Rating Traumatic Brain Injury (TBI) disorders beginning October 2008

April Maddox, Counsel
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A. Rating Criteria for TBI beginning October 23, 2008

Effective **October 23, 2008**, Diagnostic Code (DC) 8045 was revised as follows:

NOTE: The amended DC 8045 did not make it into the 2008 Code of Federal Regulations (C.F.R.). Until the new C.F.R. is published, revised DC 8045 can only be found on-line.

8045 Residuals of traumatic brain injury (TBI):

There are three main areas of dysfunction that may result from TBI and have profound effects on functioning: cognitive (which is common in varying degrees after TBI), emotional/behavioral, and physical. Each of these areas of dysfunction may require evaluation.

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

Subjective symptoms may be the only residual of TBI or may be associated with cognitive impairment or other areas of dysfunction. Evaluate subjective symptoms that are residuals of TBI, whether or not they are part of cognitive impairment, under the subjective symptoms facet in the table titled "Evaluation of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified." However, separately evaluate any residual with a distinct diagnosis that may be evaluated under another diagnostic code, such as migraine headache or Meniere's disease, even if that diagnosis is based on subjective symptoms, rather than under the "Evaluation of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified" table.

Evaluate emotional/behavioral dysfunction under §4.130 (Schedule of ratings–mental disorders) when there is a diagnosis of a mental disorder. When there is no diagnosis of a mental disorder, evaluate emotional/behavioral symptoms under the criteria in the table titled "Evaluation of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified."

Evaluate physical (including neurological) dysfunction based on the following list, under an appropriate diagnostic code: Motor and sensory dysfunction, including pain, of the extremities and face; visual impairment; hearing loss and tinnitus; loss of sense of smell and taste; seizures; gait, coordination, and balance problems; speech and other communication difficulties, including aphasia and related disorders, and dysarthria; neurogenic bladder; neurogenic bowel; cranial nerve dysfunctions; autonomic nerve dysfunctions; and endocrine dysfunctions.

The preceding list of types of physical dysfunction does not encompass all possible residuals of TBI. For residuals not listed here that are reported on an examination, evaluate under the most appropriate diagnostic code. Evaluate each condition separately, as long as the same signs and symptoms are not used to support more than one evaluation, and combine under §4.25 the evaluations for each separately rated condition. The evaluation assigned based on the "Evaluation of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified" table will be considered the evaluation for a single condition for purposes of combining with other disability evaluations.

Consider the need for special monthly compensation for such problems as loss of use of an extremity, certain sensory impairments, erectile dysfunction, the need for aid and attendance (including for protection from hazards or dangers incident to the daily environment due to cognitive impairment), being housebound, etc.

Evaluation of Cognitive Impairment and Subjective Symptoms

The table titled "Evaluation of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified" contains 10 important facets of TBI related to cognitive impairment and subjective symptoms. It provides criteria for levels of impairment for each facet, as appropriate, ranging from 0 to 3, and a 5th level, the highest level of impairment, labeled "total." However, not every facet has every level of severity. The Consciousness facet, for example, does not provide for an impairment level other than "total," since any level of impaired consciousness would be totally disabling. Assign a 100-percent evaluation if "total" is the level of evaluation for one or more facets. If no facet is evaluated as "total," assign the overall percentage evaluation based on the level of the highest facet as follows: 0 = 0 percent; 1 = 10 percent; 2 = 40 percent; and 3 = 70 percent. For example, assign a 70 percent evaluation if 3 is the highest level of evaluation for any facet.

Note (1): There may be an overlap of manifestations of conditions evaluated under the table titled "Evaluation Of Cognitive Impairment And Other Residuals Of TBI Not Otherwise Classified" with manifestations of a comorbid mental or neurologic or other physical disorder that can be separately evaluated under another diagnostic code. In such cases, do not assign more than one evaluation based on the same manifestations. If the manifestations of two or more conditions cannot be clearly separated, assign a single evaluation under whichever set of diagnostic criteria allows the better assessment of overall impaired functioning due to both conditions. However, if the manifestations are clearly separable, assign a separate evaluation for each condition.

Note (2): Symptoms listed as examples at certain evaluation levels in the table are only examples and are not symptoms that must be present in order to assign a particular evaluation.

Note (3): "Instrumental activities of daily living" refers to activities other than self-care that are needed for independent living, such as meal preparation, doing housework and other chores, shopping, traveling, doing laundry, being responsible for one's own medications, and using a telephone. These activities are distinguished from

"Activities of daily living," which refers to basic self-care and includes bathing or showering, dressing, eating, getting in or out of bed or a chair, and using the toilet.

Note (4): The terms "mild," "moderate," and "severe" TBI, which may appear in medical records, refer to a classification of TBI made at, or close to, the time of injury rather than to the current level of functioning. This classification does not affect the rating assigned under diagnostic code 8045

Note (5): A veteran whose residuals of TBI are rated under a version of § 4.124a, diagnostic code 8045, in effect before October 23, 2008 may request review under diagnostic code 8045, irrespective of whether his or her disability has worsened since the last review. VA will review that veteran's disability rating to determine whether the veteran may be entitled to a higher disability rating under diagnostic code 8045. A request for review pursuant to this note will be treated as a claim for an increased rating for purposes of determining the effective date of an increased rating awarded as a result of such review; however, in no case will the award be effective before October 23, 2008. For the purposes of determining the effective date of an increased rating awarded as a result of such review, VA will apply 38 CFR 3.114, if applicable.

