical evidence of a current diagnosed disability or persistent or recurrent symptoms of disability, establishes that the veteran suffered an event, injury, or disease in service, or has a disease or symptoms of a disease manifest during an applicable presumptive period, and indicates the claimed disability or symptoms may be associated with the established event, injury, or disease. 38 C.F.R. § 3.159(c)(4). The Court has held that when VA undertakes to provide a VA examination or obtain a VA opinion, it must ensure that the examination or opinion is adequate. *Barr v. Nicholson*, 21 Vet. App. 303, 312 (2007).

In this case, service treatment records show that the Veteran's August 1968 entrance examination report noted he had been in an automobile accident in 1966 and had a contused spleen with no subsequent trouble. Records also show that in late November 1969 he was in an automobile accident and in December 1969 he

[redacted]

complained of low back pain on the right side. Physical examination revealed range of motion limited by pain. There was no deformity or fracture. There was some pain on rotation. He was provided Parafon Forte. A note dated the next day reported complaints of pain at L5-S1 and on the right side of S1. It was noted X-ray studies were taken (no report of this study is included in the appellate record). A March 1978 Navy Reserve examination report noted the Veteran's spine and musculoskeletal system were normal upon clinical evaluation. In a March 1978 Report of Medical History the Veteran denied a history of recurrent back pain.

Private records dated in 1994 and 1995 revealed complaints of complaints of back pain. A March 1995 report noted the Veteran had back pain after lifting weight.

In correspondence dated in April 2003 the Veteran requested entitlement to service connection for a back injury on the left side in May 1969.

VA treatment records show that in May 2004 the Veteran complained of back pain and reported that he had injured his back on a flight deck in 1969. The examiner noted limited mobility due to pain. A diagnosis of acute or chronic lumbar back pain was provided. Subsequent report noted continued complaints of low back pain without opinion as to etiology.

At his Board hearing in October 2005 the Veteran testified that he injured his back aboard ship when he fell while carrying aircraft wheel chocks. He stated he had been treated for muscle strain and was given pain pills, treated with an unknown intravenous white substance, and put on light duty for three months. He indicated that he had first received treatment for his back after service at the Brecksville, Ohio, VA medical facility in 2004 and that he has been treated for muscle cramping in his back with occasional radiation down his legs. He reported he had received no other treatment for his back after service and that when he had problems with his back he took over-the-counter pain medication and stayed in bed until he was able to resume his normal activities. He stated that he had worked at Midland Steel for 22 years as a forklift operator and that he had stayed home from work sometimes every other month and sometimes a couple of times per month. He reported that these episodes varied, but that sometimes he had to remain off work for two to three

[redacted]

days. He stated he had not gone to the company doctor because he feared being fired because of a back injury.

A May 2006 VA examination report noted that on service entrance examination the Veteran was noted to have had internal bleeding from the left side of the stomach in 1966 and that during service, in April 1969, he was seen for sharp lower abdominal pain as well as vomiting of dark red-black blood after an incident where he was lifting a pulley. He was treated at that time for muscle sprain. The May 2006 examiner also noted the Veteran stated the service treatment records were inaccurate and that the incident did not involve a pulley, but involved carrying four wheel chocks. He reported that he fell and landed on the wheel chocks "gouging" his stomach and back. Since that time, he stated he had periodic severe cramping of the left side of the abdomen, flank, and back. The last episode he reported had been two weeks earlier and lasted 45 minutes. He described the cramps as being on the left side of his body and were more intense in the thoracic distribution, which at times radiated up as far as the scapula and down in the lumbar distribution. They were posterior, sometimes anterior, and sometimes both. X-ray studies of the lumbar and thoracic spine revealed minimal arthritis. A computerized tomography (CT) of the abdomen revealed fatty liver, cholelithiasis, mild prostate enlargement, and a left inguinal hernia. The examiner found the left inguinal hernia was as likely as not related to the inservice injury; however, extensive back and abdominal cramping was less likely than not attributable to the hernia.

A May 2006 VA back examination report included a diagnosis of lumbosacral strain. It was noted the Veteran reported he sustained a straining back injury in 1969 and that over the years he had intermittent episodes of back pain. He stated that about two years earlier it had gotten worse and that he had been told he may have arthritis. The examiner opined that it was not likely that the Veteran's current back symptoms were related to a simple strain in 1969, but that they had occurred as a natural occurring phenomenon.

VA spine examination in July 2007 included diagnoses of lumbosacral strain and minimal arthritis. It was noted that the Veteran had chronic back pain, that he had a back strain in service, and that he had experienced persistent over the years with

some minimal arthritis by X-ray study now. The examiner stated that these diagnoses were not related to service, but were a natural occurring phenomenon.

VA treatment records include diagnoses of chronic low back pain dated during and after August 2009 provided by the Veteran's VA gerontologist. It was noted that low back pain was ongoing since 1969 without additional comment. Records show a July 2009 magnetic resonance imaging (MRI) scan revealed severe lumbar canal stenosis and bilateral mild neuroforaminal stenosis at L4-5, right-sided mild neuroforaminal stenosis at L3-4, and moderate canal stenosis at L2-3.

A December 2011 VA medical opinion provided by an orthopedist based upon a review of the claims file found no change in opinion. It was the examiner's opinion that the Veteran's spinal stenosis was less likely related to service, but rather was the result of natural age progression. A January 2012 VA examination report provided a summary of the Veteran's medical history and his report of having self-treated the disorder over the years after his discharge from service and prior to 2005. The examiner found that it was less likely incurred or caused by the claimed in-service injury, event, or illness. It was noted that although the Veteran currently had spinal stenosis and degenerative disc disease it was less likely they were related to an acute back strain that occurred more than 30 years prior to his next back complaint and even longer before the diagnosis of spinal stenosis. The examiner stated these matters were discussed with the Veteran, but that no back examination was performed. It was further noted that due to the lack of sufficient evidence it could not be stated that the initial injury in 1969 was likely to have caused the Veteran's current back disorders.

An April 2012 VA examination report summarized the Veteran's medical history and his report of not having received any medical treatment from the 1970's to the 1990's. It was noted that in 1995 he had developed pain which radiated to his back while incarcerated, but that his low back pain was not addressed until he began receiving VA treatment in 2004. A physical examination revealed limited thoracolumbar spine motion due to pain with intervertebral disc syndrome and bilateral sciatic nerve involvement. X-ray studies revealed degenerative change and scoliosis. The examiner found that there were no medical records of evidence from

[redacted]

1970 to 2004 to establish a nexus and that it was, therefore, less likely than not that the Veteran's spinal stenosis was related to the injury described as having been sustained in service. It was more likely than not that his spinal stenosis was related to natural age progression with consideration of wear and tear throughout his life.

In a November 2012 statement in support of the Veteran's claim, G.P. reported that he had known the Veteran since the 1970's and that they had remained good friends. He recalled that the Veteran had come to him with car trouble and that he had stated he could not work on it himself because of his back. G.P. stated that the Veteran could not even bend over and he recalled having seen the Veteran experience episodes of back pain over the years. The statement was provided to the Board and addressed in correspondence from the Veteran's attorney dated in December 2012 which requested the case be remanded for an additional VA examination to consider this supporting evidence as to his observable symptoms of back pain since active service. In light of this evidence, the Board finds that additional development is required prior to appellate review.

Accordingly, the case is REMANDED for the following action:

1. The Veteran should be requested to provide the names, addresses and approximate dates of treatment of all medical care providers, VA and non-VA, who have provided any treatment pertinent to the issue on appeal. After the Veteran has signed the appropriate releases, any such records should be obtained and associated with the claims folder.

Appropriate efforts must be taken to obtain pertinent VA treatment records, unless further efforts would be futile. All attempts to procure records should be documented in the file. If the RO/AMC cannot obtain records identified by the Veteran, a notation to that effect should be inserted in the file. The Veteran is to be notified of unsuccessful efforts in this regard, in


REMAND

order to allow him the opportunity to obtain and submit those records for VA review.

2. The Veteran claims file should be reviewed by an appropriate medical specialist for an opinion as to whether there is at least a 50 percent probability or greater (*at least as likely as not*) that he has a low back disorder as a result of active service. All indicated tests and studies are to be performed. Prior to the examination, the claims folder must be made available for review of the case. A notation to the effect that this record review took place should be included in the report. The examiner should reconcile any opinion provided with the statements from the Veteran and G.P. as to reported episodes of back pain since active service. An explanation should be provided identifying the reasons if any item of evidence is considered to be not credible.

Opinions should be provided based on the results of examination, a review of the medical evidence of record, and sound medical principles. All examination findings, along with the complete rationale for all opinions expressed, should be set forth in the examination report.

3. After completion of the above and any additional development deemed necessary, the issue on appeal should be reviewed with appropriate consideration of all the evidence of record. If any benefit sought remains denied, the Veteran and his attorney should be furnished a supplemental statement of the case and should be afforded the opportunity to respond.

IN THE APPEAL OF
ERNEST L. FRANCWAY, JR.

[redacted]

Thereafter, the case should be returned to the Board for appellate review.

The appellant has the right to submit additional evidence and argument on the matter or matters the Board has remanded. *Kutscherousky v. West*, 12 Vet. App. 369 (1999).

This claim must be afforded expeditious treatment. The law requires that all claims that are remanded by the Board of Veterans' Appeals or by the United States Court of Appeals for Veterans Claims for additional development or other appropriate action must be handled in an expeditious manner. *See* 38 U.S.C.A. §§ 5109B, 7112 (West Supp. 2012).

S. L. Kennedy
Veterans Law Judge, Board of Veterans' Appeals

Under 38 U.S.C.A. § 7252 (West 2002), only a decision of the Board of Veterans' Appeals is appealable to the United States Court of Appeals for Veterans Claims. This remand is in the nature of a preliminary order and does not constitute a decision of the Board on the merits of your appeal. 38 C.F.R. § 20.1100(b) (2012).

OMB Approved No. 2900-0075
Respondent Burden: 15 minutes

Department of Veterans Affairs

STATEMENT IN SUPPORT OF CLAIM

PRIVACY ACT INFORMATION: The VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA Programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is required to obtain or retain benefits. VA uses your SSN to identify your claim file. Providing your SSN will help ensure that your records are properly associated with your claim file. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. The VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by Federal Statute of law in effect prior to January 1, 1975, and still in effect. The requested information is considered relevant and necessary to determine maximum benefits under the law. The responses you submit are considered confidential (38 U.S.C. 5701). Information submitted is subject to verification through computer matching programs with other agencies.

RESPONDENT BURDEN: We need this information to obtain evidence in support of your claim for benefits (38 U.S.C. 501(a) and (b)). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 15 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.reginfo.gov/public/do/PRAMain. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

FIRST NAME - MIDDLE NAME - LAST NAME OF VETERAN (Type or print)	SOCIAL SECURITY NO.	VA FILE NO.
Ernest Francway, Jr.		C/CSS: [redacted]

The following statement is made in connection with a claim for benefits in the case of the above-named veteran:

I have known Ernest since the 70's He is a very good friend of mine. I was working as a mechanic at a shell gas station when Ernest came in with car trouble, he said he could not work on his own car because of his back. He told me he hurt his back in the service, on the ship he was on. We started seeing back all the time and we became very good friends. He could not even bend over to do a simple tune-up. Over the years I have Ernest in pain and down with his back. We would sit and talk about when he was in the service and got his back hurt. He has been at my home a number of times where his back was hurting and I have seen him in some really bad pain. He got a lot of over the counter pills to try and help with the pain. (Aspirin) Ever since I have known Ernest he has had back trouble.

Thank You

I CERTIFY THAT the statements on this form are true and correct to the best of my knowledge and belief.

SIGNATURE	DATE SIGNED
X Glen Petry (Glen Petrry)	X 11-12-12

ADDRESS	TELEPHONE NUMBERS (Include Area Code)	
[redacted]	DAYTIME	EVENING
Maoma, WV 25140		

PENALTY: The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of a material fact, knowing it to be false.

VA FORM AUG 2011 21-4138 EXISTING STOCKS OF VA FORM 21-4138, AUG 2004, WILL BE USED CONTINUE ON REVERSE

FAX COVER SHEET

Litigation Support Division,
Board of Veterans Appeals

DATE: DECEMBER 5, 2012 VOICE: (202) 565-8788
NUMBER OF PAGES: 5 (INCLUDING COVER SHEET)
DESIGNATED RECEIVER'S FACSIMILE NO: (202) 343-1419

Veteran: Ernest Francway, Jr.
Appellant: Ernest Francway, Jr.
VA File Number: SS [redacted]

Appellant's argument in support of claim.

Sincerely yours,
Sean A. Ravin, Esq.

Sean A. Ravin, Esq.
1050 17th STREET, NW, SUITE 600
Washington, DC 20036

Telephone: (202) 607-5731
Fax: (202) 318-0205
eMail: ravinesq@earthlink.net

NOTE: HARD COPY TO FOLLOW BY MAIL: __X__ YES _____ NO

SEAN A. RAVIN, Esq.

Admitted
New York Bar
District of Columbia Bar

District of Columbia Court of Appeals
New York State Supreme Court
U.S. District Court for the District of Columbia
U.S. Court of Appeals for Veterans Claims
U.S. Court of Appeals for the Federal Circuit
U.S. Court of Appeals for the Fourth Circuit

1050 17th STREET, NW, SUIT 600 • WASHINGTON • DISTRICT OF COLUMBIA 20036
FAX: (202) 318-0205
EMAIL: ravinesq@earthlink.com
TELEPHONE (202) 607-5731

December 4, 2012

Board of Veterans Appeals
Washington, DC. 20420

Re: Argument for Remand
Veteran: Ernest Francway, Jr.
VA File Number: SS [redacted].

Dear Mr. Chairman:

Mr. Francway submits the following argument in support of his claim for entitlement to service-connection for a low back disability.

Mr. Francway asserts that his currently diagnosed back disability is related to the in-service incident in April 1969 when he fell on the flight deck of the USS Oriskany and injured his back. Mr. Francway fell directly on his back onto wheel-chucks, was taken off the flight deck by stretcher, and remained on bed rest for one week. He was then assigned to light duty for ninety days. Since that date, Mr. Francway has suffered from continuous symptoms of a back disability, to include pain and tenderness, and has since been precluded from performing simple daily tasks such as lifting and bending his back.

Following a May 2011 BVA remand, Mr. Francway was provided with a VA examination and opinion by a physician's assistant. In his one paragraph rationale, the VA examiner opined that because "there are no medical records of evidence from 1970-2004 to establish a nexus" it was less likely than not that Mr. Francway's current back disability, to include spinal stenosis, is related to injury sustained in service. The examiner further stated that "it would be more likely than not" that his disability is related to "natural age progression with considerable wear and tear throughout his life."

The April 2012 VA opinion is inadequate for ratings purposes and unfortunately remand is required yet again to provide Mr. Francway with a new opinion. 38 U.S.C. §5103A. *See Green v. Derwinski*, 1 Vet.App. 121, 124 (1991).

Specifically, Mr. Francway has provided competent and credible testimony regarding the continuity of observable symptoms of his back disability since the in-service injury. *See Layno v. Brown*, 6 Vet.App. 465, 469-70 (1994). The physician's assistant who authored the April 2012 opinion erroneously based his opinion on the lack of contemporaneous medical records corroborating Mr. Francway's account of the continuity of his symptoms of disability since service. *See Buchanan v. Nicholson*, 451 F.3d. 1331,1335 (Fed.Cir.2006).

Not only did the April 2012 examiner fail to discuss or consider statements from Mr. Francway regarding the continuity of symptoms suffered since the in-service injury, he failed to provide an adequate rationale regarding the "considerable wear and tear throughout [Mr. Francway's] life." The examiner points to no specific incidents following service which may have led to Mr. Francway's current back disability. The rationale provided consists of merely two sentences discussing mainly the lack of corroborating evidence rather than a detailed discussion of the precipitating events which could have led to the current back disability diagnosis.

In further support of continuity of symptomatology, Mr. Francway submits a statement from his longtime friend Glen Pettry, dated November 12, 2012. The statement is appended to this letter. In his letter, Mr. Pettry states that he has known Mr. Francway since the 1970s following his discharge from the service. Mr. Pettry recalls how Mr. Francway stated that he first injured his back in service and had been experiencing severe back pain since then. Mr. Pettry also states that Mr. Francway "has been at my home a number of times when his back was hurting him and have seen him in some really bad pain." For as long as they have been friends, Mr. Pettry has witnessed Mr. Francway with back pain.

Mr. Francway asserts that remand is required in order to provide a new opinion with an adequate supporting rationale. The April 2012 rationale provided erroneously relies on a lack of contemporaneous medical records as evidence that Mr. Francway has not suffered continuously from symptoms of disability since service. Mr. Francway has submitted statements regarding the observable symptoms of his back pain since the in-service injury and it was incumbent upon the examiner to discuss and consider these statements in his opinion.

Mr. Francway asks that the Board find that he is credible and competent to report his symptoms of disability related to his back. There is no evidence which contradicts Mr. Francway's assertions, and there is no inconsistency with his statements. In addition, Mr. Francway asks that the Board find that Mr. Pettry is credible and competent to provide evidence of his observations of Mr. Francway's complaints and observable symptoms of disability related to a back injury. As with Mr. Francway, Mr. Pettry's statements are no contradicted by any evidence, nor are his statements inconsistent with any other evidence.

Mr. Francway is prejudiced by the inadequate VA examination provided by the physician's assistant in April 2012, and he is entitled to a thorough and contemporaneous examination which takes into account all prior medical records as well as all relevant lay and medical evidence, to include statements which the Board finds to be both credible and competent.

For this reason, Mr. Francway asks that the Board remand this matter for the provision of a medical examination conducted by a board certified orthopedist along with all necessary tests, to include the provision of x-rays and MRI imaging. Mr. Francway asserts that such tests and imaging will demonstrate that his current disability is etiologically related to the severe injury sustained in-service and in the same vocation as noted in his service medical records.

MEDICAL RECORD Progress Notes

NOTE DATED: 04/28/2012 09:00
LOCAL TITLE: COMPENSATION & PENSION EXAMINATION
STANDARD TITLE: C & P EXAMINATION NOTE
VISIT: 04/28/2012 09:00 PRM C&P/GM/PAT HOPPERTON

Back (Thoracolumbar Spine) Conditions
Disability Benefits Questionnaire

Name of patient/Veteran: Francway, Ernest L Jr

Your patient is applying to the U. S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the Veteran's claim.

1. Diagnosis

Does the Veteran now have or has he/she ever been diagnosed with a thoracolumbar spine (back) condition? [X] Yes [ ] No

If yes, provide only diagnoses that pertain to thoracolumbar spine (back) conditions:

Diagnosis #1: Spinal Stenosis
ICD code: 724.02
Date of diagnosis: 2004

Diagnosis #2:
ICD code:
Date of diagnosis:

Diagnosis #3:
ICD code:
Date of diagnosis:

If there are additional diagnoses pertaining to thoracolumbar spine (back) conditions, list using above format:

2. Medical history

Describe the history (including onset and course) of the Veteran's thoracolumbar spine (back) condition (brief summary):
Veteran presents today for examination claiming low back condition of spinal stenosis. The veteran has a history of being MVA during his military service in 1964. The veteran describes that he was seated in the front seat of his father's car between his father and brother without a seatbelt. His father's car struck another car traveling approximately 20mph and he was thrown into the dashboard. As a result of this accindent the veteran had internal bleeding diagnosed when treated. The veteran states he did not have any back pain at that time The veteran was also noted to have been involved in a MVA in 1976. The veteran denies any back pain as a result of that accident. In 1995 he had low back pain secondary to bending over to pick up a 10 pound weight while incarcerated. He states he never injured the back actually lifting the weights just bending over. The veteran is describing injuring his back in 1969 while walking across a

** THIS NOTE CONTINUED ON NEXT PAGE **

flight deck in heavy wind situation carrying wheel chucks in both hands he was hit with a cross wind that caused him to fall. At the time of the fall he recalls immediated pain to his low back area as well as his abdomen. He states when he fell his back was injured from the twisting from the fall and then falling on the "wheel chucks" themselves. He was taken of the flight deck by stretcher and remained on bed rest for approximately one week. He was on light duty for a period of 90 days after that. He was diagnosed later with a hernia to the left side of the adbomen. The veteran states that since his discharge from the military in 1970 he has had chronic and constant low back pain. He does not describe any treatment medically from 1970-1980, 1980-1990 then is 1995 while incarcerated he developed pain to the area of his hernia on the left side that was radiating to his back. He denies that his back pain was addressed and that he was given pain medication for the "cramps" from his hernia. He states his low back pain was not addressed until 2004 with treatment at the VA. His pain today is constant and chronic in nature and present on a daily basis. Pain is located in lumbosacral area of spine both right and left sides.

Employment history: Heavy equipment operator from 1970-1994 then incarcerated from 1994-1999 then, tried working tow motors on occasion but no steady work since 1999. When operating heavy equipment he operated front end loaders, back hoes, bulldozers, overhead cranes and tow motors.

3. Flare-ups

Does the Veteran report that flare-ups impact the function of the thoracolumbar spine (back)? [ ] Yes [X] No

If yes, document the Veteran's description of the impact of flare-ups in his or her own words:

4. Initial range of motion (ROM) measurement

Measure ROM with a goniometer, rounding each measurement to the nearest 5 degrees. During the measurements, observe the point at which painful motion begins, evidenced by visible behavior such as facial expression, wincing, etc. Report initial measurements below.

Following the initial assessment of ROM, perform repetitive-use testing. For VA purposes, repetitive-use testing must be included in all exams. The VA has determined that 3 repetitions of ROM (at minimum) can serve as a representative test of the effect of repetitive use. After the initial measurement, reassess ROM after 3 repetitions. Report post-test measurements in section 5.

a. Select where forward flexion ends (normal endpoint is 90):

[ ] 0	[ ] 5	[ ] 10	[ ] 15	[ ] 20	[ ] 25	[ ] 30
[ ] 35	[X] 40	[ ] 45	[ ] 50	[ ] 55	[ ] 60	[ ] 65
[ ] 70	[ ] 75	[ ] 80	[ ] 85	[ ] 90 or greater		

** THIS NOTE CONTINUED ON NEXT PAGE **

MEDICAL RECORD Progress Notes

04/28/2012 09:00 ** CONTINUED FROM PREVIOUS PAGE **

Select where objective evidence of painful motion begins:
[ ] No objective evidence of painful motion
[X] 0 [ ] 5 [ ] 10 [ ] 15 [ ] 20 [ ] 25 [ ] 30
[ ] 35 [ ] 40 [ ] 45 [ ] 50 [ ] 55 [ ] 60 [ ] 65
[ ] 70 [ ] 75 [ ] 80 [ ] 85 [ ] 90 or greater

b. Select where extension ends (normal endpoint is 30):
[X] 0 [ ] 5 [ ] 10 [ ] 15 [ ] 20 [ ] 25 [ ] 30 or greater

Select where objective evidence of painful motion begins:
[ ] No objective evidence of painful motion
[X] 0 [ ] 5 [ ] 10 [ ] 15 [ ] 20 [ ] 25 [ ] 30 or greater

c. Select where right lateral flexion ends (normal endpoint is 30):
[ ] 0 [ ] 5 [ ] 10 [ ] 15 [X] 20 [ ] 25 [ ] 30 or greater

Select where objective evidence of painful motion begins:
[ ] No objective evidence of painful motion
[X] 0 [ ] 5 [ ] 10 [ ] 15 [ ] 20 [ ] 25 [ ] 30 or greater

d. Select where left lateral flexion ends (normal endpoint is 30):
[ ] 0 [ ] 5 [ ] 10 [ ] 15 [X] 20 [ ] 25 [ ] 30 or greater

Select where objective evidence of painful motion begins:
[ ] No objective evidence of painful motion
[X] 0 [ ] 5 [ ] 10 [ ] 15 [ ] 20 [ ] 25 [ ] 30 or greater

e. Select where right lateral rotation ends (normal endpoint is 30):
[ ] 0 [ ] 5 [ ] 10 [ ] 15 [X] 20 [ ] 25 [ ] 30 or greater

Select where objective evidence of painful motion begins:
[ ] No objective evidence of painful motion
[ ] 0 [ ] 5 [ ] 10 [ ] 15 [X] 20 [ ] 25 [ ] 30 or greater

f. Select where left lateral rotation ends (normal endpoint is 30):
[ ] 0 [ ] 5 [ ] 10 [ ] 15 [X] 20 [ ] 25 [ ] 30 or greater

Select where objective evidence of painful motion begins:
[ ] No objective evidence of painful motion
[ ] 0 [ ] 5 [ ] 10 [ ] 15 [X] 20 [ ] 25 [ ] 30 or

** THIS NOTE CONTINUED ON NEXT PAGE **

MEDICAL RECORD Progress Notes

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greater

g. If ROM for this Veteran does not conform to the normal range of motion identified above but is normal for this Veteran (for reasons other than a back condition, such as age, body habitus, neurologic disease), explain:

5. ROM measurement after repetitive use testing

a. Is the Veteran able to perform repetitive-use testing with 3 repetitions?
[X] Yes [ ] No

If unable, provide reason:

If Veteran is unable to perform repetitive-use testing, skip to section 6.

If Veteran is able to perform repetitive-use testing, measure and report ROM after a minimum of 3 repetitions.

b. Select where post-test forward flexion ends:
[ ] 0 [ ] 5 [ ] 10 [ ] 15 [ ] 20 [ ] 25 [ ] 30
[ ] 35 [X] 40 [ ] 45 [ ] 50 [ ] 55 [ ] 60 [ ] 65
[ ] 70 [ ] 75 [ ] 80 [ ] 85 [ ] 90 or greater

c. Select where post-test extension ends:
[X] 0 [ ] 5 [ ] 10 [ ] 15 [ ] 20 [ ] 25 [ ] 30 or greater

d. Select where post-test right lateral flexion ends:
[ ] 0 [ ] 5 [ ] 10 [ ] 15 [X] 20 [ ] 25 [ ] 30 or greater

e. Select where post-test left lateral flexion ends:
[ ] 0 [ ] 5 [ ] 10 [ ] 15 [X] 20 [ ] 25 [ ] 30 or greater

f. Select where post-test right lateral rotation ends:
[ ] 0 [ ] 5 [ ] 10 [ ] 15 [X] 20 [ ] 25 [ ] 30 or greater

g. Select where post-test left lateral rotation ends:
[ ] 0 [ ] 5 [ ] 10 [ ] 15 [X] 20 [ ] 25 [ ] 30 or greater

6. Functional loss and additional limitation in ROM

The following section addresses reasons for functional loss, if present, and additional loss of ROM after repetitive-use testing, if present. The VA defines functional loss as the inability to perform normal working movements of the body with normal excursion, strength, speed, coordination and/or endurance.

