	Rating
Note (5): The characteristic(s) of disfigurement may be caused by one scar or by multiple scars; the characteristic(s) required to assign a particular evaluation need not be caused by a single scar in order to assign that evaluation.	
7801 Burn scar(s) or scar(s) due to other causes, not of the head, face, or neck, that are deep and nonlinear:	
Area or areas of 144 square inches (929 sq. cm.) or greater	40
Area or areas of at least 72 square inches (465 sq. cm.) but less than 144 square inches (929 sq. cm.)	30
Area or areas of at least 12 square inches (77 sq. cm.) but less than 72 square inches (465 sq. cm.)	20
Area or areas of at least 6 square inches (39 sq. cm.) but less than 12 square inches (77 sq. cm.)	10
Note (1): A deep scar is one associated with underlying soft tissue damage.	
Note (2): If multiple scars are present, or if a single scar affects more than one extremity, assign a separate evaluation for each affected extremity, based on the total area of the qualifying scars that affect that extremity, and assign a separate evaluation for the trunk, if affected, based on the total area of the qualifying scars of the trunk. Combine the separate evaluations under §4.25. Qualifying scars are scars that are nonlinear, deep, and are not located on the head, face, or neck.	
7802 Burn scar(s) or scar(s) due to other causes, not of the head, face, or neck, that are superficial and nonlinear:	
Area or areas of 144 square inches (929 sq. cm.) or greater	10
Note (1): A superficial scar is one not associated with underlying soft tissue damage.	
Note (2): If multiple superficial scars are present, assign a separate evaluation for each affected extremity, based on the total area of the superficial scars of that extremity, and assign a separate evaluation for the trunk, if affected, based on the total area of the superficial scars of the trunk. Combine the separate evaluations under §4.25.	
7804 Scar(s), unstable or painful:	
Five or more scars that are unstable or painful	30
Three or four scars that are unstable or painful	20
One or two scars that are unstable or painful	10
Note (1): An unstable scar is one where, for any reason, there is frequent loss of covering of skin over the scar.	
Note (2): If one or more scars are both unstable and painful, add 10 percent to the evaluation that is based on the total number of unstable or painful scars.	
Note (3): Scars evaluated under diagnostic codes 7800, 7801, 7802, or 7805 may also receive an evaluation under this diagnostic code, when applicable.	
7805 Scars, other (including linear scars) and other effects of scars evaluated under Diagnostic Codes 7800, 7801, 7802, and 7804:	
Evaluate any disabling effect(s) not considered in a rating provided under diagnostic codes 7800–04 under an appropriate diagnostic code.	

* * * * *

[FR Doc. E7–25525 Filed 1–2–08; 8:45 am]

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DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 4

RIN 2900–AM75

Schedule for Rating Disabilities; Evaluation of Residuals of Traumatic Brain Injury (TBI)

AGENCY: Department of Veterans Affairs.

ACTION: Proposed rule.

SUMMARY: This document proposes to amend the Department of Veterans Affairs (VA) Schedule for Rating Disabilities by revising that portion of the Schedule that addresses neurological conditions and convulsive disorders, in order to provide detailed and updated criteria for evaluating residuals of traumatic brain injury (TBI).

DATES: Comments must be received on or before February 4, 2008.

ADDRESSES: Written comments may be submitted through *http://www.Regulations.gov*; by mail or hand-delivery to the Director, Regulations Management (00REG), Department of Veterans Affairs, 810 Vermont Ave., NW., Room 1068, Washington, DC 20420; or by fax to (202) 273–9026. Comments should indicate that they are submitted in response to RIN 2900–AM75—''Schedule for Rating Disabilities; Evaluation of Residuals of Traumatic Brain Injury (TBI).'' Copies of comments received will be available for public inspection in the Office of Regulation Policy and Management, Room 1063B, between the hours of 8 a.m. and 4:30 p.m., Monday through Friday (except holidays). Please call (202) 461–4902 (this is not a toll-free number) for an appointment. In addition, during the comment period, comments may be viewed online through the Federal Docket Management System (FDMS) at *http://www.Regulations.gov.*

FOR FURTHER INFORMATION CONTACT: Maya Ferrandino, Regulations Staff (211D), Compensation and Pension Service, Veterans Benefits Administration, Department of Veterans Affairs, 810 Vermont Avenue, NW., Washington, DC 20420, (727) 319–5847. (This is not a toll-free number.)

