MILITARY ORDER OF THE
PURPLE HEART

WEDNESDAY APRIL 22, 2009
TRAINING OUTLINE
**TUESDAY, APRIL 21, 2009**

9:00 AM – 9:50 AM  The Deeper Problem Behind Recent VA Scandals;  
The VA Claims Adjudication System: Is it broken?  
How do we fix it?

9:50 AM – 10:05 AM  Break

10:05 AM – 10:55 AM  How to Evaluate Medical Linkage Opinions

10:55 AM – 11:10 AM  Break

11:10 AM – 12:00 PM  New Developments in Housebound Benefits  
(*Bradley v. Peake*)

12:00 PM – 1:30 PM  Lunch

1:30 PM – 2:20 PM  Inadequate VA Exams: How to Identify them &  
What to do about them.

2:20 PM – 2:35 PM  Break

**WEDNESDAY, APRIL 22, 2009**

9:00 AM – 9:50 AM  Recent Developments in Veterans Law: Revised  
Rating Schedule for TBI

9:50 AM – 10:05 AM  Break

10:05 AM – 10:55 AM  Recent Developments in Veterans Law: Revised  
Rating Schedule for TBI (Continued)

10:55 AM – 11:10 AM  Break
11:10 AM – 12:00 PM  Service Connection for Hearing Loss and Tinnitus
12:00 PM – 1:30 PM  Lunch
1:30 PM – 2:20 PM  The Evaluation of Mental Health Conditions
2:20 PM – 2:35 PM  Break

WEDNESDAY EVENING

7:00 PM  Frivolous Claims (Comer v. Peake); Frostbite
          Residuals and Heart Condition
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### WEDNESDAY OUTLINE

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RECENT DEVELOPMENT IN VETERANS LAW: REVISED RATING SCHEDULE FOR TBI
RECENT DEVELOPMENTS IN VETERANS LAW:
REVISED RATING SCHEDULE FOR TBI

I. Basic Information About Traumatic Brain Injury (TBI)

A. TBI is an injury to the brain from an external force that results in immediate effects such as loss of consciousness (being knocked out), amnesia, or, sometimes, neurological impairment. 73 Fed. Reg. 54,693 (2008). Another immediate effect of TBI is alteration of mental status (being dazed, confused, or “seeing stars”). Hoge, C., Mild Traumatic Brain Injury in U.S. Soldiers Returning from Iraq, N Engl J Med 2008; 358: 455.

B. At the time of injury (or soon after) the TBI is usually classified as mild, moderate, or severe. 73 Fed. Reg. at 432-33. “This original designation as to severity of the original injury does not change, whatever the speed or extent of recovery, or the long-term disabling effects.” Id. This classification may correspond to the individual’s future impairment level, but not always. (Therefore, the designation of mild, moderate, or severe TBI “does not affect the rating assigned” by VA. 73 Fed. Reg. at 433.)

C. Mild traumatic brain injury is also called “concussion.” Hoge, C., Mild Traumatic Brain Injury in U.S. Soldiers Returning from Iraq, N Engl J Med 2008; 358: 455. Typical postconcussive symptoms are irritability, memory problems, headache, and difficulty concentrating. Id.

II. Background Information—TBI among Service Members and Veterans

A. The incidence of TBI among veterans is on the rise. 73 Fed. Reg. 432 (2008). VA is seeing a statistically larger number of veteran of the Iraq and Afghanistan conflicts with residuals of TBI than has been seen in previous conflicts. Id. TBI is considered the signature disability of the OEF/OIF conflicts. Id. This increased incidence is generally believed to be due to improved protective equipment, improved combat medicine and improved screening and diagnosis. See generally Okie S., Traumatic Brain Injury in the War Zone, N Engl J Med 2005; 352:2043-7.

B. Other service members and veterans who may have current residuals of TBI due to service are those who were injured training for combat, those who were involved in motor vehicle accidents (MVAs) during service, and those who were involved in an accident or fall during service. Any member or veteran who experienced a head injury in service and who may have current residuals may be eligible for disability compensation benefits.

III. The History of VA/DOD Problems Evaluating TBI

A. The Complexity of TBI
1. TBI is a complex disability that may have many different manifestations. A large variety of residual dysfunctions are possible and many individuals have multiple residual dysfunctions. This makes the evaluation of TBI under the VA Rating Schedule equally complex. Each of the various manifestations and residuals of TBI must be properly evaluated.

2. Some typical problems that may arise in the evaluation of TBI and residuals:
   - Failure to evaluate all residuals
   - Attribution of residuals to a condition other than TBI
   - Difficulty differentiating the cause of certain symptoms (for example, difficulty differentiating between symptoms of TBI and PTSD)

B. The Inadequacy of the Previous VA Rating Schedule for TBI

1. The VA revised the VA Rating Schedule for TBI in October 2008. Prior to that time TBI was evaluated under rating criteria that were viewed as completely inadequate to compensate for the disabilities due to TBI. When the VA published final changes to the TBI rating schedule, it said that “the need for a new approach to TBI is both immediate and critical.” 73 Fed. Reg. 54,701.

2. The previous rating criteria for TBI, which are no longer in effect, were listed under DC 8045. That DC was titled “Brain Disease due to Trauma.” The previous schedule provided:

   - Purely neurological disabilities such as hemiplegia, epileptiform seizures, facial nerve paralysis, etc., following trauma to the brain, will be rated under the DCs specifically dealing with such disabilities, with citation of a hyphenated diagnostic code (e.g., 8045-8207).
     [Note: Hemiplegia is when a vertical half of a patient's body is paralyzed. DC 8207 is paralysis of seventh (facial) cranial nerve.]
   - Purely subjective complaints such as headache, dizziness, insomnia, etc., recognized as symptomatic of brain trauma, will be rated 10 percent and no more under DC 9304—Dementia due to head trauma
   - This 10 percent rating will not be combined with any other rating for a disability due to brain trauma.
   - Ratings in excess of 10% for brain disease due to trauma under DC 9304 are not assignable in the absence of a diagnosis of multi-infarct dementia associated with brain trauma.

3. Under this rating criteria, most service members and veterans who suffered from TBI were awarded only a 10% evaluation for disabilities that may have been moderately severe, very severe or totally disabling. Complaints that this schedule was inadequate to compensate veterans and service members for the many and complex residuals of TBI brought about VA’s revision of the TBI rating criteria.
IV. October 2008 Revision of the Rating Criteria for TBI

A. The new rating schedule for TBI is effective October 23, 2008. This new schedule will apply to all VA applications received on or after October 23, 2008. The old rating criteria still apply to VA applications received before that date. Veterans can request that their current TBI evaluation be reviewed under the new criteria. A veteran doesn’t need to claim worsening of the condition—just ask for review under the new criteria. This request for a review will be treated as claim for increase.

B. Veterans are protected against a reduction in evaluation based on a change in the rating schedule. The protection given to veterans states that “in no event shall such a readjustment in the rating schedule cause a veteran’s disability rating in effect on the effective date of the readjustment to be reduced unless an improvement in the veteran’s disability [under the old schedule] is shown to have occurred. See 38 U.S.C. § 1155; VA Gen. Coun. Prec. Op. 19-92.

