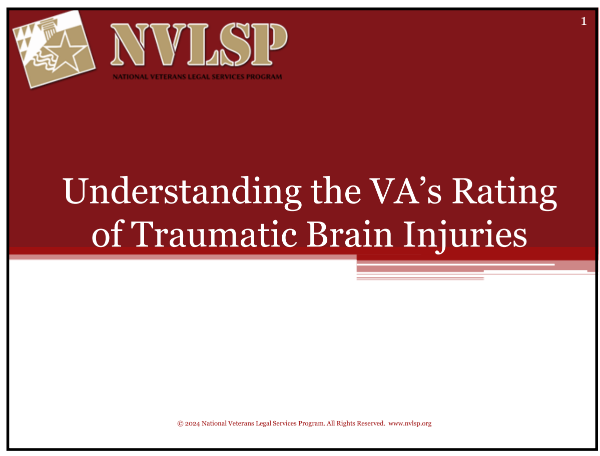

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Tech Tips: Audio Issues During the Live Webinar

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- **Helped develop NVLSP's VA Benefits Identifier App**
- **Veterans Benefits Manual author**

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AGENDA

- What is TBI?
- **Service Connection TBI Claim Reminders**
- General Rating Information
- **TBI Rating Criteria Basics**
- Overlap between PTSD and TBI symptoms
- Secondary SC/Co-Morbid Disabilities
- **VA TBI Exams**
- Special Monthly Compensation
- **Advocacy Advice**

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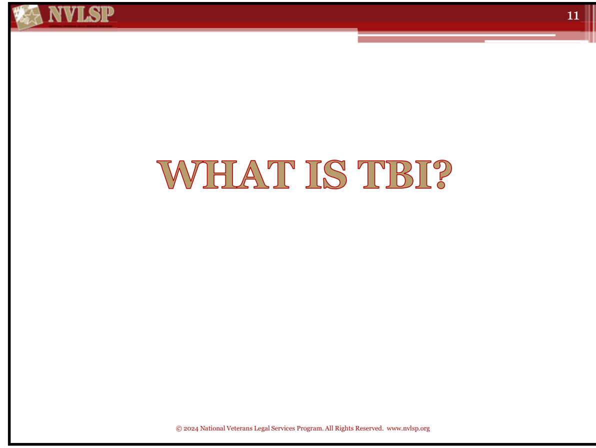

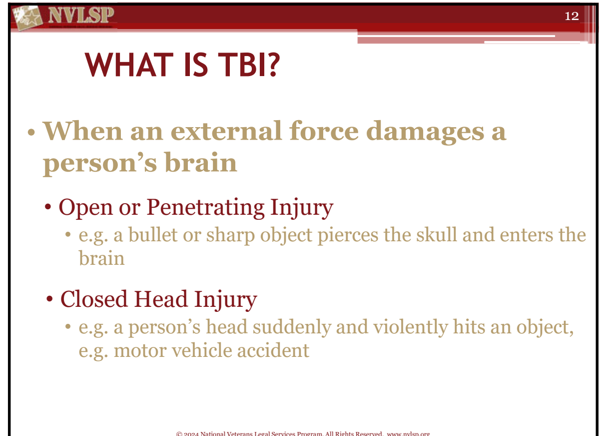

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WHAT IS TBI?

- **Need at *least one* of the following clinical signs immediately following the event:**
  - Any period of loss of consciousness or decreased consciousness
  - Any loss of memory for events immediately before or after the injury
  - Any alteration in mental state at the time of the injury (confusion, disorientation, slowed thinking, etc.)
  - Neurological deficits, whether or not transient, or
  - Intracranial lesion
- **TBI has 2 necessary components: the *external force* and the *identifiable acute manifestations* of brain injury immediately following the external force**

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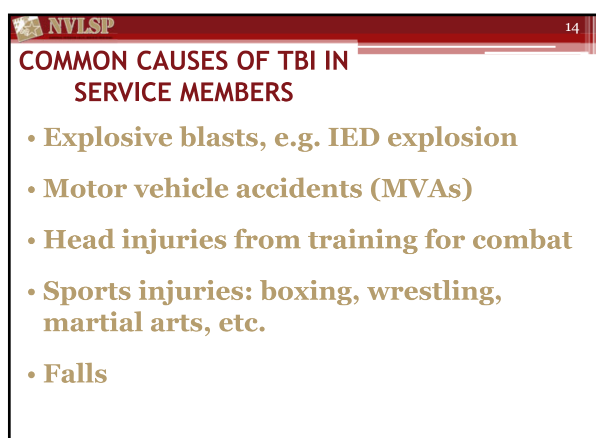

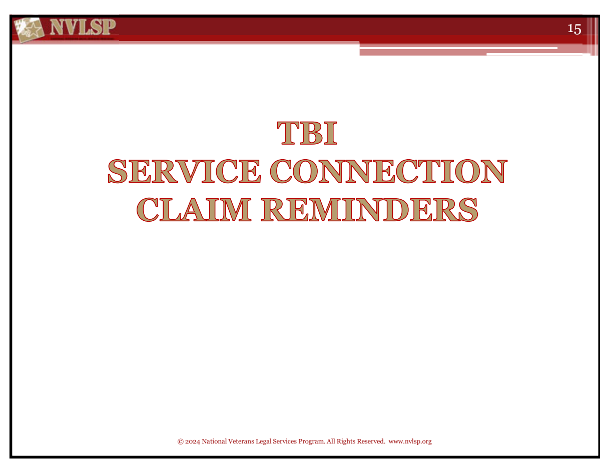

NVLSP 16

SERVICE CONNECTION CLAIMS

- **Guidance to VA adjudicators:**
  - A claim SC for TBI may also be worded as a claim for "head injury," or "concussion." A claim document mentioning these terms must be sympathetically read and understood as a claim for all identifiable TBI residuals that can be attributed to one or more TBI events.
  - A claim for "combat injuries," assault, automobile accident, fall, or other injurious events may also raise the issue of a TBI if there was an injury to the head
    - Manual M21-1, V.iii.12.B.1.e (change date Jan. 10, 2024)

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SERVICE CONNECTION CLAIMS

- **Guidance to VA adjudicators (cont'd):**
  - As recognized by 38 C.F.R. § 4.124a, DC 8045, the external force of a claimed TBI event may result not only in brain injury, but also in physical or psychological disorders distinct from brain injury residuals. An explosion, for example, may cause burns, muscle injuries, orthopedic injuries including amputations, and PTSD in addition to a brain injury. A TBI claim mentioning a specific traumatic event must be sympathetically read as a claim for SC for *all* disabling chronic residuals of the event.
    - Manual M21-1, V.iii.12.B.1.e (change date Jan. 10, 2024)

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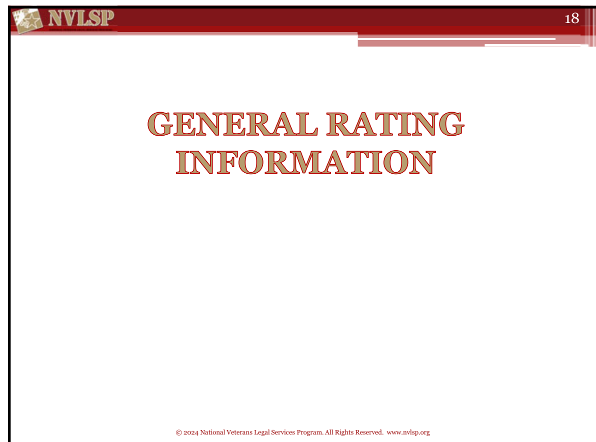

NVLSP 19

DUTY TO MAXIMIZE BENEFITS

- When Vet files original claim for evaluation of disability or claim for increase, claimant is generally presumed to be seeking highest benefit allowable
  - *AB v. Brown*, 6 Vet. App. 35 (1993)
- VA has a duty to maximize Vet's VA benefits.
  - *Bradley v. Peake*, 22 Vet. App. 280 (2008); *Morgan v. Wilkie*, 31 Vet. App. 162, 167 (2019)