** THIS NOTE CONTINUED ON NEXT PAGE **

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a. Does the Veteran have additional limitation in ROM of the thoracolumbar spine (back) following repetitive-use testing?
[ ] Yes [X] No

b. Does the Veteran have any functional loss and/or functional impairment of the thoracolumbar spine (back)?
[X] Yes [ ] No

c. If the Veteran has functional loss, functional impairment and/or additional limitation of ROM of the thoracolumbar spine (back) after repetitive use, indicate the contributing factors of disability below:

[X] Less movement than normal
[ ] More movement than normal
[ ] Weakened movement
[ ] Excess fatigability
[ ] Incoordination, impaired ability to execute skilled movements smoothly
[X] Pain on movement
[ ] Swelling
[ ] Deformity
[ ] Atrophy of disuse
[ ] Instability of station
[ ] Disturbance of locomotion
[ ] Interference with sitting, standing and/or weight-bearing
[ ] Other, describe:

7. Pain and muscle spasm (pain on palpation, effect of muscle spasm on gait)

a. Does the Veteran have localized tenderness or pain to palpation for joints and/or soft tissue of the thoracolumbar spine (back)?
[X] Yes [ ] No

If yes, describe: Pain to palpation paravertebral left and right from L1-S1

b. Does the Veteran have guarding or muscle spasm of the thoracolumbar spine (back)? [ ] Yes [X] No

If yes, is it severe enough to result in: (check all that apply)
[ ] Abnormal gait
[ ] Abnormal spinal contour, such as scoliosis, reversed lordosis, or abnormal kyphosis
[ ] Guarding and/or muscle spasm is present, but do not result in abnormal gait or spinal contour

8. Muscle strength testing

a. Rate strength according to the following scale:

** THIS NOTE CONTINUED ON NEXT PAGE **

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0/5 No muscle movement
1/5 Palpable or visible muscle contraction, but no joint movement
2/5 Active movement with gravity eliminated
3/5 Active movement against gravity
4/5 Active movement against some resistance
5/5 Normal strength

Hip flexion:
Right: [ ] 5/5 [X] 4/5 [ ] 3/5 [ ] 2/5 [ ] 1/5 [ ] 0/5
Left: [ ] 5/5 [X] 4/5 [ ] 3/5 [ ] 2/5 [ ] 1/5 [ ] 0/5

Knee extension:
Right: [ ] 5/5 [X] 4/5 [ ] 3/5 [ ] 2/5 [ ] 1/5 [ ] 0/5
Left: [ ] 5/5 [X] 4/5 [ ] 3/5 [ ] 2/5 [ ] 1/5 [ ] 0/5

Ankle plantar flexion:
Right: [ ] 5/5 [X] 4/5 [ ] 3/5 [ ] 2/5 [ ] 1/5 [ ] 0/5
Left: [ ] 5/5 [X] 4/5 [ ] 3/5 [ ] 2/5 [ ] 1/5 [ ] 0/5

Ankle dorsiflexion:
Right: [ ] 5/5 [X] 4/5 [ ] 3/5 [ ] 2/5 [ ] 1/5 [ ] 0/5
Left: [ ] 5/5 [X] 4/5 [ ] 3/5 [ ] 2/5 [ ] 1/5 [ ] 0/5

Great toe extension:
Right: [ ] 5/5 [X] 4/5 [ ] 3/5 [ ] 2/5 [ ] 1/5 [ ] 0/5
Left: [ ] 5/5 [X] 4/5 [ ] 3/5 [ ] 2/5 [ ] 1/5 [ ] 0/5

b. Does the Veteran have muscle atrophy?
[ ] Yes [X] No

If muscle atrophy is present, indicate location:

Provide measurements in centimeters of normal side and atrophied side, measured at maximum muscle bulk:

Normal side: cm. Atrophied side: cm.

9. Reflex exam

Rate deep tendon reflexes (DTRs) according to the following scale:

0 Absent
1+ Hypoactive
2+ Normal
3+ Hyperactive without clonus
4+ Hyperactive with clonus

Knee:
Right: [ ] 0 [ ] 1+ [X] 2+ [ ] 3+ [ ] 4+
Left: [ ] 0 [ ] 1+ [X] 2+ [ ] 3+ [ ] 4+

** THIS NOTE CONTINUED ON NEXT PAGE **

Ankle:
Right: [ ] 0 [ ] 1+ [X] 2+ [ ] 3+ [ ] 4+
Left: [ ] 0 [ ] 1+ [X] 2+ [ ] 3+ [ ] 4+

10. Sensory exam

Provide results for sensation to light touch (dermatome) testing:

Upper anterior thigh (L2):
Right: [X] Normal [ ] Decreased [ ] Absent
Left: [X] Normal [ ] Decreased [ ] Absent

Thigh/knee (L3/4):
Right: [X] Normal [ ] Decreased [ ] Absent
Left: [X] Normal [ ] Decreased [ ] Absent

Lower leg/ankle (L4/L5/S1):
Right: [X] Normal [ ] Decreased [ ] Absent
Left: [X] Normal [ ] Decreased [ ] Absent

Foot/toes (L5):
Right: [X] Normal [ ] Decreased [ ] Absent
Left: [X] Normal [ ] Decreased [ ] Absent

Other sensory findings, if any:

11. Straight leg raising test

(This test can be performed with the Veteran seated or supine. Raise each straightened leg until pain begins, typically at 30-70 degrees of elevation. The test is positive if the pain radiates below the knee, not merely in the back or hamstrings. Pain is often increased on dorsiflexion of the foot, and relieved by knee flexion. A positive test suggests radiculopathy, often due to disc herniation).

Provide straight leg raising test results:
Right: [X] Negative [ ] Positive [ ] Unable to perform
Left: [X] Negative [ ] Positive [ ] Unable to perform

12. Radiculopathy

Does the Veteran have radicular pain or any other signs or symptoms due to radiculopathy? [X] Yes [ ] No

If yes, complete the following section:

a. Indicate symptoms' location and severity (check all that apply):

Constant pain (may be excruciating at times)

** THIS NOTE CONTINUED ON NEXT PAGE **

Right lower extremity: [X] None [ ] Mild [ ] Moderate [ ] Severe
Left lower extremity: [X] None [ ] Mild [ ] Moderate [ ] Severe

Intermittent pain (usually dull)
Right lower extremity: [ ] None [ ] Mild [X] Moderate [ ] Severe
Left lower extremity: [ ] None [ ] Mild [X] Moderate [ ] Severe

Paresthesias and/or dysesthesias
Right lower extremity: [ ] None [ ] Mild [X] Moderate [ ] Severe
Left lower extremity: [ ] None [ ] Mild [X] Moderate [ ] Severe

Numbness
Right lower extremity: [X] None [ ] Mild [ ] Moderate [ ] Severe
Left lower extremity: [X] None [ ] Mild [ ] Moderate [ ] Severe

b. Does the Veteran have any other signs or symptoms of radiculopathy?
[ ] Yes [X] No

If yes, describe:

c. Indicate nerve roots involved: (check all that apply)

[ ] Involvement of L2/L3L/L4 nerve roots (femoral nerve)

If checked, indicate: [ ] Right [ ] Left [ ] Both

[X] Involvement of L4/L5/S1/S2/S3 nerve roots (sciatic nerve)

If checked, indicate: [ ] Right [ ] Left [X] Both

[ ] Other nerves (specify nerve and side(s) affected):

d. Indicate severity of radiculopathy and side affected:
Right: [ ] Not affected [X] Mild [ ] Moderate [ ] Severe
Left: [ ] Not affected [X] Mild [ ] Moderate [ ] Severe

13. Other neurologic abnormalities

Does the Veteran have any other neurologic abnormalities or findings related to a thoracolumbar spine (back) condition (such as bowel or bladder problems/pathologic reflexes)?
[ ] Yes [X] No

If yes, describe condition and how it is related:

If there are neurological abnormalities other than radiculopathy, also complete appropriate Questionnaire for each condition identified.

14. Intervertebral disc syndrome (IVDS) and incapacitating episodes

** THIS NOTE CONTINUED ON NEXT PAGE **

a. Does the Veteran have IVDS of the thoracolumbar spine?
[X] Yes [ ] No

b. If yes, has the Veteran had any incapacitating episodes over the past 12 months due to IVDS? [ ] Yes [X] No

NOTE: For VA purposes, an incapacitating episode is a period of acute symptoms severe enough to require prescribed bed rest and treatment by a physician.

If yes, provide the total duration of all incapacitating episodes over the past 12 months:
[ ] Less than 1 week
[ ] At least 1 week but less than 2 weeks
[ ] At least 2 weeks but less than 4 weeks
[ ] At least 4 weeks but less than 6 weeks
[ ] At least 6 weeks

15. Assistive devices

a. Does the Veteran use any assistive device(s) as a normal mode of locomotion, although occasional locomotion by other methods may be possible?
[ ] Yes [X] No

If yes, identify assistive device(s) used (check all that apply and indicate frequency):

Assistive Device:	Frequency of use:		
[ ] Wheelchair	[ ] Occasional	[ ] Regular	[ ] Constant
[ ] Brace(s)	[ ] Occasional	[ ] Regular	[ ] Constant
[ ] Crutch(es)	[ ] Occasional	[ ] Regular	[ ] Constant
[ ] Cane(s)	[ ] Occasional	[ ] Regular	[ ] Constant
[ ] Walker	[ ] Occasional	[ ] Regular	[ ] Constant
[ ] Other:			
	[ ] Occasional	[ ] Regular	[ ] Constant

b. If the Veteran uses any assistive devices, specify the condition and identify the assistive device used for each condition:

16. Remaining effective function of the extremities

Due to a thoracolumbar spine (back) condition, is there functional impairment of an extremity such that no effective function remains other than that which would be equally well served by an amputation with prosthesis? (Functions of the upper extremity include grasping, manipulation, etc.; functions of the lower extremity include balance and propulsion, etc.)

[ ] Yes, functioning is so diminished that amputation with prosthesis would

** THIS NOTE CONTINUED ON NEXT PAGE **

equally serve the Veteran.
[X] No

If yes, indicate extremity(ies) (check all extremities for which this applies):
[ ] Right lower
[ ] Left lower

17. Other pertinent physical findings, complications, conditions, signs and/or symptoms

a. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any conditions listed in the Diagnosis section above?
[ ] Yes [X] No

If yes, are any of the scars painful and/or unstable, or is the total area of all related scars greater than 39 square cm (6 square inches)?
[ ] Yes [ ] No

If yes, also complete a Scars Questionnaire.

b. Does the Veteran have any other pertinent physical findings, complications, conditions, signs or symptoms?
[ ] Yes [X] No

If yes, describe (brief summary):

18. Diagnostic testing

The diagnosis of arthritis must be confirmed by imaging studies. Once arthritis has been documented, no further imaging studies are required by VA, even if arthritis has worsened.

Imaging studies are not required to make the diagnosis of IVDS; Electromyography (EMG) studies are rarely required to diagnose radiculopathy in the appropriate clinical setting.

For purposes of this examination, the diagnosis of IVDS and/or radiculopathy can be made by a history of characteristic radiating pain and/or sensory changes in the legs, and objective clinical findings, which may include the asymmetrical loss or decrease of reflexes, decreased strength and/or abnormal sensation.

a. Have imaging studies of the thoracolumbar spine been performed and are the results available?
[X] Yes [ ] No

If yes, is arthritis documented?
[X] Yes [ ] No

** THIS NOTE CONTINUED ON NEXT PAGE **

MEDICAL RECORD Progress Notes

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b. Does the Veteran have a vertebral fracture?
[ ] Yes [X] No

If yes, provide percent of loss of vertebral body:

c. Are there any other significant diagnostic test findings and/or results?
[X] Yes [ ] No

If yes, provide type of test or procedure, date and results (brief summary):
Impression:

At L4-L5, moderate to severe spinal canal stenosis is present secondary to disc bulge and thickened ligamentum flavum.

At L2-L3, moderate spinal canal narrowing is present secondary to
disc bulge.

Primary Diagnostic Code:

Primary Interpreting Staff:
RAMON R DE GUZMAN, NEURORADIOLOGIST (Verifier)
/RRD
Report:
Clinical Information: Back pain.

Procedure: 3 views of the lumbar spine were obtained.

Findings: There is slight scoliosis convex toward the left.

There is no fracture or disc space narrowing.

There is minimal anterior osteophytic spurring at all lumbar levels.

The bones are well mineralized. There is facet hypertrophy at L4
and L5. There is a calcification within the right upper quadrant
of the abdomen which likely represents a gallstone.

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FRANCWAY,ERNEST L JR CLEVELAND VAMC Printed:04/30/2012 13:20
[redacted] /1950 Pt Loc: OUTPATIENT Vice SF 509

04/28/2012 09:00 ** CONTINUED FROM PREVIOUS PAGE **

Impression:

Degenerative change and scoliosis.

Primary Diagnostic Code:

Primary Interpreting Staff:
ALISON P. PRYCE, RADIOLOGIST (Verifier)
/APP

19. Functional impact

Does the Veteran's thoracolumbar spine (back) condition impact on his or her ability to work?
[X] Yes [ ] No

If yes describe the impact of each of the Veteran's thoracolumbar spine (back) conditions providing one or more examples:
Veteran would not be able to do physical work to include repetitive bending, squating or climbing. This would not impair his ability for some type of sedentary employment.

20. Remarks, if any:

C-file has been reviewed. 2507 opinioin:CLAIMS FILE BEING SENT FOR REVIEW BY THE EXAMINER.

CLAIMS FILE BEING SENT FOR REVIEW BY THE EXAMINER.

THIS IS A COVA REMAND CASE.

The BVA instructions stated that the Veteran should be scheduled for an appropriate VA examination for an opinion as to whether there is at least a
50 percent probability or greater (at least as likely as not) that he has a
current low back disorder as a result of active service. Prior to the examination, the claims folder must be made available for review of the case.
A notation to the effect that this record review took place should be included in the report. A complete medical history concerning the claim should be solicited from the Veteran, to include any additional information
deemed necessary to clarify notations in the record of injuries incurred as a
result of motor vehicle accidents in 1964 (vol 3)and 1976 (vol 1) and treatment for back pain after lifting weights in March 1995. All the MVAs and
lifting weights are tabbed in yellow.

** THIS NOTE CONTINUED ON NEXT PAGE **

MEDICAL RECORD Progress Notes

04/28/2012 09:00 ** CONTINUED FROM PREVIOUS PAGE **

The instructions to include "any additional information deemed necessary to clarify notations in the record of injuries incurred as a result of motor vehicle accidents in 1964 and 1976 and treatment for back pain after lifting weights in March 1995" was not done.

Opinions should be provided based on the results of examination, a review of the lay and medical evidence of record, and sound medical principles. All examination findings, along with the complete rationale for all opinions expressed, should be set forth in the examination report. The veteran was not examined and complete rationale was not provided in the exam conducted on 12-5-11.

Dr. Steurer did an "exam" on 12-5-11. His medical history was indicated as: c-file reviewed, opinion given multiple times. His stenosis is not related to a strain in service but natural age progression. No exam is needed.

This is contrary to the Court's instructions and will cause another remand for not following the remand directives.

Another examination was schedule on 1-23-12. Dr. Schechter did a nice history from the file review but did not examine the veteran--"Due to the lack of evidence that the veteran's current back condition was caused by his in-service back strain, a back exam was not conducted."

Although that may be true, the U.S. Court of Appeals for Veterans Claims wants one. The Court also wants opinions provided be based on the results of examination, a review of the lay and medical evidence of record, and sound medical principles. All examination findings, along with the complete rationale for all opinions expressed, should be set forth in the examination report.

Unless we provide what they want, this is an error for not following the remand directives.

2507 opinion: There are no medical records of evidence from 1970-2004 to establish a nexus therefore it would be less likely than not that the

** THIS NOTE CONTINUED ON NEXT PAGE **

MEDICAL RECORD Progress Notes

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veteran's spinal stenosis is related to the injury he describes above. It would be more likely than not his spinal stenosis is related to natural age progression with consideration wear and tear throughout his life.

NOTE: VA may request additional medical information, including additional examinations if necessary to complete VA's review of the Veteran's application.

Signed by: /es/ PATRICK J HOPPERTON
PHYSICIAN ASSISTANT
04/30/2012 11:54

Report from: PARMA CBOC Station #541GL [redacted]

Imaging (local only) Page 1

FRANCWAY,ERNEST L JR [redacted] 1950 (62)

*** WORK COPY ONLY *** Printed: 04/30/2012 09:46

LUMBOSACRAL SPINE, 2 OR 3 VIEWS

Exm Date: APR 30, 2012@07:36
Req Phys: HOPPERTON,PATRICK J

Pat Loc: PRM C&P/GM/PAT HOPPERTON (Req'
Img Loc: PARMA DIAG
Service: Unknown

(Case 74 COMPLETE) LUMBOSACRAL SPINE, 2 OR 3 VIEWS (RAD Detailed) CPT:72100
Reason for Study: r/o arthritis

Clinical History:
[redacted]
WESTLAKE, OHIO 44145 (440)452-6298

Clinical History:

Report Status: Verified

Date Reported: APR 30, 2012
Date Verified: APR 30, 2012

Verifier E-Sig:/ES/ALISON P. PRYCE

Report:
Clinical Information: Back pain.

Procedure: 3 views of the lumbar spine were obtained.

Findings: There is slight scoliosis convex toward the left.

There is no fracture or disc space narrowing.

There is minimal anterior osteophytic spurring at all lumbar levels.

The bones are well mineralized. There is facet hypertrophy at L4 and L5. There is a calcification within the right upper quadrant of the abdomen which likely represents a gallstone.

Impression:

Degenerative change and scoliosis.

Primary Diagnostic Code:

Primary Interpreting Staff:
ALISON P. PRYCE, RADIOLOGIST (Verifier)
/APP

*** WORK COPY ONLY ***

COMPENSATION AND PENSION EXAM INQUIRY

Name: FRANCWAY,ERNEST L JR
SSN: [redacted]
C-Number:
DOB:
Address:
City,State,Zip+4: WESTLAKE, OHIO 44145
Country: UNITED STATES
Res Phone: (440)452-6298
Bus Phone:
Entered active service: AUG 23,1968
Released active service: MAY 13,1970

>>> Future C&P Appointments <<<

Requested exams currently on file:
DBQ BACK (THORACOLUMBAR SPINE) CONDITIONS
Requested on OCT 27,2011@12:44:40 by CLEVELAND-RO - Completed

DBQ BACK (THORACOLUMBAR SPINE) CONDITIONS
Requested on JAN 5,2012@11:13:25 by CLEVELAND-RO - Completed

DBQ BACK (THORACOLUMBAR SPINE) CONDITIONS
Requested on APR 13,2012@12:44:31 by VBA TIGER TEAM 324 - Open

DBQ MEDICAL OPINION 1
Requested on JAN 5,2012@11:13:25 by CLEVELAND-RO - Completed

DBQ MEDICAL OPINION 1
Requested on APR 13,2012@12:44:31 by VBA TIGER TEAM 324 - Open

DIGESTIVE CONDITIONS, MISCELLANEOUS
Requested on JUL 13,2007@14:01:30 by APPEALS MANAGEMENT CENTER - Completed

INITIAL EVALUATION FOR POST-TRAUMATIC STRESS DISORDER (PTSD)
Requested on JUL 13,2007@14:01:30 by APPEALS MANAGEMENT CENTER - Completed

SPINE
Requested on MAY 15,2006@09:04:58 by APPEALS MANAGEMENT CENTER - Completed

SPINE
Requested on JUL 13,2007@14:01:30 by APPEALS MANAGEMENT CENTER - Completed

STOMACH, DUODENUM AND PERITONEAL ADHESIONS
Requested on MAY 15,2006@09:04:58 by APPEALS MANAGEMENT CENTER - Completed

STOMACH, DUODENUM AND PERITONEAL ADHESIONS
Requested on JUL 13,2007@14:01:30 by APPEALS MANAGEMENT CENTER - Completed

This request was initiated on APR 13,2012 at 12:44:31

Requester: MAXWELL,SANDRA
Requesting Regional Office: VBA TIGER TEAM 324
VHA Division Processing Request: PARMA CBOC

Exams on this request:
DBQ BACK CONDITIONS
DBQ MEDICAL OPINION 1

** Status of request:
New

RATED DISABILITIES:
POST-TRAUMATIC STRESS DISORDER 30 %
Service-Connected? Yes DX Code: 9411
INGUINAL HERNIA 0 %
Service-Connected? Yes DX Code: 7338

Other Disabilities:

General Remarks:
CLAIMS FILE BEING SENT FOR REVIEW BY THE EXAMINER.

CLAIMS FILE BEING SENT FOR REVIEW BY THE EXAMINER.

THIS IS A COVA REMAND CASE.

The BVA instructions stated that the Veteran should be scheduled for an appropriate VA examination for an opinion as to whether there is at least a 50 percent probability or greater (at least as likely as not) that he has a current low back disorder as a result of active service. Prior to the examination, the claims folder must be made available for review of the case. A notation to the effect that this record review took place should be included in the report. A complete medical history concerning the claim should be solicited from the Veteran, to include any additional information deemed necessary to clarify notations in the record of injuries incurred as a result of motor vehicle accidents in 1964 (vol 3)and 1976 (vol 1) and treatment for back pain after lifting weights in March 1995. All the MVAs and lifting weights are tabbed in yellow.

The instructions to include "any additional information deemed necessary to clarify notations in the record of injuries incurred as a result of motor vehicle accidents in 1964 and 1976 and treatment for back pain after lifting weights in March 1995" was not done.

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Another examination was schedule on 1-23-12. Dr. Schechter did a nice history from the file review but did not examine the veteran--"Due to the lack of evidence that the veteran's current back condition was caused by his in-service back strain, a back exam was not conducted."

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Unless we provide what they want, this is an error for not following the remand directives.

Sandra J. Maxwell
Decision Review Officer
Cleveland Regional Office
216-522-3530, ext 3432

Requested by CLEVELAND-RO
Date Requested: JAN 5,2012@11:13:25

Name: FRANCWAY,ERNEST L JR SSN: [redacted] (F4221)

General remarks (continued):

be made available for review of the case. A notation to the effect that this record review took place should be included in the report. A complete medical history concerning the claim should be solicited from the Veteran, to include any additional information deemed necessary to clarify notations in the record of injuries incurred as a result of motor vehicle accidents in 1964 and 1976 and treatment for back pain after lifting weights in March 1995.

Opinions should be provided based on the results of examination, a review of the lay and medical evidence of record, and sound medical principles. All examination findings, along with the complete rationale for all opinions expressed, should be set forth in the examination report.

POA: Sean A. Ravin

Thank You,
Lisa Harper, VSR
216-522-3530 x3242

MEDICAL RECORD Progress Notes

NOTE DATED: 01/23/2012 08:30
LOCAL TITLE: C&P EXAMINATION NOTE
STANDARD TITLE: C & P EXAMINATION NOTE
VISIT: 01/23/2012 08:30 B C&P/SCHECHTER

Medical Opinion 1
Disability Benefits Questionnaire

Name of patient/Veteran: Ernest Francaway

Your patient is applying to the U.S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the Veteran's claim.

1. Definitions

Aggravation of preexisting nonservice-connected disabilities.
A preexisting injury or disease will be considered to have been aggravated by active military, naval, or air service, where there is an increase in disability during such service, unless there is a specific finding that the increase in disability is due to the natural progress of the disease.

Aggravation of nonservice-connected disabilities.
Any increase in severity of nonservice-connected disease or injury that is proximately due to or the result of a service-connected disease or injury, and not due to the natural progress of the nonservice-connected disease, will be service connected.

2. Restatement of requested opinion

a. Insert requested opinion from general remarks:

b. Indicate type of exam for which opinion has been requested (e.g. Skin Diseases):

3. Evidence review

Was the Veteran's VA claims file reviewed?
[X] Yes [ ] No

If yes, list any records that were reviewed but were not included in the Veteran's VA claims file:

If no, check all records reviewed:
[ ] Military service treatment records
[ ] Military service personnel records
[ ] Military enlistment examination
[ ] Military separation examination
[ ] Military post-deployment questionnaire
[ ] Department of Defense Form 214 Separation Documents
[ ] Veterans Health Administration medical records (VA treatment records)
[ ] Civilian medical records
[ ] Interviews with collateral witnesses (family and others who have known

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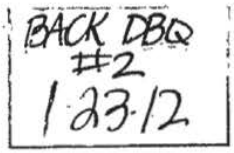
BACK DBQ
#2
1-23-12

the veteran before and after military service)
[ ] No records were reviewed
[ ] Other:

Complete only the sections below that you are asked to complete in the Medical Opinion DBQ request.