C. The effective date of any increase or award based on the new rating criteria for TBI will not be earlier than October 23, 2008. However, the VA is to apply 38 C.F.R. § 3.114 where applicable. This means that:
- If a claim is reviewed at the claimant’s request within 1 year from the October 23, 2008 effective date, the veteran should be awarded any increased benefits from October 23, 2008
- If a claim is reviewed on VA initiative more than 1 year after the effective date of October 23, 2008, the veteran should be awarded any increased benefits for 1 year prior to the date that the VA determines he/she is entitled to an increase;
- If a claim is reviewed at the claimant’s request more than 1 year after the effective date of October 23, 2008, the veteran should be awarded any increased benefits for 1 year prior to the date of his/her request.

V. The New Rating Schedule for TBI

A. The new rating schedule for TBI is at 38 C.F.R. § 4.124a (“Ratings for Neurological Conditions and Convulsive Disorders”), DC 8045.

B. VA believes that there are 3 main areas of dysfunction that can be caused by TBI:
   1. emotional/behavioral dysfunction,
   2. physical/neurological dysfunction, and
   3. cognitive impairment.

C. General Rules for Evaluating Emotional/Behavioral Residuals under the New TBI Rating Schedule
   - Each emotional/behavioral residual of TBI that is a diagnosed mental condition is rated under the appropriate mental disorder DC (i.e., a DC under 38 C.F.R. § 4.125 (Mental Disorders).
• If there is **no diagnosed mental disorder**, rate emotional/behavioral **symptoms** under the TABLE in DC 8045. (The TABLE is explained below.)

D. **General Rules for Evaluating Physical/Neurological Residuals under the New TBI Rating Schedule**

• Each physical/neurological residual of TBI that is a diagnosed condition is rated under the appropriate physical/neurological DC (or the appropriate analogous DC, see 38 C.F.R. § 4.20).

• If there are physical/neurological symptoms but no diagnosis for those symptoms, the symptoms are rated under the TABLE in DC 8045. Rate physical/neurological symptoms with no diagnosis under “subjective symptoms” or “motor activity” or other appropriate facet listed in the TABLE in DC 8045. (The TABLE is explained below.)

• The VA’s non-inclusive list of physical/neurological dysfunctions includes:
  o Motor & sensory dysfunction, including pain, of extremities & face;
  o Visual impairment;
  o Hearing loss & tinnitus;
  o Loss of sense of smell/taste;
  o Seizures (DCs 8910-8914);
  o Gait, coordination & balance problems;
  o Speech & other communication difficulties, including aphasia (inability to use/understand language);
  o Dysarthria (inability to articulate due to peripheral motor nerve problem, etc);
  o Neurogenic bladder (bladder doesn’t empty fully due to nerve damage);
  o Neurogenic Bowel (loss of function due to nerve damage);
  o Cranial nerve dysfunction (disorders of smell, vision, eyes, taste, and positional vertigo);
  o Autonomic nerve dysfunctions (regulates unconscious body functions, including heart rate, blood pressure, body temp, etc);
  o Endocrine dysfunctions.

E. **General Rules for Evaluating Subjective Symptoms Due to TBI**

• Each Subjective Symptom is evaluated under the TABLE in DC 8045

• However, if the Subjective Symptom has a distinct diagnosis (migraine headache, etc…) it is to be evaluated under the appropriate DC for that diagnosis. It should not be evaluated under the TABLE in DC 8045

• Following is a **non-inclusive** list of Subjective Symptoms, compiled from the TABLE in DC 8045:
  o Anxiety (but if there is a diagnosis of an anxiety condition, evaluate under the DC for that mental disorder)
  o Headaches (but if there is a diagnosis of migraine headaches, evaluate that condition under the appropriate DC, DC 8100)
  o Insomnia
o Hypersensitive to light, sound
o Dizziness
o Fatigability (but if there is a diagnosis of chronic fatigue syndrome, evaluate that condition under the appropriate DC, DC 6354)
o Blurred/double vision

F. **General Rules for Evaluating Cognitive Impairment Residuals of TBI**

- Any cognitive impairment symptom or dysfunction is evaluated under the TABLE in DC 8045. (The TABLE is explained below.)
- The VA defines cognitive impairment as “decreased memory, concentration, attention, and executive functions of the brain.” 38 C.F.R. § 4.124a, DC 8045.
- Executive functions are defined as:
  o Goal setting
  o Speed of information processing
  o Planning
  o Organizing
  o Prioritizing
  o Self-monitoring
  o Problem solving
  o Judgment
  o Decision-making
  o Spontaneity
  o Flexibility

G. The TABLE in DC 8045 is called “Evaluation of Cognitive Impairment & Other Residuals of TBI Not Otherwise Classified.” All residuals of TBI that are not considered part of a separately diagnosed condition (symptoms that are not accounted for by a diagnosis and rated under another DC in the VA rating schedule) should be evaluated under this TABLE.

H. **The 10 Facets Listed in the TABLE**

- Each symptom/residual of TBI (that not already accounted for by a separately diagnosed condition and evaluated under another DC) is classified under one of 10 facets in the TABLE.

- The 10 facets of TBI impairment listed in the TABLE in DC 8045 (with a short description in parentheses) are:
  o Memory, attention, concentration, executive functions (cognitive impairment)
  o Judgment (decision-making)
  o Social Interaction (interacting with people)
  o Orientation (oriented or disoriented)
  o Motor Activity (with intact motor & sensory system) (when neurological exam is normal but motor activity problematic)
o Visual spatial orientation (ability to orient self, follow directions, read maps)
o Subjective Symptoms (examples include but are not limited to headache, dizziness, insomnia)
o Neurobehavioral Effects (examples include but are not limited to irritability, impulsivity, unpredictability, lack of motivation, verbal aggression, physical aggression, apathy, lack of empathy, moodiness, lack of cooperation)
o Communication (ability to speak, write, and understand spoken and written language)
o Consciousness (persistently altered state of consciousness, vegetative state)

I. How the TABLE in DC 8045 Works

• Each of the 10 facets has at most five levels of impairment
  
  0  = 0%
  1  =10%
  2  =40%
  3  =70%
  Total =100%

• Some of the 10 facets have less than five levels of impairment. For example, the “Subjective Symptoms” facet has only three levels of impairment, a “0”, “1,” and “2”.

• Each of the levels of impairment for each of the 10 facets contains a description of that level of impairment

• For example, following are the levels of impairment listed under the “Communication” facet
  
  0  = Able to communicate by spoken and written language (expressive communication), and comprehend spoken and written language.
  1  = Comprehension or expression, or both, of either spoken language or written language is only occasionally impaired. Can communicate complex ideas.
  2  = Inability to communicate either by spoken language, written language, or both, more than occasionally but less than half of the time, or to comprehend spoken language, written language, or both, more than occasionally but less than half of the time. Can generally communicate complex ideas.
  3  = Inability to communicate either by spoken language, written language, or both, at least half of the time but not all of the time, or to comprehend spoken language, written language, or both, at least half of the time but not all of the time. May rely on gestures or other alternative modes of communication. Able to communicate basic needs.
Total = Complete inability to communicate either by spoken language, written language, or both, or to comprehend spoken language, written language, or both. Unable to communicate basic needs.

