KERRY BAKER, ASSOCIATE NATIONAL LEGISLATIVE DIRECTOR, THE DISABLED AMERICAN VETERANS

STATEMENT OF
KERRY BAKER
ASSOCIATE NATIONAL LEGISLATIVE DIRECTOR
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
JULY 9, 2008

Mr. Chairman and Members of the Committee:

I am pleased to have this opportunity to appear before you on behalf of the Disabled American Veterans (DAV), to address undue delays in the Department of Veterans Affairs' (VA) disability claims processing system.

The claims process is extremely complex and often not understood by veterans, some veterans' service representatives, and by many VA employees. Many studies have been completed on timeliness of claims processing yet the delays continue and the frustrations mount for all involved in the process of filing and adjudicating claims and appeals. Therefore, the following suggestions are intended to simplify the claims process by drastically reducing delays caused by superfluous procedures while providing sound structure with enforceable rights, where current law otherwise promotes subjectivity, resulting in large variances in decision-making, unnecessary appeals, and overdevelopment of claims.

I. REMOVE PROCEDURAL ROADBLOCKS TO EFFICIENCY IN THE APPEALS PROCESS.

To begin the appeal process, an appellant files a written notice of disagreement (NOD) with the VA regional office (RO) that issued the disputed decision. For most cases, the appeal must be filed within one year from the date of the decision. After filing an initial NOD, the VA sends the appellant an appeal election form asking him/her to choose between a traditional appellate-review process by a rating veterans' service representative (RVSR) or a review by a decision review officer (DRO). DROs provide a de novo (brand new decision), review of an appellant's entire file, and they can hold a personal hearing about an appellant's claim. DROs are authorized to grant the contested benefits based on the same evidence in the claim folder that the initial rating board used. The appellant is given 60 days to respond to the appeal election form. See 38 C.F.R. § 3.2600 (2007).

Once the appeal election form is received, the RVSR or DRO (as appropriate) issues a statement of the case (SOC) explaining the reasons for continuing to deny the appellant's claim. A VA Form 9, or substantive appeal form, which is used to substantiate an appeal to the Board of Veterans Appeals ("Board" or "BVA") is attached to the SOC. The VA Form 9 must be filed

within 60 days of the mailing of the SOC, or within one year from the date VA mailed its decision, whichever is later.

If the appellant submits new evidence or information with the substantive appeal, such as records from recent medical treatment or evaluations, the local VA office prepares a supplemental statement of the case (SSOC), which is similar to the SOC, but addresses the new information or evidence submitted. The VA must then give the appellant an additional 60 days to respond (with any additional evidence, for example) following the issuance of an SSOC. If the appellant submits other evidence, regardless of its content, another SSOC must be issued and another 60 days must pass before the VA can send the appeal to the Board. In many cases, this process is repeated multiple times before a case goes to the Board. In many of those cases, the appellants are simply unaware that they are preventing their appeal from being sent to the Board.

The VAROs are not supposed to submit a case to the Board before the RO has rendered a decision based on all evidence in the file, to include all new evidence. This restriction stems from 38 U.S.C.A. § 7104, which has been interpreted to mean that the Board is "primarily an appellate tribunal" and that consideration of additional evidence in the first instance would violate section 7104 and denies an appellant "one review on appeal to the Secretary," 38 U.S.C.A. § 7104(a) (West 2002 & Supp. 2007); see Disabled Am. Veterans v. Sec'y of Veterans Affairs, 327 F.3d 1339, 1346 (Fed. Cir. 2003).

The result of the above is that ROs are forced to issue SSOCs repeatedly in many cases, which merely lengthens the appeal, frustrates the VA, and confuses the appellant. The problem does not end there. If an appellant submits new evidence once the case is at the Board, or if the RO submits a case to the Board with new evidence attached, the Board is prohibited from rendering a decision on the case and is forced to remand the appeal (usually to the Appeals Management Center (AMC)), if for no other reason but for VA to issue an SSOC.

Notwithstanding the above, an appellant can choose to waive the RO's jurisdiction of evidence received by VA after a case has been certified to the Board by submitting a written waiver of RO jurisdiction. In the case of an appeal before the VARO, this results in VA not having to issue an SSOC concerning the newly submitted evidence. In the case of an appeal before the Board, it results in not requiring the Board to remand the case solely for issuance of an SSOC.

The Board amended its regulations in 2004 so that it could solicit waivers in those cases where an appellant or representative submits evidence without a waiver. 38 C.F.R. § 20.1304(c); see 69 Fed. Reg. 53,807 (Sep. 3, 2004). This has helped to avoid some unnecessary remands. The Board's remand rate decreased from 56.8% in fiscal year (FY) 2004, to 35.4% in FY 2007 due in part to these procedures.

The statistical data for appeals in the VA represents a significant amount of its workload. Appellants filed 46,100 formal appeals (submission of VA Form 9) in FY 2006 compared with 32,600 formal appeals in FY 2000. The annual number of BVA decisions, however, has not increased. As a result, the number of cases pending at BVA at the end of FY 2006-40,265-was almost double the number at the end of FY 2000. These numbers are exclusive to appeals at the Board and do not include the substantial number of appeals processed by the appeals teams in VAROs and the AMC.

In FY 2007, the Board physically received 39,817 cases. Despite this number of cases making it to the Board, the VBA actually issued 51,600 SSOCs, a difference of 11,783. As of May 2008, the VBA has already issued 38,634 SSOCs. Likewise, the Board has remanded an additional 1,162 cases solely for the issuance of an SSOC. This number does not include cases wherein the appellant responded to the Board's initiation of a request for waiver of RO jurisdiction, thereby eliminating the requirement for a remand for VBA to issue an SSOC.

