Compilation of PDA Guidance and Policies
Current as of 25 MAR 2010

Due Process		
Date	**Title**	**Document Type**
21 AUG 09	Physical Evaluation Board Proceedings: Standard for Findings and Recommendations	Memo to PEB Presidents
24 AUG 09	Requirement to Notify Counsel	Memo to PEB Presidents
	Evidence to be included in Case file	DRAFT: Memorandum to PEB Presidents

Compensability		
Date	**Title**	**Document Type**
28 FEB 05	Policy/Guidance Memo 3: re: Enactment of 10 USC 1207a and 10 USC 12731b for EPTS conditions	Policy/Guidance Memo
30 SEPT 09	Conditions not Constituting a Physical Disability	Memo to PEB Presidents
9 DEC 09	Medical Principles: Presumption of Soundness and Permanent service Aggravation; Placement on TDRL	Memo to PEB Presidents
28 FEB 05	Policy/Guidance **Memo 16** on Presumption of Fitness	Policy/Guidance Memo

Procedural and Processing Issues		
Date	**Title**	**Document Type**
1 FEB 10	Diagnostic Variance between the MEB and VA diagnoses within DES Pilot	Memo to PEB Presidents
8 AUG 09	Continuing Medical Treatment: PEB Actions & Rating Options	Sustainment Training
28 FEB 05	Policy/Guidance **Memo 2**: re: Conditional Adjudication	Policy/Guidance Memo
28 FEB 05	Policy/Guidance **Memo 4:** re: Processing RC Cases	Policy/Guidance Memo
28 FEB 05	Policy/Guidance **Memo 6** : re: Medical Records	Policy/Guidance Memo
12 JUL 06	Policy/Guidance **Memo 10**: re: Gulf War Illness	Policy/Guidance Memo
28 FEB 05	Policy/Guidance **Memo 17**: Identification of Cases of Soldiers Pending Promotion	Policy/Guidance Memo
8 FEB 07	Policy/Guidance **Memo 18**: re: Admin Terminations	Policy/Guidance Memo

Compilation of PDA Guidance and Policies
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VASRD Issues

Subpart A: General Policy (§§4.1 – 4.31)		
Date	**Title**	**Document Type**
19 AUG 09	VASRD § 4.20 Analogous Ratings	Memo to PEB Presidents

Subpart B: Disability Ratings (§§4.40 – 4.150)		
Date	**Title**	**Document Type**
1. Musculoskeletal System		
18 APR 08	Stress Fractures and Stress Reactions	Sustainment Training
21 AUG 09	Ankylosing Spondylitis	Memo to PEB Presidents
3 APR 09	Limitation of Motion (Arm) (DC 5201)	Memo to PEB Presidents
JAN 10	Supination and Pronation (DC 5213)	Sustainment Training
30 SEP 09	Assigning Multiple Thigh Limitation of Motion Codes (DCs 5251, 5252, 5253)	Memo to PEB Presidents
DEC 09	Foot injuries, other (DC 5284)	Sustainment Training
2. Organs of Special Sense (Vision)		
2 FEB 09	(New) Eye rule	Sustainment Training
3. Impairment of Auditory Acuity, Olfaction, and Taste)		
4. Infectious Diseases, Immune Disorders and Nutritional Disorders		
28 FEB 05	Policy/Guidance **Memo 14:** HIV rating and constitutional symptoms	Policy/Guidance Memo
5. Respiratory System		
5 MAY 09	Asthma (DC 6602): Requirement for 30% Rating	Memo to PEB Presidents
19 JUN07	Policy/Guidance **Memo 19:** Asthma and post bronchodilator PFTs	Policy/Guidance Memo
6. Cardiovascular System		
DEC 09	Ventricular arrhythmias (sustained); and Implantable Cardioverter-Defibrillators (AICDs) (DC 7011)	Sustainment Training
7. Digestive System		
DEC 09	Rectum and anus, impairment of sphincter control (DC 7332)	Sustainment Training
8. Genitourinary System		
DEC 09	Renal Dysfunction (DCs 7500 – 7541)	Sustainment Training
9. Gynecological Conditions and Disorders of the Breast		
10. Hemic and Lymphatic Systems		
28 JUL 08	CML	Sustainment Training
11. Skin		
25 MAR 10	New Skin Rule and Examples	Sustainment Training
12. Endocrine System		
13. Neurological Conditions and Convulsive Disorders		
21 JAN 09	VA Training Letter: TBI and Mental Disorders (including PTSD)	VA Training Letter

25 NOV 08	Rating Migraines	Sustainment Training
NOV 08	Rating Seizures	Sustainment Training
14. Mental Disorders		
3 NOV 09	Posttraumatic Stress Disorder (DC 9411): Stressor "Validation"	Memo to PEB Presidents
3 FEB 10	General Rating Formula for Mental Disorders: Application of 4.7, Higher of two evaluations (Requirements for 30% rating)	Memo to PEB Presidents
21 JAN 09	VA Training Letter: TBI and Mental Disorders (including PTSD)	VA Training Letter
15. Dental and Oral Conditions		

DUE PROCESS

Physical Evaluation Board Proceedings: Standard for Findings and Recommendations [Back to INDEX ↑.]

DEPARTMENT OF THE ARMY
UNITED STATES ARMY PHYSICAL DISABILITY AGENCY
6900 GEORGIA AVENUE, NW
BUILDING 7 WRAMC
WASHINGTON DC 20307-5001

AHRC-DOE

21 August 2009

MEMORANDUM TO PEB Presidents

SUBJECT: Physical Evaluation Board Proceedings: Standard for Findings and Recommendations

1. Purpose:

a. To outline the type of evidence upon which the PEB must base its findings and recommendations.

b. To outline the specific PEB requirements for recording findings and recommendations on the DA Form 199.

2. Reference. 10 U.S.C. §1222. Physical evaluation boards (providing that documents announcing a decision of the board in the case convey the findings and conclusions of the board in an orderly and itemized fashion with specific attention to each issue presented by the member in regard to that member's case both during initial consideration and upon subsequent consideration due to appeal by the member or other circumstance.)

3. Findings and Recommendations Standard:

a. PEB findings and recommendations may seem arbitrary when they appear inconsistent with or refute medical evidence regarding:

(1) The presence or absence of diagnoses;

(2) The presence or absence of Department of Veterans Affairs Schedule for Rating Disabilities rating criteria;

(3) Physical limitations as reflected on the DA Form 3349 (Physical Profile); and Stability.

b. When the totality of the medical evidence and/or the performance information is insufficient, the PEB must attempt to remediate (supplement) the MEB. For example, when the issue pertains to the presence or absence of a diagnosis or the presence or absence of particular rating criteria, the PEB must return the MEB requesting additional information. The PEB may need to request re-examination.

c. When any one piece of evidence (medical evidence and/or performance information) is of doubtful weight or credibility, the PEB may attempt to remediate the MEB. Alternatively, the PEB may make a finding based upon its weighing of the evidence. For example, when considering whether a condition is fitting, after fully considering DoDI 1332.38, Enclosure 3, part 3, the PEB may find the Commander's statement is sufficient to support a PEB finding of fit

even though the MEB indicated the condition does not meet medical retention standards because it interferes with duty performance.

d. Except as specifically indicated below, all PEB findings and recommendations must be based on information within the MEB case file. The case file must include all evidence upon which the PEB based its findings and recommendations.

e. PEB findings and recommendations (to include the specific VASRD ratings) must specifically correlate with and reflect specific medical information from documents such as the narrative summary (NARSUM), specialty consultations, oral testimony presented before a Formal Board, etc. The PEB must support each fit/unfit finding with medical information and/or performance data.

f. PEB findings regarding whether a disease or injury is combat related may appear arbitrary when the case file includes contradictory evidence regarding its etiology.

g. With respect to whether a condition is EPTS (to include addressing the presumption of permanent service aggravation), the PEB may consult with a subject expert (e.g., OTSG). The PEB may base its findings and recommendations on such opinion. The PEB may rely on accepted medical principles for EPTS. When the PEB relies on an accepted medical principle, the PEB must include the specific general medical principle *and* the clear and unmistakable evidence on the DA Form 199. The PEB must include a citation to a source that discusses the general medical principle, i.e., a recognized medical text or journal; or, a reputable online source. The PEB cannot base its findings and recommendations regarding EPTS upon the medical opinion of its medical member.

h. The PEB must consider the significance of LOD-Yes. See AR 635-40 para 4-19g (1) and AR 600-8-4.

i. Where general medical principles exist to meet the required standard of proof regarding whether the condition is stable, the PEB may rely on these medical principles despite the MEB prognosis statement. When the PEB relies on an accepted medical principle, the PEB must state the general medical principle on the DA Form 199 and include a citation to a source that discusses the general medical principle, i.e., a recognized medical text or journal; or, a reputable online source. Otherwise, the PEB must base its stability finding upon the evidence within the MEB case file, specifically the MEB prognosis statement.

j. IAW 10 U.S.C. 1222, the PEB will prepare each DA Form 199 in an orderly and itemized fashion. The DA Form 199 will include:

(1) Appropriate VASRD diagnostic codes and diagnoses;

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SUBJECT: Physical Evaluation Board Proceedings: Standard for Findings and Recommendations

(2) The foundation for the assigned VASRD percentage rating using identified medical/surgical history; objective physical findings; clinical data; and/or subjective complaints.

(3) Evidence used to support fit/unfit findings using identified relevant and cited medical or performance information;

(4) Foundation for stability findings;

(5) Foundation for combat related findings;

(6) Citations to any special regulatory provision used to support findings; and

(7) Citations to MEB case file to support i — vi above.

k. When a Soldier receives a PDES rating through the VA, the PEB will prepare a DA Form 199 which comports with the above regarding the issue of combat related; fitness determination; EPTS; and compensability. The PEB will prepare a DA Form 199 that includes citations to the evidence supporting these findings and recommendations.

FOR THE COMMANDER:

Encl

DANIEL L. CASSIDY
COL, IN
Deputy Commander

Enclosure: Physical Evaluation Board (PEB) Proceedings: Standard for Findings and Recommendations

Physical Evaluation Board (PEB) Proceedings: Standard for Findings and Recommendations	
For Each Unfitting Condition	
1.	Correct VASRD code and matching VASRD code words.*
2.	Brief history statement when relevant for 10A/C/D.
3.	Foundation for % rating using identified medical/surgical history; objective physical findings; clinical data; and/or subjective complaints.*
4.	When applicable, citation to special regulatory provisions (e.g., §4.26; §4.55a; §4.96a; etc.).*
5.	Foundation for finding unfitting EPTS with no PSA using identified evidence meeting the clear and unmistakable standard.
6.	Foundation for **unfit** using identified relevant and cited medical or performance information.
7.	When applicable, foundation for TDRL using prognosis statement and/or other permissible evidence.
8.	Citations to documents which include the specific information used for the above findings.
For Each Not unfitting condition	
9.	Specific foundation for fit to include citations to documents upon which finding was based.
For Case as a Whole	
10.	Case file includes all documents and/or evidence cited.
* Not required when VA provides PDES rating.	

DUE PROCESS
Requirement to Notify Counsel [Back to INDEX ↑.]

DEPARTMENT OF THE ARMY
UNITED STATES ARMY PHYSICAL DISABILITY AGENCY
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AHRC-DOE

24 August 2009

MEMORANDUM FOR Presidents, U.S. Army Physical Evaluation Boards

SUBJECT: Requirement to Notify Counsel

Whenever the case file indicates an attorney (or other counsel) is representing a Soldier regarding an issue under consideration by a PEB or this Agency, a copy of any memorandum or letter prepared by the PEB or this Agency on that case will be provided to the attorney (or other counsel). This includes correspondence that requests or directs Physical Evaluation Boards to take corrective action (e.g., PDA returns to PEB) or return a case to the MTF.

FOR THE COMMANDER:

DANIEL L. CASSIDY
COL, IN
Deputy Commander

COMPENSABILITY
Conditions not Constituting a Physical Disability [Back to INDEX ↑.]

DEPARTMENT OF THE ARMY
UNITED STATES ARMY PHYSICAL DISABILITY AGENCY
6900 GEORGIA AVENUE, NW
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WASHINGTON DC 20307-5001

AHRC-DOE 30 September 2009

MEMORANDUM FOR Presidents, U.S. Army Physical Evaluation Boards

SUBJECT: Conditions not Constituting a Physical Disability

1. When a Soldier's MEB includes a diagnosis of a Sexual and Gender Identity Disorder (to include Sexual Dysfunctions) and when the Soldier has been diagnosed by a psychiatrist IAW DSM-IV TR, 1332.38 Enclosure 5 applies. Specifically, IAW 1332.38, E5. 1.2.9.7. Sexual Gender and Identity Disorders, including Sexual Dysfunctions and Paraphilias, this condition is a condition not constituting a physical disability.

2. When a Soldier's MEB includes the diagnosis of "erectile dysfunction," in the absence of a psychiatric diagnosis and full description outlining how the Soldier meets each of the DSM-IV criteria for one of the DSM-IV TR conditions included within Sexual and Gender Identity Disorders, erectile dysfunction (ED) is *not* "a condition not constituting a physical disability."

DANIEL L. CASSIDY
COL, IN
Deputy Commander

DEPARTMENT OF THE ARMY
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AHRC-DOE

09 December 2009

MEMORANDUM FOR Presidents, U.S. Army Physical Evaluation Boards

SUBJECT: Medical Principles: Presumption of Soundness and Permanent Service Aggravation; Placement on TDRL

Part I: Presumption of Soundness and Permanent Service Aggravation

DoDI 1332.38 provides that each Soldier on active duty orders for more than 30 days is presumed to have been in sound physical and mental condition upon entering active duty except for medical defects and physical disabilities noted and recorded at the time of entrance.

13 MAR 2008 DTM provides that each condition determined to be EPTS (including hereditary and/or genetic diseases) is presumed to have been aggravated.

The PEB can overcome the presumption of soundness and the presumption of permanent service aggravation (only) with clear and unmistakable evidence based upon well-established medical principles.

The following explains what constitutes well-established medical principles and how the PEB considers these well-established medical principles to overcome these presumptions.[1]

DoDI 1332.38, E2.1.1 defines **accepted medical principles** as *fundamental deductions, consistent with medical facts that are so reasonable and logical as to create a virtual certainty that they are correct.* Even though neither the DTM nor DoDI 1332.38 defines what constitutes a "well-established medical principle," it is reasonable to conclude that both terms have the same meaning.

Published medical information similar to the type of information a health care professional may rely upon when rendering a diagnosis, prognosis, or treatment plan often includes one or more "well-established medical principles."

When such medical principles are sufficiently specific to the unique aspects of the Soldier's diagnosis and presentation, it may constitute "clear and unmistakable" evidence to overcome the presumption of soundness and/or the presumption of permanent service aggravation.

The following is a more detailed explanation of each of the above three steps.

First, the PEB must have an initial understanding of the general nature of the Soldier's condition regarding: causation (or etiology); symptoms; and disease progression (to include consideration

[1] USAPDA draws support for this approach based on consideration of 38 C.F.R. Part 3. See enclosed references.

of disease manifestations) over time, i.e., **well-established medical principles**. This initial understanding will come from reading standard texts and/or reputable online resources.

Reliable internet sources for appropriate information may come from ".gov" or ".edu" sites. The National Institutes of Health website is an example of such a website. See: http://www.nih.gov/index.html. Commercial websites may also have valuable information. It is also acceptable to reference articles from websites which include scientific journals, well-known encyclopedias, and archival sites that include referenced official publications.

Whatever the source of the PEB's findings of EPTS, no service aggravation, the PEB must cite to its source. If citing to an online source, include the link in the DA Form 199. If citing to a text, the 199 must include the name of the text (and page). To the extent feasible, whether with reference to the online source or the traditional source, consider quoting or paraphrasing the relevant language the PEB relied on to support its finding.

The second step in the PEB's analysis of whether a Soldier's condition is EPTS and/or permanently service aggravated involves the PEB reviewing the Soldier's history, record of manifestations, and clinical course.

Third, the PEB considers the weight of the evidence. Is the evidence so strong that it constitutes **clear and unmistakable evidence** that the disability existed before the Soldier's entrance on active duty and that it was not permanently aggravated by the military? When the evidence is not clear and unmistakable, the PEB will award a disability rating for the (unfitting) condition.

The PEB must document all findings of EPTS, not service aggravated, IAW 10 USC § 1222, by citing to all information upon which the PEB based its determination.

When such well-established medical principles are specifically relevant to the unique presentation of a Soldier, the PEB will determine whether the evidence that the condition existed prior to the Soldier's entrance on active duty is such that it is "clear and unmistakable". In this situation, the PEB must then determine whether the evidence with respect to aggravation while on active duty (due to the military vs. due to natural progression) is such that the PEB may consider it not permanently service aggravated.

"The PEB must consider all relevant, credible evidence not statutorily required to be excluded." 3 AUG 1989 DAJA-AL Opinion. This means the PEB may consider voluntary verbal statements (including verbal statements documented in writing) the Soldier provides to the MEB or to the PEB. However, the PEB *will not* base its finding using any written statement by the Soldier, relating to the origin or incurrence of any disease or injury which the Soldier was required to sign. 10 USC § 1219.

The PEB cannot rely on mere conclusory statements from the MEB regarding the issue of EPTS. The MEB should ascertain whether the Soldier's condition existed prior to military service and/or was permanently service aggravated by military service using this same method, i.e., using and citing well-established medical principles as applied to the Soldier's specific

presentation. When the MEB does not perform this detailed level of analysis, the PEB may supplement the record.

Part II: Placement on the TDRL

There are two types of PDES cases. The first type is the "legacy" case. In this type of case, the PEB assigns the disability rating. The second type of PDES cases is the "DES Pilot case" or other cases where the VA assigns the disability rating. Pending finalization of the TDRL Policy for DES Pilot cases and other cases where the VA assigns the disability rating, it appears the standard for placement on the TDRL (for these cases) will be that "a disability shall be considered unstable when there is clear and convincing evidence based on accepted medical principles that the VASRD rating percentage is likely to change within the next five years."

