

**Statement of the
Veterans' Disability Benefits Commission
To the
Institute of Medicine
Committee on Medical Evaluation of Veterans for Disability Compensation**

May 25, 2006

The Veterans' Disability Benefits Commission created by Public Law 108-136 was charged with studying the benefits provided to compensate and assist veterans for disabilities attributable to military service and mandated to consult with the Institute of Medicine (IOM) of the National Academy of Sciences with respect to the medical aspects of contemporary disability compensation policies. The Commission is to evaluate and assess:

- The appropriateness of benefits,
- The appropriateness of the level of those benefits, and
- The appropriate standard(s) for determining whether the disability should be compensated.

The Commission consists of 13 members who were appointed by the President and the leaders of Congress. The statute requires that seven members have received combat decorations, such as the Silver Star or higher. Nine of the twelve members who are veterans have combat experience and, combined, they have over 260 years of military experience. The Commission is charged to submit its report by October 1, 2007, to the President and Congress.

In order to meet the three goals above, the Commission produced a list of 31 research questions to be answered during its investigation. IOM has established four committees that will address some of these questions in whole or in part. Your Committee will research and report on the medical aspects of contemporary disability compensation policies. Another committee has been created to research and report on presumptions (the Committee on Presumptive Disability Decision Making Process). IOM also established two committees to deal with various aspects of PTSD including diagnosis, treatment, and compensation. The Commission encourages the Committee on Medical Evaluation to collaborate with the other three committees since there are many areas of overlapping and complimentary interests.

The Commission is looking forward to expert advice from your Committee on a wide range of issues related to evaluating veterans' disabilities.

The VA Schedule of Rating Disabilities (the Rating Schedule) is the guide used to evaluate disabilities resulting from all types of diseases and injuries caused by or incident to military service. The percentage evaluations are intended to represent, as far as is practicable, the average impairment in earning capacity resulting from such diseases and injuries and their residuals in civilian occupations. Applying this guide requires accurate and fully descriptive medical examinations with a representation of the limitations of activity imposed by the disabling condition. Both the Department of Veterans Affairs and the Department of Defense are required to use the Rating Schedule. Because millions of service members' and veterans' disabilities have been and will be evaluated using the Rating Schedule, it is crucial that the Rating Schedule be medically current and accurate; reflect modern medical diagnostic techniques, treatments, and therapies; and be thorough in its assessment of disabilities. The Rating Schedule also must be clear, have

sufficient detail, and be understandable to raters to allow for uniform and equitable ratings regardless of the office location where the rating is prepared.

Suggestions of additional specific measures for assessing the impact of disability on quality of life are needed from your Committee. There are few quality of life measures in the Rating Schedule presently. Quality of life measures should be considered in decisions on the severity of disability and the amount of compensation that would be appropriate. We ask that this Committee view the Rating Schedule as a means of achieving this goal.

In addition, the Commission requests the Committee on Medical Evaluation to assess the process used to change and update the Rating Schedule. Are the changes to the Rating Schedule made frequently enough to keep it relevant and current? Can the process, currently a regulatory process, react in a timely manner to the accelerating changes in medical science?

The Commission asks the Committee to research and report on the medical aspects of contemporary disability compensation policies and provides suggestions to the Commission that could result in improvements to the Rating Schedule or, if necessary, a significant change in the methodology used to evaluate severity of disability. The Commission's overall charge is to conduct a comprehensive review of the Rating Schedule to determine whether the Rating Schedule reflects (1) current medical understanding of the relationship between the event, i.e., disease and/or injury and the residuals, i.e., impairment and/or disability, (2) technological, treatment and pharmacological mitigations of conditions as they relate to functioning in the workplace and quality of life, and (3) sufficiently discrete rating levels to provide veterans with commensurate benefits without resorting to extra schedular benefit, such as Individual Unemployability. Does the Committee believe that medical or vocational impairments caused by rated disabilities can be mitigated by ancillary or special purpose benefits such as vocational rehabilitation or adaptations to housing and/or vehicles?

Another aspect of your Committee's review is to evaluate the utility of the Rating Schedule based on comprehensiveness of listed conditions and their descriptions. Does it provide detailed instructions to clinicians leading to high quality medical examinations? Does it permit initial high quality ratings by raters and decision review officers? Does it allow for consistent ratings regardless of location or level of experience of employees? Does it permit effective training of new raters and continuing training of experienced raters? How does the Rating Schedule compare with other guides such as the *American Medical Association Guides to the Evaluation of Permanent Impairment*?