4. Medical opinion for direct service connection

Choose the statement that most closely approximates the etiology of the claimed condition.

a. [ ] The claimed condition was at least as likely as not (50 percent or greater probability) incurred in or caused by the claimed in-service injury, event, or illness. Provide rationale in section c.

b. [X] The claimed condition was less likely than not (less than 50 percent probability) incurred in or caused by the claimed in-service injury, event, or illness. Provide rationale in section c.

c. Rationale: In April 1969 the veteran states he had a lumbar strain at the same time that he got a hernia. On this occasion the veteran notes he was carrying wheel chalks, walking into the wind, and a gust of wind hit him from the side and turned him and the pain hit him in his back and stomach at the same time. After falling on the wheel chalks that punched him in the back and left him black and blue, he was carried to the sick bay on a stretcher and was put on light duty for three months. These facts are not documented in the available SMR which only note that he pulled muscle in the left side and had light duty (notes about length of light duty are not legible) . In 9 Dec 1969 SMRs read "Patient complains of low back pain R side. Given Darvon 65 mg, warm soaks to back, return to sick sick call a.m. 9 Dec 69. c/o same as above/low back pain: PE ROM limited with pain, no deformity, test for fracture negative, some pain upon rotations Rx. Parafin Forto 2. Return in AM." A note from 10 December states that he had a clutch slip nd had symptorms L5-S1 without radiationon also Right SI joint. Disp: light duty chit, ?therapy (daily) A-P lat lumbar spine, A-P pelvis Return 2 days for exam" The veteran states he complained of abdominal pain related to his hernia at thee same time but this was not recorded in the SMR. He also noted that he had recurrent back pain from the April incident. This was not in the SMR either.

The veteran was honorably discharged May 13, 1970 and there are no further records of the back issue. He notes that over the years he tolerated the pain and self medicated with aspirin.He began care at the Cleveland VA 10/4/02 for various orthopedic complaints (knee, shoulder) but expressed no

** THIS NOTE CONTINUED ON NEXT PAGE **

complaint of back pain until 1-11-05. Although at that time he claimed to have a h/o chronic back pain no such history was found in CPRS or the claims file. Although currently he has a spinal stenosis and DDD, it is less likely than not that these conditions are related to an acute back strain that occured more than 30 years prior to his next back complaint and even further from the time of a diagnosis of spinal stenosis. These issues were reviewed with the veteran and for these reasons, no back examination was performed. As I explained to the veteran: there is clear evidence of a back strain in the service and there is clear evidence of spinal stenosis and arthritis in the back currently. However, due to lack of sufficient evidence, I am unable to say that the initial injury noted in 1969 is likely to have caused the veteran's current condition.

5. Medical opinion for secondary service connection

a. [ ] The claimed condition is at least as likely as not (50 percent or greater probability) proximately due to or the result of the Veteran's service connected condition. Provide rationale in section c.

b. [ ] The claimed condition is less likely than not (less than 50 percent probability) proximately due to or the result of the Veteran's service connected condition. Provide rationale in section c.

c. Rationale:

6. Medical opinion for aggravation of a condition that existed prior to service

a. [ ] The claimed condition, which clearly and unmistakably existed prior to service, was aggravated beyond its natural progression by an in-service injury, event, or illness. Provide rationale in section c.

b. [ ] The claimed condition, which clearly and unmistakably existed prior to service, was clearly and unmistakably not aggravated beyond its natural progression by an in-service injury, event, or illness. Provide rationale in section c.

c. Rationale:

7. Medical opinion for aggravation of a nonservice connected condition by a service connected condition

a. Can you determine a baseline level of severity of (claimed condition/diagnosis) based upon medical evidence available prior to aggravation or the earliest medical evidence following aggravation by (service connected condition)?
[ ] Yes [ ] No

** THIS NOTE CONTINUED ON NEXT PAGE **

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If "Yes" to question 7a., answer the following:

i. Describe the baseline level of severity of (claimed condition/diagnosis) based upon medical evidence available prior to aggravation or the earliest medical evidence following aggravation by (service connected condition):

ii. Provide the date and nature of the medical evidence used to provide the baseline:

iii. Is the current severity of the (claimed condition/diagnosis) greater than the baseline?
[ ] Yes [ ] No

If yes, was the Veteran's (claimed condition/diagnosis) at least as likely as not aggravated beyond its natural progression by (insert "service connected condition")?
[ ] Yes (provide rationale in section b.)
[ ] No (provide rationale in section b.)

If "No" to question 7a., answer the following:

i. Provide rationale as to why a baseline cannot be established (e.g. medical evidence is not sufficient to support a determination of a baseline level of severity):

ii. Regardless of an established baseline, was the Veteran's (claimed condition/diagnosis) at least as likely as not aggravated beyond its natural progression by (insert "service connected condition")?
[ ] Yes (provide rationale in section b.)
[ ] No (provide rationale in section b.)

b. Provide rationale:

8. Opinion regarding conflicting medical evidence

I have reviewed the conflicting medical evidence and am providing the following opinion:

NOTE: VA may request additional medical information, including additional examinations if necessary to complete VA's review of the Veteran's application.

****

Back (Thoracolumbar Spine) Conditions
Disability Benefits Questionnaire
** THIS NOTE CONTINUED ON NEXT PAGE **

FRANCWAY,ERNEST L JR Brecksville Printed:01/26/2012 10:53
[redacted] /1950 Pt Loc: OUTPATIENT Vice SF 509
[redacted]

Name of patient/Veteran: Ernest Francaway

Your patient is applying to the U. S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the Veteran's claim.

1. Diagnosis

Does the Veteran now have or has he/she ever been diagnosed with a thoracolumbar spine (back) condition? [X] Yes [ ] No

If yes, provide only diagnoses that pertain to thoracolumbar spine (back) conditions:

Diagnosis #1: DDD
ICD code:
Date of diagnosis:

Diagnosis #2:
ICD code:
Date of diagnosis:

Diagnosis #3:
ICD code:
Date of diagnosis:

If there are additional diagnoses pertaining to thoracolumbar spine (back) conditions, list using above format:

2. Medical history

Describe the history (including onset and course) of the Veteran's thoracolumbar spine (back) condition (brief summary):

3. Flare-ups

Does the Veteran report that flare-ups impact the function of the thoracolumbar spine (back)? [ ] Yes [ ] No

If yes, document the Veteran's description of the impact of flare-ups in his or her own words:

4. Initial range of motion (ROM) measurements

Measure ROM with a goniometer, rounding each measurement to the nearest 5 degrees. During the measurements, observe the point at which painful motion begins, evidenced by visible behavior such as facial expression, wincing, etc. Report initial measurements below.

** THIS NOTE CONTINUED ON NEXT PAGE **

Following the initial assessment of ROM, perform repetitive-use testing. For VA purposes, repetitive-use testing must be included in all exams. The VA has determined that 3 repetitions of ROM (at minimum) can serve as a representative test of the effect of repetitive use. After the initial measurement, reassess ROM after 3 repetitions. Report post-test measurements in section 5.

a. Select where forward flexion ends (normal endpoint is 90):
[ ] 0 [ ] 5 [ ] 10 [ ] 15 [ ] 20 [ ] 25 [ ] 30
[ ] 35 [ ] 40 [ ] 45 [ ] 50 [ ] 55 [ ] 60 [ ] 65
[ ] 70 [ ] 75 [ ] 80 [ ] 85 [ ] 90 or greater

Select where objective evidence of painful motion begins:
[ ] No objective evidence of painful motion
[ ] 0 [ ] 5 [ ] 10 [ ] 15 [ ] 20 [ ] 25 [ ] 30
[ ] 35 [ ] 40 [ ] 45 [ ] 50 [ ] 55 [ ] 60 [ ] 65
[ ] 70 [ ] 75 [ ] 80 [ ] 85 [ ] 90 or greater

b. Select where extension ends (normal endpoint is 30):
[ ] 0 [ ] 5 [ ] 10 [ ] 15 [ ] 20 [ ] 25 [ ] 30 or greater

Select where objective evidence of painful motion begins:
[ ] No objective evidence of painful motion
[ ] 0 [ ] 5 [ ] 10 [ ] 15 [ ] 20 [ ] 25 [ ] 30 or greater

c. Select where right lateral flexion ends (normal endpoint is 30):
[ ] 0 [ ] 5 [ ] 10 [ ] 15 [ ] 20 [ ] 25 [ ] 30 or greater

Select where objective evidence of painful motion begins:
[ ] No objective evidence of painful motion
[ ] 0 [ ] 5 [ ] 10 [ ] 15 [ ] 20 [ ] 25 [ ] 30 or greater

d. Select where left lateral flexion ends (normal endpoint is 30):
[ ] 0 [ ] 5 [ ] 10 [ ] 15 [ ] 20 [ ] 25 [ ] 30 or greater

Select where objective evidence of painful motion begins:
[ ] No objective evidence of painful motion
[ ] 0 [ ] 5 [ ] 10 [ ] 15 [ ] 20 [ ] 25 [ ] 30 or greater

e. Select where right lateral rotation ends (normal endpoint is 30):
[ ] 0 [ ] 5 [ ] 10 [ ] 15 [ ] 20 [ ] 25 [ ] 30 or greater

Select where objective evidence of painful motion begins:
[ ] No objective evidence of painful motion
[ ] 0 [ ] 5 [ ] 10 [ ] 15 [ ] 20 [ ] 25 [ ] 30 or greater

f. Select where left lateral rotation ends (normal endpoint is 30):
[ ] 0 [ ] 5 [ ] 10 [ ] 15 [ ] 20 [ ] 25 [ ] 30 or greater

Select where objective evidence of painful motion begins:

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[ ] No objective evidence of painful motion
[ ] 0 [ ] 5 [ ] 10 [ ] 15 [ ] 20 [ ] 25 [ ] 30 or greater

g. If ROM for this Veteran does not conform to the normal range of motion identified above but is normal for this Veteran (for reasons other than a back condition, such as age, body habitus, neurologic disease), explain:

5. ROM measurements after repetitive use testing

a. Is the Veteran able to perform repetitive-use testing with 3 repetitions?
[ ] Yes [ ] No

If unable, provide reason:

If Veteran is unable to perform repetitive-use testing, skip to section 6.

If Veteran is able to perform repetitive-use testing, measure and report ROM after a minimum of 3 repetitions.

b. Select where post-test forward flexion ends:
[ ] 0 [ ] 5 [ ] 10 [ ] 15 [ ] 20 [ ] 25 [ ] 30
[ ] 35 [ ] 40 [ ] 45 [ ] 50 [ ] 55 [ ] 60 [ ] 65
[ ] 70 [ ] 75 [ ] 80 [ ] 85 [ ] 90 or greater

c. Select where post-test extension ends:
[ ] 0 [ ] 5 [ ] 10 [ ] 15 [ ] 20 [ ] 25 [ ] 30 or greater

d. Select where post-test right lateral flexion ends:
[ ] 0 [ ] 5 [ ] 10 [ ] 15 [ ] 20 [ ] 25 [ ] 30 or greater

e. Select where post-test left lateral flexion ends:
[ ] 0 [ ] 5 [ ] 10 [ ] 15 [ ] 20 [ ] 25 [ ] 30 or greater

f. Select where post-test right lateral rotation ends:
[ ] 0 [ ] 5 [ ] 10 [ ] 15 [ ] 20 [ ] 25 [ ] 30 or greater

g. Select where post-test left lateral rotation ends:
[ ] 0 [ ] 5 [ ] 10 [ ] 15 [ ] 20 [ ] 25 [ ] 30 or greater

6. Functional loss and additional limitation in ROM

The following section addresses reasons for functional loss, if present, and additional loss of ROM after repetitive-use testing, if present. The VA defines functional loss as the inability to perform normal working movements of the body with normal excursion, strength, speed, coordination and/or endurance.

a. Does the Veteran have additional limitation in ROM of the thoracolumbar spine (back) following repetitive-use testing?
[ ] Yes [ ] No

** THIS NOTE CONTINUED ON NEXT PAGE **

b. Does the Veteran have any functional loss and/or functional impairment of the thoracolumbar spine (back)?
[ ] Yes [ ] No

c. If the Veteran has functional loss, functional impairment and/or additional limitation of ROM of the thoracolumbar spine (back) after repetitive use, indicate the contributing factors of disability below:

[ ] Less movement than normal
[ ] More movement than normal
[ ] Weakened movement
[ ] Excess fatigability
[ ] Incoordination, impaired ability to execute skilled movements smoothly
[ ] Pain on movement
[ ] Swelling
[ ] Deformity
[ ] Atrophy of disuse
[ ] Instability of station
[ ] Disturbance of locomotion
[ ] Interference with sitting, standing and/or weight-bearing
[ ] Other, describe:

7. Pain and muscle spasm (pain on palpation, effect of muscle spasm on gait)

a. Does the Veteran have localized tenderness or pain to palpation for joints and/or soft tissue of the thoracolumbar spine (back)?
[ ] Yes [ ] No

If yes, describe:

b. Does the Veteran have guarding or muscle spasm of the thoracolumbar spine (back)? [ ] Yes [ ] No

If yes, is it severe enough to result in: (check all that apply)
[ ] Abnormal gait
[ ] Abnormal spinal contour, such as scoliosis, reversed lordosis, or abnormal kyphosis
[ ] Guarding and/or muscle spasm is present, but do not result in abnormal gait or spinal contour

8. Muscle strength testing

a. Rate strength according to the following scale:

0/5 No muscle movement
1/5 Palpable or visible muscle contraction, but no joint movement
2/5 Active movement with gravity eliminated
3/5 Active movement against gravity
4/5 Active movement against some resistance

** THIS NOTE CONTINUED ON NEXT PAGE **

5/5 Normal strength

Hip flexion:
Right: [ ] 5/5 [ ] 4/5 [ ] 3/5 [ ] 2/5 [ ] 1/5 [ ] 0/5
Left: [ ] 5/5 [ ] 4/5 [ ] 3/5 [ ] 2/5 [ ] 1/5 [ ] 0/5

Knee extension:
Right: [ ] 5/5 [ ] 4/5 [ ] 3/5 [ ] 2/5 [ ] 1/5 [ ] 0/5
Left: [ ] 5/5 [ ] 4/5 [ ] 3/5 [ ] 2/5 [ ] 1/5 [ ] 0/5

Ankle plantar flexion:
Right: [ ] 5/5 [ ] 4/5 [ ] 3/5 [ ] 2/5 [ ] 1/5 [ ] 0/5
Left: [ ] 5/5 [ ] 4/5 [ ] 3/5 [ ] 2/5 [ ] 1/5 [ ] 0/5

Ankle dorsiflexion:
Right: [ ] 5/5 [ ] 4/5 [ ] 3/5 [ ] 2/5 [ ] 1/5 [ ] 0/5
Left: [ ] 5/5 [ ] 4/5 [ ] 3/5 [ ] 2/5 [ ] 1/5 [ ] 0/5

Great toe extension:
Right: [ ] 5/5 [ ] 4/5 [ ] 3/5 [ ] 2/5 [ ] 1/5 [ ] 0/5
Left: [ ] 5/5 [ ] 4/5 [ ] 3/5 [ ] 2/5 [ ] 1/5 [ ] 0/5

b. Does the Veteran have muscle atrophy?
[ ] Yes [ ] No

If muscle atrophy is present, indicate location:

Provide measurements in centimeters of normal side and atrophied side, measured at maximum muscle bulk:

Normal side: cm. Atrophied side: cm.

9. Reflex exam

Rate deep tendon reflexes (DTRs) according to the following scale:

0 Absent
1+ Hypoactive
2+ Normal
3+ Hyperactive without clonus
4+ Hyperactive with clonus

Knee:
Right: [ ] 0 [ ] 1+ [ ] 2+ [ ] 3+ [ ] 4+
Left: [ ] 0 [ ] 1+ [ ] 2+ [ ] 3+ [ ] 4+

Ankle:
Right: [ ] 0 [ ] 1+ [ ] 2+ [ ] 3+ [ ] 4+
Left: [ ] 0 [ ] 1+ [ ] 2+ [ ] 3+ [ ] 4+

** THIS NOTE CONTINUED ON NEXT PAGE **

10. Sensory exam

Provide results for sensation to light touch (dermatomes) testing:

Upper anterior thigh (L2):
Right: [ ] Normal [ ] Decreased [ ] Absent
Left: [ ] Normal [ ] Decreased [ ] Absent

Thigh/knee (L3/4):
Right: [ ] Normal [ ] Decreased [ ] Absent
Left: [ ] Normal [ ] Decreased [ ] Absent

Lower leg/ankle (L4/L5/S1):
Right: [ ] Normal [ ] Decreased [ ] Absent
Left: [ ] Normal [ ] Decreased [ ] Absent

Foot/toes (L5):
Right: [ ] Normal [ ] Decreased [ ] Absent
Left: [ ] Normal [ ] Decreased [ ] Absent

Other sensory findings, if any:

11. Straight leg raising test

(This test can be performed with the Veteran seated or supine. Raise each straightened leg until pain begins, typically at 30-70 degrees of elevation. The test is positive if the pain radiates below the knee, not merely in the back or hamstrings. Pain is often increased on dorsiflexion of the foot, and relieved by knee flexion. A positive test suggests radiculopathy, often due to disc herniation).

Provide straight leg raising test results:
Right: [ ] Negative [ ] Positive [ ] Unable to perform
Left: [ ] Negative [ ] Positive [ ] Unable to perform

12. Radiculopathy

Does the Veteran have radicular pain or any other signs or symptoms due to radiculopathy? [ ] Yes [ ] No

If yes, complete the following section:

a. Indicate symptoms' location and severity (check all that apply):

Constant pain (may be excruciating at times)
Right lower extremity: [ ] None [ ] Mild [ ] Moderate [ ] Severe
Left lower extremity: [ ] None [ ] Mild [ ] Moderate [ ] Severe

Intermittent pain (usually dull)
Right lower extremity: [ ] None [ ] Mild [ ] Moderate [ ] Severe

** THIS NOTE CONTINUED ON NEXT PAGE **

Left lower extremity: [ ] None [ ] Mild [ ] Moderate [ ] Severe

Paresthesias and/or dysesthesias
Right lower extremity: [ ] None [ ] Mild [ ] Moderate [ ] Severe
Left lower extremity: [ ] None [ ] Mild [ ] Moderate [ ] Severe

Numbness
Right lower extremity: [ ] None [ ] Mild [ ] Moderate [ ] Severe
Left lower extremity: [ ] None [ ] Mild [ ] Moderate [ ] Severe

b. Does the Veteran have any other signs or symptoms of radiculopathy?
[ ] Yes [ ] No

If yes, describe:

c. Indicate nerve roots involved: (check all that apply)

[ ] Involvement of L2/L3L/L4 nerve roots (femoral nerve)

If checked, indicate: [ ] Right [ ] Left [ ] Both

[ ] Involvement of L4/L5/S1/S2/S3 nerve roots (sciatic nerve)

If checked, indicate: [ ] Right [ ] Left [ ] Both

[ ] Other nerves (specify nerve and side(s) affected):

d. Indicate severity of radiculopathy and side affected:
Right: [ ] Not affected [ ] Mild [ ] Moderate [ ] Severe
Left: [ ] Not affected [ ] Mild [ ] Moderate [ ] Severe

13. Other neurologic abnormalities

Does the Veteran have any other neurologic abnormalities or findings related to a thoracolumbar spine (back) condition (such as bowel or bladder problems/pathologic reflexes)?
[ ] Yes [ ] No

If yes, describe condition and how it is related:

If there are neurological abnormalities other than radiculopathy, also complete appropriate Questionnaire for each condition identified.

14. Intervertebral disc syndrome (IVDS) and incapacitating episodes

a. Does the Veteran have IVDS of the thoracolumbar spine?
[ ] Yes [ ] No

b. If yes, has the Veteran had any incapacitating episodes over the past 12 months due to IVDS? [ ] Yes [ ] No

** THIS NOTE CONTINUED ON NEXT PAGE **

NOTE: For VA purposes, an incapacitating episode is a period of acute symptoms severe enough to require prescribed bed rest and treatment by a physician.

If yes, provide the total duration of all incapacitating episodes over the past 12 months:
[ ] Less than 1 week
[ ] At least 1 week but less than 2 weeks
[ ] At least 2 weeks but less than 4 weeks
[ ] At least 4 weeks but less than 6 weeks
[ ] At least 6 weeks

15. Assistive devices

a. Does the Veteran use any assistive device(s) as a normal mode of locomotion, although occasional locomotion by other methods may be possible?
[ ] Yes [ ] No

If yes, identify assistive device(s) used (check all that apply and indicate frequency):

Assistive Device:	Frequency of use:		
[ ] Wheelchair	[ ] Occasional	[ ] Regular	[ ] Constant
[ ] Brace(s)	[ ] Occasional	[ ] Regular	[ ] Constant
[ ] Crutch(es)	[ ] Occasional	[ ] Regular	[ ] Constant
[ ] Cane(s)	[ ] Occasional	[ ] Regular	[ ] Constant
[ ] Walker	[ ] Occasional	[ ] Regular	[ ] Constant
[ ] Other:			
	[ ] Occasional	[ ] Regular	[ ] Constant

b. If the Veteran uses any assistive devices, specify the condition and identify the assistive device used for each condition:

16. Remaining effective function of the extremities

Due to a thoracolumbar spine (back) condition, is there functional impairment of an extremity such that no effective function remains other than that which would be equally well served by an amputation with prosthesis? (Functions of the upper extremity include grasping, manipulation, etc.; functions of the lower extremity include balance and propulsion, etc.)

[ ] Yes, functioning is so diminished that amputation with prosthesis would equally serve the Veteran.
[ ] No

If yes, indicate extremity(ies) (check all extremities for which this applies):

** THIS NOTE CONTINUED ON NEXT PAGE **

[ ] Right lower
[ ] Left lower

17. Other pertinent physical findings, complications, conditions, signs and/or symptoms

a. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any conditions listed in the Diagnosis section above?
[ ] Yes [ ] No

If yes, are any of the scars painful and/or unstable, or is the total area of all related scars greater than 39 square cm (6 square inches)?
[ ] Yes [ ] No

If yes, also complete a Scars Questionnaire.

b. Does the Veteran have any other pertinent physical findings, complications, conditions, signs or symptoms?
[ ] Yes [ ] No

If yes, describe (brief summary):

18. Diagnostic testing

The diagnosis of arthritis must be confirmed by imaging studies. Once arthritis has been documented, no further imaging studies are required by VA, even if arthritis has worsened.

Imaging studies are not required to make the diagnosis of IVDS; Electromyography (EMG) studies are rarely required to diagnose radiculopathy in the appropriate clinical setting.

For purposes of this examination, the diagnosis of IVDS and/or radiculopathy can be made by a history of characteristic radiating pain and/or sensory changes in the legs, and objective clinical findings, which may include the asymmetrical loss or decrease of reflexes, decreased strength and/or abnormal sensation.

a. Have imaging studies of the thoracolumbar spine been performed and are the results available?
[ ] Yes [ ] No

If yes, is arthritis documented?
[ ] Yes [ ] No

b. Does the Veteran have a vertebral fracture?
[ ] Yes [ ] No

If yes, provide percent of loss of vertebral body:

** THIS NOTE CONTINUED ON NEXT PAGE **

c. Are there any other significant diagnostic test findings and/or results?
[ ] Yes [ ] No

If yes, provide type of test or procedure, date and results (brief summary):

19. Functional impact

Does the Veteran's thoracolumbar spine (back) condition impact his or her ability to work?
[ ] Yes [ ] No

If yes describe the impact of each of the Veteran's thoracolumbar spine (back) conditions providing one or more examples:

20. Remarks, if any:

Please see medical opinion. Due to the lack of evidence that the veteran's current back condition was caused by his in-service back strain, a back exam was not conducted.

NOTE: VA may request additional medical information, including additional examinations if necessary to complete VA's review of the Veteran's application.

Signed by: /es/ AMY B. SCHECHTER
M.D., INTERNIST
01/26/2012 10:48

MEDICAL RECORD Progress Notes

NOTE DATED: 12/05/2011 07:00
LOCAL TITLE: COMPENSATION & PENSION EXAMINATION
STANDARD TITLE: C & P EXAMINATION NOTE
VISIT: 12/05/2011 07:00 B C&P/STEURER

Back (Thoracolumbar Spine) Conditions
Disability Benefits Questionnaire

Name of patient/Veteran: Ernest Fancway

Your patient is applying to the U. S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the Veteran's claim.

1. Diagnosis

Does the Veteran now have or has he/she ever been diagnosed with a thoracolumbar spine (back) condition? [X] Yes [ ] No

If yes, provide only diagnoses that pertain to thoracolumbar spine (back) conditions:

Diagnosis #1: spinal stenosis
ICD code: 724.02
Date of diagnosis:

Diagnosis #2:
ICD code:
Date of diagnosis:

Diagnosis #3:
ICD code:
Date of diagnosis:

If there are additional diagnoses pertaining to thoracolumbar spine (back) conditions, list using above format:

2. Medical history

Describe the history (including onset and course) of the Veteran's thoracolumbar spine (back) condition (brief summary):
c-file reviewed, opinion given multiple times. His stenosis is not related to a strain in service but natural age progression. No exam is needed.

3. Flare-ups

Does the Veteran report that flare-ups impact the function of the thoracolumbar spine (back)? [ ] Yes [ ] No

If yes, document the Veteran's description of the impact of flare-ups in his or her own words:

4. Initial range of motion (ROM) measurements

** THIS NOTE CONTINUED ON NEXT PAGE **

BOCK DBQ
12-5-2011

Measure ROM with a goniometer, rounding each measurement to the nearest 5 degrees. During the measurements, observe the point at which painful motion begins, evidenced by visible behavior such as facial expression, wincing, etc. Report initial measurements below.