B. TBI VA Examination Worksheet

Name:	SSN:
Date of Exam:	C-number:
Place of Exam:	

Narrative: The potential residuals of traumatic brain injury necessitate a comprehensive examination to document all disabling effects. Specialist examinations, such as eye and audio examinations, mental disorder examinations, and others, may also be needed in some cases, as indicated below. If possible, conduct a thorough review of the service and post-service medical records prior to the examination.

Health care providers who may conduct TBI examinations: Physicians who are specialists in Physiatry, Neurology, Neurosurgery, and Psychiatry and who have training and experience with Traumatic Brain Injury may conduct TBI examinations. The expectation is that the physician would have demonstrated expertise, regardless of specialty, through baseline training (residency) and/or subsequent training and demonstrated experience. In addition, a nurse practitioner, a clinical nurse specialist, or a physician assistant, if they are clinically privileged to perform activities required for C&P TBI examinations, and have evidence of expertise through training and demonstrated experience, may conduct TBI examinations under close supervision of a board-certified or board-eligible physiatrist, neurologist, or psychiatrist.

A. Review of Medical Records:

B. Medical History (Subjective Complaints):

1. Report date(s) and nature of injury.
2. State severity rating of traumatic brain injury (TBI) at time of injury.
3. State whether condition has stabilized. If not, provide estimate of when stability may be expected (typically within 18-24 months of initial injury).
4. Inquire specifically about each symptom or area of symptoms below, since individuals with TBI may have difficulty organizing and communicating their symptoms without prompting. It is important to document all problems, whether subtle or pronounced, so that the veteran can be appropriately evaluated for all disabilities due to TBI.

For each of the following symptoms that is present, answer specific questions asked.

a. headaches - frequency, severity, duration, and if they most resemble migraine, tension-type, or cluster headaches
b. dizziness or vertigo - frequency
c. weakness or paralysis - location
d. sleep disturbance - type and frequency
e. fatigue - severity
f. malaise
g. mobility - state symptoms

h. balance - state any problems
i. if ambulatory, what device, if any, is needed to assist walking?
j. memory impairment - mild, moderate, severe
k. other cognitive problems Y/N? If yes, which?:

    i. Decreased attention
    ii. Difficulty concentrating
    iii. Difficulty with executive functions (speed of information processing, goal setting, planning, organizing, prioritizing, self-monitoring, problem solving, judgment, decision making, spontaneity, and flexibility in changing actions when they are not productive)
    iv. Other - describe

l. speech or swallowing difficulties - severity and specific type of problem - expressive aphasia?, difficulty with articulation because of injuries to mouth?, aspiration due to difficulty swallowing?, etc.
m. pain - frequency, severity, duration, location, and likely cause
n. bowel problems - extent and frequency of any fecal leakage and frequency of need for pads, if used; need for assistance in evacuating bowel (manual evaluation, suppositories, rectal stimulation, etc.) - report type and frequency of need for assistance.
o. bladder problems - report the type of impairment (incontinence, urgency, urinary retention, etc.) and the measures needed: catheterization - constant or intermittent?, pads (must be changed how often per day?), other - describe).
p. psychiatric symptoms
   mood swings
   anxiety
   depression
   other - describe
q. erectile dysfunction - If present, state most likely cause and whether vaginal penetration with ejaculation is possible. State type of treatment and if it is effective in allowing intercourse.
r. sensory changes, such as numbness or paresthesias - location and type
s. vision problems, such as blurred or double vision- describe
t. hearing problems, tinnitus - describe
u. decreased sense of taste or smell - <u>if present, follow examination protocol for Sense of Smell and Taste</u>
v. seizures - type and frequency
w. hypersensitivity to sound or light - describe
x. neurobehavioral symptoms
   irritability
   restlessness
   other - describe
y. symptoms of autonomic dysfunction, such as heat intolerance, excess or decreased sweating, etc.
z. other symptoms, including symptoms of endocrine dysfunction or cranial nerve dysfunction - describe

5. Report course of symptoms - are they improving, worsening in severity or frequency, or stable?

6. List current treatments, condition for which each treatment is being given, response to treatment, and side effects.
7. Describe any effects on routine daily activities or employment.

C. Physical Examination (Objective Findings):

Address each of the following and fully describe current findings:

1. **Motor function.** Report the motor strength of the affected muscles of all areas of weakness or paralysis using the standard muscle grading scale, for example, weakness of flexion of left elbow (3/5 strength for flexors), complete paralysis of left lower extremity (0/5 for all muscle groups). To the extent possible, identify the peripheral nerves that innervate the weakened or paralyzed muscles, even when the weakness or paralysis is of central origin.

