TRAUMATIC BRAIN INJURY

A. Medical Overview

1. What is a traumatic brain injury (TBI)?

- A TBI is the residual disability resulting from a "TBI event." The residual disability is neurologic in origin, and may be classified as physical, cognitive, and/or behavioral/emotional. VBA Manual M21-1, III.iv.4.G.2.a.
    - **NOTE**: Not all individuals exposed to an external force will have a brain injury. *Id*.

2. What is a TBI event, and how do we know it occurred?

- A TBI event occurs when an external force results in structural injury and/or physiological disruption of brain function. VBA Manual M21-1, III.iv.4.G.2.b.It is indicated by at least one of the following clinical signs, which may or may not resolve with chronic disability, immediately following the event. *Id*.
    - Any period of loss of consciousness or decreased consciousness. *Id*.
    - Any loss of memory for events immediately before or after the injury. *Id*.
    - Any alteration in mental state at the time of the injury (confusion, disorientation, slowed thinking, etc.). *Id*.
    - Neurological deficits, regardless of whether they are transient. *Id*.
    - Intracranial lesion. *Id*.
- If none of the above clinical signs are observed, there is no brain injury, and the criteria for a TBI event are not met. *Id*.
- **NOTE**: TBI events may occur during combat or non-combat situations (such as a motor vehicle accident, fall, or personal assault).

3. What is an "external force," for TBI purposes?

- Any of the following events qualify as an external force:
    - A foreign body (such as a bullet or shell fragment) penetrating the brain. VBA Manual M21-1, III.iv.4.G.2.c.
    - The head being struck by an object, e.g., a fist, a hatch, or flying debris. *Id*.

- The head striking an object (such as the ground or a windshield). *Id*.
- The brain undergoing an acceleration/deceleration movement **without** direct external trauma to the head. *Id*.
- Force generated from events such as a blast or explosion, e.g., improvised explosive device (IED). *Id*.

4. If the Veteran did sustain a TBI, how severe was it?

- The initial severity level of a TBI is determined based on the TBI symptoms at the time of the original injury, or shortly thereafter, rather than on the current level of functioning. 38 C.F.R. § 3.310(d)(3)(ii); VBA Manual M21-1, III.iv.4.G.3.a.
  - **NOTE**: The reason the severity of a TBI is determined at or shortly after the time of injury is because the neurologic deficits associated with TBI do not progress over time. Re-injury, however, may cause worsening[1].
- In general, the severity of a TBI is determined based on:
  1. Structural imaging of the brain, e.g., MRI or PET. 38 C.F.R. § 3.310(d)(3)(i).
  2. Whether there was loss of consciousness. *Id*.
  3. Whether there was alteration of consciousness/mental state including disorientation. *Id*.
  4. Whether there was post-traumatic amnesia including any loss of memory. *Id*.
  5. The Glasgow Coma Scale[2] measuring the degree of coma, if any, at or after 24 hours. *Id*.
     - **NOTE**: The evidence that establishes the initial severity of the TBI does not necessarily have to be contemporaneous to the injury as long as it relates to the condition of TBI at or shortly after the time of the injury. 38 C.F.R. § 3.310(d)(3)(i); VBA Manual M21-1, III.iv.4.G.3.b.

[1] *TBI Basics*, DEFENSE AND VETERANS BRAIN INJURY CENTER (DVBIC), www.dvbic.dcoe.mil (last checked Feb. 10, 2016) [hereinafter, "TBI Basics, DVBIC"].

[2] The Glasgow Coma Scale assigns points in three areas: eye opening, verbal response, and motor response. The sum of points in the three areas ranges from 3 to 15, with lower scores indicating greater severity of TBI. *See* Erin Bagalman, Traumatic Brain Injury Among Veterans, Congressional Research Service 2, Jan. 4, 2013, available at http://www.ncsl.org/documents/statefed/health/TBI_Vets2013.pdf.