Even though DoDI 1332.38 indicates the standard for placement on TDRL is "preponderance of the evidence," as a matter of PDA policy, the standard for both types of cases will be "clear and convincing" as set forth in the draft policy.

In either type of case, the required analysis for determining whether a Soldier is to be placed, or retained, on the TDRL is as follows:

1. The MEB examiner is asked to assess the Soldier's prognosis as follows:

> The MEB should assess the prognosis of each of the Soldier's conditions. The assessment should be based on what is known and what is not about each condition (e.g., long term response to treatment, disease progression (to include development of additional secondary conditions), etc.) The MEB should consider whether or not the Soldier's presentation is typical or atypical. The MEB should then discuss whether (and how) the Soldier's symptoms and/or physical findings are likely to occur within the next five years. If it appears the Soldier's condition will be stable, the MEB should so state. The MEB should provide a foundation for its conclusions. This may include citations to medical literature.
>
> When the MEB determines it cannot assess the Soldier's prognosis, the MEB should indicate the prognosis is uncertain. The MEB should provide a reason it is unable to offer a prognosis, e.g., lack of available data.

   The PEB will consider the *quality* of the MEB examiner's prognosis statement. Without more, the mere conclusion or statement from the MEB that the Soldier should be placed, or retained, on TDRL because the condition is unstable, does not satisfy the regulatory standards for placement or continuation on the TDRL. The PEB may return the case to the MEB for further prognosis assessment or may, in some situations, complete the required analysis as follows.

2. The PEB will consider information within standard texts and/or reputable online resources i.e., accepted medical principles (or well-established medical principles) as it relates to the nature of the Soldier's condition with respect to disease progression.

3. With reference to: the applicable VASRD code and (virtually) irrefutable medical facts relevant to the Soldier's condition (including those relevant to Soldier's specific presentation), the PEB will determine whether clear and convincing evidence supports that the Soldier's rating will change. This rating change may be predicated on consideration of additional ratings for [later] unfitting conditions developing from the currently unfitting conditions.

4. With reference to the clear and convincing evidentiary standard, when the PEB determines the evidence does not support that the Soldier's condition will change over the next five years so as to result in a change in VASRD rating, the PEB will recommend the Soldier be permanently retired.

References:

13 MAR 2008 DTM

E3.P4.5.2. Presumption for Members on Active Duty for More than 30 days. The presumptions listed in E3.P4.5.2.1., through E3.P4.5.2.3., below apply to members on orders to active duty of more than 30 days, for purposes of determining whether an impairment was incurred or aggravated while a member was entitled to basic pay.

E3.P4.5.3. Prior Service Impairment. Any medical condition incurred or aggravated during one period of active service or authorized training in any of the Armed Forces that recurs, is aggravated, or otherwise causes the member to be unfit, should be considered incurred in the line of duty, provided the origin of the such impairment or its current state is not due to the member's misconduct or willful negligence, or progressed to unfitness as the result of intervening events with the member was not in a duty status.

E3.P4.5.2.3. Presumption of Aggravation. The presumption that a disease is incurred or aggravated in the line of duty may only be overcome by compelling evidence or medical judgment that the disease was clearly neither incurred nor aggravated while serving on active duty or authorized training. Such medical evidence or judgment must be based upon **well-established medical principles**, as distinguished from personal medical opinion alone.

14 OCT 2008 DTM

E3.P4.5.2. Presumption for Members on Active Duty for More than 30 days. The presumptions listed in E3.P4.5.2.1., through E3.P4.5.2.3., below apply to members on ord to active duty
of more than 30 days, for purposes of determining whether an impairment was incurred o aggravated while a member was entitled to basic pay.

E3.P4.5.2.2. After Entry

E3.P4.5.2.2.1. Presumption of Sound Condition for members ordered on active duty for more than thirty days. This presumption applies in all cases in which a member, on active duty for more than 30 days is found to have a disability and the disability was not noted at the time of the member's entrance on active duty. This presumption is overcome if clear and unmistakable evidence demonstrates that the disability existed before the Service member's entrance on active duty and was not aggravated by

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military service. Absent such clear and unmistakable evidence, the PEB will conclude that the disability was incurred or aggravated during military service.

E3.P4.5.2.2.2. Hereditary and/or Genetic Diseases. Any hereditary or genetic disease shall be evaluated to determine whether clear and unmistakable evidence demonstrates that the disability existed before the Service member's entrance on active duty and was not aggravated by military service. However, even if the conclusion is that the disability was incurred prior to entry on active duty, any aggravation of that disease, incurred while the member is entitled to basic pay, beyond that determined to be due to natural progression shall be determined to be service aggravated. To overcome the presumption of sound condition, factual evidence based upon well-established medical principles as distinguished from personal medical opinion alone must be presented to rebut the presumption. The quality of evidence is usually more important than quantity. All relevant evidence must be weighed in relation to all known facts and circumstances relating to the condition. Findings will be made on the basis of objective evidence in the record as distinguished from personal opinion, speculation, or conjecture. When the evidence is not clear concerning whether the condition existed prior to service or if the evidence is equivocal, the presumption will not be deemed to have been rebutted and the member's condition will be found to have been incurred in or aggravated by military service.

38 CFR Part 3

§ 3.303 Principles relating to service connection.

(a) *General.* ... Determinations as to service connection will be based on review of the entire evidence of record, with due consideration to the policy of the Department of Veterans Affairs to administer the law under a broad and liberal interpretation consistent with the facts in each individual case.

(b) ...

(c) Preservice disabilities noted in service. There are medical principles so universally recognized as to constitute fact (clear and unmistakable proof), and when in accordance with these principles existence of a disability prior to service is established, no additional or confirmatory evidence is necessary. Consequently with notation or discovery during service of such residuals conditions (scars; fibrosis of the lungs; atrophies following disease of the central or peripheral nervous system; healed fractures; absent, displaced or resected parts of organs; supernumerary parts; congenital malformations or hemorrhoidal tags or tabs, etc.) with no evidence of the pertinent antecedent active diseases or injury during service the conclusion must be that they preexisted service. Similarly, manifestation of lesions or symptoms of chronic disease from date of enlistment, or so close thereto that the disease could not have originated in so short a period will establish preservice existence thereof...

§ 3.304 Direct service connection; wartime and peacetime.

...

(b) *Presumption of soundness.* The veteran will be considered to have been in sound condition when examined, accepted and enrolled for service, except as to defects, infirmities, or disorders noted at entrance into service, or where clear and unmistakable (obvious or manifest) evidence demonstrates that an injury or disease existed prior

thereto and was not aggravated by such service. Only such conditions as are recorded in examination reports are to be considered as noted.
(Authority: 38 U.S.C. 1111)

(1) History of preservice existence of conditions recorded at the time of examination does not constitute a notation of such conditions but will be considered together with all other material evidence in determinations as to inception. Determinations should not be based on medical judgment alone as distinguished from accepted medical principles, or on history alone without regard to clinical factors pertinent to the basic character, origin and development of such injury or disease. They should be based on thorough analysis of the evidentiary showing and careful correlation of all material facts, with due regard to accepted medical principles pertaining to the history, manifestations, clinical course, and character of the particular injury or disease or residuals thereof.
(2) History conforming to accepted medical principles should be given due consideration, in conjunction with basic clinical data, and be accorded probative value consistent with accepted medical and evidentiary principles in relation to value consistent with accepted medical evidence relating to incurrence, symptoms and course of the injury or disease, including official and other records made prior to, during or subsequent to service, together with all other lay and medical evidence concerning the inception, development and manifestations of the particular condition will be taken into full account.
(3) Signed statements of veterans relating to the origin, or incurrence of any disease or injury made in service if against his or her own interest is of no force and effect if other data do not establish the fact. Other evidence will be considered as though such statement were not of record.
(Authority: 10 U.S.C. 1219)

Sec. 3.306 Aggravation of preservice disability.
(a) General. A preexisting injury or disease will be considered to have been aggravated by active military, naval, or air service, where there is an increase in disability during such service, unless there is a specific finding that the increase in disability is due to the natural
progress of the disease.
(Authority: 38 U.S.C. 1153)

Pre-decisional draft Temporary Disability Retirement List (TDRL) policy.

2. PROCEDURES

1.1. Unstable. A disability shall be considered unstable when there is clear and convincing evidence based on accepted medical principles that the VASRD rating percentage is likely to change within the next five years.

FOR THE COMMANDER:

DANIEL L. CASSIDY
COL, IN
Deputy Commander

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Procedural and Processing Issues
Diagnostic Variance between the MEB and VA diagnoses within DES Pilot [Back to INDEX ↑.]

DEPARTMENT OF THE ARMY
UNITED STATES ARMY PHYSICAL DISABILITY AGENCY
6900 GEORGIA AVENUE, NW
BUILDING 7 WRAMC
WASHINGTON DC 20307-5001

AHRC-DZB 01 February 2010

MEMORANDUM FOR Presidents, U.S. Army Physical Evaluation Boards

SUBJECT: Diagnostic variance between the Medical Evaluation Board and the VA diagnoses within the DES Pilot.

1. PURPOSE: The purpose of this Memorandum is to provide a procedural solution to address diagnostic variance between the MEB and the VA diagnoses within the DES Pilot.

2. BACKGROUND:

a. A Soldier will be referred to an MEB when competent medical authority, i.e., an MEB physician, determines the following:

(1) The Soldier has one or more condition(s) which the physician suspects does not meet medical retention standards;

(2) The condition appears medically stable;

(3) The course of further recovery is relatively predictable; and

(4) The Soldier is most likely not capable of performing the duties of his office, grade, rank or rating.

b. The MEB conveys its findings on the DA Form 3947, Medical Evaluation Board Proceedings. This document lists each of the Soldier's diagnoses and whether it is cause for referral to an MEB, e.g., meets or fails medical retention standards. Implicit in the diagnoses listed on the DA Form 3947, is that the MEB properly supported, or had a basis, for each listed diagnosis. Once the MEB determines the Soldier has conditions which do not meet medical retention standards, the MEB will refer the Soldier into the DES Pilot. (See 14 OCT 2008 DTM, E3.P1.6.1, AR 40-400, Ch. 7, AR 40-501, Ch. 3, and NOV 08 DES Pilot Operations Manual, Encl 10)

c. DES Pilot MEB case processing is frustrated when a VA (VHA and QTC, the VA contractor) examination introduces a new or different diagnosis; and/or includes a markedly different description of the severity of a condition. When this happens, the examinations do not portray a consistent picture of the Soldier's diagnoses and/or severity.

3. MEB Responsibilities:

a. The MEB physician reviews the MEB documents (including the VA examinations) to verify each diagnosis remains accurate despite the passage of time. Where evidence suggests]the Soldier's condition is now more accurately described with reference to an alternate

diagnosis, the MEB will revise its diagnosis prior to forwarding the case to the PEB. This diagnosis may agree with the VHA (or QTC) diagnosis.

b. The MEB physician reviews the MEB documents (including the VA examinations) to verify its listing of the Soldier's conditions is complete. Where evidence supports Soldier has additional diagnoses, the MEB updates its documents.

c. Where, notwithstanding the opinions and/or findings set forth in the VA examination(s), the MEB finds the MEB diagnosis accurate, the MEB supplements the MEB case file with a "Diagnostic Variance Memorandum" (DVM). In this DVM, the MEB physician indicates: the MEB diagnosis; reference to documentation supporting the basis for the specified MEB diagnosis or reiteration of basis; and the associated VHA (or QTC) Diagnosis.

4. PEB Responsibilities

a. Providing the MEB Diagnosis is properly supported, and provided the PEB finds the Soldier unfit for the condition, the PEB will accept the MEB diagnosis. The PEB will request a rating from the DRAS for the PEB's unfitting diagnosis(es). In its request the PEB will specifically: identify the variance in diagnoses; reference the DVM; and reference the Nov 08 DES Pilot operations manual instructions at "concept" and "policy" (stating that the basis for determining a DES pilot participant's final disposition from the military must be "military unfitting conditions").

b. Depending on the specifics of the case, the PEB may include the following language:

(1) The PEB recognizes that for the Pilot program, 38 CFR Part 4, section 4.2 Interpretation of examination reports means that the VA, and not the PEB, is to "interpret reports of examination in the light of the whole recorded history, reconciling the various reports into a consistent picture." The PEB also recognizes that VA regulations provide that if a diagnosis is not supported by the findings on the examiner report or if the report does not contain sufficient detail, the rating board will return the report as inadequate for evaluation purposes.

(2) Notwithstanding the VA diagnosis, with reference to DTM 14 OCT 2008, E3.P1.6.1, the PEB recognizes the MEB physician (and the MEB) as the competent medical authority regarding Soldier's diagnosis of [indicate].

Daniel Cassidy
Colonel, IN
Deputy Commander

14 OCT 2008 DTM DoDI 1332.38

E3.P1.6.1. Referral. When a competent medical authority determines a Service member has one or more condition(s) which is suspected of not meeting medical retention standards, he or she will refer the Service member into the DES at the point of hospitalization or treatment when a member's progress appears to have medically stabilized (and the course of further recovery is relatively predictable) and when it can be reasonably determined that the member is most likely not capable of performing the duties of his office, grade, rank or rating. Referral will be within 1 year of being diagnosed with a medical condition(s) that does not appear to meet medical retention standards, but may be earlier if the examiner determines that the member will not be capable of returning to duty within 1 year.

The above standards are for the MTF/MEB to use in deciding when a case is medically ready for referral to a PEB.

It is normally not the responsibility of the PEB to determine the correctness of this medical decision. When an MEB has been referred to a PEB it can be assumed that the MTF/MEB has properly considered this standard and the case is ready for adjudication by the PEB.

In accordance with that portion of the standard relating to referral within one year of being diagnosed, it is appropriate for the MTF/MEB to forward a case to the PEB that has some conditions that may not have completed every possible medical treatment.

When certain facts arise that place that assumption in question (e.g., new medical treatment proposed or requests for return of case to MTF by Soldier/counsel) the PEB should request, in writing, that the MTF/MEB review, or re-affirm, its decision to refer the case to the PEB. This request does not mandate return of the case to the MTF/MEB pending the MTF/MEB's response.

The purpose of the PEB's request is to place the responsibility of the medical decision back into the appropriate channels. Either the MTF/MEB will request recall of the case or reaffirm their prior decision that the case [still] meets the standards for referral to the PEB. Having the MTF/MEB's final written medical decision concerning

this issue in the PEB's case file should reduce many appellate issues about this issue that often occur. If they continue to occur at least the case file will indicate that the issue was fully considered (and re-considered) and also will serve to direct any further questions to the appropriate medical, not disability, authorities.

In deciding cases that appear to be properly referred under the above standards, but where the MTF may not have exhausted all possible medical treatments, the PEB must adjudicate/rate the condition as it exists at that time in accordance with applicable VASRD criteria or with reference to VASRD § 4.28, prestabilization rating from date of discharge from service. For example, VASRD § 4.28 provides assigning a 50% rating in any case in which a rating of 50 percent or more is not immediately assignable under the regular provisions when the Soldier has unhealed or incompletely healed wounds or injuries where material impairment of employability is likely. Note (2) provides that diagnosis of disease, injury, or residuals will be cited, with VASRD diagnostic code number assigned for conditions listed therein. See also VASRD § 4.28 provisions for assigning a 100% rating. If the PEB uses 4.28, placement on TDRL is required and the Soldier should be reevaluated in 12 months.

When the regular schedular rating, a rating IAW VASRD § 4.28, or Soldier’s time in service, is such that TDRL cannot be authorized, the PEB must separate the Soldier with severance pay even though some medical treatment could still be forthcoming.

The PEB should consider any unusual case referrals or introduction of new medical treatment/return to the MTF requests in light of the facts of that particular case. If the situation merits, the PEB should request the MTF/MEB review their prior referral in light of the above cited standards and the new information.

POC: A. Tomlinson (202) 782 3039
8 Aug 2009

VASRD Issues: Subpart A
VASRD §4.20 Analogous Ratings [Back to INDEX ↑.]

DEPARTMENT OF THE ARMY
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WASHINGTON DC 20307-5001

AHRC-DZB 18 August 2009

MEMORANDUM FOR Presidents, U.S. Army Physical Evaluation Boards

SUBJECT: VASRD §4.20, Analogous Ratings

1. IAW DTM 14 OCT 2008 and NDAA 2008, after the PEB has determined a Soldier is unfit for a compensable condition not listed within VASRD, the PEB will determine which listed condition, i.e., which VASRD Diagnostic code (DC), is closely related based on functions affected, anatomical localization and symptomatology. See VASRD §4.20, Analogous ratings. Depending on a Soldier's unique presentation, different VASRD DCs may be used for the same (unlisted) injury or condition depending on symptomatology. When faced with a choice of DCs, the PEB must also consider VASRD §4.7, Higher of two evaluations, and assign the higher evaluation "if the disability picture more nearly approximates the criteria required for that rating."

2. When preparing the DA Form 199 disability description for a condition rated on an analogous basis IAW VASRD §4.20, the PEB will explain the relationship between the two conditions in terms of similarity of functions affected, anatomical localization, and symptomatology. See 10 U.S.C. §1222 (a).

Daniel Cassidy
Colonel, IN
Deputy Commander

Stress fractures and Stress reactions [Back to INDEX ↑.]
18 April 2008

The following is not intended to create new policy. It is the recommended way to interpret the rating schedule to rate two conditions: stress fractures and stress reactions.

The VASRD includes seven diagnostic codes referencing each of the long bones and bones of the feet. I.e., 5202, humerus impairment; 5211, ulna impairment; 5212 radius impairment; 5255 femur impairment; 5262 tibia and fibula impairment; 5273 malunion of os calcis (calcaneus) or astragalus (talus); 5283, malunion or nonunion of tarsal or metatarsal bones. The associated diagnosis and/or schemes are based, solely or in part, on the presence of either nonunion or malunion.