   Standard muscle grading scale:
   0 = Absent No muscle movement felt.
   1 = Trace Muscle can be felt to tighten, but no movement produced.
   2 = Poor Muscle movement produced only with gravity eliminated.
   3 = Fair Muscle movement produced against gravity, but cannot overcome any resistance.
   4 = Good Muscle movement produced against some resistance, but not against "normal" resistance.
   5 = Normal Muscle movement can overcome "normal" resistance

2. **Muscle tone, reflexes.** Describe any muscle atrophy or loss of muscle tone. Examine and report deep tendon reflexes and any pathological reflexes.

3. **Sensory function.** Describe exact location of any area of abnormal sensory function. State which modalities of sensation were tested. Identify the peripheral nerve(s) that innervate the areas with abnormal sensation.

4. **Gait, spasticity, cerebellar signs.** Describe any gait abnormality, imbalance, tremor or fasciculations, incoordination, or spasticity. If there is spasticity or rigidity, assess any limitation of motion of joint (including joint contracture) by following the Joints examination protocol. (A tandem gait assessment (walking in a straight line with one foot directly in front of the other) is recommended.)

5. **Autonomic nervous system.** Describe any other impairment of the autonomic nervous system, such as orthostatic (postural) hypotension (if present, state if associated with dizziness or syncope on standing), hyperhidrosis, delayed gastric emptying, heat intolerance, etc.

6. **Cranial nerves.** Conduct a screening exam for cranial nerve impairment. If positive, follow Cranial Nerves examination protocol.

7. **Cognitive impairment.** Conduct a screening examination (such as the Montreal Cognitive Assessment (MOCA) or Mini-Mental State Examination (MMSE)) to assess cognitive impairment and report results and their significance. Does the screening show problems with memory, concentration, attention, executive functions, etc.? If yes, neuropsychological testing to confirm the presence and extent of cognitive impairment is needed, unless already conducted and of record. Include test results in the examination report.

8. **Psychiatric manifestations.** Conduct a screening examination for psychiatric manifestations, including neurobehavioral effects. If a mental disorder is suggested, request a mental disorder exam or PTSD exam, as appropriate, by a mental disease specialist.

9. **Vision and hearing** screening examinations (If abnormalities are found, or there are symptoms or a claim of eye or ear impairment, request an eye or audio exam by a specialist.)

10. **Skin.** Describe any areas of skin breakdown due to neurologic problems.

11. **Endocrine dysfunction.** If evidence of endocrine function is identified or suspected, select and follow the additional appropriate examination protocol for the type of endocrine disorder identified.

12. **Autonomic dysfunction.** Report any symptoms of autonomic dysfunction, such as heat intolerance, excess or decreased sweating, etc.

13. **Other** abnormal physical findings

14. **Assessment of cognitive impairment and other residuals of TBI not otherwise classified:**

Instruction: Answer the following specific questions about each of the following items (after completion of neuropsychological testing, if done). State on the examination report which of the choices best describes each of the items. Do not report by using the number of the item or the letter of the description. Report the title of the item: "Memory, attention, concentration, executive functions," etc., and then state the correct description, e.g., " There is objective evidence on testing of mild impairment of memory (and/or attention, and/or concentration, and/or executive functions) resulting in mild functional impairment."

I. Memory, attention, concentration, executive functions

a. No complaints of impairment of memory, attention, concentration, or executive functions.
b. A complaint of mild memory loss (such as having difficulty following a conversation, recalling recent conversations, remembering names of new acquaintances, or finding words, or often misplacing items), attention, concentration, or executive functions, but without objective evidence on testing.
c. Objective evidence on testing of mild impairment of memory, attention, concentration, or executive functions resulting in mild functional impairment.
d. Objective evidence on testing of moderate impairment of memory, attention, concentration, or executive functions resulting in moderate functional impairment.
e. Objective evidence on testing of severe impairment of memory, attention, concentration, or executive functions resulting in severe functional impairment.

II. Judgment

a. Normal.
b. Mildly impaired judgment. For complex or unfamiliar decisions, occasionally unable to identify, understand, and weigh the alternatives, understand the consequences of choices, and make a reasonable decision.
c. Moderately impaired judgment. For complex or unfamiliar decisions, usually unable to identify, understand, and weigh the alternatives, understand the consequences of choices, and make a reasonable decision, although has little difficulty with simple decisions.

d. Moderately severely impaired judgment. For even routine and familiar decisions, occasionally unable to identify, understand, and weigh the alternatives, understand the consequences of choices, and make a reasonable decision.
e. 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.

III. Social interaction

a. Social interaction is routinely appropriate
b. Social interaction is occasionally inappropriate.
c. Social interaction is frequently inappropriate.
d. Social interaction is inappropriate most or all of the time.

IV. Orientation

a. Always oriented to person, time, place, and situation.
b. Occasionally disoriented to one of the four aspects (person, time, place, situation) of orientation.
c. Occasionally disoriented to two of the four aspects (person, time, place, situation) of orientation or often disoriented to one aspect of orientation.
d. Often disoriented to two or more of the four aspects (person, time, place, situation) of orientation.
e. Consistently disoriented to two or more of the four aspects (person, time, place, situation) of orientation.