- Evidence that may be relevant in ascertaining the initial severity of TBI symptoms includes:
  - lay statements provided by the Veteran. VBA Manual M21-1, III.iv.4.G.3.d.
  - lay statements from witnesses to the injury. *Id*.
  - history provided by the Veteran in medical reports, to include VA exams. *Id*.
  - STR findings at any time after the TBI. *Id*.
- The Table below, found at 38 C.F.R. § 3.310(d)(3)(ii), may be used to assess the initial severity of the TBI.
  - **NOTE**: The TBI does not need to meet *all* the criteria listed under a certain severity level in order to classify the TBI under that severity level. 38 C.F.R. § 3.310(d)(3)(ii); VBA Manual M21-1, III.iv.4.G.3.c.
  - **Practice Tip**: If the level of severity cannot be determined based on available evidence, remand for an examination/medical opinion. VBA Manual M21-1, III.iv.4.G.3.c.

MILD[3]	MODERATE	SEVERE
MRI or PET revealed normal structural imaging.	MRI or PET revealed normal or abnormal structural imaging.	MRI or PET revealed normal or abnormal structural imaging.
If there was loss of consciousness, it lasted for no more than 30 minutes.	There was loss of consciousness that lasted between 30 minutes and 24 hours.	There was loss of consciousness that lasted for more than 24 hours.
If there was alteration of consciousness, it lasted for no more than 24 hours.	There was alteration of consciousness that lasted for more than 24 hours.	There was alteration of consciousness that lasted for more than 24 hours.
If there was post-traumatic amnesia, it lasted ≤ 1 day.	There was post-traumatic amnesia that lasted 1 - 7 days.	There was post-traumatic amnesia that lasted for more than 7 days.
The Glasgow Coma Scale was between 13-15.	The Glasgow Coma Scale was between 9-12.	The Glasgow Coma Scale was between 3-8.

[3] A mild TBI may also be referred to as a concussion. A concussion is the most common form of TBI in the military. Signs and Symptoms Fact Sheet, DVBIC, https://dvbic.dcoe.mil/material/signs-symptoms-fact-sheet-english (last checked Feb. 10, 2016). Symptoms of concussion often resolve within days or weeks. *Id*.

- **NOTE**: The initial severity should be classified based on the highest level in which a criterion is met, except where the qualifying criterion is the same at both levels, and there are no other criteria present. 38 C.F.R. § 3.310(d)(3)(ii).
  - **EXAMPLES**:
    1. If alteration of consciousness lasted for more than 24 hours and no other criteria are present, determine the severity as moderate. VBA Manual M21-1, III.iv.4.G.3.c.
    2. If structural imaging is noted as normal and no other criteria are present, determine the severity as mild. *Id.*
    3. If structural imaging is noted as abnormal and no other criteria are present, determine the severity as moderate. *Id.*
- **Practice Tip:** For VA purposes, the initial severity of a TBI is important only when considering whether service connection for certain conditions are warranted as secondary to a TBI. *See* A.6 below.
- **Practice Tip:** The severity of TBI residuals does not necessarily correlate with the severity of the initial injury. Final Rule, Schedule for Rating Disabilities: Evaluation of Residuals of TBI, 73 Fed. Reg. 54,693, 54,695 (Sept. 23, 2008).

5. What are the possible sequelae of a TBI?

- The signs and symptoms of a TBI can be classified as physical, cognitive, and/or behavioral/emotional.[4] Examples include, but are not limited to, those listed in the table below.

Physical	Cognitive	Behavioral/Emotional
Apraxia (inability to execute purposeful, previously learned motor tasks, despite physical ability and willingness)	Dementias (pre-senile Alzheimer's type, dementia pugilistica, post traumatic dementia)	Depression
Aphasia (difficulty communicating orally and/or in writing)	Attention and concentration deficits	Agitation and irritability

[4] 38 C.F.R. § 4.124a, Diagnostic Code (DC) 8045; VBA Manual M21-1, III.iv.4.G.2.d; *TBI Basics*, DVBIC, www.dvbic.dcoe.mil (last checked Feb. 10, 2016).