The average number of days it took to resolve appeals, by either the Veterans Benefits Administration (VBA) or the Board, was 657 days in FY 2006. This number, however, is very deceptive, as it represents many appeals resolved at the RO level very early into the process. The actual numbers show a picture much worse. According the FY 2007 Report of the Chairman, Board of Veterans' Appeals, a breakdown of processing time between steps in the appellate process is as follows:

- NOD to receipt of SOC - 213 days - VARO;
- SOC issuance to receipt of VA Form 9 - 44 days - appellant;
- receipt of VA Form 9 to certification to the Board - 531 days -VARO;
- receipt of certified appeal to Board decision - 273 days - Board;

Total - 1,061 days from NOD to Board decision-sadly, many are much longer.

The item of special interest regarding the above numbers, is that the function that should conceivably take the least amount of time actually took the most amount of time-receipt of VA Form 9 to certification to the Board. The reason for this extraordinary time VA spends on a relatively simple task is in part the result of issuing multiple SSOCs.

Congress has the chance to eliminate tens of thousands of man-hours from VA's workload, the cost associated therewith, and to simplify an important part of the claims process with a minor legislative change. This would eliminate, as much as practicable, VA's requirement to issue SSOC's, to include the Board's requirement to remand for the issuance of an SSOC.

Recommendation

Amend 38 U.S.C.A. § 7104 in a manner that would specifically incorporate an automatic waiver of RO jurisdiction for any evidence received by the VA, to include the Board, after an appeal has been certified to the Board following submission of a VA Form 9. This type of amendment would eliminate the VA's requirement to issue an SSOC every time an appellant submits additional evidence in the appellate stage. It would also prevent the Board from having to remand an appeal to the AMC solely for the issuance of an SSOC. Such an amendment should state that the statutory change applies "notwithstanding any other provision of law." This language would prevent any contradiction with other statutes and future confusion caused by any potential judicial review.

Certain safeguards would nonetheless be necessary. VA must still be required to notify the appellant that it received the newly submitted evidence, and whether that evidence changed the outcome of the decision; if so, then the appeal would most likely be resolved. If not, a single-

page, automated letter could be issued to the appellant indicating that VA received the newly submitted evidence and that it had no effect on the outcome of the appeal. VA would then not be required to wait an additional 60 days before forwarding the appeal to the Board. If the Board receives evidence not considered by the RO, the Board would have first instance jurisdiction, but only on the newly submitted evidence. That would prevent the Board from having to initiate contact with the appellant to seek a waiver of RO jurisdiction and would prevent a needless remand by the Board.

This type of legislative change could free up significant resources from the VA and the Board that could then be utilized to focus on other causes of delay in the claims process.

Recommendation

Congress should amend 38 U.S.C. § 5104 (Decisions and Notices of Decisions) subsection (a), to eliminate the need to wait until after an appellant files an NOD in order to issue an appeal election letter. Such an amendment would further eliminate the requirement that VA allow an appellant 60 days to respond to such a letter, thereby shortening every appeal period by 60 days.

The provisions of the foregoing statute states, inter alia, that when VA notifies a claimant of a decision, "[t]he notice shall include an explanation of the procedure for obtaining review of the decision." 38 U.S.C.A. § 5104(a). This section could be amended to read: "The notice shall include an explanation of the procedure for obtaining review of the decision, to include any associated appeal election forms." The VA could then modify 38 C.F.R. § 3.2600 accordingly.

The VA currently receives over 100,000 NODs annually. This minor change would eliminate 60 days of undue delay in every one of those appeals and eliminate VA's requirement to separately mail, in letter format, all 100,000 plus appeal election forms. This recommendation, along with the foregoing recommendation, would have a tremendous effect on VA's appeals workload without the need to expend any governmental resources.

II. MODIFY THE COURT'S JURISDICTION TO INSURE EFFECTIVE JUDICIAL REVIEW-ITS CURRENT STANDARD OF REVIEW ADDS TO CLAIM DELAYS.

Over the years, the Court of Appeals for Veterans Claims (Court) has shown a reluctance to reverse errors committed by the BVA. Rather than addressing an allegation of error raised by an appellant, the Court has a propensity to vacate and remand cases to the Board based on an allegation of error made by the VA Secretary, such as an inadequate statement of reasons or bases in the board decision.

Another example occurs when the Secretary argues for remand by the Court because VA failed in its duty to assist the claimant in developing the claim notwithstanding the Board's express finding of fact that all development is complete. Such actions are particularly noteworthy because the Secretary has no legal authority to appeal a Board decision to the Court. 38 U.S.C.A, § 7252(a) (West 2002) ("The Court of Appeals for Veterans Claim shall have exclusive jurisdiction to review decisions of the Board of Veterans' Appeals. The Secretary may not seek review of any such decision.").

These types of defend-to-the-death characteristics by counsel are not at all surprising in most settings. However, they can easily rise to a level of inappropriateness in the setting at hand. The United States Court of Appeals for the Federal Circuit has addressed the American Bar Association's Model Code of Professional Responsibility, which expressly holds a government lawyer in a civil action or administrative proceeding to higher standards than a private lawyer. A government lawyer has "the responsibility to seek justice." Freeport-McMoRan Oil & Gas Co. v. F.E.R.C., 962 F.2d 45, 47 (1992). In other words, the government lawyer should not attempt to "win at any cost." The Court has drawn attention to the fact that the VA General Counsel's function of representing the Department also extends to veteran claimants, that the General Counsel should "look at all sides of the case," and is obligated "to see that the veteran gets what he or she is entitled to." Johnson v. Brown, 7 Vet.App. 95, 98 (1994). Furthermore, the General Counsel should "suggest remand where indicated" and "attempt to 'settle cases'" where appropriate. Id.