V. Motor activity (with intact motor and sensory system)

a. Motor activity normal.
b. Motor activity normal most of the time, but mildly slowed at times due to apraxia (inability to perform previously learned motor activities, despite normal motor function).
c. Motor activity mildly decreased or with moderate slowing due to apraxia.
d. Motor activity moderately decreased due to apraxia.
e. Motor activity severely decreased due to apraxia.

VI. Visual spatial orientation

a. Normal.
b. Mildly impaired. Occasionally gets lost in unfamiliar surroundings, has difficulty reading maps or following directions. Is able to use assistive devices such as GPS (global positioning system).
c. Moderately impaired. Usually gets lost in unfamiliar surroundings, has difficulty reading maps, following directions, and judging distance. Has difficulty using assistive devices such as GPS (global positioning system).
d. Moderately severely impaired. Gets lost even in familiar surroundings, unable to use assistive devices such as GPS (global positioning system).

e. Severely impaired. May be unable to touch or name own body parts when asked by the examiner, identify the relative position in space of two different objects, or find the way from one room to another in a familiar environment.

VII. Subjective symptoms

a. Subjective symptoms that do not interfere with work; instrumental activities of daily living; or work, family, or other close relationships. Examples are: mild or occasional headaches, mild anxiety.
b. Three or more subjective symptoms that mildly interfere with work; instrumental activities of daily living; or work, family, or other close relationships. Examples of findings that might be seen at this level of impairment are: intermittent dizziness, daily mild to moderate headaches, tinnitus, frequent insomnia, hypersensitivity to sound, hypersensitivity to light.
c. Three or more subjective symptoms that moderately interfere with work; instrumental activities of daily living; or work, family, or other close relationships. Examples of findings that might be seen at this level of impairment are: marked fatigability, blurred or double vision, headaches requiring rest periods during most days.

VIII. Neurobehavioral effects

a. One or more neurobehavioral effects that do not interfere with workplace interaction or social interaction. Examples of neurobehavioral effects are: irritability, impulsivity, unpredictability, lack of motivation, verbal aggression, physical aggression, belligerence, apathy, lack of empathy, moodiness, lack of cooperation, inflexibility, and impaired awareness of disability. Any of these effects may range from slight to severe, although verbal and physical aggression are likely to have a more serious impact on workplace interaction and social interaction than some of the other effects.
b. One or more neurobehavioral effects that occasionally interfere with workplace interaction, social interaction, or both but do not preclude them.
c. One or more neurobehavioral effects that frequently interfere with workplace interaction, social interaction, or both but do not preclude them.
d. One or more neurobehavioral effects that interfere with or preclude workplace interaction, social interaction, or both on most days or that occasionally require supervision for safety of self or others.

IX. Communication

a. Able to communicate by spoken and written language (expressive communication), and to comprehend spoken and written language.
b. Comprehension or expression, or both, of either spoken language or written language is only occasionally impaired. Can communicate complex ideas.
c. 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.
d. 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.

e. 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.

X. Consciousness

a. Normal
b. Persistently altered state of consciousness, such as vegetative state, minimally responsive state, coma.

Other comments.
NOTE: To clarify Item VII above: "Instrumental activities of daily living" refers to activities other than self-care that are needed for independent living, such as meal preparation, doing housework and other chores, shopping, traveling, doing laundry, being responsible for one's own medications, and using a telephone. These activities are distinguished from "Activities of daily living," which refer to basic self-care and include bathing or showering, dressing, eating, getting in or out of bed or a chair, and using the toilet.

D. Diagnostic and Clinical Tests:

1. Skull X-rays to measure bony defect, if any, due to surgery or injury.
2. Include results of all diagnostic and clinical tests conducted in the examination report.

E. Diagnosis:

1. List each diagnosis.

2. Capacity to manage financial affairs
   Mental competency, for VA benefits purposes, refers only to the ability of the veteran to manage VA benefit payments in his or her own best interest, and not to any other subject. Mental incompetency, for VA benefits purposes, means that the veteran, because of injury or disease, is not capable of managing benefit payments in his or her best interest. In order to assist raters in making a legal determination as to competency, please address the following:

a. What is the impact of injury or disease on the veteran's ability to manage his or her financial affairs, including consideration of such things as knowing the amount of his or her VA benefit payment, knowing the amounts and types of bills owed monthly, and handling the payment prudently? Does the veteran handle the money and pay the bills himself or herself?
b. Based on your examination, do you believe that the veteran is capable of managing his or her financial affairs? Please provide examples to support your conclusion. If you believe a Social Work Service assessment is needed before you can give your opinion on the veteran's ability to manage his or her financial affairs, please explain why.

3. **Note**: When a mental disorder is present, state, or ask the mental disorders examiner to state, to the extent possible, which emotional/behavioral signs and symptoms are part of a co-morbid mental disorder and which represent residuals of TBI. If it is impossible to make such a determination without speculation, so state.