SUPPLEMENTARY INFORMATION: This document proposes to amend the Department of Veterans Affairs (VA) Schedule for Rating Disabilities (38 CFR part 4) by revising the material under diagnostic code 8045, Brain disease due to trauma, in 38 CFR 4.124a (neurological conditions and convulsive disorders). TBI has been called a signature injury of the conflict in Iraq, and VA is seeing a statistically larger number of veterans of the Iraq and Afghanistan conflicts with residuals of TBI than has been seen in previous conflicts. In addition, the effects of injuries stemming from blasts resulting from roadside explosions of improvised explosive devices, which have been common sources of injury in these conflicts, appear to be somewhat different from the effects of brain trauma seen from other sources of injury. VA proposes to amend the criteria for rating residuals of TBI to update them in light of current knowledge of the condition.

We propose changing the title of diagnostic code 8045 from ''Brain disease due to trauma'' to ''Residuals of traumatic brain injury (TBI),'' which reflects modern terminology for this condition.

TBI is an injury to the brain from an external force that results in immediate effects such as loss or alteration of consciousness, amnesia, and sometimes neurological impairments. These abnormalities may all be transient, but more prolonged or even permanent problems with a wide range of impairment in such areas as physical, mental, and emotional/behavioral functioning may occur. TBI is classified as mild, moderate, or severe at, or close to, the time of the original injury, and while this classification will often

correspond to the future level of functional impairment, that will not always be the case. This original designation as to severity of the original injury does not change, whatever the speed or extent of recovery, or the long-term disabling effects. Therefore, it does not affect the rating assigned under diagnostic code 8045. We propose to include the information that ''mild,'' ''moderate,'' and ''severe'' refer to a classification of TBI at, or close to, the time of injury rather than to the current level of functioning in the regulation itself to make it clear to raters that these designations that may appear in medical records refer only to the initial evaluation and not to current functioning.

We propose to provide guidance for the evaluation of the most common, but not all possible, residuals of TBI. These residuals fall into three main areas of dysfunction: Cognitive, emotional/behavioral, and physical. In addition, a cluster of largely subjective symptoms (symptoms cluster) falling into these categories may develop following TBI.

This proposed rule provides several sets of guidelines and criteria for the evaluation of TBI residuals because of the breadth of the possible effects. These include guidance on evaluating physical (neurologic) residuals, criteria for evaluating cognitive impairment, criteria for evaluating the symptoms cluster that sometimes follows TBI (sometimes referred to as post-concussion syndrome (PCS)), and guidance on evaluating emotional/behavioral dysfunction.

Evaluating Physical Dysfunction

In the current schedule, under diagnostic code 8045, purely neurological disabilities following brain trauma, such as hemiplegia, epileptiform seizures, facial nerve paralysis, etc., are rated under the diagnostic codes dealing with the specific disabilities, using a hyphenated code to indicate the rating criteria used. We propose deleting the discussion of the use of hyphenated codes because that use is explained in 38 CFR 4.27, ''Use of diagnostic code numbers,'' and therefore need not be repeated here.

When the brain is injured, almost any function of the body can be affected, depending on the location, type, and severity of the injury. We propose to provide a list of the most common, but not all possible, physical (neurological) problems that may be seen after TBI. These problems are motor and sensory dysfunction, including pain, of the extremities and face; visual impairment; hearing loss and tinnitus; loss of sense of smell and taste; seizures; gait, coordination, and balance problems; speech and other communication difficulties, including aphasia and related disorders, and dysarthria; neurogenic bladder; neurogenic bowel; cranial nerve dysfunctions; autonomic nerve dysfunctions; and endocrine dysfunctions. We propose to rate each condition separately evaluated under an appropriate diagnostic code, as long as the same signs and symptoms are not used to support more than one evaluation, and to combine those evaluations under the provisions of 38 CFR 4.25 (Combined ratings table). Residuals that are reported but not mentioned on this list would be evaluated under the most appropriate diagnostic code.

We are also proposing to direct raters to consider special monthly compensation for such problems as loss of use of an extremity, certain sensory impairments, bowel and bladder impairments, erectile dysfunction, the need for aid and attendance (including when assistance or supervision is needed on the basis of cognitive impairment), and being housebound.

Evaluating Emotional/Behavioral Dysfunction and Comorbid Mental Disorders

Comorbid (coexisting with another medical disorder) mental disorders are common with TBI. Most common is depression, which may occur in up to 60 percent of those with TBI, but anxiety and post-traumatic stress disorder (PTSD) also commonly occur. We propose requiring comorbid mental disorders to be evaluated under 38 CFR 4.130 (Schedule of ratings—mental disorders). Some emotional/behavioral symptoms that do not reach the level of a mental disorder, as defined in DSM–IV (the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders, which is published by the American Psychiatric Association), would be evaluated under the criteria provided for the evaluation of cognitive impairment or for the evaluation of the symptoms cluster, as discussed below, because the symptoms of cognitive impairment and the symptoms cluster encompass many emotional/behavioral symptoms (Department of Veterans Affairs, Veterans Health Initiative, ''Traumatic Brain Injury,'' 83–85 (Rodney Vanderploeg, Ph.D., ed., 2003)).

