

VA Disability Medical Evaluation Example with Ratings

This VA Disability Medical Report example is offered to assist our veterans, physicians, attorneys and advocates. Since physician's medical reports are relied upon by non medically trained lay persons such as Rating Officers, lawyers, advocates, and judges it is helpful if the physician will utilize the VA nomenclature, diagnoses, codes and rating schedules. Refer to *Title 38: Pensions, Bonuses and Veterans' Relief*

For more go to: www.EllisClinic.com - click **[VA Disability]** - click **[VA Medical Exam Aids]**

- [VA Medical Evaluation Example with Ratings](#)
- [VA Joint Range of Motion Worksheet with Spinal Rating Codes & Percentages](#)
- [Index to Disability Examination Worksheets](#) (Worksheets of medical conditions)
- [Compensation & Pension Service Clinician's Guide](#) (Worksheets of medical conditions)
- [Schedule for Rating Disabilities](#) (VA Rating Codes and Percentages of Disability)

Physicians should base their medical opinions upon:

- The condition of the veteran when examined and not a future prognosticated state.
- Their education, training, experience, examination of the veteran and medical and other records, and upon *Reasonable Medical Certainty*, also known as *Reasonable Medical Probability*, also known in the VA system under the term "As Likely as Not".
- *Reasonable Medical Certainty & Probability* and *As Likely as Not* each mean that there is a 50% or greater chance that the physician's opinion is correct. A physician's expert medical opinions are not based on the criminal law criteria of *Beyond A Reasonable Doubt*. A physician's expert medical opinions are based upon the practice of medicine and seldom have concrete answers as in math and engineering. Expert medical opinions are dynamic and can change with new medical evidence as it develops. Usually, the top several medical impressions or diagnoses are within *Reasonable Medical Certainty & Probability* and *As Likely As Not* as the following example illustrates:
 - A person without a Hepatitis A vaccination goes to a country with endemic Hepatitis A and one month later has yellow eyes.
 - 1st Medical Opinion: Jaundice caused by the Hepatitis A virus.
 - A test shows a large gall stone in the common bile duct.
 - 2nd Medical Opinion: Jaundice caused by a gall stone in the bile duct.
 - Lab tests arrive and indicate acute Hepatitis A and obstructive jaundice.
 - 3rd Medical Opinion: Jaundice caused by Hepatitis A virus and a gall stone.
 - All three are correct at the time and are competent expert medical opinions.

God Bless,

John W. Ellis, M.D.

Occupational & Legal Medicine Practice in Oklahoma City, OK
Clinical Associate Professor University of Oklahoma School of Medicine
Fellowships:

American College Occupational & Environmental Medicine
American Academy Family Physicians

Board Certifications:

American Board Environmental Medicine
American Board Family Medicine

Professional Certifications:

American Board Disability Analysts
American Board Forensic Examiners
American Board Forensic Medicine

American Board Independent Medical Examiners

For Full Curriculum vitae: www.EllisClinic.com

VA Disability Medical Report Example

[The following examples are condensed and do not contain all the medical history and physical findings suggested in the *VA Disability Exam Worksheets* and the *C&P Clinician's Guide*.]

Date

To: Ima Heretohelp, Attorney at Law
123 W. Washington Street
Anywhere, USA

[Send your report to the veteran and their attorney or advocate to review and then they will forward to the appropriate Department of Veteran Affairs location]

Re: **JOHN Q DOE**
VA CSS 123 45 6789
DOB: 12/1/48, Age: 64, Sex: Male
Expert Medical Opinion Concerning Service Connected Disability

Department of Veterans Affairs:

This veteran has requested my medical opinion as to whether they have service connected injuries and/or diseases.

The veteran served honorably in the Army from 1/1/67 to 12/31/72. His top rank was Warrant Officer 2, MOS was helicopter pilot. He served for one year in Vietnam from 1/1/69 through 12/31/70.