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DUTY TO MAXIMIZE BENEFITS

- When determining the proper evaluation for a Vet's disability, VA is required to consider all possibly related Diagnostic Codes, especially those that may yield a higher rating
  - *Vogan v. Shinseki*, 24 Vet. App. 159, 164 (2010)

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DUTY TO MAXIMIZE BENEFITS

- VA Disability Ratings General Rule
  - All disabilities, including those arising from a single disease or injury, are to be rated separately and then combined pursuant to 38 C.F.R. § 4.25

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DUTY TO MAXIMIZE BENEFITS

- **Exception to the General Rule: Rule Against Pyramiding**
  - 38 C.F.R. § 4.14: evaluation of the same symptoms under various diagnoses is to be avoided
  - Rationale: Claimant would be overcompensated

EXCEPTION

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SEPARATE DISABILITY RATINGS

- **How do you reconcile the duty to maximize benefits with the rule against pyramiding?**
  - Separate disability ratings are awarded for each disabling condition, even if they all have the same etiology
    - For example, disfigurement, painful scars, muscle damage
      - *Esteban v. Brown*, 6 Vet. App. 259 (1994)

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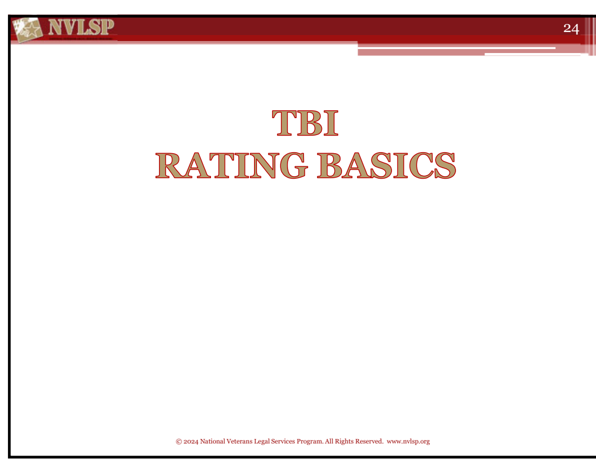

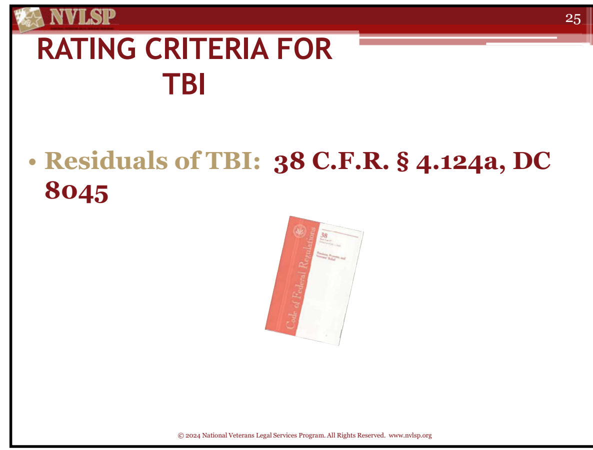

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TBI RATING PRINCIPLES

- Residuals with a **distinct diagnosis** are separately rated under the appropriate diagnostic code
- Residuals **not associated with a distinct diagnosis and cognitive residuals** of TBI are rated under the "Evaluation of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified" TABLE in 38 C.F.R. § 4.124a, DC 8045

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TBI RATING PRINCIPLES

- 4 Categories of TBI Residuals
  - **Physical/Neurological Dysfunction**
  - **Emotional/Behavioral Residuals**
  - **Cognitive Impairment Residuals**
  - **Subjective Symptoms**
    - 38 C.F.R § 4.124a, DC 8045

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PHYSICAL / NEUROLOGICAL RESIDUALS

Motor and sensory dysfunction, including pain, of extremities & face	Speech and other communication difficulties, including aphasia (inability to use/understand language)
Visual impairment	Dysarthria (can't articulate due to peripheral motor nerve problem, etc.)
Hearing loss and tinnitus	Neurogenic bladder (bladder doesn't empty fully due to nerve damage)
Loss of sense of smell/taste	Neurogenic bowel (loss of function due to nerve damage)
Seizures (DCs 8910-8914)	Cranial nerve dysfunction (disorders of smell, vision, eyes, taste, and positional vertigo)
Gait, coordination, and balance problems	Autonomic nerve dysfunctions (regulates unconscious body functions, including heart rate, blood pressure, body temperature, etc.)
Endocrine dysfunctions	

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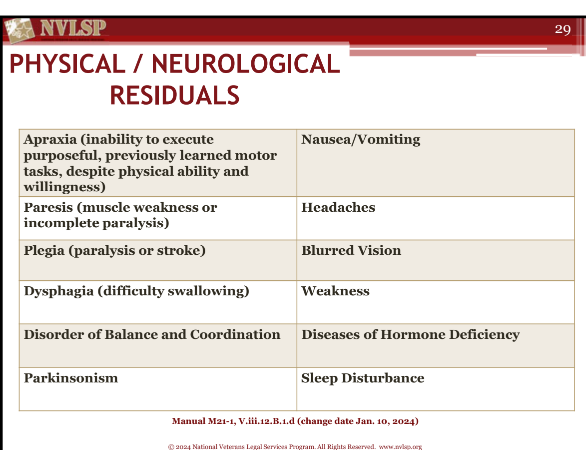
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PHYSICAL / NEUROLOGICAL RESIDUALS

Apraxia (inability to execute purposeful, previously learned motor tasks, despite physical ability and willingness)	Nausea/Vomiting
Paresis (muscle weakness or incomplete paralysis)	Headaches
Plegia (paralysis or stroke)	Blurred Vision
Dysphagia (difficulty swallowing)	Weakness
Disorder of Balance and Coordination	Diseases of Hormone Deficiency
Parkinsonism	Sleep Disturbance

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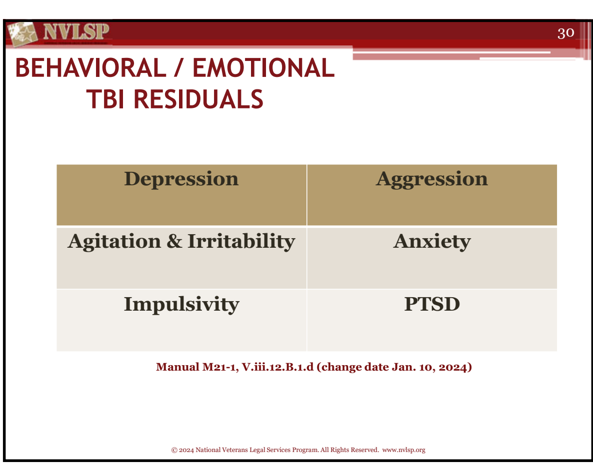
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BEHAVIORAL / EMOTIONAL TBI RESIDUALS

Depression	Aggression
Agitation & Irritability	Anxiety
Impulsivity	PTSD

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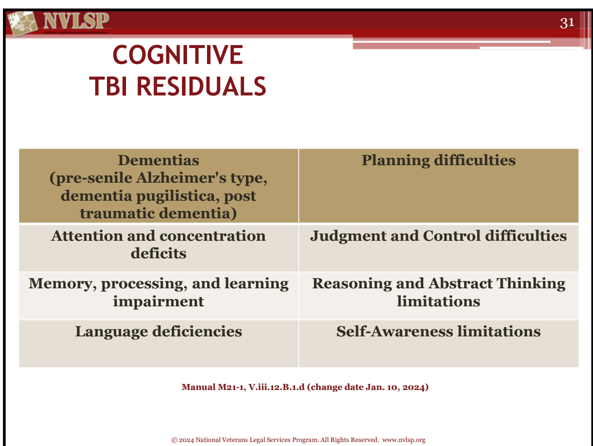