Nonetheless, the Court will generally decline to review alleged errors raised by an appellant that actually serve as the basis of the appeal. Instead, the Court remands the remaining alleged errors on the basis that an appellant is free to present those errors to the Board even though an appellant may have already done so, leading to the possibility of the Board repeating the same mistakes on remand that it had previously. Such remands leave errors by the Board, and properly raised to the Court, unresolved; reopen the appeal to unnecessary development and further delay; overburden a backlogged system already past its breaking point; exemplify far too restrictive and out-of-control judicial restraint; and inevitably require an appellant to invest many more months and perhaps years of his or her life in order to receive a decision that the Court should have rendered on initial appeal. As a result, an unnecessarily high number of cases are appealed to the Court for the second, third, or fourth time.

This type of judicial restraint is highly ineffective. It serves neither the VA nor its clientele any favorable purpose. It is merely a judicially created law that only serves the Court. The practice is rooted in the Best decision, which held: "A narrow decision preserves for the appellant an opportunity to argue those claimed errors before the Board at the readjudication, and, of course, before this Court in an appeal, should the Board rule against him." Best v. Principi, 15 Vet.App. 18, 20 (2001). The Court's language, couched speciously in a favorable tone, in practice is but a fallacy. The idea that an issue not addressed by the Court, regardless of how well framed, is better for the appellant if preserved for the Board to take a second proverbial bite at the apple is nonsensical.

The Best doctrine has been invoked no less than 1,123 times since 2001. Many of those cases have returned to the Court repeatedly. That represents significant VA resources that could have been spent on resolving original appeals rather than making the same decision on the same case for a second, third, or fourth time. Such a result is inevitable following a Court vacate/remand containing no judicial guidance whatsoever.

In addition to postponing decisions and prolonging the appeal process, the Court's reluctance to reverse BVA decisions provides an incentive for VA to avoid admitting error and settling appeals before they reach the Court. By merely ignoring arguments concerning legal errors rather than resolving them at the earliest stage in the process, VA contributes to the backlog by allowing a

greater number of cases to go before the court. If the Court were to address all properly raised assignments of error, more appeals would be reversed, which would discourage VA from standing firm on decisions that are likely to be overturned or settled late in the process.

Recommendation

Congress should amend the Court's jurisdiction to require that it decide all assignments of error properly presented by an appellant. There is currently a bill in the house (H.R. 5892) that would amend 38 U.S.C.A. § 7252(a) to require the Court to decide assignments of error when properly raised. H.R. 5892 would add the following to section 7252(a):

The Court shall have power to affirm, modify, reverse, remand, or vacate and remand a decision of the Board after deciding all relevant assignments of error raised by an appellant for each particular claim for benefits. In a case in which the Court reverses a decision on the merits of a particular claim and orders an award of benefits, the Court need not decide any additional assignments of error with respect to that claim.

This type of statutory amendment would have very positive impact in many ways, not the least of which would prevent the Court from arbitrarily remanding appeals without addressing an appellant's primary reason for appealing to the Court in the first place. This in turn would prevent the Board from rendering the exact same erroneous decision as it previously issued. The result is less undue delay in the claims process.

The DAV fully supports this bill and requests the Senate initiate similar legislation.

III. CONGRESS SHOULD SIMPLIFY, SOLIDIFY, AND PROVIDE STRUCTURE TO THE VA CLAIMS DEVELOPMENT PROCESS.

In order to understand the complexities, the bureaucratic and procedural dilemmas, and the bewildering nature of the claims process and how these characteristics unduly delay accurate and lawful conclusion of claims, one must focus on the individual processes and how they affect the program as a whole. Whether through uncontrolled judicial orders, continuously repeated mistakes that cause frequent variances in decision-making, or inherent unfairness accidentally built into the system, portions of the claims processing system have become far too complex, very loosely structured, and too open to the whims of VARO-level personal discretion. By solidifying and properly structuring these processes, Congress can build on what otherwise works.

A. PROVIDE SOLID, NONDISCRETIONARY STRUCTURE TO VA'S "DUTY TO NOTIFY."

The law regarding VA's requirement to provide notice to claimants of information needed to complete their claim is found in title 38, United States Code, section 5103, otherwise known as VA's "duty to notify." Section 5103(a) states:

Upon receipt of a complete or substantially complete application, the Secretary shall notify the claimant and the claimant's representative, if any, of any information, and any medical or lay evidence, not previously provided to the Secretary that is necessary to substantiate the claim. As

part of that notice, the Secretary shall indicate which portion of that information and evidence, if any, is to be provided by the claimant and which portion, if any, the Secretary, in accordance with section 5103A of this title [38 USCS 5103A] and any other applicable provisions of law, will attempt to obtain on behalf of the claimant.

38 U.S.C.A. § 5103. See Veterans Claims Assistance Act of 2000 (VCAA), Pub. L. No. 106-475, 114 Stat. 2096 (Nov. 9, 2000). The enactment of this section was well intended. It has nonetheless led to unintended consequences that have proven detrimental, rather than beneficial, to the claims process. Essentially, the language of section 5103(a) has led to such a procedural quagmire that it is not fulfilling its intended benefit to VA claimants.

Many Court decisions have significantly expanded VA's statutory duty to notify, in terms of both content and timing of that notice. These decisions have long-term implications. The Court has mandated specific content of VA's notice to claimants that impose both highly complex and problematic duties in a claims system that was designed to be informal-continual rework and re-notice has become unavoidable. Since VCAA's enactment in November 2000, the Court has issued at least 17 precedential decisions imposing stringent requirements of content and timing.

Although VCAA has been in effect for six years, the Court continues to expand and interpret it. In early 2006, a Court ruling required VA to send more than 450,000 supplemental notice letters.