Neither stress fractures nor stress reactions are associated with nonunion or malunion. However, IAW VASRD 4.20, analogous ratings, we interpret the VASRD as permitting rating stress fractures and stress reactions of the long bones and the pelvis with reference to, on an analogous basis, to VASRD 5202; 5211; 5212; 5255; and 5262. Likewise, stress reactions should be rated on an analogous basis to these codes.

Unlike the list of diagnostic codes for the long bones, with respect to the foot, the VASRD includes 5284, foot injuries other. The VASRD (4.71, plate IV) specifically indicates the os calcis (calcaneus) and the astragalus (talus) are bones of the foot. Given the existence of DC 5284, foot injuries, other, this diagnosis more aptly describes stress reactions and/or stress fractures of the foot than does malunion or nonunion of the os calcis, astragalus, tarsal or metatarsal bones (5273 and 5283.) Therefore, where a Soldier has stress fractures and/or stress reactions involving the calcaneus, talus; tarsals and/or metatarsals the Soldier should be assigned one rating under DC 5284, foot injuries, other.

VASRD DC and Disability Description.

Stress Fractures		**Stress Reactions**	
VASRD DC	Disability Description	VASRD DC	Disability Description
5299 5202	Humerus stress fracture rated analogous to VASRD 5202 IAW §4.20.	5299 5202	Humerus stress reaction rated analogous to VASRD 5202 IAW §4.20.
5299 5211	Ulnar Stress fracture rated analogous to VASRD 5211 IAW §4.20.	5299 5211	Ulnar stress reaction rated analogous to VASRD 5211 IAW §4.20.
5299 5212	Radius stress fracture rated analogous to VASRD 5212 IAW §4.20.	5299 5212	Radius stress reaction rated analogous to VASRD 5212 IAW §4.20.
5299 5255	Femur Stress fracture rated analogous to VASRD 5255 IAW §4.20.	5299 5255	Femur stress reaction rated analogous to VASRD 5255 IAW §4.20.
5299 5262	Tibia and/or fibular stress fracture rated analogous to VASRD 5262 IAW §4.20.	5299 5262	Tibia and/or fibula stress reaction rated analogous to VASRD 5262 IAW §4.20.
5284	Foot injuries due to stress fracture(s) of os calcis (calcaneus); astragalus (talus); tarsals and/or metatarsals	5284	Foot injuries due to stress reaction(s) of os calcis (calcaneus); astragalus (talus); tarsals; and/or metatarsals.

VASRD §4.21, application of the rating schedule, provides: "… it is not expected … that all cases will show all the findings specified. Findings sufficiently characteristic to identify the disease and the disability therefrom, and above all, *coordination of rating with impairment of function will*, however, *be expected in all instances*." Italics supplied. VASRD §4.21 can be seen as providing guidance in how to discern between the different percentage ratings provided within each rating scheme. For example, 5255, impairment of femur, provides a 10% rating for malunion with slight knee or hip disability and 20% for malunion with moderate knee or hip disability. With respect to a 10% rating for slight knee or hip disability in the absence of malunion, we interpret §4.21 as requiring some consideration/comparison between the rating under (5299) 5255 and a rating under 5003 (and associated hip ratings based on limitation of motion: 5251; 5252; 5253; and/or associated knee ratings based on limitation of motion: 5260; and 5261.) Also consider additional functional loss IAW VASRD §§4.10, 4.40, 4.45 and 4.59.

The nature of stress fractures and stress reactions is that they heal. When placing the Soldier on TDRL it is useful to indicate the expectation is complete resolution of the stress fracture and/or stress reaction. If the follow up bone scan is normal, the Soldier may be fit for duty.

Most stress fractures are uncomplicated and managed by rest and restriction from the precipitating activity. Generally, these stress fractures are not associated with significant limitations of motion and will heal within 6 months with no specific treatment other than rest and gradual return to activity. However, some are more severe.[i] [See next page.]

Below are several sample disability descriptions for stress fractures involving the femur, tibia and bones of the feet. Disability descriptions for stress reactions would be similar.

VASRD 5255, impairment of femur.

5299 5255 Stress fracture of the femoral neck. This condition is rated analogous to 5255 IAW VASRD 4.20. Soldier does not have nonunion or malunion. Soldier has preserved range of motion of the hip. Soldier experiences pain with fast walking and when carrying heavy objects. Rated as slight hip disability because of preserved range of motion and preserved ability to walk without a limp or any restrictions placed on activity. Rating includes consideration of functional loss IAW VASRD 4.10, 4.40, 4.45 and 4.59. Condition is unfitting because of risk of further injury with continuation of rigors of military activities. 10%

If the Soldier has an associated fracture of the acetabulum and the functional limitations were with reference to the hip, the two conditions would not be separately rated because of pyramiding.

5299 5255 Stress fracture of the femoral neck and acetabulum. Condition is rated analogous to 5255 IAW VASRD 4.20. Soldier has preserved range of motion of the hip. The Soldier experiences pain with fast walking and when carrying heavy objects. This is rated as slight hip disability because of preserved range of motion and preserved ability to walk without a limp or any restrictions placed on activity. Rating includes consideration of functional loss IAW VASRD 4.10, 4.40, 4.45 and 4.59. Condition is unfitting because of risk of further injury with continuation of rigors of military activities. 10%

VASRD 5299 5262. Stress fractures of tibia.

5299 5262. Anterior tibial stress fracture (radiographically demonstrated). This condition is rated analogous to 5262 IAW VASRD 4.20. He does not have malunion or non union of the tibia. Soldier has no loss of range of motion. Condition is not associated with knee or ankle disability. IAW VASRD 4.40 Soldier is rated at 10% for functional loss due to anterior shin pain with prolonged activity and impact activities. This rating includes consideration of functional loss IAW VASRD 4.10, 4.40, 4.45 and 4.59. Condition is unfitting because of risk of further injury with continuation of rigors of military activities. 10%

5299 5262. Tibial stress reaction. This condition is rated analogous to 5262 IAW VASRD 4.20. He does not have malunion or non union of the tibia. Soldier has preserved range of motion of ankle and knee. Soldier has pain at rest worsened with walking more than ¼ mile. This condition is unfitting because of risk of further injury. Soldier is rated as slight knee or ankle disability because the fracture precludes sustained use of knee and ankle but permits normal activities of daily living and will not interfere significantly with occupational endeavors. This rating includes consideration of functional loss IAW VASRD 4.10, 4.40, 4.45 and 4.59. Condition is unfitting because of risk of further injury with continuation of rigors of military activities. 10%

VASRD 5284, foot injuries, other.

5284. Moderate foot injuries due to stress fractures of third and fourth metatarsal bones and calcaneus. This condition is rated as moderate because of preserved foot function permitting walking and standing, albeit with pain. (This level of activity is not medically contraindicated.) Pain with prolonged standing and high impact activities. 10%

5284 Severe foot injuries due to multiple stress fractures and stress reactions of right foot involving calcaneus, talus and tarsals. Soldier failed conservative treatment and is now in a walking cast. Currently, Soldier is only able to stand for only 10 minutes and/or walk short distances (less than 200 yards) before experiencing significant

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[1] High-Risk Stress Fractures: Evaluation and Treatment
Barry P. Boden, MD and Daryl C. Osbahr
Dr. Boden is Adjunct Assistant Professor, Uniformed Services University of the Health Sciences, The Orthopaedic Center, Rockville, Md. Mr. Osbahr is Laboratory Researcher, Duke University Medical Center, Durham, NC.

Stress fractures are common overuse injuries seen in athletes and military recruits. The pathogenesis is multifactorial and usually involves repetitive sub-maximal stresses. Intrinsic factors, such as hormonal imbalances, may also contribute to the onset of stress fractures, especially in women. The classic presentation is a patient who experiences the insidious onset of pain after an abrupt increase in the duration or intensity of exercise. The diagnosis is primarily clinical, but imaging modalities such as plain radiography, scintigraphy, computed tomography, and magnetic resonance imaging may provide confirmation. Most stress fractures are uncomplicated and can be managed by rest and restriction from the precipitating activity. A subset of stress fractures can present a high risk for progression to complete fracture, delayed union, or nonunion. Specific sites for this type of stress fracture are the femoral neck (tension side), the patella, the anterior cortex of the tibia, the medial malleolus, the talus, the tarsal navicular, the fifth metatarsal, and the great toe sesamoids. Tensile forces and the relative avascularity at the site of a stress-induced fracture often lead to poor healing. Therefore, high-risk stress fractures require aggressive treatment.
J Am Acad Orthop Surg, Vol 8, No 6, November/December 2000, 344-353. © 2000 the American Academy of Orthopaedic Surgeons PubMed
http://www.jaaos.org/cgi/content/abstract/8/6/344

Ankylosing Spondylitis [Back to INDEX ↑.]

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AHRC-DOE

21 August 2009

MEMORANDUM FOR Presidents, U.S. Army Physical Evaluation Boards

SUBJECT: Ankylosing Spondylitis

1. When the MEB evidence supports the Soldier's Ankylosing Spondylitis (AS) fulfills the VASRD requirements for rating with reference to "as an active process", and when this provides the higher rating (vs. "for unfitting chronic residuals"), the PEB must rate the Soldier's AS with reference to VASRD 5002 using the "as an active process" scheme. The PEB will use the evidence within the MEB case file to determine whether the Soldier's AS fulfills the VASRD requirements for rating "as an active process," i.e., the MEB examiner must addresses whether the Soldier has any constitutional signs and whether the AS is active. The MEB examiner must also describe the extent of overall impairment of health. See VA Joints worksheet. 20 APR 2009. https://www.hrc.army.mil/SITE/ACTIVE/tagd/Pda/pdapage.htm. For all PEB adjudications involving unfitting AS, the PEB must indicate on the DA Form 199 that it considered assigning a rating under both rating schemes, and used the rating scheme that provided the higher evaluation, or indicate why the "as an active process" scheme was not applicable.

2. When the PEB finds the Soldier unfit due to AS which affects a body system other than the musculoskeletal system, and rates this condition, the PEB may not use symptoms from these (already rated) conditions to support another rating under the "as an active process" rating scheme. For example, if the Soldier has disability due to a separately ratable eye and separately ratable heart condition, IAW VASRD 4.14, avoidance of pyramiding, the PEB must avoid using symptomatology from these already rated conditions to support a rating based on "definite impairment of health objectively supported by examination finding" or that cause "incapacitating exacerbations occurring 3 or more times a year."

FOR THE COMMANDER:

DANIEL L. CASSIDY
COL, IN
Deputy Commander

VASRD Issues: Subpart B: By Condition and Diagnostic Code (DC)
Limitation of Motion (Arm) (DC 5201) [Back to INDEX ↑.]

DEPARTMENT OF THE ARMY
UNITED STATES ARMY PHYSICAL DISABILITY AGENCY
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WASHINGTON DC 20307-5001

AHRC-DOE 03 April 2009

MEMORANDUM FOR Presidents, U.S. Army Physical Evaluation Boards

SUBJECT: VASRD DIAGNOSTIC CODE (DC) 5201, Arm, limitation of motion of.

1. For purposes of VASRD DC 5201, Arm, limitation of motion of, assign a rating based on either forward elevation (flexion) or abduction, whichever permits the higher rating. Assign only one rating. See VASRD 4.71 and Plate I.

2. References: Mariano v. Principi, No. 01-467, Oct. 22, 2003, DC 5201; VA Student Guide.

3. Point of contact is Dr. Tomlinson at (202) 782-3039.

FOR THE COMMANDER:

DANIEL L. CASSIDY
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Deputy Commander

Supination and Pronation (DC 5213)

I. Definitions and Background

A. Anatomical Position

"The traditional anatomical **position**, which has long been agreed upon, places the body in the erect posture with the feet together, the arms hanging at the side, and the thumbs pointing away from the body. … The muscle actions and motions at the joints are given with reference to this position unless it is stated otherwise." Grey's anatomy, 1966. Page 2.

B. Supination

1. Position

Supination is the **position** when the palm faces anteriorly, or, when the arms are bent at the sides, faces up.

"*In* supination, the radius and ulna are parallel, and the palm faces ventralward or cranialward." Grey's Anatomy, 1966, p 299.

2. Motion

The rotational **motion** of supination occurs at the forearm at the radioulnar joint. **This rotational motion of supination** starts from full pronation, and corresponds to a clockwise twist for the right forearm and a counterclockwise twist for the left.

C. Pronation

1. Position

Pronation is the **position** when the palm faces posteriorly, or, when the arms are bent at the sides, faces downwards.

"In **pronation** the radius is rotated diagonally across the ulna and the palm faces dorsalward or caudalward." Grey's Anatomy, 1966, p 299.

2. Motion

Pronation is the rotational **motion** of the forearm at the radioulnar joint. **This rotational motion of pronation** starts from full supination, and corresponds to a counterclockwise twist for the right forearm and a clockwise twist for the left.

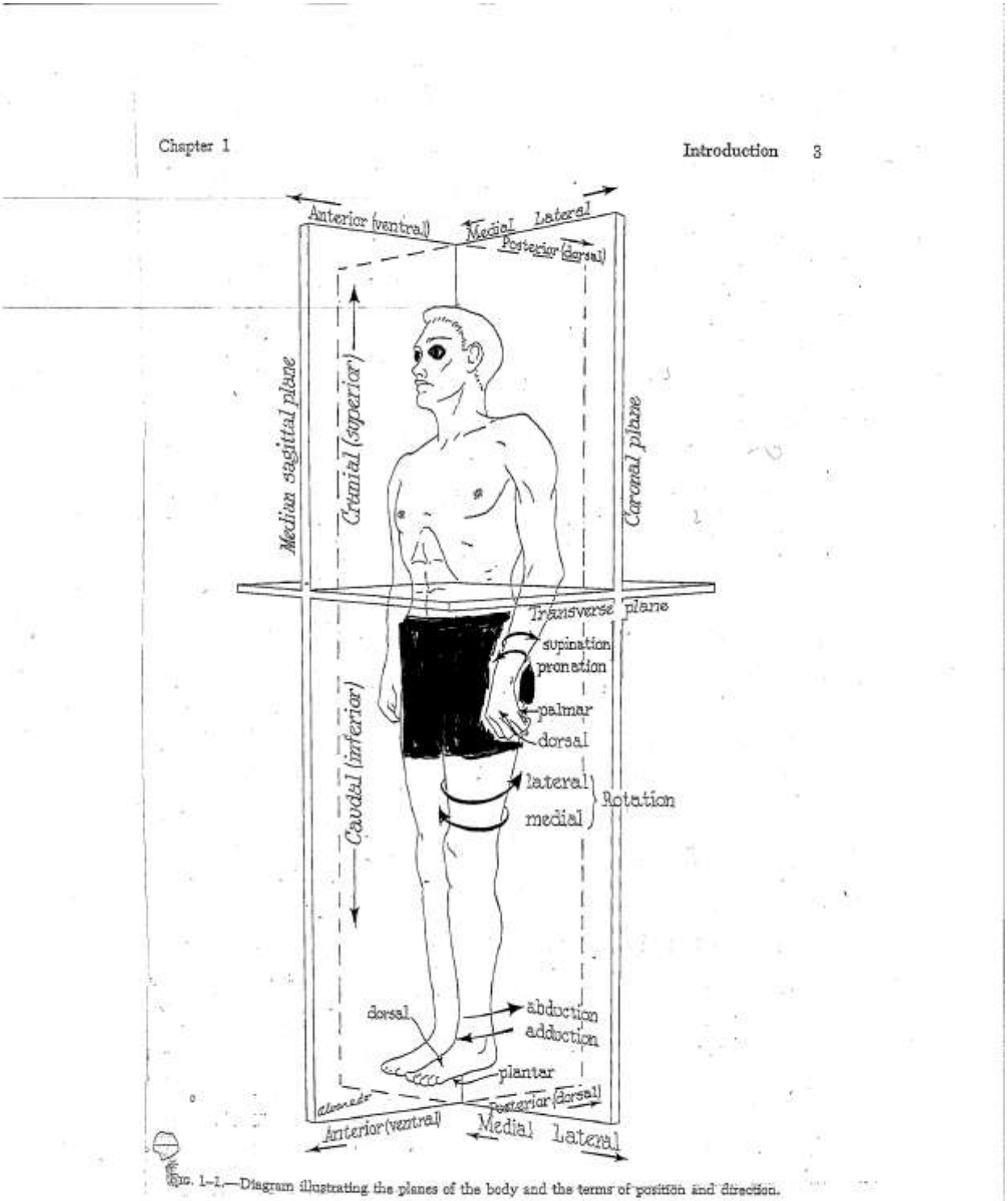


FIG. 1–1.—Diagram illustrating the planes of the body and the terms of position and direction.

