PART 8 - RATING POLICIES

3801 Policy

a. Ratable Disabilities. Disabilities determined to be physically unfitting and compensable under reference (c) shall be assigned a percentage rating.

b. Standard. Chapter 61 of reference (a) establishes the Department of Veterans Affairs' (DVA) Veterans Administration Schedule for Rating Disabilities (VASRD) as the standard for assigning percentage ratings. The percentage ratings represent, as far as can practicably be determined, the average impairment in civilian occupational earning capacity resulting from certain diseases and injuries, and their residual conditions. However, not all the general policy provisions in Sections 4.1 - 4.31 of the VASRD are applicable to the military departments. Many of these policies were written primarily for DVA rating boards, and are intended to provide guidance under laws and policies applicable only to the DVA. This instruction replaces these sections of the VASRD. The remainder of the VASRD is applicable except those portions that pertain to DVA determinations of service connection, refer to internal DVA procedures or practices, or are otherwise specifically identified in enclosure (9) as being inapplicable.

3802 Essentials Of Rating Disabilities

a. The VASRD primarily is used as a guide for evaluating disabilities resulting from all types of diseases and injuries encountered as a result of, or incident to, military service. Because of differences between military department and DVA applications of rating policies for specific cases, differences in ratings may result. Unlike the DVA, the military departments must first determine whether a service member is Fit to reasonably perform the duties of the member's office, grade, rank, or rating. Once a service member is determined to be physically Unfit for further military service, VASRD percentage ratings as modified by this instruction are applied to the unfitting condition(s). Percentages are based on the severity of the condition(s).

b. Medical Treatment at the Time of Voluntary and/or Mandatory Separation and/or Retirement. Medical and surgical procedures are frequently performed near the end of a service member's military career. Those are intended to improve a service member's health. Corrective treatment and convalescence will not be considered as a valid contribution to disability unless unexpected adverse effects occur that are expected to persist after discharge from active duty and are ratable.

c. Failure to Comply with Prescribed Treatment. A service member's degree of disability may have been aggravated or increased by an unreasonable failure or refusal to submit to medical or surgical treatment or therapy, to take prescribed medications, or to observe prescribed restrictions on diet, activities, or the use of alcohol, drugs or tobacco. The compensable disability rating may be reduced to compensate for such aggravation when the existence and degree of aggravation are ascertainable by application of accepted medical principles, and where it is clearly demonstrated that:

(1) the service member was advised clearly and understandably (documented in medical record) of the medically proper course of treatment, therapy, medication or restriction; and

(2) the service member's failure or refusal was willful or negligent, and not the result of mental disease or of physical inability to comply.

d. Illegal and/or controlled substances. The following applies to unfitting medical disorders and/or conditions that result from the use of substance abuse and/or chemical dependency:

(1) Illegal and/or controlled substances or generally known toxins; e.g., THC, cocaine, PCP, LSD, & heroin: Treat as misconduct unless use was the product of an otherwise unfitting condition or the LODI determined that there was no misconduct.

(2) Other substances; e.g., alcohol and nicotine: Any physical disability resulting from substance post Level III or equivalent treatment will be considered as non-compliance.

e. Objective Medical Findings and Disability Ratings. Physical examination findings, laboratory tests, radiographs and other findings are not, in themselves, ratable. A rating for a disability must be based on demonstrable impairment of function to the degree that this impairment makes the member Unfit unless otherwise provided in this regulation.

f. Elective Surgery or Treatment

(1) Prior to any elective treatment by the Military Health System (MHS) a service member must consult with a competent military medical authority.

(2) A service member who elects to have such treatment done by other than the MHS at his or her own expense will not be eligible for compensation under the provisions of this instruction for any adverse residuals resulting from the elected treatment, unless it can be shown that such election was reasonable or resulted from a significant impairment of judgment that is the product of a ratable medical condition.