The Commission also would value the Committee on Medical Evaluation's input on issues such as the role of clinicians in the claims/appeal process, and specifically, the role of treating and examining clinicians. The Committee could examine the sufficiency of training or certification of examining clinicians and rating officials. The Commission is aware of ongoing VA efforts to address these issues and would encourage the Committee to review those efforts and provide advice as to modifications or improvements that should be made to these efforts. The Commission would also welcome the Committee's views on whether VHA should mandate certain policies and procedures rather than seek consensus and encourage best practices.

During the Committee on Medical Evaluation's review, the Commission would ask you to analyze all key documents regarding disability compensation benefit programs to include DoD's Instruction 1332.39, Army Regulation 635-40, state and local disability retirement programs, and VA's

Vocational Rehabilitation and Employment services. We also encourage you to review published socioeconomic research studies of disabled persons in America.

Requesting the Committee on Medical Evaluation to study these issues underlining the research questions should not be taken as directing any disposition or finding with respect to these research questions. Rather the Commission is asking that particular attention be focused on these issues. We believe that your Committee's efforts will greatly assist the Commission in responding to its charge from Congress and the President.

The Commission's specific research questions that are germane to the Committee on Medical Evaluation's charge are the following:

How well do the medical criteria in the VA Rating Schedule and VA rating regulations enable assessment and adjudication of the proper levels of disability to compensate both for the impact on quality of life and impairment in earnings capacity? (RQ 6)

The Rating Schedule and rating regulations are changed in response to any of the following: new legislation, precedent decisions of federal courts, and policy changes within VA. Diagnoses are grouped into 15 body systems in the Rating Schedule. Thirteen of the 15 body systems have been updated to reflect recent knowledge concerning the effects of disabilities since VA began its project to modernize the entire the Rating Schedule in 1991. For example, prior to the revision of the cardiovascular system, ratings were assigned for cardiovascular disease because of shortness of breath, among other symptoms, which were judged by the rating specialist to be mild, moderate, or severe, depending on the veterans' reported subjective symptomatology. As part of the revision, the evaluation criteria were changed to require the more objective metabolic equivalent testing (MET). Although many changes have been made to the Rating Schedule, some critics have suggested it still may not reflect current workforce characteristics and the state-of-the-art medicine and prosthetics. If these critics are correct, current compensation rates may not correlate with lost earnings capacity or diminished quality of life.

Evaluations of 0 percent to 100 percent may be assigned in 10 percent increments based on the severity of the disability. The entire range from 0 percent to 100 percent does not exist for every disability contained in the Rating Schedule. Special Monthly Compensation (SMC) is also awarded for disabilities ranging from loss of use of a hand, arm, and creative organ to the need for the aid and attendance of another person. Not all of the known disabilities are included in the Rating Schedule. When a service-connected disability does not have its own criteria, the criteria of a closely related disability are used by analogy.

There are differences in the way mental disorders are evaluated compared to physical disorders or conditions. Mental disorders contain an element of occupational impairment or employability in the Rating Schedule's evaluation criteria that is not included in the rating criteria for most physical disorders. Veterans with mental disorders rated 100 percent disabling must be, by terms of the Rating Schedule, totally impaired, both occupationally and socially, to be so rated. With improved occupational and social interaction, lesser evaluations are assigned.

Veterans with physical disabilities rated schedular 100 percent disabled can work or be rehabilitated to another occupation and continue to be rated 100 percent disabled. The criteria in the Rating

Schedule do not include specific economic or occupational impacts since the entire Rating Schedule is based on the theory of “average loss of earnings” for all disabilities. The most severe evaluation possible for migraine headaches is 50 percent and the evaluation criteria required for that severity of rating include a severe economic impact. For the most of other physical disabilities, there are quality of life considerations. For example, a veteran with chronic renal failure requiring dialysis on a regular basis is entitled to a total (100 percent) rating. Many disabilities may financially affect a veteran with limited education and work skills more so than a veteran who can do non-physical activity. There are certainly, however, quality of life considerations for both.

