



AMERICAN
SPEECH-LANGUAGE-
HEARING
ASSOCIATION

February 4, 2008

James Peake, M.D., Secretary of Veterans Affairs
c/o Maya Ferrandino, Regulations Staff
(211D), Compensation and Pension Service
Veterans Benefits Administration
Department of Veterans Affairs
810 Vermont Avenue, NW.
Washington, DC 20420

RE: Department of Veterans Affairs (VA) Proposed rule: “Schedule for Rating Disabilities; Evaluation of Residuals of Traumatic Brain Injury (TBI)” RIN 2900–AM75

Dear Secretary Peake:

The American Speech-Language Hearing Association (ASHA) is the professional and scientific association representing approximately 130,000 speech-language pathologists, audiologists, and speech, language, and hearing scientists qualified to meet the needs of the estimated 49 million (or 1 in 6) children and adults in the United States with communication disorders. We appreciate the opportunity to provide the Department of Veterans Affairs (VA) with our concerns and input as to this proposed rule that concerns changes to Diagnostic Code 8045 of 38 C.F.R. Part 4: “Schedule for Rating Disabilities; Evaluation of Residuals of Traumatic Brain Injury (TBI),” published in the Federal Register on January 3, 2008.¹

Many of our members, both inside and outside the VA healthcare system, will be in the position to evaluate and treat veterans for a variety of residuals of TBI, including speech-language and audiological disorders. For that reason, this rating revision is of considerable interest to ASHA.

We recognize that the ratings approach articulated in the VA’s proposed rule reflects a substantial improvement over the prior rating method under Diagnostic Code (DC or Code) 9304 for “Brain Disease due to Trauma” that had a 10% limit. There is also a current prohibition on using combined ratings with Code 9304, in absence of diagnosed multi-infarct dementia. The proposed changes will provide more accurate ratings tailored to the idiosyncratic nature of TBI residuals experienced by a given person. We commend

¹ Department of Veterans Affairs Proposed rule: “Schedule for Rating Disabilities; Evaluation of Residuals of Traumatic Brain Injury (TBI);” RIN 2900–AM75 (Federal Register / Vol. 73, No. 2 / January 3, 2008).

444 NORTH CAPITOL STREET, N.W.
SUITE 715
WASHINGTON, DC 20001
FAX 202-624-5955

www.asha.org

2200 RESEARCH BLVD
ROCKVILLE, MD 20850-3289
301-296-5700 VOICE or TTY
FAX 301-296-8577

the VA on updating the underpinnings for TBI residuals ratings, based on modern medical knowledge.

However, there remain a few concerns and observations we would like to convey. Most are specific to the nature of speech-language and hearing disorders that our members evaluate, treat and research. The following comments will address and provide recommendations on these topics:

- A full, 60-day comment period;
- *Sua sponte* VA rating reviews under the new Diagnostic Code 8045;
- The rating method for cognitive impairment; need to refine the facets for rating cognitive impairment into separate facets for speech, spoken language, written language disorders and hearing disorders with clearly defined subcomponents;
- Need for a standard assessment tool for speech, spoken language, and written language disorders;
- Broadening the span of rating percentages for “symptoms cluster;”
- TBI residuals and overlapping mental disorders; and
- Additional compensation ratings

I. REGULATORY PROCEDURE: THE VA SHOULD PROVIDE THE CUSTOMARY 60 DAYS FOR PUBLIC COMMENT

The full, customary 60 days for regulatory comments should be allowed for the public to adequately assess the proposed rule and develop cogent comments to it. We note that the VA has only provided a 30-day comment period for this proposed rule, rather than the customary 60-day period. Public interest in issues concerning TBI in veterans, particularly those returning from combat duties, is especially heightened now. Other specialty providers who treat TBI residuals may also wish to submit comments to this proposed rule. Evaluation, treatment and rehabilitation of patients with TBI residuals cut across multiple medical fields, including speech-language pathology and audiology. In addition, veterans’ advocacy groups and other patient advocates may wish to comment. We believe that it is appropriate and, ultimately, in the veterans’ best medical and legal interests, to ensure that they receive the benefit of the customary 60-day period for submitting comments.

This proposed rule is certainly as meaningful and far-reaching in its impact as many other proposed federal rules and more than some. In addition, the rating methodology for TBI residuals will strongly impact the lives of some of the most vulnerable, injured veterans for many years, if not their entire lives. Formulating a new rating approach to TBI

residuals bears careful scrutiny and consideration, to ensure that an appropriate spectrum of disabling features of TBI is taken into account. The breadth and severity of TBI residuals must be accurately conceived and articulated in order for veterans to obtain adequate compensation for their disabilities. For these reasons, we request that the VA publish in the Federal Register a 30-day extension for the comment period for this proposed rule.

Recommendation: ASHA recommends that the VA provide the full, customary 60 days for public comments to this proposed rule by immediately publishing a 30-day extension for the comment period in the Federal Register.