(3) A record of the counseling will be made by the health benefits advisor or other designated individual to document that the member was counseled about the elective treatment and his or her subsequent risk of ineligibility for disability compensation for any adverse residuals incurred secondary to the elective treatment.

(4) To allow the PEB to make an appropriate determination in a case where the member’s eligibility is in question all medical records from non-MHS providers and all documentation and/or a statement explaining the member’s position as to why his/her choice to seek outside treatment was reasonable.

g. Disabilities Not Unfitting for Military Service. Conditions that do not themselves render a service member Unfit for military service will not be considered for determining the compensable disability rating unless those conditions contribute to the finding of unfitness.

h. The relative contribution of Non-Compensable Medical Conditions Not Constituting Physical Disabilities To Current Industrial Impairment Of Ratable Neuropsychiatric Conditions. Personality disorder(s), impulse control disorders, or substance use and/or abuse disorder(s) are examples of conditions not constituting a physical disability that often significantly contribute to, or may be the chief cause of, any industrial and industrially related social impairment suffered by the service member who has a compensable neuropsychiatric condition. Unfitting disability resulting there from will not be rated. In such instances, the overall rating of psychiatric impairment will be reduced to the impairment rating that would be warranted in the absence of the influence of the non-compensable condition according to generally accepted medical principles. It is imperative that the MEB reports quantify the contribution of each medical condition to the overall industrial impairment manifested by the service member.

3803 Use Of VASRD Codes

The VASRD code number appearing opposite a listed disability indicates the basis of the assigned valuation. Code numbers also are used for statistical analysis upon which policy decisions may be made. Great care must be exercised in the selection of the applicable code and in its citation on the rating sheet.

a. Each rated disability is assigned a single code number unless a hyphenated code is expressly authorized. It is not proper to use additional codes as a means of further describing defects except as authorized by the VASRD (e.g., in Gulf War cases). The written diagnosis entered on the rating sheet should include any description considered necessary to indicate the extent, severity or etiology of the coded condition.

b. Injuries are generally assigned codes that reflect the residual condition on which the rating is based.

c. Diseases are generally coded directly by the number assigned to the disease itself. If the rating is determined because of residual conditions, the number appropriate to the residual condition will be added, preceded by a hyphen. Thus, atrophic (rheumatoid) arthritis rated as ankylosis of the lumbar spine would be "5002-5289." The percentage rating in such cases is reflected in the second number ("5289" in the example). In this way, the basis of each rating can be easily identified.

d. Hyphenated codes are used only:

(1) When the VASRD provides that a listed condition is to be rated as some other code; e.g., nephrolithiasis rated as hydronephrosis (7508-7509).

(2) When the VASRD provides for a "minimum rating" and the disability is

being rated on residuals; e.g., multiple sclerosis rated as incomplete paralysis of all unilateral upper extremity radicular groups (8018-8513) in which case the minimal rating will be 30 percent.

(3) When an unlisted condition is rated by analogy; e.g., spondylolisthesis rated as sacroiliac injury and weakness (5299-5294). If an unlisted disease, injury, or residual condition is encountered, requiring rating by analogy, the diagnostic code number will be "built-up" as follows: the first two digits will be selected from that part of the schedule most closely identifying the part, or system, of the body involved; the second two digits will be "99." The resulting four-digit number will be connected by hyphen to the code for the analogous condition. This procedure facilitates monitoring of new and unlisted conditions.

(4) The DVA has prepared special analogous ratings for "undiagnosed symptom complexes" associated with Gulf War service . See enclosure (9), attachment (a) (1).

e. In the narrative citation of disabilities on rating sheets, the diagnostic terminology may be any combination of the medical examiner's or VASRD terminology which accurately reflects the degree of disability . Residuals of diseases or therapeutic procedures will not be cited without reference to the basic disease.

