regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety, and other advantages; distributive impacts; and equity). The Executive Order classifies a ''significant regulatory action'' requiring review by the Office of Management and Budget, as any regulatory action that is likely to result in a rule that may: (1) Have an annual effect on the economy of $100 million or more or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities; (2) create a serious inconsistency or interfere with an action taken or planned by another agency; (3) materially alter the budgetary impact of entitlements, grants, user fees, or loan programs or the rights and obligations of entitlement recipients; or (4) raise novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order.

VA has examined the economic, interagency, budgetary, legal, and policy implications of this interim final rule and has concluded that it is a significant regulatory action under Executive Order 12866 because it is likely to result in a rule that may raise novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order.

Paperwork Reduction Act

This document contains no provisions constituting a collection of information under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3521).

Regulatory Flexibility Act

The Secretary hereby certifies that this interim final rule will not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act, 5 U.S.C. 601–612. The rule could affect only VA beneficiaries and will not directly affect small entities. Therefore, pursuant to 5 U.S.C. 605(b), this rule is exempt from the initial and final regulatory flexibility analyses requirements of sections 603 and 604.

Catalog of Federal Domestic Assistance

The Catalog of Federal Domestic Assistance program numbers and titles for this rule are as follows: 64.109, Veterans Compensation for Service-Connected Disability; and 64.110, Veterans Dependency and Indemnity Compensation for Service-Connected Death.

List of Subjects in 38 CFR Part 3

Administrative practice and procedure, Claims, Disability benefits, Health care, Pensions, Radioactive materials, Veterans, Vietnam.

Approved: August 1, 2008.

James B. Peake,

Secretary of Veterans Affairs.

■ For the reasons set forth in the preamble, 38 CFR part 3 is amended as follows:

PART 3—ADJUDICATION

Subpart A—Pension, Compensation, and Dependency and Indemnity Compensation

■ 1. The authority citation for part 3, subpart A continues to read as follows:

Authority: 38 U.S.C. 501(a), unless otherwise noted.

■ 2. Add § 3.318 to read as follows:

§ 3.318 Presumptive Service Connection for Amyotrophic Lateral Sclerosis.

(a) Except as provided in paragraph (b) of this section, the development of amyotrophic lateral sclerosis manifested at any time after discharge or release from active military, naval, or air service is sufficient to establish service connection for that disease.

(b) Service connection will not be established under this section:

(1) If there is affirmative evidence that amyotrophic lateral sclerosis was not incurred during or aggravated by active military, naval, or air service;

(2) If there is affirmative evidence that amyotrophic lateral sclerosis is due to the veteran's own willful misconduct; or

(3) If the veteran did not have active, continuous service of 90 days or more.

(Authority: 38 U.S.C. 501(a)(1))

[FR Doc. E8–21998 Filed 9–22–08; 8:45 am]

BILLING CODE 8320–01–P

DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 4

RIN 2900–AM75

Schedule for Rating Disabilities; Evaluation of Residuals of Traumatic Brain Injury (TBI)

AGENCY: Department of Veterans Affairs.

ACTION: Final rule.

SUMMARY: This document amends the Department of Veterans Affairs (VA) Schedule for Rating Disabilities by revising the portion of the Schedule that addresses neurological conditions and convulsive disorders. The effect of this action is to provide detailed and updated criteria for evaluating residuals of traumatic brain injury (TBI).

DATES: *Effective Date:* This amendment is effective October 23, 2008.

Applicability Date: The amendment shall apply to all applications for benefits received by VA on or after October 23, 2008. The old criteria will apply to applications received by VA before that date. However, a veteran whose residuals of TBI were rated by VA under a prior version of 38 CFR 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 or whether VA receives any additional evidence. The effective date of any increase in disability compensation based solely on the new criteria would be no earlier than the effective date of the new criteria. The effective date of any award, or any increase in disability compensation, based solely on these new rating criteria will not be earlier than the effective date of this rule, but will otherwise be assigned under the current regulations governing effective dates, 38 CFR 3.400, etc. The rate of disability compensation will not be reduced based solely on these new rating criteria.

FOR FURTHER INFORMATION CONTACT: Rhonda F. Ford, Chief, Regulations Staff (211D), Compensation and Pension Service, Veterans Benefits Administration, Department of Veterans Affairs, 810 Vermont Ave., NW., Washington, DC 20420, (727) 319–5847. (This is not a toll-free number.)