II. APPLICABLE DATES FOR NEW DIAGNOSTIC CODE 8045

Background: Effective Date for New Diagnostic Code 8045

An effective date for the new Diagnostic Code 8045 rating criteria will be announced when the final rule is published in the Federal Register. The “VA proposes to make the provisions of this rule applicable to all applications for benefits received by the VA on or after the effective date of this rule.”² Ordinarily, a claim prompts a rating determination. The regulation 38 C.F.R. §3.400, requires that, “(e)xcept as otherwise provided, the effective date of an evaluation and award of pension, compensation or dependency and indemnity compensation based on an original claim, a claim reopened after final disallowance, or a claim for increase will be the date of receipt of the claim or the date entitlement arose, whichever is the later.” However, when the VA changes its rating criteria, some cases will have claims already pending review at some stage and other cases will be quiescent. Different approaches will pertain to different adjudicative scenarios that effect application of the new rating criteria:

1. Claims filed at the regional office (agency of original jurisdiction) prior to the effective date for the new Code 8045 criteria will be under the new criteria, if the adjudication is done on or after the effective date.
2. Claims filed at the regional office on or after the effective date for the new Code 8045 criteria will be under the new criteria.
3. Claims the regional office adjudicated under the old Code 8045 criteria that are on appeal at the Board of Veterans Appeals (BVA) will be remanded to the agency of original jurisdiction for re-adjudication under the new Code 8045 criteria.

² Department of Veterans Affairs Proposed rule: “Schedule for Rating Disabilities; Evaluation of Residuals of Traumatic Brain Injury (TBI);” RIN 2900–AM75 (Federal Register / Vol. 73, No. 2 / January 3, 2008), at 435:

“VA proposes to make the provisions of this rule applicable to all applications for benefits received by VA on or after the effective date of this rule. A veteran whose residuals of TBI are rated under a prior version of § 4.124a, diagnostic code 8045, will be permitted to request review under the new criteria, irrespective of whether his or her disability has worsened since the last review.”

4. The Board of Veterans Appeals and the U.S. Court of Veterans Appeals will adjudicate claims under the new Code 8045 criteria, if the agency of original jurisdiction and the BVA, respectively, made their determinations under the new Code 8045 criteria.

A. The VA Should Perform *Sua Sponte* Reviews under New Code 8045 Criteria for All Cases with Service-Connected TBI Residuals

The VA proposes to allow veterans with currently service-connected TBI residuals to request a rating review under the new criteria.³ This “review” (claim) would be prompted by both a veteran’s specific claim for an increased rating, as well as by a claim for pension, under §3.151.⁴ Such claims could be formal or informal, under §3.155.⁵ However, requesting this review would require affirmative action by the veterans, many of whom will not know that they can do this and/or are too impaired to successfully take action.

In addition, it matters whether the VA or the veteran initiates a claim for an increased rating under the new Code 8045 criteria because the filing date for a claim can change the effective date for entitlement to a higher rating.⁶ If the VA reviews these cases *sua sponte*, there is no claim receipt (filing) date to trigger an effective date later than the date entitlement arose (the effective date of the new Code 8045).

If the VA will only review Code 8045 claims upon the veteran’s request, there would be a claim, so the effective date would be the later of either: 1) the effective date for the new Code 8045 criteria; or 2) the claim’s filing date. All or nearly all veterans’ claims for increased ratings under Code 8045 will be filed after the effective date for new Code 8045 criteria because that is when most will first hear of its existence.

³ *Ibid.*

⁴ **“38 C.F.R. §3.151 Claims for disability benefits.**

(a) *General.* A specific claim in the form prescribed by the Secretary must be filed in order for benefits to be paid to any individual under the laws administered by VA. (38 U.S.C. 5101(a)). A claim by a veteran for compensation may be considered to be a claim for pension; and a claim by a veteran for pension may be considered to be a claim for compensation. . .”

⁵ **“38 C.F.R. §3.155 Informal claims.**

(a) Any communication or action, indicating an intent to apply for one or more benefits under the laws administered by the Department of Veterans Affairs, from a claimant, his or her duly authorized representative, a Member of Congress, or some person acting as next friend of a claimant who is not sui juris may be considered an informal claim. . .”

⁶ **“38 C.F.R. § 3.400 General.**

Except as otherwise provided, the effective date of an evaluation and award of pension, compensation or dependency and indemnity compensation based on an original claim, a claim reopened after final disallowance, or a claim for increase will be the date of receipt of the claim or the date entitlement arose, whichever is the later.”

Without the VA's *sua sponte* reviews, nearly all Code 8045 increased ratings would be delayed until these veterans file a claim/review request under the new Code 8045 criteria, after its effective date. If the VA requires veterans to take action for ratings under the new criteria, this would cost veterans their increased compensation money for the period between the new Code 8045's effective date and the date they file a claim. Veterans who do not know to ask for this review or happen to file an increased rating claim would not receive a compensation raise. Essentially, many veterans would lose substantial compensation funds if the VA requires them to affirmatively make a claim under the new criteria. This approach would also create two classes of TBI ratings, some on the prior criteria and some under the new Code 8045, which is inequitable. If the VA takes responsibility for applying the new Code 8045 to all existing TBI cases, eventually they would all be rated uniformly under the same criteria.

ASHA believes that it is eminently unfair and inequitable for the VA to burden already disabled veterans with additional claims requirements, just because the VA changes rating criteria. We recommend that the VA to perform ratings reviews upon its own initiative (*sua sponte*) under new Diagnostic Code 8045 criteria, where appropriate. Of course, the VA would do so after the proposed rule is finalized with an effective date.