Despite the foregoing, the DAV does not fault the Court for doing its job, nor do we fault Congress for enacting legislation meant to assist VA claimants. The root of the problem is that the statutory language is far too broad. There is nearly no limit of requirements that can be read into its language.

The Court, on the other hand, recognizes VA's benefits system as a veteran-friendly, pro-claimant, and non-adversarial process for providing benefits to our nation's disabled veterans. It has, since the enactment of VCAA, been interpreted by the Court as broadly as possible. For example, by direction of the Supreme Court, ambiguity in a veterans' benefits statute must be resolved in favor of the claimant. Brown v. Gardner, 513 U.S. 115, 118, (1994) (directing that reasonable doubt in statutory interpretation is to be "resolved in the veteran's favor"). Moreover, it is a longstanding maxim of statutory interpretation that remedial legislation, is to be interpreted broadly in order to effectuate its basic purpose. See Smith (William) v. Brown, 35 F.3d 1516, 1525 (Fed. Cir. 1994) ("courts are to construe remedial statutes liberally to effectuate their purposes . . . and veterans' benefits statutes clearly fall in this category").

When Congress writes legislation that is less than completely clear, it is the judiciary's role to make the best of the language that is enacted and to seek to find a reasonable interpretation of the statutory text consistent with the goals that Congress has indicated it sought to achieve with that legislation. If, after undertaking this analysis, the only reasonable conclusion is that Congress, notwithstanding its intention, failed to provide statutory language that can be fairly interpreted as achieving its basic legislative purpose should a court tell Congress "nice try, but you haven't done the job you apparently intended to do." However, those interpretations have actually done more to add to procedural requirements than they have ever done to resolve cases.

Recommendation

The solution behind the notice problem is somewhat simple: amend section 5103 to state the specific type of information VA is required to include in its notice, in both content and timing. The goal is to ensure such language is helpful and understandable to the claimant while specific enough to set limits aimed at shielding it from continuous judicial interpretation.

Any such amendment should specify that the notice requirements contained in section 5103 apply to benefits under title 38, chapters 11, 13, 15. (i.e., disability compensation, dependency and indemnity compensation, and pension). Further, while we will not suggest verbatim how the statutory language should be amended, we nonetheless have some specific suggestions.

The premise behind section 5103 should be that VA is required to provide the claimant notice of the "basic" type of information necessary to substantiate a claim, (for clarity, "basic" should be defined in the statute, i.e., "starting point"). The statute should also indicate that VA "may," "but is not required" to provide additional evidence as it finds necessary so as not to tie the agency's hands should it decide to expand its notice.

The statute should also be clear as to what evidence the notice should not include, such as: (1) information concerning effective dates unless such is the basis of the claim; (2) individual diagnostic code rating criteria; (3) methods of determining applicable diagnostic codes to include information concerning VA's rating scale (this information can be explained in a rating decision); and, any other criteria that is determined extraneous and/or confusing to the claimant. Despite our foregoing general advice, we must explain our suggested notice requirements for most claims of service connection somewhat more thoroughly.

Service connection connotes many factors; however, it essentially means that the facts, shown by evidence, establish that a particular injury or disease resulting in disability was incurred coincident with service in the Armed Forces, or if preexisting such service, was aggravated therein. See 38 C.F.R. § 3.303(a) (2007). Establishing service connection generally requires (1) medical evidence of a current disability; (2) medical evidence, or, in certain circumstances, lay evidence of in-service incurrence or aggravation of a disease or injury; and (3) medical evidence of a nexus between the claimed in-service disease or injury and the present disease or injury. Hickson v. West, 12 Vet.App. 247, 253 (1999); see 38 C.F.R. § 3.303(a). In some cases, continuity of symptoms between the time of discharge and the claim will suffice in the absence of a medical nexus between service and the disability. See 38 C.F.R. § 3.303(b).

Claims of service connection are the foundation of VA's benefits system. Service connection and increased-rating claims easily make up the bulk of VBAs work, but the notice required for an increased-rating claim is less controversial and not the subject here. The subject is part of the notice that should be required for service connection claims. The crux of a majority of these claims lies in either a claimant or the VA obtaining a medical opinion. In fact, there are nearly entire volumes of Veterans Appeals Reporters filled with case law regarding the subject of medical opinions, i.e., who is competent to provide them, when are they credible, when are they adequate, when are they legally sufficient, when or which ones are more probative, etc. Yet, the one group of people that still understand VA's requirements concerning medical opinions the least are its claimants.

The issue of medical opinions could easily be a subject of its own, but in the context of undue delay in the claims process, there is ample room to improve the law concerning medical opinions in a manner that would bring noticeable efficiency to VA's claims process. It must start with VA's notice requirements under section 5103.

When VA issues a VCAA letter under its current notice requirements, the letter, if addressing the issue of service connection, normally informs a claimant that he/she may submit their own medical opinion. Such letter also states that VA may obtain one for them. Likewise, most claimants understand the requirement for a medical opinion linking their current disability to their military service. In accordance with the foregoing suggested amendments to section 5103, VA should be required to inform a claimant filing for service connection the basic elements needed to substantiate the claim, one of those elements being the necessity for a medical opinion.

However, a bare statement advising a claimant of the need for a medical opinion should not suffice. Such a bare statement would also do nothing to solve the continuous problems caused by claimants' poor understanding of proper medical opinion adequacy. The VA's notice requirements should be amended to include specific information concerning the basic elements that render a medical opinion adequate for rating purposes, i.e., a medical statement indicating what records (e.g., service medical records, copy of VA claims file, etc.) were reviewed in reaching the opinion, a medical rationale for the opinion, and a conclusion to the opinion stated in terms of "as likely as not," "more likely than not," or "less likely than not" rather than "maybe," "possibly," or "could be."