Evaluating the Symptoms Cluster Due to TBI

Following TBI, a cluster of symptoms (or syndrome) is commonly seen. The symptoms fall into emotional/behavioral, cognitive, and physical areas, and may have both neurological and psychological components, but there are no objective neurologic findings or abnormalities on routine imaging. While in the majority of affected people these symptoms resolve in about 3 months, in a small percentage, they become permanent. In the medical literature, this symptoms cluster is sometimes referred to as post-concussion syndrome (although loss of consciousness at the time of the original injury is not a requirement), or simply as residuals of mild TBI (Veterans Health Initiative, ''Traumatic Brain Injury,'' 23–27).

The symptoms cluster includes such symptoms as headache (migraine or tension-type), dizziness or vertigo, fatigue, malaise, sleep disturbance, cognitive impairment, difficulty concentrating, delayed reaction time, behavioral changes (such as irritability, restlessness, apathy, inappropriate social behavior, aggression, impulsivity), emotional changes (such as mood swings, anxiety, depression), tinnitus or hypersensitivity to sound, hypersensitivity to light, blurred vision, double vision, decreased sense of smell and taste, and difficulty hearing in noisy situations or with competing sounds in the absence of objective hearing loss.

In the current schedule, under diagnostic code 8045, purely subjective complaints such as headache, dizziness, insomnia, etc., recognized as symptomatic of brain trauma, are rated 10 percent and no more under diagnostic code 9304. Furthermore, this 10-percent rating is not combined with any other rating for a disability due to brain trauma, and 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.

This guidance about evaluating subjective complaints after brain trauma is at least 45 years old and seems to reflect views that were once prevalent, that these symptoms might be due to hysteria or malingering. In recent years, abnormalities of the brain following mild TBI have been reported on the basis of the following types of special studies: Neuropathologic, neurophysiologic, neuroimaging, and neuropsychologic. Current medical thinking is that these symptoms may be due to subtle brain pathology following trauma that was undetectable on previously available studies. These symptoms may be more than 10-percent disabling. Therefore, we propose replacing the current guidance concerning the evaluation of subjective complaints after brain trauma under diagnostic code 8045 with a set of

criteria to evaluate this symptoms cluster, with evaluation levels of 20, 30, and 40 percent.

We propose to require that for evaluation under the new criteria, at least three of the symptoms listed above be present. If there are nine or more of the listed symptoms, 40 percent would be assigned; if there are five to eight of the listed symptoms, 30 percent would be assigned; and if there are three or four of the listed symptoms, 20 percent would be assigned. These levels of evaluation are consistent with the range of disability that may result from these symptoms and would promote consistent evaluations.

If, on the other hand, there is a definite diagnosis that includes one or more of these symptoms, such as migraine (which is common after TBI) or Meniere's syndrome (which has symptoms of tinnitus, vertigo, fluctuating hearing loss, and a sense of fullness in the ear), it would be separately evaluated. If there are at least 3 remaining symptoms, they would be evaluated under the criteria for evaluating the symptoms cluster.

Evaluating Cognitive Impairment

Cognitive impairment is defined as decreased memory, concentration, attention, and executive functions of the brain. Executive functions are speed of information processing, goal setting, planning, organizing, prioritizing, self-monitoring, problem solving, judgment, decision making, spontaneity, and flexibility in changing actions when they are not productive. Not all of these brain functions may be affected in a given individual with cognitive impairment, and some functions may be affected more severely than others. In a given individual, symptoms may fluctuate in severity from day to day. Cognitive impairment of varying degrees is most common and most severe following moderate or severe TBI. Therefore, primarily those who experienced a moderate or severe TBI would require evaluation under these criteria. However, an individual with mild TBI may also have these conditions.

The effects of cognitive impairment are numerous and far reaching with profound effects on many areas of functioning: mental, physical, behavioral, and emotional. Some of the major functional effects of cognitive impairment can be found at *http://grants.nih.gov/grants/guide/pa-files/PA–97–050.html, http://web.uccs.edu/dsimons/cognitive%20impairment%20handouts.pdf*, and *http://www.guideline.gov/summary/summary.aspx?ss=15&doc_id=3508&nbr=2734*. We propose to provide criteria that take into account 11 of the common major effects of cognitive impairment. These effects or facets of cognitive impairment are work or school; memory, attention, concentration; activities of daily living (ADLs); judgment; supervision for safety; appropriate response in social situations; orientation; motor activity (with intact motor and sensory system); visual-spatial function; other neurobehavioral effects; and speech and language disorders.