The effective date for any rating increase based on the VA's *sua sponte* review should be the effective date of the new Code 8045 criteria. That may mean a retroactive effective date for the increased rating benefit, prior to the date the VA reviews the case. After all, a VA-initiated review is not a "claim" that would trigger a later effective date. This approach would be entirely consistent with §3.400 for effective dates, which provides that "the effective date for a compensation evaluation will be the date of receipt of the claim or the date entitlement arose, whichever is the later." Entitlement to a higher rating under new Code 8045 criteria will have arisen as of the effective date of those criteria, which will pre-date either a *sua sponte* review or a veteran-initiated rating review claim.

While the VA notes that re-rating TBI residuals under the new Code 8045 would be to determine whether a higher rating is warranted, the proposed regulation does not specifically direct adjudicators not to reduce ratings. We believe that such a clause is necessary, in order to prevent veterans from being adversely affected by an agency rating criteria change.

Recommendation: In the final regulation, the VA should articulate the requirement for the VA to conduct a *sua sponte* review to determine eligibility for a rating increase. The VA should also prohibit ratings reductions stemming from this criteria-change review. The regulatory language should be revised to clarify that the effective date of any increased compensation rating for TBI residuals will be the effective date of the new Code 8045 criteria, even if the effective date is retroactive to the *sua sponte* rating determination.

To avoid disadvantaging veterans by an agency decision to change criteria, a reasonable time period should be established for "grandfathering" an existing rating under the prior Code 8045 criteria. This would apply only to cases where application of the new Code 8045 criteria would otherwise result in a rating reduction. No veterans who currently

have service-connected TBI residuals should be adversely impacted by the VA's rating criteria change.

III. TBI RATINGS: COGNITIVE IMPAIRMENTS AND SYMPTOMS CLUSTERS

Background:

As the VA recognizes in the narrative to the proposed rule, TBI residuals can manifest as a wide range of impairments affecting communication, hearing, sensory perceptions, motor functions, including those that affect swallowing and eating, and many other subjective symptoms that adversely impact quality of life. Hearing impairment, as documented by auditory testing conducted by a state-licensed audiologist, will be rated separately under §4.85 "Evaluation of hearing impairment."⁷ Matrix tables are used to calculate the combined, disabling effect of hearing impairment in the affected ears.

Neurological dysfunction due to TBI is to be rated under the appropriate regulatory section and diagnostic code in the Schedule of Ratings that reflects the particular disorder. Diagnosed mental disorders from TBI are to be rated under Codes for specific mental disorders. For other types of impairments, the VA proposes to rate TBI residuals under either (objectively demonstrable) cognitive impairments or subjective "symptoms cluster."

Largely subjective symptoms attributable to TBI but for which "there are no objective neurological findings or abnormalities" are termed "symptoms cluster." Many symptoms can fall under this rubric, including those indicative of speech, language and auditory impairments, such as: "dizziness or vertigo," "cognitive impairment, difficulty concentrating," "tinnitus or hypersensitivity to sound," and "difficulty hearing in noisy situations or with competing sounds in the absence of objective hearing loss."⁸

⁷ **"38 C.F.R. §4.85 Evaluation of hearing impairment.**

(a) An examination for hearing impairment for VA purposes must be conducted by a state-licensed audiologist and must include a controlled speech discrimination test (Maryland CNC) and a puretone audiometry test. Examinations will be conducted without the use of hearing aids. . . ."

⁸ Department of Veterans Affairs Proposed rule: "Schedule for Rating Disabilities; Evaluation of Residuals of Traumatic Brain Injury (TBI);" RIN 2900-AM75 (Federal Register / Vol. 73, No. 2 / January 3, 2008): "Note #2—Prohibition of Evaluation Under Cognitive Impairment Criteria and Under the Symptoms Cluster," at 433:

"The symptoms cluster includes such symptoms as headache (migraine or tension-type), dizziness or vertigo, fatigue, malaise, sleep disturbance, cognitive impairment, difficulty concentrating, delayed reaction time, behavioral changes (such as irritability, restlessness, apathy, inappropriate social behavior, aggression, impulsivity), emotional changes (such as mood swings, anxiety, depression), tinnitus or hypersensitivity to sound, hypersensitivity to light, blurred vision, double vision, decreased sense of smell and taste, and difficulty hearing in noisy situations or with competing sounds in the absence of objective hearing loss."

The VA intends that, under Diagnostic Code 8045 “cognitive impairment may not be evaluated both under the cognitive impairment criteria and as part of the symptoms cluster because this would constitute pyramiding.”⁹ It is understandable that pyramiding must be avoided, so that ratings cannot be assigned for different disabilities stemming from the same TBI signs and symptoms.¹⁰ Cognitive impairment can be rated either under criteria in the table for “Facets of cognitive impairment” or “symptoms cluster,” whichever is most advantageous to the veteran.¹¹ However, where the pyramiding rule is not violated, separate disorders should be service connected and separately rated, to compensate a disabled veteran fully.