BACK

While flying in Vietnam his helicopter engine was shot. He had to auto rotate. As he came through the trees, the rotator blades hit the trees. He had a sudden rapid vertical descent. At impact, the skids were splayed out and broken. He had immediate pain between his shoulders and his lower back. Initially he did not notice any pain down his legs. He was seen by a medic and placed on bed rest for two days. In about one week he was flying helicopters again. He continued to have low back pain in the service. About one month after the crash, he developed pain down his right leg into his foot. The pain would increase with prolonged sitting.

At the time when he left the Army he was still having low back pain, pain in his sacroiliac areas and pain and numbness into the lateral aspect of his right foot. Within two years after leaving the service, he noticed some pain going also to the top of his right foot and associated more weakness in his right leg.

After the Army, he went to college and obtained a degree in accounting. He became a CPA and worked for Acme Brick. He treated his back and leg pain with over the counter medications and back massages several times a year.

By July, 1990, he was having more pain and weakness down his right leg and had begun to have numbness into the lateral aspect of his left leg and foot.

He began seeking medical treatment. The MRI of the lumbar spine of 7/15/90, revealed a bulging discs at the L4-5 and L5-S1 levels, greater into the right side. His second MRI on 7/10/95 revealed a herniated disc at L5-S1 centrally and to the right and left impinging on the right neuroforaminal canal and a central herniation of the L4-5 disc.

On 7/1/05, he underwent his first of two back surgeries, a lumbar discectomy L4-5 and L5-S1. After the back surgery, he did not receive very much relief from the pain and numbness in his leg and then gradually developed more back pain and pain and numbness down both legs.

On 7/1/07, he underwent the second of two back surgeries, a fusion of L4 and L5-S1 vertebrae.

Current Complaints:

He continues to have pain in his back and buttocks, numbness down both legs into the dorsal and lateral aspect of both feet with weakness in both legs. He began having to use a cane in 2007 before his second back surgery. It is difficult to get out of a chair and to walk and drive. Bladder and bowel functions have not changed.

[Condensed example]

BACK: Service Connected Diagnosis:

5237 Lumbosacral strain.

5243 Intervertebral disc syndrome L4-5 and L5-S1.

8520 Bilateral sciatic nerve L5 spinal nerve impairment.

8520 Bilateral sciatic nerve S1 spinal nerve impairment.

BACK: Service Connected Disability:

60% 5243 Intervertebral disc syndrome and/or lumbosacral strain.

60% 8520 Right sciatic nerve incomplete paralysis due to L5 and S1 spinal nerve impingement.

20% 8520 Left sciatic nerve incomplete paralysis due to L5 and S1 spinal nerve impingement.

Over the years the veteran has filed several claims for his back injury therefore there may be several dates of claim filed to be considered. The following are my medical opinions as to the veteran's service connected disability ratings over time.

[The apportioning of the different impairments through the chronology of history is only necessary if the veteran has filed a several back claim many years previously. If the veteran filed only one back claim then only the current disability rating is needed.]

Back Disability Percentages in the Past

From the date of his injury in 1969 until 2001:

- 10% 5237 Lumbosacral strain with spasm and localized tenderness and inability to work for an accumulative total of one to two weeks a year.
- 10% 8520 Right sciatic nerve incomplete paralysis due to L5 and S1 spinal nerve impingement.

From 2001 to 2005:

- 20% 5237 Lumbosacral strain, inability to work two to four weeks a year.
- 20% 8520 Right sciatic nerve incomplete paralysis due to L5 and S1 spinal nerve impingement.
- 10% 8520 Left sciatic nerve incomplete paralysis due to L5 and S1 spinal nerve impingement.

From 2005 to 2007:

- 40% 5243 Intervertebral disc syndrome and unable to work 4 to 6 weeks a year
- 40% 8520 Right sciatic nerve incomplete paralysis due to L5 and S1 spinal nerve impingement.
- 10% 8520 Left sciatic nerve incomplete paralysis due to L5 and S1 spinal nerve impingement.