There is a wide variation in the occurrence and severity of cognitive impairments. Some individuals may have impairments in some facets but not others, some individuals may have impairments in all facets, and some functions affected by cognitive impairment may be impaired more severely than others in a given individual (for example, one may have severe speech and other communication problems but no problem with activities of daily living, while another may have no problem with speech, but considerable difficulty with ADLs and other facets). Using a standard set of evaluation criteria by assigning a specific level of evaluation for a standard set of signs or symptoms would disadvantage veterans who do not have the particular signs and symptoms in the standard set chosen, but who have equally disabling signs and symptoms of cognitive impairment. On the other hand, it would be too burdensome to include criteria for all possible signs and symptoms of cognitive impairment. Therefore, we propose using the table we have developed for evaluating cognitive impairment that includes the 11 most important types or facets of impairment, titled ''EVALUATION OF COGNITIVE IMPAIRMENT UNDER DIAGNOSTIC CODE 8045.''

In addition, we propose providing separate criteria, representing logical increments of functioning for each facet, for assessing the severity of each of these 11 common facets of impairment following TBI. Scores of severity for each facet would range from 0 to 4, although not all facets would have all 5 levels of severity. For example, for ADLs, a score of 0 would be assigned if the individual is able to perform all activities of daily living without assistance. However, if some assistance is needed for ADLs, even part of the time, a level of 1 or 2 would be too low for such a substantial impairment. Therefore, if the individual requires assistance with activities of daily living some of the time (but less than half of the time), a score of 3 would be assigned, and if the individual requires assistance with activities of daily living most or all of the time, a score of 4 would be assigned. For the ''judgment'' facet, a score of 0 would be assigned for ''Normal.'' A score of 1 would be assigned for ''Mildly impaired.'' A score of 2 would be assigned for ''Moderately impaired.'' A score of 4 would be assigned for ''Severely impaired.'' Note that there would be no score of 3 for judgment.

The rater would assign the appropriate score from 0 to 4 for each facet, based on the information about the severity of impairment for each facet that has been provided (on the disability examination report). The rater would then add only the 3 highest scores and divide that sum by 3 to determine the overall score for cognitive impairment, that is, 0, 1, 2, 3, or 4. Numbers between whole numbers would be rounded to the nearest whole number. For example, scores of 1.0, 1.1, 1.2, 1.3, and 1.4 would all be rounded to 1, while scores of 1.5, 1.6, 1.7, 1.8, and 1.9 would all be rounded to 2. The percentage evaluations available for cognitive impairment would be 0, 10, 40, 70, and 100 percent. A score of 1 would equate to an evaluation of 10 percent, a score of 2, to 40 percent, a score of 3, to 70 percent, and a score of 4, to 100 percent. As in all cases, per 38 CFR 4.31 (0 percent evaluations), an evaluation of 0 percent would be assigned if the score is below 1, after rounding.

Using the three most impaired facets of functioning balances the problems of using only one or two facets, which would result in a limited view of overall functioning, and using all 11 facets, which would cause the better areas of functioning to dilute the more severely impaired ones, and would result in an impression of better overall functioning than is actually present.

The proposed criteria are long and complex. To assist the rater, we propose providing the 11 facets, the levels of impairment, and the criteria for each level in the table, ''Evaluation of Cognitive Impairment Under Diagnostic Code 8045.'' Because of the length of the table, we are not repeating it in this summary.

Note #1—Cognitive Impairment and Comorbid Mental Disorder

We also propose adding two notes under the cognitive impairment criteria for further clarification. Note #1 would explain the evaluation process when both cognitive impairment and one or more comorbid mental disorders are present, in which case there may be an overlap of signs and symptoms. In such cases, two evaluations, one under the

cognitive impairment criteria and another under the General Rating Formula for Mental Disorders, based on the same findings would not be assigned. If the signs and symptoms of the mental disorder(s) and of cognitive impairment cannot be clearly separated, a single evaluation either under the General Rating Formula for Mental Disorders or under the evaluation criteria for cognitive impairment, whichever provides the better assessment of overall impaired functioning due to both conditions, would be assigned. If the signs and symptoms are clearly separable, separate evaluations for the mental disorder(s) and for cognitive impairment would be assigned.