Once the various TBI-related impairments are assigned separate ratings, the VA intends to use the combined ratings table (38 C.F.R. 4.25) to formulate the ultimate rating assignment.¹² Use of this table results in ratings which are less than the additive value of the separate ratings, on the premise that additive disabilities diminish a person’s functional efficiency further but in a manner that is less than additive.

A. “Facets of Cognitive Impairment:” Rating Method

The VA constructed a table of eleven “Facets of cognitive impairment” with criteria for each facet assigned to a “Level of Impairment” from a five-point numerical range (low 0-4 high). Regardless how many of the eleven “facets” the veteran has from TBI and how high their levels, the ultimate rating assigned will be based on the average of the three top-scored levels. The resultant average “Level of Impairment” correlates to a rating percentage that increases in 30% increments: 1 = 10%, 2 = 40%, 3 = 70% and 4 = 100%.¹³

⁹ Department of Veterans Affairs Proposed rule: “Schedule for Rating Disabilities; Evaluation of Residuals of Traumatic Brain Injury (TBI);” RIN 2900–AM75 (Federal Register / Vol. 73, No. 2 / January 3, 2008): “Note #2—Prohibition of Evaluation Under Cognitive Impairment Criteria and Under the Symptoms Cluster,” at 435.

¹⁰ **“38 C.F.R. §4.14 Avoidance of pyramiding.**

The evaluation of the same disability under various diagnoses is to be avoided. . . . Both the use of manifestations not resulting from service-connected disease or injury in establishing the service-connected evaluation and the evaluation of the same manifestation under different diagnoses are to be avoided.”

¹¹ Department of Veterans Affairs Proposed rule: “Schedule for Rating Disabilities; Evaluation of Residuals of Traumatic Brain Injury (TBI);” RIN 2900–AM75 (Federal Register / Vol. 73, No. 2 / January 3, 2008): “Note #2—Prohibition of Evaluation Under Cognitive Impairment Criteria and Under the Symptoms Cluster,” at 435.

¹² **“38 C.F.R. §4.25 Combined ratings table.**

Table I, Combined Ratings Table, results from the consideration of the efficiency of the individual as affected first by the most disabling condition, then by the less disabling condition, then by other less disabling conditions, if any, in the order of severity. Thus, a person having a 60 percent disability is considered 40 percent efficient. . . .”

¹³ Department of Veterans Affairs Proposed rule: “Schedule for Rating Disabilities; Evaluation of Residuals of Traumatic Brain Injury (TBI);” RIN 2900–AM75 (Federal Register / Vol. 73, No. 2 / January 3, 2008): “Note #2—Prohibition of Evaluation Under Cognitive Impairment Criteria and Under the Symptoms Cluster,” at 434; 437-438.

This method is problematic in that it can easily under-rate the overall disability level. For example, Veteran X may have three facets of TBI cognitive impairment, each scored at level three. Three is the average score for the three facets, so this veteran would receive a 70% rating. In a second case, Veteran Y may also have three facets of cognitive impairment all at level three, plus eight more facets, seven at level three and one at level two. Although Veteran Y appears to be much more disabled overall than Veteran X, using the average of the top three highest facet levels would result in the same overall 70% rating for both. This is obviously inequitable and can be corrected by a more sophisticated rating method.

Recommendation: Code 8045 ratings for cognitive impairment should be calculated with a method that incorporates the number of impaired facets weighted by the level of each facet. That would more accurately reflect overall TBI-related disability. Once a each facet receives an assigned value, the rater could use a combination table, similar to the Combined Ratings Table but created especially for TBI residuals, to calculate the additive, disabling effect of multiple, TBI-related cognitive impairments.¹⁴

B. “Facets of Cognitive Impairment:” Speech and Language Disorders Should Be Further Stratified

We are concerned about the structure of the facet, “Speech and Language Disorders,” which conglomerates too many elements that should be assessed separately. Speech disorders should not be combined with spoken and written language disorders as a single “Facet of cognitive impairment” to determine disability level. Doing this produces a too highly generalized, inaccurate concept of communicative disability. Other elements that should be separately assessed for rating purposes are, among others: 1) speech; 2) expressive and receptive spoken and written language abilities; speech and language impairments; and speech, spoken language and writing impairments.

Speech disorders are quite different from language disorders, involving different neural, motor and cognitive pathways. Speech disorders include problems with speech sound production (articulation), fluency (stuttering), and voice. Spoken language disorders impact a person’s ability to understand others (receptive language) or to share thoughts, ideas, and feelings (expressive language). Written language disorders include reading comprehension and writing difficulties.

A person can have both speech and language impairments after TBI or may have deficits in only one area. Language disorders vary, as well. For example, spoken language can be more impaired than written language or reception more than expression. The degree of disability in each area is highly individual. For this reason, the proposed rating construct for the speech and language disorders facet is problematic and may result in the same level choice, whether there is impairment of only spoken or written language, only

¹⁴ “38 C.F.R. §4.25 Combined ratings table.

Table I, Combined Ratings Table, results from the consideration of the efficiency of the individual as affected first by the most disabling condition, then by the less disabling condition, then by other less disabling conditions, if any, in the order of severity.”

speech, or both. Overall disability is substantially more severe if both communication modalities are affected, and this should be captured in the rating system.