- The VA determines what symptoms/residuals are to be classified under which facet. Each symptom/residual is then assigned the appropriate number (0, 1, 2, 3, 4, or total) under the appropriate facet.

J. How the VA Arrives at a Percentage Evaluation for TBI under DC 8045

- After each symptom/residual has been classified under one of the 10 facets, and assigned a number—the VA takes the highest number assigned to any one facet. That highest number assigned to any one of the 10 facets is the percentage evaluation assigned for TBI.
- VA should assign a 100% evaluation if any facet (or more than 1 facet) is determined to be totally disabling
- If none of the 10 facets is total, assign the evaluation based on the highest-evaluated facet
- For example, the veteran or service member should receive a 70% evaluation under DC 8045 if “3” is the highest level for any facet.
- If veteran or service member has a “3” under 5 different facets, he or she will be evaluated as 70% disabled
- A veteran or service member can have a “2” under each of the 10 facets—but will still be evaluated as only 40% disabled—the same evaluation as a veteran who has a “2” under only 1 of the 10 facets.

K. General Rules to Keep in Mind

- The same symptoms/manifestations of TBI cannot support more than 1 evaluation
- The ultimate evaluation arrived at under the TABLE in DC 8045 is considered the evaluation for a single condition and will be combined with other disability evaluations (for physical & emotional dysfunctions) under the combined rating table in 38 C.F.R. § 4.25
- Note 1 under DC 8045—There may be an overlap between manifestations of conditions that could be evaluated under the TABLE and mental or physical disorders that can be separately evaluated under other DCs. The VA advises not to assign more than one evaluation based on same TBI manifestation. If the manifestations are clearly separable, assign a separate evaluation under a separate DC. If manifestations of TBI can’t be clearly separated, assign one (single) evaluation under the DC that allows the best assessment of overall impaired function due to both conditions
- Note 2 under DC 8045—The symptoms listed as examples at the evaluations levels in the TABLE are only examples. The examples that are listed do not have to be present to assign a particular evaluation. (For example, the symptoms listed under the “1” in the “subjective symptoms” facet include intermittent dizziness, daily mild headaches, tinnitus, frequent insomnia. Note 2 states that these particular examples need not be present in order to get a “1” assigned under
that facet. So long as the veteran has three subjective symptoms that “mildly interfere with work, instrumental IADLs, or work, family, or other relationships, he or she would meet the criteria for a “1”.

- Note 3 contains definitions of terms used in the “subjective symptoms” facet. Instrumental activities of daily living (IADLs) refers to activities other than self-care, needed for independent living, such as preparing meals, housework, shopping, traveling, laundry, taking medications, using the phone. Activities of Daily Living (ADLs) refers to basic self-care and includes bathing, showering, dressing, eating, getting in/out of bed, using toilet.

- Note 4 states that the terms “mild” “moderate” and “severe” TBI, which may appear in medical records, “refers to a classification of TBI made at, or close to, the time of injury rather than to the current level of functioning.” 73 Fed. Reg. 54,693, 54,706. The VA states that this initial classification should not affect the rating assigned under DC 8045.

- Note 5 states that a veteran rated under the previous DC 8045 may request review under the new DC 8045. The veteran does not need to claim worsening—the claim will be treated as a claim for increase. (In a claim for increase, a VA exam is usually always scheduled.) However, in no case will the effective date of any increase due to this review be prior to the effective date of the changes, October 23, 2008.

- The VA also states in Note 5 that 38 C.F.R. § 3.114 should be applied in determining the correct effective date of any increase. This means that:
  - If a claim is reviewed at the claimant’s request within 1 year from the October 23, 2008 effective date, the veteran should be awarded any increased benefits from October 23, 2008
  - If a claim is reviewed on VA initiative more than 1 year after the effective date of October 23, 2008, the veteran should be awarded any increased benefits for 1 year prior to the date that the VA determines he/she is entitled to an increase;
  - If a claim is reviewed at the claimant’s request more than 1 year after the effective date of October 23, 2008, the veteran should be awarded any increased benefits for 1 year prior to the date of his/her request.

VI. Advocacy Advice on the New Rating Schedule for TBI

A. Make Sure TBI Examination is Adequate

1. Probably the most critical advice to advocates is to make sure that the veteran undergoes an adequate, thorough, comprehensive TBI exam. This is critical because the percentage evaluation that is assigned to the disability is usually based on the examiner’s comments (or lack thereof).

2. The VA provides its examiners with templates that outline what factors are to be considered with regard to various disabilities, what tests must be performed, and what information should be elicited from the veteran. The
VA’s guidance about exams, and the exam templates (called worksheets) are in the VA’s “Clinician’s Guide.”

3. The advocate should, at the very least, make sure that any exam that is being used to assess the extent and severity of the TBI complies with the Clinician’s Guide worksheet on TBI. This worksheet can be found at [http://www.vba.va.gov/bln/21/Benefits/exams/disexam58.htm](http://www.vba.va.gov/bln/21/Benefits/exams/disexam58.htm).

4. The VA worksheet contains several things that advocates should keep in mind.
   - for TBI, additional exams by specialists may be needed
   - Veterans and service members with TBI need prompting, so the examiner is required to ask specifically about each symptom or area of symptoms, such as: headaches, dizziness, vertigo; weakness, paralysis; sleep disturbance, fatigue, malaise; mobility, balance, devices to assist walking; memory impairment; cognitive problems such as decreased attention, concentration, executive functioning; speech or swallowing problems; pain; bowel problems; bladder problems; psychiatric symptoms; erectile dysfunction; sensory changes (numbness, paresthesias (abnormal sensation on skin—tingling, pricking, burning)); vision problems, hearing problems; decreased sense of taste, smell; seizures; hypersensitivity to sounds, light; neurobehavioral symptoms—irritability, restlessness; autonomic dysfunction (heat intolerance, excess or decreased sweating); other symptoms
   - The examiner is to describe the effects of any of the above symptoms on routine daily activities and on employment

5. **Physical Examination**
   - The examiner must **examine** the following: Motor function, muscle tone, reflexes; Sensory function; Gait, spasticity, cerebellar signs (if any spasticity or rigidity, follow Joint Exam protocol); Autonomic nervous system; Cranial nerves—perform a SCREENING EXAM (if positive, follow Cranial Nerves exam protocol); Cognitive Impairment—perform a SCREENING EXAM such as Montreal Cognitive Assessment (MOCA) or Mini-Mental State Exam (MMSE) (If screening shows problems, neuropsychiatric testing is needed to confirm presence and extent of cognitive impairment); Psychiatric manifestations—perform a SCREENING EXAM for psychiatric symptoms (examiner must order a Mental or PTSD Exam if the screening is positive.); Vision & Hearing—perform a SCREENING EXAM (if abnormalities found, examiner is to order an eye or audiology exam by a specialist.); Skin (describe skin breakdown due to neurological problems); Endocrine dysfunction—if evidence of endocrine problems are suspected or identified, follow the examination
6. **Cognitive Impairment & Other TBI Residuals not otherwise classified.**
   - The examiner must assess cognitive impairment & other TBI residuals not otherwise classified.
   - The examiner must indicate where the veteran falls on the TABLE in DC 8045—for each of the 10 listed facets.
   - **In other words, the examiner is asked to identify where the veteran falls on the TABLE with respect to each facet.** The VA rater will most likely rely on the examiner’s assessment of the level of impairment to determine the veteran’s level of disability from TBI.