Dementias (pre-senile Alzheimer's type, dementia pugilistica, post traumatic dementia)	Planning difficulties
Attention and concentration deficits	Judgment and Control difficulties
Memory, processing, and learning impairment	Reasoning and Abstract Thinking limitations
Language deficiencies	Self-Awareness limitations

Manual M21-1, V.iii.12.B.1.d (change date Jan. 10, 2024)

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SUBJECTIVE SYMPTOMS TBI RESIDUALS

- **DC 8045 non-exhaustive list of subjective symptoms includes:**
  - Anxiety (unless there is a diagnosed anxiety disorder, which is evaluated under appropriate mental health DC)
  - Headaches
  - Insomnia
  - Hypersensitivity to light or sound
  - Fatigability (unless it's chronic fatigue syndrome, which is evaluated under DC 6354)
  - Blurred or double vision

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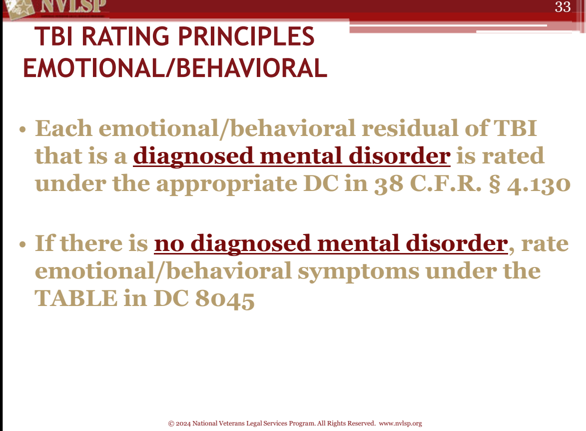

TBI RATING PRINCIPLES SUBJECTIVE SYMPTOMS

- If subjective symptom has a distinct diagnosis, e.g. migraine headaches, VA should evaluate it separately under the appropriate DC
- If subjective symptom has no distinct diagnosis, then evaluate under the Table in DC 8045
  - Table in DC 8045 isn't just for cognitive impairments

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TBI RATING PRINCIPLES IMPAIRMENT SCALE

- 10 Facets of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified:

1. Memory, attention, concentration, executive functions	6. Visual spatial orientation
2. Judgment	7. Subjective symptoms
3. Social interaction	8. Neurobehavioral effects (irritability, impulsivity, unpredictability, lack of motivation, verbal aggression, physical aggression, apathy, lack of empathy, moodiness, lack of cooperation, etc.)
4. Orientation	9. Communication
5. Motor activity (with intact motor & sensory system)	10. Consciousness

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TBI RATING PRINCIPLES IMPAIRMENT SCALE

- VA rater evaluates each facet and assigns a level of impairment
- Generally, 5 levels of impairment, but not all facets have all 5 levels

0	= 0% rating
1	= 10% rating
2	= 40% rating
3	= 70% rating
4 (Total)	= 100% rating

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10 FACETS TABLE & IMPAIRMENT SCALE

- **After each symptom has been categorized and Vet is assigned a number for each facet, VA assigns a single evaluation under DC 8045 based on the highest rated facet**
- **Example:**
  - 70% evaluation is awarded under DC 8045 if "3" is the highest level for any facet (regardless of whether Vet has a "3" in only 1 facet, or all 10 facets)

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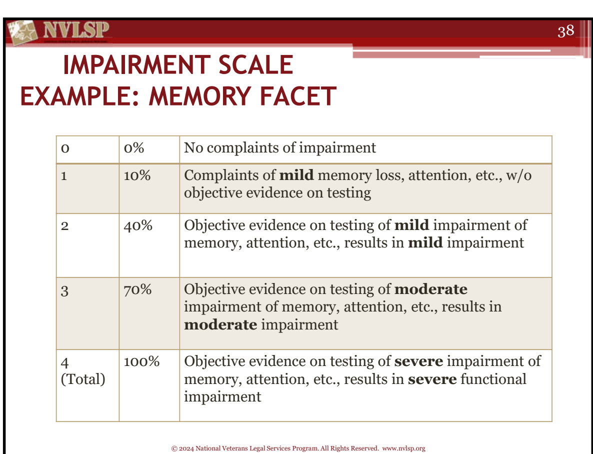
IMPAIRMENT SCALE EXAMPLE: MEMORY FACET



0	0%	No complaints of impairment
1	10%	Complaints of **mild** memory loss, attention, etc., w/o objective evidence on testing
2	40%	Objective evidence on testing of **mild** impairment of memory, attention, etc., results in **mild** impairment
3	70%	Objective evidence on testing of **moderate** impairment of memory, attention, etc., results in **moderate** impairment
4 (Total)	100%	Objective evidence on testing of **severe** impairment of memory, attention, etc., results in **severe** functional impairment

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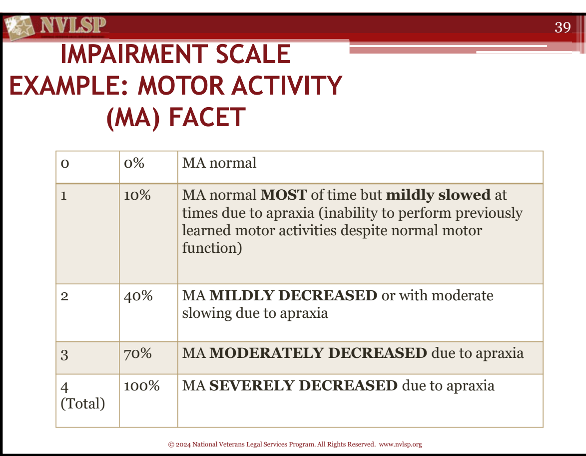
IMPAIRMENT SCALE EXAMPLE: MOTOR ACTIVITY (MA) FACET



0	0%	MA normal
1	10%	MA normal **MOST** of time but **mildly slowed** at times due to apraxia (inability to perform previously learned motor activities despite normal motor function)
2	40%	MA **MILDLY DECREASED** or with moderate slowing due to apraxia
3	70%	MA **MODERATELY DECREASED** due to apraxia
4 (Total)	100%	MA **SEVERELY DECREASED** due to apraxia

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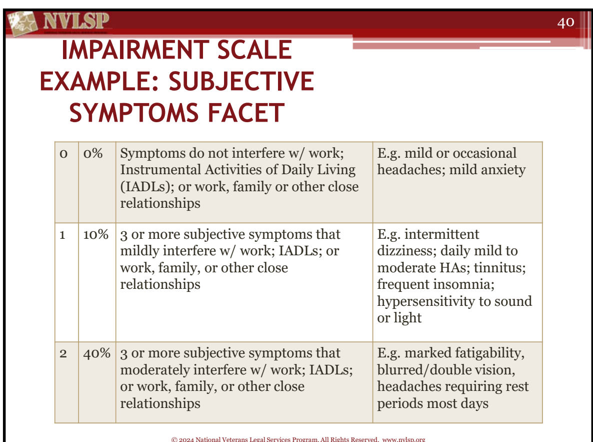
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IMPAIRMENT SCALE EXAMPLE: SUBJECTIVE SYMPTOMS FACET

0	0%	Symptoms do not interfere w/ work; Instrumental Activities of Daily Living (IADLs); or work, family or other close relationships	E.g. mild or occasional headaches; mild anxiety
1	10%	3 or more subjective symptoms that mildly interfere w/ work; IADLs; or work, family, or other close relationships	E.g. intermittent dizziness; daily mild to moderate HAs; tinnitus; frequent insomnia; hypersensitivity to sound or light
2	40%	3 or more subjective symptoms that moderately interfere w/ work; IADLs; or work, family, or other close relationships	E.g. marked fatigability, blurred/double vision, headaches requiring rest periods most days