Physical	Cognitive	Behavioral/Emotional
Paresis (muscle weakness or incomplete paralysis)	Memory, processing, and learning impairment	Impulsivity
Plegia (paralysis or stroke)	Language deficiencies	Aggression
Dysphagia (difficulty swallowing)	Planning difficulties	Anxiety
Disorders of balance and coordination	Judgment and control difficulties	Posttraumatic stress disorder
Diseases of hormone deficiency	Reasoning and abstract thinking limitations	
Parkinsonism	Self-awareness limitations	
Nausea/vomiting	Tinnitus	
Headaches	Confusion	
Dizziness		
Blurred vision		
Seizure disorder		
Sensory loss		
Weakness		
Sleep disturbance		
Hearing loss		
Respiratory problems		
Fatigue		
Loss of bowel and bladder control		

- **NOTE**: TBI sequelae can resolve in a short period of time or can persist chronically or even permanently. Chronic TBI residuals may include some or all of the clinical signs that developed immediately during the TBI event. Others (such as seizures or spasticity) may have a delayed onset. VBA Manual M21-1, III.iv.4.G.2.d.

6. Are there any medical conditions that may develop secondary to a TBI?

- Yes. There are 5 conditions which may be presumed[5] to develop secondary to a TBI that was **moderate or severe** at the time of the TBI event. 38 C.F.R § 3.310(d)(i); VBA Manual M21-1, III.iv.4.G.3.a.

- The 5 conditions which may be presumed to develop secondary to a TBI include:

  1. Parkinsonism, including Parkinson's disease. *Id.*
  2. Unprovoked seizures. *Id.*
  3. Dementias (presenile dementia of the Alzheimer's type, frontotemporal dementia, and dementia with Lewy bodies), **if** the condition manifests **within 15 years** of the TBI. *Id.*
  4. Depression, **if** the condition manifests **within three years** of the TBI. *Id.*
     - **NOTE**: Secondary service connection will be awarded for depression that develops within 12 months of a **mild** TBI. *Id.*
  5. Diseases of hormone deficiency that result from hypothalamo-pituitary changes, **if** the condition manifests **within 12 months** of the TBI. *Id.*

B. Service Connection

1. When is the claim on appeal properly characterized as a claim for service connection for the residuals of a TBI?

- The claim is properly characterized as a claim for service connection for the residuals of a TBI when there was a claimed "TBI event[6]" in service and/or where the Veteran claims service connection related to a documented in-service TBI.[7]
  - **REMINDER**: The external force involved in a TBI event may be unrelated to combat. For example, sports injuries, motor vehicle accidents, and personal assaults may involve head trauma.

[5] There is no need to obtain a medical opinion to determine whether the 5 conditions (parkinsonism, unprovoked seizures, dementia, depression, and diseases of hormone deficiency) are associated with TBI if they develop within the requisite time period and the TBI was of qualifying severity. VBA Manual M21-1, III.iv.4.G.3.a.

[6] *See* A.2 for the definition of "TBI event."

[7] For additional information on the scope of claims, *see* Case Law Review training, June 2015.

- **Practice Tip**: A claim for service connection for one of the sequelae listed in the table in A.5 may properly be characterized as a claim for service connection for the residuals of a TBI if there was a TBI event in service.
  - **Example**: A claim for SC headaches should be characterized as "Entitlement to service connection for headaches, to include as the residuals of a TBI," where the record reflects a history of head injury during service.
- **Practice Tip**: Where the Veteran claims entitlement to SC for the residuals of a TBI and the evidence of record does not support the disability being related to a TBI, but does otherwise suggest a possible relationship to service, broaden the claim per *Clemons* and address entitlement to service connection both as a residual of a TBI (as claimed by the Veteran) and on a direct basis.
  - **Example**: Veteran files a claim for SC residuals of a TBI and mentions only headaches as the residuals of the TBI. The record does not support a finding that there was a TBI event in service, but does show occasional complaints of headaches in service. The claim should be characterized as "Entitlement to service connection for headaches, to include as the residuals of a TBI".
    - **NOTE**: If the record is not sufficient to make a determination as to whether SC is warranted on a direct basis (that is, apart from as a residual of a TBI), a remand for additional development is warranted.
- **Practice Tip**: Where the Veteran claims entitlement to service connection for a single disability *both* as the residuals of a TBI and otherwise, the issue should be collapsed per *Clemons*, and entitlement to SC should be addressed as a residual of TBI and on a direct basis.
  - **Example**: The Veteran files separate claims for SC headaches and SC residuals of a TBI, but mentions no residuals apart from headaches. Recharacterize the issue as "Entitlement to SC for headaches, to include as a residual of TBI."