SUPPLEMENTARY INFORMATION: On January 3, 2008, VA published in the **Federal Register** (73 FR 432) a proposal to amend VA regulations to revise the material under diagnostic code 8045, Brain disease due to trauma, in 38 CFR 4.124a (neurological conditions and convulsive disorders) in the VA Schedule for Rating Disabilities (the rating schedule). Interested persons were invited to submit written comments, suggestions, or objections on or before February 4, 2008. We received comments from the following groups and associations: American Optometric Association, Brain Injury Association of America, American Speech-Language-Hearing Association, Moss TBI Model System Centers, Senate Committee on Veterans' Affairs, The American Legion and National Veterans Legal Services Program, Disabled American Veterans, Department of the Army Surgeon General, National Organization of Veterans Advocates, Blinded Veterans Association, Veterans Outreach of the

Cape and Islands, Wounded Warrior Project, and American Federation of Government Employees Local #2823 of Cleveland, Ohio. In addition, we received comments from 6 concerned individuals, including one affiliated with the Department of Kinesiology, Indiana University, and one affiliated with Yale Occupational and Environmental Medicine. We have made many changes based on these comments.

Title of Diagnostic Code 8045

One commenter disagreed with the change in the title of diagnostic code 8045 from ''Brain disease due to trauma'' to ''Residuals of traumatic brain injury''. The commenter said that this represents an obfuscation of the disease process of brain injury and that raters could misunderstand the conditions they are evaluating as static versus dynamic, potentially evolving conditions. Another commenter supported the updated title.

We disagree that the revised title would cause rater misunderstanding. Raters use the information provided in medical examinations to determine an evaluation based on the criteria under the diagnostic code for the condition. The examiner who conducts TBI disability examinations for the Compensation and Pension Service will be asked if the condition has stabilized, and, if not, when stability is expected. If the condition has not stabilized, a future examination will be scheduled. Furthermore, any time a service-connected condition such as TBI worsens, a veteran may provide additional medical information and request a re-evaluation. Therefore, there are provisions to take into account changes in the status of TBI residuals and to re-evaluate when appropriate.

Comment Period

One commenter recommended that we provide a full 60-day comment period for the public to adequately assess the proposed rule and develop cogent comments because 30 days is an inadequate time frame for response. We agree that 30 days is a short time in which to analyze a complex regulation. However, there is a critical need for specific criteria to evaluate the many veterans who have suffered a TBI, and we made a decision to expedite the regulation to the extent possible. We did receive a wide array of comments on numerous aspects of the proposed regulation from many organizations and individuals.

Anoxic Brain Injury

We received three comments concerning anoxic brain injury, a condition resulting from a severe decrease in the oxygen supply to the brain that may be due to any of a number of possible etiologies, including trauma, strangulation, carbon monoxide poisoning, stroke, and many others. These commenters felt that when anoxic brain injury is due to brain trauma, it should be taken into account in this regulation, and one commenter also felt it should be added to the title of diagnostic code 8045.

As stated in the supplementary information to the proposed rule, revised diagnostic code 8045 addresses a specific condition, namely, an injury to the brain from an external force that results in immediate effects such as loss or alteration of consciousness, amnesia, or sometimes neurological impairments. Anoxic brain injury does not necessarily fit this definition since it has many possible etiologies other than trauma. Raters have flexibility in many cases in selecting the most appropriate diagnostic code(s) to use to evaluate a condition, particularly when the specific condition is not listed in the rating schedule. They could, therefore, evaluate anoxic brain injury under diagnostic code 8045 if the TBI criteria are appropriate to the findings. However, anoxic brain injury is common enough in veterans to warrant its own diagnostic code, and adding a specific diagnostic code would also allow statistical tracking of the numbers of veterans who suffer an anoxic brain injury.

We therefore plan to add anoxic brain injury to the neurological conditions and convulsive disorders section of the rating schedule (§ 4.124a of this part) as part of the overall revision of that section. Until anoxic brain injury is added to the rating schedule, it can be rated analogously, depending on the specific medical findings in a particular case, to TBI under diagnostic code 8045 or to another condition, such as brain, vessels, hemorrhage from (diagnostic code 8009), if hemorrhage is the cause; organic mental disorder, other (including personality change due to a general medical condition) (diagnostic code 9327 in the mental disorders section of the rating schedule (§ 4.130 of this part)); nerve damage, under one or more diagnostic codes for specific nerves that are affected; etc.