Following the initial assessment of ROM, perform repetitive-use testing. For VA purposes, repetitive-use testing must be included in all exams. The VA has determined that 3 repetitions of ROM (at minimum) can serve as a representative test of the effect of repetitive use. After the initial measurement, reassess ROM after 3 repetitions. Report post-test measurements in section 5.

a. Select where forward flexion ends (normal endpoint is 90):
[ ] 0 [ ] 5 [ ] 10 [ ] 15 [ ] 20 [ ] 25 [ ] 30
[ ] 35 [ ] 40 [ ] 45 [ ] 50 [ ] 55 [ ] 60 [ ] 65
[ ] 70 [ ] 75 [ ] 80 [ ] 85 [ ] 90 or greater

Select where objective evidence of painful motion begins:
[ ] No objective evidence of painful motion
[ ] 0 [ ] 5 [ ] 10 [ ] 15 [ ] 20 [ ] 25 [ ] 30
[ ] 35 [ ] 40 [ ] 45 [ ] 50 [ ] 55 [ ] 60 [ ] 65
[ ] 70 [ ] 75 [ ] 80 [ ] 85 [ ] 90 or greater

b. Select where extension ends (normal endpoint is 30):
[ ] 0 [ ] 5 [ ] 10 [ ] 15 [ ] 20 [ ] 25 [ ] 30 or greater

Select where objective evidence of painful motion begins:
[ ] No objective evidence of painful motion
[ ] 0 [ ] 5 [ ] 10 [ ] 15 [ ] 20 [ ] 25 [ ] 30 or greater

c. Select where right lateral flexion ends (normal endpoint is 30):
[ ] 0 [ ] 5 [ ] 10 [ ] 15 [ ] 20 [ ] 25 [ ] 30 or greater

Select where objective evidence of painful motion begins:
[ ] No objective evidence of painful motion
[ ] 0 [ ] 5 [ ] 10 [ ] 15 [ ] 20 [ ] 25 [ ] 30 or greater

d. Select where left lateral flexion ends (normal endpoint is 30):
[ ] 0 [ ] 5 [ ] 10 [ ] 15 [ ] 20 [ ] 25 [ ] 30 or greater

Select where objective evidence of painful motion begins:
[ ] No objective evidence of painful motion
[ ] 0 [ ] 5 [ ] 10 [ ] 15 [ ] 20 [ ] 25 [ ] 30 or greater

e. Select where right lateral rotation ends (normal endpoint is 30):
[ ] 0 [ ] 5 [ ] 10 [ ] 15 [ ] 20 [ ] 25 [ ] 30 or greater

Select where objective evidence of painful motion begins:
[ ] No objective evidence of painful motion
[ ] 0 [ ] 5 [ ] 10 [ ] 15 [ ] 20 [ ] 25 [ ] 30 or greater

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MEDICAL RECORD Progress Notes

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f. Select where left lateral rotation ends (normal endpoint is 30):
[ ] 0 [ ] 5 [ ] 10 [ ] 15 [ ] 20 [ ] 25 [ ] 30 or greater

Select where objective evidence of painful motion begins:
[ ] No objective evidence of painful motion
[ ] 0 [ ] 5 [ ] 10 [ ] 15 [ ] 20 [ ] 25 [ ] 30 or greater

g. If ROM for this Veteran does not conform to the normal range of motion identified above but is normal for this Veteran (for reasons other than a back condition, such as age, body habitus, neurologic disease), explain:

5. ROM measurements after repetitive use testing

a. Is the Veteran able to perform repetitive-use testing with 3 repetitions?
[ ] Yes [ ] No

If unable, provide reason:

If Veteran is unable to perform repetitive-use testing, skip to section 6.

If Veteran is able to perform repetitive-use testing, measure and report ROM after a minimum of 3 repetitions.

b. Select where post-test forward flexion ends:
[ ] 0 [ ] 5 [ ] 10 [ ] 15 [ ] 20 [ ] 25 [ ] 30
[ ] 35 [ ] 40 [ ] 45 [ ] 50 [ ] 55 [ ] 60 [ ] 65
[ ] 70 [ ] 75 [ ] 80 [ ] 85 [ ] 90 or greater

c. Select where post-test extension ends:
[ ] 0 [ ] 5 [ ] 10 [ ] 15 [ ] 20 [ ] 25 [ ] 30 or greater

d. Select where post-test right lateral flexion ends:
[ ] 0 [ ] 5 [ ] 10 [ ] 15 [ ] 20 [ ] 25 [ ] 30 or greater

e. Select where post-test left lateral flexion ends:
[ ] 0 [ ] 5 [ ] 10 [ ] 15 [ ] 20 [ ] 25 [ ] 30 or greater

f. Select where post-test right lateral rotation ends:
[ ] 0 [ ] 5 [ ] 10 [ ] 15 [ ] 20 [ ] 25 [ ] 30 or greater

g. Select where post-test left lateral rotation ends:
[ ] 0 [ ] 5 [ ] 10 [ ] 15 [ ] 20 [ ] 25 [ ] 30 or greater

6. Functional loss and additional limitation in ROM

The following section addresses reasons for functional loss, if present, and additional loss of ROM after repetitive-use testing, if present. The VA defines functional loss as the inability to perform normal working movements of the body with normal excursion, strength, speed, coordination and/or

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endurance.

a. Does the Veteran have additional limitation in ROM of the thoracolumbar spine (back) following repetitive-use testing?
[ ] Yes [ ] No

b. Does the Veteran have any functional loss and/or functional impairment of the thoracolumbar spine (back)?
[ ] Yes [ ] No

c. If the Veteran has functional loss, functional impairment and/or additional limitation of ROM of the thoracolumbar spine (back) after repetitive use, indicate the contributing factors of disability below:

[ ] Less movement than normal
[ ] More movement than normal
[ ] Weakened movement
[ ] Excess fatigability
[ ] Incoordination, impaired ability to execute skilled movements smoothly
[ ] Pain on movement
[ ] Swelling
[ ] Deformity
[ ] Atrophy of disuse
[ ] Instability of station
[ ] Disturbance of locomotion
[ ] Interference with sitting, standing and/or weight-bearing
[ ] Other, describe:

7. Pain and muscle spasm (pain on palpation, effect of muscle spasm on gait)

a. Does the Veteran have localized tenderness or pain to palpation for joints and/or soft tissue of the thoracolumbar spine (back)?
[ ] Yes [ ] No

If yes, describe:

b. Does the Veteran have guarding or muscle spasm of the thoracolumbar spine (back)? [ ] Yes [ ] No

If yes, is it severe enough to result in: (check all that apply)
[ ] Abnormal gait
[ ] Abnormal spinal contour, such as scoliosis, reversed lordosis, or abnormal kyphosis
[ ] Guarding and/or muscle spasm is present, but do not result in abnormal gait or spinal contour

8. Muscle strength testing

a. Rate strength according to the following scale:

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FRANCWAY,ERNEST L JR Brecksville Printed:12/06/2011 12:01
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0/5 No muscle movement
1/5 Palpable or visible muscle contraction, but no joint movement
2/5 Active movement with gravity eliminated
3/5 Active movement against gravity
4/5 Active movement against some resistance
5/5 Normal strength

Hip flexion:
Right: [ ] 5/5 [ ] 4/5 [ ] 3/5 [ ] 2/5 [ ] 1/5 [ ] 0/5
Left: [ ] 5/5 [ ] 4/5 [ ] 3/5 [ ] 2/5 [ ] 1/5 [ ] 0/5

Knee extension:
Right: [ ] 5/5 [ ] 4/5 [ ] 3/5 [ ] 2/5 [ ] 1/5 [ ] 0/5
Left: [ ] 5/5 [ ] 4/5 [ ] 3/5 [ ] 2/5 [ ] 1/5 [ ] 0/5

Ankle plantar flexion:
Right: [ ] 5/5 [ ] 4/5 [ ] 3/5 [ ] 2/5 [ ] 1/5 [ ] 0/5
Left: [ ] 5/5 [ ] 4/5 [ ] 3/5 [ ] 2/5 [ ] 1/5 [ ] 0/5

Ankle dorsiflexion:
Right: [ ] 5/5 [ ] 4/5 [ ] 3/5 [ ] 2/5 [ ] 1/5 [ ] 0/5
Left: [ ] 5/5 [ ] 4/5 [ ] 3/5 [ ] 2/5 [ ] 1/5 [ ] 0/5

Great toe extension:
Right: [ ] 5/5 [ ] 4/5 [ ] 3/5 [ ] 2/5 [ ] 1/5 [ ] 0/5
Left: [ ] 5/5 [ ] 4/5 [ ] 3/5 [ ] 2/5 [ ] 1/5 [ ] 0/5

b. Does the Veteran have muscle atrophy?
[ ] Yes [ ] No

If muscle atrophy is present, indicate location:

Provide measurements in centimeters of normal side and atrophied side, measured at maximum muscle bulk:

Normal side: cm. Atrophied side: cm.

9. Reflex exam

Rate deep tendon reflexes (DTRs) according to the following scale:

0 Absent
1+ Hypoactive
2+ Normal
3+ Hyperactive without clonus
4+ Hyperactive with clonus

Knee:
Right: [ ] 0 [ ] 1+ [ ] 2+ [ ] 3+ [ ] 4+
Left: [ ] 0 [ ] 1+ [ ] 2+ [ ] 3+ [ ] 4+

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Ankle:
Right: [ ] 0 [ ] 1+ [ ] 2+ [ ] 3+ [ ] 4+
Left: [ ] 0 [ ] 1+ [ ] 2+ [ ] 3+ [ ] 4+

10. Sensory exam

Provide results for sensation to light touch (dermatomes) testing:

Upper anterior thigh (L2):
Right: [ ] Normal [ ] Decreased [ ] Absent
Left: [ ] Normal [ ] Decreased [ ] Absent

Thigh/knee (L3/4):
Right: [ ] Normal [ ] Decreased [ ] Absent
Left: [ ] Normal [ ] Decreased [ ] Absent

Lower leg/ankle (L4/L5/S1):
Right: [ ] Normal [ ] Decreased [ ] Absent
Left: [ ] Normal [ ] Decreased [ ] Absent

Foot/toes (L5):
Right: [ ] Normal [ ] Decreased [ ] Absent
Left: [ ] Normal [ ] Decreased [ ] Absent

Other sensory findings, if any:

11. Straight leg raising test

(This test can be performed with the Veteran seated or supine. Raise each straightened leg until pain begins, typically at 30-70 degrees of elevation. The test is positive if the pain radiates below the knee, not merely in the back or hamstrings. Pain is often increased on dorsiflexion of the foot, and relieved by knee flexion. A positive test suggests radiculopathy, often due to disc herniation).

Provide straight leg raising test results:
Right: [ ] Negative [ ] Positive [ ] Unable to perform
Left: [ ] Negative [ ] Positive [ ] Unable to perform

12. Radiculopathy

Does the Veteran have radicular pain or any other signs or symptoms due to radiculopathy? [ ] Yes [ ] No

If yes, complete the following section:

a. Indicate symptoms' location and severity (check all that apply):

Constant pain (may be excruciating at times)

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Right lower extremity: [ ] None [ ] Mild [ ] Moderate [ ] Severe
Left lower extremity: [ ] None [ ] Mild [ ] Moderate [ ] Severe

Intermittent pain (usually dull)
Right lower extremity: [ ] None [ ] Mild [ ] Moderate [ ] Severe
Left lower extremity: [ ] None [ ] Mild [ ] Moderate [ ] Severe

Paresthesias and/or dysesthesias
Right lower extremity: [ ] None [ ] Mild [ ] Moderate [ ] Severe
Left lower extremity: [ ] None [ ] Mild [ ] Moderate [ ] Severe

Numbness
Right lower extremity: [ ] None [ ] Mild [ ] Moderate [ ] Severe
Left lower extremity: [ ] None [ ] Mild [ ] Moderate [ ] Severe

b. Does the Veteran have any other signs or symptoms of radiculopathy?
[ ] Yes [ ] No

If yes, describe:

c. Indicate nerve roots involved: (check all that apply)

[ ] Involvement of L2/L3L/L4 nerve roots (femoral nerve)

If checked, indicate: [ ] Right [ ] Left [ ] Both

[ ] Involvement of L4/L5/S1/S2/S3 nerve roots (sciatic nerve)

If checked, indicate: [ ] Right [ ] Left [ ] Both

[ ] Other nerves (specify nerve and side(s) affected):

d. Indicate severity of radiculopathy and side affected:
Right: [ ] Not affected [ ] Mild [ ] Moderate [ ] Severe
Left: [ ] Not affected [ ] Mild [ ] Moderate [ ] Severe

13. Other neurologic abnormalities

Does the Veteran have any other neurologic abnormalities or findings related to a thoracolumbar spine (back) condition (such as bowel or bladder problems/pathologic reflexes)?
[ ] Yes [ ] No

If yes, describe condition and how it is related:

If there are neurological abnormalities other than radiculopathy, also complete appropriate Questionnaire for each condition identified.

14. Intervertebral disc syndrome (IVDS) and incapacitating episodes

** THIS NOTE CONTINUED ON NEXT PAGE **

a. Does the Veteran have IVDS of the thoracolumbar spine?
[ ] Yes [ ] No

b. If yes, has the Veteran had any incapacitating episodes over the past 12 months due to IVDS? [ ] Yes [ ] No

NOTE: For VA purposes, an incapacitating episode is a period of acute symptoms severe enough to require prescribed bed rest and treatment by a physician.

If yes, provide the total duration of all incapacitating episodes over the past 12 months:
[ ] Less than 1 week
[ ] At least 1 week but less than 2 weeks
[ ] At least 2 weeks but less than 4 weeks
[ ] At least 4 weeks but less than 6 weeks
[ ] At least 6 weeks

15. Assistive devices

a. Does the Veteran use any assistive device(s) as a normal mode of locomotion, although occasional locomotion by other methods may be possible?
[ ] Yes [ ] No

If yes, identify assistive device(s) used (check all that apply and indicate frequency):

Assistive Device:	Frequency of use:		
[ ] Wheelchair	[ ] Occasional	[ ] Regular	[ ] Constant
[ ] Brace(s)	[ ] Occasional	[ ] Regular	[ ] Constant
[ ] Crutch(es)	[ ] Occasional	[ ] Regular	[ ] Constant
[ ] Cane(s)	[ ] Occasional	[ ] Regular	[ ] Constant
[ ] Walker	[ ] Occasional	[ ] Regular	[ ] Constant
[ ] Other:			
	[ ] Occasional	[ ] Regular	[ ] Constant

b. If the Veteran uses any assistive devices, specify the condition and identify the assistive device used for each condition:

16. Remaining effective function of the extremities

Due to a thoracolumbar spine (back) condition, is there functional impairment of an extremity such that no effective function remains other than that which would be equally well served by an amputation with prosthesis? (Functions of the upper extremity include grasping, manipulation, etc.; functions of the lower extremity include balance and propulsion, etc.)

[ ] Yes, functioning is so diminished that amputation with prosthesis would

** THIS NOTE CONTINUED ON NEXT PAGE **

equally serve the Veteran.
[ ] No

If yes, indicate extremity(ies) (check all extremities for which this applies):
[ ] Right lower
[ ] Left lower

17. Other pertinent physical findings, complications, conditions, signs and/or symptoms

a. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any conditions listed in the Diagnosis section above?
[ ] Yes [ ] No

If yes, are any of the scars painful and/or unstable, or is the total area of all related scars greater than 39 square cm (6 square inches)?
[ ] Yes [ ] No

If yes, also complete a Scars Questionnaire.

b. Does the Veteran have any other pertinent physical findings, complications, conditions, signs or symptoms?
[ ] Yes [ ] No

If yes, describe (brief summary):

18. Diagnostic testing

The diagnosis of arthritis must be confirmed by imaging studies. Once arthritis has been documented, no further imaging studies are required by VA, even if arthritis has worsened.

Imaging studies are not required to make the diagnosis of IVDS; Electromyography (EMG) studies are rarely required to diagnose radiculopathy in the appropriate clinical setting.

For purposes of this examination, the diagnosis of IVDS and/or radiculopathy can be made by a history of characteristic radiating pain and/or sensory changes in the legs, and objective clinical findings, which may include the asymmetrical loss or decrease of reflexes, decreased strength and/or abnormal sensation.

a. Have imaging studies of the thoracolumbar spine been performed and are the results available?
[ ] Yes [ ] No

If yes, is arthritis documented?
[ ] Yes [ ] No

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MEDICAL RECORD Progress Notes

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b. Does the Veteran have a vertebral fracture?
[ ] Yes [ ] No

If yes, provide percent of loss of vertebral body:

c. Are there any other significant diagnostic test findings and/or results?
[ ] Yes [ ] No

If yes, provide type of test or procedure, date and results (brief summary):

19. Functional impact

Does the Veteran's thoracolumbar spine (back) condition impact his or her ability to work?
[ ] Yes [ ] No

If yes describe the impact of each of the Veteran's thoracolumbar spine (back) conditions providing one or more examples:

20. Remarks, if any:

After c-file review there is no change in opinion. His spinal sstenosis is less likely than not related to service but natural age progression.

NOTE: VA may request additional medical information, including additional examinations if necessary to complete VA's review of the Veteran's application.

Signed by: /es/ PAUL ANTHONY STEURER
ORTHOPEDIST
12/05/2011 07:18

FRANCWAY,ERNEST L JR [redacted] 1950 Brecksville Pt Loc: OUTPATIENT Printed:12/06/2011 12:01 Vice SF 509

DEPARTMENT OF VETERANS AFFAIRS
Board of Veterans' Appeals
Washington DC 20420

MAY 24 2011

[redacted]

ERNEST L FRANCWAY
[redacted]

Dear Appellant:

The Board of Veterans' Appeals has made a decision in this case, and a copy is enclosed. The records are being returned to the Department of Veterans Affairs office having jurisdiction over this matter.

Sincerely yours,

Bruce P. Gipe

Bruce P. Gipe
Director, Office of Management, Planning and Analysis

Enclosures (1)

cc: SEAN RAVIN
2800 Quebec Street, NW, 818
Washington, DC 20008

BOARD OF VETERANS' APPEALS
DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON, DC 20420

IN THE APPEAL OF
ERNEST L. FRANCWAY, JR.

[redacted]

DOCKET NO. 04-09 153) DATE MAY 24 2011
)
)

On appeal from the
Department of Veterans Affairs Regional Office in Cleveland, Ohio

THE ISSUE

Entitlement to service connection for a low back disorder.

REPRESENTATION

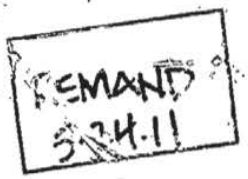
Appellant represented by: Sean A. Ravin, Attorney

WITNESS AT HEARING ON APPEAL

Appellant

ATTORNEY FOR THE BOARD

T. L. Douglas, Counsel


REMAND
5-24-11

IN THE APPEAL OF
ERNEST L. FRANCWAY, JR.

[redacted]

INTRODUCTION

The appellant is a Veteran who served on active duty from August 1968 to May 1970.

This matter comes before the Board of Veterans' Appeals (Board) by order of the United States Court of Appeals for Veterans Claims (hereinafter "the Court") on December 15, 2010, which vacated a May 2009 Board decision, in pertinent part, and remanded the issue on appeal for additional development. The issue initially arose from a May 2003 rating decision by the Cleveland, Ohio, Regional Office (RO) of the Department of Veterans Affairs (VA). In October 2005, the Veteran testified at a videoconference hearing before the undersigned Veterans Law Judge. A copy of the transcript of that hearing is of record.

The appeal is REMANDED to the Department of Veterans Affairs Regional Office. VA will notify the appellant if further action is required.

REMAND

A review of the record reveals that the Court, by incorporating the findings of a Joint Motion for Remand, found the Board in its May 2009 decision had not provided adequate reasons and bases in finding that VA had met its duty to assist in providing an examination or medical opinion. It was noted that the May 2006 and July 2007 VA examination reports indicating the Veteran's lumbosacral strain was due to a "natural occurring phenomenon" was, in essence, not accompanied by an adequate rationale. *See Barr v. Nicholson*, 21 Vet. App. 303, 312 (2007) (noting that when VA undertakes to provide a VA examination or obtain a VA opinion it must ensure that the examination or opinion is adequate). Therefore, additional development is required.

The Veterans Claims Assistance Act of 2000 (VCAA) describes VA's duty to notify and assist claimants in substantiating a claim for VA benefits. 38 U.S.C.A. §§ 5100, 5102, 5103, 5103A, 5107, 5126 (West 2002 & Supp. 2010); 38 C.F.R.

[redacted]

§§ 3.102, 3.156(a), 3.159, 3.326(a) (2010). The Court, in *Dingess v. Nicholson*, 19 Vet. App. 473 (2006), held that the VCAA notice requirements applied to all elements of a claim. The Veteran was notified of the VCAA duties to assist and of the information and evidence necessary to substantiate his claim by correspondence dated in July 2003 and July 2009.

The VCAA duty to assist requires that VA make reasonable efforts to assist the claimant in obtaining evidence necessary to substantiate a claim and in claims for disability compensation requires that VA provide medical examinations or obtain medical opinions when necessary for an adequate decision. 38 C.F.R. § 3.159. For records not in the custody of a Federal department or agency, reasonable efforts will generally consist of an initial request for the records and, if the records are not received, at least one follow-up request. 38 C.F.R. § 3.159(c)(1). For records in the custody of a Federal department or agency, VA must make as many requests as are necessary to obtain any relevant records, unless further efforts would be futile; however, the claimant must cooperate fully and, if requested, must provide enough information to identify and locate any existing records. 38 C.F.R. § 3.159(c)(2). VA has a duty to assist the veteran which includes conducting a thorough and contemporaneous medical examination. *See Hyder v. Derwinski*, 1 Vet. App. 221 (1991); *Green v. Derwinski*, 1 Vet. App. 121, 124 (1991).

In this case, a review of the record also reveals that during a July 2007 VA examination the Veteran reported that his claim for Social Security Administration (SSA) disability benefits had been denied. The Court has held that SSA decisions are not controlling for VA purposes, but they are pertinent to the adjudication of a claim for VA benefits and VA has a duty to assist the Veteran in gathering such records. *See Murincsak v. Derwinski*, 2 Vet. App. 363, 370-372 (1992). Where SSA disability benefits have been granted, a remand to obtain SSA records is required. *See Quartuccio v. Principi*, 16 Vet. App. 183, 187-88 (2002) (stating that "the possibility that the SSA records could contain relevant evidence . . . cannot be foreclosed absent a review of those records."). The Board finds that further development is required prior to appellate review.

IN THE APPEAL OF
ERNEST L. FRANCWAY, JR.

[redacted]

Accordingly, the case is REMANDED for the following action:

1. Appropriate efforts should be taken to obtain a complete copy of the Veteran's Social Security Administration benefit claim, as well as, all associated medical records.

2. The Veteran should be scheduled for an appropriate VA examination for an opinion as to whether there is at least a 50 percent probability or greater (*at least as likely as not*) that he has a current low back disorder as a result of active service. Prior to the examination, the claims folder must be made available for review of the case. A notation to the effect that this record review took place should be included in the report. A complete medical history concerning the claim should be solicited from the Veteran, to include any additional information deemed necessary to clarify notations in the record of injuries incurred as a result of motor vehicle accidents in 1964 and 1976 and treatment for back pain after lifting weights in March 1995.

Opinions should be provided based on the results of examination, a review of the lay and medical evidence of record, and sound medical principles. All examination findings, along with the complete rationale for all opinions expressed, should be set forth in the examination report.

3. After completion of the above and any additional development deemed necessary, the issue on appeal should be reviewed with appropriate consideration of all the evidence of record. If any benefit sought remains denied, the Veteran and his attorney should be

furnished a supplemental statement of the case and should be afforded the opportunity to respond. Thereafter, the case should be returned to the Board for appellate review.

The Veteran has the right to submit additional evidence and argument on the matter or matters the Board has remanded. *Kutscherousky v. West*, 12 Vet. App. 369 (1999).

This claim must be afforded expeditious treatment. The law requires that all claims that are remanded by the Board of Veterans' Appeals or by the United States Court of Appeals for Veterans Claims for additional development or other appropriate action must be handled in an expeditious manner. *See* 38 U.S.C.A. §§ 5109B, 7112 (West Supp. 2010).

S. L. Kennedy
Veterans Law Judge, Board of Veterans' Appeals

Under 38 U.S.C.A. § 7252 (West 2002), only a decision of the Board of Veterans' Appeals is appealable to the United States Court of Appeals for Veterans Claims. This remand is in the nature of a preliminary order and does not constitute a decision of the Board on the merits of your appeal. 38 C.F.R. § 20.1100(b) (2010).

IN THE UNITED STATES COURT OF APPEALS FOR VETERANS CLAIMS

ERNEST L. FRANCWAY, JR.,	)	
	)	
Appellant,	)	
	)	
v.	)	Vet.App. No. 09-3435
	)	
ERIC K. SHINSEKI, Secretary of Veterans Affairs,	)	
	)	
Appellee.	)	

JOINT MOTION FOR PARTIAL REMAND

Pursuant to U.S. Vet.App. R. 27 and 45(g)(2), Appellee, Eric K. Shinseki, Secretary of Veterans Affairs, and Appellant, Ernest L. Francway, through their respective attorneys, respectfully move the Court to vacate, in part, and remand the May 27, 2009, decision of the Board of Veterans' Appeals (BVA or Board) to the extent that it denied entitlement to service connection for a low back disorder. Record Before the Agency (R.) at 3-16. However, the parties respectfully request that the Court not disturb that part of the instant decision that granted entitlement to service connection for an abdominal disorder to include an inguinal hernia.

BASIS FOR REMAND

The parties agree that remand is warranted in this case because the Board did not provide an adequate statement of reasons or bases for its determinations.

In the decision now on appeal, the Board denied entitlement to service connection for a low back disorder because there was no evidence of nexus between Appellant's currently diagnosed low back disorder and his active military service. R. at 5. Although it is evident that the Board relied on the Department of Veterans Affairs (VA) examination reports of record in making its determination, it is unclear if the Board properly considered whether these VA examination reports were adequate for rating purposes. R. at 14-15, 95, 128.

Specifically, in the May 2006 and the July 2007 VA examinations, the examiner[1] diagnosed Appellant with lumbosacral strain and opined that the lumbosacral strain is "not likely" related to active military service, but, instead, that it is a result of "natural occurring phenomenon." R. at 95, 128. Yet, for the following reasons, it does not appear as though these medical opinions provided an adequate rationale to allow for a fully-informed decision by the Board. *See Stefl v. Nicholson,* 21 Vet.App. 120, 123 (2007) (a medical opinion is adequate "where it is based upon consideration of the veteran's prior medical history and examinations and also describes the disability, if any, in sufficient detail" so that the Board's evaluation of the disability will be a fully informed one).