**B. Eligibility for Special Monthly Compensation Based on TBI Residuals?**

Advocates should ensure that the VA considers Special Monthly Compensation issues, especially if:

- There is loss of use of an extremity.
- There are certain sensory impairments (blindness in one eye, deafness, aphonia (loss of speech), etc.).
- There is erectile dysfunction.
- The veteran may need the aid and attendance of another to perform the personal functions of daily living can receive increased compensation. 38 U.S.C. § 1114(l). (The following factors will be considered in determining whether the veteran is entitled to SMC based on need for aid and attendance: inability of claimant to dress or undress without assistance; to keep ordinarily clean and presentable without assistance; inability of claimant to feed himself or herself without assistance; inability to attend to the wants of nature; and incapacity which requires care or assistance on a regular basis to protect the claimant from the hazards or dangers incident to his or her daily environment.)
- The veteran may be determined to have “housebound” status in one of 2 ways, which would entitle him or her to additional compensation per month.
  - First, the veteran may be eligible for housebound benefits if there is a single service-connected disability rated as 100 percent disabling and additional service-connected disability(ies) (involving a different bodily system) that are independently rated at 60 percent. 38 U.S.C. § 1114(s). (A determination that the veteran is entitled to total disability based on individual unemployability (TDIU) will meet the requirement that the veteran have a single service-connected disability rated as 100% disabling.)
Or, a veteran is entitled to housebound benefits if he or she has a single service-connected disability rated 100 percent disabling and the veteran is permanently housebound because of a service-connected disability or disabilities. 38 U.S.C. § 1114(s). The requirement of being permanently housebound is met when (1) the veteran is "substantially confined as a direct result of service-connected disabilities to his or her dwelling; and (2) it is reasonably certain that the disability or disabilities will continue throughout his or her lifetime.

C. Try to get a Separate Diagnosis for Each Residual/Manifestation

- It would most likely be beneficial to the veteran or service member to try to obtain a separate diagnosis for every physical, emotional/behavioral and cognitive disability that is a residual of the TBI.
- The advocate should then attempt to get highest evaluation appropriate to each diagnosed condition.
- It appears that veterans and service members will receive a higher evaluation if they are able to obtain a separate diagnosis of a mental condition—rather than have symptoms of emotional/behavioral problems evaluated under the TABLE in DC 8045. If that is not possible, try to get highest possible evaluation under the TABLE in DC 8045 for each residual manifestation of TBI.

D. Where Manifestations/Symptoms Not Clearly Separable

- Note 1 explains that where the individual manifestations/symptoms of TBI are not clearly separable, then a single evaluation under whichever DC allows the better assessment of overall impaired functioning due to both conditions should be assigned.
- Where symptoms are not clearly separable, advocates should compare DC 8045 with other potentially applicable DCs to determine what DC would give the highest evaluation. That DC would probably provide the better assessment of overall impaired functioning.

E. The Importance of Lay Evidence

- In any case involving the evaluation of a disability, it is important to have not only a thorough exam and proper application of the rating schedule. It is also important to obtain as much lay evidence from family, friends, co-workers, etc. The lay statements should address the symptoms and behavior of the veteran or service member. Also, lay statements should address the frequency and seeming severity of the symptoms, which vivid descriptions of exactly what the veteran is doing or complaining of.
• These lay statements should be submitted both to the VA (or other relevant body) and to the examiner. These statements can assist the examiner in determining the veteran’s level of impairment for each facet in the TABLE.

F. Potential Difficulties with the Subjective Symptoms Facet

• It is unclear at this time whether the VA will require that an examiner mention or verify that the veteran is experiencing certain subjective symptoms.
• Advocates should be aware that this may present problems in evaluating TBI residuals. Be prepared to argue that nothing more than a veteran’s statement as to experiencing a subjective symptom is needed. In order to accelerate the evaluation process advocates may want to obtain lay statements from family and friends concerning the veteran’s behavior when experiencing subjective symptoms (i.e., have the spouse mention that the veteran went to bed several times a day complaining of headaches, and visibly winced as though in pain).

Examples of Facets and their Levels of Impairment

The Memory Facet (Memory, Attention, Concentration, Executive Functions)

<table>
<thead>
<tr>
<th>Level</th>
<th>Percentage</th>
<th>Description</th>
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<tbody>
<tr>
<td>0</td>
<td>0%</td>
<td>No complaints of impairment</td>
</tr>
<tr>
<td>1</td>
<td>10%</td>
<td>Complaints of mild loss of memory, attention, etc. without objective evidence on testing</td>
</tr>
<tr>
<td>2</td>
<td>40%</td>
<td>Objective evidence on testing of mild impairment of memory, attention, etc…, results in mild impairment</td>
</tr>
<tr>
<td>3</td>
<td>70%</td>
<td>Objective evidence on testing of moderate impairment of memory, attention, etc…, results in moderate impairment</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>Objective evidence on testing of severe impairment of memory, attention, etc…, result in severe functional impairment</td>
</tr>
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</table>

The Judgment Facet (Decision making)

<table>
<thead>
<tr>
<th>Level</th>
<th>Percentage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0%</td>
<td>Normal</td>
</tr>
<tr>
<td>1</td>
<td>10%</td>
<td>Mildly impaired judgment. For complex decisions, occasionally unable to identify, understand &amp; weigh the alternatives, understand the consequences &amp; make a reasonable decision.</td>
</tr>
<tr>
<td>2</td>
<td>40%</td>
<td>Moderately impaired judgment. For complex or unfamiliar decisions, usually unable to identify, understand &amp; weigh the alternatives, understand the consequences of choices, and make a make a reasonable decision, although has little difficulty with simple decisions.</td>
</tr>
</tbody>
</table>
3  =  70%  moderately severely impaired judgment. For even routine decisions, occasionally unable to identify, understand, and & weigh the alternatives, understand the consequences of choices, and make a reasonable decision.

Total  =  100%  Severely impaired judgment. For even routine and familiar decisions, usually unable to identify, understand, and weigh the alternatives, understand the consequences of choices, and make a reasonable decision. For example, unable to determine appropriate clothing for current weather conditions or judge when to avoid dangerous situations or activities.