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IMPAIRMENT SCALE EXAMPLE: SOCIAL INTERACTION FACET

0	0%	Routinely appropriate Social Interaction
1	10%	Occasionally inappropriate Social Interaction
2	40%	Frequently inappropriate Social Interaction
3	70%	Inappropriate Social Interaction most or all of time

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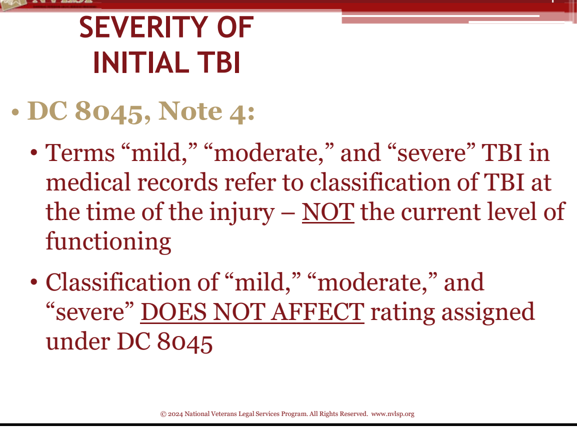

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TBI RATING PRINCIPLES RECAP

- **Evaluate each residual separately**
  - But same symptoms/manifestations cannot support more than one evaluation
- **Evaluation under the TABLE in DC 8045 is considered the evaluation for a single condition and will be combined with other disability evaluations (for physical & emotional dysfunctions) under 38 C.F.R. § 4.25**
- **Combine residuals/conditions under § 4.25 (combined rating table)**

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TBI & PTSD OVERLAP

- **Many post-9/11 Vets (and other Vets) suffer from both mental disabilities (particularly PTSD) and TBI residuals**
- **In many cases, an incident that causes TBI is also a stressor that causes PTSD**

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DIFFICULTIES WHEN RATING BOTH TBI AND MENTAL DISORDERS

- When Vet has residuals of TBI and a separate diagnosed mental disorder, it is sometimes difficult or impossible to determine what symptoms are the result of TBI and which are the result of the mental disorder
- Sometimes the TBI and the mental disorder manifest in some of the same symptoms (e.g., both cause irritability, sleep problems, and memory problems)

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DIFFICULTIES WHEN RATING BOTH TBI AND MENTAL DISORDERS

- Where manifestations/symptoms are not separable, or attributable to both TBI and mental disorder, VA should compare DC 8045 w/ other appropriate DCs
- Under its duty to maximize benefits, VA should attribute symptoms to DC that will give Vet higher evaluation
- But, DC 8045, Note 1, might require different result…

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DC 8045: NOTE 1

"…. If the manifestations of two or more conditions cannot be clearly separated, assign a single evaluation under whichever set of diagnostic criteria allows the better assessment of overall impaired functioning due to both conditions…."

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DC 8045: NOTE 1

- **Also instructs that when there is overlap between TABLE symptoms and mental or physical symptoms:**
  - Don't assign more than one evaluation based on same manifestation
  - If manifestations clearly separable, assign a separate evaluation under separate DC

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VA GUIDANCE ON MEDICAL OPINIONS

- **For medical opinions on whether TBI and a mental disorder are distinct and can be separately rated:**
  - It must be a sufficiently clear and unequivocal medical opinion
  - It may be provided by either an examiner assessing the TBI or an examiner assessing the mental disorder, as long as the individual offering the opinion is properly qualified
  - If a medical provider can't make the determination without resorting to mere speculation, then it may be inadequate
  - VBA decision makers are not qualified to make such determinations (absent a medical opinion)
    - Manual M21-1, V.iii.12.B.1.k (change date Jan. 10, 2024)

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NO DSM-5 DIAGNOSIS?

- **Remember, if Vet has subjective feelings of anxiety, depression, or other mental complaints associated with TBI, but without a DSM-5 diagnosis of a mental health condition:**
  - Evaluate in the subjective symptoms facet under 38 CFR 4.124a, DC 8045
  - NOTE: Subjective mental complaints are not a distinct comorbid diagnosis

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SAMPLE RATING CRITERIA FOR MENTAL CONDITIONS

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

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HYPO #1 FACTS

- Vet A has SC PTSD and SC residuals of TBI
- VA examiners have found:
  - **PTSD** causes occupational and social impairment with reduced reliability and productivity due to symptoms of **flattened affect, stereotyped speech, multiple panic attacks per week, disturbances of motivation and mood, and difficulty in establishing and maintaining effective work and social relationships**
  - **TBI** causes **mild loss of memory** (level 1), **moderately impaired judgment** (level 2), **occasional disorientation to time and place** (level 2), and **mildly impaired visual spatial orientation** (level 1)

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SURVEY #1

- How should Vet A be rated?
  - A. 50% under DC 9411 (General Rating Formula for Mental Disorders)
  - B. 40% under DC 8045 (highest level of impairment = level 2 in Table)
  - C. Both A & B
  - D. Other

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HYPO #1 ANSWER

C

- **Because the manifestations of PTSD and TBI can be clearly separated, Vet A should be assigned the following ratings:**
  - 50% under DC 9411 (General Rating Formula for Mental Disorders)
  - 40% under DC 8045 (highest level of impairment = level 2 in Table)

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HYPO #2 FACTS

- **Vet B has PTSD and residuals of TBI, with same symptoms as Vet A:**
  - flattened affect, stereotyped speech, multiple panic attacks per week, disturbances of motivation and mood, and difficulty in establishing and maintaining effective work and social relationships, mild loss of memory, moderately impaired judgment, occasional disorientation to time and place, and mildly impaired visual spatial orientation
- **Doctors cannot differentiate which symptoms are attributed to PTSD and which are due to TBI**

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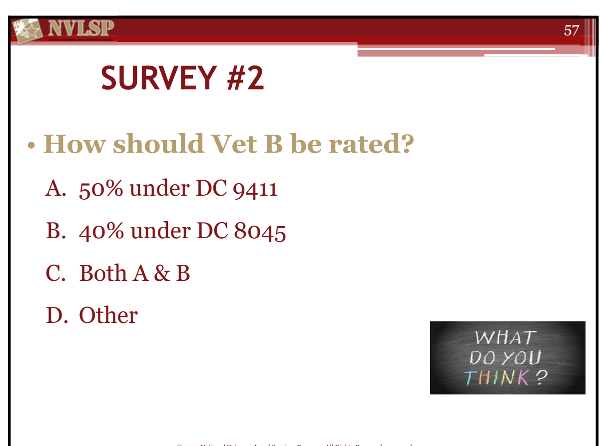

SURVEY #2

- **How should Vet B be rated?**

A. 50% under DC 9411

B. 40% under DC 8045

C. Both A & B

D. Other

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HYPO #2 ANSWER

- **Because the manifestations of PTSD and TBI cannot be clearly separated, Vet B should be assigned the following rating:**
  - 50% under DC 9411 (General Rating Formula for Mental Disorders)
    - This would result in a higher rating than under DC 8045, and Note 1 prohibits a rating under both DCs

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HYPO #3 FACTS

- **Vet C has SC PTSD and SC residuals of TBI**
- **VA examiners have found:**
  - **PTSD causes occupational and social impairment with reduced reliability and productivity due to symptoms of flattened affect, stereotyped speech, multiple panic attacks per week, disturbances of motivation and mood, and difficulty in establishing and maintaining effective work and social relationships**
  - **TBI causes mild loss of memory (level 1), moderately impaired judgment (level 2), occasional disorientation to time and place (level 2),** and **mildly impaired visual spatial orientation (level 1)**

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HYPO #3 FACTS

- **Vet C also has the symptom of social interaction that is inappropriate most of the time due to either PTSD or TBI, but doctors are unable to determine if this symptom is due to PTSD or a residual of TBI**
  - Level 3 impairment (70%) under DC 8045
  - Would not likely support higher rating under DC 9411