Recommendation: ASHA recommends that the VA refine the facets for rating cognitive impairment into separate facets for speech, spoken language, written language disorders and hearing disorders with clearly defined subcomponents.

C. “Facets of Cognitive Impairment:” Standardized Speech-Language Assessment Tool Needed

Adding to the problems with the overly combined speech and language disorders facet is the absence of a common reference point for assessing level of impairment. There is no indication that the VA will require results from a standard assessment tool accepted in the field of speech-language pathology to gauge speech or language impairment. It seems appropriate to require evidence of type and level of impairment based on objective measurements of speech-language and writing functions. Moreover, it is consistent with the VA’s rating principles to require medical documentation as a basis for rating assignments. As required by 38 C.F.R. §4.1 Essentials of evaluative rating: “(f)or the application of this schedule, accurate and fully descriptive medical examinations are required, with emphasis upon the limitation of activity imposed by the disabling condition.”¹⁵ Any speech-language assessment tool accepted as reliable evidence should be administered by an appropriately credentialed speech-language pathologist.

ASHA notes that a field-accepted assessment tool already exists that the VA can use to re-craft the rating criteria for speech-language and writing impairments. It has the additional value of being able to gauge progress across various components of function, which is also useful in rating. That tool is the system known as ASHA's Functional Communication Measures (FCMs), used in ASHA’s National Outcomes Measurement System (NOMS) data collection system. FCMs are “a series of disorder-specific, seven-point rating scales designed to describe the change in an individual's functional communication and/or swallowing ability over time. Based on an individual's treatment plan, FCMs are chosen and scored by a certified speech-language pathologist on admission and again at discharge to depict the amount of change in communication and/or swallowing abilities after speech and language intervention.”¹⁶

¹⁵ “**38 C.F.R. §4.1 Essentials of evaluative rating.**

This rating schedule is primarily a guide in the evaluation of disability resulting from all types of diseases and injuries encountered as a result of or incident to military service. The percentage ratings represent as far as can practicably be determined the average impairment in earning capacity resulting from such diseases and injuries and their residual conditions in civil occupations. . . . Over a period of many years, a veteran’s disability claim may require reratings in accordance with changes in laws, medical knowledge and his or her physical or mental condition. . . .”

¹⁶ The American Speech-Language-Hearing’s (ASHA) National Outcomes Measurement System (NOMS) is on the ASHA website: <http://www.asha.org/members/research/NOMS>:

“FCMs are a series of disorder-specific, seven-point rating scales designed to describe the change in an individual's functional communication and/or swallowing ability over time. Based on an individual's treatment plan/IEP, FCMs are chosen and scored by a certified speech-language pathologist on admission and again at discharge to depict the amount of change in communication and/or swallowing

Recommendation: To ensure that rating determinations are consistent and based on reliable evidence, ASHA recommends that the VA require the use of speech-language assessment tools accepted in the field of speech-language pathology to gauge speech or language impairment from TBI. Such tools should be administered by an appropriately credentialed speech-language pathologist.

D. “Facets of Cognitive Impairment:” Criteria Lack Precision

Another issue with these criteria is the use of undefined and overly general terms, along with a lack of clarity as to how to determine whether the criteria are met. The italicized

abilities after speech and language intervention. By examining the scores from admission and discharge, clinicians can assess the amount of change and, thus, the benefits of treatment.”

EXAMPLE: Sample FCM - Adult Component: Spoken Language Comprehension

- Level 1:** The individual is alert, but unable to follow simple directions or respond to yes/no questions, even with cues.
- Level 2:** With consistent, maximal cues, the individual is able to follow simple directions, respond to simple yes/no questions in context, and respond to simple words or phrases related to personal needs.
- Level 3:** The individual usually responds accurately to simple yes/no questions. The individual is able to follow simple directions out of context, although moderate cueing is consistently needed. Accurate comprehension of more complex directions/messages is infrequent.
- Level 4:** The individual consistently responds accurately to simple yes/no questions and occasionally follows simple directions without cues. Moderate contextual support is usually needed to understand complex sentences/messages. The individual is able to understand limited conversations about routine daily activities with familiar communication partners.
- Level 5:** The individual is able to understand communication in structured conversations with both familiar and unfamiliar partners. The individual occasionally requires minimal cueing to understand more complex sentences/messages. The individual occasionally initiates the use of compensatory strategies when encountering difficulty.
- Level 6:** The individual is able to understand communication in most activities but some limitations in comprehension are still apparent in vocational, avocational, and social activities. The individual rarely requires minimal cueing to understand complex sentences. The individual usually uses compensatory strategies when encountering difficulty.
- Level 7:** The individual's ability to independently participate in vocational, avocational, and social activities is not limited by spoken language comprehension. When difficulty with comprehension occurs, the individual consistently uses a compensatory strategy.