First, it is unclear how the examiner reached this medical conclusion—opining that the lumbosacral strain is "not likely" related to

[1] The same VA examiner conducted both the May 2006 and the July 2007 VA examinations. R. at 95, 128.

active military service—when the medical history, as noted in the July 2007 VA examination report, reflects 1) low back strain in service, 2) that "over the years" Appellant has had "persistent back pain," and 3) that Appellant now has "a chronic back pain problem." R. at 95. A similar medical history was provided in the May 2006 VA examination report, and in both examination reports no intercurrent causes of the low back strain were noted or implied. R. at 95, 128. As such, both examination reports are unclear to the extent that the medical history, on its face, implies a medical link to service based on a continuation of symptomatology, while the resulting nexus opinion concludes that any medical link to service is "unlikely." *See Nieves-Rodriguez v. Peake*, 22 Vet.App. 295, 304 (2008) ("It is the factually accurate, fully articulated, sound reasoning for the conclusion, not the mere fact that the claims file was reviewed, that contributes probative value to a medical opinion"); *see D'Aries v. Peake,* 22 Vet.App. 97, 104 (2008) (a medical opinion is adequate when it is based upon the Veteran's medical history and examinations, and describes the disability in sufficient detail).

Secondly, the examiner's rationale for both medical opinions appear to be somewhat vague. Particularly, the examiner merely opined that the lumbosacral strain is a "natural occurring phenomenon." R. at 95, 128. Yet, it is, simply, unclear what it means for a lumbosacral strain to be a "natural occurring phenomenon." *Id.* Although the Board interpreted this

rationale to mean that "the Veteran's current back disorder naturally occurred over time," this is not explicit in either examination report and the examiner does not discuss age considerations, how a lumbosacral strain could, potentially, occur over time, or any other factors that would allow for such an interpretation. *Id.*; *See Daves v. Nicholson*, 21 Vet.App. 46, 51 (2007) (when medical examination reports were susceptible to multiple fair but inconsistent meanings, Board erred in failing to seek clarification). As a result, it is unclear whether the Board properly considered the adequacy of the May 2006 or the July 2007 VA examination reports.

It is well-established that the Board is required to include in its decision "a written statement of the reasons or bases for its findings and conclusions on all material issues of fact and law presented in the record;" that statement must be adequate to enable an appellant "to understand the precise basis for the Board's decision, as well as to facilitate informed judicial review in this Court." *See Allday v. Brown*, 7 Vet.App. 517, 527 (1995); *see also* 38 U.S.C. § 7104(d)(1).

Moreover, "decisions of the Board shall be based on the entire record in the proceeding and upon consideration of all evidence and material of record and applicable provisions of law and regulation." 38 U.S.C. § 7104(a); *see Majeed v. Principi,* 16 Vet.App. 421, 431 (2002). Deficiencies in the Board's analysis preclude effective judicial review, warranting remand. *See Simington v. West*, 11 Vet.App. 41, 45 (1998);

see also Meeks v. Brown, 5 Vet.App. 284, 288 (1993); *see also Gilbert v. Derwinski,* 1 Vet.App. 49, 57 (1990).

Therefore, because it is unclear whether the Board properly considered the adequacy of the May 2006 or the July 2007 VA examination reports, partial remand is warranted in this case for the Board to provide an adequate statement of reasons or bases for its determinations, fully considering the adequacy of these examination reports and whether clarification or a new VA examination is warranted.

Upon remand, Appellant may submit additional evidence and argument on the questions at issue, and BVA may "seek any other evidence it feels is necessary" to the timely resolution of the Appellant's claim. *Fletcher v. Derwinski*, 1 Vet.App. 394, 397 (1991); *see also Quarles v. Derwinski*, 3 Vet.App. 129, 141 (1992); *Kutcherousky v. West*, 12 Vet.App. 369 (1999). In any subsequent BVA decision, the Board should provide adequate reasons or bases for its findings and conclusions on all material issues of fact and law presented on the record. *See* 38 U.S.C. § 7104(d)(1); *see also Gilbert,* 1 Vet.App. at 57. A copy of this motion for remand should be associated with the claims folder along with a copy of the Order.

WHEREFORE, the parties respectfully request the Court to vacate in and remand that part of the May 27, 2009, Board decision that denied

Appellant's claim of entitlement to service connection for a low back disorder.

Respectfully submitted,

FOR APPELLANT:

DATE 12/3/10

/s/ Sean A. Ravin
SEAN A. RAVIN, ESQ.
2800 Quebec St., NW, # 818
Washington, DC 20008
202-607-5731

FOR APPELLEE:

WILL A. GUNN
General Counsel

R. RANDALL CAMPBELL
Assistant General Counsel

/s/ Nisha C. Wagle
NISHA C. WAGLE
Deputy Assistant General Counsel

DATE 12/3/10

/s/ Dustin P. Elias
DUSTIN P. ELIAS
Senior Appellate Attorney
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810 Vermont Avenue, N.W.
Washington, D.C. 20420
202-461-1319

DEPARTMENT OF VETERANS AFFAIRS
Board of Veterans' Appeals
Washington DC 20420

MAY 27 2009

[redacted]

ERNEST L FRANCWAY

[redacted]

Dear Appellant:

The Board of Veterans' Appeals has made a decision in this case, and a copy is enclosed. The records are being returned to the Department of Veterans Affairs office having jurisdiction over this matter.

Sincerely yours,

Gaynelle L. Davis
Chief, Decision Team Support Division
Office of Management, Planning
and Analysis

Enclosures (1)

cc: DAV

BOARD OF VETERANS' APPEALS
DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON, DC 20420

IN THE APPEAL OF
ERNEST L. FRANCWAY, JR.

[redacted]

DOCKET NO. 04-09 153) DATE MAY 27 2009
)
)

On appeal from the
Department of Veterans Affairs Regional Office in Cleveland, Ohio

THE ISSUES

1. Entitlement to service connection for an abdominal disorder to include an inguinal hernia.

2. Entitlement to service connection for a low back disorder.

REPRESENTATION

Appellant represented by: Disabled American Veterans

WITNESS AT HEARING ON APPEAL

Veteran

IN THE APPEAL OF
ERNEST L. FRANCWAY, JR.

[redacted]

ATTORNEY FOR THE BOARD

J. Connolly, Counsel

INTRODUCTION

The Veteran served on active duty from August 1968 to May 1970.

This matter comes before the Board of Veterans' Appeals (Board) on appeal from May 2003 and January 2004 rating decisions of the Department of Veterans Affairs (VA) Regional Office (RO) in Cleveland, Ohio. In October 2005, the Veteran testified at a video conference hearing before the undersigned. In January 2006, the Board remanded this case.

In an October 2007 statement, the Veteran clarified that he was seeking service connection for a left inguinal hernia, which was what he meant by a "stomach disorder."

FINDINGS OF FACT

1. A left inguinal hernia is attributable to service.

2. Currently diagnosed lumbosacral strain and minimal arthritis are not etiologically related to service.

CONCLUSIONS OF LAW

1. A left inguinal hernia was incurred in active service. 38 U.S.C.A. §§ 1101, 1110 (West 2002 & Supp. 2008); 38 C.F.R. §§ 3.303, 3.304 (2008).

2. A low back disorder, to include lumbosacral strain and minimal arthritis, was not incurred in or aggravated by service and arthritis may not be presumed to have been incurred or aggravated therein. 38 U.S.C.A. §§ 1101, 1110, 1112, 1113 (West 2002 & Supp. 2008); 38 C.F.R. §§ 3.303, 3.307, 3.309 (2008).

REASONS AND BASES FOR FINDINGS AND CONCLUSIONS

Veterans Claims Assistance Act of 2000 (VCAA)

With respect to the claimant's claim, VA has met all statutory and regulatory notice and duty to assist provisions. *See* 38 U.S.C.A. §§ 5100, 5102, 5103, 5103A, 5106, 5107, 5126; 38 C.F.R. §§ 3.102, 3.156(a), 3.159, 3.326.

Prior to the initial adjudication of the claimant's claim, a VCAA letter was sent in July 2003. Thereafter, an additional VCAA letter was sent in July 2006. Cumulatively, the VCAA letters fully satisfied the duty to notify provisions. 38 U.S.C.A. § 5103(a); 38 C.F.R. § 3.159(b)(1); *Quartuccio v. Principi*, 16 Vet. App. 183, 187 (2002). The claimant was aware that it was ultimately the claimant's responsibility to give VA any evidence pertaining to the claim. The VCAA letters told the claimant to provide any relevant evidence in the claimant's possession. *See Pelegrini v. Principi*, 18 Vet. App. 112, 120-21 (2004) (*Pelegrini II*).). In particular, the VCAA notification: (1) informed the claimant about the information and evidence not of record that is necessary to substantiate the claim; (2) informed the claimant about the information and evidence that VA will seek to provide; and (3) informed the claimant about the information and evidence that the claimant is expected to provide.

In any event, the Board finds that any deficiency in the notice to the claimant or the timing of these notices is harmless error. *See Overton v. Nicholson*, 20 Vet. App. 427, 435 (2006) (finding that the Board erred by relying on various post-decisional documents to conclude that adequate 38 U.S.C.A. § 5103(a) notice had been provided to the claimant, the United States Court of Appeals for Veterans Claims (Court) found that the evidence established that the claimant was afforded a

[redacted]

meaningful opportunity to participate in the adjudication of the claim, and found that the error was harmless, as the Board has done in this case.)

If any notice deficiency is present in this case, the Board finds that the presumption of prejudice on VA's part has been rebutted in this case by the following: (1) based on the communications sent to the claimant over the course of this appeal, the claimant clearly has actual knowledge of the evidence the claimant is required to submit in this case; and (2) based on the claimant's contentions as well as the communications provided to the claimant by VA, it is reasonable to expect that the claimant understands what was needed to prevail. *See Shinseki v. Sanders/Simmons*, No. 07-1209 (U.S. Sup. Ct. Apr. 21, 2009); 556 U.S. ____ (2009); *Fenstermacher v. Phila. Nat'l Bank,* 493 F.2d 333, 337 (3d Cir. 1974) ("[N]o error can be predicated on insufficiency of notice since its purpose had been served."). In order for the Court to be persuaded that no prejudice resulted from a notice error, "the record must demonstrate that, despite the error, the adjudication was nevertheless essentially fair." *Dunlap v. Nicholson*, 21 Vet. App. 112, 118 (2007).

VA also fulfilled its duty to obtain all relevant evidence with respect to the issue on appeal. 38 U.S.C.A. § 5103A; 38 C.F.R. § 3.159. The claimant's service treatment records, VA medical treatment records, and identified private medical records have been obtained, to the extent available. 38 U.S.C.A. § 5103A; 38 C.F.R. § 3.159. There is no indication in the record that any additional evidence, relevant to the issue decided herein, is available and not part of the claims file. The claimant was also afforded a VA examination. 38 C.F.R. § 3.159(c)(4). Although the Veteran's representative requested that the case be remanded for a medical expert opinion, the Board finds that the VA examination reports are adequate to render a decision as to each issue. The examiners reviewed the claims file, the pertinent history, and examined the claimant. The records satisfy 38 C.F.R. § 3.326.

The claimant was also sent information regarding the appropriate disability rating or effective date to be assigned in April 2009. *See Dingess/Hartman v. Nicholson*, 19 Vet. App. 473 (2006).

In summary, the Board finds that "it is difficult to discern what additional guidance VA could have provided to the veteran regarding what further evidence he should submit to substantiate his claim." *Conway v. Principi*, 353 F.3d 1369 (Fed. Cir. 2004); *see also Livesay v. Principi*, 15 Vet. App. 165, 178 (2001) (en banc) (observing that "the VCAA is a reason to remand many, many claims, but it is not an excuse to remand all claims."); *Reyes v. Brown*, 7 Vet. App. 113, 116 (1994); *Soyini v. Derwinski*, 1 Vet. App. 540, 546 (1991) (both observing circumstances as to when a remand would not result in any significant benefit to the claimant).

Competency and Credibility

The Veteran can attest to factual matters of which he had first-hand knowledge, e.g., experiencing pain in service, reporting to sick call, being placed on limited duty, and undergoing physical therapy. *See Washington v. Nicholson*, 19 Vet. App. 362, 368 (2005). However, the Veteran as a lay person has not been shown to be capable of making medical conclusions, thus, his statements regarding causation are not competent. *Espiritu v. Derwinski*, 2 Vet. App. 492, 495 (1992). Competent medical evidence means evidence provided by a person who is qualified through education, training or experience to offer medical diagnoses, statements or opinions. *See Duenas v. Principi*, 18 Vet. App. 512, 520 (2004). A layperson is generally not capable of opining on matters requiring medical knowledge. *Routen v. Brown*, 10 Vet. App. 183, 186 (1997); *see also Bostain v. West*, 11 Vet. App. 124, 127 (1998). Thus, while the Veteran is competent to report what comes to him through his senses, he does not have medical expertise. *See Layno v. Brown*, 6 Vet. App. 465 (1994).

However, the United States Court of Appeals for the Federal Circuit (Federal Circuit) has held that lay evidence is one type of evidence that must be considered and competent lay evidence can be sufficient in and of itself. The Board, however, retains the discretion to make credibility determinations and otherwise weigh the evidence submitted, including lay evidence. *See Buchanan v. Nicholson*, 451 F.3d 1331, 1335 (Fed. Cir. 2006). This would include weighing the absence of contemporary medical evidence against lay statements.

[redacted]

In *Barr v. Nicholson*, 21 Vet. App. 303 (2007), the Court indicated that varicose veins was a condition involving "veins that are unnaturally distended or abnormally swollen and tortuous." Such symptomatology, the Court concluded, was observable and identifiable by lay people. Because varicose veins "may be diagnosed by their unique and readily identifiable features, the presence of varicose veins was not a determination 'medical in nature' and was capable of lay observation." Thus, the veteran's lay testimony regarding varicose vein symptomatology in service represented competent evidence.

In *Jandreau v. Nicholson*, 492 F. 3d 1372 (Fed. Cir. 2007), the Federal Circuit determined that lay evidence can be competent and sufficient to establish a diagnosis of a condition when (1) a layperson is competent to identify the medical condition (noting that sometimes the layperson will be competent to identify the condition where the condition is simple, for example a broken leg, and sometimes not, for example, a form of cancer), (2) the layperson is reporting a contemporaneous medical diagnosis, or (3) lay testimony describing symptoms at the time supports a later diagnosis by a medical professional. The relevance of lay evidence is not limited to the third situation, but extends to the first two as well. Whether lay evidence is competent and sufficient in a particular case is a fact issue.

However, although the Veteran is competent in certain situations to provide a diagnosis of a simple condition such as a broken leg or varicose veins, the Veteran is not competent to provide evidence as to more complex medical questions. *See Woehlaert v. Nicholson*, 21 Vet. App. 456 (2007).

Once evidence is determined to be *competent,* the Board must determine whether such evidence is also *credible. See Layno, supra* (distinguishing between competency ("a legal concept determining whether testimony may be heard and considered") and credibility ("a factual determination going to the probative value of the evidence to be made after the evidence has been admitted")). *See Barr.*

The issues do not involve simple diagnoses. *See Jandreau*; *see also Woehlaert.* The Veteran is not competent to provide more than simple medical observations.

The current diagnoses may not be diagnosed via lay observation alone and the Veteran is not competent to provide a complex medical opinion regarding the etiology of the claimed disability. *See Barr*. Thus, the Veteran's lay assertions are not competent or sufficient.

Service Connection

Service connection may be granted for disability resulting from disease or injury incurred in or aggravated by service. 38 U.S.C.A. § 1110; 38 C.F.R. §§ 3.303, 3.304.

In addition, arthritis will be presumed to have been incurred in or aggravated by service if it had become manifest to a degree of 10 percent or more within one year of the veteran's separation from service. 38 U.S.C.A. §§ 1101, 1110, 1112, 1113; 38 C.F.R. §§ 3.307, 3.309. This presumption is rebuttable by affirmative evidence to the contrary. 38 U.S.C.A. §§ 1101, 1112, 1113, 1137; 38 C.F.R. §§ 3.307, 3.309.

Further, VA regulation provides that, with chronic disease shown as such in service (or within an applicable presumptive period under section 3.307) so as to permit a finding of service connection, subsequent manifestations of the same chronic disease at any later date, however remote, are service connected, unless clearly attributable to intercurrent causes. For the showing of chronic disease in service there is required a combination of manifestations sufficient to identify the disease entity, and sufficient observation to establish chronicity at the time, as distinguished from merely isolated findings or a diagnosis including the word "chronic." When the disease identity is established (leprosy, tuberculosis, multiple sclerosis, etc.), there is no requirement of an evidentiary showing of continuity. Continuity of symptomatology is required only where the condition noted during service (or in the presumptive period) is not, in fact, shown to be chronic or where the diagnosis of chronicity may be legitimately questioned. When the fact of chronicity in service is not adequately supported, then a showing of continuity after discharge is required to support the claim. 38 C.F.R. § 3.303(b).

In addition, service connection may be granted for any disease diagnosed after discharge, when all the evidence, including that pertinent to service, establishes that the disease was incurred in service. 38 C.F.R. § 3.303(d).

A claim for service connection generally requires competent evidence of a current disability; proof as to incurrence or aggravation of a disease or injury in service, as provided by either lay or medical evidence, as the situation dictates; and competent evidence as to a nexus between the inservice injury or disease and the current disability. *Cohen v. Brown*, 10 Vet. App. 128, 137 (1997); *Layno v. Brown*, 6 Vet. App. 465 (1994).

In determining whether service connection is warranted for a disability, VA is responsible for determining whether the evidence supports the claim or is in relative equipoise, with the veteran prevailing in either event, or whether a preponderance of the evidence is against the claim, in which case the claim is denied. *Gilbert v. Derwinski*, 1 Vet. App. 49 (1990). To do so, the Board must assess the credibility and weight of all the evidence, including the medical evidence, to determine its probative value, accounting for evidence that it finds to be persuasive or unpersuasive, and providing reasons for rejecting any evidence favorable to the appellant. *See Masors v. Derwinski*, 2 Vet. App. 181 (1992).

The service treatment records reflect that on his August 1968 entrance examination, it was noted that the Veteran had been in an automobile accident in 1966 and had a contused abdominal viscera with internal bleeding; it was further noted that it was a contused spleen with no trouble since.

On April 16. 1969, the Veteran was working on the flight deck and was lifting the pulley when he got a sharp pain in the left lower abdomen. The Veteran then complained of vomiting dark red-black blood and of being in severe pain. He was treated for a muscle sprain. Two days later, on April 18, 1969, the Veteran vomited a white solution. The next day, he complained of having sea sickness and was given compozine. In a separate note, it was indicated that the Veteran was admitted after he "fainted" on the flight deck and complained of being "sea sick." He was hospitalized for one day and was given fluid. The diagnosis was motion sickness.

IN THE APPEAL OF
ERNEST L. FRANCWAY, JR.

[redacted]

In September 1969, the Veteran complained of having an upset stomach. He reported that he had no appetite, was belching, and his stomach was growling. The impression was acidity. The diagnosis was Maalox.

In late November 1969, the Veteran was in an automobile accident. In December 1969, the Veteran complained of having low back pain on the right side. He was given Darvon and warm soaks were applied. Physical examination revealed that range of motion was limited by pain. There was no deformity or fracture. There was some pain on rotations. The Veteran was also provided Parafon Forte. The next day, it was noted that the Veteran had been in an automobile accident in November 1969. He currently had pain at L5-S1 and on the right side of S1. X-rays were taken, but are not of record.

In January 1970, the Veteran was seen for complaints of a stomachache. The Veteran reported that he had vomiting and diarrhea. Physical examination revealed no rebound and normal bowel sounds. He was told to force fluids and take Kaopectate.

In March 1978, the Veteran underwent a Nasal Reserve examination. His abdomen and viscera were normal. The spine and musculoskeletal system were normal. On his Report of Medical History, the Veteran stated that he did not have frequent indigestion, stomach trouble, or recurrent back pain.

Private records dated 1994-1995 reveal complaints of abdominal pain and complaints of back pain. With regard to the abdomen, the Veteran also complained of severe right flank pain in March 1995 which radiated to the right testicle. The diagnosis was right flank discomfort and hematuria, rule out possible nephrolithiasis.

Post-service, medical records dating from 2002 reflect VA treatment. An October 2002 evaluation reflects that the abdomen was protuberant, there were normal bowel sounds, no tenderness, no masses, and no organomegaly. A March 2003

evaluation revealed no musculoskeletal problems, other than the shoulder and knee, and no gastrointestinal complaints.

In May 2004, the Veteran complained of having back pain. He related that he had injured his back on a slight deck in 1969. The current diagnosis was acute or chronic lumbar back pain. The Veteran continued to report low back pain through August 2004. In addition, in June 2004, the Veteran reported that he had pain in the abdominal area which was burning and stabbing. It also felt numb. He related that this type of pain began in 1969. In July 2005, the Veteran reported having a "back cramp."

In October 2005, the Veteran testified at a video conference hearing. With regard to his back, the Veteran reported that he injured his back and stomach in April 1969 onboard a carrier. He related that he was on the flight deck, carrying about 4-5 chalks to lock the wheels on the aircraft. He was leaning in the wind and it was blowing hard and all of a sudden a big gust of wind hit him sideways and he left a stabbing pain in his back and he fell down. He related that he hurt his stomach and his back. He reported that he had big black and blue marks in his left side from falling down. He indicated that he was in sick bay for weeks and was on light duty for 3 months. He said that the diagnosis was muscle strain and he was given pain pills and an IV with "white stuff" in it. Recently, he indicated that he had been treated for muscle cramping in his back with occasional radiation down his legs. He related that he was also treated for stomach cramps and pains.

In May 2006, the Veteran was afforded a VA examination. It was noted that on entrance, it was noted that the Veteran had internal bleeding from the left side of the stomach in 1966. During service, in April 1969, the Veteran was seen for sharp lower abdominal pain as well as vomiting of dark red-black blood after an incident where he was lifting a pulley. He was treated for muscle sprain. The Veteran indicated that the service treatment records were inaccurate and that the incident did not involve a pulley, but involved carrying four wheel chalks. He stated that he fell and landed on the wheel chalks, "gouging" his stomach and back. Since that time, he related that he had suffered periodic severe cramping of the left side of the abdomen, flank, and back. The last episode was 2 weeks ago and lasted 45 minutes.

[redacted]

He described the cramps as being on the left side of his body and were more intense in the thoracic distribution, although they did at times radiate up as far as the scapula and down in the lumbar distribution. They were posterior, sometimes anterior, and sometimes both. More detailed descriptions of the cramping were noted and a physical examination was performed. In addition, x-rays of the lumbar and thoracic spine were taken which showed minimal arthritis. A computerized tomography (CT) of the abdomen was performed which resulted in the diagnoses of fatty liver, cholelithiasis; mild prostate enlargement; and small fat containing left inguinal hernia.

The examiner opined that the left inguinal hernia was as likely as not related to the inservice injury; however extensive back and abdominal cramping was less likely than not attributable to the hernia. The examiner stated that it was less likely than not that a stomach disorder was etiologically related to any event in service as there was no stomach disorder identified.

A different VA examiner performed a back examination which resulted in a diagnosis of lumbosacral strain and the examiner opined that it was not likely that his current back symptoms were related to a simple strain in 1969, but had occurred as a natural occurring phenomena.

In July 2007, the Veteran was afforded another VA stomach examination. The diagnosis was left inguinal hernia. In a July 2007 addendum, it was noted that there was no known stomach condition and that the Veteran's vague complaints of abdominal pain could not be related to the April 1969 medical record without resort to pure speculation.

In July 2007, the Veteran was afforded a VA spine examination which yielded a diagnosis of lumbosacral strain with minimal arthritis. The examiner stated that these diagnoses were not related to service, but were a natural occurring phenomenon.

Abdominal Disorder

As noted in the introductory portion of this decision, the Veteran has clarified that he is seeking service connection for a left inguinal hernia. The May 2006 and July 2007 VA examinations diagnosed the Veteran as having a left inguinal hernia. A VA examiner, after reviewing the claims file, referring to pertinent medical records and history, and examining the Veteran, concluded that the left inguinal hernia was etiologically related to service.

The Board may not base a decision on its own unsubstantiated medical conclusions but, rather, may reach a medical conclusion only on the basis of independent medical evidence in the record. *Hensley v. Brown*, 5 Vet. App. 155 (1993). Neither the Board nor the Veteran is competent to supplement the record with unsubstantiated medical conclusions. *Colvin v. Derwinski*, 1 Vet. App. 171, 175 (1991). Conversely, health professionals are experts and are presumed to know the requirements applicable to their practice and to have taken them into account in providing a diagnosis. *See Cohen*.

Accordingly, service connection for a left inguinal hernia is warranted.

Low Back Disorder

The Veteran was treated during service in December 1969 for low back pain. There is no documentation of any incident with regard to falling on wheel chalks. There are no other records of low back complaints, findings, treatment, or diagnosis. A Naval Reserve examination from approximately 9 years later revealed no complaints of recurrent back pain nor did the physical examination yield any low back findings or diagnosis. Rather, the records reflect that over 30 years after service separation, the Veteran has been treated for low back complaints and has been diagnosed as having lumbosacral strain and arthritis. The VA examiner, after reviewing the claims file and the pertinent history, and examining the Veteran, concluded that current diagnoses are not related to service. Rather, the examiner opined that the Veteran's current back disorder naturally occurred over time.

The Board finds that the VA examiner's opinion is competent as the examiner has the expertise to make a diagnosis and provide a medical opinion. In addition, the examiner's opinion is probative as it is well reasoned, detailed, consistent with other evidence of record, and included an access to the accurate background of the Veteran. *See Prejean v. West*, 13 Vet. App. 444, 448-9 (2000) (Factors for assessing the probative value of a medical opinion include the thoroughness and detail of the opinion.). Although it was noted in the VA records that the Veteran reported that he had low back pain since service, this notation is only a recording of the Veteran's contentions. As noted, the Veteran is not competent to make a complex medical assessment. The Board affords more probative value to the VA medical opinion as the examiner is able to make a complex medical assessment. In addition, the VA medical opinion is supported by the clinical findings which showed no back complaints or diagnoses about one decade after service separation and no complaints or diagnoses thereafter for decades.