2. Is the Veteran competent to report a TBI event?

- Yes, most of the time. A Veteran is competent to report exposure to an external force, and is competent to report each of the clinical signs indicative of a TBI

event[8], with the exception of intracranial lesions, which are visible only by MRI or PET scans.

3. **Does the record support a finding that the Veteran's report of a TBI event is credible?**

- Yes, if, for example:
  - The STRs reflect treatment consistent with the reported TBI event, or reflect that the Veteran underwent a TBI Registry examination.
    1. **NOTE**: DoD conducts TBI screenings and maintains a database which documents TBI events and individuals with known traumatic brain injuries.[9]
  - Unit records independently confirm the TBI event.
  - The SPRs contain records from law enforcement consistent with the reported TBI event.
  - The SPRs reflect behavioral changes or changes in duty consistent with the reported TBI event.
  - The TBI event is otherwise consistent with the circumstances of the Veteran's service.
    - **NOTE**: TBI has been dubbed the "signature wound" of the Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) conflicts (i.e., the conflicts in Iraq and Afghanistan).[10] Veterans with service in these conflicts have an increased risk of exposure to IEDs.
  - VA records show that the Veteran underwent TBI screening. (All OIF/OEF Veterans enrolled in VA healthcare undergo TBI screening).[11]
- No, if, for example:

[8] *See* A.2.

[9] *See* Erin Bagalman, Traumatic Brain Injury Among Veterans, CONGRESSIONAL RESEARCH SERVICE 1, Jan. 4, 2013, available at http://www.ncsl.org/documents/statefed/health/TBI_Vets2013.pdf.

[10] *Id*.

[11] TBI Screening, http://www.polytrauma.va.gov/system-of-care/TBI Screening.asp (last visited Feb. 11, 2016).

- The Veteran reports TBI of severity that should have been documented in the STRs.
- The Veteran reports a blast explosion in a non-combat area.
  - **NOTE**: The U.S. Army Medical Research and Materiel Command Joint Trauma Analysis and Prevention of Injury in Combat (JTAPIC) has developed a registry of service members who were within 50 feet of a blast since mid-2010. When existing DoD records, to include STRs, are not sufficient to verify exposure to a blast injury that occurred since mid-2010, verification may be requested from JTAPIC.
- The record reflects a post-service head injury.

4. Is there a current disability?

- The acute manifestations of a TBI event may resolve without chronic disability, or a chronic disability may result. VBA Manual M21-1, III.iv.4.G.2.b. In order to grant service connection, there must be current residuals of the TBI. *Shedden v. Principi*, 381 F.3d 1163, 1167 (Fed. Cir. 2004).
- If it is unclear whether the signs and symptoms claimed by the Veteran as residuals of a TBI are etiologically related to a confirmed in-service TBI event, development is warranted. *See McLendon v. Nicholson*, 20 Vet. App. 79, 83 (2006).
- If it is clear that there are *some* residuals, or even one, the criteria for a current disability are met.
- **Practice Tip**: In finding that the criteria for a current disability are met, do not attempt to identify the residuals with precision, for the reasons stated in B.5 below. Instead, make a finding that is not limiting. For example, "The TBI the Veteran sustained in service resulted in chronic residuals **such as** X and Y." *See Mauerhan v. Principi*, 16 Vet. App. 436, 442 (2002) (noting that the use of the term "such as" in the rating criteria demonstrates that the symptoms after that phrase are not intended to constitute an exhaustive list).