Signature: Date:

C. TBI Facet Worksheet

	0	1	2	3	Total
Memory, Attention, concentration, executive functions	no complaints of impairment of memory, attention, concentration, executive functions.	A complaint of mild loss of memory (such as difficulty following a conversation, recalling recent conversations, remembering names of new acquaintances, or finding words, or misplacing items), attention, concentration, or executive functions w/o objective evidence on testing.	Objective evidence on testing of mild loss of memory, attention, concentration executive functions resulting in mild functional impairment	Objective evidence on testing of moderate loss of memory, attention, concentration executive functions resulting in moderate functional impairment	Obj. evidence on testing of severe impairment resulting in severe functional impairment.
Judgment	Normal	mildly impaired judgment. For complex or unfamiliar decisions occasionally unable to identify understand and weigh the alternatives, understand the consequences of choices and make a reasonable decision	moderately impaired judgment. For complex or. unfamiliar decisions occasionally unable to identify understand and weigh the alternatives, understand the consequences of choices and make a reasonable decision Although has little difficulty with simple decisions	Moderately severe impaired judgment for even routine and familiar decisions, occasionally unable to identify, understand and weigh the alternatives, understand the consequences of choices and make a reasonable decision	Severely impaired judgment. For even routine and familiar decisions usually unable to identify understand and weigh alternatives. Understands consequences .eg. Unable choose clothes for current weather conditions.
Social Interaction	appropriate	occasionally inappropriate	frequently inappropriate	inappropriate most of all of the time	N/A
Orientation	always oriented to person, time place and situation	occasionally disoriented to 1 of 4 phases	occasionally disoriented to 2 of 4	often disoriented to 2 or more phases	Consistently disoriented to 2 or more phases.
Motor activity (with intact motor and sensory systems)	normal	normal most of time, but mildly slowed at times due to apraxia	mildly decreased or with moderate slowing due to apraxia	moderately decreased due to apraxia	Motor activity severely decreased due to apraxia

Visual Spatial Orientation	normal	mildly impaired. Occasionally gets lost in unfamiliar settings, has difficulty reading maps or following directions. Is able to use GPS	Moderately impaired. Usually gets lost in unfamiliar settings. Has difficulty reading maps following directions and judging distance. Has difficulty using GPS	Moderately severe. Gets lost even in familiar settings. Unable to use GPS	Severe. May be unable to touch or name own body parts when asked by Dr, identity the relative position of 2 objects.
Subjective Sx	Sx that do not interfere w/ work; instrumental ADLs; or work, family or other close relationships e.g. mild or occasional headaches or mild anxiety	3 or more Sx that mildly interfere w/ work; instrumental ADLs, work, family or close relationships e.g. dizziness, daily mild to mod headaches tinnitus, frequent insomnia, hypersensitive to light or sound	3 or more Sx that moderately interfere w/work instrumental ADLs, work, family or close relationships e.g. marked fatigability, blurred or double vision, headaches requiring rest periods during most days.	N/A	N/A
Neurobehavioral Effects	1 or more neurobehavioral effects that do not interfere with workplace or social interaction. e . g . irritability , impulsivity unpredictability, lack of motivation verbal or physical aggression, apathy moodiness, lack of cooperation inflexibility and impaired awareness of disability	1 or more neurobehavioral effects that occasionally interfere with workplace interaction social interaction or both but do not preclude them	1 or more neurobehavioral effects that frequently interfere with work p l ace interaction, social interaction or both but do not preclude them	1 or more neurobehavioral effects that interfere with or preclude workplace interaction, social interaction or both on most days or that occasionally require for safety of self or others	N/A
Communication	Able to communicate by spoken or language (expressive communication) and to comprehend spoken and written language	Comprehension or expression, or both, of either spoken or written language is only occasionally impaired. Can communicate complex ideas.	Inability to communicate either by spoken or written language, or both , more than occasionally, but less than 1/2 the time. Or to comprehend spoken language, written language or both more than occasionally but less than 1/2 the time. Can generally communicate complex ideas.	Inability y to communicate either by spoken or written language, or both, at least ½ the time, but not all the time; or to comprehend spoken language, written language or both at least 1/2 the time, but not all the time. May rely on gestures or other alternative modes of communication. Able to communicate basic needs.	Compete inability to
Consciousness	N/A	N/A	N/A	N/A	persistently altered slate of consciousness, such as vegetative state, minimally responsive state, coma.

D. TBI Text Generator

HTTP://10.220.1.4/BL/21/TBI/DEFAULT.ASP

Evaluation of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified

Note: Physical and/or emotional/behavioral disabilities that are determined to be residuals of traumatic brain injury are evaluated separately.

Please select from the choices below, then click "Submit" to generate your text.

Facets	Criteria					
Memory, Attention, Concentration, Executive Functions	0 ○	1 ○	2 ○	3 ○	Total ○	N/A ◉
Judgment	0 ○	1 ○	2 ○	3 ○	Total ○	N/A ◉
Social Interaction	0 ○	1 ○	2 ○	3 ○		N/A ◉
Orientation	0 ○	1 ○	2 ○	3 ○	Total ○	N/A ◉
Motor Activity (with intact motor and sensory system)	0 ○	1 ○	2 ○	3 ○	Total ○	N/A ◉
Visual Spatial Orientation	0 ○	1 ○	2 ○	3 ○	Total ○	N/A ◉
Subjective Symptoms	0 ○	1 ○	2 ○			N/A ◉
Neurobehavioral Effects	0 ○	1 ○	2 ○	3 ○		N/A ◉
Communication	0 ○	1 ○	2 ○	3 ○	Total ○	N/A ◉

Consciousness					Total ○	N/A ◉

Submit Reset

Please contact the **webmaster** for any questions or suggestions regarding this site.