Despite the Veteran's contentions that he had low back problems since service, the record is devoid of supporting evidence. In essence, the Veteran's assertions of chronicity and continuity are unsupported. *See Mense v. Derwinski*, 1 Vet. App. 354, 356 (1991) (normal medical findings at the time of separation from service, as well as absence of any medical records of a diagnosis or treatment for many years after service, is probative evidence against a claim.).

As noted, health professionals are experts and are presumed to know the requirements applicable to their practice and to have taken them into account in providing a diagnosis. *See Cohen*. Accordingly, service connection is not warranted.

The evidence in this case is not so evenly balanced so as to allow application of the benefit-of-the-doubt rule as required by law and VA regulations. 38 U.S.C.A. § 5107(b); 38 C.F.R. § 3.102. The preponderance is against the Veteran's claim, and it must be denied.

IN THE APPEAL OF
ERNEST L. FRANCWAY, JR.

[redacted]

ORDER

Service connection for a left inguinal hernia is granted.

Service connection for a low back disorder, to include lumbosacral strain and minimal arthritis, is denied.

S. L. Kennedy
Veterans Law Judge, Board of Veterans' Appeals

Jul 25,2007 11:00 B C&p/Gm/Birdsell Checked Out

FRANCWAY,ERNEST L [redacted] [redacted], 1950 (57)

*** WORK COPY ONLY *** Printed: Jul 31, 2007 08:38

vomiting dark red blood. Patient has severe pain.
-April 15, 1969 "c/o pulled muscle in left side"
-September 7, 1969 complains of upset stomach No appetite, belching and stomach" growling" impression acidity plan Maalox
-Report of Medical Examination August 9, 1968
"Contused abdominal viscera-no surgery from car accident in 1966"
Per previous C and P:
"internal bleeding from the left side of the stomach in 1966 at St. John's Hospital."
-Report of physical/medical examination March 4, 1978 no abdominal complaints and normal abdominal physical exam

E. DIAGNOSIS:
Left inguinal hernia, asymptomatic. Declines surgical intervention.

MTM099(072607)23454
$END

/es/ JOHN P BIRDSELL
PHYSICIAN ASSISTANT
Signed: 07/31/2007 06:47

Receipt Acknowledged By:
* AWAITING SIGNATURE * FLEMING,BARBARA J

07/30/2007 ADDENDUM STATUS: COMPLETED
OPINION: This veteran presently complains of a vague nonspecific abdominal pain. There is no known stomach condition. This veteran had multiple post service accidents-injuries. Veteran's reported medical examination dated March 4 1978 offered no abdominal complaints and had a normal abdominal physical exam. To state that this veteran's vague abdominal pain has any relationship to his previous injury April 16 1969 is impossible without resort to pure speculation.

/es/ BARBARA J FLEMING
ENDOCRINOLOGIST
Signed: 07/30/2007 19:14

End of report

Jul 25,2007 10:30 B C&p/Steurer Checked Out

FRANCWAY,ERNEST L [redacted] [redacted], 1950 (57)

*** WORK COPY ONLY *** Printed: Jul 27, 2007 09:39

LOCAL TITLE: COMPENSATION & PENSION EXAMINATION
STANDARD TITLE: C & P EXAMINATION NOTE
DATE OF NOTE: JUL 25, 2007@10:30 ENTRY DATE: JUL 26, 2007@12:31:44
AUTHOR: STEURER,PAUL ANTHON EXP COSIGNER:
URGENCY: STATUS: COMPLETED
SUBJECT: 179912

SPINE

REVIEW OF MEDICAL RECORDS: C-file was reviewed. My report from May of 2006 was reviewed where I had reviewed the C-file.

MEDICAL HISTORY:
1. This veteran has chronic back pain. He did have a strain in the service and over the years, he has had persistent back pain and now has some minimal arthritis by x-ray. He has a chronic back pain problem. He has aching, pains, soreness, and tenderness across his lumbar spine. No surgery has been done.
2. There is no radicular component to it.
3. He does not wear a back brace or use a cane.
4. He has been disabled due to a combination of other problems.
5. Exam of the back: He has some tenderness to palpation. No deformity noted. He could forward flex 80 degrees, extend 0 degrees, lateral flex to the right and left 25 degrees, and lateral rotate to the right and left 25 degrees with pain at the extremes of motion.
6. Repetitive use causes increasing soreness and tenderness. No change in range of motion in the office today.
7. Flare-ups do occur with repetitive use.
8. He has painful motion and some tenderness across the left side of the back.
9. Sensory and motor exam is intact.
10. No incapacitating episodes in the past year.
11. X-rays already document minimal arthritis. No new x-rays needed today.

FINAL DIAGNOSIS: Lumbosacral strain with minimal arthritis.

CONCLUSION: Relationship to service had already been made in my exam of 2006. It is not likely related, but rather a natural occurring phenomenon. Opinion has not changed.

MTM25(072607)23425
$END

/es/ PAUL ANTHONY STEURER
ORTHOPEDIST
Signed: 07/27/2007 06:53

End of report

Report from: BRECKSVILLE VANPH Station #541A0

LAB INTERIM (Jul 18, 2007 - Jul 26, 2007@23:59) Page 1

FRANCWAY,ERNEST L [redacted] [redacted],1950 (57)

*** WORK COPY ONLY *** Printed: 07/26/2007 08:50

Provider : BIRDSELL,JOHN P

Specimen: URINE. WUR 0725 181
07/25/2007 11:23

Test name	Result	units	Ref. range	Site Code
URINE PH	6.00		4.6 to 8.0	[541]
URINE COLOR	Yellow			[541]
URINE CLARITY	Clear		Clear	[541]
SPECIFIC GRAVITY	1.011 L		1.016 to 1.022	[541]
URINE PROTEIN	Negative	mg/dL	Neg.	[541]
URINE GLUCOSE	Negative	mg/dL	Neg.	[541]
URINE KETONES	Negative	mg/dL	Neg.	[541]
URINE BILIRUBIN	Negative		Neg.	[541]
UROBILINOGEN	Negative		Neg.	[541]
URINE BLOOD	Negative		Neg.	[541]
ESTERASE(WBC)	Negative		Neg.	[541]
NITRITE, URINE	Negative		Neg.	[541]

---- MICROBIOLOGY ----

Accession: MIC 07 16054 Received: Jul 25, 2007 11:23

Collection sample: URINE Collection date: Jul 25, 2007 11:23

Provider: BIRDSELL,JOHN P

Test(s) ordered: CULTURE & SUSCEPTIBILITY

Performing Lab Sites

[541] CLEVELAND VAMC
10701 EAST BLVD CLEVELAND, OH 44106

*** WORK COPY ONLY ***

Order Details - 33672629;1

FRANCWAY,ERNEST L [redacted] [redacted], 1950 (56)

*** WORK COPY ONLY *** Printed: May 31, 2006 15:14

CT ABDOMEN WITH & W/O CONTRAST

Activity:
05/24/2006 10:24 New Order entered by SCHECHTER,AMY B (INTERNIST)
Order Text: CT ABDOMEN WITH & W/O CONTRAST
Nature of Order: ELECTRONICALLY ENTERED
Elec Signature: SCHECHTER,AMY B (INTERNIST) on 05/24/2006 10:25

Current Data:
Treating Specialty:
Ordering Location: B C&P/SCHECHTER
Start Date/Time: 05/24/2006
Stop Date/Time:
Current Status: PENDING
Orders that have been placed but not yet accepted by the service filling the order. e.g., Pharmacy orders awaiting verification, Lab orders awaiting collection.
Order #33672629

Order:
Procedure: CT ABDOMEN WITH & W/O CONTRAST
History and Reason for Exam:

Please review chart for active DNR order.

Allergies: Patient has answered NKA

Reason for Exam: left sided abdominal and thoracic injury ~ 40 years ago.
Sicne then
severe periodic cramping of entire left side. On exam left side warmer than right from T4 and caudal, abd tender but not distended. While these symptoms are most likely from ddd/radicular pain would like to rule out splenic or visceral damage. Contrast at radioligist's discretion. Pt not taking metformin w/ nl renal fxn.
Category: OUTPATIENT
Ordering Location: B C&P/SCHECHTER
Date Desired: TODAY
Mode of Transport: AMBULATORY
Is patient on isolation procedures? NO
Urgency: ROUTINE
Submit request to: W CT SCAN

Clinical Indicators
Diagnosis of: 789.02 - ABDOM PAIN, L U QUADR
Order Checks:
HIGH: Procedure uses intravenous contrast media - no creatinine results within 180 days
Override: SCHECHTER,AMY B (INTERNIST) on 05/24/2006 10:25
...

End of report

May 24,2006 10:15 B C&p/Steurer Checked Out

FRANCWAY,ERNEST L [redacted] [redacted], 1950 (56)

*** WORK COPY ONLY *** Printed: May 26, 2006 08:58

TITLE: COMPENSATION & PENSION EXAMINATION
DATE OF NOTE: MAY 24, 2006@10:15 ENTRY DATE: MAY 25, 2006@12:43:20
AUTHOR: STEURER,PAUL ANTHONY EXP COSIGNER:
URGENCY: STATUS: COMPLETED
SUBJECT: 162235

SPINE AMI

REVIEW OF MEDICAL RECORDS: C-file was reviewed. C-file documents a sprain and strain to the back in 1969.

MEDICAL HISTORY:
1. This veteran sustained a straining injury back in 1969 to his back. It took about three months to go away. Over the years, he has had some intermittent episodes of back pain. About two years ago this got worse and he has been told now that he may have arthritis. He has arthritis in multiple other areas of his body as well. He gets pain, soreness, and tenderness strictly into the back itself.
2. No real radiation of pain with it.
3. He is not wearing a back brace. He does wear a brace on his left knee.
4. He has been on total disability and unable to work due to multiple comorbidities.
5. Examination of the back: He has tenderness and soreness to palpation. No increased kyphosis or scoliosis. He could only forward flex today 70 degrees, extend 0 degrees, lateral flex to the right and left 20 degrees, and lateral rotate to the right and left 20 degrees with pain throughout the range of motion.
6. According to Deluca, repetitive use does cause increased aches, pains, soreness, tenderness, and fatigability. No other change noted on office exam. Any of other range of motion change is speculative.
7. No other flare-ups noted.
8. He has painful motion and some muscle tenderness. No muscle spasms today.
9. Neurological examination is normal.
10. No incapacitating episodes in the past year.
11. An x-ray shows minimal arthritis.

FINAL DIAGNOSIS: Lumbosacral strain.

CONCLUSION: It is not likely his current back symptoms are related to a simple strain back in 1969, but rather a natural occurring phenomenon.

MTM25(052506)12534
$END

/es/ PAUL ANTHONY STEURER
ORTHOPEDIST
Signed: 05/26/2006 07:00

End of report

Report from: BRECKSVILLE VANPH Station #541A0

Imaging (local only) Page 1

FRANCWAY,ERNEST L [redacted] [redacted]3,1950 (56)

*** WORK COPY ONLY *** Printed: 05/24/2006 13:00

LUMBOSACRAL SPINE, 2 OR 3 VIEWS

Exm Date: MAY 24, 2006@10:35
Req Phys: STEURER,PAUL ANTHONY

Pat Loc: B C&P/STEURER (Req'g Loc)
Img Loc: BRECKSVILLE RADIOLOGY
Service: Unknown

(Case 1270 COMPLETE) LUMBOSACRAL SPINE, 2 OR 3 VIEWS (RAD Detailed) CPT:72100

Clinical History:
ROUTINE C&P RULE OUT ARTHRITIS

Report Status: Verified

Date Reported: MAY 24, 2006
Date Verified: MAY 24, 2006

Verifier E-Sig:/ES/MIGUEL M AVENIDO

Report:
No fracture or dislocation. No destructive bone changes. Minimal arthritis.

Impression:

Minimal arthritis.

Primary Diagnostic Code:

Primary Interpreting Staff:
MIGUEL M AVENIDO, RADIOLOGIST (Verifier)
/MMA

*** WORK COPY ONLY ***

BOARD OF VETERANS' APPEALS
DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON, DC 20420

IN THE APPEAL OF
ERNEST L. FRANCWAY, JR.

[redacted]

DOCKET NO. 04-09 153) DATE JAN 27 2006
)
)

On appeal from the
Department of Veterans Affairs Regional Office in Cleveland, Ohio

THE ISSUES

1. Entitlement to service connection for post-traumatic stress disorder (PTSD).

2. Entitlement to service connection for a stomach disorder.

3. Entitlement to service connection for a low back disorder.

REPRESENTATION

Appellant represented by: Disabled American Veterans

WITNESS AT HEARING ON APPEAL

Appellant

IN THE APPEAL OF [redacted]
ERNEST L. FRANCWAY, JR.

[redacted]

ATTORNEY FOR THE BOARD

Rhonda M. Kauf, Counsel

INTRODUCTION

The veteran served on active duty from August 1968 to May 1970. This matter comes before the Board of Veterans' Appeals (BVA or Board) on appeal from May 2003 and January 2004 rating decision of the Department of Veterans Affairs (VA) Regional Office (RO) in Cleveland, Ohio.

This appeal is REMANDED to the RO via the Appeals Management Center (AMC), in Washington, DC. VA will notify the veteran if further action is required on his part.

REMAND

The Board initially notes that for all claims now on appeal, the RO has provided insufficient notice and assistance under the Veterans Claims and Assistance Act of 2000 (VCAA), and so all claims require a remand at this time. *See generally* 38 U.S.C.A. §§ 5103, 5103A, 5107 (West 2002); 38 C.F.R. §§ 3.102, 3.159 (2005).

First, the RO has not advised the veteran to provide any additional evidence in his possession that pertains to his claims, in accordance with 38 U.S.C.A. § 5103(a) (West 2002) and 38 C.F.R. § 3.159(b)(1) (2005). The RO should therefore send the veteran a new VCAA letter that addresses this notice requirement.

Second, at his October 2005 videoconference hearing before the undersigned, the veteran testified that since 2004, he has received treatment for his claimed stomach and low back disorders through the Louis Stokes VA Medical Center (VAMC) in Cleveland, Ohio (via the Wade Park and Brecksville divisions). At this time, only VA medical reports as dated into May 2003 are of record. As such, the RO should

[redacted]

obtain the more recent VA treatment records for all of the veteran's claimed disorders now on appeal. *See Bell v. Derwinski*, 2 Vet. App. 611 (1992); *see also* VAOPGCPREC 12-95.

Third, in light of in-service and post-service symptomatology and treatment, the Board finds that after all record development is complete with respect to the claims for service connection for stomach and low back disorders, the RO should schedule the veteran for VA examination in order to determine the nature and etiology of any currently diagnosed disorder(s). 38 C.F.R. § 3.159(c)(4) (2005).

Next, the Board observed that for the claim of service connection for PTSD, as noted in a March 2003 VA report and other VA treatment notes, medical personnel have already diagnosed the veteran with this disorder, in relation to his described stressors. As well, in July 2003, the veteran provided the RO with a detailed description of his claimed stressors, as well as a letter from the National Archives and Records Administration (NARA) advising that because certain records pertaining to the veteran's ship were embargoed, only VA or the United States Army and Joint Services Records Research Center (JSRRC) could submit a request for deck logs on his behalf. Thereafter, however, the RO did not undertake any action to attempt to verify the veteran's claimed stressors. The RO should do so at this time. *See* 38 C.F.R. § 3.159(c)(2) (2005). Once such action is complete, the RO should also ascertain whether the veteran requires a new VA examination in order to assess whether his currently diagnosed PTSD is related to any confirmed stressor. *See Pentecost v. Principi*, 16 Vet. App. 124 (2002); *Suozzi v. Brown*, 10 Vet. App. 307, 311 (1997).

Therefore, in order to give the veteran every consideration with respect to the present appeal, this matter is REMANDED to the RO (via the AMC) for the following:

1. The RO should send the veteran a new VCAA letter with regard to all three claims now on appeal, which specifically requests that he provide any additional evidence in his possession that pertains to his claims.

[redacted]

2. The RO should obtain the veteran's record of treatment for PTSD, stomach, and/or low back disorders from the VAMC system in Cleveland, Ohio, as dated from May 2003 to the present.

3. After the RO completes the development requested in paragraphs 1 and 2, the RO should schedule the veteran for a VA examination in order to determine the nature and etiology of any current stomach disorder. The RO must forward the claims file for review by the examiner in conjunction with this examination, and the examiner should acknowledge such review in the examination report. After claims file review and clinical evaluation, including the completion of all necessary testing, is complete, the examiner should opine in the examination report as to whether it is at least as likely as not (i.e., a 50 percent likelihood or more) that any currently diagnosed stomach disorder is etiologically related to any event of active service. The examiner should also set forth a complete rationale for all opinions expressed and conclusions reached in the examination report.

4. After the RO completes the actions requested in paragraphs 1 and 2, the RO should schedule the veteran for a VA examination in order to determine the nature and etiology of any current low back disorder. The RO must forward the claims file for review by the examiner in conjunction with this examination, and the examiner should acknowledge such review in the examination report. After claims file review and clinical evaluation, including the completion of all necessary testing, is complete, the examiner should opine in the examination report as to whether it is at least as likely as not (i.e., a

[redacted]

50 percent likelihood or more) that any currently diagnosed low back disorder is etiologically related to any event of active service. The examiner should also set forth a complete rationale for all opinions expressed and conclusions reached in the examination report.

5. The RO should contact NARA, JSRRC, or any other such appropriate repository for the purpose of conducting a search of deck logs of the *U.S.S. Oriskany*, so as to confirm the occurrence of any aircraft accidents involving that carrier during the periods of: June 1969 to July 1969; August 1969 to September 1969; October 1969; January 1970 to February 1970; March 1970 to April 1970; and May 1, 1970, to May 13, 1970. For preparation of this request, the RO should utilize the veteran's July 2003 statement and October 2005 testimony before the Board in order to ascertain his claimed PTSD stressors.

6. If the RO is able to confirm the occurrence of a claimed PTSD stressor as addressed in paragraph 5, then it should determine whether a VA examination is necessary in order to find that the veteran currently has PTSD in relation to such stressor. If yes, then the RO should schedule that examination (to be conducted in conjunction with complete claims file review by the examiner).

IN THE APPEAL OF
ERNEST L. FRANCWAY, JR.

[redacted]

7. After the RO completes all of the development requested above to the extent possible, it should again review the claims on the basis of all additional evidence associated with the claims file. If the RO cannot grant the benefits sought on appeal in their entirety, then it should furnish the veteran and his representative with a supplemental statement of the case, and afford a reasonable opportunity for response before returning the record to the Board for further review.

The purpose of this REMAND is to obtain additional development, and the Board does not intimate any opinion as to the merits of the case, either favorable or unfavorable, at this time. The veteran is free to submit any additional evidence and/or argument he desires to have considered in connection with his current appeal. *See Kutscherousky v. West,* 12 Vet. App. 369 (1999). No action is required of the veteran, however, until he is so notified.

These claims must be afforded expeditious treatment. The law requires that all claims that are remanded by the Board or by the United States Court of Appeals for Veterans Claims (Court) for additional development or other appropriate action must be handled in an expeditious manner. *See* 38 U.S.C.A. §§ 5109B, 7112 (West Supp. 2005).

S. L. Kennedy
Veterans Law Judge, Board of Veterans' Appeals

Under 38 U.S.C.A. § 7252 (West 2002), only a decision of the Board is appealable to the Court. This remand is in the nature of a preliminary order and does not constitute a decision of the Board on the merits of your appeal. 38 C.F.R. § 20.1100(b) (2005).

Department of Veterans Affairs

TRANSCRIPT OF HEARING

BEFORE

BOARD OF VETERANS' APPEALS

WASHINGTON, D.C. 20420

Video Conference, Cleveland, Ohio

IN THE APPEAL OF	:	FRANCWAY, Ernest L., Jr. [redacted]
DATE	:	October 4, 2005
REPRESENTED BY	:	Leslie James Disabled American Veterans
MEMBER OF BOARD	:	Susan Kennedy, Chairman
WITNESSES	:	Ernest L. Francway, Jr., appellant

VA FORM 1-4050, APR 1980 605158

CHAIRMAN: This is Susan Kennedy presiding at a formal hearing of the Board of Veterans' Appeals; I'm in Washington, D.C., on October 4, 2005. This is in the appeal of Ernest L. Francway, Jr., whose claim number with the Department of Veterans Affairs is [redacted]

Mr. Francway is present in our VA Regional Office in Cleveland, Ohio, and he's accompanied by his accredited representative, Mr. Leslie James, with Disabled American Veterans.

There are three issues that have been certified to the Board for review; they are all service connection issues and for the following disabilities: Post-traumatic stress disorder or PTSD; a stomach disorder; and a back disorder.

Mr. Francway, I would like to administer the oath or affirmation to you sir. Please remain seated and raise your hand.

(OATH ADMINISTERED)

CHAIRMAN: If I have correctly identified the issues that are for consideration, I would like to turn the hearing over to Mr. James for any opening comments and questions for Mr. Francway and before I do that, let me just remind you Mr. Francway to please speak up, nice and clearly. We want to make sure we get a good tape and that the transcriber can make a good transcription of this hearing. With that, I would like to turn the hearing over to Mr. James. Mr. James?

MR. JAMES: Thank you Ms. Kennedy. First, on behalf of Mr. Francway, I would like to thank you for providing us this opportunity to present oral testimony in his pending appeal.

Mr. Francway had honorable military service in the United States Navy from August 23, 1968, to May 13, 1970.

Concerning the issues on appeal, Mr. Francway was notified on January 21, 2004, that service connection for these three conditions had been denied. He filed a notice of disagreement on February 5, 2004, and the local rating agency furnished Mr. Francway a statement of the case on February 24, 2004. Mr. Francway perfected his appeal by submitting VA Form 9 on March 4, 2004.

Now, we feel that with Mr. Francway's testimony today and all of the evidence contained in the claims folder that a favorable decision may be reached. At this time, I would like to ask him a few questions if I may?

CHAIRMAN: Yes, please.

MR. JAMES to Veteran:

Q. Mr. Francway, did you have any psychiatric problems before you went on active duty?

A. No sir.

Q. Did you have any psychiatric problems in boot camp?

A. No sir.

Q. Did you have any type of psychiatric problems at all while you were on active duty?

A. No sir.

Q. Speak up a little bit.

A. No sir.

Q. What was your job in the Navy?

A. I was an Aviation Boatswain's Mate.

Q. Could you describe, just tell me what that means?

A. My job was to tie down and untie aircraft, chalk the wheels with wheel chalks to keep them from moving and to hook them up to tractors with a tow bar to tow them to the bow of the ship and back and forth, wherever they needed to be relocated from.

Q. What is a wheel chalk?

A. A wheel chalk is a big long bar with two blocks, one on each end that you slide up against the wheel, to keep the wheel locked; it's a wheel lock.

Q. And how long did you do this job?

A. From the time I was in the service until my discharge date.

Q. Where were you assigned? You were assigned to the U.S.S. Oriskany. When were you assigned to that ship?

A. I went aboard in March of '69.

Q. What type of ship was it?

A. I believe it was a medium class aircraft carrier.

Q. How long did you serve on the ship?

A. Until the 13th of 1970, May.

Q. What was your job on this ship?

A. I was an Aviation Boatswains Mate; to tie down aircraft, untie it, move it, chalk it.

Q. Approximately, when did you arrive in Vietnam?

A. Somewhere around June of '69.

Q. Is there one or more particular incidents that you remember, that you feel has caused your PTSD?

A. There was three incidents.

Q. Could you start with the first one?

A. The first one we were launching an A-4 fighter off of the bow and as the plane got out about 150 feet or so from the deck, it went straight up in the air as it normally does and it just kept climbing and climbing and the pilot ejected as it shortly took off from the deck and the captain hollered ...(inaudible) and the plane just kept climbing and climbing, flipping over, and got up. We were zig-zagging back and forth in the water and this plane was just flipping over and coming down, trying to get us in the ocean and it just landed off over on the port bow just a little bit and it was fully loaded with armor.

Q. About how close to the ship was it when it crashed in the sea?

A. I'd say about--we were lucky. It was about a fourth of a mile or something.

Q. And this was over in Vietnam?

A. The Vietnam waters. We were launching for an Alpha Strike.

Q. What's an Alpha strike?

A. It's where they launch 40 planes at one time and then launch the other 40 when those recover for a routine constant bombing.

Q. And this plane crashed in the Pacific correct?

A. Yes sir.

Q. Do you remember the pilot's name?

A. No.

Q. And you said the pilot ejected from the plane. What happened to the pilot?

A. I believe he was taken back to the Philippines for a physical examination or injuries or what, I don't know.

Q. He was picked up by Alpha?

A. He was picked up by the Helo, yes.

Q. OK, and then flown straight from after he was picked up to the Philippines?

A. I guess that's where they took him .

Q. Can you describe the second incident?

A. The second incident, we were doing night qualifications and a plane came in on back of the fantail, hit the fantail, broke it in half like, and the pilot ejected just as he was hitting the fantail, shot off the back and the plane slid across the deck and parts from the plane were just flying everywhere.

Q. Where did the pilot go?

A. He went out in the ocean on the fantail.

Q. Where were you at when this hit?

A. I was up here by the Island, which is Control Tower, and I was running for the Control Tower to look for cover, to keep from getting hit from the flying debris, sparks and everything was flying and the plane shot off to the side, went right into the ocean and sank.

Q. Again, do you know what happened to the pilot?

A. I assume they took him to San Diego or San Francisco or some medical base there, because the Helo picks up all the pilots.

Q. Where was this incident located at?

A. It was off the coast of San Diego, some place.

Q. But you were back from Vietnam?

A. Right, we were just back in the seventies.

Q. And describe the third incident that happened?

A. The third incident is a plane came flying in. He grabbed the hook; he comes all the way out to the edge of the aircraft carrier. His port wheel falls into the catwalk; we're running out to tie him down because the yellow shirts tie the plane down; we're running out there, he ejects out of the plane as I'm running up to it and the blast knocks me down and then he goes out into the ocean and a plane is standing there on the side of the ship running with the engine, and no pilot in it; and they didn't know what to do; they told us to stand back so we stand back and it eventually falls off into the ocean and it's still running, hanging on a cable on the

side of the ship and it hung there for about an hour or so and then the water finally drowned out the engine and it fell off the hook, because it kept rocking the boat back and forth, to knock it off into the water, because you can't release a 40-ton aircraft from a cable. You had to rock the boat back and forth to get it to fall off.