3804 Rating Issues

a. Higher of Two Evaluations. When the circumstances of a case are such that two percentage evaluations could be applied, assign the higher percentage only if the service member's disability more nearly approximates the criteria for that rating. Otherwise, assign the lower rating. When, after careful consideration of all reasonably procurable and assembled data, their remains a reasonable doubt as to which rating should be applied, resolve the doubt in the member’s favor.

b. Changes in Rating Criteria. In accordance with Title 10, Chapter 61, United States Code, the pertinent VASRD codes in effect at the time of final case determination will be used when making that decision regardless of when the member first entered the DES. Specific guidance follows:

(1) TDRL

(a) Final Reevaluation. Rate members on the TDRL under the VASRD criteria in effect at the time of their final case determination.

(b) New Conditions. Although reference (b) through (d) permit new diagnoses to be added during periodic updates, do not rate new diagnoses until the case is finalized. New diagnoses included: (1) new condition(s) caused by the medical condition for which the member was placed on the TDRL , or directly related to its treatment; or (2) new condition(s) either incurred while the member was entitled to basic pay or as a proximate result of performing duty, whichever is applicable, and was an unfitting disability

at the time the member was placed on the TDRL but was not included in the Medical Board report or not rated.

(2) PLD. Rate members placed on PLD under the VASRD criteria in effect at the time of final reevaluation.

(3) Cases Terminated or Suspended by the PEB. When the case returns for final determination, the following rule applies (provided PEB determines the member remains Unfit due to an eligible condition): if a case has been suspended or has been terminated pending medical treatment or an LODI, or if the medical board is incomplete, submit a new medical board and apply the rating standards in effect at the time of the new board's date.

(4) The military standards and policies in effect on the date the medical board report is received at the PEB will be applied for the following:

(a) Addenda.

(b) Reconsideration by the Informal PEB.

(c) Appearance before the Formal PEB.

(d) PFR.

c. Pyramiding. Pyramiding is the term used to describe the application of more than one rating to any area or system of the body when the total functional impairment of that area or system adequately is reflected under a single appropriate code. Disability from injuries to the muscles, nerves, and joints of the extremity may overlap to a great extent. Special rules for their valuation are included in appropriate sections of the VASRD and in enclosure (9) of this instruction. Merge related diagnoses for rating purposes when the VASRD provides a single code covering all manifestations. This prevents pyramiding and reduces the chance of over-rating. For example, disability from fracture of a tibia involving malunion, limitations of dorsiflexion, eversion, inversion, and subtalar motion, as well as traumatic arthritis of the ankle would be rated using one diagnostic code (5271) that reflects overall ankle function, rather than by adding separate ratings for the limitations of motion and the traumatic arthritis.

d. Amputation Rule. The combined rating for disabilities of an extremity shall not exceed the rating for the amputation at the elective level, were amputation to be performed. For example, the combined evaluations for disabilities below the knee shall not exceed the 40 percent evaluation, diagnostic code 5165. This 40 percent rating may be further combined with evaluation for disabilities above the knee but not exceed the above the knee amputation elective level. Painful neuroma of a stump after amputation shall be assigned the evaluation for the elective site of reamputation.

e. Bilateral Factor. When partial disability results from injury or disease of both arms, or both legs, or of paired skeletal muscles, the ratings for the disabilities of the right and left paired sides are first combined in the standard manner. Ten percent of the result (called the Bilateral Factor) will be added to the first combined rating before proceeding with further combinations, or converting to degree of disability. The Bilateral Factor is applied to the bilateral disability combination before final combinations with unpaired disabilities are carried out. The rating for a "Bilateral" disability (combined rating plus the Bilateral Factor) is to be treated as one disability rating when arranging multiple impairments in order of severity prior to calculating further combinations. For example, with disabilities evaluated at 60 percent, 20 percent, 10 percent and 10 percent (the two 10s representing bilateral disabilities), the order of severity would be 60, 21 and 20. The 60 and 21 combine to 68 percent and the 68 and 20 to 74 percent converted to 70 percent as the final degree of disability.