Definition and Classification of TBI

In the preamble to the proposed regulation, we provided a brief definition of TBI as an injury to the brain from an external force that results in immediate effects such as loss or alteration of consciousness, amnesia, or sometimes neurological impairments. We further stated that these abnormalities may all be transient, but more prolonged or even permanent problems with a wide range of impairment in such areas as physical, mental, and emotional/behavioral functioning may occur. We received multiple comments concerning this definition. One commenter suggested using the guidelines developed by the Mild Traumatic Brain Injury Committee of the Head Injury Interdisciplinary Special Interest Group of the American Congress of Rehabilitation Medicine because the use of the term ''immediate effects'' in the proposed definition would discount effects that emerge later. The definition in the preamble to the proposed regulation is very similar to the commenter's suggested definition, which requires, in part, a period of loss of consciousness, any loss of memory for events immediately before or after the accident, and any alteration in mental state at the time of the accident (e.g., feeling dazed, disoriented, or confused); or focal neurological deficit(s) that may or may not be transient. Therefore, the commenter's suggested definition also requires immediate effects, and has very similar provisions, and we make no change based on this comment.

A related comment was that there may not always have been loss or serious alteration of consciousness in patients with TBI and that the immediate effects may be subtle and unnoticed in the chaos of battle and that the language should make this point clear to adjudicators. The adjudicators (raters) who evaluate the effects of TBI do not make the diagnosis of TBI. Raters rely upon a diagnosis made by clinicians, based on a standard definition and criteria, and the brief definition in the proposed regulation does not require a ''serious'' alteration of consciousness but simply ''loss or alteration of consciousness''. We therefore make no change based on this comment.

Another commenter suggested we focus more attention on an objective, standardized assessment of acute TBI severity as near as possible to the time of injury. This comment is beyond the scope of this regulation as veterans do not present for disability evaluation at or near the time of injury, and this comment is more pertinent to those who assess injured service members at the time of injury.

Another commenter stated that the categories of ''minimal'' or ''sub

clinical'' should be added to ''mild,'' ''moderate,'' and ''severe'' TBI (which are the usual categories of TBI in standard definitions), since TBI may show no documentable focal neurological dysfunction or serious concussion in the immediate post-injury period. We make no change based on this comment, as we have provided a brief version of a standard definition of TBI that was developed and concurred in by a panel of TBI experts from VA and the Department of Defense and that is now in standard use by both Departments. The definition does not require that either ''focal neurological dysfunction'' or ''serious concussion'' be present for a diagnosis of TBI. Moreover, even if TBI results in immediate documentable focal neurological dysfunction or serious concussion, those effects need not persist for a veteran to be compensated for TBI residuals. The regulation provides compensation for a wide variety of residuals, including emotional impairment, impaired judgment, social behavior, etc.

We also note that the definition of TBI commented upon does not even appear in our regulation. If a veteran claims compensation for residuals of TBI and has an in-service diagnosis of TBI, it is unlikely that VA would question such a diagnosis absent an evidentiary reason to do so. The purpose of this regulation is to provide our evaluators with a basis to rate any symptoms—objective or subjective—that a medical professional has linked to one or more in-service TBIs. If such an injury has already been noted during service, the medical examiner will simply have to determine whether the current disability is etiologically consistent with that injury.

Another commenter said that the proposed definition of TBI does not take into account the fact that mild TBI is epidemiologically distinct from moderate and severe TBI and that failure to consider the different epidemiological factors of mild TBI may result in awarding disability ratings for impairments associated with other non-neurological disorders.

It is clinicians, rather than raters, who examine veterans with TBI and make decisions regarding the diagnosis of TBI and what findings are associated with that diagnosis. This regulation does not provide separate criteria for mild, moderate, and severe TBI, which are designations made at the time of the initial injury and, as stated in the proposed regulation, do not necessarily correlate with the severity of residual effects. We make no change based on his comment.

Minimum Evaluation for TBI and Suggestion for Interim Regulation

We received two comments suggesting that we provide a minimum evaluation for TBI. There is a wide range of severity in residuals of TBI. Some veterans are totally disabled by the residuals, while others suffer minimal or no effect on their employability as a result of their TBI. There is no anticipated minimum level of severity of TBI residuals that would apply to all veterans, even those discharged due to a TBI. Some veterans may be discharged because they are totally or significantly disabled, while others may be discharged because the injury was sufficient to prevent the carrying out of the individual's particular service duties, even if the residuals would not prevent the individual from being able to be gainfully employed as a civilian.