D. Range of Motion

1. Normal range of motion

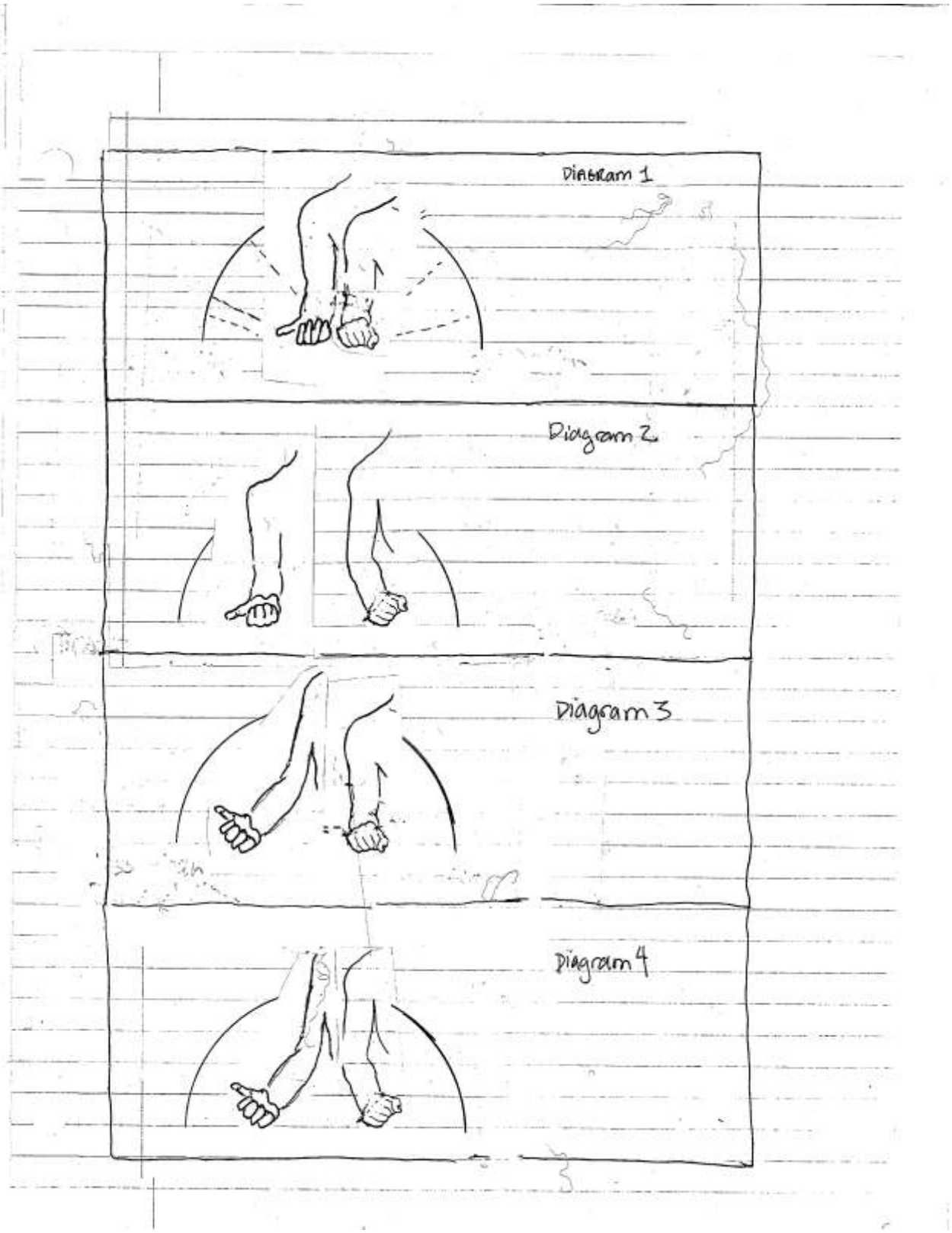
Normal range of motion back and forth *between the positions of full pronation and the position of full supination* (and back) requires equal measures motion of supination and pronation.

Without reference to degrees, diagram 1 attempts to portray normal range of motion.

Diagram 2 attempts to portray an impairment of supination and pronation such that the forearm cannot reach the position of full pronation.

Diagram 3 attempts to portray an impairment of supination and pronation such that the forearm cannot reach the position of full supination.

Diagram 4 attempts to portray an impairment of supination and pronation such that the forearm reaches neither the position of full pronation nor the position of full supination



II. Application of VASRD DC 5213, supination and pronation

A. §4.46 accurate measurement

This section indicates that examiners are to use a goniometer to measure range of motion.

B. VASRD §4.71 **Measurement** of ankylosis and joint motion

§4.71 provides that Plate I provides a standardized description of joint motion measurement. Noting two exceptions, it provides that the anatomical position is considered zero degrees. For supination and pronation, 4.71 provides that *when describing forearm supination and pronation* - the arm is next to the body, elbow flexed to 90 degrees, and the forearm is in midposition 0 degrees between supination and pronation.

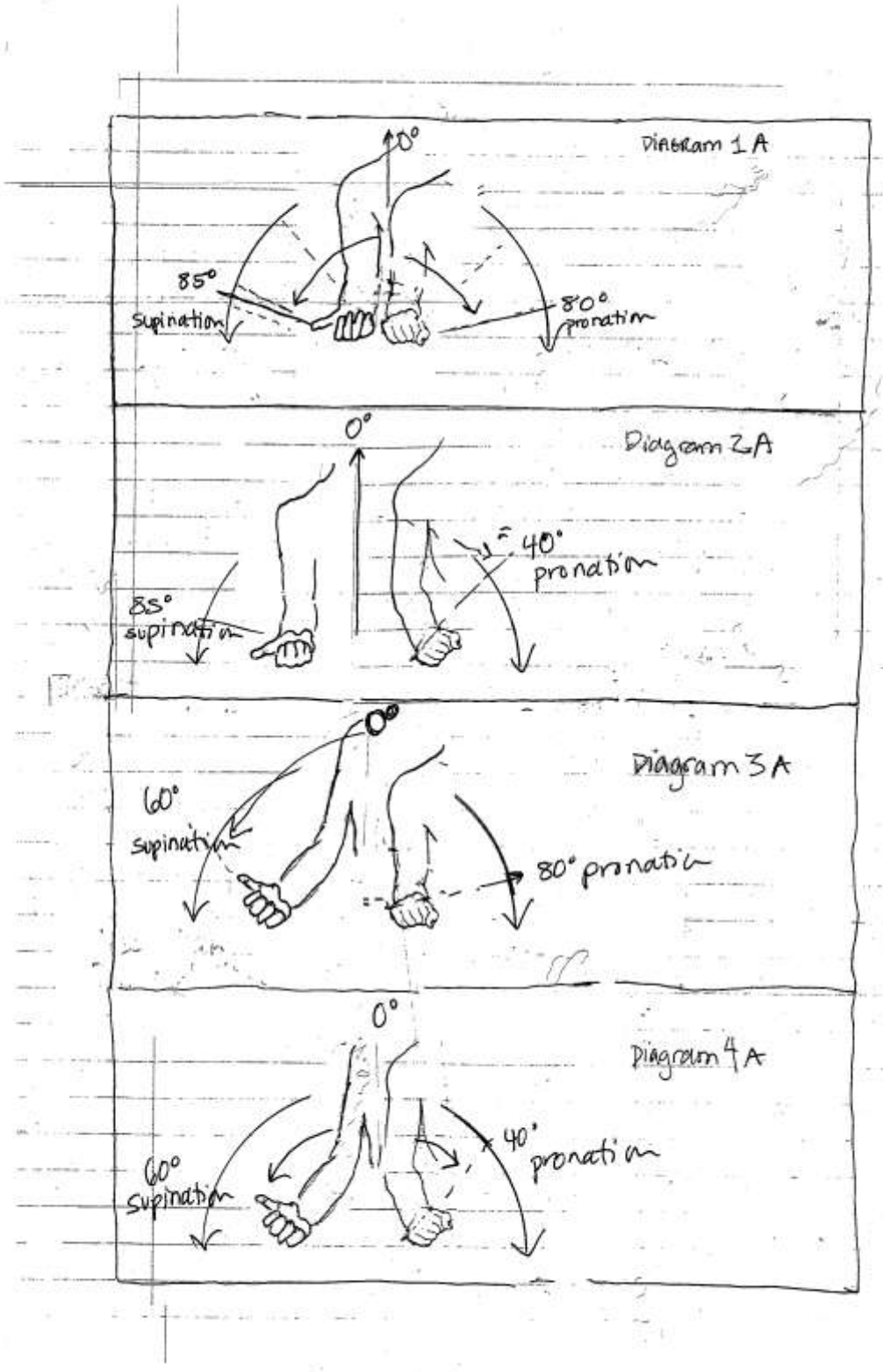
C. VA Worksheet

E. Normal Range of Motion: All joint Range of Motion measurements must be made using a **goniometer**. *Show each measured range of motion separately* rather than as a continuum. For example, if the veteran lacks 10 degrees of full knee extension and has normal flexion, show the range of motion as extension to minus 10 degrees (or lacks 10 degrees of extension) *and flexion 10 to 140 degrees*.
…
Forearm supination = zero to 85 degrees.
Forearm pronation = zero to 80 degrees.

D. VASRD DC 5213

VASRD DC 5213 Supination and Pronation, impairment of	**Major**	**Minor**
Loss of (bone fusion):		
Hand fixed in supination or hyperpronation	40	30
Hand fixed in full pronation	30	20
Hand fixed near the middle of the arc or moderate pronation	20	20
Limitation of pronation:		
Motion lost beyond middle of arc	30	20
Motion lost beyond **last quarter of arc**, the hand does not approach full pronation	20	20
Limitation of supination:		
To 30 degrees or less	10	10
NOTE: In all the forearm and wrist injuries, codes 5205 through 5213, multiple impaired finger movements due to tendon tie-up, muscle or nerve injury, are to be separately rated and combined not to exceed rating for loss of use of hand.		

For purposes of impairment of supination and pronation, and with reference to VA conventions, and anatomy, normal pronation is from 85 supination (anatomical position) to 80 degrees pronation. The examiner would report this as 0 to 80 pronation and implicit in the 0 to 85 degrees supination is the 85 to 0 degrees pronation that necessarily follows.



An impairment of pronation could manifest as a range of motion that could not be reported from the midposition between supination and pronation. The VA examiner could report this as motion between 45 and 85 degrees supination.

Plate I does not redefine the limits of normal range of motion of pronation and supination. By VA convention, normal range of motion of pronation and supination is communicated as follows: 0 to 80 degrees pronation and 0 to 85 degrees supination. The title of VASRD DC 5213 is impairment of supination and pronation. The arc of normal pronation is from 85 degrees supination through the midposition between (the positions of) supination and pronation to 80 degrees pronation. VASRD DC 5213 is impairment of supination and pronation. This title underscores the fact that supination and pronation are interconnected and interdependent movements. §4.71 discusses and Plate I illustrates the arc of movement midposition 0 between supination and pronation. VASRD DC 5213 later references this same midposition. VASRD DC 5213 did not redefine the normal limit of motion for pronation (and hence, a new arc from which a new middle could to be determined). Therefore, for purposes of VASRD DC 5213, impairment of supination and pronation, the arc of motion – whether it be pronation or supination is the same: the arc refers to motion between 85 degrees supination (or anatomical position) and 80 degrees pronation (full pronation).

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AHRC-DOE

30 September 2009

MEMORANDUM FOR Presidents, U.S. Army Physical Evaluation Boards

SUBJECT: Assigning Multiple Thigh Limitation of Motion Codes

1. Based on the PDA's reading of the VASRD (4.14, Avoidance of Pyramiding; DC 5003, Osteoarthritis; DC 5251, Thigh, limitation of extension; 5252, Thigh limitation of flexion of; 5253, Thigh, impairment of), case law (Esteban v. Brown, 1994), and informal communication with Veterans Benefits Administration (VBA), it is acceptable to assign multiple ratings for the same injury causing the requisite unfitting limitation of motion (to include combined effect) with reference to VASRD 5251, and/or 5252 and/or 5253.

2. In Esteban v. Brown, the Court of Veterans Appeals held that different manifestations of a single injury are to be separately rated.

3. Following this rationale, the PDA considers separate ratings under multiple thigh limitation of motion codes as different manifestations of a single condition, and therefore, separately rated when unfitting, to include combined effect.

DANIEL L. CASSIDY
COL, IN
Deputy Commander

THE ORGANS OF SPECIAL SENSE (Eyes) [Back to INDEX ↑.]
[With Particular Emphasis on Visual Impairment]
Effective Date: 10 DEC 2008.

SUBJECT: Rating eye conditions.

VASRD §§ 4.75; 4.76; 4.76a; 4.77; 4.78 and 4.79. See http://www.warms.vba.va.gov/bookc.html#e for e-version of these provisions.

General: Simplifies and clarifies rating eye conditions.

A. Overview.

1. Scheduled steps of visual acuity.

Scheduled steps (steps) of visual acuity in feet (per eye) with metric equivalents in meters are as follows:

20/40 (6/12)
20/50 (6/15)
20/70 (6/21)
20/100 (6/30)
20/200 (6/60)
15/200 (4.5/60)
10/200 (3/60)
5/200 (1.5/60)
No more than light perception
(Anatomical loss of one eye)

2. Visual impairment is generally rated based on the best corrected distance visual acuity of each eye. See § 4.76 (b).

3. If visual acuity falls between two of the scheduled steps, rate using the visual acuity permitting higher % rating (use “worse” vision; i.e., if visual acuity 20/60, use 20/70).

4. Visual impairment may be due to a field defect. Examiners must perform testing using either: Goldmann kinetic perimetry; or Humphrey 750, Octopus Model 101, (or later versions of these perimetric devices) with simulated kinetic Goldmann testing capability. See § 4.77 (a). Instructions (to examiners) on using Humphrey equipment is outlined in the document titled: Kinetic Visual Field Testing on PDA Website at: https://www.hrc.army.mil/site/Active/TAGD/Pda/pdapage.htm . [Note: this document was prepared by the Army OTSG Ophthalmology Consultant.] See also VA Worksheet titled Eye Examination. http://www.vba.va.gov/bln/21/Benefits/exams/index.htm

5. To determine the rating where the Soldier has a field defect, often the adjudicator will need to calculate the “average concentric contraction of the visual field of each eye by measuring the remaining visual field at the 8 principle meridians. See § 4.76a: Table III; Figure 1; VASRD § 4.77(b); and Figure 2. If a Soldier has both decreased (best corrected) visual acuity and field defect, rate both and combine IAW VASRD § 4.25.

6. Visual impairment may be due to diplopia (double vision.) Examiners must use a Goldmann perimeter chart. See § 4.78 (a). Instructions (to examiners) on how to convert data to a Goldmann chart are included in the document titled: "Performing Diplopia Fields" on PDA Website at: https://www.hrc.army.mil/site/Active/TAGD/Pda/pdapage.htm [Note: this document was prepared by the Army OTSG Ophthalmology Consultant.] For rating, the general rule is: when a Soldier has diplopia in addition to decreased (best corrected) visual acuity and/or field defect(s), the corresponding scheduled step of visual acuity for only one eye (the poorer eye) is deemed one (or more) step(s) poorer. See VASRD § 4.78 (b).

7. General Approach:

    a. Use best corrected distance vision of right and left eye to determine rating.
    b. If Soldier has an associated field defect, assign additional rating based on extent of right and left eye field defect.
    c. If Soldier has diplopia, depending on the severity of the diplopia, assign a scheduled step of visual acuity one or more steps poorer than best corrected (distance) vision. The extent of diplopia will determine the number of steps poorer to assign. See § 4.78 (b).
    d. Consider whether the Soldier is entitled to a "minimum rating." For example, if continuous medication required (See 6013, open angle glaucoma); 6036 Corneal transplant 10% if there is pain, photophobia, and glare sensitivity.
    e. For VASRD DC 6000 – 6009, rate based on "incapacitating episodes" when that provides a higher rating.
    f. Consider additional ratings, e.g., disfigurement.

B. Examples.

VASRD § 4.76 (b) (3); § 4.76a; and § 4.77 (c).

Soldier's (uncorrected) distance vision is: 20/70 right eye (O.D.) and 20/100 left eye (O.S.). Corrected distance vision is 20/60 both eyes. Near vision is the same. Left eye has field defect as outlined in VASRD 4.76a, Figure 1. This works out to be 22 ½ degrees. What is the rating? 6066 Visual acuity in one eye 10/200 or better. IAW VASRD 4.76 (b) (1) and (4) Soldier is rated for 20/70 (both eyes) 30% 6080 Unilateral (left eye) visual field defect left with remaining field of 16 to 30 degrees (22 ½ degrees). 10% 30 + 10 = 37 = 40%

VASRD § 4.75 (e); and § 4.76 (b) (3).

Soldier's best corrected vision in right eye (O.D.) is 20/20 distance; 20/70 near. Examiner includes two recordings of near and distance corrected vision and explains the reason for the difference. Left eye is absent. Soldier

cannot wear a prosthesis. What is the rating?

§ 4.76 (b) (3) applies. For rating purposes, we consider 20/20 as 20/40. The difference between near and distance is two steps, i.e., 20/40; 20/50 and then 20/70. The examiner included two recordings of near and distance corrected. Instead of considering the right eye as 20/40, we use 20/50 because this is one step poorer than measured best corrected distance vision.

6063 Anatomical loss of one eye with inability to wear prosthesis. Soldier's best corrected near vision is worse than best corrected distance vision. IAW VASRD 4.75 (e) and 4.76 (b) (3), Soldier's visual impairment is rated at 60% (50% + 10%). This rating includes consideration of Soldier's inability to wear a prosthesis and associated disfigurement.

VASRD § 4.75 (b) and (d).

An ophthalmologist conducts an examination and provides the following:

Soldier sustained an IED injury to his right eye while in Iraq. He has corneal and retinal scarring. Best corrected distance vision of right eye is 20/200. Near vision is best corrected is also 20/200. Soldier also has a visual field defect of the right eye. The Soldier has a remaining visual field of 35 degrees that is supported by data plotted on a Goldmann bowl perimeter chart. This is included within the MEB. Left eye was not injured and vision is 20/20.

The rating for the Soldier's decreased visual acuity is 20%. See VASRD 6066 Visual acuity in one eye 10/200 or better. The rating for the Soldier's field defect is 10%. See VASRD 6080 Visual field defects; With remaining field of 31 to 45 degrees; Unilateral. The combined rating for the Soldier's visual impairment is 20 + 10 = 28 = 30%.

VASRD 4.75 (d) provides a 30% maximum evaluation for visual impairment of one eye unless there is anatomical loss of the eye. This example illustrates why, even without 4.75 (d), it is unlikely a Soldier would be rated higher than 30% for visual impairment (in the absence of anatomical loss of the eye): this Soldier has significant visual impairment and the combined rating for both decreased visual acuity and field defect does not exceed 30%. Thus an adjudicator will rarely use 4.75 (d) to lower a rating. VASRD 4.75 (b) requires either a licensed optometrist or an ophthalmologist conduct the examination.