Note #2—Prohibition of Evaluation Under Cognitive Impairment Criteria and Under the Symptoms Cluster

Note #2 would point out that cognitive impairment may not be evaluated both under the cognitive impairment criteria and as part of the symptoms cluster because this would constitute pyramiding. In addition, cognitive impairment encompasses many more symptoms than are specifically listed in the rating table for evaluation of cognitive impairment, including some of the subjective symptoms in the symptoms cluster. Therefore, if evaluation is made under the cognitive impairment criteria, no evaluation would be assigned for the symptoms cluster. When cognitive impairment is present, it would be evaluated either as part of the symptoms cluster, if cognitive impairment and at least 2 of the additional cluster symptoms listed are present, or under the cognitive impairment criteria, whichever method of evaluation is more advantageous to the veteran.

Note #3—TBI That Is Unclassified as to Severity

We propose adding a third note to direct raters to evaluate under the set of criteria that is most in accord with the reported residuals, regardless of whether a classification of the severity of TBI (mild, moderate, or severe) determined at, or close to, the time of injury is available. In other words, if subjective symptoms are the primary residuals, evaluation would be made under the criteria for evaluating the symptoms cluster. If cognitive impairment alone is diagnosed, evaluation would be made instead under the criteria for evaluating cognitive impairment. In any case, physical (neurologic) residuals would be evaluated as directed under diagnostic code 8045, and comorbid mental disorders would be evaluated as directed under § 4.130.

Applicability Date

VA proposes to make the provisions of this rule applicable to all applications for benefits received by VA on or after the effective date of this rule. A veteran whose residuals of TBI are rated under a prior version of § 4.124a, diagnostic code 8045, will be permitted to request review under the new criteria, irrespective of whether his or her disability has worsened since the last review. VA would review that veteran's disability rating to determine whether the veteran may be entitled to a higher disability rating under the provisions established by this rulemaking. The effective date of any award of an increase in disability compensation based on the new criteria would be no earlier than the effective date of the new criteria. The effective date of an award would be decided under the current regulations regarding effective dates for increases in disability compensation, 38 CFR 3.400, etc. and 38 CFR 3.114, if applicable, would be considered. We propose adding this information under diagnostic code 8045 as Note #4 to insure veterans are fully notified of the availability of the review.

We propose establishing this process for veterans potentially affected by this rulemaking in order to ensure that veterans, especially those wounded during Operation Enduring Freedom or Operation Iraqi Freedom, are compensated as fully as possible for their wounds.

Benefits Costs

Two groups of veterans may be affected by this regulation change. The first group is those veterans who will come on the rolls in the future. VA also anticipates some current TBI beneficiaries will reopen their claims. Future caseload estimates are based on historical trends of service connected accessions related to TBI by degree of disability. VA identified the potential population of reopened claims based on current beneficiaries on the rolls with a combined evaluation that included a rating for TBI. Average monthly payments for each disability rating were applied to calculate the benefits cost. The assumptions used to generate the affected population are based on historical caseload trends and are not based on DoD information, nor should they be construed to imply any future DoD policy decisions.

VA estimates the total caseload affected for years 2008–2017 as follows: 2,846, 3,546, 3,746, 3,946, 4,146, 4,343, 4,546, 4,746, 4,946, and 5,146. Benefits costs ($ in millions) associated with the caseload for the same time period are as follows: $3.6, $10.1, $10.1, $11.1, $12.1, $13.1, $14.2, $15.3, $16.5, and $17.7 for a 10-year total of $123.8 million over 10 years.

Paperwork Reduction Act

This document contains no provisions constituting a collection of information under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3521).

Regulatory Flexibility Act

The Secretary hereby certifies that this proposed rule would not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act, 5 U.S.C. 601–612. This proposed rule would govern disability ratings in individual cases and would not directly affect small entities. Therefore, pursuant to 5 U.S.C. 605(b), this proposed amendment is exempt from the initial and final regulatory flexibility analysis requirements of sections 603 and 604.

Executive Order 12866—Regulatory Planning and Review

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety, and other advantages; distributive impacts; and equity). The Executive Order classifies a ''significant regulatory action,'' requiring review by the Office of Management and Budget (OMB), as any regulatory action that is likely to result in a rule that may: (1) Have an annual effect on the economy of $100 million or more or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities; (2) create a serious inconsistency or otherwise interfere with an action taken or planned by another agency; (3) materially alter the budgetary impact of entitlements, grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raise novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order.

The economic, interagency, budgetary, legal, and policy implications of this proposed rule have been examined, and it has been determined to be a significant regulatory action under Executive Order 12866

because it is likely to result in a rule that may raise novel legal or policy issues arising out of legal mandates, the President's priorities, or principles set forth in the Executive Order.