Another commenter suggested that we issue an interim regulation similar to 38 CFR 4.129 (Mental disorders due to traumatic stress), which states that when a mental disorder that develops in service as a result of a highly stressful event is severe enough to bring about the veteran's release from active military service, the rating agency shall assign an evaluation of not less than 50 percent and schedule an examination within the six-month period following the veteran's discharge to determine whether a change in evaluation is warranted. The commenter suggested that the interim regulation provide that if a veteran is discharged due to TBI, VA should assign an evaluation of not less than 50 percent and schedule an examination 6 months following the veteran's discharge.

As discussed above, the fact that a veteran is discharged due to TBI does not necessarily imply that it is at least 50-percent disabling. It would therefore not be appropriate to assign a 50-percent evaluation in all cases, no matter how minor the residuals. In addition, certain residuals of TBI, in particular, the group of subjective symptoms that commonly occur after TBI, may be very disabling in the short term, but the great majority of subjective symptoms substantially improve or completely resolve within 3 months following the TBI. Such residuals would not warrant a post-discharge evaluation of at least 50 percent for 6 months or more. There is an existing regulation (38 CFR 4.28, Prestabilization rating from date of discharge from service) that applies under certain conditions to TBI and any other disability resulting from disease or injury. It provides for the assignment of a 100-percent evaluation in the immediate post-discharge period for an unstabilized condition with severe disability, such that substantially gainful employment is not feasible or advisable, or a 50-percent evaluation for unhealed or incompletely healed wounds or injuries with material impairment of employability likely. These evaluations do not require an examination before assignment and will be continued for 12 months following discharge. Section 4.28 provides substantially the same benefit for veterans with TBI as the suggested interim regulation would, but does require that a certain level of severity be met. We find the criteria in § 4.28 to be a reasonable and appropriate way to evaluate many veterans with TBI residuals in the immediate post-discharge period and therefore do not agree that an interim regulation is needed. While 38 CFR 4.28 also applies to mental disorders, determining the stability, likelihood of improvement, and effect on employment of post-traumatic stress disorder (PTSD) and related mental disorders is considerably more difficult than in the case of a neurologic disorder such as TBI and often requires a long period of observation and treatment to determine. Section 4.129 ensures that veterans with certain mental disorders, primarily PTSD, receive an immediate post-discharge evaluation of at least 50 percent, when discharged for those mental disorders, since applying 38 CFR 4.28 might be very difficult in the case of those mental disorders.

Limited Scope of Abnormalities in Regulation

We received 2 comments on the scope of the abnormalities included in the regulation. The commenters said that the proposal only takes into account one body system and one injury rather than the totality of the pathophysiology of the whole body and associated injuries and that there could be permanent problems in the areas of cognitive, physical, mental, communicative, emotional, behavioral, social, vocational or medical (neurological, cardiovascular, neuroendocrine, immunological, orthopedic, respiratory, renal) function.

We disagree with the commenter because the regulation does take into account all possible affected body systems and all disabling effects. It provides specific criteria only for evaluating cognitive impairment and subjective symptoms that result from TBI because all other disabling effects can be evaluated under existing diagnostic codes regardless of the body system affected. The regulation lists

numerous additional effects of TBI: Motor and sensory dysfunction, including pain, of the extremities and face; visual impairment; hearing loss and tinnitus; loss of sense of smell and taste; seizures; gait, coordination, and balance problems; speech and other communication difficulties, including aphasia and related disorders, and dysarthria; neurogenic bladder; neurogenic bowel; cranial nerve dysfunctions; autonomic nerve dysfunctions; and endocrine dysfunctions. It further states that these are not the only possible residuals and that residuals either on this list or not on this list that are reported on an examination are to be evaluated under the most appropriate diagnostic code. Therefore, the regulation directs how to evaluate any residual of TBI.

Symptoms Cluster Evaluation

The proposed regulation provided criteria for the evaluation of a cluster of subjective symptoms, which may be the only residual of TBI. Currently, subjective symptoms due to TBI can be rated under diagnostic code 8045 at a maximum of 10 percent. The proposed regulation based the evaluation of subjective symptoms on the number of symptoms present, and provided evaluation levels of 20, 30, and 40 percent. It required that at least 3 of a specified group of symptoms be present to qualify as a cluster. We received many comments on this proposal, including some stating that subjective complaints can be more than 40 percent disabling as individual symptoms, that the levels of evaluation do not take the severity and frequency of symptoms or functional impairment into account, that a veteran could be catastrophically disabled by a single symptom, and that veterans with TBI should not need an extra-schedular evaluation to receive a total disability rating.