From 2007 to the present:

- 60% 5243 Intervertebral disc syndrome and unable to work.
- 60% 8520 Right sciatic nerve incomplete paralysis due to L5 and S1 spinal nerve impingement.
- 20% 8520 Left sciatic nerve incomplete paralysis due to L5 and S1 spinal nerve impingement.

Due to his service connected back injury he has been a totally disabled individual and unemployable and has been unable to work, even a sedentary job as a CPA, since 5/3/2007.

BACK: Causal Relationship to Military Service:

The original deceleration injury caused a strain in the muscles and ligaments in the back and injured the discs in the lower back. A deceleration injury, such as in the helicopter crash, causes greater forces in the low back than an injury such as lifting. Once the fibers of the discs in his lower back were injured, they continued to stretch and weaken causing the nuclear pulposus in the discs to begin to bulge out and then subsequently herniate. Initially, he was having lumbosacral strain with some tightness in the buttocks muscles causing some of the numbness in the back of his thighs, which would be a sciatic nerve impingement. Subsequently he developed symptoms and findings of bilateral L5 and S1 spinal nerve root impingement requiring a back surgery. The spinal nerve impingement down the legs continued to the point that he required a second surgery and fusion. But for his original service connected injury of the tearing of the muscles, ligaments and discs in his back, he would not have progressed to the spinal nerve impingements and the requirement of the two back surgeries.

LEFT KNEE

While stationed at Fort Carson, Colorado, on 11/1/72, he missed a step as he was walking. His left knee twisted inwardly. He had immediate pain and a popping sensation in the medial aspect of his left knee. He had some swelling. He took some Ibuprofen and put ice on his knee for the next two nights. He continued to have pain in the medial aspect of his left knee. He was having pain in the knee, even at the time of his discharge. He was reluctant to complain of his knee during his discharge medical exam because he was afraid that it would delay his discharge.

[Military Medical Records are the most important in establishing service connectedness. If there are no or scant military medical records then explain why. It is not uncommon for military personnel to be reluctant to go to medical. It is common for military medical records to be scant with little information - military personnel cannot sue their doctors. It is also common that an initial injury may be thought of as minor. As time goes by the torn muscles, ligaments, discs, etc. can worsen resulting in a veteran not going for medical treatment until years after the initial injury. It is not uncommon for the veteran nor having money or insurance to seek medical help after their military service. Many veterans do not want to go to a VA hospital for treatment.]

Within a year of leaving the military service, he continued to have pain in his knee. He saw a physician. He was treated with medication. He continued to have pain in his knee. He was seen by an orthopedic surgeon. The 11/1/74, MRI was obtained, which revealed a partial medial meniscal tear and chondromalacia of the medial tibial plateau. On 11/1/74, he underwent arthroscopic medial meniscectomy. He has continued to have pain in the medial aspect of his knee. Cold weather bothers his knee. In the last five years, he has noticed some instability of his left knee, especially if he gets up out of a chair after he has been sitting or if he tries to rotate to the right. It is difficult to flex and extend his left knee. **[Condensed example]**

LEFT KNEE: Service Connected Diagnosis:

5259 Medial meniscus tear requiring meniscectomy.

5257 Traumatic arthritis and chondromalacia of the patella and medial femoral condyle causing instability and laxity of the medial collateral and lateral collateral ligament.

LEFT KNEE: Service Connected Disability:

10% 5259 Cartilage, semilunar, removal of, symptomatic

20% 5261 Minus 17 degrees extension of the left knee.

20% 5257 Moderate instability of the medial collateral ligament and mild instability of the lateral collateral ligament of the left knee.

LEFT KNEE: Causal Relationship to Military Service:

The injury to his knee in the service was a tearing of the medial meniscus. The torn meniscus allowed the cartilage of the knee to become abraded causing chondromalacia and weakness in the collateral ligaments.