Prepared by AT
2 Feb 2009

DEPARTMENT OF THE ARMY
UNITED STATES ARMY PHYSICAL DISABILITY AGENCY
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AHRC-DOE

05 May 2009

MEMORANDUM FOR Presidents, U.S. Army Physical Evaluation Boards

SUBJECT: VASRD DIAGNOSTIC CODE Diagnostic Code (DC) 6602, Asthma

1. For purposes of VASRD DC 6602, asthma, "inhalational anti-inflammatory medication" as set forth in the 30% rating is met when the evidence of record indicates the Soldier uses inhaled anti-inflammatories at least intermittently. *For purposes of the VASRD*, when rating a Soldier for unfitting asthma, there is no requirement the Soldier use inhaled anti-inflammatory medication daily or that a minimum amount be used on days the Soldier uses the inhaled anti-inflammatory medication.

2. Point of contact is Dr. Tomlinson at (202) 782-3039.

FOR THE COMMANDER:

Daniel Cassidy
Colonel, IN
Deputy Commander

The Heme and Lymphatic Systems: VASRD § 4.117 [Back to INDEX ↑ .]
Sustainment Training – 28 July 2008
(Edited (no substantive change) 25 MAR 2010)

1. CML

When reviewing an MEB where the Soldier has CML, the first consideration is whether the condition renders the Soldier fit or unfit for further military duty.

As outlined in DoDI 1332.38, E3.P3, the evidence may support finding the Soldier unfit for a variety of reasons/considerations. Specifically, in a Soldier with CML, and based on the Soldier's PMOS, the PEB should specifically consider the Soldier's recent performance data; whether continuing on active duty poses a "decided risk" to the Soldier; and whether managing the condition "imposes unreasonable requirements on the military to maintain or protect the member."

Gleevec targets and turns off the production of a protein that is important in maintaining the growth of leukemia cells. Gleevec suppresses the biological markers for the Philadelphia chromosome, normalizes the appearance of the bone marrow and may, in some cases, eliminate all detectable evidence of disease. Indefinite continuation of Gleevec appears to be the standard of care in treatment of CML even after tumor markers are undetectable.

Based on this, where the PEB finds the Soldier is unfit, and when the Soldier is on Gleevec, the rating is 100% based on "during a treatment phase."

The general VASRD rating scheme for rating leukemia (including CML) is:

7703	Leukemia:
	With active disease or during a treatment phase 100%
	Otherwise rate as anemia (code 7700) or aplastic anemia (Code 7716), whichever would result in the greater benefit.
Note: The 100 percent rating shall continue beyond the cessation of any surgical, radiation, antineoplastic chemotherapy or other therapeutic procedures. Six months after discontinuance of such treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of §3.105(e) of this chapter. If there has been no recurrence, rate on residuals.	

http://www.medicinenet.com/script/main/art.asp?articlekey=77983

New Skin Rule and Examples [Back to INDEX ↑ .]
(Updated 25 MAR 2010)

Example 1:
A Soldier has two unfitting burn scars on their face. One scar measures 4 sq inches; is hyperpigmented; shiny; and indurated and inflexible. The second scar measures 3 square inches and is also hyperpigmented, shiny, and indurated and inflexible. What is the rating?

7800	Two facial burn scars (1) 4 sq in; (2) 3 sq in., total 7 sq in. Each with (1) hyperpigmentation; (2) abnormal skin texture (shiny); (3) indurated and inflexible; (4) at least ¼ inch wide at widest part. Combined area exceeds 6 sq in. Rated for 4 characteristics of disfigurement IAW Note (5).	50%

COMMENT: New VASRD DC 7800 Note (5) specifically indicates the characteristics of disfigurement may be caused by one scar or by multiple scars.

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.

This note distinguishes individual scars vs. (individual) "characteristics of disfigurement." Specifically, with reference to counting *characteristics of disfigurement*, the rater will "add up" or combine the surface area (or length) of the scars to determine whether, when added, the total facial scarring meets the requirements for one or more characteristics of disfigurement.
Example 1 demonstrates application of the note. Neither of the Soldier's scars individually meets the requirements for characteristics of disfigurement based on hyperpigmentation (or abnormal skin texture (shiny); or, indurated and inflexible) *in an area exceeding 6 sq in.* because neither exceeds 6 sq. in. However, the *combined area* of the scars manifesting hyperpigmentation (and abnormal skin texture (shiny); and indurated and inflexible) exceeds 6 sq. in.

Note (5) means the Soldier meets the requirements for the *three* characteristics of disfigurement based on: *hyperpigmentation; abnormal skin texture (shiny); and skin that is indurated and inflexible* because these two scars (which manifest these skin changes) *exceed*, in Toto, *6 sq. in.*

Also, the note means the Soldier is awarded [only] one characteristic of disfigurement based on "scar at least ¼ inch wide at widest part" even though two scars manifest this [same] characteristic of disfigurement because "[t]he characteristic(s) of disfigurement may be caused … by multiple scars."

Example 2:
The same two scars as above. The scars are also painful and unstable. The Soldier is unfit due also, in part, to this pain and due to the unstable aspect of the scars. What is the rating?

7800	Two facial burn scars (1) 4 sq in; (2) 3 sq in., total 7 sq in. Each with (1) hyperpigmentation; (2) abnormal skin texture (shiny); (3) indurated and inflexible; (4) at least ¼ inch wide at widest part. Combined area exceeds 6 sq in. Rated for 4 characteristics of disfigurement IAW Note (5).	50%
7804	Scars, unstable and painful. Two with both characteristics. Rated at 20% IAW Note (2).	20%
IAW VASRD 4.25, the combined rating is 50 + 20 = 60		

COMMENT: New VASRD DC 7804 Note (3) indicates this additional rating is permitted even though these same scars were already rated under VASRD 7800.

SUMMARY: A Soldier may be rated for multiple characteristics of disfigurement for one scar. In addition, the Soldier can be awarded an additional rating *for these same scars* provided they are painful and/or unstable. *However,* each characteristic of disfigurement can only be counted once, regardless of how many scars manifest that (same) characteristic of disfigurement.

COMMENT: If a Soldier has multiple unfitting scars [due to disfigurement], each with the same characteristic(s) of disfigurement, the PEB may conclude the case presents such an exceptional or unusual disability picture that the regular scheduler rating is inadequate. In such cases, consider AR 635-40, B-9 (and VASRD § 3.321(b). The PEB must document the basis of its conclusion if it awards a rating higher than provided by the regular scheduler rating. Prior to considering such a rating, verify the rating includes consideration of VASRD 7804 (for painful and/or unstable scars) and the combined area of the scars with hypo- or hyperpigmentation; abnormal skin texture; underlying soft tissue loss; and skin that is indurated/inflexible.

Example:

7800 Five disfiguring facial scars. Length 5.0 in., width 0.30 in. (two characteristics of disfigurement). Each associated with missing underlying soft tissue. Combined area of soft tissue defect exceeds 6 sq. in. (third characteristic of disfigurement). Soldier has no gross distortion or asymmetry of features or paired set of features. Color photos indicate startling and unusual appearance. Each scar is immediately obvious. It is difficult to imagine more obvious facial disfigurement. Given Soldier's appearance, an employer is unlikely to rely on this Soldier to interact with the public. This is the reason for concluding the regular scheduler provisions do not apply. IAW AR 635-40, B-9, Soldier is rated at 80%, as if each scar had one separate characteristic of disfigurement. Scars are not painful. Soldier's PMOS is 46A, Public Affairs Officer. Scars are unfitting because they preclude the Soldier's willingness to interact with people.

Example 3:
A Soldier has one unfitting (postsurgical) facial scar with 4 characteristics of disfigurement. The scar is painful and this contributes to why the scar is unfitting. What is the rating?

7800	Postsurgical facial scar with 4 characteristics of disfigurement including: 5 inches in length, ¼ inch wide with elevated surface contour on palpation and adherent to underlying tissue.	50%
7804	Painful scar.	10%
IAW VASRD 4.25, the combined rating is 50 + 10 = 55 which rounds to 60%.		

Example 4:
This Soldier is an 11B. He has one painful facial scar measuring 5 X 3 inches. It is hypopigmented and there is loss of underlying soft tissue. This scar interferes with his getting a tight seal with his gas mask. He has five hypopigmented scars with a combined surface are of 7 square inches. These five scars are not painful and do not interfere with his ability to wear a helmet or a gas mask. What is the rating?

7800	Facial scar with 2 characteristics of disfigurement including: hypopigmentation and loss of underlying soft tissue in an area exceeding six sq. in.	30%
7804	Painful scar.	10%
IAW VASRD 4.25, the combined rating is 30 + 10 = 37 which rounds to 40%.		

Remaining facial scars are not unfitting and not rated. These scars do not interfere with the Soldier's performance of duty.

COMMENT: Prior to rating a condition, the PEB considers whether the condition, i.e., the scar, is fitting or unfitting. Only after the PEB determines the condition is unfitting does the PEB assign a rating.

Example 5:
A Soldier has a deep scar on the posterior aspect of the left knee measuring 14 sq. inches. The PEB has determined it is unfitting. It is painful and causes limitation of extension of left knee to 5 degrees. Both the pain and limitation of motion are unfitting. What is the rating? **[We are using this case as an example of how to rate noncompensable limitation of motion due to deep scarring. Note, however, it is not clear how this noncompensable minimal limitation of motion, alone, would be unfitting. We provided two "answers" depending on the facts of the case.]**

ANSWER 1

7801	Deep scar, posterior left knee. 14 sq inches.	20%
7804	Painful scar.	10%
7805-5261	Limitation of extension, left knee caused by deep scar. Extension limited to 5 degrees without additional functional loss due to pain or other factors associated with this scar. Examination indicates the Soldier's condition causes no additional functional loss as contemplated by VASRD 4.10, 4.40, 4.45 and 4.59. No evidence of periarticular pathology or joint involvement.	0%
IAW VASRD 4.25, the combined rating is 20 + 10 + 0 = 28 which rounds to 30%.		

ANSWER 2:

7801	Deep scar, posterior left knee. 14 sq inches.	20%
7804	Painful scar.	10%
7805-5261	Limitation of extension, left knee caused by deep scar. Extension limited to 5 degrees with additional functional loss due to pain associated with this deep scarring. Specifically, the examination indicates evidence that the Soldier's condition causes additional functional loss as contemplated by VASRD 4.10, 4.40.	10%
IAW VASRD 4.25 the combined rating is: 20 + 10 + 10 = 35 which rounds to 40%.		

Example 6:
Same as Example 5, ANSWER 1 scenario. Soldier also has 3 superficial painful scars (each measuring 3 square inches) on the right thigh. The painful nature of the scars is unfitting. What is the bilateral factor? What is the rating?

7804	Painful scars. Three on right thigh.	20%
7801	Deep scar, posterior left knee. 14 sq inches.	20%
7804	Painful scar, posterior left knee.	10%
7805-5261	Limitation of extension, left knee caused by deep scar. Extension limited to 5 degrees without additional functional loss due to pain or other factors associated with this scar. Examination indicates the Soldier's condition causes no additional functional loss as contemplated by VASRD 4.10, 4.40, 4.45 and 4.59. No evidence of periarticular pathology or joint involvement.	0%
IAW VASRD 4.25 and 4.26, bilateral factor, the combined rating is: 20 + 20 + 10 + 0 = 42 + 4.2 (BLF) = 46 which rounds to 50%		

VA Training Letter: [Back to INDEX ↑ .]
TBI Rule with discussion on when mental disorders (including PTSD) may be separately rated.

January 21, 2009

Director (00/21) In Reply Refer To: 211D
All VA Regional Offices Training Letter 09-01

SUBJ: Evaluating Residuals of Traumatic Brain Injury under Revised Criteria

BACKGROUND INFORMATION

TL 06-03, titled "Traumatic Brain Injury," was issued in February 2006. It provided extensive medical information about the causes of traumatic brain injury (TBI), especially as related to combat, the anatomy and physiology of the brain, signs and symptoms of TBI, grades of severity of TBI, the course of recovery and consequences of TBI, and disabilities resulting from TBI. It also provided some basic rating information about TBI.

TL 07-05, titled "Evaluating Residuals of Traumatic Brain Injury," was issued in August 2007. It provided additional information about the specifics of rating TBI. However, that material is now obsolete in part because of the new regulation, and parts of TL 07-05 have been superseded by TL-09-01.

CURRENT EFFORTS

This training letter provides new information and guidance about evaluating TBI, based on the regulation revising diagnostic code 8045 in the "Neurological conditions and convulsive disorders" section of the rating schedule (38 CFR 4.124a) that was published in the Federal Register on September 23, 2008 (73 FR 54693-54708). It also provides the common definition of TBI that was jointly developed by VA and the Department of Defense.

WHO TO CONTACT FOR HELP

Questions should be e-mailed to the Q&A Committee.

/S/
Bradley G. Mayes
Director
Compensation and Pension
Service

Enclosure

New Criteria for Evaluating Residuals of Traumatic Brain Injury

A. Introduction

New criteria for evaluating the residuals of traumatic brain injury (TBI) under diagnostic code 8045 have been published. Therefore, we are issuing this training letter to explain the revised criteria and their application.

This letter also provides and explains the common VA and Department of Defense (DoD) definition of TBI, which was developed by the DoD/VA Definition and Taxonomy Working Group and other joint consensus panels.

This letter supersedes the guidance for evaluating residuals of mild TBI and the discussion of the assessment of cognitive impairment that were provided in TL 07-05.

B. Definition of TBI

VA and DoD have developed and approved a common definition of TBI that is now in general use by both departments. It establishes a common definition of TBI, severity of brain injury stratification, and method of data collection.

Both Departments use the common DoD/VA definition as the foundation of data systems, policies, and regulations.

Part I of definition: VA/DoD Common Definition of TBI

A traumatically induced structural injury and/or physiological disruption of brain function as a result of an external force that is indicated by new onset or worsening of at least one of the following clinical signs, immediately following the event:

Any period of loss of or a decreased level of consciousness;

Any loss of memory for events immediately before or after the injury;

Any alteration in mental state at the time of the injury (confusion, disorientation, slowed thinking, etc.);

Neurological deficits (weakness, loss of balance, change in vision, praxis, paresis/plegia, sensory loss, aphasia, etc.) that may or may not be transient;

Intracranial lesion.

External forces may include any of the following events: the head being struck by an object, the head striking an object, the brain undergoing an acceleration/deceleration movement without direct external trauma to the head, a foreign body penetrating the brain, forces generated from events such as a blast or explosion, or other force yet to be defined.

The above criteria define the event of a traumatic brain injury (TBI). Sequelae of TBI may resolve quickly, within minutes to hours after the neurological event, or they may persist longer. Some sequelae of TBI may be permanent.

Most signs and symptoms will manifest immediately following the event. However, other signs and symptoms may be delayed from days to months (e.g., subdural hematoma, seizures, hydrocephalus, spasticity, etc.).

Signs and symptoms may occur alone or in varying combinations and may result in a functional impairment. These signs and symptoms are not better explained by pre-existing conditions or other medical, neurological, or psychological causes except in cases of an exacerbation of a pre-existing condition. These generally fall into one or more of the three following categories:

Physical: Headache, nausea, vomiting, dizziness, blurred vision, sleep disturbance, weakness, paresis/plegia, sensory loss, spasticity, aphasia, dysphagia, dysarthria, apraxia, balance disorders, disorders of coordination, seizure disorder.

Cognitive: Attention, concentration, memory, speed of processing, new learning, planning, reasoning, judgment, executive control, self-awareness, language, abstract thinking.

Behavioral/emotional: Depression, anxiety, agitation, irritability, impulsivity, aggression.

Note: The signs and symptoms listed above are typical of each category but are not an exhaustive list of all possible signs and symptoms.

Comments on Part I of the common definition of TBI:
1. Regarding the requirements for clinical signs immediately following the traumatic event, note that only 1 of the 5 listed items is needed for the diagnosis.

Notably, there is NO requirement that there be loss or decreased level of consciousness at the time of the injury, although it is a common occurrence.

Any one of the 5 findings is sufficient for the diagnosis.

2. The definition also describes the mechanisms of injuries that may lead to TBI. TBI may therefore result from a motor vehicle accident, fall, blow to the head, penetrating brain wound, and other types of trauma, both in combat and not in combat, in addition to the blasts/explosions that have been a common source of TBI in veterans of the Afghanistan and Iraq conflicts.

3. The definition also mentions some of the possible delayed effects of TBI, including subdural hematoma, seizures, hydrocephalus, and spasticity. These will warrant service connection even if they don't appear for days, months, or possibly longer after the trauma, if attributable to an in-service TBI. A medical opinion will be needed in cases where the records do not indicate a clearcut etiology for a condition that is claimed as a delayed effect.

4. The definition also names the 3 categories of signs and symptoms that may be residuals of TBI, as discussed in previous training letters: physical, cognitive, and behavioral/emotional.

5. The definition also includes a discussion of the severity of TBI, as follows:

Part II of definition: Severity of Brain Injury Stratification

Not all individuals exposed to an external force will sustain a TBI. TBI varies in severity, traditionally described as mild, moderate and severe. These categories are based on measures of length of unconsciousness, post-traumatic amnesia.

The trauma may cause structural damage or may produce more subtle damage that manifests by altered brain function, without structural damage that can be detected by traditional imaging studies such as Magnetic Resonance Imaging or Computed Tomography scanning.

In addition to traditional imaging studies, other imaging techniques such as functional magnetic resonance imaging (fMRI), diffusion tensor imaging, positron emission tomography (PET) scanning, as well as electrophysiological testing such as electroencephalography may be used to detect damage to or physiological alteration of brain function.

In addition, altered brain function may be manifest by altered performance on neuropsychological or other standardized testing of function.

