# 4

# Rating Process and System

# I VA Schedule for Rating Disabilities

## I.1 Introduction

The Department of Veterans Affairs (VA) has a disability evaluation guide called the Schedule for Rating Disabilities (hereafter referred to as the “Rating Schedule”). The Rating Schedule is a key component in the process of adjudicating claims for disability compensation. It is used to assess the severity of disability. In turn, the severity, expressed as a percentage of disability, or rating, determines the amount of monthly compensation (Table 4.1).

The Rating Schedule consists of slightly more than 700 diagnostic codes organized under 14 body systems, such as the musculoskeletal system, organs of special sense, and mental disorders. For each code, the schedule provides criteria for assigning a percentage rating. The criteria are primarily based on loss or loss of function of a body part or system, as verified by medical evidence, although the criteria for mental disorders are based on the individual’s “social and industrial inadaptability,” i.e., overall ability to function in the workplace and everyday life. The ratings may range from 0 percent to 100 percent, or total, in intervals of 10 percent, although in most cases, a smaller number of percentages is used. Mental disorders, for example, may be rated 0, 10, 30, 50, 70, or 100 percent. The schedule includes procedures for rating conditions that are not among the 700 plus diagnostic codes. It also includes procedures for combining ratings into a single overall rating when a veteran has more than one disability.

**Table 4.1 2007 Disability Compensation Amounts**

| COMBINED RATING | COMPENSATION | | | |
|---|---|---|---|---|
| | Veteran Alone | Veteran with Spouse | Veteran, Spouse, and Child | Veteran, Spouse, Two Parents, Child |
| 10% | $115 | $115 | $115 | $115 |
| 20% | $225 | $225 | $225 | $225 |
| 30% | $348 | $389 | $420 | $486 |
| 40% | $501 | $556 | $597 | $685 |
| 50% | $712 | $781 | $832 | $944 |
| 60% | $901 | $984 | $1,045 | $1,179 |
| 70% | $1,135 | $1,232 | $1,303 | $1,459 |
| 80% | $1,319 | $1,430 | $1,511 | $1,689 |
| 90% | $1,483 | $1,608 | $1,699 | $1,899 |
| 100% | $2,471 | $2,610 | $2,711 | $2,935 |

NOTE: The VA compensation rate table includes additional categories, such as a veteran and two parents, and add-on amounts for additional children under age 18, additional children in school over 18, and spouses requiring aid and attendance.

SOURCE: Compensation Rate Table, Effective 12/1/06. Available at: http://www.vba.va.gov/bln/21/Rates/comp01.htm (accessed August 15, 2007).

It is critical that the Rating Schedule be as accurate as possible, so that rating decisions based on it are as valid and reliable—and therefore fair—as possible. Validity means that ratings based on the Rating Schedule reflect the actual degree of disability of the veteran. Reliability means that veterans with the same disability receive the same rating or that two raters would give the same veteran the same rating. Validity and reliability of rating decisions depend on the accuracy of the Rating Schedule in determining degree of disability and on additional factors. Additional factors include the quality and relevance of medical information, accuracy and ease of use of information systems, training and experience of raters, effectiveness of the quality review system, and number of raters and other personnel involved in the claims adjudication process. These issues are addressed later in this report.

This section of the report addresses the effectiveness of the Rating Schedule as a tool for determining degree of disability. But before the schedule's effectiveness can be evaluated, the purposes of the VA disability compensation program must first be specified. As the Commission considered these purposes, several questions presented themselves.

The purpose of compensation as stated in statute is to make up for the average impairment of earning capacity caused by service-connected disabilities. Given this purpose, is the Rating Schedule effective in determining the impairment of earning capacity experienced on average by veterans with the same rating level? Moreover, it is commonly acknowledged that the disability compensation program compensates for injuries and diseases that do not impair earning capacity but have negative consequences for veterans. Therefore, is the purpose of the Rating Schedule to also compensate for noneconomic losses, such as ability to participate in everyday life activities; physical or mental losses that do not have economic impacts; disfigurement; or shorter life spans? If so, how effective is the schedule for providing compensation for these noneconomic loses? Should the Rating Schedule compensate for overall loss of quality of life?

The origins and historical development of the Rating Schedule are described next, because the current schedule has been strongly shaped by earlier schedules. The history is followed by a review of the findings on the currency of the current schedule in the Institute of Medicine's report, *A 21st Century System for Evaluating Veterans for Disability Benefits*, and the Commission's findings and recommendations on the medical adequacy of the Rating Schedule. The chapter then turns to the assessment of the medical evaluation and rating determination processes in the IOM report and the improvements recommended in that report, followed by the Commission's recommendations.

## I.2 Historical Origins and Development

The present Rating Schedule was developed in 1945 and was based on revisions of schedules dating from 1917.[1] Since 1917, the head of VA has been directed to adopt and apply a schedule of ratings based "as far as is practicable upon the average impairments in earning capacity . . . in civil occupations."[2] The economic purpose of the Rating Schedule was amplified in the first revision of the law in 1919, when an additional sentence directed the bureau during the development of the Rating Schedule to consider "the impairment in ability to secure employment" resulting from permanent injury (Pub. L. No. 104, (1919). According to statute, the secretary "shall from time to time readjust this schedule of ratings in accordance with experience" (38 U.S.C. § 1155). The first official

[1] President's Commission, *Administration of Veterans' Benefits,* 33. A "Provisional Rating Table" was issued in September 1919, although it was never approved officially.

[2] Compensation was first authorized by the War Risk Insurance Act of 1917, Pub. L. No. 90 (1917). Before the present Department of Veterans Affairs was established in 1989, veterans' compensation was administered by the heads of the Bureau of War Risk Insurance (1917–1921), Veterans' Bureau (1921–1930), and Veterans Administration (1930–1989), respectively.

rating schedule was promulgated in 1921, and comprehensive revisions of the schedule were made in 1925, 1933, and 1945.[3]

The U.S. veterans' disability compensation program was implemented soon after workers' compensation programs were established at the state and federal levels, and the programs have similarities as well as important differences.[4] Both programs were intended to compensate for disability (i.e., the consequences of injury), not for injury itself (although in practice, degree of loss has often been used as a proxy for degree of disability). In both programs, disability was limited to economic loss, not to all damages—physical, mental, and social as well as economic—allowed under common law. The two programs were also alike, except in a few states, in using schedules based on the average loss of earning capacity of beneficiaries with similar impairments, rather than on the actual loss of earning capacity of each individual claimant.

A major difference between the programs as they have evolved has been the basis for compensation. Workers' compensation programs in the United States, which compensate for injuries and diseases caused by work, have remained based on loss of wages, while the veterans' disability compensation program, which compensates for injuries and diseases acquired while in national military service, has expanded the basis for compensation over time to include noneconomic losses. For example, the disability compensation program pays additional reparations for certain severe conditions, such as the loss of both hands or both feet.[5] Another difference is in the duration of payments. Workers' compensation programs typically pay a fixed amount for a given impairment, calculated as a percentage of the injured worker's pay (usually two-thirds) for a certain number of weeks; VA compensation is paid monthly for life.

## I.2.A First Official Rating Schedule: 1921

According to the 1921 Rating Schedule, "A disability is considered to be a mental or physical condition which would cause to the average person an impairment of earning capacity in civil occupation."[6] Although the Rating Schedule was intended to measure degree of disability associated with impairment of earning capacity, the 1921 authors had little information on the relationship between degree of disability and earnings on which to base the schedule. They drew on the practices of workers' compensation programs and private disability insurance companies, but these were only a few years old and had accumulated little practical experience. The law recognized this situation by directing that the

[3] A "Provisional Rating Table" was issued in September 1919, although it was never approved officially.
[4] President's Commission, "Veterans' Administration Contrasted."
[5] Called "special monthly compensation."
[6] Veterans' Bureau, *Disability Rating Table,* 5.