**VIETNAM AGENT ORANGE EXPOSURE:
HYPERTENSION, MYOCARDIAL INFARCTION and DIABETES**

While being a helicopter pilot in Vietnam, he flew in II Corp and III Corp areas. In many areas he had numerous exposures to the Agent Orange as a herbicide defoliant.

At age 50, he developed hypertension and began treatment with medications. In the last two years, he has developed shortness of breath with walking up a flight of stairs and walking quickly. He did not have any pitting edema, orthopnea or shortness of breath until he had a myocardial infarction on 1/5/11.

On 1/5/11, he suffered an ST elevation myocardial infarction in the anterior wall of the heart with a thrombus and clot in the left anterior descending and circumflex arteries. Since then, he has had shortness of breath. He wakes up short of breath at night. At the end of the day he has pitting edema and swelling in his feet. He now cannot climb a flight of stairs or walk quickly.

At age 50, he developed diabetes mellitus type II. He has been on oral medications and diet control. He started having to wear glasses at age 43. He has not noticed any peripheral neuropathy symptoms of burning in the bottom of his feet. He does have the shooting electrical symptoms consistent with bilateral L5 and S1 spinal nerve impairment down his legs as set forth in the above evaluation of his back injury. He has not noticed any burning peripheral neuropathy sensations on the bottom of his feet.

[Condensed example]

AGENT ORANGE: Service Connected Diagnosis:

7007 Hypertensive heart disease with heart failure.
7006 Myocardial infarction
7913 Diabetes mellitus Type II

AGENT ORANGE: Service Connected Disability:

30% 7007 Hypertensive heart disease with heart failure.
60% 7006 Myocardial infarction with congestive heart failure
20% 7913 Diabetes mellitus requiring oral hypoglycemic medications and restricted diet.

AGENT ORANGE: Causal Relationship to Military Service:

His exposures to Agent Orange and defoliants in Vietnam are presumptive evidence of causation for his hypertensive heart disease and diabetes mellitus. The hypertensive heart disease and diabetes mellitus made him much more prone to developing atherosclerosis of the coronary arteries resulting in the myocardial infarction. The hypertensive heart disease and the myocardial infarction have contributed to his congestive heart failure.

PTSD POST TRAUMATIC STRESS DISORDER:

He flew a Huey helicopter in Vietnam. He was actively engaged in the war. He also actively had to go into the hot LZs. He has had bullet holes in his helicopter. He had to pick up wounded and dead soldiers. He has continued to have intrusive thoughts of being shot at and of wounded and dead bodies. These intrusive thoughts occur as nightmares while he is sleeping and intrude into his thinking during the daytime. He has continued to be hyper vigilant and irritable. I concur with the 4/27/11 psychological evaluation by Ima Shrink, PhD. His GAF score of 45 is reasonable and consistent with my examination today. **[Condensed example]**

PTSD: Service Connected Diagnosis:

9411 PTSD Post traumatic stress disorder.

PTSD: Service Connected Diagnosis:

70% 9411 PTSD Post traumatic stress disorder.

PTSD: Causal Relationship to Military Service:

He was actively involved in the war. He was shot at and had bullet holes in his helicopter. He was not shot down. He went into hot landing zones and had to extract wounded and grossly deformed soldiers with visible wounds and dead soldiers. These experiences caused outpouring of excessive stress chemicals and changes in the brain. Studies have shown that there is measurable shrinkage in parts of the brain areas that will subsequently not allow the veteran suppress these stressful memories resulting in the continued stress chemical outpouring causing anxiety, the hyper vigilance and irritability and the veteran's Post Traumatic Stress Syndrome.

HEARING LOSS and TINNITUS:

He was exposed to loud noise of the helicopters while in the service. While in the service, he developed the difficulty in understanding speech, hearing and he developed tinnitus. Since the service, he has not had any noise exposure other than mowing his lawn. He continues to have ringing in both ears. He has difficulty understanding people if there is a noisy environment such as the television being on or in a restaurant.