As a matter of fairness, the VA does relay this exact information to its own doctors when it seeks a medical opinion. If VA claimants were aware of what constitutes a medical opinion adequate for rating purposes, it would prevent the VA from having to delay a decision on the claim by seeking its own opinion. This would also reduce the numerous appeals that result from conflicting medical opinions-appeals that are ultimately decided in an appellant's favor more often than not.

If Congress amends 38 U.S.C. § 5103 as requested above, it should also amend section 5103A(d)(1), which currently states: "In the case of a claim for disability compensation, the assistance provided by the Secretary under subsection (a) shall include providing a medical examination or obtaining a medical opinion when such an examination or opinion is necessary to make a decision on the claim." A sentence should be added to section 5103A(d)(1) that states: "However, when a claimant submits private medical evidence, to include a medical opinion, that is competent, credible, probative, and otherwise adequate for rating purposes in accordance with sections 5103 and 5125 [section 5125 to be discussed below] of this title, the Secretary shall not request such evidence from a Department healthcare facility."

While some may view the foregoing suggestion as tying VA's hands with respect to private medical evidence, or more specifically, medical opinions, it does not nor is it our intention to do so. The new language suggested above concerning section 5103A(d)(1) would not bind the VA to accepting such private evidence if it finds the evidence is, for example, not credible or not adequate for rating purposes. The goal is, as discussed below, to eliminate overdevelopment of claims.

B. REMOVE DUPLICATIVE PROCESSES FROM VA'S "DUTY TO ASSIST."

VA claimants should be encouraged to participate in the development of their own claims to the extent possible. Apart from filling out an application, one of the easiest functions that a claimant can perform happens to be the cause of some of the longest delays in the claims process-obtaining private records. While this function can sometimes prove difficult for unrepresented claimants who are very elderly, severely disabled, or incompetent, most claimants can easily obtain their own private records. In fact, most claimants prefer to do so as they can then ensure the VA receives the pertinent records.

The VA will obtain these types of records for a claimant. However, undue delays in the claims process arise out of statutory and regulatory requirements that cause the VA to request the same private treatment records repeatedly. The pertinent section of the VA's "duty to assist" statute, 38 U.S.C.A. § 5103A(b) states:

(b) Assistance in obtaining records.--(1) As part of the assistance provided under subsection (a), the Secretary shall make reasonable efforts to obtain relevant records (including private records) that the claimant adequately identifies to the Secretary and authorizes the Secretary to obtain.

(2) Whenever the Secretary, after making such reasonable efforts, is unable to obtain all of the relevant records sought, the Secretary shall notify the claimant that the Secretary is unable to obtain records with respect to the claim. Such a notification shall--
(A) identify the records the Secretary is unable to obtain;
(B) briefly explain the efforts that the Secretary made to obtain those records; and
(C) describe any further action to be taken by the Secretary with respect to the claim.

38 U.S.C.A. § 5103A(b) (West 2002 & Supp. 2007).

The VA promulgated a regulation concerning the above statutory requirements that states:

Obtaining records not in the custody of a Federal department or agency. VA will make reasonable efforts to obtain relevant records not in the custody of a Federal department or agency, to include records from State or local governments, private medical care providers, current or former employers, and other non-Federal governmental sources. Such 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) (2007).

These provisions of law have evolved to cause the VA to request the same set of records multiple times, usually to no avail. Alternatively, when such attempts fail, the pertinent private records are usually submitted by the claimants themselves. These duplicative development procedures cause massive delays in the claims process and feed otherwise empty litigating positions of many attorneys representing appellants before the Court. The latter, just as in litigating positions regarding the VA's "duty to notify," continues to result in numerous judicial precedent that merely adds hollow procedures to the VA's development requirements.

Recommendation

The undue delays caused by these requirements can be made much more efficient by amending section 5103A(b) to limit the VA's requirement that it request no individual private record or set of private records more than once. This would reduce by hundreds of thousands the number of duplicative letters mailed by VA.

C. PREVENT OVERDEVELOPMENT OF CLAIMS

Numerous developmental procedures in the VA claims process collectively add undue delay in the claims process. For example, rather than making timely decisions on C&P claims when evidence development may be complete, the VA routinely continues to develop claims. These actions lend validity to many veterans' accusations that whenever VA would rather not grant a claimed benefit, VA intentionally overdevelops cases to obtain evidence against the claim. Despite these accusations, a lack of adequate training is just as likely the cause of some overdevelopment.

Such actions result in numerous appeals, followed by needless remands from the Board and/or the Court. In many of these cases, the evidence of record supports a favorable decision on the appellant's behalf yet the appeal is remanded nonetheless. These unjustified remands usually do nothing but perpetuate the hamster-wheel reputation of veterans' law. In fact, the BVA is guilty of remanding an untold number of appeals solely for unnecessary medical opinions. From October 2006 to October 2007, the Board remanded 12,269 appeals in order to obtain medical opinions. While many were legitimate, far too many were remanded for no other reason but to obtain a VA medical opinion merely because the appellant had submitted a private medical opinion. Such actions are a complete waste of VA's resources.

The foregoing amendments to section 5103A(d)(1) suggested in "III.A." of this testimony would have a significant positive effect on this problem. Essentially, VA requests unnecessary medical opinions in cases where the claimant has already submitted one or more medical opinions that are adequate for rating purposes. VA claimants desiring to secure their own medical evidence, including a fully informed medical opinion, are entitled by law to do so. If a claimant does secure an adequate medical opinion, there is no need in practicality or in law for VA to seek its own opinion. Congress enacted title 38, United States Code, section 5125 for the express purpose of eliminating the former 38 Code of Federal Regulations, section 3.157(b)(2) requirement that a private physician's medical examination report be verified by an official VA examination report prior to an award of VA benefits. Section 5125 states:

For purposes of establishing any claim for benefits under chapter 11 or 15 of this title, a report of a medical examination administered by a private physician that is provided by a claimant in support of a claim for benefits under that chapter may be accepted without a requirement for confirmation by an examination by a physician employed by the Veterans Health Administration if the report is sufficiently complete to be adequate for the purpose of adjudicating such claim. [Emphasis added]

38 U.S.C.A. § 5125 (West 2002). Therefore, Congress codified section 5125 to eliminate unnecessary delays in the adjudication of claims and to avoid costs associated with unnecessary medical examinations.