5. What exactly do I service connect?

- "Residuals of a TBI." Do not stated with specificity what the residuals of the TBI are. In implementing the grant of service connection, the RO will identify the

residuals and assign a rating or ratings based on those residuals. *See* Section C below.

- In granting service connection generally, the Board avoids possibly having to conduct development to determine which signs and symptoms present are etiologically related to the TBI, and avoids making potential *Colvin v. Derwinski,* 1 Vet. App. 171, 175 (1991) violations in assuming that the record otherwise adequately identifies all residuals.
    - **Practice Tip:** Phrase the Order for a grant of service connection as follows: "Service connection for the residuals of a TBI is granted."

6. Can service connection for the residuals of a TBI be granted on a presumptive basis as a chronic disease?

- Yes. All residuals of a TBI are associated with neurologic injury, and may be classified as "other organic diseases of the nervous system," per 38 C.F.R. § 3.309(a).

7. Can service connection be awarded for conditions *secondary* to TBI residuals?

- Yes. Service connection may be awarded secondary to residuals of a TBI on a presumptive and non-presumptive basis. 38 C.F.R. § 3.310.
    - Presumptive
        - There are 5 conditions which may be presumed to develop secondary to a TBI that was **moderate or severe** at the time of the TBI event. 38 C.F.R. § 3.310(d)(1); VBA Manual M21-1, III.iv.4.G.3.a. These 5 conditions are:
            1. Parkinsonism, including Parkinson's disease.
            2. Unprovoked seizures.
            3. Dementias (presenile dementia of the Alzheimer's type, frontotemporal dementia, and dementia with Lewy bodies), **if** the condition manifests **within 15 years** of the TBI.
            4. Depression, **if** the condition manifests **within three years** of the TBI.
                - **NOTE**: Secondary service connection will be awarded for depression that develops within 12 months of a **mild** TBI.

5. Diseases of hormone deficiency that result from hypothalamo-pituitary changes, **if** the condition manifests **within 12 months** of the TBI.

- The table below may be used to determine whether secondary service connection is warranted on a presumptive basis. VBA Manual M21-1, III.iv.4.G.3.e.

If there is a diagnosis of…	**And the initial severity of the TBI was …**	**Then…**
Parkinsonism, including Parkinson's disease	moderate or severe	award SC.
unprovoked seizures,	moderate or severe	award SC.
dementia of the following types • presenile dementia of the Alzheimer type • frontotemporal dementia, and • dementia with Lewy bodies	moderate or severe	award SC if dementia *manifested within 15 years* after the TBI.
depression	moderate or severe	award SC if depression *manifested within three years* after the TBI.
	mild	award SC if depression *manifested within one year* after the TBI.
a disease of hormone deficiency that results from hypothalamo-pituitary changes (any condition in the endocrine system section of the rating schedule, 38 CFR 4.119, DCs 7900-7912, or any condition evaluated analogous to one of those conditions),	moderate or severe	award SC if the condition *manifested within one year* after the TBI

- **NOTE**: Effective dates - The rule authorizing VA to establish the five secondary TBI-related conditions in 38 C.F.R. § 3.310(d) constitutes a liberalizing VA regulation under 38. U.S.C.A. § 5110(g) and 38 C.F.R. § 3.114. Apply these principles when determining the appropriate effective date. VBA Manual M21-1, III.iv.4.G.3.i.

- **Practice Tip**: If in reviewing the record for an unrelated claim, one of the five conditions in 38 C.F.R. § 3.310(d) is identified, instruct the AOJ to "take appropriate action." For evidence or argument dated prior to March 24, 2015, this would include referral of the claim to the AOJ. After March 24, 2015, however, the Board may not

refer a claim unless it is submitted on an application form prescribed for that purpose, or the record reflects the claimant's attempt to file a claim orally. *See* Standard Claims and Appeals Forms, 79 Fed. Reg. 57,660 (Sept. 24, 2014) (codified in 38 C.F.R. Parts 3, 19, and 20 (2015)); *see also* 38 C.F.R. § 3.155(d) (2015) (outlining criteria for complete claims).