The Social Interaction Facet

0  =  0%  social interaction is routinely appropriate
1  =  10%  social interaction is occasionally inappropriate
2  =  40%  social interaction is frequently inappropriate
3  =  70%  social interaction is inappropriate most or all of time

The Motor Activity Facet

0  =  0%  Motor activity normal
1  =  10%  Motor activity normal most of time but mildly slowed due to apraxia (inability to perform previously learned motor activities despite normal motor function)
2  =  40%  Motor activity mildly decreased or with moderate slowing due to apraxia
3  =  70%  Motor activity moderately decreased due to apraxia

The Subjective Symptoms Facet

0  =  0%  Symptoms do not interfere with work, IADLs, work, family or other relationships. Examples are: mild or occasional headaches, mild anxiety
1  =  10%  three or more subjective symptoms that mildly interfere with work, IADLs, or work, family, or other relationships. Examples of findings that might be seen at this level of impairment are: intermittent dizziness, daily mild headaches, tinnitus, frequent insomnia
2  =  40%  three or more symptoms that moderately interfere with work, IADLs, or work, family or other close relationships.
Example: marked fatigability, blurred /double vision, headaches requiring rest periods most days
SERVICE CONNECTION FOR HEARING LOSS AND TINNITUS
FACTS
SERVICE CONNECTION FOR BILATERAL HEARING LOSS AND TINNITUS

I. Facts

A. The veteran appealed a March 2006, rating decision of the Detroit, Michigan regional office (RO) denying entitlement to service connection for bilateral hearing loss and tinnitus.

B. The veteran served in the U.S. Army from February 1968 to February 1970. He served in Vietnam from July 1968 through July 1969. During his Vietnam service, his occupational specialty was as a light weapons infantryman. The Army honored him with several awards including the Combat Infantryman Badge, National Defense Service Medal, Vietnam Service Medal, Vietnam Unit Citation, Vietnam Campaign Medal and a Marksman Rifle badge.

C. When the veteran entered active service, his pre-induction audiological evaluation on August 2, 1967 did not note any hearing loss or tinnitus. As a light weapons infantryman in Vietnam and as indicated by his commendations for combat service, the veteran experienced significant noise exposure. Upon his return from Vietnam, the Army posted the veteran to Fort Riley, Kansas, where he
served until his discharge on February 18, 1970. As indicated in the veteran’s Service Medical Records, the Army performed a Whispered Voice hearing test on January 21, 1970 during his separation examination; no hearing loss was indicated.

D. After his discharge from service in 1970, the veteran worked at Sears as a parts salesman for 35 years. He claims that he did not experience significant noise exposure at his job or through recreational activities (e.g. hunting).

E. In 2005, the veteran filed claims for entitlement to service connection for hearing loss and tinnitus. He asserted that he had current hearing loss as a result of inservice acoustic trauma stemming from exposure to gunfire.

F. In support of his claims, the veteran submitted a 2005 private audiological examination showing bilateral mild/ moderate high frequency hearing loss binaurally. He also submitted medical nexus opinion by the audiologist in which he stated that “it is highly likely that the veteran’s hearing loss can be attributed to noise exposure in the military. On the issue of tinnitus, the audiologist did not address the veteran’s complaints of tinnitus in her statement. However, she noted a diagnosis of tinnitus on her audiological report.
G. In March 2006, the veteran underwent audiometric testing by VA.

The VA audiologist diagnosed bilateral hearing loss based on elevated puretone thresholds in the right ear and hearing impairment based on poor speech recognition scores in the left ear. In addition, the VA diagnosed bilateral tinnitus of three to four years duration.

H. The 2006 VA examiner provided a medical nexus opinion based on his examination of the veteran and a review of his VA claims file. It was the audiologist’s opinion that because the veteran’s audiological examination at discharge showed normal bilateral hearing, it was not as least as likely as not that his hearing loss was due to military noise exposure. In regards to the tinnitus claim, the VA physician opined that it was not at least as likely as not that tinnitus was related to military noise exposure based upon the fact that its onset did not occur until approximately 32 years after service separation.

I. In a March 2006 rating decision, the VA Regional Office (VARO) denied service connection for hearing loss based on the negative VA opinion that no hearing loss was found in service or at service separation. Likewise, the RO denied service connection for tinnitus based on the opinion of the doctor which relied on the veteran’s statement that his tinnitus was of 3 or 4 years duration.
J. The veteran filed a timely Notice of Disagreement which was received in May 2006 and timely substantive appeal which was received in the same month. In his filings, the veteran stated that his tinnitus began in service, and that the VA examination was concerning tinnitus onset was inaccurate. He also stated that he had worked as a parts salesman since service and was not exposed to high noise levels.

K. In September 2008, prior to the disposition of his claim, the veteran underwent a private audiological examination showing mild to severe sensorineural hearing loss in the veteran’s right ear and mild to moderate-to-severe sensorineural hearing loss in the left ear. A puretone audiometry test revealed the following auditory thresholds:

<table>
<thead>
<tr>
<th></th>
<th>500 Hz</th>
<th>1000 Hz</th>
<th>2000 Hz</th>
<th>4000Hz</th>
<th>8000 Hz</th>
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<tr>
<td>Right</td>
<td>30 dB</td>
<td>40 dB</td>
<td>45 dB</td>
<td>60 dB</td>
<td>70 dB</td>
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<tr>
<td>Left</td>
<td>30 dB</td>
<td>45 dB</td>
<td>55 dB</td>
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<td>60 dB</td>
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The examination of the veteran also revealed bilateral tinnitus.

L. The September 2008 private audiologist provided medical nexus opinion. The audiologist based her opinion on the examination of the veteran, her expertise as an audiologist, and her documented review of the veteran’s VA claims file. The medical opinion linked the veteran’s hearing loss and tinnitus with his combat service in the
Army. Specifically, the opinion was that noise exposure during the veteran’s service in combat in Vietnam more likely than not caused both his current hearing loss and tinnitus.

M. The veteran’s wife submitted a lay statement in support of the veteran’s claims for hearing loss and tinnitus in December 2008. She provided a statement of her observations of the veteran’s difficulty hearing (playing the radio and television more loudly) and tinnitus complaints shortly after returning from service.
THE EVALUATION OF MENTAL HEALTH CONDITIONS
The Evaluation of Mental Health Disorders

I. Intro

A. It is no secret that many veterans of Operation Enduring Freedom and Operation Iraqi Freedom are returning from the war zones with mental disorders, particularly post-traumatic stress disorder (“PTSD”). Additionally, veterans of other eras, including veterans of the Vietnam War, Korean War and World War II continue to receive new diagnoses of PTSD and other mental disorders related to their military service.

B. Unfortunately, as many Veterans Service Officers (“VSOs”) and NVLSP attorneys can attest, VA evaluations of mental health disorders have been inconsistent at best and inaccurate at worst. Therefore, it is important for advocates to understand the VA’s rules for evaluating mental disorders and learn how to obtain the highest disability rating to which their client is entitled.