Unfunded Mandates

The Unfunded Mandates Reform Act of 1995 requires, at 2 U.S.C. 1532, that agencies prepare an assessment of anticipated costs and benefits before issuing any rule that may result in the expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of $100 million or more (adjusted annually for inflation) in any 1 year. This proposed rule would have no such effect on State, local, and tribal governments, or on the private sector.

Catalog of Federal Domestic Assistance Numbers and Titles

The Catalog of Federal Domestic Assistance program numbers and titles for this proposal are 64.104, Pension for Non-Service-Connected Disability for Veterans, and 64.109, Veterans Compensation for Service-Connected Disability.

List of Subjects in 38 CFR Part 4

Disability benefits, Pensions, Veterans.

Approved: November 16, 2007.

Gordon H. Mansfield,

Acting Secretary of Veterans Affairs.

For the reasons set out in the preamble, 38 CFR part 4, subpart B, is proposed to be amended as set forth below:

PART 4—SCHEDULE FOR RATING DISABILITIES

1. The authority citation for part 4 continues to read as follows:

Authority: 38 U.S.C. 1155, unless otherwise noted.

Subpart B—Disability Ratings

2. In § 4.124a, in the table entitled, ''Organic Diseases Of The Central Nervous System'', the entry for 8045 is revised in its entirety and a new table titled ''Evaluation Of Cognitive Impairment Under Diagnostic Code 8045'' is added after the ''Organic Diseases Of The Central Nervous System'' table, to read as follows:

§ 4.124a Schedule of ratings—neurological conditions and convulsive disorders.

* * * * *

ORGANIC DISEASES OF THE CENTRAL NERVOUS SYSTEM

	Rating
8045 Residuals of traumatic brain injury (TBI):	
There are three main areas of dysfunction that may result from TBI and require evaluation: Cognitive, emotional/behavioral, and physical effects. In addition, a cluster of largely subjective symptoms, which may include Cognitive, emotional/behavioral, and physical symptoms, may develop that may also require evaluation. ''Mild,'' ''moderate,'' and ''severe'' refer to a classification of TBI at, or close to, the time of injury rather than to the current level of functioning. This classification does not affect the rating assigned under diagnostic code 8045.	
Evaluate cognitive impairment under the criteria in the table titled ''Evaluation Of Cognitive Impairment Under Diagnostic Code 8045.''	
Evaluate the symptoms cluster that sometimes follows TBI under the set of criteria for evaluating the symptoms cluster due to TBI provided as part of the rating criteria under diagnostic code 8045.	
Evaluate emotional/behavioral dysfunction under § 4.130 (Schedule of ratings—mental disorders) when there is a diagnosis of a mental disorder. When there is no diagnosis of a mental disorder, evaluate symptoms under the criteria in the table titled ''Evaluation Of Cognitive Impairment Under Diagnostic Code 8045'' or under the criteria for evaluation of the symptoms cluster due to TBI.	
Evaluate physical (neurological) dysfunction based on the following list, under an appropriate diagnostic code, as applicable.	
Motor and sensory dysfunction, including pain, of the extremities and face; visual impairment; hearing loss and tinnitus; loss of sense of smell and taste; seizures; gait, coordination, and balance problems; speech and other communication difficulties, including aphasia and related disorders, and dysarthria; neurogenic bladder; neurogenic bowel; cranial nerve dysfunctions; autonomic nerve dysfunctions; and endocrine dysfunctions.	
These lists do not encompass all possible residuals of TBI. For residuals not listed here that are reported on an examination, evaluate under the most appropriate diagnostic code. Evaluate each condition separately, as long as the same signs and symptoms are not used to support more than one evaluation, and combine the evaluations for each separately rated condition under § 4.25. Consider special monthly compensation for such problems as loss of use of an extremity, certain sensory impairments, bowel and bladder impairments, erectile dysfunction, the need for aid and attendance (including when assistance or supervision is needed on the basis of cognitive impairment), and being housebound.	
Evaluation of Symptoms Cluster due to TBI	
A cluster of symptoms, physical, cognitive, and emotional/behavioral, often occurs following TBI. There are usually no objective neurologic findings or abnormalities on routine imaging. While in the majority of affected people this cluster of symptoms resolves in about 3 months, in a small percentage, the symptoms become permanent. In the medical literature, this symptoms cluster may be referred to as post-concussion syndrome, or simply as residuals of mild TBI. For evaluating such residuals of TBI under the criteria below, at least three of the following symptoms must be present: Headache (migraine or tension-type), dizziness or vertigo, fatigue, malaise, sleep disturbance, cognitive impairment, difficulty concentrating, delayed reaction time, behavioral changes (such as irritability, restlessness, apathy, inappropriate social behavior, aggression, impulsivity), emotional changes (such as mood swings, anxiety, depression), tinnitus or hypersensitivity to sound, hypersensitivity to light, blurred vision, double vision, decreased sense of smell and taste, and difficulty hearing in noisy situations or with competing sounds in the absence of objective hearing loss.	
If there is a definite diagnosis of a condition that includes one or more of these symptoms, such as migraine headache or Meniere's disease, evaluate that condition separately under the appropriate diagnostic code and evaluate the remaining symptoms based on the following criteria, as long as there are at least three symptoms remaining.	
With nine or more of the listed symptoms	40
With five to eight of the listed symptoms	30