Rating Schedule be readjusted from time to time based on actual program experience (War Risk Insurance Act of 1917, Pub. L. No. 90). The developers of the first schedule also consulted leading medical experts in the United States and the schedules for rating veterans used in France, Canada, England, and Belgium.[7]

In line with then-prevailing concepts, the schedule was based on the idea that a whole person who suffers injury or illness with permanent effects loses a percentage of his or her capacity. This was made explicit in the procedure adopted for combining multiple rating percentages, which was used to construct the combined ratings table in the 1921 schedule that is still used today. For example, if a veteran has two disabilities rated 50 and 30 percent, the combined rating is 65 percent. This is determined as follows: The highest rating is subtracted from 100 percent first, leaving the veteran in this case with 50 percent capacity. The 50 percent remaining capacity is then reduced by the next highest rating, in this case, 30 percent (50 - (.3 x 50)), leaving him or her with 35 percent capacity and a combined rating of 65 percent (100 percent minus 35 percent). Any additional disabilities, if there are any, are applied against the remaining 35 percent, starting with the highest remaining rating, until all disabilities are accounted for.[8] After all disabilities have been considered and combined, the combined value is "then converted to the nearest number divisible by 10, and the combined values ending in 5 will be adjusted upward" (38 C.F.R. § 4.25(a). So, in this example, the combined rating would be adjusted upward to 70 percent.

The 1921 schedule also reflected then-prevailing practice in using degree of impairment of a body part or system as the measure of disability, because tools to measure the impacts of impairment on a person's ability to work did not exist. Thus the schedule tied the degree of disability to the extent that a body part was missing or unusable, not on how well the average person could accomplish work-related functions given their impairments. For example, the percent disability caused by amputation of an arm or thigh was based on the amount of limb lost. The percent disability caused by impairment of a limb was based on the amount of range of motion lost, and the percent disability caused by impairment of vision was based on degree of refractive error (Table 4.2) (e.g., 0 percent for 20/40 in both eyes, 100 percent for less than 10/200 in both eyes).

[7] Veterans' Bureau, *Disability Rating Table,* 13, 25, 39, 45, 57, 75, 82.

[8] Beginning with the 1933 schedule, the combined rating is rounded to the nearest number divisible by 10 and ratings ending in 5 are rounded up. Thus, in the example given above, the combined rating of 65 would be rounded up to 70.

**Table 4.2 Reproduced Excerpt of 1921 Rating Schedule**

| DISABILITY | MAJOR[a] | MINOR[a] |
|---|---|---|
| Arm, amputation of | | |
| Disarticulation (total) | 94% | 85% |
| Upper and middle third | 89% | 80% |
| Lower third | 84% | 75% |
| Thigh, amputation of | **EITHER** | |
| Disarticulation (total) | 80% | |
| Upper third | 80% | |
| Middle third | 63% | |
| Lower third | 58% | |
| | **MAJOR** | **MINOR** |
| Forearm, limitation of flexion of | | |
| 50° (160°–110°) | 25% | 20% |
| 70° (160°–90°) | 20% | 15% |
| 110° (180°–70°) | 5% | 5% |

[a] Major and minor refer to handedness, i.e., the major arm of a right-handed person is his or her right arm, and the minor arm is his or her left arm.

## I.2.B 1925 Rating Schedule

The 1925 Rating Schedule was developed in response to a change in the law in 1924, which added "similar to the occupation of the injured man at the time of enlistment" to the original standard, "The ratings shall be based, as far as practicable, upon the average impairments of earning capacity resulting from such injuries in civil occupations." Accordingly, the 1925 schedule included a method to adjust the ratings in accord with the physical and mental demands of each claimant's occupation. Under the 1925 schedule, two veterans with the same percentage of impairment would receive different amounts of compensation depending on their occupation. For example, a musician who lost a finger would receive more compensation than an accountant. The impairment table was developed primarily by a medical expert; the occupational table was developed by a panel of occupational specialists.[9] They were assisted by experts who designed the California Schedule of Rating Permanent Disabilities, by data from the Bureau International du Travail in Geneva, Switzerland, other national and international sources of correspondence, and publications of the

[9] Director Veterans' Bureau, *1926 Annual Report*, 46-47.

Departments of the Army, Commerce, and Labor, and the Census Bureau.[10] The Veterans' Bureau's Medical Service established a board of medical, legal, and occupational experts for regional offices to consult about questions arising from application of the schedule and to evaluate and revise the schedule, and a number of revisions were made.[11]

## I.2.C 1933 Rating Schedule

The Rating Schedule was revised twice in 1933. The first revision included only five grades of disability, and each grade had an associated degree rating and a computational value used when there were multiple disabilities. A second revision followed on the heels of the first, and it is this second revision that is commonly called the 1933 Rating Schedule.

The 1933 Rating Schedule returned to the original 1917 concept of average impairment of earning capacity without regard to occupation, but its ratings were derived from the 1925 schedule by using the midrange of the occupational ratings in the 1925 schedule. In some places, the 1933 schedule elaborated on the 1925 schedule, for example, by replacing two ratings for peripheral nerve injuries (complete and partial) with four ratings (complete, severe, moderate, and mild), and by making "social and industrial inadaptability" the measure of psychiatric disability (previously, the measure was just "social inadaptability"). The 1933 schedule was the first to use diagnostic codes. There were seven "extensions" (revisions) to the 1933 schedule before it was superseded by the 1945 schedule.

## I.2.D 1945 Rating Schedule

The 1945 Rating Schedule was in turn based on the 1933 schedule, with revisions made by experienced rating personnel (most of them physicians), physicians in VA's Department of Medicine and Surgery, and representatives of the Board of Veterans Appeals and other VA offices.[12] The VA Department of Medicine and Surgery provided the revision group, called the Disability Policy Board, with

> a medical monograph—a detailed description of etiology and manifestations—for each of the conditions included in the schedule at that time. The Board used these monographs to estimate the relative effects different levels of severity of a condition have on the

[10] President's Commission, *Disability Rating Schedule: Historical Development,* 43.
[11] Weber and Schmeckebier, *Veterans' Administration,* 139.
[12] President's Commission, *Administration of Veterans' Benefits*, 33.

> average veteran's ability to compete for employment in the job market. It set disability ratings on this basis.[13]

The revisions were based on consensus because no empirical studies of the average earnings of veterans with different rating levels had been done.

> The Chairman of the VA Rating Schedule Board, in a statement dated January 21, 1952, . . . indicated that the 1945 schedule is an outgrowth of other rating schedules which had been in use at various times from 1921 to April 1, 1946. He stated that the disability ratings provided in the 1921 schedule were not calculated on statistical or economic data regarding the average reduction in earning capacities from any disability because such data were not available, and that they undoubtedly represented the opinions of the physicians who had developed the schedules as to the effect of the various disabilities upon the earning capacity of the average man. He also stated that the disability percentage ratings provided in the 1945 schedule are based on very little calculation but that they represent the consensus of informed opinion of experienced rating personnel, for the most part physicians, and reflect many compromises of their views.[14]

The 1945 Rating Schedule was reorganized and more detailed than its predecessor, although the basis was the same (average impairment of earning capacity) and the main unit of measurement was still impairment (extent of loss or loss of use of a body part or function). The 1933 schedule had five broad groupings of conditions. The 1945 schedule split musculoskeletal and neurological disorders, and it divided a general medical and surgical disabilities category into a number of body systems—cardiovascular, digestive, gynecological, and so forth—for a total of 14 body systems. The eye, ear, nose, and throat category became the organs of special sense, after nose and throat disorders were moved into the new respiratory system. The diagnoses were renumbered in separate series under each body system, so that, for example, the codes for musculoskeletal disorders began with 5000, the codes for vision impairment began with 6000, and so forth, through the codes for dental and oral conditions, which began with 9900 (Table 4.3).

[13] Government Accountability Office, Need to Update, 11.
[14] President's Commission, *Disability Rating Schedule: Historical Development*, 33.