Acute injury severity is determined at the time of the injury, but this severity level, while having some prognostic value, does not necessarily reflect the patient's ultimate level of functioning. It is recognized that serial assessments of the patient's cognitive, emotional, behavioral and social functioning are required.

The patient is classified as mild/moderate/severe if he or she meets any of the criteria below within a particular severity level. If a patient meets criteria in more than one category of severity, the higher severity level is assigned.

If it is not clinically possible to determine the brain injury level of severity because of medical complications (e.g., medically induced coma), other severity markers are required to make a determination of the severity of the brain injury.

It is recognized that the symptoms associated with post traumatic stress disorder (PTSD) may overlap with symptoms of mild traumatic brain injury. Differential diagnosis of brain injury and PTSD is required for accurate diagnosis and treatment.

Mild	Moderate	Severe
Normal structural imaging	Normal or abnormal structural imaging	Normal or abnormal structural imaging
LOC = 0-30 min	LOC >30 min and < 24 hours	LOC > 24 hrs
AOC = a moment up to 24 hrs	AOC >24 hours. Severity based on other criteria	
PTA = 0-1 day	PTA >1 and <7 days	PTA > 7 days
GCS=13-15	GCS=9-12	GCS=3-8

AOC – Alteration of consciousness/mental state
LOC – Loss of consciousness
PTA – Post-traumatic amnesia
GCS - Glasgow Coma Scale

Note: For purposes of injury stratification, the Glasgow Coma Scale is measured at or after 24 hours.

This stratification does not apply to penetrating brain injuries where the dura mater is breached.

Comments on Part II of the common definition (severity of brain injury stratification)

For rating purposes, these 3 points are most important.
Determination of the level of severity (mild, moderate, severe) is made at the time of the injury, that is, it is a determination of ***acute*** injury severity.
Once this acute level of severity is determined, it ***does not change***, regardless of the veteran's course or extent of residuals.
Classification of the level of severity ***has no bearing on C&P evaluations***.

As the definition says: " … this severity level, while having some prognostic value, does not necessarily reflect the patient's ultimate level of functioning." This means that a veteran who was initially designated as having mild TBI may have severe residuals, and one who was designated as having severe TBI may have only mild residuals. Every individual recovers at his or her own rate and to an individual extent.

Therefore, the severity level assigned at the time of the acute trauma may or may not correspond to the severity of residuals that are the basis of the evaluation level you assign, and **should not be a factor** in determining the evaluation.

Note: The Glasgow Coma Scale, which is referenced in the table above as one of the criteria that may be used to determine the acute injury level, was included as part of previous training letter TL 07-05.

C. General Information About Rating Residuals of TBI

1. **Categories of residuals**. As the definition notes, the major residuals of TBI fall into three main categories: physical, cognitive, and behavioral/emotional. Examples of residuals that may be seen in each of these categories were provided in TL 07-05. Review the material in TL 07-05 and TL 06-03 for additional information about TBI.

2. **Diagnostic codes for rating**. Some of these residuals can be rated under the criteria in diagnostic code 8045; others will require evaluation under other diagnostic codes in the neurologic system, as well as under diagnostic codes in the mental disorders, eye, audio, and other body systems. TL 07-05 provides considerable information about evaluating physical residuals of TBI.

3. **Levels of severity**.
TL 07-05 referred to "mild TBI" and "post-concussion syndrome". However, because the acute severity determination has no effect on current evaluation, we have removed all references to mild, moderate, or severe from the regulation. You should ignore the discussions regarding these terms, as well as references to "post-concussion syndrome," that were discussed in TL 07-05 when evaluating TBI.

Therefore, the material in TL 07-05 under the section titled Evaluating Residuals of mild TBI (mTBI) no longer applies, nor does the material concerning assessment of cognitive function in the section titled "Evaluating residuals of moderate or severe TBI".

4. **SMC:** Revised diagnostic code 8045 points out the importance of considering the need for special monthly compensation for such problems as loss of use of an extremity, certain sensory

impairments, erectile dysfunction, the need for aid and attendance (including for protection from hazards or dangers incident to the daily environment due to cognitive impairment), being housebound, etc.

5. **Combining under § 4.25/avoidance of pyramiding**. Evaluate each residual condition separately, as long as the same signs and symptoms are not used to support more than one evaluation. Then combine the evaluations under § 4.25.

6. **Prestabilization ratings.** TL 07-05 addressed prestabilization ratings and this is another reminder to consider the possible benefits of an evaluation based on § 4.28 in a recently discharged veteran.

7. **Associated injuries.** Do not overlook the additional injuries that may also be present in a veteran with TBI – burns, shrapnel wounds, fractures, amputations, spine injuries, etc. These will require separate evaluations based on additional special examinations. For example, recently discharged veterans with severe burns will require a Scars examination, while those with facial injuries may require a Dental/oral examination as well as a Scars examination, Some veterans will need a Residuals of amputation examination or a Brain and Spinal Cord examination (when there is a spinal injury). Be sure to order all necessary special examinations, as indicated, rather than simply ordering a General Medical examination.

8. **Future examinations**. The TBI examination worksheet and template ask examiners whether the condition has stabilized, and if not, to provide an estimate of when stability may be expected. The information provided should **guide the rater concerning the need for a future examination.** If the examiner states that the condition has not stabilized, a future examination should be scheduled to take place soon after the estimated date of stability. A record of ongoing rehabilitation therapy would also be an indication that further improvement is possible and that a future examination should be scheduled. However, physical therapy and other treatments may be continued indefinitely to maintain functioning, even after stability has been reached. In most cases, stability is expected by 18-24 months after the date of injury. Therefore, scheduling a future examination after that date is often unwarranted, but should be determined for an individual veteran by the available information of record.

9. **Delayed effects**. See discussion above under definition.

D. Evaluating physical residuals of TBI

1. A list of some, but not all, physical residuals of TBI is included under diagnostic code 8045, as follows:
   - 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
endocrine dysfunctions.

2. All physical residuals that are reported on an examination should be evaluated under the most appropriate diagnostic code and body system and combined under § 4.25.

3. These guidelines are basically unchanged from prior guidance.

E. Evaluating behavioral/emotional dysfunction in veterans with TBI

1. Behavioral/emotional symptoms are common in veterans with TBI and may arise from the effects of the TBI itself. However, comorbid mental disorders (especially depression, PTSD, and anxiety) are common in veterans with TBI and may also be the cause of behavioral/emotional problems. In some cases, TBI and one or more comorbid mental disorders both result in behavioral/emotional symptoms in the same veteran. The examiner has the task of determining the etiology of the symptoms that are present, and the rater has the task of determining how to evaluate them based on the examiner's determination of etiology.

2. Behavioral/emotional symptoms due to TBI fall most often under the neurobehavioral symptoms facet of the table in diagnostic code 8045, but at times (such as when mild anxiety is a major symptom) may also fall under the subjective symptoms facet.

3. Overlap of symptoms between comorbid mental disorders and residuals of TBI is common, and at times it is hard or impossible for an examiner to attribute the symptoms to one or the other. The examination protocol states: When a mental disorder is present, state, or ask the mental disorders examiner to state, to the extent possible, which emotional/behavioral signs and symptoms are part of a co-morbid mental disorder and which represent residuals of TBI. If it is impossible to make such a determination without speculation, so state.

4. The following table provides examples of situations that may be encountered in rating veterans with TBI when behavioral/emotional symptoms are present and offers guidelines on their evaluation.

Situations	**Conditions(s) diagnosed**	**Behavioral/emotional symptoms attributed to**	**Evaluate under**
#1	TBI No diagnosis of mental disorder	TBI	Table titled “Evaluation of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified"
NOTE: In this case, all behavioral/emotional symptoms are attributed to TBI, as there is no diagnosis of a mental disorder, and are evaluated under diagnostic code 8045.			
	Example: Veteran has TBI residuals that include mood swings, mild anxiety, and occasional troubling impulsive behavior. He does not meet the criteria for the diagnosis of a mental disorder. His behavioral/emotional symptoms result in moderate disruption of relationships with his family and friends. He does not work because of other TBI residuals that include severe migraine headaches, memory loss, and loss of concentration. His evaluation would be primarily under the table in diagnostic code 8045 for the neurobehavioral effects facet (at level 2). His mild anxiety alone would fall under the subjective symptoms facet (but only at level 0). His overall percentage evaluation under the table would depend on the severity of other problems he has, such as cognitive impairment, that could be assessed under this table, with the level of the facet with the highest level of severity being assigned.		

Situations	**Conditions(s) diagnosed**	**Behavioral/emotional symptoms attributed to**	**Evaluate under**
#2	TBI Mental disorder	None Mental disorder	General Rating Formula for Mental Disorders in § 4.130
NOTE: In this case, all behavioral/emotional symptoms are attributed to a mental disorder and are evaluated under § 4.130.			
	Example: Veteran has numerous physical residuals of TBI. He also has classical symptoms of PTSD and meets the criteria for a diagnosis of PTSD associated with the trauma (nearby grenade explosion) that led to his TBI. The examiner states that his behavioral/emotional symptoms can all be attributed to his comorbid PTSD rather than to the TBI itself.		
Situations	**Conditions(s) diagnosed**	**Behavioral/emotional symptoms attributed to**	**Evaluate under**
#3	TBI Mental disorder	TBI None	Table titled "Evaluation of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified"
NOTE: In this case, all behavioral/emotional symptoms are attributed to TBI and are evaluated under the table in diagnostic code 8045. While there is a diagnosis of a mental disorder, no current symptoms are attributed to it.			
	Example: Veteran suffered a TBI due to a roadside bomb in Iraq. He has minor physical symptoms but is more troubled by symptoms of depression, apathy, and verbal aggression that occasionally interfere with workplace and social interaction. He has a diagnosis of mild obsessive compulsive disorder, but it is currently in remission. His symptoms would be evaluated as part of his TBI under the neurobehavioral effects facet (at level 1).		
Situations	**Conditions(s) diagnosed**	**Behavioral/emotional symptoms attributed to**	**Evaluate under**
#4	TBI Mental disorder	Some specific symptoms Some specific symptoms	Table titled "Evaluation of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified" General Rating Formula for Mental Disorders in § 4.130
NOTE: In this case, the examiner has distinguished which symptoms arise from TBI and which arise from a mental disorder. Therefore, 2 separate evaluations are needed.			
	Example: Veteran was struck by falling debris after an explosion damaged a building when he was on patrol. He has loss of concentration and attention and is confused and fearful when trying to follow directions, getting lost on a daily basis in the community, although never at home. He is also very tense and anxious, and at times is belligerent		

	and uncooperative. Another major problem is a lack of self-awareness of the severity of his disability. The examiner diagnosed both a generalized anxiety disorder (manifested by tenseness and anxiety) and neurobehavioral residuals of TBI (lack of self-awareness, belligerence, and lack of cooperation). Two separate evaluations are needed, one for anxiety disorder under § 4.130 and one for neurobehavioral effects under diagnostic code 8045. The level of severity of the neurobehavioral effects facet may be less than the level of severity of other facets that require evaluation under the table in diagnostic code 8045 (such as the cognitive impairment and impaired visual spatial orientation facets). The percentage evaluation would be based on the level of the facet with the highest level of severity.

Situations	**Conditions(s) diagnosed**	**Behavioral/emotional symptoms attributed to**	**Evaluate under**
#5	TBI Mental disorder	Unable to determine Unable to determine	Evaluate under either General Rating Formula for Mental Disorders in § 4.130 or under Table titled "Evaluation of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified."
NOTE: In this case, the examiner has been unable to distinguish the source of symptoms. Evaluation is made under whichever set of evaluation criteria allows the better assessment of overall impaired functioning due to behavioral/emotional symptoms of both conditions.			
	Example: Veteran has numerous behavioral/emotional symptoms (depression that severely affects his work and his family relationships, frequent suicidal thoughts, confusion, apathy, and unpredictability) and meets the diagnostic criteria for TBI and for major depression, after 3 combat tours in Iraq during which he suffered at least 4 TBI's. Since the examiner was unable to sort which symptoms are associated with TBI and which with major depression, an evaluation under either the General Rating Formula for Mental Disorders in § 4.130 or under the table in diagnostic code 8045 could be made, depending on which better assesses overall functional impairment. In this case, the depressive symptoms are severe and prominent, affecting all aspects of this veteran's life, and, in combination with the symptoms of confusion, apathy, and unpredictability, are totally disabling. A 100% evaluation under the General Rating Formula for Mental Disorders would better represent the overall extent of his severely impaired functioning because the table in diagnostic code 8045 does not allow an evaluation of "total" under the neurobehavioral effects facet.		

F. Table for "Evaluation of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified"

1. Introduction

a. 10 facets: The table includes 10 facets of dysfunction that may be seen after TBI, in addition to the types of physical dysfunction and the comorbid mental disorders that may be present and are evaluated elsewhere. The facets are: memory, attention, concentration, executive functions; judgment; social interaction; orientation; motor activity (with intact motor and

sensory system); visual spatial orientation; subjective symptoms; neurobehavioral effects; communication; and consciousness.

b. Levels of facets: The potential levels that may be assigned for each facet based on the severity of findings are 0, 1, 2, 3, or "total". However, not every facet has all 5 potential choices of severity. For example, the consciousness facet has only a single level, "total," since any level of impaired consciousness would be totally disabling.

c. Evaluation level under the table: Once the level of severity of each facet has been determined, if one or more facets is deemed to be at the level of "total," assign a 100% evaluation. If no facet meets the criteria for "total," base the overall percentage evaluation on the level of the highest facet as follows: 0 = 0 percent; 1 = 10 percent; 2 = 40 percent; and 3 = 70 percent. For example, assign a 70 percent evaluation if 3 is the highest level of evaluation for any facet.

d. Note: The evaluation assigned based on this table will be considered the evaluation for a single condition for purposes of combining with other disability evaluations.

e. Examples in facets: When specific examples of symptoms are listed under a facet, remember that these are only examples, and there is no requirement that any of the listed examples be present in order to assign a particular evaluation level.

2. The memory, attention, concentration, executive functions facet.

a. Evaluation levels:

This facet has levels of 0 through "total" that are based on the extent of loss of memory, concentration, attention, or executive functions and their effect on functional impairment.

Levels 2, 3, and "total" require that there be *objective evidence on testing* of impairment of memory, concentration, attention, or executive functions. In many cases, such evidence may be of record based on neuropsychological testing done previously. If not, testing will be required. There are an array of available neuropsychological tests, and the specialist conducting the examination can best determine what tests, if any, are needed in a particular case.

Level 1 may be assigned based solely on a complaint of mild loss of memory, etc., without objective evidence on testing, and level 0 means there are no complaints in these areas.

b. Impairment of only one element is needed:

Note that this facet requires only that either memory, attention, concentration, or executive functions be impaired, for a 1, 2, 3, or "total" evaluation level, so that all but one of these elements may be normal and any of these 4 levels may still be assigned as long as one of the elements meets the criteria.

3. Subjective symptoms due to TBI.

a. General information about subjective symptoms:

Subjective symptoms such as headache, dizziness, fatigue, and sleep disturbances are common after TBI and may be its only residuals. However, they may also be associated with, or part of, cognitive impairment or other areas of dysfunction. As discussed above, subjective symptoms may also be associated with a comorbid mental disorder.

b. Subjective symptoms under former diagnostic code 8045:
Former diagnostic code 8045 stated that 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, that this 10 percent rating will not be combined with any other rating for a disability due to brain trauma, and that 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.

Diagnostic code 9304 is "dementia due to head trauma". Multi-infarct dementia is now referred to in DSM-IV as "vascular dementia" and is the title of diagnostic code 9305.

All of these rules concerning subjective symptoms evaluation have been removed.

c. New evaluation of subjective symptoms:
Under the new regulation, both cognitive impairment and subjective symptoms that are residuals of TBI, are evaluated under the table titled “Evaluation of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified”. The subjective symptoms need not be part of or associated with cognitive impairment to be evaluated under this table.

There is no longer a prohibition on assigning more than 10 percent for subjective symptoms. A level of 0, 10, or 40% may be assigned under the table based solely on subjective symptoms.

There is also no longer a prohibition on assigning an evaluation for subjective symptoms in addition to assigning one or more evaluations for other residuals of TBI. However, in many cases, subjective symptoms will be the only residuals of TBI.

The lowest level, 0, which equates to 0%, is assigned if there are subjective symptoms that do not interfere with work; instrumental activities of daily living; or work, family, or other close relationships.
Examples for this level are mild or occasional headaches and mild anxiety.

The highest level, 2, is assigned if there are three or more subjective symptoms that moderately interfere with work; instrumental activities of daily living; or work, family, or other close relationships. Examples of findings that might be seen at this level of impairment are: marked fatigability, blurred or double vision, headaches requiring rest periods during most days.

d. Distinct conditions with subjective symptoms:
Separately evaluate any residual with a distinct diagnosis that may be evaluated under another diagnostic code, such as migraine headache or Meniere’s disease, even if that diagnosis is

based on subjective symptoms, rather than under the table titled “Evaluation of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified.”

If only some of the subjective symptoms can be evaluated under other diagnostic codes, the remaining symptoms may be evaluated under the "Subjective symptoms" facet, as long as the criteria are met.

e. IADLs:
The term "Instrumental Activities of Daily Living" (IADLs) is used in the criteria for this facet. IADLs refers to activities other than self-care that are needed for independent living, such as meal preparation, doing housework and other chores, shopping, traveling, doing laundry, being responsible for one's own medications, and using a telephone.

These activities are distinguished from "Activities of daily living," which refer to basic self-care and include bathing or showering, dressing, eating, getting in or out of bed or a chair, and using the toilet.