II. General Rating Principles for Mental Disorders

A. 38 C.F.R. § 4.126 – Evaluation of Disability from Mental Disorders:

1. When evaluating a mental disorder, the rating agency shall consider the frequency, severity, and duration of psychiatric
symptoms, the length of remissions, and the veteran’s capacity for adjustment during periods of remission. The rating agency shall assign an evaluation based on all the evidence of record that bears on occupational and social impairment rather than solely on the examiner’s assessment of the level of disability at the moment of the examination. 38 C.F.R. § 4.126(a) (2008).

2. When evaluating the level of disability from a mental disorder, the rating agency will consider the extent of social impairment, but shall not assign an evaluation solely on the basis of social impairment. 38 C.F.R. § 4.126(b) (2008). (This is because the rating schedule is based on average impairment of earning capacity, which is more closely related to occupational impairment than social impairment. See 38 C.F.R. § 4.1).

B. 38 C.F.R. § 4.130 –Schedule of Ratings – Mental Disorders: The VA uses the General Rating Formula for Mental Disorders in assigning disability rating percentage.

1. 100% - Total occupational and social impairment, due to such symptoms as: gross impairment in thought processes or communication; persistent delusions or hallucinations; grossly inappropriate behavior; persistent danger of hurting self or others; intermittent inability to perform activities of daily living (including maintenance of minimal personal hygiene); disorientation to time or place; memory loss for names of close relatives, own occupation, or own name.
2. **70% - Occupational and social impairment, with deficiencies in most areas, such as work, school, family relations, judgment, thinking, or mood, due to such symptoms as: suicidal ideation; obsessional rituals which interfere with routine activities; speech intermittently illogical, obscure, or irrelevant; near-continuous panic or depression affecting the ability to function independently, appropriately and effectively; impaired impulse control (such as unprovoked irritability with periods of violence); spatial disorientation; neglect of personal appearance and hygiene; difficulty in adapting to stressful circumstances (including work or a worklike setting); inability to establish and maintain effective relationships.**

3. **50% - Occupational and social impairment with reduced reliability and productivity due to such symptoms as: flattened affect; circumstantial, circumlocutory, or stereotyped speech; panic attacks more than once a week; difficulty in understanding complex commands; impairment of short- and long-term memory (e.g., retention of only highly learned material, forgetting to complete tasks); impaired judgment; impaired abstract thinking; disturbances of motivation and mood; difficulty in establishing and maintaining effective work and social relationships.**

4. **30% - Occupational and social impairment with occasional decrease in work efficiency and intermittent periods of inability to perform occupational tasks (although generally functioning satisfactorily, with routine behavior, self-care, and conversation normal), due to such symptoms as: depressed mood, anxiety, suspiciousness, panic attacks (weekly or less often), chronic sleep impairment, mild memory loss (such as forgetting names, directions, recent events).**

5. **10% - 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.**

6. **0% - A mental condition has been formally diagnosed, but symptoms are not severe enough either to interfere with**
III. Deconstructing the Schedule for Rating Mental Disorders

A. After consideration of all the factors of 38 C.F.R. § 4.126, and based on all the evidence of record bearing on occupational and social impairment, the VA must assign a disability rating that most closely reflects the level of social and occupational impairment that a veteran is suffering.

B. Mauerhan v. Principi, 16 Vet. App. 436, 442 (2002). A veteran does not need to exhibit every symptom or effect listed for a particular disability evaluation in 38 C.F.R. § 4.130 in order to be entitled to that rating percentage. The Veterans Court emphasized that the described symptoms “are not intended to constitute an exhaustive list, but rather are to serve as examples of the type and degree of the symptoms, or their effects, that would justify a particular rating.” Id. at 442 (emphasis added). The Court noted that the presence of all, most or even some of the listed symptoms is not required for the VA to assign a particular disability rating. Id. The Court summarized, “the evidence considered in determining the level of impairment under § 4.130 is not restricted to the symptoms
provided in the diagnostic code. Instead, the rating specialist is to consider all symptoms of a claimant’s condition that affect the level of occupational and social impairment, including, if applicable, those identified in the DSM-IV…. If the evidence demonstrates that a claimant suffers symptoms or effects that cause occupational or social impairment equivalent to what would be caused by the symptoms listed in the diagnostic code, the appropriate, equivalent rating will be assigned.” *Id.* at 443.

C. *Bowling v. Principi*, 15 Vet. App. 1 (2001). In assigning a disability rating for a mental disorder, the VA must consider evidence regarding the veteran’s work history and difficulties on the job, such as lost time due to illness, altercations with supervisors, inability to concentrate and impaired memory.

IV. GAF Ratings

A. A factor highly relevant to the disability rating assigned by the VA for a mental disorder is the veteran’s Global Assessment of Functioning (“GAF”) rating or score. A GAF score represents a clinician’s judgment of an individual’s overall level of functioning with respect to psychological, social, and occupational functioning. The GAF scale ranges from 1 to 100, in increments of single digits,
with 1 representing the most severe symptoms and lowest level of functioning and 100 representing the least severe symptoms and highest level of functioning. Impairment in functioning due to physical or environmental limitations is not taken into consideration. See Diagnostic and Statistical Manual of Mental Disorders, 4th Ed., Text Revision, 32-33 (DSM-IV-TR).

B. The GAF rating has two components – symptom severity and level of functioning. If the components are discordant (symptoms warrant one score, but level of functioning warrants a different score), the GAF rating will reflect the score associated with the worse/lower component. See DSM-IV-TR at 32-33.

C. Although GAF scores do not directly correspond to disability ratings, and are not specifically discussed in 38 C.F.R. § 4.130, they constitute important evidence of the severity of a veteran’s mental disorder that must be considered and discussed by the VA when it assigns a disability rating. See Bowling v. Principi, 15 Vet. App. 1, 14-15 (2001). This is because the GAF score represents a mental health professional’s expert medical opinion of the veteran’s social and occupational impairment. Furthermore, certain scores are persuasive evidence that a particular disability rating is warranted.
See Carpenter v. Brown, 8 Vet. App. 240, 242 (1995) (veteran’s GAF scores from 55-60 represented moderate difficulty in social, occupational, or school functioning, therefore the veteran was entitled to a 50% rating, but not a 70% rating, for his mental disorder); Richard v. Brown, 9 Vet. App. 266, 267-68 (1996) (veteran’s GAF score of 50 indicated serious impairment and the veteran was entitled to a 70% disability rating for PTSD) (Note that both of these cases pre-dated the VA’s current standards for rating mental disorders).

D. The GAF Scale is as follows:

100-91 Superior functioning in a wide range of activities, life’s problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.

90-81 Absent or minimal symptoms (e.g., mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g., an occasional argument with family members).

80-71 If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g., difficulty concentrating after family argument); no more than slight impairment in social, occupational, or school functioning (e.g., temporarily falling behind in schoolwork).

70-61 Some mild symptoms (e.g., depressed mood and mild insomnia) OR some difficulty in social, occupational, or
school functioning (e.g., occasional truancy, or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships.

60-51 Moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with peers or co-workers).

50-41 Serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job).

40-31 Some impairment in reality testing or communication (e.g., speech is at times illogical, obscure, or irrelevant) OR major impairment in several areas, such as work or school, family relations, judgment, or mood (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).