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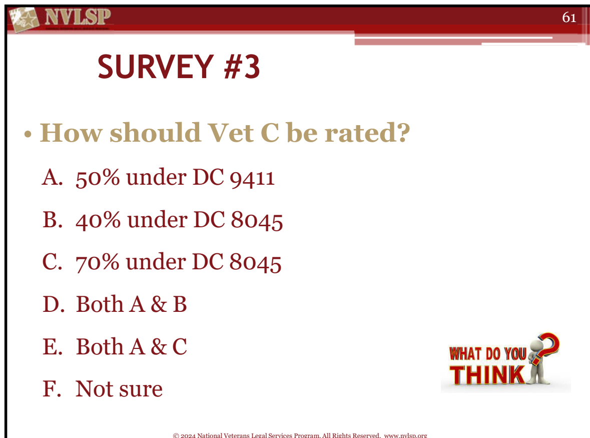

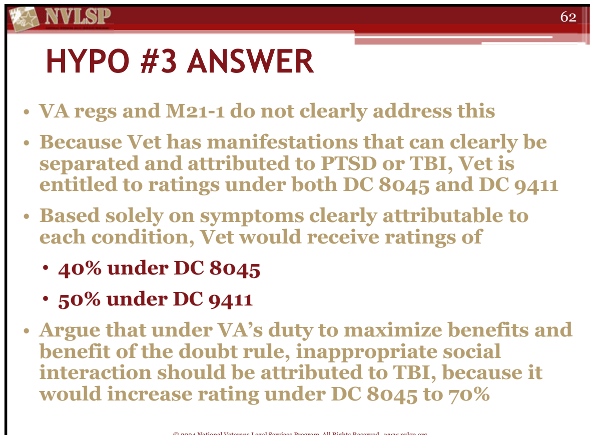

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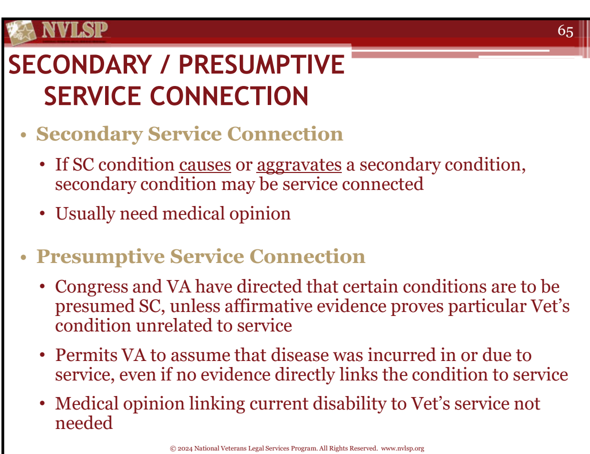

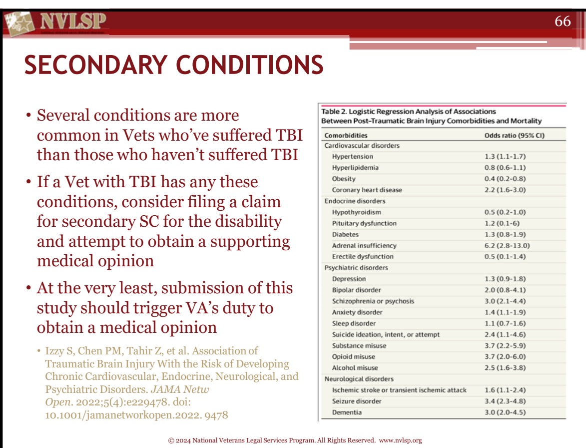

Table 2. Logistic Regression Analysis of Associations Between Post-Traumatic Brain Injury Comorbidities and Mortality

Comorbidities	Odds ratio (95% CI)
Cardiovascular disorders	
Hypertension	1.3 (1.1-1.7)
Hyperlipidemia	0.8 (0.6-1.1)
Obesity	0.4 (0.2-0.8)
Coronary heart disease	2.2 (1.6-3.0)
Endocrine disorders	
Hypothyroidism	0.5 (0.2-1.0)
Pituitary dysfunction	1.2 (0.1-6)
Diabetes	1.3 (0.8-1.9)
Adrenal insufficiency	6.2 (2.8-13.0)
Erectile dysfunction	0.5 (0.1-1.4)
Psychiatric disorders	
Depression	1.3 (0.9-1.8)
Bipolar disorder	2.0 (0.8-4.1)
Schizophrenia or psychosis	3.0 (2.1-4.4)
Anxiety disorder	1.4 (1.1-1.9)
Sleep disorder	1.1 (0.7-1.6)
Suicide ideation, intent, or attempt	2.4 (1.1-4.6)
Substance misuse	3.7 (2.2-5.9)
Opioid misuse	3.7 (2.0-6.0)
Alcohol misuse	2.5 (1.6-3.8)
Neurological disorders	
Ischemic stroke or transient ischemic attack	1.6 (1.1-2.4)
Seizure disorder	3.4 (2.3-4.8)
Dementia	3.0 (2.0-4.5)

NVLSP 67

CONDITIONS PRESUMED SECONDARY TO TBI

- **VA presumes that some disabilities are secondary to TBI**
  - 38 C.F.R. § 3.310(d)
- **Presumptions based on:**
  1. Severity of INITIAL TBI (mild, moderate, or severe)
     - Based on factors including time of lost consciousness, altered consciousness, and amnesia; and Glasgow Coma Scale score (based on eye, verbal, motor responsiveness after TBI)
  2. When disability first manifests

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NVLSP 68

CONDITIONS PRESUMED SECONDARY TO TBI

- **Presumptive Diseases:**
  - Parkinsonism, including Parkinson's Disease
    - Moderate or severe TBI, no time limit
  - Unprovoked seizures
    - Moderate or severe TBI, no time limit
  - Dementias (presenile of the Alzheimer type, frontotemporal, or with Lewy bodies)
    - Moderate or severe TBI, w/in 15 years of TBI

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NVLSP 69

CONDITIONS PRESUMED SECONDARY TO TBI

- **Presumptive Diseases (cont'd):**
  - Depression
    - Moderate or severe TBI, w/in 3 years;
    - Mild TBI, w/in 1 year
  - Diseases of hormone deficiency that result from hypothalamo-pituitary changes
    - Moderate or severe TBI, w/in 1 year

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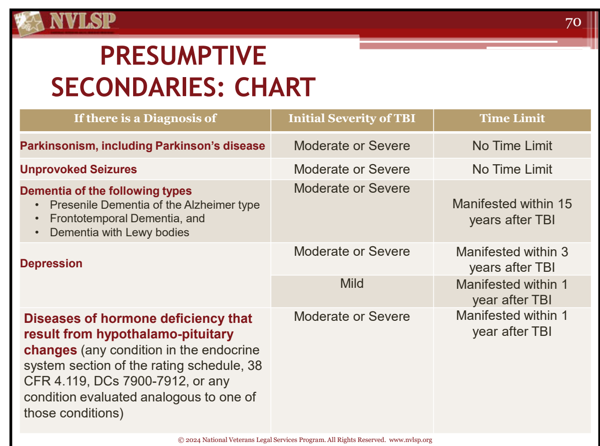

If there is a Diagnosis of	Initial Severity of TBI	Time Limit
Parkinsonism, including Parkinson's disease	Moderate or Severe	No Time Limit
Unprovoked Seizures	Moderate or Severe	No Time Limit
Dementia of the following types • Presenile Dementia of the Alzheimer type • Frontotemporal Dementia, and • Dementia with Lewy bodies	Moderate or Severe	Manifested within 15 years after TBI
Depression	Moderate or Severe	Manifested within 3 years after TBI
	Mild	Manifested within 1 year after TBI
Diseases of hormone deficiency that result 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	Manifested within 1 year after TBI