(1) The terms "arms" and "legs" refer to the whole upper and lower extremities respectively. Thus, when there is a compensable disability of the right thigh (for example, amputation), and of the left foot (for example, amputation of the great toe), the Bilateral Factor applies. Similarly, the Bilateral Factor is applied whenever there are compensable disabilities affecting use of paired extremities regardless of location or specified type of impairment, except as noted in paragraph (3), below.

(2) The correct procedure when applying the Bilateral Factor to disabilities affecting both upper extremities and both lower extremities is to combine the ratings of the disabilities affecting the four extremities in order of their individual severity and apply the Bilateral Factor by adding 10 percent of the result to the total combined value thus attained.

(3) The Bilateral Factor is not applicable unless there is an unfitting disability in each of two paired extremities or paired skeletal muscles. Special instructions regarding the applicability of the Bilateral Factor are provided in various parts of the VASRD. For example, codes 7114 - 7117 and codes 8205 - 8412. The Bilateral Factor is not applicable in skin disabilities.

f. Total Disability Rating (Unemployability). Total disability will be considered to exist when the member's impairment is sufficient to render it impossible for the average person suffering the same medical condition to engage in substantially gainful employment. Accordingly, in cases in which the VASRD does not provide a 100 percent rating under the appropriate (or analogous) code, a member may be assigned a disability rating of 100 percent if the member's impairment is sufficient to render it impossible to engage in substantially gainful employment.

g. Extra-Scheduling Ratings in Exceptional Cases. The requirement to use the VASRD in rating disabilities does not prevent the Secretary of the military department concerned from assigning ratings in unusual cases not covered by the VASRD. In such cases, extra-schedule ratings commensurate with the average earning capacity impairment due exclusively to service-connected disability may be assigned. Such cases must be rated in accordance with procedures established by the Secretary of the military department

concerned. The basis of the conclusion that the case presents such an exceptional or unusual disability picture that the regular VASRD standards do not apply must be documented.

h. Convalescent Ratings. Under certain diagnostic codes, the VASRD provides for a convalescent rating to be awarded for specified periods without regard to the actual degree of impairment of function. SUCH RATINGS DO NOT APPLY TO THE MILITARY DEPARTMENTS. Convalescence ordinarily will have been completed by the time optimum medical improvement (for disposition purposes) has been attained. If not, rate according to the manifest impairment.

i. Observation Ratings of Malignancies. The VASRD, in cases of malignancy, has ratings applicable for a period of observation of 6 months or more. Following this period of observation residuals will be rated. Observation ratings do apply to the military departments. Note that members with malignancies are not automatically continued for the 5-year TDRL period. The member will be reevaluated after the observation period and if, at the time, continued treatment is deemed necessary the member will be continued on the TDRL. If there is not a recurrence of tumor, regardless of whether the member has reached a 5 years tumor free period or not, the member's case will be finalized and any rating will relate to residuals, if any.

j. Analogous Ratings. When an unlisted condition is encountered, it is permissible to rate it by analogy to a closely related disease or injury. The unlisted and analogous conditions should reflect adverse impact upon reasonably similar functions, anatomical structures, or be symptomatically similar. Conjectural analogies, analogous ratings for conditions of doubtful diagnosis, and diagnoses not fully supported by clinical/laboratory findings are not acceptable. Organic diseases or injuries will not be rated by analogy to disorders of psychiatric origin, except when directed by law; e.g., Gulf War cases.

k. Overall Effect. A member may be determined Unfit as a result of the overall effect of two or more impairments even though each of them, standing alone, would not cause the member to be referred into the DES or be found Unfit because of physical disability. There is no VA code assigned and the only disability percent awarded is 0%.

l. Zero Percent Ratings and Minimum Ratings

(1) Zero Percent Rating for Residuals. Occasionally, a medical condition that causes or contributes to unfitness for military service is of such mild degree that it does not meet the criteria for even the lowest rating provided in the VASRD under the applicable code. A zero percent rating may be applied in such cases even though the lowest rating listed is 10 percent or more, except when "minimum ratings" are specified. Apply the "Bilateral Factor" (see paragraph 3804e) when a disability is present in two paired extremities , even though one extremity is rated at zero percent.