30-21 Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) OR inability to function in almost all areas (e.g., stays in bed all day; no job, home, or friends).

20-11 Some danger of hurting self or others (e.g., suicide attempts without clear expectation of death; frequently violent; manic excitement) OR occasionally fails to maintain minimal personal hygiene (e.g., smears feces) OR gross impairment in communication (e.g., largely incoherent or mute).

10-1 Persistent danger of severely hurting self or others (e.g., recurrent violence) OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.
V. Special Rating Considerations for Veterans Released from Active Duty Because of a Mental Disorder due to Traumatic Stress.

A. 38 C.F.R. § 4.129 – Mental Disorders due to Traumatic Stress:

“When a mental disorder that develops in service as a result of a highly stressful event is severe enough to bring about the veteran's release from active military service, the rating agency shall assign an evaluation of not less than 50 percent and schedule an examination within the six month period following the veteran’s discharge to determine whether a change in evaluation is warranted.” (Emphasis added).

B. The VA recently recognized that § 4.129 warrants particular attention by its decision makers because of the exposure of many service members to highly stressful effects while serving in Iraq and Afghanistan. This rule generally affects veterans who were determined to be unfit for duty based on their mental disorder by the Medical Evaluation Board/Physical Evaluation Board process. See VA Fast Letter 08-08, Additional Guidance of Post Traumatic Stress Disorder, 2 (Apr. 7, 2008). Although PTSD is obviously covered by § 4.129, other mental disabilities, such as major depressive disorder,
could also be linked to a traumatic event and fall within the scope of § 4.129.

C. The VA must maintain the initial 50%-or-higher rating until evidence from a VA examination provides a basis for reconsideration. A new examination may provide the basis for an increased evaluation. However, if a reduction in the evaluation is warranted based on the results of the medical examination, the VA must follow the due process procedures outlined in 38 C.F.R. 3.105(e) unless the new, lower evaluation does not change the veteran’s overall or combined evaluation. See VA Fast Letter 08-08, at 3.

VI. Other Considerations – TDIU

A. The criteria for a 100% rating under 38 C.F.R. § 4.130 are difficult to satisfy, as total occupational and social impairment is required. The evidence of record may indicate that a veteran is unable to work due to his or her mental disorder, but is not entitled to a 100% schedular rating. In other words, although the veteran is unable to work because of his mental disorder, his or her social impairment may be considered only slight or moderate.
B. In situations where a veteran’s mental disorder prevents him or her from working, but does not warrant a 100% schedular rating, the veteran is probably entitled to a total disability rating based on individual unemployability (TDIU). The VA must assign the appropriate schedular rating and then consider the veteran’s entitlement to TDIU if the veteran claims to be unable to work due to his or her service-connected disabilities or the evidence indicates the same. See 38 C.F.R. § 4.16; VA Fast Letter 08-08 at 5.

VII. In-Service Mental Health Treatment Records

A. In-service mental health treatment records may contain information relevant to a veteran’s initial disability rating for a mental health disorder if the veteran was recently released from active duty.

B. The Department of Defense does not maintain in-service mental health treatment records with traditional service medical records. Therefore, unless such records were specifically requested by VA, separately from other service medical records, this important evidence is likely missing from the veteran’s VA claims folder. The military or civilian treating facility maintains those records and they are typically destroyed after five years from the date the case was closed at the facility. Further, if the treatment was at a civilian
facility, the records cannot be obtained by VA through the National Personnel Records Center through the Personnel Information Exchange System (“PIES”). See VA Fast Letter 08-08, at 1.

C. In order for the VA to obtain mental health treatment records from a civilian mental health facility, the veteran must complete a VA Form 21-4142, Authorization and Consent to Release Information. The VA is required to request that the veteran complete this form if a review of the claims folder indicates that the veteran underwent such treatment. See VA Fast Letter 08-08, at 1.

VIII. Advocacy Advice

A. Basic principles of proving entitlement to a certain disability rating:

In order to convince the VA to assign a particular disability rating, the advocate should explain how the evidence of the severity of the veteran’s condition closely corresponds to the criteria for that rating.

1. Point out the symptoms described in the veteran’s medical records that are specifically mentioned in 38 C.F.R. § 4.130, such as: problems with thought process, communication, speech, hygiene, impulse control, sleeping and memory; suicidal ideation; obsessional rituals; panic attacks; delusions or hallucinations; depressed mood; irritability; etc. Also point out
favorable references in the medical records to the veteran’s ability to work and maintain social relationships. Emphasize the frequency, severity, and duration of the symptoms and argue that they closely match the criteria for a particular rating.

2. Argue that the GAF score entitles the veteran to a particular disability rating. For example, if the veteran has a GAF score between 41 and 50, which represents “Serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job)”, argue that the score demonstrates that the veteran’s level of disability most closely corresponds with the criteria for a 70% rating.

3. Review the lay statements of record for evidence of occupational and social impairment. The record may contain lay evidence documenting problems at work (such as discipline reports) and marital and parenting difficulties (such as counseling records and divorce decrees). The advocate should argue that such lay evidence demonstrates social and occupational impairment commensurate with a certain disability rating.
B. **Develop supporting evidence:** The advocate should attempt to obtain medical and lay evidence supporting the veteran’s entitlement to the highest possible disability rating for his or her mental disorder.

1. To best support a claim for a high evaluation of a mental disorder, the advocate should refer the claimant to a psychiatrist. The psychiatrist should be asked to provide a statement describing the effects of the service-connected mental disability on the veteran’s ability to obtain or retain employment. The advocate should make the psychiatrist aware of the rating criteria that apply to the veteran. The psychiatrist should also be asked to provide a statement describing the extent of the veteran’s symptoms with particular attention to those specifically listed in the General Rating Formula for Mental Disorders in 38 C.F.R. § 4.130. Then the advocate should submit the expert’s credentials to the VA along with any supportive statement received from the expert.

2. If the veteran was recently released from active duty, ensure that the veteran’s mental health treatment records are associated with
the claims file. If necessary, request such records on behalf of the veteran.

3. Obtain lay statements from the veteran and the veteran’s family, friends, co-workers, and supervisors which show social and occupational impairment. Help them prepare statements recording their observations of the veteran’s difficulties at work, marital problems, trouble in relationships with family and friends, etc. For example, a statement from a supervisor that the veteran cannot be assigned customer service-related work, has difficulty maintaining focus, and has occasional outbursts could be helpful. Similarly, a statement from former employer that the veteran was fired due to behavior that is likely related to his mental disorder would be supportive.

4. Obtain lay records indicating social and occupational impairment. Interview the veteran to determine if he or she has participated in family or marital counseling. Find out if performance evaluations or disciplinary records are available from places the veteran has worked.

C. **What if the assigned rating does not adequately account for the veteran’s occupational impairment?** Two avenues that may be
pursued to obtain a higher disability rating in such circumstances are an extraschedular rating and TDIU.