- Non-presumptive
  - Secondary service connection may be awarded for **any** condition not meeting the above criteria under the generally applicable principles of service connection. 38 C.F.R. § 3.310(d)(2).

C. Increased Rating

1. How are TBI residuals rated?

- TBIs are rated based on the residuals of the neurologic injury sustained at the time of the TBI event rather than based on the severity of the initial injury. 38 C.F.R. § 4.124a, DC 8045, Note (4). [12]
  - **REMINDER**: If it is not clear whether a claimed residual sign, symptom, or diagnosis is etiologically related to the TBI, additional development may be warranted.
- TBI residuals may be subjective in nature, or they may meet the criteria for distinct diagnoses.
  - Subjective symptoms are rated under DC 8045, which broadly provides for ratings in the three main areas of dysfunction[13] that may result from a TBI. 38 C.F.R. § 4.124a, DC 8045. If the Veteran exhibits residuals in each of the three areas of dysfunction, each area will require evaluation. *Id*.

[12] The regulation for rating disability associated with traumatic brain injury was revised, effective October 23, 2008. 73 Fed. Reg. 54,693, 54,693 (Sept. 23, 2008). Prior to October 23, 2008, DC 8045 directed that TBI disorders were to rated under DC 9304, as Brain Disease Due to Trauma. The associated disability was to be rated as 10 percent disabling unless there was multi-infarct (vascular) dementia associated with brain trauma. For additional information regarding rating TBI under the old diagnostic criteria, *see* material from the May 2007 Grand Rounds.

[13] *See* A.1.

- **NOTE**: The three areas of dysfunction are broken down into 10 facets of cognitive impairment and subjective symptoms. 38 C.F.R. § 4.124a, DC 8045. A level of impairment must be assigned to each applicable facet. *Id*.

- **NOTE**: Subjective symptoms (which do not meet the criteria for a distinct diagnosis) may not be rated by analogy using another diagnostic code. They must be rated under DC 8045. *Id*.

  - **EXAMPLE**: Occasional subjective headaches are not a distinct comorbid diagnosis, and as such, should be rated under DC 8045 rather than under a separate diagnostic code. VBA Manual M21-1, III.iv.4.G.2.h.

    - **Example**: Subjective feelings of anxiety are not a distinct comorbid diagnosis, and as such, should be rated under DC 8045 rather than under a separate diagnostic code. *Id*.

    - **Example**: Vertigo is a subjective symptom that is included in the facets of the TBI criteria. It should not be separately evaluated under another diagnostic code. *Id*.

- Distinct comorbid diagnoses should be separately evaluated under the applicable diagnostic code UNLESS the associated signs and symptoms overlap with those used to assign the rating under DC 8045. *See* 38 C.F.R. § 4.124a, DC 8045, Note (1); *Copeland v. McDonald*, 27 Vet. App. 333, 337 (2015) (stating that "a listed condition should be rated under the DC that specifically pertains to it").

2. How should I approach one of these claims?

i. First, assign a level of impairment to each applicable facet under DC 8045. Then, based on the levels assigned, determine which facet allows for the highest disability rating under DC 8045.

ii. Then, as applicable, evaluate distinct comorbid diagnoses, including any conditions service-connected secondary to the TBI, under the appropriate DCs.

- Provided that the symptoms associated with the distinct comorbid diagnoses **do not** overlap with those used to assign the highest disability rating under DC 8045 in Step 1 above, assign separate ratings under the applicable diagnostic code or codes in addition to the rating under DC 8045.

  - **EXAMPLE** – no overlapping symptoms: TBI residuals include level 2 motor impairment (equates to 40 percent rating) (other facets are evaluated at less

than 2). Migraine headaches and tinnitus have been separately diagnosed as related to TBI and are ratable at 30 and 10 percent respectively.

- Because there is no overlap between the symptoms forming the basis for the level 2 motor impairment and the symptoms associated with the separately diagnosed migraine headaches and tinnitus, the Veteran in this case is entitled to a 40 percent rating under DC 8045, a 30 percent rating under DC 8100, and a 10 percent rating under DC 6260.