We agree in general with the commenters and, based on those comments, have substantially changed the method of evaluating subjective symptoms. We have incorporated subjective symptoms into a rating table (proposed as a table for rating only cognitive impairment) that now combines the evaluation of cognitive impairment and other residuals of TBI not otherwise classified. The subjective symptoms are now evaluated in a facet called subjective symptoms at a level between 0 and 2 based on functional impairment, that is, the extent of interference with the veteran's ability to work; to perform instrumental activities of daily living; or to have close relationships in work, family, or other settings. We have retained the requirement that three or more subjective symptoms be present but have removed the requirement that the symptoms be from a defined list, because some of the items on our proposed list, such as inappropriate social behavior, aggression, and impulsivity, overlap with, or may themselves be considered to be neurobehavioral effects. We will rely on the examiner to determine what constitutes a subjective symptom and what constitutes an observable neurobehavioral effect for purposes of evaluating these facets using the table in the regulation.

In conjunction with this change, we added a note defining ''instrumental activities of daily living'' as referring to activities other than self-care that are needed for independent living, such as meal preparation, doing housework and other chores, shopping, traveling, doing laundry, being responsible for one's own medications, and using a telephone. We also explain in the note that ''instrumental activities of daily living'' are distinguished from ''activities of daily living,'' which refers to basic self-care and includes bathing or showering, dressing, eating, getting in or out of bed or a chair, and using the toilet.

We also received a comment that the frequency, severity, and duration of other neurobehavioral effects in the cognitive impairment table should be assessed instead of the number of effects. We therefore changed the way of evaluating neurobehavioral effects from a method based on the number of effects to one based on the extent of interference with workplace interaction and social interaction. These changes provide a more functional-based assessment for both subjective symptoms and neurobehavioral effects.

The proposed rule prohibited separate evaluations for cognitive impairment and the symptoms cluster. One commenter stated that this prohibition should include only those disabilities with overlapping symptoms. This prohibition no longer applies since both cognitive impairment and subjective symptoms are evaluated under the same table, and the effects of both would be considered in determining an evaluation.

We received 2 comments about the current maximum 10-percent evaluation for subjective symptoms. The first commenter said that this maximum evaluation should be removed immediately. The other commenter said that the current 10-percent limitation is not an issue as most veterans also have PTSD and the cognitive/emotional impairments are considered in the evaluation for PTSD. The second commenter also said that, if substantiated on medical examination, complaints are no longer ''purely subjective''.

Since the 10-percent limitation is a regulatory requirement, we must proceed with the regulatory process to remove it, as we have done in this regulation. If we removed it in a separate rulemaking without replacing it with another rule, there would be no provision at all for rating subjective symptoms, a lack that would clearly disadvantage veterans. In any case, we proposed to eliminate the 10-percent limitation on ratings for subjective symptoms and adopt that proposal in this final rule. As for the second comment, we disagree that subjective symptoms reported on examination are no longer purely subjective. While a clinician's judgment is important in assessing the validity of complaints, there are no tests, for example, that would prove or disprove that a headache is present. The fact that symptoms are reported on an examination does not establish them as objective. Finally, not all veterans with disabling subjective symptoms due to TBI also have PTSD, and we therefore need a way to take the subjective symptoms into account, as we have done in the table in this regulation. We make no change based on these comments.

One commenter stated that it is unclear which set of diagnostic criteria, the DSM–IV research criteria for postconcussional disorder or the ICD–10–CM criteria for postconcussional syndrome, are to be used when evaluating symptoms clusters. (''DSM–IV'' refers to the Diagnostic and Statistical Manual of Mental Disorders, 4th edition, and ''ICD–10–CM'' refers to the International Classification of Diseases, Tenth Revision, Clinical Modification.) The proposed rule did not use either set of criteria for evaluating symptoms clusters, nor does the final rule. We did not limit the evaluation of symptoms clusters to post-concussion syndrome or mild TBI (a term sometimes used interchangeably with post-concussion syndrome), as the commenter suggests. The table for the evaluation of cognitive impairment and subjective symptoms in the final rule is also not limited to TBI that was classified at any particular level. The regulation states in note (4) under diagnostic code 8045 that the initial classification of TBI at or near the time of injury as mild, moderate, or severe does not affect the rating assigned under diagnostic code 8045. We therefore make no change based on this comment.