1. If the disability rating for a veteran who suffers severe industrial impairment from his or her service-connected mental disorder is unsatisfactory, the advocate should consider filing a specific claim for an extraschedular rating.

2. If the evidence indicates that the veteran is unable to engage in substantially gainful employment due to his or her service-connected mental disorder, file a claim for a total disability rating based on individual unemployability under 38 C.F.R. § 4.16.

D. GAF Score Issues:

1. If an advocate believes that the veteran’s GAF score warrants a higher evaluation than the disability rating assigned by the VA, the advocate should encourage the veteran to appeal. On appeal to a Decision Review Officer or the Board of Veterans’ Appeals, the advocate should argue that the GAF score represents a medical expert’s evaluation of the veteran’s occupational and social impairment that closely approximates the higher rating and should be assigned great probative value.
2. Occasionally, in the opinion of a rating activity specialist, the objective symptomatology contained within a medical report does not support the low GAF score assigned by a medical expert. In other words, the VA believes that the objective medical evidence shows that the veteran’s disability is not as severe as the doctor has concluded with the assigned GAF score. In this situation, the VA may ignore the GAF score assigned by the doctor and rate the veteran’s disability according to the symptomatology described in the medical reports. The advocate should argue that rather than rejecting the doctor’s medical opinion represented by the GAF score, the VA should treat the examination report as being inadequate for rating purposes under and send the report back to the medical examiner to explain how he or she arrived at the medical opinion regarding the GAF score. See 38 C.F.R. § 4.1.

3. Conversely, an advocate may believe that the objective medical symptomatology establishes that the GAF score assigned by the physician is too high and does not accurately reflect the severe degree of the veteran’s disability. In such a situation, the
advocate should argue that the objective medical evidence contradicts the physician’s medical opinion.

E. Veterans Discharged From Active Service Due Because of a Mental Disorder Caused by Traumatic Stress. Advocates should pay particular attention when their client was released from active duty as the result of a mental disorder that was caused by traumatic stress.

1. The advocate should ensure that the VA assigns the veteran an initial disability rating of at least 50% for the mental disorder, pursuant to 38 C.F.R. § 4.129. Advocates should be aware that this is true, even if a military Physical Evaluation Board (“PEB”) rated the disorder less than 50% disabling. (If the PEB found that the mental disorder caused the veteran to be unfit for service, and rated the condition less than 50%, the PEB committed a legal error that should be challenged. Contact NVLSP for more information if you find a veteran in this situation).

2. The advocate should also ensure that the VA does not improperly reduce the initial rating. If the VA attempts to reduce the rating based on a post-separation examination, the VA must comply with due process requirements, if necessary, by properly notifying the veteran of the proposed reduction and providing
him or her with the opportunity for a hearing. The advocate should encourage the veteran to request a hearing because, at the very least, it will delay the rating reduction by several months.

IX. **Hypothetical Situation #1**

A. **Facts:**

1. A VA examiner diagnosed the veteran with PTSD, linked to a verified stressor, in January 2006.

2. The doctor assigned a GAF Score of 60.

3. The symptoms identified were:
   - blunted affect,
   - increased anxiety when Vietnam was mentioned (close to tears)
   - guilt feelings,
   - suicidal ideation with crying spells,
   - trouble concentrating,
   - intrusive thoughts,
   - nightmares,
   - veteran keeps to himself outside of family,
   - anxiety and depression,
   - difficulty with his marriage (he has been married 4 times).

4. A May 2007 rating decision granted the veteran service connection for PTSD, and assigned a 10% disability rating.

B. **QUESTION – How would you prepare an argument that would support a higher evaluation for PTSD?**
C. ANSWER: Based on the medical evidence, the PTSD is underestimated.

1. The veteran has social impairment. Someone with four marriages who keeps to himself has at least some social impairment.

2. This veteran has suicidal ideation, suffers from crying spells, and has trouble concentrating. These symptoms combined with his anxiety and depression show occupational impairment.

3. The veteran has “occasional decrease in work efficiency and intermittent periods of inability to perform occupational tasks.” Anyone with crying spells, anxiety, depression feelings of guilt, and sleep problems because of nightmares will have at least an occasional decrease in work efficiency and intermittent periods where they cannot perform occupational tasks, even though they are generally functioning satisfactorily.

4. Some of the veteran’s symptoms are indicative of a 70% evaluation. For example, the veteran suffers from suicidal ideation and an inability to establish and maintain effective relationships.

5. The veteran’s GAF score of 60 indicates moderate symptoms or functional impairment.
D. **NEXT ACTIONS:** The veteran should file an immediate claim for an increased rating for PTSD. If the veteran is not working, the advocate should consider filing a claim for TDIU. The RO should consider, on its own, correcting this error based on CUE. In the alternative, because there is no doubt that the 10% evaluation was clearly erroneous, the advocate should file a claim for at least a 30% evaluation from date of claim based on CUE.

X. **Hypothetical Situation #2**

A. **FACTS:**

1. In November 2008, the veteran was granted service connection for PTSD with a 50% rating, based on a VA examination report.

2. The rating decision noted the following symptoms: mood anxious, unable to do serial 7s or spell word “world” backwards. Had sleep disturbances and nightmares. He also had to check his doors before going to sleep. The GAF assigned was 45.

3. The rating decision did not mention that:
   a. The examination report found severe memory impairment for recent memory and immediate memory.
   b. The examiner stated there was not *total* social and occupational impairment.
c. The doctor said there was no deficiency in judgment.
d. There was a thinking deficiency (constant fear of dying and leaving family).
e. There was a deficiency in family relations (limited intimacy).
f. No deficiency was found in work (veteran is retired – also the RO has conceded occupational impairment).
g. Deficiency in mood (bouts of sadness, guilt, dysphoria).

B. QUESTION – How would you prepare an argument that would support a higher evaluation for PTSD?

C. ANSWER:

1. The RO assigned a 50% evaluation. Therefore, occupational and social impairment is conceded.

2. To be evaluated as 70% disabled, the veteran has to have deficiencies in most areas. The examples provided in the diagnostic code are work, school, family relations, judgment or mood. The examiner found deficiencies in family relations, mood, and thinking.

3. The school and work areas do not seem to be applicable because the veteran is not in school and is retired. However, how could
this veteran work when he has severe problems with recent and short term memory (linked to his PTSD)?

4. As noted above, the symptoms listed in General Rating Formula for Mental Disorders were not meant to be an exhaustive list or to be requirements, but, rather to serve as examples of the type and degree of the symptoms, or their effects, that would justify a particular rating. See Mauerhan.

5. Here, the veteran exhibited: obsessional rituals (checking his doors every night before going to sleep), near-continuous depression affecting the ability to function independently, appropriately and effectively; a mood disorder, a thinking disorder and severe memory problems.

6. The GAF score of 45 shows the examiner found serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) or any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job).

7. It is clear that the veteran has serious occupational impairment with deficiencies in most areas. The evaluation for the PTSD should be 70%.
D. NEXT ACTIONS: The advocate should file a Notice of Disagreement challenging the assigned rating and arguing that the VA should assign a 70% rating for the reasons cited above.