(2) Minimum Rating. In some instances, the VASRD provides a "minimum rating", without qualifications as to residuals or impairment. Diagnosis alone is sufficient to justify the minimum rating. Syringomyelia, code 8024, is an example. Although higher

ratings may be awarded in consonance with degree of severity, do not use a rating lower than the "minimum" if the diagnosis is satisfactorily established.

(3) Minimum Rating for Residuals. The VASRD provides a minimum rating for "residuals" in certain medical conditions. A given instruction may state, "rate residuals, minimum ___ percent," or may specify what impairment to rate and give a minimum rating for that impairment. Examples are code 8011, anterior poliomyelitis, and 6015, benign new growth of eyeball and adnexa, other than superficial. To justify the minimum rating for residuals, a functional impairment or other residual caused by the condition must exist. Otherwise, a zero percent is appropriate if the primary condition is unfitting.

m. Rating of Medical Impairments Existing Prior to Service

(1) Permanent Service Aggravation. A medical condition manifesting itself or existing prior to entry into military service will be considered "permanently service aggravated" when military service lastingly worsens that medical condition beyond its natural progression. Use generally accepted medical principles to determine "natural progression."

(2) No Permanent Aggravation. For service members for whom no permanent service aggravation has occurred, and whom do not meet the conditions outlined in paragraph 3804m(7), no rating will be listed. However, the Formal PEB rationale and/or Informal PEB workcard will state the basis for the determination that the unfitting condition existed prior to service (EPTS) and was not permanently aggravated by service. When the condition is considered unfitting due to natural progression without permanent service aggravation, the accepted medical principle that supports the finding of "natural progression" will be addressed in the Formal PEB rationale and/or Informal PEB workcard.

(3) Aggravation and Present Degree of Disability Less than 100 Percent

(a) In cases involving service members with permanent service aggravation and a current degree of impairment less than total, the rating will reflect only the degree of disability over and above that existing at the time of entrance into active service. This requirement applies whether the particular condition was noted at the time of entrance into active service or later is determined, upon the evidence of record, to have existed at that time. It is necessary, therefore, to deduct from the present degree of disability the degree of disability, if ascertainable, that existed prior to entrance into active service. In assessing EPTS disability, the full EPTS clinical course of the impairing medical condition will be taken into consideration. Such deduction should be in terms of the rating schedule for the given condition. The deduction will be recorded on the rating sheet. If the degree of disability at the time of entrance into the military service is not ascertainable in terms of the schedule, there will be a zero percent deduction. The rating sheet will reflect that the EPTS factor is indeterminable, and a zero percent deduction will be made.

(b) It is not uncommon that the PEB disagrees with or

overrides the medical board's designation as to whether a condition is EPTS or not. The service member and the medical board members must understand that the PEB's determination of EPTS factors and how those factors do or do not contribute to other conditions and the resulting degree of impairment may be different from the views contained in the medical board report, and that the decision of the PEB is final, unless overturned by a PFR decision.

(4) Aggravation and Present Degree of Disability 100 percent. When permanent service aggravation has occurred and the current degree of disability is 100 percent, the rating sheet will reflect the EPTS factor and percent, but no actual deduction will be made. However, if upon TDRL finalization, the total rating drops below 100 percent, the original EPTS deduction percentage will be applied.

(5) Congenital and Hereditary Conditions. Congenital and hereditary conditions that do not manifest symptomatology until after a member enters active duty under orders specifying a period of more than 30 days shall not be considered service-incurred. These conditions will be presumed service aggravated unless a preponderance of evidence based on accepted medical principles clearly establishes that the condition is solely the time result of the natural progression of the congenital or hereditary condition.