One commenter said that data are insufficient to support VA's statement that symptoms following mild TBI resolve in 3 months for most affected people and in a small percentage become permanent. Research is continuing in this area, but there are numerous references that support this statement, including ''Mild Traumatic Brain Injury and Postconcussion Syndrome'' (Michael A. McCrea, 86, 2008), which states that symptoms after mild TBI are typically transient, with rapid or gradual resolution within days to weeks after injury in an overwhelming majority of patients with mild TBI.

One commenter felt that the term post-concussion syndrome should be dropped. That term is synonymous with the term mild TBI. We did not in the proposed rule, and have not in the final rule, limited the evaluation of mild, moderate, or severe TBI to any single criterion or set of criteria. Therefore, we have not used the term post-concussion syndrome in the final rule. Another commenter stated that the proposed criteria do not acknowledge all of the complexities of evaluating residuals of mild TBI and that self-reported symptoms should not be ignored. A third commenter said that all types of TBI should be assessed for cognitive function because an individual with mild TBI may also have cognitive impairment. The final rule evaluates cognitive impairment and subjective symptoms under a single table, so that the severity of all residuals can be taken into account, regardless of the initial severity designation of the episode of TBI. We therefore make no changes based on these comments.

Cognitive Impairment Evaluation

The proposed regulation included a table for the evaluation of cognitive impairment based on 11 facets of the condition, with criteria for evaluation of each of the facets at levels of 0 through 4, although not every facet contained all 5 levels, since certain levels were not appropriate for some facets. The 3 highest evaluation levels were to be added and the sum divided by 3 and rounded to the nearest whole number. The resulting numbers equated to percentage evaluations as follows: 0 = 0 percent, 1 = 10 percent, 2 = 40 percent, 3 = 70 percent, and 4 = 100 percent. We received many comments concerning the table's reliability and validity, the specificity of the facets in general, the content of specific facets, and the evaluation formula itself.

Comments Concerning Reliability, Validity, and Scientific Evidence of Accuracy of the Table

Three commenters said the cognitive impairment table lacked reliability, validation, and scientific evidence of accuracy. By statute (38 U.S.C. 1155), VA disability ratings are based on average impairment of earning capacity, as reflected by evaluation criteria in the rating schedule, which the Secretary may revise from time to time ''in accordance with experience.'' While medical information and expertise are significant factors in revising the list of rating schedule disabilities and evaluation criteria, they are not the only relevant factors that VA must rely upon in crafting its rating schedule. We must also consider social and sociological factors in determining the level of impaired employability caused by a particular disability.

The American Medical Association Guides to the Evaluation of Permanent Impairment (AMA Guides) represent a widely used disability evaluating system, especially in evaluating disability for workers' compensation. The AMA relies on a large group of editors, advisory panelists, and contributors who are MDs and PhDs. VA has consulted with numerous TBI experts from various specialty areas (psychology, neurology, etc.) in developing this regulation. It thus appears that percentage evaluations are derived by the AMA in ways similar to VA's, and we make no change based on this comment. VA has considered the AMA's approach and has sought and relied on expert opinion in a similar manner.

Comment Concerning Lack of Specificity of Data To Determine Rating

Another commenter stated that there is lack of specificity about what data will be used to determine the ratings and asked if they will be based solely on medical records review or whether VA will accept input from family, caregivers, and medical and rehabilitation personnel. The commenter also asked if ratings can be assigned without neuropsychological testing and asked about veterans for whom English is not their first language. The commenter also asked if education level is a factor. One commenter said that there are a mixture of subjective and objective findings in the table, but the type of information to be used for rating is unclear.

VA has a duty to assist veterans in gathering evidence necessary to substantiate their claims, and there is a complex set of regulations, guidelines, and case law that raters follow in doing so. Raters are required to consider all evidence of record in making a disability determination. This includes the service medical records plus any evidence or statements the veteran chooses to submit from VA or non-VA medical facilities, family, friends, caretakers, or any others familiar with the veteran's disability. In most cases, a Compensation and Pension disability examination will be conducted, and the report based on that examination will be an important part of the record to be reviewed. There is no need to include in a particular rating schedule provision information about what evidence VA will use in applying that provision, since the same general regulations and procedures governing evidence to be considered apply in all cases.