With three or four of the listed symptoms	20

Evaluation of Cognitive Impairment

Cognitive impairment is defined as decreased memory, concentration, attention, and executive functions of the brain. Executive functions are speed of information processing, goal setting, planning, organizing, prioritizing, self-monitoring, problem solving, judgment, decision making, spontaneity, and flexibility in changing actions when they are not productive. Not all of these brain functions may be affected in a given individual with cognitive impairment, and some functions may be affected more severely than others. In a given individual, symptoms may fluctuate in severity from day to day.

These types of losses can have profound effects on many areas of functioning: mental, physical, behavioral, and emotional. Cognitive impairment of varying degrees is common after TBI.

The table titled ''EVALUATION OF COGNITIVE IMPAIRMENT UNDER DIAGNOSTIC CODE 8045'' contains 11 common facets of cognitive impairment with levels of impairment for each ranging from 0 to 4, with 4 representing the most severe level. Not all facets have criteria for every level from 0 to 4. Add the *3 highest numbers* from 0 to 4 assigned to facets of cognitive impairment, divide that sum by 3, and round to the nearest whole number (for example, 1.0, 1.1, 1.2, 1.3, and 1.4 are rounded to 1, while 1.5, 1.6, 1.7, 1.8, and 1.9 are rounded to 2). Once the whole number from 0 to 4 has been calculated, assign the percentage evaluation as follows: 0 = 0%; 1 = 10%; 2 = 40%; 3 = 70%; and 4 = 100%.

Note (1): When both cognitive impairment and one or more comorbid mental disorders are present, there may be an overlap of signs and symptoms. In such cases, do not assign two evaluations, one under the cognitive impairment criteria and another under the General Rating Formula for Mental Disorders, based on the same findings. If the signs and symptoms of the mental disorder(s) and of cognitive impairment cannot be clearly separated, assign a single evaluation either under the General Rating Formula for Mental Disorders or under the evaluation criteria for cognitive impairment, whichever provides the better assessment of overall impaired functioning due to both conditions. However, if the signs and symptoms are clearly separable, assign separate evaluations for the mental disorder(s) and for cognitive impairment.

Note (2): Do not assign separate evaluations for cognitive impairment and for the symptoms cluster due to TBI; rather, assign one or the other, whichever results in a higher evaluation. However, separate evaluations may be assigned for cognitive impairment or for the symptoms cluster, and for other physical (neurological) abnormalities or comorbid mental disorders if the same signs and symptoms are not used to support more than one evaluation.

Note (3): Whether or not a classification of the severity of TBI (mild, moderate, or severe) determined at, or close to, the time of injury is available, evaluate under the set of criteria that is most in accord with the reported residuals. If a cluster of subjective symptoms is the primary residual, evaluate under the criteria for symptoms cluster due to TBI. If cognitive impairment is diagnosed, evaluate under the criteria for cognitive impairment if it is the only residual, or under either the criteria for cognitive impairment or under the symptoms cluster if there are at least 2 other residual subjective symptoms. In any case, evaluate physical (neurologic) residuals and comorbid mental disorders as directed under diagnostic code 8045.

Note (4): A veteran whose residuals of TBI are rated under a version of § 4.124a, diagnostic code 8045, in effect prior to [insert date 30 days after date of publication of the final rule in the **Federal Register**], can request review under diagnostic code 8045, irrespective of whether his or her disability has worsened since the last review. VA will review that veteran's disability rating to determine whether the veteran may be entitled to a higher disability rating under diagnostic code 8045. A request for review pursuant to this rulemaking will be treated as a claim for an increased rating for purposes of determining the effective date of an increased rating awarded as a result of such review; however, in no case will the award be effective before [insert date 30 days after date of publication of the final rule in the **Federal Register**]. For the purposes of determining the effective date of an increased rating awarded as a result of such review, VA will apply the provisions of 38 CFR 3.114, if applicable.