4. Neurobehavioral effects of TBI

a. This facet refers to behavioral changes resulting from TBI. The types of effects and their severity depend on the location (frontal lobes, temporal lobes, diffuse brain injury, etc.) and extent of the injury.

b. The facet lists the following examples of neurobehavioral effects: irritability, impulsivity, unpredictability, lack of motivation, verbal aggression, physical aggression, belligerence, apathy, lack of empathy, moodiness, lack of cooperation, inflexibility, and impaired awareness of disability. These are among the more common neurobehavioral effects but are not the only ones possible.

c. Any of the effects has a potential range of slight to severe. Therefore, it is not necessarily the type of effect that is present but the resulting impact on workplace interaction, social interaction, or both, that determines the level of evaluation. However, in general, verbal and physical aggression are likely to have a more serious impact on interaction than some of the other effects.

d. The level of evaluation for neurobehavioral effects range from 0 through 3, based on the extent of interference with workplace interaction, social interaction, or both.

5. Overlapping manifestations of facets in table and manifestations of a mental or neurologic or other physical disorder.
The manifestations of conditions evaluated under the “Evaluation Of Cognitive Impairment And Other Residuals Of TBI Not Otherwise Classified” facet may overlap with those due to a comorbid mental disorder or with those of a neurologic or other physical disorder that can be separately evaluated under another diagnostic code.

In such cases, as always, based on § 4.14, do not assign more than one evaluation based on the same manifestations.

If the manifestations of two or more conditions cannot be clearly separated, assign a single evaluation under whichever set of diagnostic criteria allows the better assessment of overall impaired functioning due to both conditions.

However, if the manifestations are clearly separable, assign a separate evaluation for each condition.

6. Determining the facets levels.
The examination protocols include the criteria for the various levels of severity of each facet, and the examiner will be asked to select the appropriate choice. Therefore, the rater will generally not need to make these determinations of severity but will need to review all the available pertinent material to make sure the examiners' responses are consistent with other information.

G. Types of examinations and examiners.

1. Health care providers who may conduct TBI examinations.
The change in the way cognitive impairment is assessed under the new regulations requires that the list of qualified examiners to conduct examinations for TBI be much more limited than the list of those who could conduct TBI examinations under the former regulations.

Formerly, cognitive impairment could only be assessed under the General Rating Formula for Mental Disorders, so a special mental disorder examination was required whenever cognitive impairment was at issue. A general medical examiner could conduct other parts of the TBI examination. Under the new regulations, cognitive impairment is evaluated under diagnostic code 8045 rather than under § 4.130, and the primary examiner must assess cognitive impairment as well as other TBI residuals as part of the TBI examination. The examiner must also be able to assess whether stability has been reached, and if not, when it is likely. This requires an examiner with training, experience, and expertise in TBI, and one who has the capability of assessing cognitive impairment, neurobehavioral problems, visual spatial problems, etc.

Veterans Health Administration TBI experts have determined that the following examiners qualify to conduct TBI examinations: Physicians who are **specialists in Physiatry, Neurology, Neurosurgery, and Psychiatry** and who have training and experience with Traumatic Brain Injury may conduct TBI examinations. The expectation is that the physician would have demonstrated expertise, regardless of specialty, through baseline training (residency) and/or subsequent training and demonstrated experience.

In addition, a **nurse practitioner, a clinical nurse specialist, or a physician assistant**, if they are clinically privileged to perform activities required for C&P TBI examinations, and have evidence of expertise through training and demonstrated experience, may conduct TBI examinations **under close supervision of a board-certified or board-eligible physiatrist, neurologist, or psychiatrist**. These examinations would require a second signature by one of the qualified specialists listed above**.**

There is no longer a need for a mental disorder examination whenever cognitive impairment is at issue. Any of the qualified examiners, including psychiatrists, may conduct the entire TBI examination. When a non-psychiatrist conducts the examination, a mental disorder examination by a specialist will still be needed if a mental disorder is at issue. Additional special examinations, such as those for hearing and vision, will also still be needed when indicated.

2. Tests that may be needed

X-rays in the case of a skull defect.

Neuropsychological testing when indicated. Some or all of the Halstead-Reitan Neuropsychological Battery, for example, is often used. But there are numerous tests that may be used, depending on particular needs and preferences. See http://www.brainsource.com/nptests.htm for a list of over 60 specific tests that may be used and their purposes.

Other special tests may be called for, depending on the particular residuals.

H. Rating review under new diagnostic code 8045

1. Re-review. Note 6 in new diagnostic code 8045 provides that a veteran whose residuals of TBI were rated under a prior version of diagnostic code 8045 may request review under the new criteria. This differs from a regular claim for increase in that there is no requirement that there be an indication that the disability has worsened. This review will allow veterans to be re-rated with new examinations that conform to the new criteria to ensure an adequate rating is provided.

2. Effective Date. The effective date of any increase in disability rating will be based on the regulations for effective dates for increased ratings, § 3.400(o), etc. However, the effective date of any award or any increase in disability compensation, based solely on the new rating criteria, will not be earlier than the effective date of the new criteria.

3. Reduction. Under § 3.951, any review under the new criteria will not result in a reduction in a veteran's disability rating, unless the veteran's disability has been shown to have improved. A rating may be reduced under § 3.105 if the veteran has shown improvement since the last review.

Rating Migraines
(From 25 NOV 08)

[Back to INDEX ↑.]

1. Medical Retention Standards for Migraines

AR 40-501, 3-30. g. provides migraine headaches do not meet medical retention standards "when manifested by frequent incapacitating attacks."

With reference to migraine headaches, DoDI 1332.38, E4.12.1 provides that the physician must indicate "the number of incapacitating episodes (those that require the individual to stop the activity in which engaged and seek medical treatment) per week, month or year."

2. Applicable Rating Regulations

VASRD DC 8100 Migraine

With very frequent completely prostrating* and prolonged attacks productive of severe economic inadaptability	50%
With characteristic prostrating* attacks occurring on an average once a month over last several months	30%
With characteristic prostrating* attacks averaging one in 2 months over last several months	10%
With less frequent attacks	0%

*DoDI 1332.39 provided that ""prostrating" means that the Service member must stop what he or she is doing and seek medical attention." *However,* DoDI 1332.39 was *rescinded* 14 Oct 2008 and is no longer in effect.

VASRD § 4.7, higher of two evaluations.
Where there is a question as to which of two evaluations shall be applied, the higher evaluation will be assigned if the disability picture more nearly approximates the criteria required for that rating. Otherwise, the lower rating will be assigned.

AR 635-40, B-9, and 38 CFR § 3.321. Extraschedular ratings.

38 CFR § 3.321. General rating considerations.
(b) Exceptional cases. To accord justice ... to the exceptional case where the scheduler evaluations are found to be inadequate ...[the PEB] is authorized to approve ... an extra-schedular evaluation commensurate with the average earning capacity impairment due [to the disability]. The governing norm in these exceptional cases is: A finding that the case presents such an exceptional or unusual disability picture with such related factors as marked interference with employment or frequent periods of hospitalization as to render impractical the application of the regular scheduler standards.

3. Discussion

The rating scheme for migraine considers the *frequency* of the Soldier's prostrating migraines (i.e., prolonged attacks productive of severe economic inadaptability; on an average once a month over last several months; one in 2 months over last several months; less frequent than one in 2 months over last several months).

The rating scheme for migraine also considers the *severity* of the Soldier's migraines (i.e., completely prostrating; prostrating).

The common/generic meaning of prostrating is completely exhausted or overwhelmed; incapacitated. Headaches described as "incapacitating episodes that require the individual to stop the activity in which engaged and seek medical treatment" fit the requirements for a prostrating attack. See AR 40-501, 3-30 g. However, *a Soldier may have a prostrating attack and not seek medical treatment. I.e., stopping activity is within the common/generic meaning of prostrating, seeking medical treatment is not.* The guidance for MEB examiners asks the examiner to describe the intensity and duration of the Soldier's headaches and whether they would describe the Soldier's headaches as prostrating.

When adjudicating a Soldier with reference to VASRD 8100, migraine, consider:

The frequency of the Soldier's prostrating headaches.
The severity of the Soldier's prostrating headaches. The VASRD appears to consider only the most severe of headaches (i.e., "prostrating") as warranting a compensable (10% or higher) rating. The VA worksheet contrasts prostrating headaches with lesser headaches in terms of the Soldier's ability to permit ordinary activity.

If Migraine: - Obtain the history of frequency and duration of attacks and description of level of activity the veteran can maintain during the attacks. For example, state if the attacks are prostrating in nature or if ordinary activity is possible. http://www.vba.va.gov/bln/21/Benefits/exams/disexm40.htm

4. Practical application of VASRD DC 8100 and additional regulatory provisions.

To determine the correct rating, consider the types of activities the Soldier performs while the Soldier has a migraine. If they include ordinary activities, the examiner is not likely to label the migraine as prostrating. An example of a headache an examiner will likely find not prostrating is one that may cause the Soldier to want to lie down but, if required, the Soldier is able to perform ordinary activities, such as work.

The PEB should consider the impact of the Soldier's migraine treatment.

For example, the Soldier has a history of migraines with incapacitating episodes and is going through the MEB because he fails retention standards. The Soldier's doctor prescribed medications and instructed the Soldier to take the medication, as soon as practicable, when the Soldier feels a migraine coming on, i.e., when the Soldier begins to experience a migraine aura. The Soldier has experienced a migraine aura on average of once a month over the last several months. Each time, the Soldier immediately drives home and takes his medication. The evidence establishes the Soldier uses the prescribed medications and subsequently cannot return to work because of either the ineffectiveness and/or the side effects of the medication. In either situation, the PEB may find the Soldier meets the requirements for a 30% rating based on prostrating attacks occurring on an average once a month over last several months.

An example of a 199 write-up based on the effect of the Soldier's medications in conjunction with a history of incapacitating migraines would read as follows:

8100. Migraine headaches. Soldier has a history of prostrating migraines. Currently, Soldier's physician instructs Soldier to stop activities, leave work and take medication. Three times a month over the last several months, Soldier gets a migraine aura, stops activities, leaves work and takes his prescribed

medication. While medication helps to prevent Soldier's headache from becoming as severe as to preclude *all* ordinary activity, Soldier does not return to work because for a period of 6 to 8 hours, medication makes him *too drowsy to continue ordinary activities*. IAW VASRD 4.7, higher of two evaluations, Soldier rated at 30% because the disability picture more nearly approximates the criteria for 30% vs. 10%. 30%

An example of a 199 write-up using VASRD § 4.7, higher of two evaluations, would read as follows:

8100. Migraine headaches. Soldier's physician instructed Soldier to stop activities, leave work and take medication with onset of migraine symptoms. On average of twice a week over last several months, Soldier experiences the onset of migraine symptoms, stops activities, leaves work and takes prescribed medication. To some extent medication alleviates headache. However, Soldier does not return to work because medication makes him too drowsy to continue ordinary activities. Headache resolves within four hours. *In addition*, at least once a week, Soldier uses medication at work and, after brief rest in dark room, is able to return to work within 2 hours. Over past month, Soldier missed approximately 10 half-days of work. Headaches are not prolonged. Disability picture is significantly more than that described for 30% rating, i.e., prostrating attacks occurring on an average once a month over the last several months. IAW VASRD § 4.7, higher of two evaluations, Soldier rated at 50% because disability picture more nearly approximates very frequent completely prostrating and prolonged attacks productive of severe economic inadaptability. 50%

CAVEAT:

The MEB examiner should indicate whether or not the Soldier's headaches are prostrating. If the MEB examiner fails to provide a foundation for "prostrating" the PEB should seek additional information/clarification. Within block 8b, the 199 disability description, include the evidence supporting the rating, particularly with respect to whether or not the Soldier headaches are prostrating.

An example of a write up could read as follows:

VASRD DC 8100. Migraine headaches without prostrating attacks. IAW VASRD § 4.7, PEB determined Soldier warrants compensable rating even though Soldier does not have prostrating attacks. MEB examiner indicated Soldier's headaches not prostrating because while Soldier has photophobia with migraines, Soldier able to interact with co-workers, carry on normal conversation and function at work despite having migraine. Soldier experiences migraines several times a week requiring use of migraine medication. Medication causes drowsiness and decreased productivity for several hours most days of the week. PEB determined Soldier better rated at 10% even though Soldier does not have prostrating attacks. See also 38 CFR § 3.321, extraschedular ratings. 10%

Rating Seizures [Back to INDEX ↑.]

VASRD §§ 4.121- 4.122
VASRD DC 8910 – 8914
General Rating Formula for Major and Minor Epileptic Seizures

Background.

Seizure disorders are rated with reference to the VASRD general rating formula for major and minor epileptic seizures. In relevant part, this section reads as follows:

_____

Note (1): A major seizure is characterized by the generalized tonic-clonic convulsion with unconsciousness.

Note (2): A minor seizure consists of a brief interruption in consciousness or conscious control associated with staring or rhythmic blinking of the eyes or nodding of the head ("pure" petit mal), or sudden jerking movements of the arms, trunk, or head (myoclonic type) or sudden loss of postural control (akinetic type).

General Rating Formula for Major and Minor Epileptic Seizures:

Averaging at least 1 major seizure per month over the last year	100
Averaging at least 1 major seizure in 3 months over the last year; or more than 10 minor seizures weekly	80
Averaging at least 1 major seizure in 4 months over the last year; or 9-10 minor seizures per week	60
At least 1 major seizure in the last 6 months or 2 in the last year; or averaging at least 5 to 8 minor seizures weekly	40
At least 1 major seizure in the last 2 years; or at least 2 minor seizures in the last 6 months	20
A confirmed diagnosis of epilepsy with a history of seizures	10

Note (1): When continuous medication is shown necessary for the control of epilepsy, the minimum evaluation will be 10 percent. This rating will not be combined with any other rating for epilepsy.

Note (2): In the presence of major and minor seizures, rate the predominating type.

Note (3): There will be no distinction between diurnal and nocturnal major seizures.

____

The initial manifesting seizure is sometimes referred to as the "index seizure". The index seizure precedes the actual diagnosis of the Soldier's seizure disorder. When rating based on the General Rating Formula for Major and Minor Epileptic Seizures, include the index seizure in the tally. For additional rating considerations, see VASRD § 4.121, § 4.122 and footnotes titled, "Mental Disorders in Epilepsies" and "Epilepsy and Unemployability".

Example 1

It is July 2008 when this case comes to you for adjudication. Soldier developed a seizure disorder. Evidence indicates Soldier had a major seizure in May 2007. This lead to a diagnosis of seizure disorder and he was immediately started on medication. IAW VASRD § 4.121, the doctor "verified" the Soldier's seizures are major seizures. The Soldier has had no other seizures. What is the rating?

Answer: In accord with the General Rating Formula for Major and Minor Epileptic Seizures, the rating is 20%, for at least one major seizure in the last two years. You properly include the "index seizure" in your tally.

Example 2

It is November 2008. Soldier has first (major) seizure in January 2008. Soldier was immediately started on medication. Diagnosis confirmed as a seizure disorder. Soldier experienced another major seizure in March 2008. What is the rating?

Answer: In accord with the General Rating Formula for Major and Minor Epileptic Seizures, the rating is 40%, for at least two major seizures in the last year. You properly include the "index seizure" in your tally.

VASRD Issues: Subpart B: By Condition and Diagnostic Code (DC)
Posttraumatic Stress Disorder (DC 9411): Stressor Validation [Back to INDEX ↑.]

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AHRC-DZB

8 December 2009

MEMORANDUM FOR Presidents, U.S. Army Physical Evaluation Boards

SUBJECT: Posttraumatic Stress Disorder: Stressor "Validation"

1. This memorandum supersedes the memorandum dated 15 December 2008, "Requirement to Validate Post-Traumatic Stress Disorder (PTSD)".

2. The USAPDA does not require Medical Evaluation Boards (MEB) or Soldiers to provide credible supporting evidence of a PTSD stressor.

3. Although it is the responsibility of the MEB examiner/MEB to establish the diagnosis of PTSD in accordance with the diagnostic criteria in DSM-IV, PEBs must ensure that the MEB findings are consistent with the case facts. There must be competent medical evidence to support the diagnosis of PTSD as defined in DSM-IV, TR. This includes attending to the DSM-IV differential diagnosis discussion found on page 467 of *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision, Washington, DC, American Psychiatric Association, 2000. The MEB assessment must follow the guidance found in the Initial Evaluation for Post-Traumatic Stress Disorder (PTSD) VA worksheet. The fundamental and first requirement for the diagnosis of PTSD involves "exposure to an extreme traumatic stressor" as further detailed in DSM-IV. That stressor must be identified by the medical examiner who must also establish the link between the Soldier's current symptoms and the stressor. If the MEB examiner fails to do so, the PEB will return the case with a clear discussion of where the deficit exists and what is required of the MEB to correct the deficit.

4. If the PEB has cause for concern about the validity of the MEB diagnosis, there must be a reasonable basis for the concern. The PEB must clearly articulate that basis in any further dealings with the MTF. The mere fact that the MEB bases the diagnosis of PTSD, as far as the requisite stressor criterion is concerned, solely on the statement of the affected Soldier is not sufficient grounds for challenging the validity of the diagnosis. However, if the PEB finds evidence that conflicts with the Soldier's version or casts reasonable doubt on the diagnosis of PTSD, the PEB should return the case to the MTF, citing the evidence and indicating how it appears to cast doubt on whether the diagnostic criteria have been met.

5. When making 10a/c decisions, if the PEB accepts PTSD as a diagnosis, and the primary stressor identified in the examination report is combat related, the PEB will award 10a/c.

Daniel Cassidy
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AHRC-DZB

03 February 2010

MEMORANDUM FOR Presidents, U.S. Army Physical Evaluation Boards

Subject: General Rating Formula for Mental Disorders Application of §4.7, Higher of Two Evaluations to Ratings

Background

The General Rating Formula for Mental Disorders for the 30% evaluation and 10% evaluation is as follows:

Occupational and social impairment with occasional decrease in work efficiency *and* intermittent periods of inability to perform occupational tasks (although generally function 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%**

VASRD §4.7, higher of two evaluations provides, "Where there is a question as to which of two evaluations shall be applied, the higher evaluation will be assigned if the disability picture more nearly approximates the criteria required for that rating. Otherwise, the lower rating will be assigned."