- **EXAMPLE** – no overlapping symptoms: TBI residuals include level 3 motor impairment (equates to 70 percent rating) (other facets are evaluated at less than 2). Depression has been separately diagnosed and is ratable at 50 percent.

  - Because there are no overlapping symptoms, the Veteran in this case is entitled to a 70 percent rating under DC 8045, and a 50 percent rating under DC 9434 for depression.

- If the symptoms associated with the distinct comorbid diagnoses **do** overlap with those used to assign the highest disability rating under DC 8045 in Step 1 above, determine which diagnostic code or codes allow for the highest rating for the overall level of impaired functioning due to both conditions. *See* 38 C.F.R. § 4.124a, DC 8045, Note (1).

  - **EXAMPLE** – overlapping symptoms: TBI residuals include only level 3 neurobehavioral impairment (equates to 70 percent rating) and level 1 motor activity impairment (equates to 10 percent rating). PTSD has been separately diagnosed and is ratable at 70 percent. The symptoms attributable to PTSD and those attributable to the TBI cannot clearly be differentiated.

    - In this case, because the PTSD symptoms overlap with those used to assign the level 3 neurobehavioral impairment, and the symptoms attributable to each cannot clearly be differentiated, the Veteran may not be awarded separate evaluations under both 8045 and 9411. It is to the Veteran's advantage to assign a 70 percent rating under DC 9411 and a 10 percent rating under DC 8045 for the motor activity impairment.

  - **EXAMPLE** - overlapping symptoms: TBI residuals include only level 2 subjective symptoms impairment (equates to 40 percent rating). Migraine headaches and tinnitus have been separately diagnosed as related to TBI, and are ratable at 30 and 10 percent, correspondingly.

- If the migraine headaches and tinnitus have been included in the level of impairment assigned to the subjective symptoms facet, and there are no other subjective symptoms to be accounted for, the Veteran is entitled to no more than a single 40 percent rating under DC 8045, and no more than a combined 40 percent rating under the separate diagnostic codes 8100 and 6260. In this instance, reduce the rating assigned under DC 8045 to 0 percent, and assign the separate ratings under 8100 and 6260 because there are distinct comorbid diagnoses. *See* 38 C.F.R. § 4.124a, DC 8045; *Copeland v. McDonald*, 27 Vet. App. 333, 336-37 (2015). Notably, reducing the rating under DC 8045 from 40 to 0 percent does not constitute a reduction because the overall evaluation of the residuals of the TBI is not reduced.

  - **NOTE**: Depending on the most advantageous combined evaluation, it is permissible to reduce an existing TBI evaluation as long as the overall evaluation of both TBI and the distinctly diagnosed condition is not reduced. *O'Connell v. Nicholson*, 21 Vet. App. 89, 93 (2007); VBA Manual M21-1, III.iv.4.G.3.g.

iii. Lastly, consider entitlement to SMC. 38 C.F.R. §§ 3.155(d)(2) (2015); 4.124a, DC 8045; *Akles v. Derwinski*, 1 Vet. App. 118, 121 (1991). Neurological injury associated with TBI may result in loss of use of an extremity, sensory impairments, erectile dysfunction, and the need for regular aid and attendance (including need for protection from hazards of the daily living environment due to cognitive impairment), without which the Veteran would require hospitalization, nursing home care, or other residential institutional care. 38 U.S.C.A. § 1114(s), (t). The residual disability may also render the Veteran factually or statutorily housebound. *Id*.

3. Are there any special considerations if the claim before me is not an initial rating claim?

- Although the conditions that develop secondary to the residuals of a TBI may worsen over time, the neurologic deficits associated with the TBI itself do not progress.[14]
  - If the record does not contain competent evidence that a new sign, symptom, or diagnosis is a result of the TBI, additional development may be warranted.

[14] *See supra* Note 1.