[Condensed example]

HEARING LOSS: Service Connected Diagnosis:

6100 Hearing loss.

6120 Tinnitus.

HEARING LOSS: Service Connected Disability:

0% 6100 Hearing loss.

10% 6120 Tinnitus.

Causal Relationship to Military Service:

This veteran's audiogram is consistent with the loud noise exposures while in military service causing noise induced injury to the veteran's hearing cells. The injured hearing cells have caused hearing loss and tinnitus. The injured hearing cells will continue to degenerate causing worsening hearing loss and tinnitus.

The following is an explanation to those veterans with a 10% service connected disability due to tinnitus but low or 0% disability due to hearing loss. Zero percent disability due to hearing loss does not mean that there should not be an accepted service connected hearing loss finding. The same loud noises that caused the tinnitus also caused hearing loss. A 0% rating may occur because noise induced hearing loss starts in the higher frequencies. Although, higher frequency hearing loss makes it difficult to understand speech, the VA Disability and other impairment systems do not rate the hearing loss in the higher frequencies. VA Disability hearing loss is calculated using both the pure tone audiogram results plus the Maryland CNC Speech Discrimination Test. This may result in a veteran with hearing aides and yet having a 0% hearing loss rating. A VA hearing loss rating is frequently lower than impairment rating of other systems such as the American Medical Association's, *Guides to the Evaluation of Permanent Impairment* which utilizes only the pure tone audiogram.

[The VA system uses a standard audiogram plus speech discrimination. This can result in many veterans, even those with hearing aids to have a disability rating of 0% hearing loss. The hearing loss diagnosis should still be actively pursued to get it rated at 0%. As the injured hearing cells continue to die the vet's hearing loss will worsen and future audiograms will result in a disability percentage rating. It is easier to go from 0% disability to a percentage disability than to wait to when the vet is older to get the hearing loss claim accepted]

RECORDS REVIEWED:

[List Records or attach a list of records reviewed.]

EXAMINATION and DIAGNOSTIC TESTS: [Condensed example]

Ht: 5.9", Wt: 198 Without Shoes, BP: 142/88, Pulse 84, Respirations 24

GENERAL: Appears to be stated age.

HEAD: Unremarkable.

EYES: Pupils are equal and round. There is mild AV nicking but no hemorrhagic exudates. He does wear glasses.

ENT: He has bilateral tinnitus cannot hear a soft whisper. Weber does not refer. Air conduction is louder than bone conduction. Canals are clear and drums are intact.

CHEST: When he is sitting, there are faint rales in the bases. When I have him stand up and take a deep breath, the rales disappear.

HEART: Regular rhythm without murmurs. There is no scar on the anterior chest wall.

He underwent stenting on 1/5/12 of the left anterior descending and the circumflex.

Point of maximum impulse is a centimeter left of the mid clavicular line in the fifth intercostal space. He has good radial pulses, dorsalis pedis and posterior tibial pulse.

There is good capillary filling in his fingers, feet and toes. There is 1+ edema in the lower legs from the calf into the ankles.

ORTHOPEDIC AND NEUROLOGICAL EXAM:

[Making Topic Header for each claim's physical findings makes it easier for the VA Rating Office to check against the Title 38 criteria]