Notwithstanding the elimination of 38 C.F.R. § 3.157, and the enactment of 38 U.S.C.A. § 5125, VA consistently refuses to render decisions in cases wherein the claimant secures a private medical examination and medical opinion until a VA medical examination and medical opinion are obtained. Such actions are an abuse of discretion that delay decisions and prompt needless appeals. When claimants submit private medical evidence that is competent, credible, and otherwise adequate for rating purposes, Congress should mandate that VA must decide the case based on such evidence rather than delaying the claim by arbitrarily and unnecessarily requesting additional medical examinations and opinions from the agency. Such enactment will preserve VA's manpower and budgetary resources; help reduce the claims backlog and prevent needless appeals; and most importantly, better serve disabled veterans and their families.

Recommendation

Congress should amend title 38, United States Code, section 5125, insofar as it states that a claimant's private examination report "may be accepted . . . if . . . the report is sufficiently complete to be adequate for the purpose of adjudicating such claim." The foregoing statutory language should be amended to read that a claimant's private examination report, including medical opinion, "must be accepted . . . if . . . the report is (1) provided by a competent healthcare professional, (2) probative to the issue being decided, (3) credible, and (4) otherwise adequate for the purpose of adjudicating such claim."

D. RESTORE FAIRNESS TO THE CLAIMS PROCESS.

In order for us to reach the conclusion regarding this recommendation, we must explain the story of James Halvatgis. Mr. Halvatgis served approximately 25 years of honorable service. He was diagnosed with a right lumbar strain following a lifting injury in February 1963. Mr. Halvatgis also hurt his back when he fell approximately 20 feet while rappelling and then again in a jeep accident when he was thrown from the vehicle while swerving to avoid a landmine in Vietnam.

He reported low back pain in July 1966, December 1968, September through November 1973, September through October 1974, and again in 1976. Many of these symptoms spanned months at a time and were accompanied by neurological symptoms indicating nerve involvement. X-rays of the veteran's low back taken prior to military discharge revealed minimal sacralization of the L5 with secondary slight narrowing of the L5-S1 (i.e., stenosis), spina bifida occulta of the S1 segment and slight right scoliosis.

Numerous private treatment records following discharge continued to document a definite back disability. A board-certified orthopedic surgeon, who was also an Associate Professor of Orthopedic Surgery, diagnosed degenerative joint disease of the lumbar spine with spinal stenosis. The VA subsequently received a medical opinion from this same orthopedic surgeon wherein he stated that he felt that the veteran had symptoms since the 1960s with respect to his

low back and opined that in all likelihood, the Vietnam War injuries contributed to his early onset of arthritis and spinal stenosis.

Mr. Halvatgis filed a claim of service connection for his low back condition in January 2002 wherein he explained in detail the circumstances of his injuries during service. Mr. Halvatgis explained how his fall during rappelling training produced severe pain in the neck and back, but that he was scheduled to graduate from Ranger school the following day. The veteran further explained that he did not seek medical treatment despite the pain he experienced as he did not want to jeopardize his chances of graduating from Ranger school. Mr. Halvatgis also explained the circumstance surrounding the jeep accident. He indicated that when thrown from the jeep he landed on his head, neck, shoulders, and back.

Mr. Halvatgis submitted a statement to VA that all doctors who provided statements regarding his claims were afforded one complete copy of his service medical records. In April 2002, the VA received another medical opinion from a second board-certified orthopedic surgeon, who again was also an Associate Professor of Orthopedic Surgery. This physician stated that he had treated Mr. Halvatgis since March 1993 for chronic back problems and that he had also reviewed the veteran's service medical records. The physician opined that the veteran's "condition is a continuation of the difficulties he developed in the service."

The veteran submitted a second medical (totaling three) opinion from one of the surgeons that stated the low back pain Mr. Halvatgis complained of while in the military "gradually progressed to the point where he now has post-traumatic arthritis of the lumbar spine." A second opinion from the other surgeon (totaling four) was submitted that stated, "[h]e had problems dating back to 1974 when . . . he was noted to have collapse, narrowing, and degeneration at the L5-S1 level. I have reviewed his medical service record which indicates this difficulty to that point in time."

In developing the claim, the VA conducted an examination of Mr. Halvatgis, in which it asked for a medical opinion, despite the opinions already of record. The examination, to include the medical opinion was performed by a non-certified physician assistant. ("PA" rather than "PA-C") Without referring to all of the treatment records in service, and without acknowledging the evidence that included four opinions presented by the two orthopedic surgeons, the physician assistant opined that Mr. Halvatgis' condition was congenital and otherwise age related, and therefore not related to his service. Based on the physician assistant's opinion, the VA denied the claim.

Mr. Halvatgis appealed to the Board. After reviewing all the evidence from the SMRs, the private medical evidence and medical opinions based on the veteran's service records from two board-certified orthopedic surgeons, together with one medical opinion from a non-certified physician assistant, the Board found that there was "no competent evidence linking the veteran's low back disorder with his service . . . ." The Board arbitrarily provided the physician assistant's opinion more probative value simply because that examiner had reviewed the veteran's claims file, despite the fact that each orthopedic surgeon had reviewed Mr. Halvatgis' SMRs (the remainder of evidence in the claims file was mostly the private treatment records that were actually from the treating orthopedic surgeons).