**Table 4.3 Rating Schedule Body Systems and Diagnostic Code Series**

| BODY SYSTEM | BODY SUBSYSTEM | DIAGNOSTIC CODE SERIES |
|---|---|---|
| Musculoskeletal | Acute, subacute, or chronic diseases | 5000 |
| | Amputations and loss of use of extremities | 5100 |
| | Ankyloses, limitation of motion, and other impairments of joints and bones | 5200 |
| | Muscle injuries | 5300 |
| Organs of special sense | Eye | 6000 |
| | Hearing | 6100 |
| | Ear and other sense organs, diseases of | 6200 |
| Systemic conditions[a] | | 6300 |
| Respiratory | Nose and throat | 6500 |
| | Trachea and bronchi | 6600 |
| | Lungs and pleura | 6700 |
| Cardiovascular | Heart | 7000 |
| | Arteries and veins | 7100 |
| Digestive | Mouth and esophagus | 7200 |
| | Gastrointestinal | 7300 |
| Genitourinary | | 7500 |
| Gynecological conditions | | 7600 |
| Hemic and lymphatic | | 7700 |
| Skin | | 7800 |
| Endocrine | | 7900 |
| Neurological conditions and convulsive disorders | Central nervous system | 8000 |
| | Miscellaneous | 8100 |
| | Cranial nerves | 8200 |
| | Peripheral nerves, paralysis | 8500 |
| | Peripheral nerves, neuritis | 8600 |
| | Peripheral nerves, neuralgia | 8700 |
| | Epilepsies | 8900 |
| Mental disorders | | 9000 |
| Dental and oral conditions | | 9900 |

[a] The “systemic conditions” category was renamed “infectious diseases, immune disorders, and nutritional deficiencies” in 1996 (Final Rule: Schedule for Rating Disabilities; Infectious Diseases, Immune Disorders and Nutritional Deficiencies (Systemic Conditions, 61 FR 39,873 [July 31, 1996]).

The new 1945 Rating Schedule had approximately 700 diagnostic codes, compared with the 500 in the 1933 schedule. The increase in the number of codes included mostly new conditions, but about 60 resulted from assigning separate codes to (1) each combination of fingers, (2) neuritis and neuralgia of each of the 21 peripheral nerves, and (3) to 25 combinations of injuries also entitled to special monthly compensation.

## I.3 History of Revisions of the 1945 Rating Schedule

The 1945 Rating Schedule became effective on April 1, 1946. The first revision, called an "extension," was issued on July 14, 1947. As with many of the early revisions, extension 1 concerned the rating of tuberculosis, because rapid advances in chemotherapy, beginning with the availability of streptomycin in 1946, were making the criteria for tuberculosis ratings steadily obsolete. By 1956, when the President's Commission on Veterans Pensions (Bradley Commission) reported, there had been 14 extensions, most of them revising a specific section.[15]

The Bradley Commission conducted three studies of the Rating Schedule: a survey and analysis of the views of 169 medical specialists on how up to date and valid the schedule was, a survey and comparative analysis of the earnings of more than 12,000 veterans receiving compensation and 7,000 veterans not receiving compensation, and an actuarial study of the mortality rates of veterans receiving compensation. The Commission summarized the results as follows:

> The Commission's studies show that the rating standards, presumptions, and follow-up procedures have many inconsistencies and are not in line with present-day medical science. The progression of ratings from degree to degree does not accurately reflect differences in capacity to earn or in longevity. The rates of compensation for those rated totally disabled appear inadequate. There is an overemphasis on obvious disabilities in comparison with equal disabilities which are not so evident. Consideration should be given to incorporating the statutory awards within a comprehensive rating scale that will encompass economic, physical, life impairment, and other factors.[16]

The Bradley Commission survey results showed that total median income of veterans with disabilities, including compensation, was 97 percent of the total median income of all veterans, but looked at by age, older veterans (55 years old

[15] President's Commission, *Disability Rating Schedule: Historical Development*, 52.
[16] President's Commission, *Veterans' Benefits*, 13.

and older) with disabilities made only 88 percent of the median income of all veterans in that age group. The survey analysis also compared median earnings plus compensation of veterans with disabilities with the median earnings of all veterans and found that they were about the same for all rating levels except 90 and 100 percent. Those rated 90 percent made about 20 percent more on average than all veterans while those rated 100 percent made 42 percent less.[17]

The Bradley Commission recommended that

> the Veterans' Administration Schedule for Rating Disabilities should be revised thoroughly so that it will reflect up-to-date medical, economic, and social thinking with respect to rating and compensation of disability…based on thorough factual studies by a broadly representative group of experts, including physicians, economists, sociologists, psychologists, and lawyers.

The Commission recommended that, while impairment of earning capacity should be the "primary factor in the determination of rating criteria," noneconomic factors should also be considered, such as loss of "physical integrity" (i.e., anatomical losses) not affecting earning capacity, "social inadaptability," and shortened life expectancy. The Commission also recommended that the rates of compensation should be related to the average earnings of a representative group of workers and adjusted every 2 years "if measurable change has occurred."[18]

The medical specialists who were surveyed identified a number of obsolete terms, rating criteria outmoded by medical advances, and missing diagnoses. Most of these, such as the lack of a code for psychomotor epilepsy and outdated nomenclature for psychoses, have been remedied, but some remain, such as using the number of daily insulin doses as a measure of the degree of disability of a diabetic.[19]

In 1961, VA addressed a part of the Rating Schedule largely dating from 1933. The designers of the 1945 schedule had kept the classifications and nomenclature for mental disorders from the 1933 schedule, that is, having two categories of mental disorders—psychoses and psychoneuroses—and using older terms such as dementia praecox for schizophrenia.[20] The 1961 revision adopted four classifications of mental disorders: psychotic disorders, organic brain disorders, psychoneurotic disorders, and psychophysiologic disorders. The

[17] Ibid.,162.
[18] Ibid., 168, 181.
[19] President's Commission, *Disability Rating Schedule: Historical Development*, 168.
[20] Ibid., 162.

1961 revision also updated the nomenclature; added up-to-date diagnoses from the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), such as dissociative, conversion, phobic, obsessive-compulsive, and depressive reactions; and dropped outmoded diagnoses, such as neurasthenia and involutional psychoses.[21]

In 1971, VA submitted the report of a study, "Economic Validation of the Rating Schedule" (ECVARS), to the Senate Committee on Veterans' Affairs.[22] By this time, according to ECVARS, there had been 15 revisions of the Rating Schedule since the Bradley Commission, with input from the VA Department of Medicine and Surgery, staff of the congressional committees, and major service organizations.[23]

"ECVARS was conducted in response to the Bradley Commission recommendations and recurring criticisms that ratings in the schedule were not accurate."[24] The report noted that technological advances had changed the workplace greatly since 1945, which "have placed a lower premium on physical capacity and dexterity.…The muscle-oriented society of the World War II era no longer exists, and the instrument that served so well as a yardstick to measure disablement in that era must now be updated and refined."[25]

ECVARS surveyed the 1967 earnings of 485,000 veterans each receiving compensation for a single disability and compared the median earnings of those with the same rating level for the same disability with a control group of 14,000 veterans not receiving compensation and matched for age, education, and region of residence. The sample size was enough to compare at least one rating level for about 400 diagnostic codes, for a total of about 1,000 comparisons. The data showed that the percentage of earnings loss was less than the percentage rating in 82 percent of the comparisons, more than the percentage rating in 11 percent of the comparisons, and the same or about the same in 7 percent of the comparisons.[26] More than half (71 of 110) of the comparisons in which earnings losses exceeded the rating level involved neurological and mental disorders. For example, veterans rated 70 percent for schizophrenia, other psychotic reaction,

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[21] The DSM is promulgated and periodically updated by the American Psychiatric Association and is consistent with, although more detailed than, the *International Classification of Diseases* promulgated by the World Health Organization.

[22] U.S. Congress, "Economic Validation." The report was submitted to the Senate Committee on Veterans' Affairs in 1971 but was not published until 1973.

[23] VA, *ECVARS,* 319.

[24] Government Accountability Office, *VA Disability Compensation*, 15.

[25] VA, *ECVARS*, 323.

[26] The "same or about the same" category includes all comparisons in which the earnings loss was between 90 and 110 percent of the rating level, such as between 90 and 110 percent for cases rated 100 percent, between 45 and 55 percent for cases rated 50 percent, and between 9 and 11 percent for cases rated 10 percent.

chronic brain syndrome associated with brain trauma, and anxiety reaction earned on average 85 percent, 77 percent, 83 percent, and 84 percent less, respectively, than veterans without disabilities. After adding compensation to earnings, these veterans still averaged between 51 and 59 percent less than control-group veterans. Veterans rated 90 percent for amputation of an arm had earnings losses of 26 percent. After adding compensation to earnings, these veterans averaged 7 percent more than control-group veterans.