NVLSP 71

38 C.F.R. § 3.310(d)

- VA will grant secondary SC if requirements met and there is not clear evidence to the contrary
- VA does not need to obtain a medical opinion to determine whether these conditions are associated with TBI when there is a TBI of a qualifying degree of severity (based on time of injury or shortly thereafter)
  - Manual M21-1, V.iii.12.B.2.a (change date Apr. 16, 2020)

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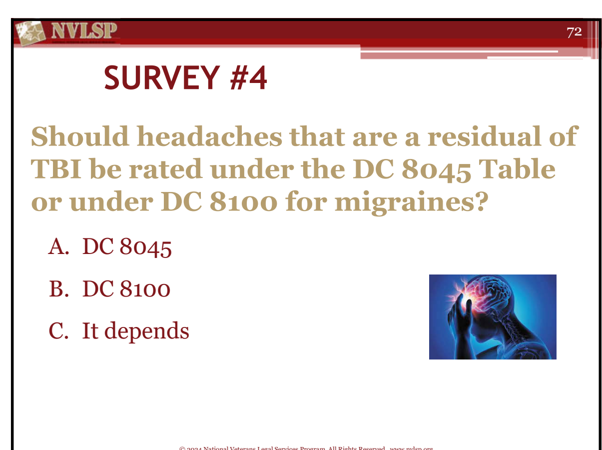

NVLSP 73

CO-MORBID SYMPTOMS/CONDITIONS

- **Subjective complaints of headaches**
  - Evaluate as part of the TBI evaluation under DC 8045 rather than under a separate DC
  - NOTE: Occasional subjective headaches are not a distinct comorbid diagnosis
- **A distinct comorbid diagnosis of a headache disorder (migraine headaches, post-concussive headaches, tension headaches)**
  - Assign a separate evaluation under DC 8100, as long as the manifestations do not overlap with those used to assign the evaluation of TBI under DC 8045
    - Manual M21-1,V.iii.12.B.1.i (change date Jan. 10, 2024)

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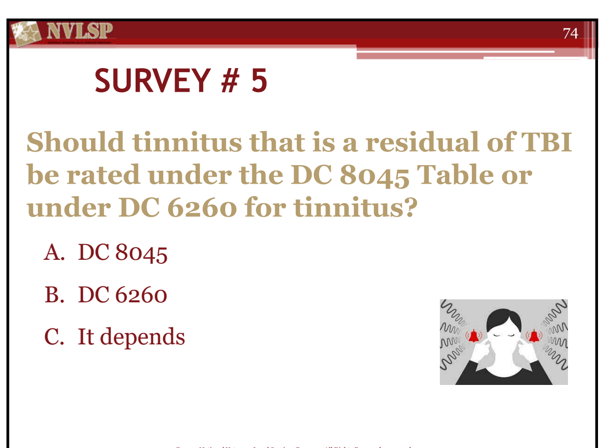

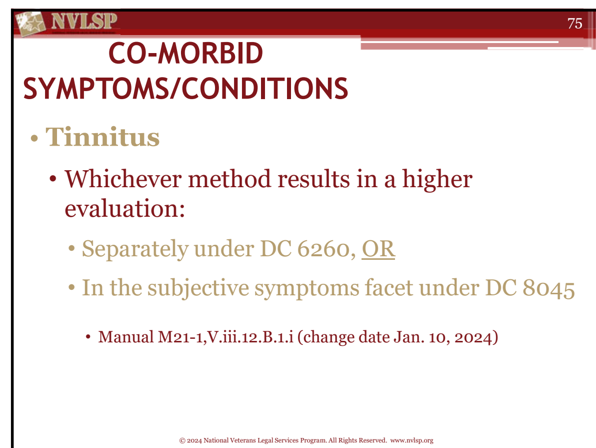

SURVEY #6

Should vertigo be rated under the DC 8045 Table or DC 6204 for peripheral vestibular disorders?

A. DC 8045

B. DC 6204

C. It depends

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CO-MORBID SYMPTOMS/CONDITIONS

- **Vertigo (whether referred to as "vertigo," "constant vertigo," "peripheral vestibular disorder," "benign paroxysmal positional vertigo," or something similar)**
  - Evaluate in the subjective symptoms facet under DC 8045
  - NOTE: If vertigo was awarded a separate compensable evaluation prior to 3/15/2012, VA should not change or correct the evaluation
    - Manual M21-1,V.iii.12.B.1.i (change date Jan. 10, 2024)

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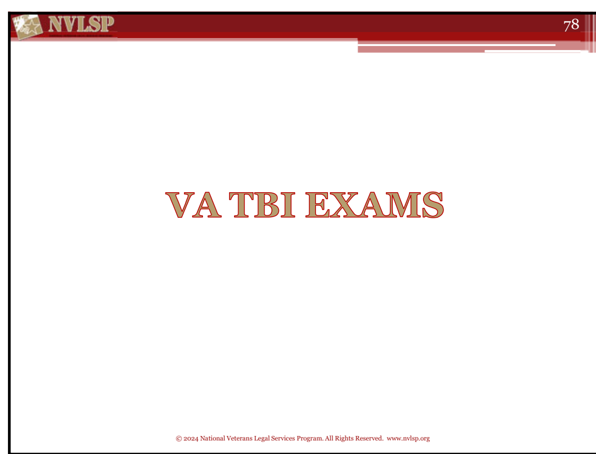

TBI EXAMS

- VA must obtain a comprehensive medical exam to properly evaluate TBI for a service connection claim
- VA TBI exam must include testing sufficient to give the VA adjudicator adequate info about the several areas of TBI-related issues considered in the Rating Schedule

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TBI EXAMS

- Initial TBI diagnosis must be made by:
  - Physiatrist
  - Psychiatrist
  - Neurosurgeon, or
  - Neurologist
- If a TBI diagnosis of record was established by one of the above specialists, a generalist clinician who has successfully completed the Disability Examination Management Office TBI training module may conduct a TBI exam

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TBI EXAMS

- If VA exam report is unfavorable:
  - Request qualifications of examiner (*curriculum vitae*) and info about completion of TBI training module
  - If not a specialist and did not complete TBI training module, argue that exam was inadequate and request new exam
    - From 2007 to 2015, VA performed thousands of TBI exams with examiners who were not qualified
  - Consider getting private exam that addresses DC 8045 Table criteria and related diagnoses
    - But VA TBI DBQ not publicly available

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NVLSP 83

BACKGROUND & SMC BASICS (38 U.S.C. § 1114)

- **SMC is available for Vets who suffer from certain types of SC disabilities, such as:**
  - anatomical loss or loss of use (e.g., loss of use of a hand, foot, creative organ, voice)
  - impairment of senses (loss of vision, hearing)
- **Certain combinations of loss or loss of use and other circumstances may also warrant SMC**
- **SMC is provided in addition to (lowest level) or in lieu of (higher levels) compensation Vet is entitled to under the VA rating schedule**

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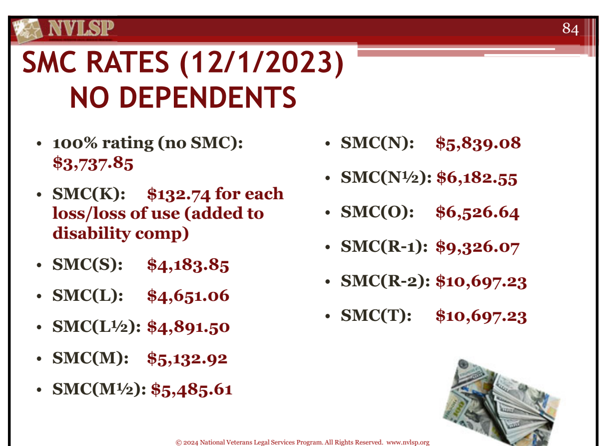