Mr. Halvatgis appealed to the Court. See Halvatgis v. Mansfield, No. 06-0149, 2007 WL 4981384 (U.S. Vet.App., November 02, 2007). Because of the Board's nearly unreviewable authority to assign probative value as arbitrarily as it sees fit, regardless of how abusive, and because of the Court's refusal to reverse such ludicrous decisions if they contain the slightest scintilla of plausibility, the Court denied Mr. Halvatgis' claim of service connection for his back condition.

Unfortunately, cases such as this are not at all uncommon. A combination of reasons explains the inherent unfairness displayed in Mr. Halvatgis' case, to include countless others like his. Part of the problem is because a claimant's statutory right to the benefit of the doubt in cases like this, (see 38 U.S.C.A. § 5107) has been converted by the Court's jurisprudence to nothing more than meaningless window dressing consisting only of smoke and mirrors. See The Independent Budget's Judicial Review section for a complete explanation of the flaws concerning the benefit of the doubt.

Another reason, as explained above, is that the Board has nearly unreviewable authority to assign probative value to evidence. The Board is fully aware that its power to assign such value to evidence is practically untouchable; therefore, rather than using that power to ensure fairness and objectivity when reviewing evidence, it consistently yields it as a proverbial double-edged sword to marginalize and minimize evidence to fit its own subjective view.

Each of the above problems is significant in and of itself-each deserves attention from this Committee. Nonetheless, the root of these problems lies in the inefficient, sometimes unfair, and far too subjective processes for obtaining medical opinions in the VA's benefits system. As unfair, unlawful, and subjective as the circumstances in Mr. Halvatgis' case are, and as many problems that exist between the Board and the Court regarding this subject, the procedural mess and undue delays effect far more cases at the VARO level. Improving the process locally will have a positive ripple effect throughout the system.

Recommendation

Congress should further amend section 5103A to indicate that in circumstances where a claimant submits a private medical opinion in accordance with the remainder of sections 5103A, 5103, and 5125 (if amended in accordance with suggestions herein), and that where the VA finds such medical opinion competent, credible, and probative, but otherwise not entirely adequate for rating purposes, and based on such finding decides to obtain a medical opinion from a Department health care provider, such opinion shall be obtained from a medical expert with equal qualifications as that of the private health care provider who rendered the private medical opinion on behalf of the claimant. Mr. Halvatgis' case, and thousands of others like his, serves as a perfect example for such a change in law.

Mr. Halvatgis took an active role in the development of his own case by obtaining evidence from multiple physicians of the highest stature; in turn, the VA obtained a contradictory opinion from a non-certified physician assistant, which are some of the lowest qualified professionals in the health care field.

In order to qualify as a physician assistant under current VA standards, the minimum requirements are 12 months of formal training, certified by ARC-PA, and what is otherwise on-the-job training. See VA Handbook 5005, Part II, Appendix G8 (April 2002). Additionally, while the VA, the Board, and the Court generally recognized physician assistants as having authority to render medical opinions, the Veterans Health Administration (VHA) has not. VA prescribed utilization of physician assistants in VHA Directive 2004-029.

That Directive contains VA's published "Physician Assistant Scope of Practice," which does not authorize physician assistants to provide medical opinions on any issue. Performing routine physical examinations are authorized; providing medical opinions are not. Yet the practice continues. Nonetheless, please understand that DAV is not advocating that physician assistants not be allowed to render opinions, but they certainly should not be allowed to counter the opinions of one or more Board-certified experts, especially when each opinion is based on a review of the exact same evidence.

E. REVERSE VA'S REJECTION OF THE TREATING PHYSICIAN RULE.

Appellants and many legal advocates have long urged the Court to adopt the "treating physician rule" (the Rule), as applied by the majority of federal courts in evaluating claims for disability benefits under the Social Security Act. 42 U.S.C.A. § 301 et seq. The Rule "governs the weight to be accorded to the medical opinion of the claimant's treating physician relative to other evidence before the factfinder, including the opinions of other physicians." Schisler v. Heckler, 787 F.2d 76, 81 (2nd Cir.1986). In Schisler, the United States Court of Appeals for the Second Circuit stated the "Rule" as follows:

[The] treating source's opinion on the subject of medical disability, i.e., diagnosis and nature and degree of impairment, is (i) binding on the factfinder unless contradicted by substantial evidence; and (ii) entitled to some extra weight, ... although resolution of genuine conflicts between the opinion of the physician, with its extra weight, and any substantial evidence to the contrary remains the responsibility of the fact-finder.

Schisler, 787 F.2d at 81.

The "Rule" was formulated specifically to address problems generated by the Social Security system, where the factfinder must weigh the diagnosis of a claimant's physician against the opinions of Social Security's consulting physicians. The Rule is applied to help resolve conflicting medical evidence by giving legal recognition to the assumption that a Social Security claimant's own treating doctor is the physician best able to present a complete picture of the claimant's medical condition. A similar rule adopted by the VA would provide sound legal structure to an otherwise far too subjective system insofar as medical opinions within the VA are concerned.

The Social Security Administration's "Rule" is grounded in statute. 42 U.S.C.A. § 423(d)(5)(B). Since the VA has no equal statute, the VA's General Counsel has argued in return that VA should not adopt the "Rule." See Guerrieri v. Brown, 4 Vet.App. 467, 471-73 (1993). It is rather surprising given the non-adversarial, pro-claimant, veteran-friendly system that the VA touts, that

any valid argument exists for not adopting such a rule in title 38. This is especially true considering the anti-veteran tactics displayed in the Halvatgis case.