VA revised the Rating Schedule based on the ECVARS findings and submitted it to Congress in 1973. The revised schedule would have raised some ratings and reduced many others. For example, it proposed increasing the 70 percent rating for mental disorders to 80 percent and reducing the rating levels for many musculoskeletal impairments, such as amputation of the arm at the shoulder (from 90 to 60 percent) and amputation of the leg at the hip (from 90 to 40 percent). The revised schedule was not adopted.

After the failure of ECVARS to affect the Rating Schedule, VA's revisions of the schedule "concentrated on improving the appropriateness, clarity, and accuracy of the descriptions of the conditions in the schedule rather than on attempting to ensure that the schedule's assessments of the economic loss associated with these conditions are accurate."[27] In 1989, the General Accounting Office (GAO)—now the Government Accountability Office—issued the report *Need to Update Medical Criteria Used in VA's Disability Rating Schedule* based in part on a clinical review of the schedule that was conducted by a group of medical specialists on the faculty of Jefferson Medical College in Philadelphia. The specialists reported that a "major overhaul" was needed to reduce the probability of inaccurate classifications of impairments,[28] citing outdated terminology; diagnostic classifications that were outdated, ambiguous, or missing; evaluation criteria made obsolete by medical advances, and out-of-date specifications of laboratory tests.

In response to the 1988 GAO report, VA published its intent to update the entire Rating Schedule in a series of Advance Notices of Proposed Rulemaking (ANPRM) in the *Federal Register* beginning in August 1989. The first ANPRM—to review and update the genitourinary section of the schedule—had the following statements, which appeared in each of the subsequent ANPRMs:

> This ANPRM is necessary because of a General Accounting Office (GAO) study and recommendation that the medical criteria in the rating schedule be reviewed and updated as necessary. The

[27] Government Accountability Office, *Need to Update*, 33–34.
[28] Ibid., 15.

> intended effect of this ANPRM is to solicit and obtain the comments and suggestions of various interest groups and the general public on necessary additions, deletions and revisions of terminology and how best to proceed with a systematic review of the medical criteria used to evaluate disabilities of the genitourinary system. Other body systems will be subsequently scheduled for review until the medical criteria in the entire rating schedule has been analyzed and updated . . . this ANPRM is the first step in a comprehensive rating schedule review plan which will ultimately be converted into a systematic, cyclical review process.

(Advance Notice of Proposed Rulemaking, 54 Fed. Reg. 34,531 [August 21, 1989]).

In preparing proposed and final versions of the sections of the Rating Schedule, VA considered the views of Veterans Health Administration clinicians, Veterans Benefits Administration raters, groups of non-VA medical specialists assembled by a contractor, and comments received in response to the ANPRM and Notice of Proposed Rule Making (NPRM).[29] Revisions of nine body systems and the muscle injury part of the musculoskeletal system were made final and published in the *Federal Register* between 1994 and 1997. The hearing part of the special senses was finalized in 1999, and a 10th body system, the skin, was finalized in 2002. NPRMs were published for the vision part of the organs of special sense in 1999, the gastrointestinal part of the digestive system in 2000, and the orthopedic part of the musculoskeletal system in 2003, but final rules were never completed.[30] The ANPRMs for the neurological and digestive systems were never followed by an NPRM. The part of the schedule on impairment of vision has been updated several times previously, but the digestive, orthopedic, and neurological body systems have not been comprehensively updated since 1945.

## I.4 Currency of the Rating Schedule

According to the study of the Schedule for Rating Disabilities conducted for this Commission by the Institute of Medicine (IOM)

> The Rating Schedule contains a number of obsolete diagnostic categories, terms, tests, and procedures, and does not recognize

[29] Proposed and final versions are Notices of Proposed Rule Making (NPRMs) and Final Rules, respectively, as published in the *Federal Register*. For example, the following responded to the NPRM for revising the mental disorder section: The American Legion, Disabled American Veterans, Veterans of Foreign Wars, Vietnam Veterans of America, American Psychological Association, American Psychiatric Association, Association of VA Chief Psychologists, and a concerned individual.

[30] The gastrointestinal and orthopedic NPRMs were formally withdrawn from VA's regulatory agenda in 2004.

> many currently accepted diagnostic categories.…In other cases, the diagnostic categories are current but do not specify appropriate procedures to measure disability for the conditions.

The IOM report identified examples of conditions in need of updating, including craniocerebral trauma (because, for example, a number of chronic effects are not included), neurodegenerative disorders (because some currently known disorders are not included while some disorders now known to be autoimmune are included), spinal cord injury (because it relies on an outmoded classification system), posttraumatic arthritis (because it requires x ray rather than more up-to-date imaging techniques that provide much more information, such as computerized tomography [CT] and magnetic resonance imaging [MRI]), and mental disorders (because the rating criteria are based on sets of symptoms that do not apply to all mental disorders).[31] Another IOM report reached a similar conclusion regarding posttraumatic stress disorder (PTSD), namely, that the rating criteria were not appropriate for PTSD because they included some symptoms consistent with other mental disorders but not PTSD.[32]

The problem with evaluating disability caused by PTSD stems from the decision in the 1996 revision of the mental disorders section of the Rating Schedule to use a single rating formula to rate all mental conditions except eating disorders.[33] The 1961 revision of the mental disorders section had increased the classifications of disorders from two to four; the 1996 revision reclassified the conditions into eight categories to "conform more closely to the categories in DSM–IV, thus making it easier for rating specialists to correlate the diagnoses given on VA and non-VA exams with the conditions in the rating schedule" (Proposed Rule: Schedule for Rating Disabilities; Mental Disorders, 60 Fed. Reg. 54,825 [(October 26, 1995]). But in place of three rating formulas in the 1961 revision—for psychotic disorders, organic mental disorders, and psychoneurotic disorders—VA proposed a single rating formula with the intent of "providing objective criteria based on signs and symptoms that characteristically produce a particular level of disability."

> **General Rating Formula for Mental Disorders**
>
> Total occupational and social impairment, due to such symptoms as: gross impairment in thought processes or communication; persistent delusions or hallucinations; grossly inappropriate behavior; persistent danger of hurting self or others; intermittent inability to perform activities of daily living (including maintenance of minimal personal hygiene); disorientation to time or place; memory

[31] Institute of Medicine, *21st Century System*, 93–95.
[32] Institute of Medicine, *PTSD Compensation*, 156–157, 162.
[33] VA, *Schedule*, Box VI.3.C-1.

loss for names of close relatives, own occupation, or own name…… 100

Occupational and social impairment, with deficiencies in most areas, such as work, school, family relations, judgment, thinking, or mood, due to such symptoms as: suicidal ideation; obsessional rituals which interfere with routine activities; speech intermittently illogical, obscure, or irrelevant; near-continuous panic or depression affecting the ability to function independently, appropriately, and effectively; impaired impulse control (such as unprovoked irritability with periods of violence); spatial disorientation; neglect of personal appearance and hygiene; difficulty in adapting to stressful circumstances (including work or a worklike setting); inability to establish and maintain effective relationships..... 70

Occupational and social impairment with reduced reliability and productivity due to such symptoms as: flattened affect; circumstantial, circumlocutory, or stereotyped speech; panic attacks more than once a week; difficulty in understanding complex commands; impairment of short- and long-term memory (e.g., retention of only highly learned material, forgetting to complete tasks); impaired judgment; impaired abstract thinking; disturbances of motivation and mood; difficulty in establishing and maintaining effective work and social relationships..... 50

Occupational and social impairment with occasional decrease in work efficiency and intermittent periods of inability to perform occupational tasks (although generally functioning satisfactorily, with routine behavior, self-care, and conversation normal), due to such symptoms as: depressed mood, anxiety, suspiciousness, panic attacks (weekly or less often), chronic sleep impairment, mild memory loss (such as forgetting names, directions, recent events)..... 30

Occupational and social impairment due to mild or transient symptoms which decrease work efficiency and ability to perform occupational tasks only during periods of significant stress, or symptoms controlled by continuous medication..... 10

A mental condition has been formally diagnosed, but symptoms are not severe enough either to interfere with occupational and social functioning or to require continuous medication..... 0

A commenter responding to the NPRM suggested adopting separate rating formulas tailored to each psychiatric disorder. Another commenter suggested

that PTSD be evaluated under a separate formula based on the frequency of symptoms particular to PTSD, such as nightmares, flashbacks, troubling intrusive memories, uncontrollable rage, and startle response. A third commenter noted that the proposed criteria for a 100 percent rating included more symptoms of thought disorders than of mood disorders, which might make mood disorders less likely than thought disorders to be evaluated as totally disabling (Final Rule: Schedule for Rating Disabilities; Mental Disorders, 61 Fed. Reg. 52,695 [October 8, 1996]).