C&P Service Internet | VBA Internet | VA Internet

E. Practical Considerations

1. Adequacy of VA examination

Make sure the appropriate examination worksheet has been completed. It is recommended that you review the actual VA examination and the VA examination worksheet side by side. You may have to go back and forth with the VA examiner several times at first to make sure the report is adequate.

http://vbaw.vba.va.gov/bl/21/rating/Medical/exams/disexm58.htm

Also, make sure that competency is addressed and look to see if neuropsychiatric testing has been completed.

2. Overlapping symptoms

An emphasis under the new 8045 is that, if the disability manifests in two (or more) different disabilities, then two (or more) separate ratings should be assigned. Tropf v. Nicholson, 20 Vet. App. 317 (2006); Smith v. Nicholson, 19 Vet. App. 63 (2005); Esteban v. Brown, 6 Vet. App. 259 (1994). However, see Note (1):

> **Note (1):** There may be an overlap of manifestations of conditions evaluated under the table titled "Evaluation Of Cognitive Impairment And Other Residuals Of TBI Not Otherwise Classified" with manifestations of a comorbid mental or neurologic or other physical disorder that can be separately evaluated under another diagnostic code. In such cases, do not assign more than one evaluation based on the same manifestations. If the manifestations of two or more conditions cannot be clearly separated, assign a single evaluation under whichever set of diagnostic criteria allows the better assessment of overall impaired functioning due to both conditions. However, if the manifestations are clearly separable, assign a separate evaluation for each condition.

Training Letter 09-01 provides a table which contains "…examples of situations that may be encountered in rating veterans with TBI when behavioral/emotional symptoms are present and offers guidelines on their evaluation." That table should be utilized when granting service connection for residuals of traumatic brain injury

3. Claims filed prior to October 23, 2008

- Use the revised DC 8045 for claims filed prior to October 23, 2008 if the veteran requests review under the new criteria.

- Consider 38 C.F.R. 3.114(a) when appropriate. Section 3.114(a) refers to claims being reviewed "…on the initiative of VA…"

4. Boilerplate for available evaluations under diagnostic code 8045: 0, 10, 40, 70,

and 100 percent.
The "RBI Text Generator" does **not** generate the criteria for the next higher evaluation.

Where a veteran has specifically requested an increase in the evaluation assigned for his service connected disability, the adjudicator has an obligation to explain why symptoms comported with the criteria for the determined rating, but not with the criteria for higher disability rating(s). *Shoemaker v. Derwinski*, 3 Vet. App. 248 (1992). A claimant will be presumed to be seeking the maximum benefit allowed by law on a claim for an original or increased rating. *AB v. Brown*, 6 Vet. App. 35 (1998).

"If a higher evaluation is possible under a particular diagnostic code (DC), discuss the criteria for the next higher evaluation." M21-1MR, Part III, Subpart iv, Chapter 6, Section C, Block 11, Topic c.

Suggested boilerplate:

> Ratings for cognitive impairment and other residuals of traumatic brain injury not otherwise classified are based on a table of 10 important facets related to cognitive impairment and subjective symptoms. A 100 percent evaluation is assigned if "total" is the level of evaluation for one or more facets. If no facet is "total," then the overall percentage evaluation is based on the highest facet. A 70 percent evaluation is assigned if "3" is the highest level of evaluation for any facet. If the highest level of evaluation for any facet is "2," then the appropriate disability rating is 40 percent. A 10 percent evaluation is warranted when the highest level of evaluation for any facet is "1." Finally, a noncompensable (0 percent) rating is assigned when the level of the highest facet is "0."

5. How to assign 0/A, 1/B, 2/C, or 3/D or "total"/E to each facet

Per Fast Letter 08-34, VA examiners are instructed to:

> Answer the following specific questions about each of the following items (after completion of neuropsychological testing, if done). State on the examination report which of the choices best describes each of the items. Do not report by using the number of the item or the letter of the description. Report the title of the item: "Memory, attention, concentration, executive functions," etc., and then state the correct description, e.g., " There is objective evidence on testing of mild impairment of memory (and/or attention, and/or concentration, and/or executive functions) resulting in mild functional impairment."

As an example, for memory, attention, concentration, and executive functions, the examiner is to choose one of the following:

a. No complaints of impairment of memory, attention, concentration, or executive functions.
b. A complaint of mild memory loss (such as having difficulty following a conversation, recalling recent conversations, remembering names of new acquaintances, or finding words, or often misplacing items), attention, concentration, or executive functions, but without objective evidence on testing.
c. Objective evidence on testing of mild impairment of memory, attention, concentration, or executive functions resulting in mild functional impairment.
d. Objective evidence on testing of moderate impairment of memory, attention, concentration, or executive functions resulting in moderate functional impairment.
e. Objective evidence on testing of severe impairment of memory, attention, concentration, or executive functions resulting in severe functional impairment.