Congress should also be aware that, as in other recommendations herein concerning medical opinions, that we do not desire to tie the VA's hands. If a claimant's treating-physician medical opinion is not adequate as discussed herein, then the VA should not be bound to accept it. Likewise, if such an opinion is genuinely contradicted by evidence of obvious greater probative value, then the VA should not be bound by the opinion.

Recommendation

Congress should add a subsection to section 5125 that adopts a treating physician rule, whether such physician happens to a private or VA health care provider. Consideration of a claimant's evidence from his/her treating physician would be subject to the suggested amendment herein to sections 5103, 5103A, and 5125.

IV. THE VA MUST ADDRESS ITS PROBLEMS WITH ACCOUNTABILITY.

We have consistently stated that quality is the key to timeliness. Timeliness follows from quality because omissions in record development, failure to afford due process, and erroneous decisions require duplicative work, which add to the load of an already overburdened system. Quality is achieved with adequate resources to perform comprehensive and ongoing training, to devote sufficient time to each case, and to impose and enforce quality standards through effective quality assurance methods and accountability mechanisms.

One of the most essential resources is experienced and knowledgeable personnel devoted to training. More management devotion to training and quality requires a break from the status quo of production goals above all else. In a 2005 report from VA's Office of Inspector General, VBA employees were quoted as stating: "Although management wants to meet quality goals, they are much more concerned with quantity. An RVSR is much more likely to be disciplined for failure to meet production standards than for failing to meet quality standards;" and that "there is a lot of pressure to make your production standard. In fact, your performance standard centers around production and a lot of awards are based on it. Those who don't produce could miss out on individual bonuses, etc."

In addition to basing awards on production, the DAV strongly believes that quality should be awarded at least on parity with production. However, in order for this to occur, VBA must implement stronger accountability measures for quality assurance.

VA's quality assurance tool for compensation and pension claims is the Systematic Technical Accuracy Review (STAR) program. Under the STAR program, VA reviews a sampling of decisions from regional offices and bases its national accuracy measures on the percentage with errors that effect entitlement, benefit amount, and effective date.

Inconsistency signals outright arbitrariness in decision-making, uneven, or overall insufficient understanding of governing criteria or rules for decisions or rules that are vague or overly broad

to allow them to be applied according to the prevailing mindset of a particular group of decision makers. Obviously, VA must detect inconsistencies before the cause or causes can be determined and remedied.

Simply put, there is a gap in quality assurance for purposes of individual accountability in quality decision making. In the STAR program, a sample is drawn each month from a regional office workload divided between rating, authorization, and fiduciary end-products. For example, a monthly sample of "rating" related cases generally requires a STAR review of 10 rating-related end products. Reviewing 10 rating-related cases per month for an average size regional office, an office that would easily employee more than three times that number of raters, is undeniable evidence of a total void in individual accountability. If an average size regional office produced only 1,000 decisions per month, which we feel is quite conservative, the STAR program would only review one percent of the total cases decided by that regional office. Those figures leave no room for trend analysis, much less personal accountability.

Another method of measuring the VA's need for more accountability is an analysis of the Board's Summary of Remands, while keeping in mind that its summary represents a statistically large and reliable sample of certain measurable trends. The examples must be viewed in the context of the VA (1) deciding 700,000 to 800,000 cases per year; (2) receives over 100,000 NODs; and (3) submits 40,000 appeals to the Board. The examples below are from October 2006 to October 2007.

Remands resulted in 998 cases because no "notice" under section 5103 was ever provided to the claimant. The remand rate was much higher for inadequate or incorrect notice; however, considering the confusing (and evolving) nature of the law concerning "notice," we can only fault the VA when it fails to provide any notice.

VA failed to make initial requests for SMRs in 667 cases and failed to make initial requests for personnel records in 578 cases. The number was higher for additional record requests following initial. This number is disturbing because initially requesting a veteran's service records are the foundation to every compensation claim. It is claims development 101.

The Board remanded 2,594 cases for initial requests for VA medical records and 3,393 cases for additional requests for VA medical records. The disturbing factor here is that a VA employee can usually obtain VA medical records without ever leaving the confines of one's computer screen.

Another 2,461 cases were remanded because the claimant had requested a travel board hearing or video-conference hearing. Again, there is a disturbing factor here. A checklist is utilized prior to sending an appeal to the Board that contains a section that specifically asked whether the claimant has asked for such a hearing.

The examples above totaled 7,298 cases, all of which cleared the local rating board and the local appeals board with errors that are elementary in nature. Yet they were either not detected or they were ignored. The problem with the VA's current system of accountability is that it does not matter if they were ignored because those that commit such errors are usually not held responsible. They therefore have no incentive to concern themselves with the quality of their

work. Above all else, these figures showing that the VA's quality assurance and accountability systems require significant enhancement.

To recap the various issues regarding medical opinions mentioned herein in relation to the above analysis, the numbers in all categories of remands are completely overshadowed in comparison to the total number of remands for initial and/or subsequent medical opinions-12,269.

Recommendation

Congress should authorize the formation of a committee comprised of congressional staff from the House and Senate Committees on Veterans Affairs, select personnel from service organizations, and key employees of the Department with a defined purpose of establishing a quality assurance and accountability program that will detect, track, and hold responsible those VA employees who commit egregious errors.

Conclusion

The recommendations herein have been formulated from a perspective of "building on what works." With the potential exception of the last recommendation, all other recommendations are highly cost effective, in both monetary resources and human resources-they will not require expenditure of any additional appropriations. Additionally, no recommendation herein relaxes any burden of proof or provides for any benefit not already provided in law.

We are confident these recommendations, if enacted, will help simplify the confusing claims process, will make efficient its cumbersome procedures, and drastically reduce undue delays in the claims process. It has been a pleasure to appear before this honorable Committee today.