BACK

There is tightness of the posterior lower cervical, the thoracic and lumbar paraspinous muscles. This is consistent with spasm, especially in the lower thoracic and lumbar paraspinous muscles. There is decreased range of motion of the thoracic and lumbar

spine. See joint range of motion worksheet. There is a well healed surgical scar in the midline of the back. There is tenderness over the iliolumbar and sacroiliac ligaments. Pressure on the buttocks reproduces tingling in the back of the thighs but not all the numbness and weakness he has down the dorsal and lateral aspect of the feet. There is decreased sensation in the dorsal and lateral aspect of both feet consistent with bilateral L5 and S1 spinal nerve root impairment, greater in the right leg. There is weakness in dorsiflexion of the big toes, plantar flexion of the feet and toe and heel walking, greater in the right leg. Straight leg raising is positive in both legs, greater in the right. Dorsiflexion of the right foot causes more pain in the midline of the back than a similar procedure on the left leg, although it is positive in the left leg. He walks with an antalgic gait. He is weak. He has to hold the chair handles to get up. I do not find any diabetic peripheral neuropathy. The findings are more consistent with the bilateral L5 and S1 spinal nerve impairment. He does not have the burning sensation. It is more of a numbness shooting electrical sensation rather than the diabetic neuropathy causalgia symptoms in his feet and the bottom of his feet.

LEFT KNEE

There is 101 degrees of flexion and -17 degrees extension. There are arthroscopic scars on the knee. There is tenderness over the medial joint line. There is moderate laxity of the medial collateral ligament and mild laxity of the lateral collateral ligament.

PTSD (Add any findings not covered in your medical history)

PAST and/or NON SERVICE CONNECTED MEDICAL HISTORY:
[Put only pertinent major medical history or delete Past History]

[KEY! THE FOLLOWING WORDING MUST BE IN YOUR REPORT!]
MEDICAL OPINION and CAUSE of INJURY:

My medical opinions are based upon my examination of the veteran, review of medical and/or service records, my education training and experience and upon reasonable medical probability and reasonable medical certainty. It is my medical opinion that the injuries, impairments and disabilities set forth in my diagnosis and computation of service connected disability were, as likely as not, due to and a consequence of this veteran's military service.

Respectfully,
Marcus Welby, M.D

[List your qualifications or attach your curriculum vitae helps the VA and the veteran]

Enclosures:

1. List of Medical Records Reviewed (Not shown in this example)
2. VA Joint Range of Motion Worksheet

[As a teaching aid I have also attached The Knee and Leg page from The Electronic Code of Federal Regulations. You do not need to attach such pages.]