VA decided to stay with the single rating formula, because a single formula would be "a better way to assure that mental disorders producing similar impairment will be evaluated consistently." In the Final Rule, VA stated that the symptoms in the rating formula are "representative examples of symptoms that often result in specific levels of disability," and indeed the rating formula refers to "such symptoms as," which implies that these are the kinds of symptoms to consider in deciding on a percentage rating, not that each of them must be present in one person to assign the rating. Thus, for example, in rating someone with a mood disorder, VA's response was that veterans with mood disorders who demonstrate grossly inappropriate behavior, persistent danger of hurting self or others, or intermittent inability to perform activities of daily living—which are three of the representative symptoms listed for a 100 percent rating—would clearly support a rating of total disability, even though they do not exhibit other symptoms, such as gross impairment in thought processes or delusions or hallucinations.

The fundamental problem with the general rating scale for mental disorders is the weak nexus between severity of symptoms and degree of social and occupational disability, which makes the inclusion of symptoms in the criteria problematic in terms of determining disability. The mixing of symptoms and functional measures is also a weakness of the Global Assessment of Functioning Scale, which was criticized in the IOM report, *PTSD Compensation and Military Research*, which recommends looking at symptoms, function, and other dimensions of PTSD separately.[34] There are also practical problems if raters are not able to identify which symptoms are appropriate for evaluating the claimant's disorder or expect the claimant to exhibit all the symptoms listed for a particular rating level, even though the particular sets of symptoms in the general rating scale were chosen to be representative of various disorders.

The IOM report found that the current criteria under diagnostic code 8045 for rating craniocerebral trauma, commonly called traumatic brain injury (TBI), are not adequate for rating all conditions in this classification, and IOM recommended that the criteria be updated.[35] Diagnostic code 8045 was added to

[34] Institute of Medicine, *PTSD Compensation*, 90–93, 105–106.
[35] Institute of Medicine, *21st Century System*, 93.

the Rating Schedule in 1961 and has not changed substantively since that time.[36] The Rating Schedule entry for 8045 currently reads:

> 8045 Brain disease due to trauma:
>
> Purely neurological disabilities, such as hemiplegia, epileptiform seizures, facial nerve paralysis, etc., following trauma to the brain, will be rated under the diagnostic codes specifically dealing with such disabilities, with citation of a hyphenated diagnostic code (e.g., 8045-8207).
>
> Purely subjective complaints such as headache, dizziness, insomnia, etc., recognized as symptomatic of brain trauma, will be rated 10 percent and no more under diagnostic code 9304 [Dementia due to head trauma]. This 10 percent rating will not be combined with any other rating for a disability due to brain trauma. Ratings in excess of 10 percent for brain disease due to trauma under diagnostic code 9304 are not assignable in the absence of a diagnosis of multi-infarct dementia associated with brain trauma.

TBI per se is not rated directly; rather, it is rated according to the resulting impairments. The guidance at 8045 gives hemiplegia, epileptiform seizures, and facial nerve paralysis, which are physical effects, as examples of conditions that could be rated. The guidance limits a rating based on symptoms such as headache, dizziness, and insomnia, to 10 percent. This made sense in 1961, because the deleterious effects of even mild brain trauma on a person's cognitive and emotional condition, and the negative impacts of these effects on social and occupational functioning, were not well understood. Today, postconcussional effects are recognized and under intense study. The proposed clinical management edition of the *International Classification of Diseases*, tenth revision (ICD-10) include criteria for postconcussional syndrome. The *Diagnostic and Statistical Manual of Mental Disorders*, *Fourth Edition* (DSM-IV) identifies postconcussional disorder as a potential diagnosis depending on further research.[37] The clinical criteria for postconcussional syndrome in ICD-10 would call for a history of TBI and the presence of three or more of the following eight symptoms: (1) headache, (2) dizziness, (3) fatigue, (4) irritability, (5) insomnia, (6) concentration difficulty, (7) memory difficulty, and (8) intolerance of stress, emotion, or alcohol. The DSM-IV criteria are: (1) a history of TBI causing "significant cerebral concussion"; (2) cognitive deficit in attention, memory, or both; (3) presence of at least three of eight symptoms—fatigue, sleep disturbance, headache, dizziness, irritability, affective disturbance, personality change, or apathy—that appear after injury and persist for 3 months; (4)

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[36] In 1976, tinnitus was deleted from the list of subjective complaints recognized as symptomatic of brain trauma; in 1989, the term "chronic brain syndrome" was replaced by "multi-infarct syndrome" when diagnostic code 9306 was renamed "multi-infarct dementia due to causes other than arteriosclerosis" in the mental disorders section.

[37] Boake et al., "Diagnostic Criteria."

symptoms that begin or worsen after injury; (5) interference with social role functioning; and (6) exclusion of dementia due to head trauma or other disorders that better account for the symptoms.

Currently, the Rating Schedule criteria for TBI do not refer to evaluation of cognitive and emotional impacts through structured clinical interviews or neuropsychological testing. Such impacts may be the only manifestations of closed-head TBIs. The guide for VA clinicians performing compensation and pension (C&P) examinations and the worksheet for brain and spinal cord examinations do not provide guidance for assessments of the cognitive effects of TBI (although the worksheet calls for a detailed description of any psychiatric manifestations).[38,39]

In addition to rating criteria for PTSD and TBI, rating criteria for other conditions are in need of updating as well. For example, two sections of the schedule have not been updated for some time, as indicated by the presence of obsolete terms identified by Jefferson Medical College clinicians in 1988. Examples of such terms include “encephalitis,” “epidemic," and “chronic” (diagnostic code 8000) and “paramyoclonus multiplex” (diagnostic code 8104) in the neurological conditions section and “gastritis,” and “hypertrophic” (diagnostic code 7307) in the digestive system section.

The IOM report pointed out that the Rating Schedule should be up to date medically to ensure that:

- The diagnostic categories reflect the classification of injuries and diseases currently used in health care, so that the appropriate condition in the Rating Schedule can be more easily identified and confirmed using the medical evidence;
- the criteria for successively higher rating levels reflect increasing degrees of anatomic and functional loss of body structures and systems (i.e., impairment), so that the greater the extent of loss, the greater the amount of compensation; and
- current standards of practice in assessment of impairment are followed and appropriate severity scales or staging protocols are used in evaluating the veteran and applying the rating criteria.

The IOM report recommended that VA update the current Rating Schedule immediately, beginning with those body systems that have gone the longest without a comprehensive update. IOM also recommended that VA adopt a regular process for keeping the schedule updated and establish an external

[38] VA, *C&P Service Clinician’s Guide*.
[39] VA, *Brain and Spinal Cord*.

advisory committee of disability experts to assist in the updating process.[40] The report suggests that after the Rating Schedule is comprehensively revised, it should be revised every 10 years thereafter.

## I.5 Commission Findings and Recommendations on the Medical Adequacy of the VA Schedule for Rating Disabilities

The Commission is in general agreement with the findings and most of the recommendations of the Institute of Medicine. The Commission agrees that the Rating Schedule is out of date in important respects and that VA has neither an adequate system for keeping the medical criteria in the Rating Schedule up to date nor the resources to create such a system.[41]

The IOM's *A 21st Century System for Evaluating Veterans for Disability Benefits* report recommendations endorsed by the Commission are:

**Recommendation 4.1**

**The purpose of the current veterans disability compensation program as stated in statute currently is to compensate for average impairment in earning capacity, that is work disability. This is an unduly restrictive rationale for the program and is inconsistent with current models of disability. The veterans disability compensation program should compensate for three consequences of service-connected injuries and diseases: work disability, loss of ability to engage in usual life activities other than work, and loss in quality of life. (Specific recommendations on approaches to evaluating each consequence of service-connected injuries and diseases are in *A 21st Century System for Evaluating Veterans for Disability Benefits*, Chapter 4.) [IOM Rec. 3-1]**

**Recommendation 4.2**

**VA should compensate for nonwork disability, defined as functional limitations on usual life activities, to the extent that the Rating Schedule does not, either by modifying the Rating**

[40] Institute of Medicine, *21st Century System*, 97. Again, the IOM committee on PTSD compensation offered a consistent recommendation, which is for VA to revise the rating criteria for PTSD (IOM, *PTSD Compensation,* 162).
[41] Institute of Medicine, *21st Century System*, 92–131.