(6) Paired Organs Involving EPTS and Service Aggravation . No deduction for EPTS factor will be made when the member is Unfit for any of the following situations involving paired organs. However, the rating sheet will reflect the EPTS factor, and that the EPTS deduction is zero (0) percent.

(a) Blindness in one eye as a result of service-connected disability and blindness in the other eye as a result of non-service connected disability.

(b) Loss or loss of use of one kidney as a result of service-connected disability and involvement of the other kidney as a result of non-service connected disability.

(c) Total deafness in one ear as result of service-connected disability and total deafness in the other ear as a result of non-service connected disability.

(d) Permanent service-connected disability of one lung, rated 50 percent or more disabling, in combination with a non-service connected disability of the other lung.

(7) Disability Compensation for Certain Members with Pre-existing Medical Conditions. In the case of a member who is on active duty for more than 30 days whose disability is determined to have been incurred before the member became entitled to basic pay in the member's current period of active duty, the disability shall be deemed to have been incurred while the member was entitled to basic pay and shall be so considered for purposes of determining whether the disability was incurred in the line of duty provided the member has over 8 years of active service. The 8 years of active service does not have to be

continuous. Each stage of the PEB review process (Informal Board, Formal Board, PPEB issuance of findings, PFR) that considers a particular case will make an independent determination as to whether the member has 8 years of active service at the time of its review. A member's injuries will be deemed to be service aggravated if he/she is found to meet the 8-year rule at any time during the PEB review process.

n. Presumption of Service Aggravation. Any injury or disease discovered after a service member enters active duty -- with the exception of congenital and hereditary conditions -- is presumed to have been incurred in the line of duty. Any hereditary and/or genetic disease shall be presumed to have been incurred prior to entry into active duty. However, any aggravation of that disease, incurred in the line of duty, beyond that determined to be due to natural progression shall be deemed service aggravated. The presumption that a disease is incurred or aggravated in the line of duty only may be overcome by competent medical evidence establishing by a preponderance of evidence that the disease was clearly neither incurred nor aggravated while serving on active duty or authorized training . Such medical evidence must be based upon well-established medical principles, as distinguished from personal medical opinion alone. Preponderance of evidence is defined as that degree of proof necessary to fully satisfy the board members that there is greater than a 50 percent probability that the disease was neither incurred during nor aggravated by military service.

o. Presumption of Sound Physical and Mental Condition Upon Entry. A service member 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.

p. Conditions Presumed to be Pre-Existing. Occurrence of disease as described in paragraphs (1) and (2), below, shall be presumed to have existed prior to entry into military service .

(1) Signs or symptoms of chronic disease identified so soon after the day of entry on military service (usually within 180 days) that the disease could not have originated in that short a period will be accepted as proof that the disease manifested prior to entrance into active military service.

(2) Signs or symptoms of communicable disease within less than the medically recognized minimum incubation period after entry on active service will be accepted as evidence that the disease existed prior to military service .

(3) Congenital and hereditary conditions, even though they do not manifest symptomatology until the member enters active duty, are considered EPTS. Service aggravation of these conditions is discussed in paragraph 3804 m (5).

q. Treatment of Pre-Existing Conditions. Generally, recognized risks associated with treating preexisting conditions shall not be considered service aggravation.

r. Combined Ratings Table. When a member has more than one compensable disability, the percentages are combined rather than added (except when the VASRD modified by enclosure (3) indicates otherwise). The combined rating is based on the "whole person concept." A person without a medical impairment is considered 100 percent Fit. An unfitting ratable medical impairment renders an individual less than 100 percent Fit. A revised fitness level results. Subsequent impairments are calculated as a percentage basis of the new fitness level that is always less than 100 percent. Thus, a person having a 60 percent disability is considered to have a remaining efficiency or fitness of 40 percent. If there is a second disability rated at 20 percent, then the person is considered to have lost 20 percent of that remaining 40 percent (20 percent x 40 percent = 8 percent). Hence, a 60 percent disability combined with a 20 percent disability results in a combined rating of 68 percent, which is rounded off to a 70 percent rating in accordance with the VASRD. The combined rating for any combination of disabilities is always determined by first arranging the disabilities in their exact order of severity and then referring to the Combined Ratings Table in the VASRD in accordance with the following Instructions:

(1) Combining Two Percentages. The higher impairment percentage is located in the left-hand column. The combined percentage is found where the row indicating the percentage of the first (higher) impairment intersects with the column headed by the percentage of the second impairment.