There are also evaluations for disabilities in the Rating Schedule that, on the surface, may not have an economic impact. A splenectomy, for example, is rated as a 20 percent disability. While there may not be a discernable economic impact resulting from the removal of the spleen, the loss may increase risk for some infections and malaria. A complete hysterectomy is evaluated at 50 percent plus Special Monthly Compensation for loss of use of a creative organ. While there is a quality of life issue associated with a hysterectomy, there may not be an economic impact resulting from this surgery.

A disability can worsen or improve over time or because of treatment or medication. As specified in 38 CFR 3.327, a veteran may be re-examined to determine if his/her disability has worsened or improved. Re-examinations can be scheduled from two to five years after initial rating, if the disability may improve. Are there certain disabilities that should be re-examined more frequently or some that need not be re-examined at all? Currently, rating officials have considerable discretion as to when or whether a disability should be re-examined. Should re-examinations be subject to more directive requirements from a medical standpoint?

The Commission requests that the Committee consider determining if a sufficient cross section of conditions are represented in the Rating Schedule. In the Rating Schedule, there are hundreds of diagnostic codes as compared to less than 200 impairment codes used by Social Security. Is the description associated with each condition’s percentage sufficient? Are the existing percentages with their levels of severity sufficient? Do the present disability percentages reflect the total continuum of a condition? Specifically, does a condition’s disability percentages mirror its impact on a veteran’s quality of life impairment and impairment in average earnings capacity? What disability percentages would be appropriate, especially when compared to the overall medical, functional, and occupational assessments used with physical disabilities? .

The Rating Schedule offers limited Quality of Life (QoL) indicators and focuses mainly on medical or functional impairments. QoL indicators should cover occupational and social impairment as well as satisfaction with life. How could QoL be assessed in conjunction with medical and/or functional impairments within the Rating Schedule? Should quality of life be rated and compensated separately from the medical, functional, and occupational limitations as is done in several countries?

These issues need to be further evaluated by the Committee on Medical Evaluation and advice provided as to the appropriate overall rating assessment process to be used in determining compensation for veterans diagnosed with a disability.

The role of clinicians in the claims and appeal processes. (RQ8a)

The roles of clinicians in the claims/appeals processes in VA, DoD, Social Security Administration, and federal employee disability benefits programs differ greatly. In DoD, for example, physicians serve on the Medical Evaluation Boards, Physical Evaluation Boards, and at every level of appeals. In VA, physicians and others conduct examinations, but do not participate in the disability rating decisions. What might an appropriate role for clinicians be during the examination process and in the rating process at the VA regional offices? What should the appropriate board certification or licensure requirements be for examining clinicians? Should only psychiatrists or psychologists, physician assistants, and licensed clinical social workers be allowed to conduct examinations for mental disorders? Should they be required to be board certified or licensed as examining clinicians for mental disorders?

Should universal medical diagnostic codes be adopted by VA for disability and medical conditions rather than using a unique system? Should the VA Schedule for Rating Disabilities be replaced with the *American Medical Association Guides to the Evaluation of Permanent Impairment*? (RQ 11)

VA uses a unique set of diagnostic codes to classify diseases and disabilities under 15 body systems for evaluation of their severity. DoD also uses the Rating Schedule for this purpose. The World Health Organization classifies disease through its International Classification of Disease (ICD) codes, and the American Psychiatric Association has its Diagnostic and Statistical Manual (DSM) for mental disorders. Medical personnel are more accustomed to ICD and DSM codes in their day-to-day practice of medicine. The ICD diagnoses do not have associated degrees of disability, which is an essential factor for VA in evaluating disabilities. The Rating Schedule is used to identify the chronic condition and assign a severity level to it. The ICD codes include many conditions that are acute and transitory or are procedures performed, which are not commonly thought of as disabilities for which service connection can be granted. Procedures performed are included in evaluation of disabilities in some cases. For example, the Rating Schedule has determined that when coronary artery disease requires coronary bypass surgery, the condition will be evaluated as 100 percent disabling for three months following surgery. After surgery and postoperative recovery period, the condition is re-evaluated using the same coronary artery disease criteria to assess the post surgery residuals.

The AMA Guides to the Evaluation of Permanent Impairment is used in many workmen's compensation programs and in the medical community as well. The AMA Guides do not include any assessment of severity. VA does not use *the AMA Guides to the Evaluation of Permanent Impairment*.