**Schedule criteria to take account of the degree of functional limitation or by developing a separate mechanism. [IOM Rec. 4-5]**

**Recommendation 4.3**

**VA should determine the feasibility of compensating for loss of quality of life by developing a tool for measuring quality of life validly and reliably in the veteran population, conducting research on the extent to which the Rating Schedule already accounts for loss in quality of life, and, if it does not, developing a procedure for evaluating and rating loss of quality of life in veterans with disabilities. [IOM Rec. 4-6]**

**Recommendation 4.4**

**VA should develop a process for periodic updating of the disability examination worksheets. This process should be part of, or closely linked to, the process recommended above for updating and revising the Schedule for Rating Disabilities. There should be input from the disability advisory committee recommended above (see IOM Rec. 4-1). [IOM Rec. 5-1]**

**Recommendation 4.5**

**VA should mandate the use of the online templates that have been developed for conducting and reporting disability examinations. [IOM Rec. 5-2]**

**Recommendation 4.6**

**VA should establish a recurring assessment of the substantive quality and consistency, or inter-rater reliability, of examinations performed with the templates and, if the assessment finds problems, take steps to improve quality and consistency, such as revising the templates, changing the training, or adjusting the performance standards for examiners. [IOM Rec. 5-3]**

**Recommendation 4.7**

**The rating process should have built-in checks or periodic evaluations to ensure inter-rater reliability as well as the accuracy and validity of rating across impairment categories, ratings, and regions. [IOM Rec. 5-4]**

**Recommendation 4.8**

**VA raters should have ready access to qualified health care experts who can provide advice on medical and psychological issues that arise during the rating process (e.g., interpreting evidence or assessing the need for additional examinations or diagnostic tests). [IOM Rec. 5-5]**

**Recommendation 4.9**

**Educational and training programs for VBA raters and VHA examiners should be developed, mandated, and uniformly implemented across all regional offices with standardized performance objectives and outcomes. These programs should make use of advances in adult education techniques. External consultants should serve as advisors to assist in the development and evaluation of the educational and training programs. [IOM Rec. 5-6]**

**Recommendation 4.10**

**VA and the Department of Defense should conduct a comprehensive multidisciplinary medical, psychological, and vocational evaluation of each veteran applying for disability compensation at the time of service separation. [IOM Rec. 6-1]**

**Recommendation 4.11**

**VA should sponsor research on ancillary benefits and obtain input from veterans about their needs. Such research could include conducting intervention trials to determine the effectiveness of ancillary services in terms of increased functional capacity and enhanced health-related quality of life. [IOM Rec. 6-2]**

**Recommendation 4.12**

**The concept underlying the extant 12-year limitation for vocational rehabilitation for service-connected veterans should be reviewed and, when appropriate, revised on the basis of current employment data, functional requirements, and individual vocational rehabilitation and medical needs. [IOM Rec. 6-3]**

**Recommendation 4.13**

**VA should develop and test incentive models that would promote vocational rehabilitation and return to gainful employment among veterans for whom this is a realistic goal. [IOM Rec. 6-4]**

**Recommendation 4.14**

**In addition to medical evaluations by medical professionals, VA should require vocational assessment in the determination of eligibility for Individual Unemployability (IU) benefits. Raters should receive training on how to interpret findings from vocational assessments for the evaluation of IU claims. [IOM Rec. 7-1]**

**Recommendation 4.15**

**VA should monitor and evaluate trends in its disability program and conduct research on employment among veterans with disabilities. [IOM Rec. 7-2]**

**Recommendation 4.16**

**VA should conduct research on the earnings histories of veterans who initially applied for Individual Unemployability benefits past the normal age of retirement under the Old Age, Survivors, and Disability Insurance Program under the Social Security Act. [IOM Rec. 7-3]**

**Recommendation 4.17**

**Eligibility for Individual Unemployability should be based on the impact of an individual's service-connected disabilities, in combination with education, employment history, and the medical effects of that individual's age on his or her potential employability. [IOM Rec. 7-4]**

**Recommendation 4.18**

**VA should implement a gradual reduction in compensation to recipients of Individual Unemployability benefits who are able to return to substantial gainful employment rather than abruptly terminate their disability payments at an arbitrary level of earnings. [IOM Rec. 7-5]**

**Recommendation 4.19**

**VA should adopt a new classification system using the codes from the *International Classification of Disease* (ICD) and the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). This system should apply to all applications, including those that are denied. During the transition to ICD and DSM codes, VA can continue to use its own diagnostic codes, and subsequently track and analyze them comparatively for trends affecting veterans and for program planning purposes. Knowledge of an applicant's ICD or DSM codes should help raters, especially with the task of properly categorizing conditions. [IOM Rec. 8-1]**

**Recommendation 4.20**

**Considering some of the unique conditions relevant for disability following military activities, it would be preferable for VA to update and improve the Rating Schedule on a regular basis rather than adopt an impairment schedule developed for other purposes. [IOM Rec. 8-2]**

**Recommendation 4.21**

**VA should seek the judgment of qualified experts, supported by findings from current peer-reviewed literature, as guidance for adjudicating both aggravation of preservice disability and Allen aggravation claims. Judgment could be provided by VHA examiners, perhaps from VA centers of excellence, who have the appropriate expertise for evaluating the condition(s) in question in individual claims. [IOM Rec. 9-1]**

**Recommendation 4.22**

**VA should guide clinical evaluation and rating of claims for secondary service connection by adopting specific criteria for determining causation, such as those cited above (e.g., temporal relationship, consistency of research findings, strength of association, specificity, plausible biological mechanism). VA should also provide and regularly update information to compensation and pension examiners about the findings of epidemiological, biostatistical, and disease mechanism research concerning the secondary consequences of disabilities prevalent among veterans. [IOM Rec. 9-2]**

The Commission rejected the following IOM recommendations and has replaced them with their own interpretations of the findings and offers its rationale. The Commission rejected:

> **IOM Recommendation 4-1**. VA should immediately update the current Rating Schedule, beginning with those body systems that have gone the longest without a comprehensive update, and devise a system for keeping it up to date. VA should reestablish a disability advisory committee to advise on changes in the Rating Schedule.

The Commission takes exception to updating the Rating Schedule by beginning with the body systems that have gone the longest without change. It believes there are more urgent body systems that have come to the forefront as problematic (e.g., traumatic brain injury, mental health/PTSD) and those should be given primary consideration.

> **IOM Recommendation 4-2.** VA should regularly conduct research on the ability of the Rating Schedule to predict actual loss in earnings. The accuracy of the Rating Schedule to predict such losses should be evaluated using the criteria of horizontal and vertical equity.

> **IOM recommendation 4-3.** VA should conduct research to determine if inclusion of factors in addition to medical impairment, such as age, education, and work experience, improves ability of the Rating Schedule to predict actual losses in earnings.

> **IOM Recommendation 4-4.** VA should regularly use the results from research on the ability of the Rating Schedule to predict actual losses in earnings to revise the rating system, either by changing the rating criteria in the Rating Schedule or by adjusting the amounts of compensation associated with each rating degree.

In reviewing IOM's recommendations 4-2 to 4-4, the Commission finds that VA's Rating Schedule and disability compensation system are not designed nor intended to predict actual loss of earnings, so could not accept the premise with which those recommendations were made..

The Commission does agree with the IOM's recommendation that VA undertake a comprehensive update of the Rating Schedule, devise a system for keeping it up to date, and establish a disability advisory committee to assist in the updating process.[42] The Commission prefers, however, to give highest priority to updating the evaluation and rating of mental disorders, especially PTSD, and traumatic brain injury as the first order of business, because of their prevalence among veterans currently returning from the Global War on Terror.. The Commission also believes that five years is a realistic timetable for completing the comprehensive update of the schedule. The Commission agrees that a disability advisory committee to advise on diagnostic classifications, medical criteria, terminology, and requirements for medical tests and examinations for every body system would be appropriate.