Copyright American Speech-Language-Hearing Association (ASHA) 1998. This scale is intended for the use of participants in the National Outcomes Measurement System who have successfully passed the NOMS User Registration Test. Use of this material by unqualified or unauthorized persons without the written consent of ASHA is prohibited.

words in the “Facet of cognitive impairment” criteria require more definition and precision as to how they will be measured.¹⁷

Recommendation: Criteria for assessing TBI-induced impairment should be separated into different categories for disorders of speech, spoken language, and written language. There should be subcategories of assessment, such as for features of speech, expressive and receptive language abilities, and writing ability. Measurements for levels should be formulated with clearly defined terms. (See “ATTACHMENT 1: SAMPLE RECOMMENDED STRUCTURE SPOKEN LANGUAGE DISORDERS: COMPREHENSION”)

Assessment tools accepted in the field of speech-language pathology should be required to provide evidence of consistent, objective measurements of speech-language impairment across categorical criteria. ASHA highly recommends that the VA use ASHA's Functional Communication Measures (FCMs) as a reference model to revise the facets of impairment for rating TBI residuals and for assessing veterans' functional abilities in speech, spoken language, and written language. ASHA offers its assistance to the VA in crafting meaningful, precise criteria for the purpose of rating speech, spoken language, and written language disorders from TBI.

IV. “SYMPTOMS CLUSTER:” SPAN OF RATINGS

The VA proposes to use 20%, 30% and 40% ratings for various subjective symptoms listed under “symptoms cluster” attributable to TBI but for which “there are no objective neurological findings or abnormalities on routine imaging.”¹⁸ The “symptoms cluster” would be rated on the basis of its current manifestations, without regard to the severity level of the original brain injury. While this is a great improvement over the current 10% limit on DC 8045 for “Brain disease due to trauma,” veterans need more rating increments and higher ratings levels to adequately and fairly account for TBI-related disability.

If the veteran carries a diagnosis that includes one or more of the listed symptoms in the cluster, the diagnosed disorder is to be separately rated under the relevant Diagnostic Code and the other symptoms from the cluster rated separately, based on how many remain apart from the diagnosed disorder(s). Percentage ratings are assigned, starting at 20%, based on the number of remaining symptoms: 20% for 3-4 symptoms; 30% for 5-8, and 40% for 9 or more.

¹⁷ Department of Veterans Affairs Proposed rule: “Schedule for Rating Disabilities; Evaluation of Residuals of Traumatic Brain Injury (TBI);” RIN 2900-AM75 (Federal Register / Vol. 73, No. 2 / January 3, 2008): “Note #2—Prohibition of Evaluation Under Cognitive Impairment Criteria and Under the Symptoms Cluster,” Table at 437-438.

¹⁸ Department of Veterans Affairs Proposed rule: “Schedule for Rating Disabilities; Evaluation of Residuals of Traumatic Brain Injury (TBI);” RIN 2900-AM75 (Federal Register / Vol. 73, No. 2 / January 3, 2008), at 433.

The proposed limit of 40% for TBI residuals classified as “symptoms cluster” would preclude a veteran from receiving a total rating based on unemployability, regardless how disabled s/he may be in reality. Where TBI “symptoms cluster” constitutes the veteran’s sole service-connected disability, that veteran must have a schedular rating of at least 60% in order to be eligible to receive a total rating based on unemployability.

Recommendation: ASHA recommends that the VA expand the breadth of ratings increments to more fully account for TBI-related disability due to these symptoms. At minimum, we urge the VA to add 10%, 50%, 60% ratings for TBI symptoms clusters. Unless a 60% rating is available under 8045 for TBI symptoms clusters, a veteran would be ineligible to receive a total (100%) disability rating for compensation based on unemployability, per 38 C.F.R. §4.16.

V. COMPENSATION FOR TBI RESIDUALS SHOULD NOT BE COMPROMISED BY UNRELATED MENTAL DISORDERS

TBI impairments, such as speech, language, and hearing disorders, can co-exist with unrelated mental disorders. Some cognitive functions necessary for spoken and written language, i.e., concentration, memory, word retrieval and composition, comprehension and the ability to express oneself, can be affected by mental disorders. The VA will assign a Code 8045 rating, depending upon whether signs and symptoms of TBI impairment can be “clearly separated” from a service-connected mental disorder.¹⁹ If so, it is rated under Section 4.130 Diagnostic Codes for mental disorders. Veterans with speech, language, and hearing disorders due to TBI (as well as those with other residual disability) should not be precluded from full compensation for those disabilities because they have a mental disorder unrelated to TBI.

Recommendation: VA rating officials must be careful to avoid the inappropriate attribution of TBI signs and symptoms to a non-service-connected mental disorder. For that reason, ASHA recommends that the VA should ensure that ratings are based upon reliable medical evidence that clearly sorts out which of the veterans’ signs and symptoms are TBI residuals and which can be legitimately attributed to any non-service-connected mental disorder. This may require obtaining an Independent Medical Opinion from a speech-language pathologist. VA adjudicators should be required to make specific findings in their decisions as to their reasons for excluding any signs and

¹⁹ Department of Veterans Affairs Proposed rule: “Schedule for Rating Disabilities; Evaluation of Residuals of Traumatic Brain Injury (TBI);” RIN 2900–AM75 (Federal Register / Vol. 73, No. 2 / January 3, 2008): “Note #2—Prohibition of Evaluation Under Cognitive Impairment Criteria and Under the Symptoms Cluster,” at 435:

“If the signs and symptoms of the mental disorder(s) and of cognitive impairment cannot be clearly separated, a single evaluation either under the General Rating Formula for Mental Disorders or under the evaluation criteria for cognitive impairment, whichever provides the better assessment of overall impaired functioning due to both conditions, would be assigned. If the signs and symptoms are clearly separable, separate evaluations for the mental disorder(s) and for cognitive impairment would be assigned.”

symptoms from consideration in rating TBI residuals, if they are determined to be part of a non-service-connected mental disorder.