NVLSP 85

SPECIAL MONTHLY COMPENSATION

- **Vet's with SC TBI may qualify for SMC based on loss or loss of use of body parts, deafness, blindness, or aphonia, just like Vets w/out TBI**
- **In addition to the possibility of qualifying for SMC(k)-(r2), just as other Vets can, Vets with severe residuals of TBI may qualify for SMC(t)**
- 38 U.S.C. § 1114(t); 38 C.F.R. §§ 3.350(j); 3.352(b)(2)

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NVLSP 86

SMC(t)

- **SMC(t) available if Vet meets all of the following requirements:**
  1. Has SC TBI and/or TBI residuals
  2. Needs regular A&A for residuals of TBI
     - Other SC and NSC conditions can't be considered

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NVLSP 87

SMC(t)

3. Vet needs "higher level of care" than required for SMC(L) (regular A&A rate)
   - Need for personal health care services provided on a daily basis in Vet's home by
     - A person licensed to provide such services, OR
     - A person (such as a family member) who provides such services under the regular supervision of a licensed health-care professional
   - **38 C.F.R. § 3.352(b)**

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NVLSP 88

SMC(t)

4. Not eligible for SMC(r)(2)
   - SMC(t) paid at same rate as SMC(r)(2), which is highest monthly benefit available from VA
5. Would require hospitalization, nursing home care, or other residential institutional care without regular in-home A&A

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NVLSP 89

SMC(t) – Possible Upcoming Court Update

- ***Laska v. McDonough*, No. 22-1018**
  - SMC(t) case involving question of whether 38 C.F.R. § 3.352(b)(2) is contrary to the plain language of 38 U.S.C. § 1114(t)
  - Appellant argued that Section 1114(t) unambiguously does not require a **"higher level of care,"** and the regulation is invalid and should be set aside
  - Case argued on 8/15/2023; awaiting decision

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NVLSP 90

SMC HYPO FACTS

- **Vet had two claims before BVA:**
  - IR for SC vascular headaches, cluster type due to TBI
  - SMC based on the need for regular A&A
    - Vet already granted TDIU
- **10/2013 – Dr. G (private doctor)**
  - Completed VAF 21-2680, *Exam for Housebound Status or Permanent Need for Regular Aid and Attendance*, and stated Vet could feed himself, but not prepare own meals
- **3/2015 – Vet's wife stated that she:**
  - Provided regular A&A to Vet for several ADLs
  - Managed his meals, his care, payment of household bills, household cleaning, grocery shopping, and medical care

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SMC HYPO FACTS

- **3/2022 Vet's wife statement:**
  - Vet spends majority of his time in bed, because his temple throbs when he is not laying down and this throbbing is a precursor to a headache
  - She administers injections to Vet, obtains all of his medication, and oversees him during syncopal episodes which result in loss of consciousnesses and loss of breath
  - Listed all of the tasks she does for Vet daily, weekly, and monthly, and noted that she regularly meets with Vet's doctors to assist in overseeing and managing his medical care

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SMC HYPO FACTS

- **4/2022 – Dr. G (private doctor):**
  - SC headache disability requires Vet to spend most days completely in bed and he requires regular assistance with grooming, bathing, dressing, and food prep
  - Vet required injectable pain medication multiple times per week that he cannot self-administer
  - Vet needed assistance to/from the bathroom during pain flares, as he will often have syncopal episodes due to his pain level and cannot risk further brain injury
  - Vet needed assistance ordering his meds, scheduling doctor appts, transportation to/from his medical appts, and managing bill-paying and household finances
  - Vet absolutely meets VA's A&A eligibility criteria

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SMC HYPO FACTS

- **6/2022 – BVA granted SMC(L) based on Vet's need for regular A&A:**
  - Based on the record, the Board concluded that the evidence is at least in relative equipoise as to whether Vet's SC disabilities cause him to be so helpless as to be in need of personal assistance from others. He requires assistance in grooming, bathing, dressing, and food preparation due to SC disability.

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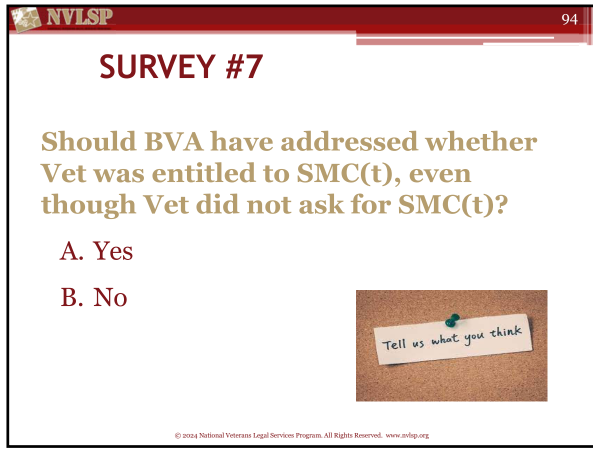
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SURVEY #7
Should BVA have addressed whether Vet was entitled to SMC(t), even though Vet did not ask for SMC(t)?
A. Yes
B. No
Tell us what you think
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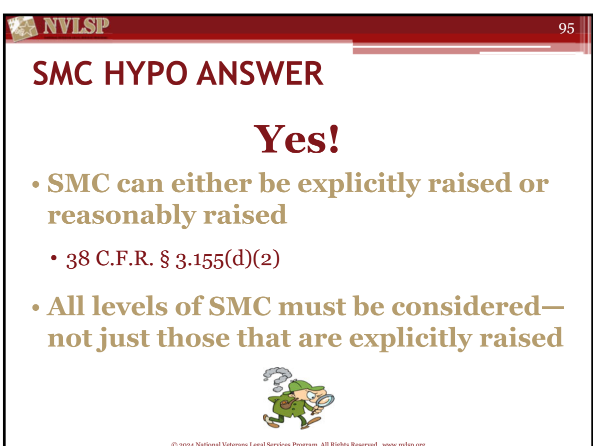
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SMC HYPO ANSWER
Yes!
• SMC can either be explicitly raised or reasonably raised
• 38 C.F.R. § 3.155(d)(2)
• All levels of SMC must be considered—not just those that are explicitly raised
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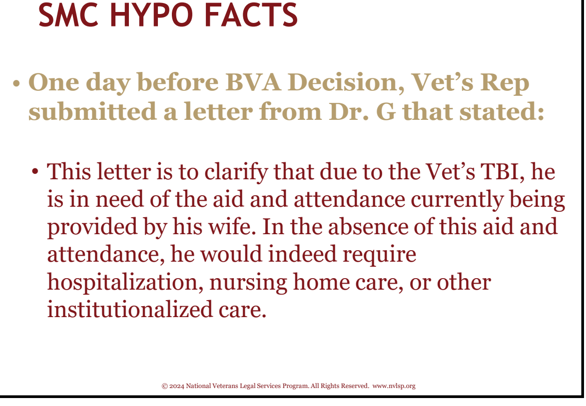
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SMC HYPO FACTS
• One day before BVA Decision, Vet's Rep submitted a letter from Dr. G that stated:
• This letter is to clarify that due to the Vet's TBI, he is in need of the aid and attendance currently being provided by his wife. In the absence of this aid and attendance, he would indeed require hospitalization, nursing home care, or other institutionalized care.
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NVLSP 97

SMC HYPO FACTS

- Vet's Rep filed motion for reconsideration, because it did not appear that BVA considered the new statement from Dr. G; therefore, the award was less than it should have been
- BVA denied the motion
  - "You argue that the Board did not consider evidence, resulting in a reduced award. I note that all your claims were either granted or dismissed as moot, because even if granted, they would not give you a greater monetary benefit. Thus, your Motion fails to establish that any error, even if it occurred, would change the outcome of the appeal."