**Recommendation 4.23**

**VA should immediately begin to update the current Rating Schedule, beginning with those body systems addressing the evaluation and rating of post-traumatic stress disorder, other mental disorders, and traumatic brain injury. Then proceed through the other body systems until the Rating Schedule has been comprehensively revised. The revision process should be completed within 5 years. VA should create a system for keeping the Rating Schedule up to date, including a published schedule for revising each body system.**

# II Evaluation and Rating Process

## II.1 Introduction

The Veterans Benefits Administration (VBA) is responsible for processing claims for veterans' disability compensation. VA's strategic goal 1 is to "Restore the capability of veterans with disabilities to the greatest extent possible, and improve the quality of their lives and that of their families."[43] VA's strategic plan includes objectives under each goal, the most relevant of which is objective 1.2:

[42] IOM Recommendation 4-1 from *A 21st Century System for Evaluating Veterans for Disability Benefits* (p.115) reads: "VA should immediately update the current Rating Schedule, beginning with those body systems that have gone the longest without a comprehensive update, and devise a system for keeping it up to date. VA should reestablish a disability advisory committee to advise on changes in the Rating Schedule."

[43] VA, *Strategic Plan 2006-2011,* 18.

"Provide timely and accurate decisions on disability compensation claims to improve the economic status and quality of life of service-disabled veterans."[44]

At the request of the Commission, the IOM Committee on Medical Evaluation of Veterans for Disability Compensation reviewed the (1) medical evaluation processes and (2) rating determination processes, and recommended improvements.

## II.2 Medical Evaluation

The rating decision is based primarily on the nature and extent of the veteran's medical condition. The key medical parts of the disability determination process are:[45]

- development of medical evidence, such as information about degree of impairment, functional limitation, and disability;
- the rating process, in which the medical evidence is compared with the criteria in the Rating Schedule and a percentage rating is determined; and
- the appeal process, in which the adequacy and meaning of the medical evidence is often the central question.

The quality of medical information critically affects the timeliness, accuracy, and consistency of decisions on claims. VBA must request the correct information needed from the medical examiners, examiners must conduct thorough examinations and report the results completely and accurately, and raters must interpret the medical information correctly in light of the criteria in the Rating Schedule.

### II.2.A Update Compensation & Pension Examination Templates on a Regular Basis

In addition to submitting their past medical records, nearly every veteran applying for disability compensation is examined by a physician or other appropriate clinician (e.g., psychologist, audiologist) working for or under contract to VA. A series of investigations of the claims process in the 1990s found serious problems with completeness and timeliness of these compensation and pension (C&P) examinations. The Veterans Benefits Administration (VBA), Board of Veterans Appeals (BVA), and Veterans Health Administration (VHA) have worked to improve this process, but the IOM report concluded that more needs to be done. IOM called for stronger implementation of the improved procedures that have been developed by VBA and VHA under the auspices of the Compensation

[44] Ibid, 18.
[45] Institute of Medicine, *21st Century System*, 115-116.

and Pension Examination Program (CPEP) established by VBA and VHA in 2001 to improve the examination process. For example, VA has developed C&P examination worksheets to guide examiners, but VA does not systematically update the C&P examination worksheets and some—developed as long ago as 10 years—are seriously out of date. The IOM accordingly recommended that VA have a process for updating the worksheets on a regular basis:

> **IOM Recommendation 5-1**. VA should develop a process for periodic updating of the disability examination worksheets. This process should be part of, or closely linked to, the process recommended above for updating and revising the Schedule for Rating Disabilities. There should be input from the disability advisory committee recommended above (see IOM Recommendation 4-1).[46]

## II.2.B Require the Use of C&P Examination Templates

Subsequent to developing the examination worksheets, CPEP developed online templates for completing and reporting the examination worksheets. Although use of the online templates has increased rapidly, examiners are not required to use them, even though early results have shown template examination reports have higher quality than dictated reports, often significantly higher. In addition, template reports were released from 7 to 17 days sooner than dictated reports. Currently, VA is considering mandating their use. The IOM report recommended that VA do so immediately.

> **IOM Recommendation 5-2**. VA should mandate the use of the online templates that have been developed for conducting and reporting disability examinations.

## II.2.C Assess and Improve Quality and Consistency of C&P Examinations

VA, through CPEP, has developed a quality assurance process for evaluating C&P examinations. Currently, it is process oriented—meaning, it focuses on whether the information provided on the examination form was complete and timely but not whether it was correct. Independent examinations of a sample of claimants to assess inter-rater reliability are not performed. CPEP reviews a sample of ratings substantively, but the results are not systematically analyzed

[46] This and all the following IOM recommendations are from the IOM report, *A 21st Century System for Evaluating Veterans for Disability Benefits*.

for general problems or consistency. The IOM report recommended that VA evaluate the substantive quality and consistency of the C&P examinations and make appropriate changes based on the results:

> **IOM Recommendation 5-3**. VA should establish a recurring assessment of the substantive quality and consistency, or inter-rater reliability, of examinations performed with the templates and, if the assessment finds problems, take steps to improve quality and consistency, for example, by revising the templates, changing the training, or adjusting the performance standards for examiners.

### II.2.D Commission Recommendations

The Commission concurs with the recommendations in the IOM report for improving the C&P examination process (IOM recommendations 5-1, 5-2, and 5-3). The Commission also recommends that comparable steps be taken with regard to C&P examinations performed by contract providers, which accounted for 16 percent of the examinations in FY 2005.[47] Their templates should be updated on a regular basis, their use should be mandated, and the substantive quality and consistency of the examinations performed by clinicians used by contract examination companies should be assessed and the results used to improve the examinations.

## II.3 Rating Process

When the medical evidence is complete and other needed information (for example, to establish service connection) is included, the file is sent to a rating veterans service representative (RVSR) for rating. The IOM report made several recommendations for improving the rating process.

### II.3.A Quality of Rating Decisions

VBA's quality assurance program for rating decisions, Systemic Technical Accuracy Review (STAR), has improved the accuracy rate from 80 percent in FY 2002 to 88 percent in FY 2006. However, the sample is only large enough to determine the aggregate accuracy rate of regional offices. It cannot assess accuracy at the diagnostic code level or even at the body system level, and it does not measure consistency across regional offices. The IOM report concluded that the many sources of variability in decision making make it unlikely that veterans with similar disabilities will be treated similarly if these sources of variability are not addressed and reduced to the extent possible. Variability

[47] QTC, *Exam Process.*

cannot be totally eliminated, but IOM called for addressing training, guidelines, rater qualifications, and the other sources of variability that can be controlled:

> **IOM Recommendation 5-4**. The rating process should have built-in checks or periodic evaluations to ensure inter-rater reliability as well as the accuracy and validity of rating across impairment categories, ratings, and regions.

The report gave some examples of evaluations that could be conducted:

- VA could have a sample of claims rated by two or more RVSRs and analyze the degree of consistency in the ratings given.
- The same claims could be analyzed by RVSRs using standard procedures and information sources and by raters with access to medical advisers, and the results compared to see if having medical advisers for raters improves decision making.
- A comparison of raters with a medical background, such as nurses and physician assistants, and raters without medical backgrounds would inform decisions about the qualifications of raters.
- VA could sample claims involving the rating of a particular diagnostic code across field offices and analyze inter-rater and inter-regional differences.

In this last example, the next step could be to determine the degree to which regulations, the adjudication manual, and other forms of guidance could be revised to reduce variability. Training or the quality review system could also increase consistency.

IOM also mentioned another approach to reducing unwanted variability in the rating process—the identification and use of best practices.

## II.3.B Better Access to Medical Expertise

Sometimes, the raters are able to use an authoritative medical finding, such as a particular test score, to make a rating decision. Over time, however, the evidence is less clear, more complex, and perhaps conflicting. Raters are not required to have medical backgrounds (although some may happen to have relevant education and training), yet they must understand the medical evidence and use judgment, for example, in weighing conflicting medical evidence and opinions, to determine the percentage of disability.