VI. ADDITIONAL COMPENSATION RATINGS

Due to the potential for TBI residuals to cause a wide spectrum of disability from minimal to total, the VA recognizes the need for rating officials to consider compensation outside the rating schedule of DC 8045. The VA proposed rule, Section 4.12a, states, “(c)onsider special monthly compensation for such problems as . . . certain sensory impairments . . . the need for aid and attendance (including when assistance or supervision is needed on the basis of cognitive impairment), and being housebound.”²⁰ “§3.350 provides for “special monthly compensation ratings” for various anatomical losses, including “deafness of both ears” [§3.350 (5)], having absence of air and bone conduction or “complete organic aphonia with constant inability to communicate by speech” [§3.350 (6)].²¹

According to the VA, “Special Monthly Compensation (L) can at times be designated an aid & attendance benefit.” However, “Special Monthly Pension (SMP)” is either the aid and attendance or housebound allowance that comes under different sections, “§3.351 (Special monthly Dependency and Indemnity Compensation (DIC), death compensation, pension and spouse's compensation ratings) and §3.552 (Determining need for aid & attendance, housebound).”^{22, 23} It is also possible to assign “Total disability ratings for

²⁰ Department of Veterans Affairs Proposed rule: “Schedule for Rating Disabilities; Evaluation of Residuals of Traumatic Brain Injury (TBI);” RIN 2900–AM75 (Federal Register / Vol. 73, No. 2 / January 3, 2008): “Note #2—Prohibition of Evaluation Under Cognitive Impairment Criteria and Under the Symptoms Cluster,” at 436.

²¹ “§3.350 Special monthly compensation ratings.

The rates of special monthly compensation stated in this section are those provided under 38 U.S.C. 1114. (a) *Ratings under 38 U.S.C. 1114(k)*. Special monthly compensation under 38 U.S.C. 1114(k) is payable for each anatomical loss or loss of use of one hand, one foot, both buttocks, one or more creative organs, blindness of one eye having only light perception, deafness of both ears, having absence of air and bone conduction, complete organic aphonia with constant inability to communicate by speech . . . The limitations on the maximum compensation payable under this paragraph are independent of and do not preclude payment of additional compensation for . . . the special allowance for aid and attendance provided by 38 U.S.C. 1114(r). . .

“(5) *Deafness*. Deafness of both ears, having absence of air and bone conduction will be held to exist where examination in a Department of Veterans Affairs authorized audiology clinic under current testing criteria shows bilateral hearing loss is equal to or greater than the minimum bilateral hearing loss required for a maximum rating evaluation under the rating schedule. (Authority: Pub. L. 88-20)

(6) *Aphonia*. Complete organic aphonia will be held to exist where there is a disability of the organs of speech which constantly precludes communication by speech. (Authority: Pub. L. 88-22)

²² United States Department of Veterans Affairs Benefits Index:

“Aid & Attendance Allowance

An additional benefit paid to veterans, their spouses, surviving spouses and parents. This allowance is paid in all Compensation, Dependency and Indemnity Compensation (DIC) and Pension Programs. It is paid based on the need of aid and attendance by another person or by specific disability. Special Monthly Compensation (L) can at times be designated an aid & attendance benefit.

compensation based on unemployability (§4.16); and “ Total disability ratings for pension based on unemployability and age (§4.17).

TBI residuals can create a considerable spectrum of subjective symptoms and objective manifestations that may be: 1) temporary or permanent; 2) affecting a broad spectrum of physical and mental functions; 3) of widely differing severity levels. These residuals may be temporary or permanent. In addition to TBI residuals, veterans may have other service-connected disabilities that synergistically diminish veterans’ ability to function in their personal and professional lives. Also, these disabled veterans are especially challenged in their ability to navigate the VA claims process due to their cognitive and physical impairments. For these reasons, there should be a clear requirement for rating officials to automatically consider assigning the following special ratings:^{24, 25, 26}

Eligibility criteria, see 38 CFR §§3.350 (Special Monthly Compensation), 3.351 (Special monthly Dependency and Indemnity Compensation (DIC), death compensation, pension and spouse's compensation ratings), 3.552 (Determining need for aid & attendance, housebound).”
Retrieved January 24, 2008 from <http://www.vba.va.gov/bln/21/Benefits/#BM07>

²³ **“§3.351 Special monthly dependency and indemnity compensation, death compensation, pension and spouse’s compensation ratings.**

(a) *General.* This section sets forth criteria for determining whether:

(1) Increased pension is payable to a veteran by reason of need for aid and attendance or by reason of being housebound. (Authority: 38 U.S.C. 1521(d), (e))

(2) Increased compensation is payable to a veteran by reason of the veteran’s spouse being in need of aid and attendance. (Authority: 38 U.S.C. 1115(1)(E)). . .”