(2) Combining Three or More Percentages. The first two percentages are combined as indicated in subparagraph 3804r (1). The result is a new impairment percentage that can be combined with a third percentage following the same procedure as in subparagraph 3804r (1). (Example: 50 combined with 30 equals 65, 65 combined with 20 equals 72). If there are additional percentages, the procedure is repeated using the new combined value and the next percentage. Rounding off is not done until the final value has been calculated and converted as described below in paragraph 3804r (3).

(3) Converting a Combined Rating. After all percentages have been combined, the resulting combined value is converted to the nearest number divisible by 10. Combined values ending in 5 are adjusted upward. If the combined value includes a decimal fraction of 0.5 or more as a result of applying the bilateral factor (see paragraph 3804e), the fraction is converted to the next higher whole number; otherwise the decimal fraction is disregarded. (Example: If the combined value is 64.5, the fraction is rounded to a combined value of 65, which is adjusted upward to 70. If the combined value is 64.4, the decimal fraction is disregarded and the combined value of 64 is rounded off to 60.)

s. Organ Transplants

(1) Joint prosthetic transplants are discussed under codes 5051 through 5056.

(2) Vascular system prosthetics are addressed under the 7000 code.

(3) Service members requiring transplant ordinarily will be Unfit, regardless

of their current ability to perform their duties, due to organ failure. This determination will be made based on the fact that the member's duties may seriously compromise his/her health or well-being and may also prejudice the best interests of the government if the member were to remain in the military service. The service member should be placed on the TDRL. In those cases in which a definite or imminent date has been set for transplantation, disposition shall be postponed and residuals rated after the transplantation.

(4) Rate cases that have not come before the PEB before transplantation on the following factors:

(a) Functional status of the transplanted organ.

(b) The need for sustained immunosuppression or its adverse effects. Adverse effects may be rated because of specific infections or by analogy (see enclosure (9), attachment (a), Table of Analogous Ratings).

(5) To encourage organ and tissue donations, NAVMEDCOMINST 6300.8 (NOTAL) authorizes military members to participate in organ donation. Loss of an organ as a result of donation of an organ will not become a basis for special duty assignment and such donation by the member may result in subsequent ineligibility for disability compensation for any adverse residuals incurred secondary to organ donation.

t. Rating Principles for Specific Disabilities. Enclosure (9) provides instructions and explanatory notes for rating certain disabilities. This guidance will be followed unless a subsequent change to the VASRD makes the guidance obsolete. The VASRD is a living document and is continuously being revised. Changes to the VASRD will supersede direction contained in this instruction. Where service specific variations are necessary, change transmittals or NCPB policy letters will be generated to cover any special interpretations for new VASRD ratings.

3805 Assignment Of Aggravation Factors When Prescribed Treatment Is Refused Or Omitted

Although a service member would not be Fit to continue naval service, a member's degree of disability may have been aggravated or increased by, among other things, an unreasonable failure or refusal to submit to medical or surgical treatment or therapy, to take prescribed medications, or to observe prescribed restrictions on diet, alcohol, drugs, or tobacco. The compensable disability rating may be reduced to compensate for such aggravation or increase when the existence and degree of aggravation are ascertainable by application of accepted medical principles, and where it is clearly demonstrated that:

a. the member was advised clearly (with appropriate documentation) and understandably of the medically proper course of treatment, therapy, medication or restriction; and

b. the member's failure or refusal was willful or negligent, and not the result of mental disease or of physical inability to comply.

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