Q. Again, you don't know what happened to this pilot neither?

A. No, the Helo picks them all up as far as I know.

Q. Why are the pilots not brought back to the aircraft carrier?

A. Because the medic facility on a carrier is not adequate to take care of the pilot hit in the water; they send them to a regular hospital.

Q. Then, when did you first notice you had some problems with the PTSD?

A. When I got discharged, I was having dreams at nighttime; I couldn't sleep; I was waking up sweating; I was restless. I felt like I was running from the incidents that were taking place in my dream; I was actually running in bed.

Q. And this is when you started having nightmares?

A. Yeah.

Q. Shortly after service?

A. Shortly after service.

Q. Do you still have those nightmares?

A. Yes sir.

Q. Can you describe what one of these nightmares is like?

A. I'm just roll, tossing and turning; I'm sweating; it brings me out of the sleep. I can't sleep and it takes me a while to go back to sleep. I just can't sleep.

Q. Is this nightmare a repeat of the plane crashing?

A. Yes sir.

Q. And is there ever a time that you actually feel like you're back on that ship?

A. In the dreams.

Q. When did you first see a doctor for PTSD?

A. When I went out to the VA and filed for post-traumatic stress disorder and they gave me that test that you take for post-traumatic stress disorder.

Q. Which VA was this?

A. The one at Brookpark, Clarksville. It's down from ...(inaudible).

Q. And you've been diagnosed with PTSD correct?

A. They said I had it, but they wouldn't do anything about it until I got some kind of ruling with my evidence.

Q. Have you ever been diagnosed with any other type of psychiatric disability?

A. No sir.

Q. Do you isolate yourself?

A. Yeah.

Q. How do you do that?

A. I stay to myself.

Q. Do you have any social life?

A. No.

MR. JAMES: That's all the questions I have on PTSD. Would you like me to continue with the other two issues?

CHAIRMAN: Let me just ask a couple of questions; you covered in some detail most of what I wanted to ask. I just had a few things.

CHAIRMAN to Veteran:

Q. With respect to the first incident that happened in the Pacific, Mr. Francway, could you give me an idea--I know you arrived in Vietnam waters, I guess you said in March 1969. Can you give me an idea of when that first incident occurred, even within a few months if you could?

A. Well, we left in April to go to Vietnam. We got there somewhere around June.

Q. I'm sorry, you did say June. That's right, I'm sorry.

A. Yes Ma'am.

Q. Go ahead.

A. We were off the coast of Hawaii doing some kind of qualifications with the ammo and stuff and then we went to Vietnam, but the plane shot off the flight deck was launched and within 150 feet, 200 feet, after the pilot leaves the deck with the

plane, it went up like this; he just shot straight out because the commander onboard the ship must have told him in ...(inaudible) or something what to do, because I don't know. I was just on the deck. The plane shot up, straight in the air, and it was fully loaded with all bombs, 500 pounders, 250, 1,000, whatever that thing could carry; it had about 8-9 bombs on it; it was loaded out like it was really going to do some damage when it got to 'Nam.

Q. OK, so tell me when, approximately when would that incident have occurred? Can you give me a time frame?

A. Out there, I didn't look at a calendar; all I know is it was hot, sunny, beautiful day, blue-sky day, and we were working our regular combat flights day-to-day.

MR. JAMES to Veteran:

Q. When did you come back from Vietnam?

A. We came back it was somewhere around November or something and they put the ship in dry dock because it had a 150-foot crack in the hull and they were welding it up.

Q. So that had to be?

A. Between April and November is all I know.

CHAIRMAN: OK, all right.

VETERAN: From the time we left until the time we went out there. To me, I didn't look at a calendar. I was just there doing my time, wasn't concerned about a calendar, didn't even have one in my bed.

CHAIRMAN to Veteran:

Q. Tell me, what about the second incident? Now that happened, you said when the plane hit the fantail? Now, that was near San Diego, right?

A. Yeah, we were doing Flight Ops at night time. These pilots, they were rookies; they were trying to qualify themselves to land on carriers so they can go--this was Airway 19; Airway 19 was the assigned squadron and they're the ones that are trying to qualify the next pilots for the next tour of duty and at that time frame, those pilots, one of those pilots didn't make the ship; he just hit the back end of it and he was practicing landing, didn't land properly; the LSO on the back has those little green and yellow lights that tells you when to come in, how elevation and speed and everything is, and apparently he just messed up, or the ship kicked up, because the water was kind of rough, but anyway and he just hit that--he hit that thing the mid part of the aircraft and it just sort of just fell apart and it hit the deck. It's one big explosion. All you can see is a big spark back there like a bomb going off and it just--the plane just slides across the deck, because he had already lost his wheels and everything and it just slid across the deck and right off; the pilot was already out of the plane and the plane is running across the deck with nobody in it and it's loose, nothing to hold it, no, nothing; it's just sliding.

Q. And again, can you give me a general time frame of when that would have happened, the second incident?

A. It was at nighttime. It was late at night; it must have been 11 or 12 o'clock at night, somewhere around there maybe one in the morning 'cause we fly all night.

Q. I'm looking--excuse me. Let me just jump in.

A. You're looking for a date.

Q. I'm looking more--and even not a specific date, even if you can nail it down to a few months?

A. Well, that is the only time I can give is between when we came out of dry dock and sometime in February to May, so there is only a three-month period to look through.

Q. So February 1970 and May?

A. Yeah, between February, March, April, and then May 13 was the day I got out; so we were in Florida about a week early.

Q. And what about the third incident that you talked about where the plane sort of hung off the ship, hanging off the cable. I didn't hear you say where that happened? Could you tell me where that incident was located?

A. We were around San Diego in the same time frame; somewhere off the coast there, or San Francisco, somewhere around there because at nighttime I don't know, I'm just a crewman. The captain's guiding the ship around out there and all I know is it was late at night and they're still in qualification. It was in that same time frame; so we got two planes between February and May 13. They are at the bottom of the ocean, from wrecks--

Q. OK.

A. --from crashing, but the incident of the plane hanging on the side definitely has to be in the log, because the ship had to shut down flight quarters for over an hour while we shook a plane off of the hook.

Q. That's what I wanted to--

A. And the pilot has to be--yeah, the pilot has to be reported in the hospital because he's got 30 days down for an investigation of the plane; his flight time is canceled and they have to assign him a new plane; he has to go to the hospital; so I don't know what they do with those pilots, but I know they didn't come back to the ship 'cause we never saw the Helo land.

Q. OK, that's what I wanted to sort of pin down the time frame with respect to the incident because I would imagine those kind of incidents should be documented, documentation somewhere. Tell me one other thing about the post service treatment. You indicated that your first post service treatment was at the VA at Brecksville. What date would that have been?

A. That was last year sometime. I had to go take a test and I took the test and they said I was one point within their verification that I had it. They did verify that I had post-traumatic stress but they were waiting for a decision on my evidence from my claim before they would treat me.

Q. OK, all right. So you're not actually receiving any treatment then at Brecksville for your post-traumatic stress disorder right now?

A. No, they won't give me any treatment. They made me take a test and then I went to a class or something for some anger management stuff and that's all they done for me.

CHAIRMAN: OK, all right. Those are the questions I had on that issue, thank you so much. Mr. James, do you have any follow-up questions on that issue, the post-traumatic stress disorder?

MR. JAMES: I don't have any follow-up questions. I would like to say that Mr. Francway is trying to obtain records indicating or verifying these plane crashes and they got a letter from the National Archives saying they had been embargoed; the date of that letter is July 7, I believe?

VETERAN: Yes.

MR. JAMES: And that record is part of the VA claims folder.

CHAIRMAN: OK, good.

VETERAN: I have it here and he has a copy of it.

CHAIRMAN: OK, all right.

MR. JAMES: I have no questions on the PTSD.

CHAIRMAN to Veteran:

Q. So Mr. Francway, you were trying to get copies of the deck log?

A. I had set up an appointment to go up to Washington to the Archives to research my records, to get the evidence that I needed and two weeks after I had set up my appointment and everything, they sent me a letter telling me that the Energy Commission had seized the records and they were embargoed and they had to cancel my interview; so I also made a phone call. A veteran, Walter Dreiser, called him personally and talked to the man and spoke to him and he said the records had been seized and there was no way that they would let me even look at the records, they would only allow the people at Washington or VA whoever, and that was it. I've done everything I can to try to get the evidence. They just won't let me near my records.

CHAIRMAN: All right. I appreciate that, thank you. Mr. James?

MR. JAMES to Veteran:

Q. Mr. Francway, did you have any type of back problem before you went in service?

A. No sir.

Q. When was the first time you injured your back in service?

A. The day we pulled out to go over to Vietnam in April '69 on board the carrier.

Q. Can you explain to us what happened?

A. I was up on the flight deck carrying about 4 or 5 chalks at the time, that you lock the wheels on the aircraft, and I was leaning into the wind and it was blowing real hard and I wasn't used to that kind of leaning into the wind like that and all of a sudden went, stopped, and then a big gust hit me sideways, it turned me and I felt this stabbing pain in my back and I went down, dropped the chalks, and I fell down on the chalks and that's what hurt my stomach and back because I had a big, black-and-blue mark on my left side from falling down.

Q. From the middle of your back to the front of your stomach?

A. Yeah, all the way around from the back, from the left side all the way to the front side, I was black and blue and I had a stabbing pain in the back, but they had to carry me down to sickbay on a stretcher because I couldn't move. The wind had twisted me around.

Q. How long were you in sickbay?

A. A couple of weeks.

Q. Did the doctor give you a diagnosis of a back problem?

A. He said that I had a back problem with the injury on the flight deck.

Q. Did he say it was a muscle strain or a muscle injury?

A. He said it was muscle strain from the work of carrying the chalks.

Q. Did he give you any type of medication?

A. He gave me pain pills and an IV with, whatever that white stuff is. He gave me an IV. That's all I know; he gave me an IV and stuff.

Q. Did you ever have any other type of--I'm sorry, let me back up a minute. Were you put on light duty?

A. I was put on light duty for three months.

Q. And did you--when was the first time you got treatment for your service--for your back after service?

A. When I went out to the VA.

Q. Brecksville?

A. Yes sir.

Q. In 2004?

A. Yes.

Q. And what type of--do you know if a diagnosis has been given for your back at this time?

A. They say I got a muscle cramp back there or something that is causing it and they give me muscle relaxers to relieve the strain.

Q. The pain you have in your back now, the same place you had it while you were on active duty?

A. The identical, same spot.

Q. Does it ever radiate down your legs?

A. Yeah, sometimes it goes down, I get cramps down there, but, uh, they go away eventually.

Q. Have you ever had any type of old job injury since service?

A. Never.

Q. Did you ever get treatment after service up until 2004 for your back?

A. From when?

Q. Have you--did you ever get any treatment for that too, where you got discharged from service, from the date you got discharged up until last year for your back?

A. No, I never had no treatment for my back.

Q. Did you just self--if you had a problem with your back--

A. I took pain pills; Tylenol, Advil. I took whatever I could and just stayed in bed until it healed up and then I went back to my normal activities.

Q. Who did you work for after you got out of service?

A. I went to work for Midland Steel.

Q. Are they currently in business?

A. Then folded up and gone out of business.

Q. Approximately, when was that?

A. About three years ago.

Q. Did you ever see a doctor at Midland Steel?

A. No.

Q. Why not?

A. Because if you reported you had any kind of back injuries or something, you would be fired from your job.

Q. So if you had back problems, you just had your wife call in sick?

A. Call in sick, take medicine, stay in bed, take your vacation time or sick leave time, whatever you could take and then that's how I got through.

Q. About how many times did you have to do this for the 22 years you worked for them?

A. Sometimes every other month or sometimes a couple times a month. The times vary. It depends on how my muscle and back was healing and sometimes it wouldn't heal and I'd just stay off 2-3 days.

Q. So in order to protect your job and your livelihood after service, instead of reporting a back problem to your employer, you would just take over-the-counter medication and take off work?

A. Yes sir.

MR. JAMES: That's all the questions I have on the back issue.

CHAIRMAN: Thank you Mr. James. Just a couple of questions for you and I just didn't hear your answer.

CHAIRMAN to Veteran:

Q. Mr. Francway, you said that you were in sickbay for a couple of weeks after the incident when you twisted your back and fell and then did I hear you say you were on light duty for three months, is that how long?

A. Yes Ma'am, three months.

Q. All right.

A. I was in sickbay for two weeks; the doctor had an IV hooked up to me and gave me painkillers; and then when I was released, I went to light duty for three months. They had me cleaning--

Q. OK, that was my next question was what--what did the light duty consist of?

A. They had me--the light duty was just cleaning air duct vents, just go by with a broom and sweep them off, that was all I did.

Q. OK, so you didn't--for those three months, did you do any--have any, or perform any type of duties on the flight deck at all? You said you cleaned the air ducts?

A. No.

Q. No, OK, all right. I had another question. Oh--and what type of work--you worked--I think Mr. James said for Midland Steel for 22 years, is that right?

A. I was a ...(inaudible) operator, a forklift driver. I sat down and drove a forklift. It picks up pallets of steel; so I didn't do any lifting, the truck did it.

Q. You're ahead of me again, that was my next question. Was did it involve any lifting or--so let's see, one other question. Have you had any other injuries to your back since that time in 1969 in service, any other kind of back injury?

A. No Ma'am. I was only 19 at the time of that injury in the service and I never had any problems in my entire life until I got hurt that day on board the flight deck.

Q. And no injury since that time, no motor vehicle accidents or anything like that?

A. Not for the back, no Ma'am.

CHAIRMAN: OK, all right, thank you so much. Those are all the questions I have on that issue. Mr. James, anything on that issue or would you like to move on to the third issue?

MR. JAMES: The third issue.

CHAIRMAN: OK, all right.

MR. JAMES to Veteran:

Q. Mr. Francway, can tell us did you have any type of stomach or abdominal problems before service?

A. Yes, my Dad had a car accident and I sort of hit the dashboard and had internal bleeding from hitting the dashboard.

Q. Approximately, when was that.

A. I was a kid and I believe it was in '64, but the recruiter put down on the thing, '66; so I think he made a mistake on that, you know, but as I kid, it was before I got my driver's license; I didn't get my driver's license until '66; so it was in '64, sometime when that happened.

Q. So after you recovered that you had no more stomach problems before service?

A. Never had any more stomach trouble, no.

Q. How did you injure your stomach or abdominal wall in service?

A. In the service, it was the day that I was carrying those chalks on the flight deck, tie down the aircraft, and that wind gust took me down; as I was going down from the back, I fell on the chalks and they hit me in the stomach and the side, and I've been bruised from there ever since.

Q. So this is more like an abdominal wall injury instead of a gastrointestinal condition, where you don't have reflux?

A. Yes.

Q. And you getting treatment for this condition at the present time?

A. Yes.

Q. Where at?

A. At Brecksville Hospital.

Q. And you've been getting treatment there since 2004?

A. Yes. They've been giving me muscle relaxers to handle the cramps and pains that I get. They're the same type of--it's for the back and the stomach because when the pain hits you, it's like it's going through you from both angles at the same time; it hits you in the back and the stomach, front and rear at the same time, so it's the same injury.

Q. The same type of problem you're having now is the same type of problem you had when you injured your back?

A. The same injury from the active duty.

Q. Have you ever had any type of injury to your stomach since service?

A. No, none whatsoever.

MR. JAMES: That's all the questions I have at this time.

CHAIRMAN: OK. I did notice from just a quick review that there was some question of kidney stones that they might want to rule out that as a diagnosis.

CHAIRMAN to Veteran:

Q. Mr. Francway, have you any diagnosis of kidney stones by any chance?

A. Never had any kidney stones.

Q. OK, all right.

A. I don't have a problem going to the bathroom.

Q. Have the doctors at Brecksville said to you, that they think the problem that you're having in the same place in your abdomen is related to the injury in service?

A. Yes, they think--it's believed that, yes.

Q. And right now you said the treatment consists of pain medication and that's pretty much it?

A. I take muscle relaxers and pain pills.

Q. And muscle relaxers, OK.

A. Yeah, the muscle relaxers relieve the cramps that I'm getting, so that I could straighten up, because they puff when you walk.

Q. OK, all right, and all of your treatment is at Brecksville, I believe you said, is that correct?

A. Well, it goes from Brecksville to--that's where my main doctor is, but I can also go to Wade Park where I've gone for--I've had a couple of emergencies, where I've gone in there from the cramps; I think it was last month I had one hit me, and they gave me--or the month before that. I can't remember. They give me the muscle relaxers and my doctor just prescribed me 90 pills when I went for--in July for my physical; I told her I was still having problems and she gave me a bottle of muscle relaxers.

Q. Was that at Brecksville they gave you the 90 pills, at Brecksville?

A. Yes, yes. Brecksville gave me the 90 and the other doctor at Wade Park gave me the first prescription from there.

Q. And that was either last month or the month before that?

A. That was a couple of months ago. This is what--this is October now, right, so it would be June, July and August. Somewhere between June and now, it's on the record--

CHAIRMAN: OK.

VETERAN: --the medical.

CHAIRMAN: OK, good, thank you. I have no further questions for you Mr. Francway. What I would like to do at this time is turn the hearing back over to Mr. James. Mr. James, do you have any questions on any of the three issues, any further questions, I should say?

MR. JAMES: I don't have any further questions, but I would like again to thank you for your kind consideration. I feel Mr. Francway has done an excellent job of presenting his testimony and providing enough evidence to grant service connection for these conditions and I request that should any doubt arise, it be resolved in Mr. Francway's favor under 38 C.F.R. 3.102 and offer Mr. Francway an opportunity to make any closing statement that he wishes to make.

CHAIRMAN: Thank you. That's what I was going to do too. Mr. Francway, is there anything else that we didn't cover with respect to the three issues that are on appeal?

VETERAN: Well, the squadron that was going off on the next tour was Air Wing 19; they left on the 14th of May; and this is the squadron outfit that was doing the flight qualifications and I wanted to research to get the evidence that I needed; like I said, the National Archives has got them and I would still like the opportunity to research my records so I can present them in detail, more evidence if I need it.

CHAIRMAN: OK. If you have something specific that you want to do, we can hold the record open for a period of time; that's up to you. If you think that you would like me to hold the record open for 30 or 60 days, we can keep the record open if there is some other avenues that you would like to research in terms of the evidence; that's fine, you can consult with Mr. James if you need to; that's entirely your decision.

MR. JAMES: They told him to go to the Unit Records Research and request those records. I'm not sure that the VA, the local agency, has researched enough in trying to obtain those records especially since the records show that they've been embargoed.

VETERAN: They just won't let me get to them.

MR. JAMES: I think Mr. Francway's opportunity to obtain those are slim.

CHAIRMAN: Yeah, OK, well, I'll let you--

MR. JAMES: The letter dated July 7, 2003, a copy of it is in the C -file and they told him to--they would accept ...(inaudible)for VA office or from the following office, U.S. Armed Services Center for Unit Records Research. The National Archives will not release it to him.

CHAIRMAN: OK, all right. So that doesn't look like that's going to be an avenue that's going to be useful to you, but they might release them to us.

VETERAN: No.

CHAIRMAN: So I'll let you guys decide what you want to do. Do you want me to hold the record open or not? I mean obviously, it looks like there is some development that might need to be done in this case. Mr. James, I will leave that up to you all.

MR. JAMES: I don't think it's necessary to hold it open, but I do feel ...(inaudible) is needed in order to try to obtain those records.

CHAIRMAN: Fair enough, so we won't leave the record open. Mr. Francway, if you do get something, you know, in the near future, you can certainly always send it to Mr. James and he can get it to us, but I won't leave the record open just for that purpose.

We are coming to the close of the hearing here this afternoon. Mr. Francway, I would like to thank you. I think you presented yourself very well today and I appreciate you taking time out of your day to come meet with me this afternoon. Mr. James, thank you so much for your assistance this afternoon; and with that, gentlemen, I'm going to close the record. Thank you.

(HEARING ADJOURNED)

WB--052911140.308--rtw

Form Approved: OMB No. 2900-0085
Respondent Burden: 1 Hour

Department of Veterans Affairs

APPEAL TO BOARD OF VETERANS' APPEALS

IMPORTANT: Read the attached instructions before you fill out this form. VA also encourages you to get assistance from your representative in filling out this form.

1. NAME OF VETERAN (Last Name, First Name, Middle Initial)	2. CLAIM FILE NO. (Include prefix)	3. INSURANCE FILE NO., OR LOAN NO.
FRANCWAY, ERNEST L.	[redacted]	

4. I AM THE:
☐ VETERAN ☐ VETERAN'S WIDOW/ER ☐ VETERAN'S CHILD ☐ VETERAN'S PARENT
☐ OTHER (Specify)

[redacted]

IMPORTANT: Read the information about this block in paragraph 6 of the attached instructions. This block is used to request a Board of Veterans' Appeals hearing. DO NOT USE THIS FORM TO REQUEST A HEARING BEFORE A VA REGIONAL OFFICE HEARING OFFICER.
Check one (and only one) of the following boxes:

A. ☐ I DO NOT WANT A BVA HEARING.
B. ☐ I WANT A BVA HEARING IN WASHINGTON, DC.
C. ☒ I WANT A BVA HEARING AT A LOCAL VA OFFICE BEFORE A MEMBER, OR MEMBERS, OF THE BVA. *(Not available at Washington, DC, or Baltimore, MD, Regional Offices.)*

9. THESE ARE THE ISSUES I WANT TO APPEAL TO THE BVA: *(Be sure to read the information about this block in paragraph 6 of the attached instructions.)*

A. ☒ I WANT TO APPEAL ALL OF THE ISSUES LISTED ON THE STATEMENT OF THE CASE AND ANY SUPPLEMENTAL STATEMENTS OF THE CASE THAT MY LOCAL VA OFFICE SENT TO ME.

B. ☐ I HAVE READ THE STATEMENT OF THE CASE AND ANY SUPPLEMENTAL STATEMENT OF THE CASE I RECEIVED. I AM ONLY APPEALING THESE ISSUES: *(List below.)*

RECEIVED
MAR -4 AM 9:56
VETERANS SERVICES DIV
VARO, CLEVELAND, OHIO

10. HERE IS WHY I THINK THAT VA DECIDED MY CASE INCORRECTLY: *(Be sure to read the information about this block in paragraph 6 of the attached instructions.)*

SEE ATTACHED LETTER OF 7-7-03 FROM NATIONAL ARCHIVES.

I FEEL THAT THERE ARE DOCUMENTS (UNDER FEDERAL GOVERNMENT CONTROL) THAT ARE ESSENTIAL TO MY CLAIM. HOWEVER, THEY ARE "EMBARGOED" AS SET FORTH IN THE ABOVE LETTER. THIS IS VA RESPONSIBILITY (OVER)

(Continue on the back, or attach sheets of paper, if you need more space.)

11. SIGNATURE OF PERSON MAKING THIS APPEAL	12. DATE	13. SIGNATURE OF APPOINTED REPRESENTATIVE, IF ANY (Not required if signed by appellant. See paragraph 6 of the instructions.)	14. DATE
Ernest L Francway Jr	3-1-04		

VA FORM JAN 1998(RS) 9 JetForm

CONTINUATION SHEET FOR ITEM 10

I WILL ACCEPT EITHER AN IN-PERSON, OR VIDEO HEARING, WHICHEVER CAN BE SCHEDULED SOONER. IN THE EVENT OF A VIDEO HEARING, I WAIVE THE IN-PERSON APPEARANCE.

(Attach additional sheets, if necessary)

DEPARTMENT OF VETERANS AFFAIRS
Cleveland Regional Office
1240 East Ninth Street
Cleveland OH 44199

FILE

January 21, 2004

ERNEST L FRANCWAY
[redacted]

In Reply Refer To: [redacted]
FRANCWAY, E L

Dear Mr. Francway:

We must confirm our previous decision which denies service connection for a back condition, stomach condition, and post traumatic stress disorder. This decision will not affect your current payments.

We have enclosed a copy of your Rating Decision for your review. It provides a detailed explanation of our decision, the evidence considered and the reasons for our decision. You can find the decision discussed in the section titled *"Decision."* The evidence we considered is discussed in the section titled *"Evidence."* The reasons for our decision can be found in the portion of the rating titled *"Reasons for Decision"* or *"Reasons and Bases."*

What You Should Do If You Disagree With Our Decision.

If you do not agree with our decision, you should write and tell us why. You have *one year from the date of this letter to appeal the decision.* The enclosed *VA Form 4107, "Your Rights to Appeal Our Decision,"* explains your right to appeal.

Do You Have Questions Or Need Assistance?