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EVALUATION OF COGNITIVE IMPAIRMENT UNDER DIAGNOSTIC CODE 8045

Facets of cognitive impairment	Level of impairment	Criteria
Work or school	0	Able to work or attend school at a level equivalent to that prior to injury with no special accommodation, and without difficulty.
	1	Able to work or attend school at a level equivalent to that prior to injury with no special accommodation, and with only minor difficulty, mainly at times of increased duties or demands.
	2	Able to work or attend school, but requires some accommodation (for example, may need special environment, special equipment, or closer supervision).
	3	Able to work or attend school, but only in a situation with decreased demands compared to pre-injury employment or school or in a sheltered workplace.
	4	Unable to work or attend school.
Memory, attention, concentration	0	No complaints of memory loss and no objective evidence of memory loss.
	1	Mildly impaired. Any combination of memory loss (although memory tests on exam are normal), occasional difficulty following a conversation, occasional difficulty recalling recent conversations, occasional difficulty remembering names of new acquaintances, occasional difficulty finding words, misplaces items.
	2	Any combination of mild impairment of memory (which must be objectively shown), mildly impaired attention, mildly impaired concentration, difficulty following complex instructions, easily distractible, poor retention of written material, difficulty multi-tasking, problems planning, problems organizing, difficulty completing tasks.
	3	Any combination of moderately impaired memory, attention, concentration, or executive functions.
	4	Any combination of severely impaired memory, attention, concentration, or executive functions.
ADLs (activities of daily living)	0	Able to perform all activities of daily living without assistance.
	3	Requires assistance with activities of daily living some of the time (but less than half of the time).
	4	Requires assistance with activities of daily living most or all of the time.
Judgment	0	Normal.

EVALUATION OF COGNITIVE IMPAIRMENT UNDER DIAGNOSTIC CODE 8045—Continued

Facets of cognitive impairment	Level of impairment	Criteria
	1	Mildly impaired.
	2	Moderately impaired.
	4	Severely impaired.
Supervision for safety	0	Does not need supervision for safety, even in risky situations.
	2	Rarely or occasionally needs supervision for safety, but only for risky activities.
	3	Often requires supervision for safety (but less than half of the time).
	4	Requires supervision for safety most or all of the time.
Appropriate response in social situations.	0	Appropriate response in social situations always.
	1	Appropriate response in social situations almost always.
	2	Inappropriate response in social situations much of the time.
	3	Inappropriate response in social situations most or all of the time.
Orientation	0	Always oriented to person, time, and place.
	2	Oriented to person and time; occasional or rare disorientation to place.
	3	Sometimes disoriented to time or place.
	4	Often or always disoriented, especially to time or place.
Motor activity (with intact motor and sensory system).	0	Motor activity normal.
	1	Motor activity normal most of the time. May be slowed at times.
	2	Motor activity mildly decreased due to apraxia (inability to perform previously learned motor activities, despite normal motor function), or with moderate slowing.
	3	Motor activity moderately decreased due to apraxia.
	4	Motor activity severely decreased due to apraxia.
Visual-spatial function	0	Normal.
	1	Rare indication of slight impairment, such as getting lost in unfamiliar surroundings.
	2	Mildly impaired. May get lost in unfamiliar surroundings, occasional difficulty recognizing faces.
	3	Moderately impaired. May get lost even in familiar surroundings, frequent difficulty recognizing faces.
	4	Severely impaired. May be unable to touch or name own body parts when asked by the examiner, identify the relative position in space of two different objects, copy sentences, read maps, or find way from one room to another.
Other neurobehavioral effects		Symptoms: Physically aggressive, verbally aggressive, impulsive, uninhibited, sleep problems, apathetic, inflexible, fatigability, mood swings, lack of motivation, impaired awareness of disability.
	0	None of these effects.
	1	One or two of these effects.
	2	Three to five of these effects.
	3	Six or more of these effects.
Speech and language disorders	0	Able to communicate by spoken and written language, and to comprehend spoken and written language.
	1	Impaired articulation for some words, but speech is understandable, or comprehension of either spoken language, written language, or both, is only occasionally impaired.
	2	Inability to communicate either by spoken language, written language, or both, more than occasionally but less than half of the time, or to comprehend spoken language, written language, or both, more than occasionally but less than half of the time.
	3	Inability to communicate either by spoken language, written language, or both, at least half of the time but not all of the time, or to comprehend spoken language, written language, or both, at least half of the time but not all of the time.
	4	Complete inability to communicate either by spoken language, written language, or both, or to comprehend spoken language, written language, or both.

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