Veteran: John Q. Doe VA# 123-45-6789 Date DDMMYYYY

VA Joint Range of Motion Worksheet

Federal Regulations Title 38 - Pensions, Bonuses & Veterans Relief

General Rating Formula for Spine		Normal	Veteran	Rounded	Rating%	General Rating Formula for Spine	
Cervical Neck	Flexion	45			40%	Unfavorable ankylosis entire cervical spine	
	Extension	45			30%	Flexion 15 or less or favorable ankylosis entire cervical spine	
	Right Lateral Flexion	45			20%	Flexion 15 to 30 or combined ROM not greater than 170 degrees, or	
	Left Lateral Flexion	45			20%	Spasm- abnormal spinal contour: scoliosis, reversed lordosis, or kyphosis	
	Right Rotation	80			10%	Flexion 30 to 40 or combined ROM 170 to 335, or	
	Left Rotation	80			10%	Spasm- localized tenderness but not abnormal spinal contour	
		340	Total:		10%	Vertebral body fracture with loss of 50% or more in height	
Thoraco Lumbar Back	Flexion	90	32	30	50%	Unfavorable ankylosis entire thoracolumbar spine	
	Extension	30	12	10	40%	Flexion 30 or less or favorable ankylosis entire thoracolumbar spine	
	Right Lateral Flexion	30	10	10	20%	Flexion 30 to 60 or combined ROM not greater than 120, or	
	Left Lateral Flexion	30	13	15	20%	Spasm- abnormal gait or spinal contour: scoliosis, reversed lordosis, or kyphosis	
	Right Rotation	30	10	10	10%	Flexion 60 to 85 or combined ROM 120 to 235 or	
	Left Rotation	30	14	15	10%	Spasm- localized tenderness but not abnormal gait or spinal contour	
		240	Total:	90	10%	Vertebral body fracture with loss of 50% or more in height	
Diseases and Injuries of the Spine							
Shoulders	Flexion	180			5235	Vertebral fracture or dislocation	
	Extension	50			5236	Sacroiliac injury and weakness	
	Abduction/Pronation	180			5237	Lumbosacral or Cervical Strain Based on Incapacitating episodes in the last 12 months	
	Adduction	40					60% 6 weeks +
	Internal Rotation	90					40% 4 to 6 weeks
	External Rotation	90					20% 2 to 4 weeks
Elbows	Flexion	145			10% 1 to 2 weeks	20% 5237 2001 to 2005 10% 5237 1969 to 2001	
	Extension	0			5238	Spinal stenosis	
	Pronation	80			5239	Spondylolisthesis	
Hands	Supination	85			5240	Ankylosing spondylitis	
	Palmar Flexion	80			5241	Spinal fusion	
	Dorsiflexion/Extension	70			5242	Degenerative arthritis of the spine	
Hips	Radial Deviation	20			60%	5243	Intervertebral Disc Syndrome Based on Incapacitating episodes in the last 12 months
	Ulnar Deviation	45					
	Flexion	125			40% 4 to 6 weeks	40% 5243 2005 to 2007	
	Extension	30			20% 2 to 4 weeks		
	Abduction	45			10% 1 to 2 weeks		
	Adduction	25					
Knees	Internal Rotation	40			Cervical Spinal Nerves (Complete Paralysis/Incomplete Severe/Moderate/Mild)		
	External Rotation	60			8510	Upper radicular group C5 & C6 (Major: 70/50/40/20 Minor: 60/40/30/20)	
Ankles	Flexion	140	101		8511	Middle radicular group C7 (Major: 70/50/40/20 Minor: 60/40/30/20)	
	Extension	0	-17		8512	Lower radicular group C8 & T1 (Major: 70/50/40/20 Minor: 60/40/30/20)	
	Plantar Flexion	45			8513	All radicular groups C5 thru T1 (Major: 90/70/40/20 Minor: 80/60/30/20)	
	Dorsiflexion/Extension	20			Lumbar Spinal Nerves (Complete Paralysis/Incomplete Severe & Atrophy/Moderate Severe/Moderate/Mild)		
	Inversion	20			60/20	8520	Sciatic nerve L2 thru S1 (Right or Left Leg: 80/60/40/20/10)
	Eversion	10			932012 C:\MVA\NOVA\VA Joint ROM Rating Example.xlsx		

John Q. Doe

VA# 123-45-6789
The Knee and Leg

Rate of Exam

	Rating
5256 Knee, ankylosis of:	
Extremely unfavorable, in flexion at an angle of 45° or more	60
In flexion between 20° and 45°	50
In flexion between 10° and 20°	40
Favorable angle in full extension, or in slight flexion between 0° and 10°	30
5257 Knee, other impairment of:	
Recurrent subluxation or lateral instability:	
Severe	30
Moderate	20
Slight	10
5258 Cartilage, semilunar, dislocated, with frequent episodes of "locking," pain, and effusion into the joint	20
5259 Cartilage, semilunar, removal of, symptomatic	10
5260 Leg, limitation of flexion of:	
Flexion limited to 15°	30
Flexion limited to 30°	20
Flexion limited to 45°	10
Flexion limited to 60°	0
5261 Leg, limitation of extension of:	
Extension limited to 45°	50
Extension limited to 30°	40
Extension limited to 20°	30
Extension limited to 15° -17°	20
Extension limited to 10°	10
Extension limited to 5°	0
5262 Tibia and fibula, impairment of:	
Nonunion of, with loose motion, requiring brace	40
Malunion of:	
With marked knee or ankle disability	30
With moderate knee or ankle disability	20
With slight knee or ankle disability	10
5263 Genu recurvatum (acquired, traumatic, with weakness and insecurity in weight-bearing objectively demonstrated)	10