If you have any questions, call us toll-free by dialing 1-800-827-1000. Our TDD number for the hearing impaired is 1-800-829-4833. *If you call, please have this letter with you.*

Sincerely yours,

Duane A. Honeycutt

Veterans Service Center Manager

Email us at: cleveland.query@vba.va.gov

Enclosure(s): Rating Decision
VA Form 4107

cc: DAV

DATE OF CLAIM OR ISSUE	END PRODUCT	TRANSACTION	R.O. NO.	POWER OF ATTORNEY	FID. R.O.	PAYEE NO.	PAYEE NAME	FILE NUMBER
06-19-03	020	13C-SUPP	325	DAV		00	E L FRANC	[redacted]

SOCIAL SECURITY NUMBERS: VETERAN [redacted] SPOUSE PAYEE

BIRTH: VETERAN [redacted] SPOUSE WIDOW FATHER MOTHER

NAME AND ADDRESS - PAYEE

ERNEST L FRANCWAY
[redacted]
WESTLAKE OH

NAME OF VETERAN	SEX	NAME OF SPOUSE
E L FRANC	M	

BR.	EOD	RAD	PAY GR.
B	08-23-68	05-13-70	

ASC	SERVICE NO.	CROSS REFERENCE NO.
	00451815	

CHAR. DIS.	SEP. RSN.	DATE OF DEATH	AGE AT DEATH	VET. SPOUSE
HON	SAT			

PRIOR NET AWARD DATA

MONTHLY RATE	EFFECTIVE DATE	WITHHOLD - RECOUP TYPE	WITHHOLD - RECOUP AMOUNT

ZIP CODE	CONS. PAY. NO.	COLLECTION	CODE	AMOUNT
44145				

DIRECT DEPOSIT

DISALLOWANCE ▶ CODE-REASON

EFFECTIVE DATE	RSN CODE	NET MONTHLY RATE	WITHHOLDING TYPE	WITHHOLDING AMOUNT	OFFSET/RECOUP TYPE	OFFSET/RECOUP AMOUNT	ENT CODE	DISABILITY ENTITLEMENT	INCOME	DEPENDENCY TOT	DEPENDENCY THIS	SCHL/ HLP	SPECIAL LAW/MISC
01-01-04	00	824.00					7L	PT	0	00	00	0/0	

RATING

EFFECTIVE DATE	COMB DEG	SMC BAS HOS	SPL PRO	EMPL	W-PCT.	LOSSES USE	LOSSES ANAT	LOSSES OTH	CONTROLS MO	CONTROLS YR	CONTROLS RSN	OFFSET - RECOUPMENT TYPE	OFFSET - RECOUPMENT BALANCE	OFFSET - RECOUPMENT DEDUCTION
01-01-04	020		3	YES										

COMPETENCY

RATING	PAYMENT
YES	

INCOME

	NET WORTH	MO. SOC. SEC.	ANN. SOC. SEC	ANN. EARNING	MO. CIVIL SERV.	MO. MILITARY	MO. BLACK LUNG	MO. RAILROAD	MO. OTHER RET.	ANN. OTH. INC.
PAYEE	01		0	0						0
SPOUSE										

DEPENDENCY

NAME OF CHILD	BIRTH DATE	STAT.	NW	MO. SOC. SEC.	ANN. SOC. SEC.	ANN. EARNINGS	ANN. OTH. INC.	FUTURE DATE	RSN	DEDUCTIBLE EXPENSES
										MEDICAL
										LAST
										FAMILY
										SOC. SEC.
										OTH. RET.
										WAIVER
										EDUCATION

ADDL. CHILDREN ▶ TOTAL: THIS: ▶ IVAP: 0

BURIAL

DESCRIPTION	AMOUNT	PERSON TO BE NOTIFIED	
S/C BURIAL	5261	02	010
NSC BURIAL	5203	02	010
PLOT/INTER.	5292	08	000
HDST./MARKER	7310	08	000
TRANSPORTATION	9411	08	000
TOTAL			

ACCRUED

BASIS FOR PAYMENT:
AMOUNT PAYABLE:
SHARE:
AMOUNT THIS PAYEE:
LESS COLLECTION:
NET PAY:

"X" ltr

REMARKS

VITAL M/R EXISTS - REVIEW VUPD MAYBE REQ

ENTERED BY		DATE	AUTHORIZED BY	DATE
1470	FALLEN TIM	01-17-04		12/04

VA FORM 21-8947 JAN 1984

COMPENSATION AND PENSION AWARD

DEPARTMENT OF VETERANS AFFAIRS
VA Regional Office
Cleveland
1240 East 9th Street
Cleveland, Ohio 44199

ERNEST L. FRANCWAY

VA File Number [redacted]

Represented by:
DISABLED AMERICAN VETERANS

Rating Decision
January 9, 2004

INTRODUCTION

The records reflect that you are a veteran of the Vietnam Era. You served in the Navy from August 23, 1968 to May 13, 1970. We received a request to reopen a previous claim on June 15, 2003. Based on a review of the evidence listed below, we have made the following decisions on your claim.

DECISION

1 . Service connection for post traumatic stress disorder remains denied.

2 . Service connection for back condition remains denied.

3 . Service connection for stomach condition remains denied.

EVIDENCE

ERNEST L FRANCWA [redacted]

- Statement in support of claim received June 15, 2003, June 19, 2003
- Treatment records from Ohio Department of Rehabilitation and Correction dated October 20, 1994 through May 6, 1998
- Claim submitted by Disabled American Veterans, received July 15, 2003
- Letter sent to veteran from Modern Military Records, dated June 30, 2003, submitted by veteran
- Statement from veteran dated July 18, 2003
- Internet information on history of the Oriskany
- Previous rating decision dated May 20, 2003 and all evidence reviewed therein

REASONS FOR DECISION

1. Service connection for post traumatic stress disorder.

We grant service connection for a disability that you currently have if this disability began in military service or was caused by some event or experience in service. Your claim for service connection for PTSD was denied previously because there was no credible supporting evidence of an in-service stressor. Service connection for post traumatic stress disorder requires medical evidence diagnosing the condition in accordance with 38 CFR 4.125 (a); a link, established by medical evidence, between current symptoms and an in-service stressor, and credible supporting evidence supporting evidence that the claimed in service stressor occurred. If the evidence establishes that the veteran engaged in combat with the enemy and the claimed stressor is related to that combat, in the absence of clear and convincing evidence to the contrary, and provided that the claimed stressor is consistent with the circumstances, conditions, or hardships of the veteran's service, occurrence of the claimed in-service stressor may be established by the veteran's testimony alone. If the evidence establishes that the veteran was a prisoner-of-war under the provisions of 38 CFR 3.1 (y) and the claimed stressor is related to that prisoner-of-war experience, in the absence of clear and convincing evidence to the contrary, and provided that the claimed stressor is consistent with the circumstances, conditions, or hardships of the veteran's service, occurrence of the claimed in-service stressor may be established by the veteran's lay testimony alone. A veteran's report of an incident must be supported by service or civilian documentation of the incident, or if that is not available, there must be other evidence that would lead to the reasonable conclusion that the incident occurred. Relevant specific information concerning what happened must be described along with as much detailed information as the veteran can provide regarding the time of the event(s), geographical location, and the names of others who may have been involved in the incident(s). While evidence submitted was reviewed, more specific dates are needed Background information on the Oriskany, similar to evidence received, was considered on the previous rating decision dated May 20, 2003. As new evidence

[redacted]

does not show post traumatic stress disorder related to military service, service connection is denied.

2. Service connection for back condition.

We grant service connection for a disability that you currently have if this disability began in military service or was caused by some event or experience in service. You were previously denied service connection for a back condition in rating decision dated May 20, 2003. Evidence received shows you received treatment for right flank pain, however there is no evidence relating this to your military service time. As evidence does not show a back condition related to military service, service connection for back condition remains denied.

3. Service connection for stomach condition.

We grant service connection for a disability that you currently have if this disability began in military service or was caused by some event or experience in service. You were previously denied service connection for a stomach condition in the rating decision dated May 20, 2003. Evidence received shows you were treated for abdominal discomfort, however there is no evidence relating that abdominal discomfort to your military service, therefore service connection for stomach condition remains denied.

REFERENCES:

Title 38 of the Code of Federal Regulations, Pensions, Bonuses and Veterans' Relief contains the regulations of the Department of Veterans Affairs which govern entitlement to all veteran benefits. For additional information regarding applicable laws and regulations, please consult your local library, or visit us at our web site, www.va.gov.

Rating Decision	*Department of Veterans Affairs* *VA Regional Office*	Page 1 01/09/2004

NAME OF VETERAN	VA FILE NUMBER / SOCIAL SECURITY NO.	POA	COPY TO
ERNEST I. FRANCWAY	[redacted]	DISABLED AMERICAN VETERANS	

ACTIVE DUTY			
EOD	RAD	BRANCH	CHARACTER OF DISCHARGE
08/23/1968	05/13/1970	Navy	Honorable

LEGACY CODES			
ADD'L SVC CODE	COMBAT CODE	SPECIAL PROV CDE	FUTURE EXAM DATE
	1	3	

JURISDICTION: Reopened Claim Received 06/15/2003

NOT SERVICE CONNECTED/NOT SUBJECT TO COMPENSATION (8.NSC Vietnam Era)

5299-5292 BACK CONDITION
Not Service Connected, Not Incurred/Caused by Service
0%

7399-7310 STOMACH CONDITION
Not Service Connected, Not Incurred/Caused by Service
0%

9411 POST TRAUMATIC STRESS DISORDER [PTSD/Other/Unknown-PTSD]
Not Service Connected, Not Incurred/Caused by Service
0%

PENSION ENTITLEMENT DECISIONS (2 PT, 9 NOT PT, 11A, and 11B)

Permanent and Total for NSC from 03/24/2003 (Grant P&T under 38 CFR 3.321(b)2)

DISABILITIES CONSIDERED FOR PENSION PURPOSES ONLY

5010-5261 DEGENERATIVE JOINT DISEASE, LEFT KNEE
Pension
10%

5299-5203 DEGENERATIVE CHANGES, RIGHT SHOULDER, S/P ROTATOR CUFF REPAIR
Pension
10%

COMBINED EVALUATION FOR PENSION : 20%

Rating Decision	*Department of Veterans Affairs* *VA Regional Office*	Page 2 01/09/2004
NAME OF VETERAN ERNEST I. FRANCWAY	[redacted]	POA DISABLED AMERICAN VETERANS
		COPY TO

D. Podsiadlo, RVSR

DEPARTMENT OF VETERANS AFFAIRS
Cleveland Regional Office
1240 East Ninth Street
Cleveland OH 44199

30 MAY 2003

FILE

REC

ERNEST L FRANCWAY JR
[redacted]3
WESTLAKE OH 44145

In Reply Refer To: 325/211E/HD
CSS [redacted]1
FRANCWAY, Ernest L

Dear Mr. Francway:

We made a decision on your claim for non-service connected pension and service connected compensation received March 24, 2003.

This letter tells you about your entitlement amount, payment start date, what we decided, and how we calculated your benefits. It also tells you of your responsibilities as a veteran in receipt of disability pension, what to do if you disagree with our decision, and who to contact if you have questions or need assistance.

What Is Your Entitlement Amount And Payment Start Date?

Your monthly entitlement amount is shown below:

Monthly Entitlement Amount	Payment Start Date	Reason For Change
$807.00	Apr 1, 2003	Pension granted

We are paying you as a single veteran with no dependents.

When Can You Expect Payment?

Your payment begins the first day of the month following your effective date. You will receive a payment covering the initial amount due under this award, minus any withholdings, in approximately 15 days. Payment will then be made at the beginning of each month for the prior month. For example, benefits due for May are paid on or about June 1.

What Did We Decide?

We granted disability pension benefits effective March 24, 2003.

We determined that the following conditions were not related to your military service, so service connection couldn't be granted:

2 [redacted]

Francway, Ernest L

Medical Description
Post traumatic stress disorder
Back condition
Stomach condition

We have enclosed a copy of your Rating Decision for your review. It provides a detailed explanation of our decision, the evidence considered and the reasons for our decision. You can find the decision discussed in the section titled *"Decision."* The evidence we considered is discussed in the section titled *"Evidence."* The reasons for our decision can be found in the portion of the rating titled *"Reasons for Decision"* or *"Reasons and Bases."*

We enclosed a VA Form 21-8768, "Disability Pension Award Attachment-Important Information," which explains important factors concerning your benefits.

What Income And Expenses Did We Use?

We awarded your benefit because you have no income from March 24, 2003.

What Are Your Responsibilities?

You are responsible to tell us right away if:

- your income or the income of your dependents changes (i.e., earnings, Social Security Benefits, lottery and gambling winnings)
- your net worth increases (i.e., bank accounts, investments, real estate)
- you gain or lose a dependent
- your address or phone number changes

How Do You Start Direct Deposit?

Your money may be deposited directly into your checking or savings account. This is the safest and most reliable way to get your money. For more information about Direct Deposit, please call us toll free by dialing 1-877-838-2778.

What You Should Do If You Disagree With Our Decision.

If you do not agree with our decision, you should write and tell us why. You have *one year from the date of this letter to appeal the decision.* The enclosed *VA Form 4107, "Your Rights to Appeal Our Decision,"* explains your right to appeal.

[redacted]

Francway, Ernest L

Do You Have Questions Or Need Assistance?

If you have any questions or need assistance with this claim, please call us at 1-800-827-1000. If you use a Telecommunications Device for the Deaf (TDD), the number is 1-800-829-4833.

If you call, please refer to your VA file numbe[redacted] If you write to us, put your full name and VA file number on the letter. Please send all correspondence to the address at the top of this letter. You can visit our web site at www.va.gov for more information about veterans' benefits.

We sent a copy of this letter to DAV because you appointed them as your representative. If you have questions or need assistance, you can also contact them.

Sincerely yours,

Sande Jones

Sande Jones
Veterans Service Center Manager

Email us at: cleveland.query@vba.va.gov

Enclosures: Rating Decision
VA Form 21-8768
VA Form 4107

cc: DAV

DEPARTMENT OF VETERANS AFFAIRS
Cleveland Regional Office
1240 East Ninth Street
Cleveland OH 44199

ERNEST I. FRANCWAY

[redacted]

Represented by:
DISABLED AMERICAN VETERANS

Rating Decision
May 20, 2003

INTRODUCTION

The records reflect that you are a veteran of the Vietnam Era. You served in the Navy from August 23, 1968 to May 13, 1970. You filed an original disability claim that was received on March 24, 2003. Based on a review of the evidence listed below, we have made the following decision(s) on your claim.

DECISION

1 . Entitlement to nonservice-connected pension is granted.

2 . Service connection for post-traumatic stress disorder is denied.

3 . Service connection for back condition is denied.

4 . Service connection for stomach condition is denied.

[redacted]VAY

EVIDENCE

- Service Medical Records from August 23, 1968 through May 13, 1970 (to include Navy Reserve examination dated March 4, 1978)
- VA Form 21-526, Veteran's Application for Compensation and/or Pension received March 24, 2003
- You were notified of the VA's duty to assist under VCAA on April 17, 2003 - as of this date a reply has not been received
- VA Form 21-4138, Statement in Support of Claim received April 23, 2003
- VA Form 21-527, Income-Net Worth and Employment Statement received May 7, 2003
- VA Form 119, Report of Contact dated May 7, 2003
- Outpatient treatment reports, VA Medical Center, Cleveland, Ohio, from October 4, 2002 through May 15, 2003

REASONS FOR DECISION

1. Entitlement to nonservice-connected pension.

We have granted entitlement to nonservice connected pension effective March 24, 2003, which is the date your application for benefits was received.

The evidence shows that you are prevented from working due to your degenerative joint disease of the left knee and degenerative changes of your right shoulder. We made this decision based upon medical evidence, your age of 53, high school education and unemployment. Based on all the evidence, we consider you to be permanently and totally disabled for the purpose of this benefit.

Permanent and total disability for pension purposes is held to exist under the provisions of the VA Rating Schedule when there is a single disability ratable at 60 percent or more, or where there are two or more disabilities with a combined evaluation of 70 percent or more, with at least one of the disabilities rated at least 40 percent, and the veteran is, in the judgment of the rating agency unable to secure or follow a substantially gainful occupation as the result of such disability(ies). You do not meet the schedular requirements of a single disability ratable at 60 percent or more, or two or more disabilities combining to 70 percent with at least one ratable at 40 percent. However, considering the level of disability and other factors, such as age, education and occupational background, an extraschedular permanent and total disability rating is authorized subject to approval by the Service Center Manager.

2. Service connection for post-traumatic stress disorder.

[redacted]VAY

We have denied your claim for service connection for PTSD because there is no credible supporting evidence of an in-service stressor. Service connection for post-traumatic stress disorder requires medical evidence diagnosing the condition in accordance with 38 CFR 4.125(a); a link, established by medical evidence, between current symptoms and an in-service stressor; and credible supporting evidence that the claimed in-service stressor occurred. If the evidence establishes that the veteran engaged in combat with the enemy and the claimed stressor is related to that combat, in the absence of clear and convincing evidence to the contrary, and provided that the claimed stressor is consistent with the circumstances, conditions, or hardships of the veteran's service, occurrence of the claimed in-service stressor may be established by the veteran's lay testimony alone. If the evidence establishes that the veteran was a prisoner-of-war under the provisions of 38 CFR 3.1(y) and the claimed stressor is related to that prisoner-of-war experience, in the absence of clear and convincing evidence to the contrary, and provided that the claimed stressor is consistent with the circumstances, conditions, or hardships of the veteran's service, occurrence of the claimed in-service stressor may be established by the veteran's lay testimony alone. A veteran's report of an incident must be supported by service or civilian documentation of the incident, or if that is not available, there must be other evidence that would lead to the reasonable conclusion that the incident occurred. Relevant specific information concerning what happened must be described along with as much detailed information as the veteran can provide regarding the time of the event(s), geographical location, and the names of others who may have been involved in the incident(s).

Your service medical records are silent for any complaints, findings or diagnosis for any pathology for any mental disorder to include PTSD. There is no evidence to show that you were engaged in combat or awarded the Purple Heart, Combat Infantry Badge or similar combat citation. You have reported an aircraft crashing on deck as your stressor; however, there is no evidence to confirm this stressor. A noncombat veteran's testimony alone does not qualify as "credible supporting evidence" of the occurrence of an in-service stressor and the available evidence is insufficient to confirm an in-service stressor. A diagnosis of post-traumatic stress disorder must meet all diagnostic criteria as stated in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. Although you are currently receiving treatment for PTSD, there is no evidence of a credible stressor for VA purposes, and no evidence of a nexus or relationship between the treating diagnosis of PTSD and any injury or incident in service.

3. Service connection for back condition.

We have denied your claim for service connection for a back condition. Service connection may be granted for a disability which began in military service or was caused by some event or experience in service. However, a disability which began in service or was caused by some event in service must be considered "chronic" before service

[redacted]

connection can be granted. Although you were treated in service for low back pain in December 1969, no further treatment findings or diagnosis of a disease or disability is shown during service or at the time of your Naval Reserve examination in March 1978. No permanent residual or chronic disability subject to service connection is shown by the service medical records or demonstrated by evidence following service.

4. Service connection for stomach condition.

We have denied your claim for service connection for a stomach condition. Service connection may be granted for a disability which began in military service or was caused by some event or experience in service. However, a disability which began in service or was caused by some event in service must be considered "chronic" before service connection can be granted. Although you were treated in service for abdominal pain in April 1969, no further treatment findings or diagnosis of a disease or disability is shown during service or at the time of your Naval Reserve examination in March 1978. No permanent residual or chronic disability subject to service connection is shown by the service medical records or demonstrated by evidence following service.

REFERENCES:

Title 38 of the Code of Federal Regulations, Pensions, Bonuses and Veterans' Relief contains the regulations of the Department of Veterans Affairs which govern entitlement to all veteran benefits. For additional information regarding applicable laws and regulations, please consult your local library, or visit us at our web site, www.va.gov.

OMB Approved No. 2900-0075
Respondent Burden: 15 minutes

Department of Veterans Affairs

STATEMENT IN SUPPORT OF CLAIM

PRIVACY ACT INFORMATION: The law authorizes us to request the information we are asking you to provide on this form (38 U.S.C. 501(a) and (b)). The responses you submit are considered confidential (38 U.S.C. 5701). They may be disclosed outside the Department of Veterans Affairs (VA) only if the disclosure is authorized under the Privacy Act, including the routine uses identified in the VA system of records, 58VA21/22, Compensation, Pension, Education and Rehabilitation Records - VA, published in the Federal Register. The requested information is considered relevant and necessary to determine maximum benefits under the law. Information submitted is subject to verification through computer matching programs with other agencies.

RESPONDENT BURDEN: VA may not conduct or sponsor, and respondent is not required to respond to this collection of information unless it displays a valid OMB Control Number. Public reporting burden for this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have comments regarding this burden estimate or any other aspect of this collection of information, call 1-800-827-1000 for mailing information on where to send your comments.

FIRST NAME - MIDDLE NAME - LAST NAME OF VETERAN *(Type or print)*	SOCIAL SECURITY NO.	VA FILE NO.
Ernest L Francway		C/[redacted]

The following statement is made in connection with a claim for benefits in the case of the above-named veteran:

Evidence to support claim for PTSD.

I would also like to file a claim for stomach and back injury on left side dated 5/69. On the USS Oriskany.

I would also like to file for Non-Service Connected pension.

"Homeless Vet"

Please Expedite

(CONTINUE ON REVERSE)

I CERTIFY THAT the statements on this form are true and correct to the best of my knowledge and belief.

SIGNATURE	DATE SIGNED
Ernest L Francway Jr	4/23/03

[redacted] (Include Area Code)
EVENING

PENALTY: The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of a material fact, knowing it to be false.

VA FORM JUN 2000 21-4138 EXISTING STOCKS OF VA FORM 21-4138, APR 1994, WILL BE USED

DEPARTMENT OF VETERANS AFFAIRS
Cleveland REGIONAL OFFICE
1240 E. 9th Street
Cleveland, OH 44199

ERNEST L. FRANCWAY JR

[redacted]

Represented by:
DISABLED AMERICAN VETERANS

Rating Decision
November 2, 2009

INTRODUCTION

The records reflect that you are a veteran of the Vietnam Era. You served in the Navy from August 23, 1968 to May 13, 1970. You filed a claim for increased evaluation that was received on June 24, 2009. Based on a review of the evidence listed below, we have made the following decision(s) on your claim.

DECISION

1 . Evaluation of post traumatic stress disorder, which is currently 10 percent disabling, is increased to 30 percent effective June 24, 2009.

2 . Evaluation of left inguinal hernia claimed as stomach condition (previously 7399-7310), which is currently 0 percent disabling, is continued.

EVIDENCE

- Statement from veteran, received 06-24-09

[redacted]AY JR

- Letter to veteran, dated 07-21-09
- Medical records, VAMC Cleveland, dated 2-09 to 8-09
- VA exam, dated 08-21-09
- VA exam, dated 08-07-09

REASONS FOR DECISION

1. Evaluation of post traumatic stress disorder currently evaluated as 10 percent disabling.

You requested an increased evaluation for your service connected PTSD.

VA records show no specific treatment or medication for PTSD. You complained of nightmares. Depression was noted to be due to pain issues. You were referred to mental health by the Center for Stress Recovery because it was determined that your personality disorder would prevent you from benefiting from treatment for PTSD. You were noted to be living in your car since 2003. You were focused on obtaining compensation and you refused various resources offered to you.

At VA exam, you indicated that you have nightmares about 20 days out of each month. You said you are "shot all night." You get soaking wet, are irritable and are sweating. You kick the dashboard (you sleep in your car). You avoid driving past the airport. You don't like loud noises. You feel agitated sometimes, are not friendly and feel aggravated. You also noted depression and always feeling stressed. You write things down to remember them. You are not currently employed but did not allege that it was due to PTSD symptoms. You noted you were in prison and employment options have been hindered due to that fact. At exam, you had no impairment of thought process. Impairment of communication was noted but not described. Speech was normal, no panic attacks were noted. The examiner said you show the minimum symptoms needed to make a PTSD diagnosis. Depression is present but is not related to your PTSD. An anti-social personality disorder was also diagnosed and not related to your PTSD. The examiner said that your PTSD symptoms are transient or mild and do not require medications.

The evaluation of post traumatic stress disorder is increased to 30 percent disabling effective June 24, 2009.

An evaluation of 30 percent is assigned from June 24, 2009, date of claim. An evaluation of 30 percent is granted whenever there is occupational and social impairment with occasional decrease in work efficiency and intermittent periods of inability to perform occupational tasks (although generally functioning satisfactorily, with routine behavior, self-care, and conversation normal), due to such symptoms as: depressed mood, anxiety, suspiciousness, panic attacks (weekly or less often), chronic sleep impairment, mild memory loss (such as forgetting names, directions, recent events). A higher evaluation of

[redacted]NCWAY JR

50 percent is not warranted unless there is reduced reliability and productivity due to such symptoms as: flattened affect; circumstantial, circumlocutory, or stereotyped speech; panic attacks more than once a week; difficulty in understanding complex commands; impairment of short- and long-term memory (e.g., retention of only highly learned material, forgetting to complete tasks); impaired judgment; impaired abstract thinking; disturbances of motivation and mood; difficulty in establishing and maintaining effective work and social relationships.

Although many of your symptoms are attributed to non-service connected personality disorder and depression, you do experience PTSD related sleep impairment and nightmares. This warrants a 30% evaluation.

2. Evaluation of left inguinal hernia claimed as stomach condition (previously 7399-7310) currently evaluated as 0 percent disabling.

You requested an increased evaluation for your service connected inguinal hernia.

VA records show no complaints related to a hernia.

At VA exam, no complaints were documented. You apparently told the examiner you cannot lift more than 10-15 pounds. Exam showed no evidence of any inguinal hernia. There was evidence of a ventral hernia, this was reducible. Status of muscles and fascia of abdominal wall were noted to be "firm with defect in left lower quadrant." No related scars were noted (no surgery was ever done).

The evaluation of left inguinal hernia claimed as stomach condition (previously 7399-7310) is continued as 0 percent disabling. {38 CFR 3.321(a); 38 CFR 3.321(b)(1)}

A noncompensable evaluation is assigned from April 24, 2003. A noncompensable evaluation is assigned for a remediable hernia, or one which is small, reducible, or without true hernia protrusion. A higher evaluation of 10 percent is not warranted unless evidence demonstrates a postoperative recurrent hernia which is readily reducible and well supported by a truss or belt.

FORM 30. Certificate of Service

UNITED STATES COURT OF APPEALS FOR THE FEDERAL CIRCUIT

CERTIFICATE OF SERVICE

I certify that I served a copy on counsel of record on January 23, 2019 by:

- ☐ U.S. Mail
- ☐ Fax
- ☐ Hand
- ☒ Electronic Means (by E-mail or CM/ECF)

William H. Milliken	/s/ William H. Milliken
Name of Counsel	Signature of Counsel

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Fax Number	202-371-2540
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NOTE: For attorneys filing documents electronically, the name of the filer under whose log-in and password a document is submitted must be preceded by an "/s/" and typed in the space where the signature would otherwise appear. Graphic and other electronic signatures are discouraged.

Reset Fields