Per diagnostic code 8045:

Memory, attention, concentration, executive functions	0	No complaints of impairment of memory, attention, concentration, or executive functions.
	1	A complaint of mild loss of memory (such as having difficulty following a conversation, recalling recent conversations, remembering names of new acquaintances, or finding words, or often misplacing items), attention, concentration, or executive functions, but without objective evidence on testing.
	2	Objective evidence on testing of mild impairment of memory, attention, concentration, or executive functions resulting in mild functional impairment.
	3	Objective evidence on testing of moderate impairment of memory, attention, concentration, or executive functions resulting in moderate functional impairment.
	Total	Objective evidence on testing of severe impairment of memory, attention, concentration, or executive functions resulting in severe functional impairment.

From the RBI 2000 Text Generator:

Memory, Attention, Concentration, Executive Functions	0 ○	1 ○	2 ○	3 ○	Total ○	N/A ◉

So, in simplest terms, if the examiner defines one TBI residual as no complaint of impairment of memory, attention, concentration, or executive function, she or he has selected "a." For rating purposes "a" equals 0, "b" equals 1, "c" equals 2, "d" equals 3, and "e" equals total.

Therefore, in a sense, the criteria under 8045 can now be considered analogous to rating hearing impairment; that is, a VA examiner is assigning letters which raters convert to numeric designations for certain effects/facets of TBI.

However, from Fast Letter 08-36 (emphasis added):

> "The rater assigns the appropriate score from 0 to "total" for each facet, based on the information about the severity of the impairment for each facet that has been provided on the disability examination report by the examiner, *as well as other relevant evidence of record*."

Using the example above, under what circumstances does a rater have for "changing" a letter designation assigned by a VA examiner which results in a higher or lower evaluation?

Independent medical evidence is required to support findings of a factual nature. VA decisionmakers must support medical findings with independent medical evidence and may not refute expert medical conclusions based on unsubstantiated opinion. *Winsett v. West*, 11 Vet. App. 420 (1998); *Flash v. Brown*, 8 Vet. App, 332 (1995); *Shipwash v. Brown*, 8 Vet. App. 218 (1995); *Allday v. Brown*, 7 Vet. App. 517 (1995); *Colvin v. Derwinski*, 1 Vet. App. 171 (1991).

VA medical records, including examination reports, do not enjoy a higher degree of probative value simply because they are generated by VA. In cases involving multiple medical opinions, each medical opinion should examined, analyzed, and discussed for corroborative value. *Curtis v. Brown*, 8 Vet. App. 104 (1995). However, it is acceptable to rely upon a VA physician's opinion over the opinion of private examiners when the VA examiner reviewed the claimant's file and other evidence, and the private physicians relied on a history that conflicts with the history in the claims file and/or materially relied on the claimant's unsupported history as the premise for the opinion. *Evans v. West*, 12 Vet. App. 22 (1998); *Owens v. Brown*, 7 Vet. App. 429 (1995); *Wood v. Derwinski*, 1 Vet. App. 190 (1991).

F. Sample: TBI VA Examination and Rating Decision

February 2009 VAX from Salt Lake VA Medical Center

1. Memory, attention, concentration, and executive functions: The Veteran is classified as C with objective evidence of testing of mild impairment of memory, attention, and concentration. Executive function appears to be normal.
2. Judgment: After review of the above information and review of the Veteran's medical records, it is the examiner's opinion that his judgment is normal.
3. Social interaction: It is the examiner's opinion that the Veteran's social interaction is frequently inappropriate. This tends to occur on a daily basis, particularly after he has been working at the Veteran's administration hospital all day. He is fatigued when he returns home and demonstrates significant anger and irritability toward his wife and family and friends.
4. Orientation: This examiner concludes that the Veteran was occasionally disoriented to one of the four aspects (person, time, place, situation) or orientation.
5. Motor activity: It is the examiner's opinion that the Veteran's motor activity is generally quite normal. One must point out, however, the recurrent facial and head tics and mannerisms the Veteran demonstrates. There are very disconcerting to him and become more evident when he is anxious and tense.
6. Visual special orientation: This examiner determines that this aspect of testing is normal.
7. Subjective symptoms: This Veteran clearly has three or more subjective symptoms that mildly interfere with work, instrumental activities of daily living, family, and other close relationships. These include the intermittent dizziness the Veteran complains of, the frequent headaches, tinnitus, hypersensitivity to sound and to light.
8. Neural behavior effects: The Veteran clearly demonstrates one or more neural behavior effects that occasionally interfere with work place interaction, social interaction, or both, but do not preclude them. There are discussed above in the Veteran's social interaction.
9. Communication: The Veteran demonstrates occasional impairment of comprehension and expression of both spoken and written language. The Veteran, however, is capable of communicating complex ideas.
10. Consciousness: This is normal. The Veteran has had no episodes of loss of consciousness since his discharge from active duty.

April 2009 Rating Decision from Salt Lake Regional Office

The evaluation assigned is based upon the highest level of severity for any facet of cognitive impairment and other residuals of traumatic brain injury (TBI) not otherwise classified as determined on examination. Only one evaluation is assigned for all the applicable facets. A higher evaluation is not warranted unless a higher level of severity for a facet is established on examination. Physical and/or emotional/behavioral

disabilities found on examination that are determined to be residuals of traumatic brain injury are evaluated separately.

