For clinician review. Not a signed medical opinion. FICTIONAL EXAMPLE. Do not submit as evidence.

[CLINICIAN: letterhead: practice name, address, phone]

[CLINICIAN: date]

RE: **[VETERAN: full name]**, **[VETERAN: last four of SSN or VA file number]**

Medical nexus opinion: Lumbar spine condition and direct connection to the in-service lifting injury

To whom it may concern:

I am a **[CLINICIAN: specialty and board certification]** physician licensed in **[CLINICIAN: state and license number]**. **[CLINICIAN: relationship to the veteran: treating since (date), or records review only]**. I was asked to give a medical opinion on whether the veteran's lumbar spine condition was incurred in or caused by the documented lifting injury during service. For this opinion, I reviewed in full the supplied service clinic note, separation history, urgent care note, current spine assessment, prior VA opinion, and the medical literature cited at the end of this letter. I have reviewed the records listed below in full, and I have reviewed the medical literature cited at the end of this letter.

Records reviewed

1. Service clinic note, dated April 18, 2012, page 1.
2. Separation history, dated July 9, 2014, page 2.
3. Urgent care note, dated February 12, 2019, page 3.
4. Current spine assessment, dated November 6, 2025, page 4.
5. The veteran's written statement describing the history, symptoms and course, as supplied to me.

Pertinent history

On April 18, 2012, the service clinic note assessed lumbar strain after the veteran lifted an equipment case during duty. The clinician documented local tenderness and issued a temporary lifting restriction. The veteran did not report leg symptoms.

On July 9, 2014, the separation history recorded intermittent back discomfort with heavy lifting. The examination documented normal strength and gait. No imaging was obtained at that visit.

On February 12, 2019, the urgent care note recorded new back pain after the veteran moved furniture at home. The same note also recorded earlier intermittent discomfort. The supplied records contain no treatment documentation for the intervening period.

On November 6, 2025, the current spine assessment diagnosed lumbar degenerative disc disease with activity-related low back pain. Imaging described lower lumbar disc degeneration. The assessment did not state when the degeneration began or attribute it to a particular injury. At present, the veteran describes back discomfort brought on by extended standing and by lifting.

Current diagnosis

The November 6, 2025 current spine assessment states the diagnosis as lumbar degenerative disc disease with activity-related low back pain. Imaging obtained for that assessment described lower lumbar disc degeneration. The supplied records do not state the veteran's current treatment.

Opinion

It is at least as likely as not (a 50 percent or greater probability) that the veteran's lumbar spine condition was incurred in or caused by the April 18, 2012 lifting injury during duty.

Rationale

Manual lifting transfers compression and shear forces through the lumbar discs, joints, muscles, and ligaments. When the load exceeds tissue tolerance, those forces produce a lumbar strain and mechanically provoked pain. An injured lumbar region can remain sensitive to later loading, producing recurrent symptoms during lifting or prolonged standing. Lumbar strain and degenerative disc disease are not the same diagnosis, so I do not base this nexus on the diagnostic label alone. I base it on the documented in-service injury, the subsequent record of intermittent mechanically provoked symptoms, the later imaging diagnosis, and the established loading mechanism.

Skals found that load mass had the greatest effect on L5-S1 compression, that increasing asymmetry produced large increases in mediolateral shear, and that load mass and asymmetry significantly affected anteroposterior shear during lifting (Skals, 2021, PMID 34126573). This applies because the April 18, 2012 service clinic note documents an actual lumbar strain while lifting an equipment case. The record does not state the mass or position of that case, so the study supports the biological mechanism but does not quantify the force experienced by this veteran.

Luoma reported that occupational load affected the risk of lumbar disc degeneration and that accidental back injuries were associated with an increased risk of disc degeneration (Luoma, 1998, PMID 9869307). The study also found that all evaluated signs of disc degeneration were related to a history of back accidents. This veteran has a documented lifting injury during service and a later furniture-moving injury. The study therefore identifies both events as medically relevant, but the veteran's intermittent back discomfort was documented before the later event, including in the July 9, 2014 separation history.

McGill reviewed the tissue loads involved in low back injury and identified spine posture and prolonged tissue loading as important considerations in injury risk (McGill, 1997, PMID 9109558). This applies because the service clinic note directly links the veteran's lumbar strain to lifting, while the separation history and current symptom report identify lifting as a recurring trigger. This literature supports the mechanical pathway connecting lumbar loading to injury; it does not independently determine causation in an individual veteran.

The veteran's documented course fits that mechanism. The April 18, 2012 service clinic note provides contemporaneous evidence of an actual lumbar injury, local tenderness, and a temporary lifting restriction. The July 9, 2014 separation history then records intermittent discomfort with heavy lifting. Normal strength and gait at separation do not exclude activity-related lumbar pain, and the absence of imaging means that visit did not assess disc structure. The February 12, 2019 urgent care note records earlier intermittent discomfort in addition to the new furniture-moving episode. The November 6, 2025 assessment supplies the current imaging-supported diagnosis.

The timing supports the nexus. The documented course begins with a lumbar strain during service, continues with intermittent lifting-related discomfort at separation, and includes a history of earlier intermittent discomfort when the veteran sought care for the later episode. Continuous treatment records were not supplied, which limits assessment of symptom frequency and severity during the intervening period. It does not establish that the condition resolved, particularly because the available records describe intermittent rather than constant symptoms.