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NVLSP 98

SMC HYPO

- **Problem with BVA reconsideration decision:**
  - "… even if granted, they would not give you a greater monetary benefit."
  - **What???**
    - SMC(l) $4,651.50
    - SMC(t) is **$10,967.23**

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NVLSP 99

SMC ADVOCACY ADVICE

- **It is best to explicitly claim entitlement to SMC so VA does not overlook it, but if it is reasonably raised by the record, VA still must address it**
- **If Vet has SMC A&A and TBI residuals, see if SMC(t) might be warranted**

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SMC ADVOCACY ADVICE

- **Have Vet and family members/friends write detailed lay statements about the activities they do for the Vet to establish that Vet needs regular A&A and would be hospitalized or in nursing home/ residential care without it**
  - But remember, to qualify for SMC(t), in-home care must be provided by person licensed to provide such services or under the regular supervision of a licensed health-care professional

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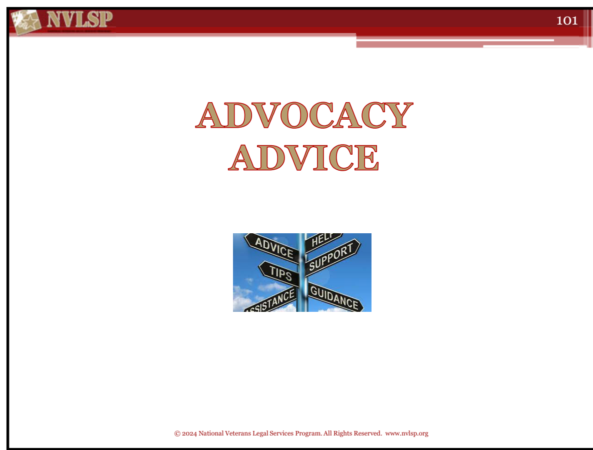
ADVOCACY ADVICE



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DON'T FORGET

- **Each emotional/behavioral residual of TBI that is a diagnosed mental health condition is rated under the appropriate DC in 38 C.F.R. § 4.130 (General Rating Formula for Mental Disorders)**
- **If there is no diagnosed mental disorder, rate emotional/behavioral symptoms under the TABLE in DC 8045**

Don't forget

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NVLSP 103

DON'T FORGET

- Residuals with a **distinct diagnosis** are **separately rated** under the appropriate diagnostic code
- Residuals **not associated** with a **distinct diagnosis and cognitive residuals** of TBI are **rated under** the "Evaluation of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified" TABLE in 38 C.F.R. § 4.124a, DC 8045

Don't FORGET!

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NVLSP 104

ADVOCACY ADVICE

- Get as much lay evidence as possible from family, friends, and co-workers regarding subjective symptoms, frequency, severity, etc.
- Have Vet write a statement to give to the examiner prior to the exam
- Try to have examiner mention all symptoms in report
  - It is unclear if VA will require the doctor to mention/verify subjective symptoms
- Argue that nothing more than Vet's statement is needed regarding subjective symptoms

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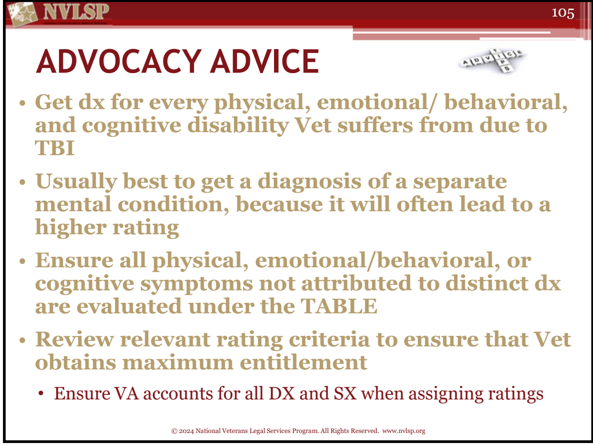

ADVOCACY ADVICE

- If examiner can't determine if symptoms are due to TBI or a mental condition, argue that symptoms should be attributed to condition that provides highest rating
- If Vet has some symptoms that can be attributed to mental condition and others that can be attributed to TBI, ensure VA assigns separate ratings for the conditions
  - When there are additional symptoms caused by either TBI or the mental condition, but it can't be determined which, argue that they should be considered under the DC that gives the Vet the highest combined rating
- Remember – the same symptom can't be considered under multiple DCs

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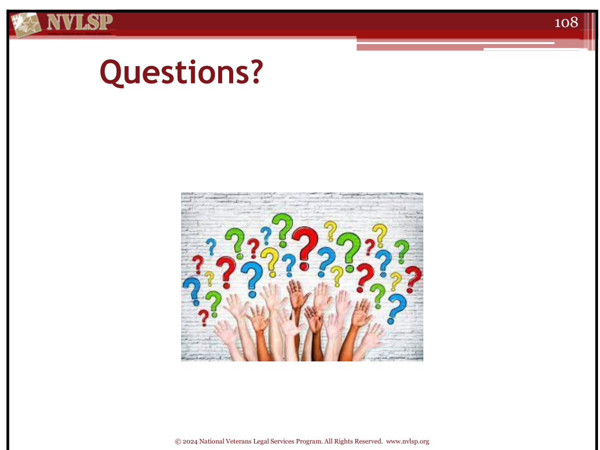

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Dates | Topic | Presenter
June 25 & 26 | Changes to the VA's Character of Discharge Regulation | Renee Burbank
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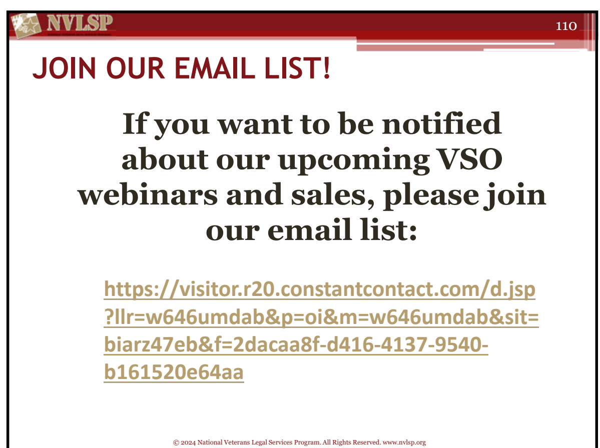
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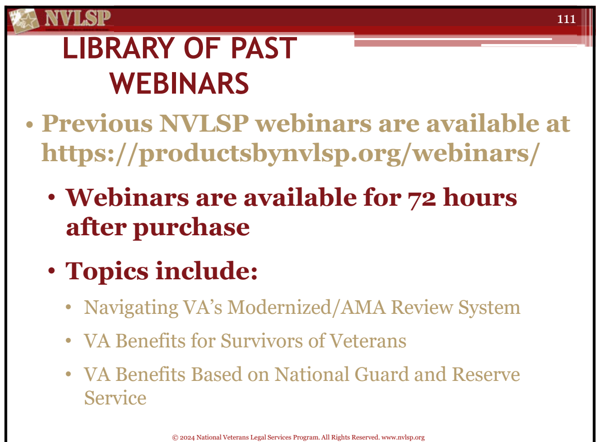
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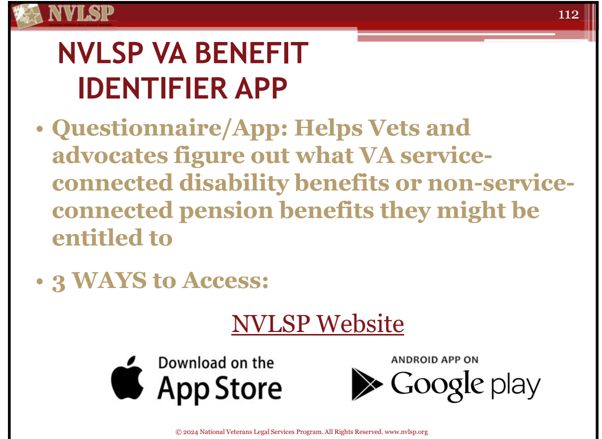

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