4. **Is the analysis different if the Veteran only appeals the rating assigned for a condition service-connected secondary to the TBI?**

- No. The rating assigned for a secondary condition cannot be evaluated in isolation from the rating or ratings assigned for the residuals of the TBI. Care must be taken to ensure that the rating assigned for the secondary condition does not double compensate the Veteran for symptoms already accounted for by the rating assigned for the TBI residuals under DC 8045 and/or any other diagnostic codes.
    - **EXAMPLE** – no overlapping symptoms**:** Secondary service connection is awarded for depression related to the residuals of the TBI. The residuals of the TBI currently are rated 40 percent disabling for level 2 motor impairment.
        - Because the symptoms associated with depression do not overlap with those that form the basis for the assignment of a level 2 motor impairment, the Veteran in this case is entitled to a 40 percent rating under DC 8045, and a separate rating under DC 9434.
- If the symptoms associated with the secondary condition **do** overlap with those used to assign the highest disability rating under DC 8045, determine which diagnostic code or codes allow for the highest rating for the overall level of impaired functioning due to both conditions. *See* 38 C.F.R. § 4.124a, DC 8045, Note (1).
    - **EXAMPLE** – overlapping symptoms: The residuals of the TBI are rated 70 percent due to level 3 neurobehavioral impairment. The residuals of the TBI otherwise include only level 1 motor activity impairment (equates to 10 percent rating). Major depressive disorder has been service-connected secondary to the residuals of the TBI, and is ratable at 70 percent. The symptoms attributable to major depressive disorder and those attributable to the TBI cannot clearly be differentiated.
        - In this case, because the depressive symptoms overlap with those used to assign the level 3 neurobehavioral impairment, and the symptoms attributable to each cannot clearly be differentiated, it would amount to pyramiding to assign ratings under both DC 8045 and 9434. Because the Veteran's TBI residuals include symptoms which do not overlap with those associated with depression (the motor impairment), it is to the Veteran's advantage to assign a 70 percent rating under DC 9434 and a 10 percent rating under DC 8045 for the motor activity impairment.

- **EXAMPLE** – overlapping symptoms: TBI residuals include only level 2 neurobehavioral impairment (equates to 40 percent rating). Major depressive disorder has been has been service-connected secondary to the residuals of the TBI, and is ratable at 50 percent. A VA examiner has opined that some of the symptoms associated with major depressive disorder overlap with those used to form the basis for the assignment of a level 2 neurobehavioral impairment, but has determined that some of the symptoms associated with major depressive disorder can be distinguished from those related to the TBI.

  - In this case, although some symptoms overlap, because there are symptoms attributable to major depressive disorder which have been differentiated from those attributable to the TBI, the Veteran is entitled to a 40 percent rating under DC 8045, and a separate rating under DC 9434 for **the symptoms which are distinct from** those contemplated by the rating currently assigned under DC 8045.

    - NOTE: the rating assigned under DC 9434 may or may not be 50 percent, depending on the severity of the symptoms that are distinct.

- **EXAMPLE** – overlapping symptoms: TBI residuals include only level 2 subjective symptoms (equates to 40 percent rating). Dementia has been service-connected secondary to the residuals of the TBI, and is ratable at 50 percent. A VA examiner has stated that the symptoms attributable to dementia cannot be distinguished from those used to the TBI under DC 8045.

  - If after considering the symptoms attributable to the dementia in conjunction with those currently considered in the subjective symptoms facet, the evidence does not support the assignment of a level 3 impairment under DC 8045 (which equates to a 70 percent rating), then assign the rating that is more favorable to the Veteran. Here, the symptoms overlap and cannot be differentiated. However, due to the rule against pyramiding, ratings may not be assigned under both DC 8045 and DC 9434. This means that a single rating should be assigned under whichever diagnostic code allows for the higher rating - in this case, DC 9304. Notably, this does not constitute a reduction because the overall evaluation of the TBI and the separate secondary condition is not reduced.

    - **NOTE**: Depending on the most advantageous combined evaluation, it is permissible to reduce an existing TBI evaluation as long as the overall evaluation of both TBI and the secondary condition is not reduced.

O'Connell v. Nicholson, 21 Vet. App. 89, 93 (2007); VBA Manual M21-1, III.iv.4.G.3.g.