The February 12, 2019 furniture-moving injury is the principal competing cause in the record and represents a separate lumbar stressor. Luoma supports the medical relevance of back accidents generally, but it does not apportion degeneration between separate injuries (Luoma, 1998, PMID 9869307). I do not treat the later event as the onset of all lumbar symptoms because the April 18, 2012 service clinic note and July 9, 2014 separation history place the lumbar injury and recurrent discomfort before it. The November 6, 2025 current spine assessment neither dates the onset of degeneration nor attributes it to the furniture-moving event. The records do not separately document a pattern of repetitive occupational lifting, so my opinion rests on the documented

in-service lifting injury rather than an unsupported history of repetitive stress. The January 10, 2026 prior VA opinion relied on the premise that no in-service back complaint was documented, but the service clinic note and separation history directly contradict that premise.

Response to the prior VA examination

The January 10, 2026 prior VA opinion did not provide a separately stated conclusion or use probability language. Its stated rationale was: "No back complaint during service is documented in the records supplied for this fictional examination. "

That opinion rests on an inaccurate factual premise. The April 18, 2012 service clinic note assessed lumbar strain after lifting an equipment case during duty, documented local tenderness, and issued a temporary lifting restriction. The July 9, 2014 separation history also recorded intermittent back discomfort with heavy lifting. Because the examiner did not address these records, the rationale did not evaluate the documented in-service injury, the symptoms present at separation, or the mechanical relationship between lifting and lumbar tissue loading.

Summary of the basis for this opinion

1. The April 18, 2012 service clinic note documented lumbar strain, local tenderness, and a lifting restriction after an equipment-case lift during duty.
2. The July 9, 2014 separation history documented intermittent back discomfort with heavy lifting after the in-service injury.
3. The February 12, 2019 urgent care note recorded earlier intermittent discomfort in addition to the new furniture-moving episode.
4. The November 6, 2025 assessment diagnosed lumbar degenerative disc disease based on imaging that described lower lumbar disc degeneration.
5. The cited literature supports lumbar compression and shear during lifting and an association between back injuries and later disc degeneration.

Conclusion

For these reasons, it is at least as likely as not (a 50 percent or greater probability) that the veteran's lumbar spine condition was incurred in or caused by the April 18, 2012 lifting injury during duty. I am available to provide further clinical explanation if requested.

[CLINICIAN: signature]
[CLINICIAN: name and degree]
[CLINICIAN: specialty and board certification]
[CLINICIAN: state license number]
[CLINICIAN: practice address and phone]
Date: **[CLINICIAN: date]**
I have reviewed the records listed above.

Literature cited

1. Sebastian Skals, Rúni Bláfoss, Mark de Zee, et al. Effects of load mass and position on the dynamic loading of the knees, shoulders and lumbar spine during lifting: a musculoskeletal modelling approach. Applied ergonomics. 2021. PMID 34126573. https://pubmed.ncbi.nlm.nih.gov/34126573/
2. K Luoma, H Riihimäki, R Raininko, et al. Lumbar disc degeneration in relation to occupation. Scandinavian journal of work, environment & health. 1998. PMID 9869307. https://pubmed.ncbi.nlm.nih.gov/9869307/
3. S M McGill. The biomechanics of low back injury: implications on current practice in industry and the clinic. Journal of biomechanics. 1997. PMID 9109558. https://pubmed.ncbi.nlm.nih.gov/9109558/

Review notes for the practitioner

Supporting instructions outside the letter body.

Draft for clinician review

Every date, value and citation in this letter was traced to a supplied source and the reasoning passed an independent check. That is completeness, not medical validation. The clinician reviews the records and literature, changes what they disagree with, and signs only what they believe.

Clinical statements written from general medical knowledge rather than a cited source. By signing, the clinician adopts these as their own:
- Manual lifting transfers compression and shear forces through the lumbar discs, joints, muscles, and ligaments.
- When the load exceeds tissue tolerance, those forces produce a lumbar strain and mechanically provoked pain.
- An injured lumbar region can remain sensitive to later loading, producing recurrent symptoms during lifting or prolonged standing.
- Lumbar strain and degenerative disc disease are not the same diagnosis, so I do not base this nexus on the diagnostic label alone.
- Normal strength and gait at separation do not exclude activity-related lumbar pain, and the absence of imaging means that visit did not assess disc structure.
- This literature supports the mechanical pathway connecting lumbar loading to injury; it does not independently determine causation in an individual veteran.
- The study supports the biological mechanism but does not quantify the force experienced by this veteran.

FICTIONAL EXAMPLE. These invented records were processed through the Raven Nexus draft engine. No real veteran, clinician, or medical opinion is represented. Do not submit this example as evidence.

This is an unreviewed working draft, not medical evidence. The clinician must independently review the records and literature, reach their own conclusion, and author or adopt any final opinion.

Bold bracketed fields identify actions for the clinician. Review all drafted medical content, not only those fields. Correct, remove, or independently adopt the proposed reasoning before signing a final opinion. This packet does not verify a signature or make a draft ready to submit to VA.