The 14 OCT 2008 DTM requires the MEB to prepare psychiatry reports IAW the (minimum requirements of the) applicable VA worksheet. Accordingly, when examining a Soldier for a mental disorder, the examiner must follow the applicable VA worksheet and must describe symptoms of the mental disorder (i.e., due to symptoms of the mental disorder vs. due to another condition) and the examiner must support the occupational/social impairment with examples.

The VA worksheet provides choices of occupational and social impairment to the examiner and asks the examiner to choose one. One choice reads as follows:

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There is occasional decrease in work efficiency ***"or"*** there are intermittent periods of inability to perform occupational tasks due to signs and symptoms, but generally satisfactory functioning (routine behavior, self-care, and conversation normal). (Italics supplied.)

Note: The rating formula requires "and"; the VA worksheet asks for "or."

When the MEB examiner follows the VA worksheet and chooses the above evaluation of occupational and social functioning and provides examples and pertinent symptoms (due to PTSD or other mental disorder being described, as requested on the VA worksheet), the rating formula does not appear to support a 30% rating because the 30% description indicates *both* occasional decrease in work efficiency *and* intermittent periods of inability to perform occupational tasks are required.

Comparison between the 10% and 30% Evaluation

There are two aspects of the disability picture at both the 10 and 30% evaluation: (1) occupational and social impairment, (2) and the nature of the symptoms.

1. The ***occupational and social impairment*** at the 10% evaluation is less pervasive than that at the 30% evaluation. At the **10% evaluation**, the occupational and social impairment is *only during periods of significant stress or there is no occupational and social impairment because symptoms controlled by continuous medication*. NOTE: The Soldier qualifies for the 10% rating *because they require continuous medications for control of symptoms*. Compare with 0% evaluation: 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*. At the **30% evaluation**, the occupation and social impairment is associated with *occasional decrease in work efficiency and intermittent periods of inability to perform occupational tasks*.

2. The ***nature of the symptoms*** causing the requisite occupational and social impairment (if any) at the 10% evaluation is less severe than that at the 30% evaluation. The nature of the symptoms (*if any*) at the 10% evaluation is *mild or transient*. (The Soldier may have no symptoms because the symptoms are controlled by medication). The nature of the symptoms associated with the 30% evaluation is more severe, i.e., symptoms such as *depressed mood, anxiety, suspiciousness, panic attacks (weekly or less often), chronic sleep impairment and mild memory loss (such as forgetting names, directions, recent events.)*

NOTE: The psychiatrist is free to indicate the Soldier has both occasional decrease in work efficiency *and* intermittent periods of inability to perform occupational tasks.

However, when the psychiatrist indicates a Soldier has *either* occasional decrease in work efficiency *or* intermittent periods of inability to perform occupational tasks (and symptoms such

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as: depressed mood, anxiety, suspiciousness, panic attacks (weekly or less often), chronic sleep impairment, mild memory loss (such as forgetting names, directions, recent events)), the PEB must consider 4.7, Higher of two evaluations. When the psychiatrist indicates the decrease in work efficiency occurs occasionally and/or there are now intermittent periods where the Soldier cannot perform in their job, it is clear that the problems are occurring more than only when there is significant stress.

Application of §4.7, Higher of Two Evaluations

In this situation, the **disability picture** more nearly approximates the criteria required for the 30% evaluation for the following reasons.

a. The ***occupational and social impairment*** is much greater than that in the 10% evaluation, i.e., this Soldier has either an *occasional decrease in work efficiency or intermittent periods of inability to perform occupational tasks* vs. (only) a decrease in work efficiency and ability to perform occupational tasks only during period of significant stress *or no decrease in work efficiency or no decreased ability to perform occupational tasks* because symptoms are controlled by continuous medication;

b. The Soldier has the very same symptoms as required to support a 30% evaluation when associated with both occasional decrease in work efficiency *and* intermittent periods of inability to perform occupational tasks are required.

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DC 5284, Foot injuries, other

5284. Foot Injuries, other:	**Rating**
Severe	**30**
Moderately severe	**20**
Moderate	**10**
Note: With actual loss of use of the foot, rate 40 percent.	

MEB examiners should describe foot injuries IAW the VA Feet Worksheet. http://www.vba.va.gov/bln/21/Benefits/exams/disexm21.htm . Depending on the nature of the injury, the examiner may need to complete additional worksheets, e.g., Peripheral Nerves; http://www.vba.va.gov/bln/21/Benefits/exams/disexm42.htm ; Joints (Shoulder, Elbow, Wrist, Hip, Knee, and Ankle) http://www.vba.va.gov/bln/21/Benefits/exams/disexm34.htm. Anatomically, the foot is often considered to be made up of three sections: the forefoot; the midfoot; and the hindfoot. See http://en.wikipedia.org/wiki/Foot .

Relevant VASRD Provisions:

- Plate IV indicates the foot bones.
- For the purpose of "joints," §4.45 The joints, instructs that multiple involvements of the interphalangeal, metatarsal and tarsal joints of the foot are considered groups of minor joints, ratable on parity with major joints.
- §4.59 provides that painful, unstable or malaligned joints, due to healed injury are entitled to at least a 10% rating.
- DC 5301, Group X muscle injury provides a minimum 10% rating for through-and-through wounds of the foot.

When evaluating foot injuries, it is important to consider:

- VASRD §4.68, amputation rule
- §4.14, Avoidance of pyramiding
- §4.7, Higher of two evaluations
- Combined Effect

VASRD §4.68, amputation rule
For example, if the Soldier's unfitting disabilities are limited to below the knee with no knee or hip impairment, the maximum rating is 40%.

§4.14, Avoidance of pyramiding
The rating should not include a rating for both a peripheral nerve injury and an orthopedic injury where the disability is adequately captured in either a peripheral nerve or musculoskeletal rating.

§4.7, Higher of two evaluations
For example, if a Soldier has sustained injury to the bones and nerves of the foot, the adjudicator should consider the Soldier's rating with reference to the peripheral nerve codes and the musculoskeletal

codes. Subject to the amputation rule, the Soldier should be awarded the highest rating permitted under the VASRD.

Consider also nerve injuries and the rating provided for compromised flexion and separation of toes (see VASRD DC 8X24, internal popliteal nerve) and weakness or paralysis of muscles of the sole of the foot (see VASRD DC 8X25, posterior tibial nerve).

Combined Effect
The ankle, or **talocrural joint**, connects the distal ends of the tibia and fibula in the lower limb with the proximal end of the talus bone in the foot. http://en.wikipedia.org/wiki/Ankle . VASRD § 4.45 provides that the ankle joint is a major joint. Therefore, once the PEB has determined whether the Soldier's foot injury is unfitting, the PEB should consider whether any associated ankle injury is (also) unfitting based on combined effect.

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DC 7011, Ventricular arrhythmias (sustained); and Implantable Cardioverter-Defibrillators (AICDs)

The VA training manual indicates the following:

AICDs are used in the following clinical situations:

a. For people at high risk for sudden death.
b. B. For episodes of ventricular tachycardia.
c. For those who have survived ventricular fibrillation but have not had an acute heart attack; or those who are at high risk for another episode of ventricular fibrillation.
d. For those with structural defects of the heart, like massive dilation or excessive thickening of the heart muscle.

VASRD DC 7018 is "Implantable Cardiac Pacemakers." The training manual references the "Note under DC 7018. This note reads: "Evaluate implantable Cardioverter-Defibrillators (AICD's) under 7011. With reference to AICDs, the training manual instructs that the presence of an AICD supports the 100% rating *because of the severity of the conditions that require this implantable device.*

Therefore, when the PEB finds the Soldier unfit for a cardiac condition for which the Soldier required an AICD, the rating will be 100% with reference to 7011, Ventricular arrhythmias (sustained) and note 1 under VASRD DC 7011.

Example:
7020 Cardiomyopathy. IAW VASRD instruction in Note under DC 7018, and DC 7011, this condition is rated at 100% because Soldier has an implantable cardioverter-defibrillator. This (one) 100% rating for cardiac disability includes consideration of Soldier's associated cardiac impairment manifesting as METS of 4 and ejection fraction of 35%.

DC 7010, Supraventricular arrhythmias

A condition where the heart rate suddenly increases to 100-200 beats a minute. At the beginning of an episode a sudden, rapid, regular fluttering sensation in the chest is easily noticed. Most patients feel weak and faint but syncope is rare. Shortness of breath is not uncommon and older patients may develop angina during the attacks. Polyuria often occurs during or after attacks.

The criteria require more than four episodes a year of paroxysmal atrial fibrillation or other supraventricular tachycardia for the 30-percent level, and permanent atrial fibrillation or one to four episodes a year of paroxysmal atrial fibrillation or other supraventricular tachycardia for the 10-percent level. Both sets of criteria require documentation by ECG or Holter monitor.

Rating schedule:

- Paroxysmal atrial fibrillation or other supraventricular tachycardia, with more than four episodes per year documented by ECG or Holter monitor 30%
- Permanent atrial fibrillation (lone atrial fibrillation), or; one to four episodes per year of paroxysmal atrial fibrillation or other supraventricular tachycardia documented by ECG or Holter monitor 10%

DC 7011, Ventricular Arrhythmias (Sustained)

A condition involving depolarization of the atria or ventricles, or both, that occurs before the next expected sinus beat. In other words this is a premature heartbeat. Most complain of a skipped beat, flutter or extra beats in the chest but usually disregard them until they become frequent. The cause must be found before treatment can be started. ECG is the most likely method of determining a cause.

The criteria are the same objective measurements that are used for arteriosclerotic heart disease and other heart diseases. However, there are specific provisions for a total evaluation while an Automatic Implantable Cardioverter-Defibrillator (AICD) is in place.

AICD - Automatic Implantable Cardioverter-Defibrillator - A pulse generator (smaller than a deck of cards) is implanted in the abdomen underneath the skin. Electrodes sense the rhythm of the heart and deliver a powerful shock when a life-threatening rhythm occurs (ventricular tachycardia or fibrillation). If necessary, it can give three to four additional shocks. The batteries are designed to last 4 to 5 years and deliver about 100 shocks. It originally required open-chest surgery for implantation. Now electrodes are inserted into the heart through veins. The pulse generator must be replaced (minor surgery) when batteries die. Firing may cause depression, anxiety, thoughts of dying, etc.

Uses of AICD:

- For people at high risk for sudden death.
- For episodes of ventricular tachycardia.
- For those who have survived ventricular fibrillation but have not had an acute heart attack; or those who are at high risk for another episode of ventricular fibrillation.
- For those with structural defects of the heart, like massive dilation or excessive thickening of the heart muscle.

After implantation, recovery of normal activity is expected in 4 to 6 weeks.

Rating Schedule:

- For indefinite period from date of hospital admission for initial evaluation and medical therapy for a sustained ventricular arrhythmia, or; for indefinite period from date of hospital admission for ventricular aneurysmectomy, or; with an automatic implantable Cardioverter-Defibrillator (AICD) in place 100%
- Chronic congestive heart failure, or; workload of 3 METs or less results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of less than 30 percent 100%
- More than one episode of acute congestive heart failure in the past year, or; workload of greater than 3 METs but not greater than 5 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of 30 to 50 percent 60%
- Workload of greater than 5 METs but not greater than 7 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; evidence of cardiac hypertrophy or dilatation on electrocardiogram, echocardiogram, or X-ray 30%
- Workload of greater than 7 METs but not greater than 10 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; continuous medication required 10%

Note: A rating of 100 percent shall be assigned from the date of hospital admission for initial evaluation and medical therapy for a sustained ventricular arrhythmia or for ventricular aneurysmectomy. Six months following discharge, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of 38 C.F.R. § 3.105(e).

DC 7015, Atrioventricular Block

The contraction of muscle fibers in the heart is controlled by an electrical discharge that flows from the heart's pacemaker, the sinoatrial node. When impulses fail to emerge or emerge tardily from the sinus node, there is an SA block present. If the impulse merely takes an undue length of time to enter the atrial muscle, there is a first-degree block present. If one or more impulses fail to emerge, a second-degree block exists. If no impulses emerge, a complete SA block is present.

The criteria for DC 7015 provide the same objective evaluation criteria we have used for ventricular arrhythmias (DC 7011) and many other heart conditions, since heart block may result in a variety of cardiac signs and symptoms and a wide range of disabilities. The only difference in the criteria for atrioventricular block (DC 7015) and ventricular arrhythmias (DC 7011) is that a 10-percent evaluation for DC 7015 will be assigned when either a pacemaker (a common method of treatment for this condition) ***or*** continuous medication is required.

7016, Heart valve replacement (prosthesis)

The level of residual disability following valve replacement can also be objectively determined based on the level of activity that results in symptoms in the same manner as for valvular heart disease.

The criteria for evaluating heart valve replacement are those previously described utilizing METs and the alternatives; i.e., percentage evaluations based on the level of activity that causes symptoms.

A total evaluation following heart valve replacement can be assigned for an indefinite period, with a mandatory VA examination six months after the surgery, with any change in evaluation based on that or any subsequent examination to be made under the provisions of 38 CFR 3.105(e). This requires a 60-day notice before VA reduces an evaluation and an additional 60-day notice before the reduced evaluation takes effect.

DC 7017, Coronary Bypass Surgery

Coronary bypass surgery consists of grafting veins or arteries from the aorta to the coronary artery thus bypassing the obstructed area thus allowing oxygen rich blood to nourish the heart muscle. The veins are usually taken from the leg.

The length of the total evaluation following coronary artery bypass surgery (DC 7017) is three months. For the individual who requires a longer than average period of convalescence, a total evaluation may be assigned for a longer period under the provisions of §§ 4.29 and 4.30 of the rating schedule.

The criteria for evaluating condition following coronary artery bypass surgery are those previously described utilizing METs and the alternatives; i.e., percentage evaluations based on the level of activity that causes symptoms.

DC 7018, Implantable Cardiac Pacemakers

An electronic device that acts in the place of the heart's own pacemaker, the sinoatrial node, and is programmed to imitate the normal conduction sequence of the heart. They are usually surgically implanted under the skin of the chest and have wires running to the heart.

A two-month convalescence evaluation is provided. Following that, the condition is to be rated as supraventricular arrhythmias (DC 7010), ventricular arrhythmias (DC 7011) or atrioventricular block (DC 7015). The minimum evaluation under this code following pacemaker insertion is 10%.

A note following the rating criteria directs that Automatic Implantable Cardioverter-Defibrillators (AICDs) are to be rated under DC 7011 with an evaluation of 100%. An AICD is similar in many respects to an artificial pacemaker; however, pacemakers are usually chosen to correct a heart rhythm that is too slow (bradycardia) whereas AICDs are used to correct a heart rhythm that is too fast. AICDs are used to correct more serious heart irregularities than typical pacemakers, as described under DC 7011. People with AICDs need to be much more careful in certain situations. Because of the severity of the conditions that require an AICD, it is the *only* implantable pacemaker that supports the 100% evaluation.

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DC 7332 Rectum and anus, impairment of sphincter control

7332 Rectum and anus, impairment of sphincter control:	**Rating**
Complete loss of sphincter control	**100%**
Excessive leakage and fairly frequent involuntary bowel movements	**60%**
Occasional involuntary bowel movements, necessitating wearing of a pad	**30%**
Constant slight, or occasional moderate leakage	**10%**
Healed or slight, without leakage	**0%**

38 CFR § 3.350 (e) (iv) (2) ***Paraplegia.*** Paralysis of both lower extremities together with loss of anal and bladder sphincter control will entitle to the maximum rate under 38 U.S.C. 1114(o), through the combination of loss of use of both legs and helplessness. The requirement of loss of anal and bladder sphincter control is met even though incontinence has been overcome under a strict regimen of rehabilitation of bowel and bladder training and other auxiliary measures.

§4.7, Higher of two evaluations

Where there is a question as to which of two evaluations shall be applied, the higher evaluation will be assigned if the disability picture more nearly approximates the criteria required for that rating. Otherwise, the lower rating will be assigned.

Based on the above 38 CFR § 3.350 (e) (iv) (2), § 4.7, Higher of two evaluations, where the PEB finds a Soldier unfit because of issues relating to impairment of sphincter control due to a spinal cord injury or disease affecting the spinal cord, the rating will be 100% even if the Soldier overcomes loss of anal control with a strict regimen of bowel rehabilitation training and other auxiliary measures.

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Renal dysfunction

What constitutes “definite decrease in kidney function”?

Renal dysfunction	**Rating**
Requiring regular dialysis, or precluding more than sedentary activity from one of the following: persistent edema and albuminuria; or, BUN more than 80mg%; or, creatinine more than 8mg%; or, markedly decreased function of kidney or other organ systems, especially cardiovascular	**100%**
Persistent edema and albuminuria with BUN 40 to 80mg%; or, creatinine 4 to 8mg%; or, generalized poor health characterized by lethargy, weakness, anorexia, weight loss, or limitation of exertion	**80%**
Constant albuminuria with some edema; or, definite decrease in kidney function; or, hypertension at least 40 percent disabling under diagnostic code 7101	
Albumin constant or recurring with hyaline and granular casts or red blood cells or, transient	**10%**

or slight edema or hypertension at least 10 percent disabling under diagnostic code 7101	
Albumin and casts with history of acute nephritis; or, hypertension non-compensable under diagnostic code 7101	**0%**

Discussion:

Blood urea nitrogen (BUN) and creatinine are blood tests to measure kidney function.

The normal range for BUN is generally 7 to 20 mg/dL (2.5 to 7.1 mmol/L). Men have slightly higher levels than women.

The normal range for creatinine is generally between .6 and 1.2 mg/dL. The normal range may vary from lab to lab, between men and women, and by age. The amount of creatinine increases with muscle mass. Men usually have higher creatinine levels than women.

http://wwwmayoclinic.com/