The Commission is asking the Committee on Medical Evaluation to provide advice as to the appropriateness of using the existing Rating Schedule, adopting the ICD, DSM, the AMA Guide, or an entirely new system.

To what extent should service connection on a “secondary” basis be redefined? (RQ15c)

A disability that is proximately due to, or the result of a service connected disease or injury, shall be service connected (38 CFR 3.310.) Because this represents one avenue of entitlement to service connection, the Commission is asking your Committee to review the medical evidence used to implement this principle. The question: Is the current methodology appropriate in assessing the medical evidence available and in determining whether a claimed condition is causally related to or secondary to an existing service connected condition? The Commission asks the Committee on Medical Evaluation to determine if, and how, the current process might be refined and enhanced.

To what extent should service connection on an “aggravation” basis be redefined? (RQ 15d)

A pre-existing injury or disease will be considered to have been aggravated by active duty, where there is an increase in severity of the disability during such service, unless there is a specific finding that the increase in severity of the disability is due to the natural progress of the disease (38 CFR 3.306.) Does the current state of medicine allow the Committee on Medical Evaluation to provide advice as to which diseases or injuries are susceptible to aggravation by service or an increased level of severity beyond the natural progression of the disease or injury?

Do changes need to be recommended for the Individual Unemployability (IU) benefit? (RQ 16)

Where a disabled veteran’s schedular rating is sixty percent or more (but less than one hundred percent or totally disabled), a total disability evaluation may be assigned when the disabled person is unable to secure or follow a gainful occupation because of one or more service-connected disabilities. This means that the veteran is paid as if 100 percent disabled, but the permanent schedular rating remains as rated according to the Rating Schedule. GAO issued a report on IU and the Committee on Medical Evaluation is asked to include the GAO report in their literature review and deliberations. Age is not a factor that is considered in making an IU determination. Approximately 40 percent of veterans rated 60 to 90 percent service connected disabled have been rated as individually unemployable. The Commission would like the Committee on Medical Evaluation to provide advice on IU, considering the status and relationship of the current state of medicine, aging as a factor, and the prevailing societal views on retirement and unemployment. Originally, IU was intended to accommodate exceptions, disabilities that normally do not result in a severe impact on employment but in individual cases causes a greater impact on the veteran. With such a sizable percentage of veterans in the 60 to 90 percent range rated unemployable, is the Rating Schedule meeting its intended purpose?

Certain criteria and/or levels of disability are required for entitlement to ancillary and special purpose benefits. To what extent, if any, do the required thresholds need to change? (RQ 20)

From a medical standpoint, are the established disability thresholds that determine ancillary or special purpose benefits eligibility appropriate? Some examples include, but are not limited to, the following: A veteran is generally required to be 20 percent disabled before entitlement to vocational rehabilitation can be established. To be found entitled to financial assistance in the purchase of automobile and necessary adaptive equipment, a veteran has to have a service-connected loss or permanent loss of use of one or both feet or one or both hands. We ask that the Committee on

Medical Evaluation consider medical criteria thresholds for ancillary and special purpose benefits as part of their review of the Rating Schedule.

Summary

The Commission recognizes the challenges that the Committee on Medical Evaluation faces in dealing with these questions. Ensuring that the Rating Schedule contains a breadth of conditions commensurate with the current state of medicine; reflects current medications, treatments, diagnostic tests, etc.; and has a sufficiently diverse range of impairment levels to reflect a condition's entire disability picture are of critical importance to the Commission. Suggestions as to how to make the Individual Unemployability benefit more reflective of the current world of medicine given the nation's mindset on working, retirement and the state of the economy will be appreciated. Suggestions on the role of clinicians and what conditions should be considered as secondary to or aggravated by other conditions are eagerly anticipated. Suggestions as to contemporary ancillary benefits that are responsive to the evolving world of disabled veterans would be helpful. An example might be suggesting a new approach to compensating veterans suffering multiple effects from blast trauma. These suggestions will be used to determine the appropriateness of benefits, the appropriateness of the level of such benefits, and the appropriate standard or standards for determining whether a disability or death of a veteran should be compensated. The Commission will consider these suggestions in framing its response to the charge from Congress and the President.

We look forward to hearing the results of your Committee's deliberations in the coming months.