²⁴ **“38 C.F.R. §4.15 Total disability ratings.**

The ability to overcome the handicap of disability varies widely among individuals. The rating, however, is based primarily upon the average impairment in earning capacity . . . Total disability will be considered to exist when there is present any impairment of mind or body which is sufficient to render it impossible for the average person to follow a substantially gainful occupation; *Provided*, That permanent total disability shall be taken to exist when the impairment is reasonably certain to continue throughout the life of the disabled person. The following will be considered to be permanent total disability: . . . becoming permanently helpless or permanently bedridden. . . .”

²⁵ **“38 C.F.R. §4.16 Total disability ratings for compensation based on unemployability of the individual.**

(a) Total disability ratings for compensation may be assigned, where the schedular rating is less than total, when the disabled person is, in the judgment of the rating agency, unable to secure or follow a substantially gainful occupation as a result of service-connected disabilities: *Provided*, That, if there is only one such disability, this disability shall be ratable at 60 percent or more, and that, if there are two or more disabilities, there shall be at least one disability ratable at 40 percent or more, and sufficient additional disability to bring the combined rating to 70 percent or more. For the above purpose of one 60 percent disability, or one 40 percent disability in combination, the following will be considered as one disability. . . :

(2) Disabilities resulting from common etiology or a single accident . . .”

²⁶ **“38 C.F.R. §4.17 Total disability ratings for pension based on unemployability and age of the individual.**

All veterans who are basically eligible and who are unable to secure and follow a substantially gainful occupation by reason of disabilities which are likely to be permanent shall be rated as permanently and totally disabled. For the purpose of pension, the permanence of the percentage requirements of §4.16 is a requisite. . . .”

It is not entirely clear whether the VA means to mandate that rating officials make determinations as to a veterans' entitlement to special monthly compensation under for aid and attendance or housebound benefits. Also unspecified is whether an adjudicator must consider all potentially pertinent benefits under other regulatory sections, i.e., §3.350, §351 and §3.552.

Recommendation: ASHA recommends that the VA clarify the proposed regulatory language to specifically direct adjudicators in all claims involving TBI residuals to automatically cross-consider eligibility for additional benefits along with ratings increases, and vice versa. ASHA urges the VA to adopt an extremely liberal approach to adjudicating claims for veterans with TBI residuals. Ratings officials should broadly interpret any TBI residuals claims to cover potential benefits and related ratings approaches to which such veterans may be entitled, such as extra-schedular ratings, special monthly compensation, special monthly pension for aid and attendance and being housebound.

CONCLUSION

ASHA commends the VA on its progress in adopting a more modern approach to TBI residuals in veterans, including revising the rating schedule for disabilities related to service-connected TBI. Some easily made modifications in methodology and rating criteria formulation can allow the VA to reach its goal to create an improved, more comprehensive compensation approach for veterans disabled by TBI.

Thank you for the opportunity to set forth our concerns on behalf of ASHA's members.

Please contact Angela Foehl, JD, MPH, Director of Private Health Plans Advocacy, at afoehl@asha.org or 1-800-498-2071 ext. 5677 if you have questions about these comments.

Sincerely,

Catherine H. Gottfred, PhD
President

**ATTACHMENT 1: SAMPLE RECOMMENDED STRUCTURE
SPOKEN LANGUAGE DISORDERS: COMPREHENSION**

UNDER

“FACET OF IMPAIRMENT:” SPEECH-LANGUAGE DISORDERS

(Revisions in Italics)

FROM: ASHA’s EXAMPLE: Sample FCM - Adult Component: Spoken Language Comprehension*

* Spoken language disorders		
Comprehension	0	The individual's ability to independently participate in vocational, avocational, and social activities is not limited by spoken language comprehension. When difficulty with comprehension occurs, the individual consistently uses a compensatory strategy. (Level 7)
	1	The individual consistently responds accurately to simple yes/no questions and occasionally follows simple directions without cues. Moderate contextual support is usually needed to understand complex sentences/messages. The individual is able to understand limited conversations about routine daily activities with familiar communication partners. (Level 4) The individual is able to understand communication in structured conversations with both familiar and unfamiliar partners. The individual occasionally requires minimal cueing to understand more complex sentences/messages. The individual occasionally initiates the use of compensatory strategies when encountering difficulty. (Level 5)
	2	The individual is able to understand communication in most activities but some limitations in comprehension are still apparent in vocational, avocational, and social activities. The individual rarely requires minimal cueing to understand complex sentences. The individual usually uses compensatory strategies when encountering difficulty. (Level 6)
	3	The individual usually responds accurately to simple yes/no questions. The individual is able to follow simple directions out of context, although moderate cueing is consistently needed. Accurate comprehension of more complex directions/messages is infrequent. (Level 3) With consistent, maximal cues, the individual is able to follow simple directions, respond to simple yes/no questions in context, and respond to simple words or phrases related to personal needs. (Level 2)
	4	The individual is alert, but unable to follow simple directions or respond to yes/no questions, even with cues. (Level 1)

*Source: The American Speech-Language-Hearing’s (ASHA) National Outcomes Measurement System (NOMS) is on the ASHA website: <http://www.asha.org/members/research/NOMS>:

“FCMs are a series of disorder-specific, seven-point rating scales designed to describe the change in an individual's functional communication and/or swallowing ability over time. . . “