VBA does not have medical consultants or advisers to support the raters. Currently, if a rater encounters conflicting or unclear evidence, he or she must

send the file back to VHA. The IOM report concluded that medical consultants or advisers in VBA would provide raters with needed support, for example, by helping to identify what medical examinations and tests are needed to sufficiently prepare a case for rating or to weigh medical information that seems conflicting or ambiguous.

At one time, VBA and BVA had physicians on three-person rating boards or panels (the other VBA rating board members were a legal expert and a vocational specialist; the other BVA panel members were legal experts). In a series of decisions, the Court of Appeals for Veterans Claims barred physicians from serving as adjudicators, on the grounds that their participation was not fair or impartial. The IOM report pointed out that all other major disability programs (e.g., Social Security, DoD's Disability Evaluation System, the federal employee workers' compensation, and disability retirement) employ physicians as adjudicators or as consultants to adjudicators. At the Social Security Administration, initial decisions are made by a two-person team, one of whom must be a physician or psychologist (known as a "medical consultant") who takes the lead in evaluating the medical evidence.[48] Medical consultants are adjudicators; they do not have a doctor-patient relationship with the claimant. Like the lay disability evaluator, the other person on the team, the medical consultant is barred from substituting his or her judgment in place of the treating physician's. By law, medical evidence and opinions from treating physicians must be given "controlling weight," except under specified circumstances, such as internal inconsistency or opinions at odds with test and examination results.

The IOM report concluded that VBA should have medical consultants accessible to RVSRs in regional offices to improve the quality and timeliness of rating decisions:

> **IOM Recommendation 5-5**. VA raters should have ready access to qualified health care experts who can provide advice on medical and psychological issues that arise during the rating process (e.g., interpreting evidence, or assessing the need for additional examinations or diagnostic tests).

The report noted that, with modern communications technology, the medical consultants could be located in regional centers or a national center and have access to the claims file, C&P examination report, and VA and DoD electronic medical records.

[48] In appeal cases, Social Security administrative law judges can have a medical expert at hearings (the claimant or claimant's representative also may question the medical expert).

## II.3.C Training of Examiners and Adjudicators

VBA has a training program and is implementing a certification program for veterans service representatives (VSRs), which it plans to extend it to RVSRs and decision review officers. Also, with VHA, VBA is implementing a training and certification program for C&P medical examiners. VBA has developed an extensive training program for VSRs to support the certification effort. A centralized 2-week training course is given every quarter to new VSRs, followed by a nationally standardized 23-week training curriculum given at the regional office where they work. Newly hired RVSRs are also provided a nationally consistent training program. A computer-based training program, the Training and Performance Support System, has a series of modules on rating-related topics, including evaluation of disability conditions by body system. BVA also has an extensive training program, part of it given by an on-staff medical adviser. The quality review programs of both VBA and BVA are used to identify training needs, whether on particular topics or at particular regional offices. VBA is not evaluating the effectiveness of its training programs, however.

The IOM report concluded that the training should be more intensive and the training program should be rigorously evaluated:

> **IOM Recommendation 5-6**. Educational and training programs for VBA raters and VHA examiners should be developed, mandated, and uniformly implemented across all regional offices with standardized performance objectives and outcomes. These programs should make use of advances in adult education techniques. External consultants should serve as advisors to assist in the development and evaluation of the educational and training programs.

## II.3.D Commission Discussion and Recommendations

The Commission concurs with the recommendations in the IOM report to improve the rating process (IOM recommendations 5-4, 5-5, and 5-6). The recommendation that VBA have medical consultants to advise raters and other adjudicators will require congressional action to guide the Court of Appeals for Veterans Claims in what medical consultants may do (e.g., weigh medical evidence) and may not do (e.g., substitute their opinion for the treating physician's). Medical consultants can assist VSRs and RVSRs in the regional office predetermination units on identifying missing medical evidence, and they can assist RVSRs on the regional office rating teams in evaluating and weighing medical evidence. This will improve and expedite claims decisions.

# References


Boake, C., S. R. McCauley, H. S. Levin, C. Pedroza, C. F. Contant, J. X. Song, S. A. Brown, H. Goodman, S. I. Brundage, and P. J. Diaz-Marchan. "Diagnostic Criteria for Postconcussional Syndrome After Mild to Moderate Traumatic Brain Injury." *Journal of Neuropsychiatry and Clinical Neuroscience* 17 (2005): 350–356, at 351.

Government Accountability Office. *Medical Criteria Used in VA's Disability Rating Schedule*. GAO/HRD-89-28. Washington, DC: GAO, 1988, 11. http://archive.gao.gov/d17t6/137639.pdf.

Government Accountability Office. *Need to Update Medical Criteria Used in VA's Disability Rating Schedule*. GAO/HRD-89-28. Washington, DC: GAO, 1988, 33–34.

Government Accountability Office. *VA Disability Compensation: Disability Ratings May Not Reflect Veterans' Economic Losses*. GAO/HEHS-97-9. Washington, DC: GAO, 1997, 15.

Institute of Medicine. *A 21st Century System for Evaluating Veterans for Disability Benefits*. Washington, DC: The National Academies Press, 2007.

Institute of Medicine. *PTSD Compensation and Military Service*. Washington, DC: The National Academies Press, 2007, 156–157, 162.

President's Commission on Veterans' Pensions. "Disability Rating: Veterans' Administration Contrasted with Workmen's Compensation Experience," Ch. 7 in *Compensation for Service-Connected Disabilities: A Report on Veterans' Benefits in the United States.* Staff Report No. VIII, Part A. Washington, DC: U.S. Government Printing Office, 1956.

President's Commission on Veterans' Pensions. *The Administration of Veterans' Benefits: A Study of the Interrelationship of Organization and Policy: A Report on Veterans' Benefits in the United States.* Staff Report No. VI. Washington, DC: U.S. Government Printing Office, 1956, 33.

President's Commission on Veterans' Pensions. *The Veterans' Administration Disability Rating Schedule: Historical Development and Medical Appraisal: A Report on Veterans' Benefits in the United States.* Staff Report No. VIII, Part B. Washington, DC: U.S. Government Printing Office, 1956, 43.

President's Commission on Veterans' Pensions. *Veterans' Benefits in the United States: Report to the President of the President's Commission on Veterans' Pensions*. Washington, DC: Government Printing Office, 1956, 13.

QTC. *QTC Exam Process and Demo*. Presentation to the Veterans' Disability Benefits Commission. 2006. http://www.1888932-2946.ws/vetsCommission/e-documentmanager/gallery/Documents/June_2006/QTCOverview_June2006.pdf.

U.S. Congress, Senate. "Economic Validation of the Rating Schedule." Appendix to *Veterans' Administration Proposed Revision of Schedule for Rating Disabilities submitted to the Committee on Veterans' Affairs, United States Senate*, Senate Committee Print No. 3, 93rd Cong., 1st Sess., 1973.

VA. Brain and Spinal Cord Worksheet. https://www.vba.va.gov/bln/21/Benefits/exams/disexm07.htm.

VA. *C&P Service Clinician's Guide*. Version 3.0. http://www.warms.vba.va.gov/Admin21/GUIDE/Cliniciansguide.doc.

VA. *Economic Validation of the Rating Schedule*. Washington, DC: VA, 1971.

VA. *Schedule for Rating Disabilities* (1996 rev.). Washington, DC: VA, 1996.

VA. *VA Strategic Plan FY 2006-2011*. http://www.va.gov/op3/docs/VA_2006_2011_Strategic_Plan.pdf.

Veteran's Bureau. "1926 Annual Report of the Director of the Veterans' Bureau," quoted in President's Commission on Veterans' Pensions. *The Veterans' Administration Disability Rating Schedule: Historical Development and Medical Appraisal: A Report on Veterans' Benefits in the United States.* Staff Report No. VIII, Part B. Washington, DC: U.S. Government Printing Office, 1956, 46–47.

Veterans' Bureau, *United States Veterans Bureau Disability Rating Table.* Approved September 22. Washington, DC: Veterans' Bureau, 1921, 5.

Weber, G. A., and L. F. Schmeckebier. *The Veterans' Administration: Its History, Activities and Organization*. Washington, DC: Brookings Institution, 1934, 139.