A level of severity of "2" has been assigned for the Memory, attention, concentration, executive functions facet, indicating that an examiner has found evidence such as objective evidence on testing of mild impairment of memory, attention, concentration, or executive functions resulting in mild functional impairment. A higher level of severity of "3" is not warranted unless an examiner finds evidence such as objective evidence on testing of moderate impairment of memory, attention, concentration, or executive functions resulting in moderate functional impairment.

A level of severity of "0" has been assigned for the Judgment facet, indicating that an examiner has found evidence of normal judgment. A higher level of severity of "1" is not warranted unless an examiner finds evidence of mildly impaired judgment, including symptoms such as for complex or unfamiliar decisions, occasionally unable to identify, understand, and weigh the alternatives, understand the consequences of choices, and make a reasonable decision.

A level of severity of "2" has been assigned for the Social interaction facet, indicating that an examiner has found evidence that social interaction is frequently inappropriate. A higher level of severity of "3" is not warranted unless an examiner finds evidence that social interaction is inappropriate most or all of the time.

A level of severity of "1" has been assigned for the Orientation facet, indicating that an examiner has found evidence such as occasionally disoriented to one of the four aspects (person, time, place, situation) of orientation. A higher level of severity of "2" is not warranted unless an examiner finds evidence such as occasionally disoriented to two of the four aspects (person, time, place, situation) of orientation or often disoriented to one aspect of orientation.

A level of severity of "0" has been assigned for the Motor activity (with intact motor and sensory system) facet, indicating that an examiner has found evidence of motor activity normal. A higher level of severity of "1" is not warranted unless an examiner finds evidence such as motor activity normal most of the time, but mildly slowed at times due to apraxia (inability to perform previously learned motor activities, despite normal motor function).

A level of severity of "0" has been assigned for the Visual spatial orientation facet, indicating that an examiner has found evidence of normal. A higher level of severity of "1" is not warranted unless an examiner finds evidence such as mildly impaired. Occasionally gets lost in unfamiliar surroundings, has difficulty reading maps or following directions. Is able to use assistive devices such as GPS (global positioning system).

A level of severity of "1" has been assigned for the Subjective symptoms facet, indicating that an examiner has found evidence of three or more subjective symptoms that mildly

interfere with work; instrumental activities of daily living; or work, family, or other close relationships. Examples of findings that might be seen at this level of impairment are: intermittent dizziness, daily mild to moderate headaches, tinnitus, frequent insomnia, hypersensitivity to sound, hypersensitivity to light. A higher level of severity of "2" is not warranted unless an examiner finds evidence of three or more subjective symptoms that moderately interfere with work; instrumental activities of daily living; or work, family, or other close relationships. Examples of findings that might be seen at this level of impairment are: marked fatigability, blurred or double vision, headaches requiring rest periods during most days.

A level of severity of "1" has been assigned for the Neurobehavioral effects facet, indicating that an examiner has found evidence of one or more neurobehavioral effects that occasionally interfere with workplace interaction, social interaction, or both but do not preclude them. A higher level of severity of "2" is not warranted unless an examiner finds evidence of one or more neurobehavioral effects that frequently interfere with workplace interaction, social interaction, or both but do not preclude them.

A level of severity of "1" has been assigned for the Communication facet, indicating that an examiner has found evidence such as comprehension or expression, or both, of either spoken language or written language is only occasionally impaired. Can communicate complex ideas. A higher level of severity of "2" is not warranted unless an examiner finds evidence such as 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.

The evaluation assigned for cognitive impairment and other residuals of TBI not otherwise classified is based upon the highest level of severity for any facet as determined by examination. Only one evaluation is assigned for all the applicable facets. The evaluation assigned is 40 percent based upon the highest severity level of "2," which was assigned for the following facets: memory, attention, concentration, executive functions; social interaction.

G. References

- Training Letter 06-03 (February 13, 2006) (Rating Traumatic Brain Injury Cases).
- Training Letter 07-05 (Evaluating Residuals of Traumatic Brain Injury) (parts of which were superseded by Training Letter 09-01).
- Fast Letter 07-21 (Traumatic Brain Injury (TBI) worksheet) (Rescinded by FL 09-32 on 07-22-09).
- Federal Register: January 3, 2008 (Volume 73, Number 2, pages 432-438).
- Federal Register: September 23, 2008 (Volume 73, Number 185, pages 54693-54708).
- RBA2000 Reference Guide – TBI (October 2008). The "TBI Text Generator" tool is used to for evaluating cognitive impairment and other residuals of TBI not otherwise classified.
- Fast Letter 08-34 (October 10, 2008) (contains the TBI disability examination worksheet).
- Fast Letter 08-36 (October 24, 2008) (Final Rule: Schedule for Rating Disabilities; Evaluation of Residuals of Traumatic Brain Injury (TBI)).
- Fast Letter 09-02 (February 18, 2009) (Subject: Traumatic Brain Injury (TBI) Outreach Letter).
- Training Letter 09-01 (January 21, 2009) (Subject: Evaluating Residuals of Traumatic Brain Injury under Revised Criteria).