Neuropsychological testing is not conducted in all cases. The need for such testing is left to the discretion of the clinician who conducts the disability examination. Many veterans will have had such testing prior to entering the disability evaluation process, and, if so, their results would be part of the evidence considered by raters. In other cases, while the veteran may claim to have suffered a TBI, the history may not confirm that such an injury occurred, or there may be no current symptoms, if one did occur. Conducting neuropsychological testing in such cases would be unnecessary and a wasteful use of resources. Concerning veterans for whom English is not their first language, the examiner determines whether or not an adequate history can be obtained. If not, the examiner can order a translator to appear with the veteran at a new exam. In the alternative, the veteran's history can be obtained from other sources (family, friends, caretakers, medical records, etc.), as noted above. The comment about whether education level is a factor is unclear but does not appear to be pertinent. We make no change based on this comment.

Comments Concerning Specificity and Objectivity of Facets of Table

A number of commenters expressed concern that the proposed cognitive impairment table did not include sufficient specificity and objectivity for the evaluation of facets in the table, and said that there was a lack of clarity as to how raters will determine whether the criteria are met.

We agree in general and have revised the contents of the table to enrich the criteria by including additional specificity, to the extent feasible. For example, we proposed to evaluate judgment at level 2 of impairment based

solely on the criterion of ''Moderately impaired.'' We have changed the criteria for level 2 to ''Moderately impaired judgment. For complex or unfamiliar decisions, usually unable to identify, understand, and weigh the alternatives, understand the consequences of choices, and make a reasonable decision, although has little difficulty with simple decisions.'' Another example is visual spatial function, where the proposed criteria for level 2 were ''Mildly impaired. May get lost in unfamiliar surroundings, occasional difficulty recognizing faces.'' We have revised the criteria for level 2 to ''Moderately impaired. Usually gets lost in unfamiliar surroundings, has difficulty reading maps, following directions, and judging distance. Has difficulty using assistive devices such as GPS (global positioning system).'' The changes not only add more specificity but help distinguish the impairment levels from one another. In some cases, this added precision allowed us to provide additional impairment levels so that now all facets except social interaction, subjective symptoms, neurobehavioral effects, and consciousness have all impairment levels of 0 through total. In the proposed regulation, 6 of the 11 facets lacked one or more of the 0 through 4 levels.

For the most part, medical examiners, not raters, will be responsible for providing specific information about each facet that is sufficient to allow raters to assign levels of evaluation. For example, the examiners will be specifically asked to state the level of severity of impaired judgment. Examiners will be guided by an examination worksheet (for dictated examination reports) or a computerized examination template (for electronically generated examination reports) for TBI, which will be developed in partnership with the Veterans Health Administration to ensure that the examination guidance is technically accurate and sufficiently descriptive to assist examiners in considering all possible ratable criteria. This is standard practice for VA disability examinations for all conditions and assures that sufficient information is provided to raters so that they can make accurate and consistent decisions nationwide.

We have also revised the titles of some of the facets for more clarity, specificity, and precision. We changed the title of the ''Memory, attention, concentration'' facet by adding ''executive functions'' to the title, since these 4 functions are most commonly affected in cognitive impairment. We revised the title of the ''Appropriate response in social situations'' facet to ''Social interaction,'' the ''Visual-spatial function'' facet to ''Visual spatial orientation,'' and the ''Speech and language disorders'' facet to ''Communication.'' We also revised the title of the ''Other neurobehavioral effects'' facet to ''Neurobehavioral effects''.

Comments Concerning Accuracy of Functional Impairment and Vocational Incapacity in the Table

One commenter stated that many of the criteria in the table do not appear to accurately reflect the degree of functional impairment and vocational incapacity that should be expected from such loss. The commenter stated that several criteria that are assigned a score of 3 or 4 should be individually rated at 100 percent for unemployability without reference to other criteria, including a veteran limited to working in a sheltered workshop or unable to work or attend school, a veteran needing assistance with Activities of Daily Living (ADLs), a veteran who often requires supervision for safety, etc.

We agree with the commenter and have revised the table in several ways. We changed the facet levels from the proposed 0 through 4 to levels of 0 through 3, with an additional higher level called ''total,'' representing a 100-percent evaluation, included in most facets. We removed altogether the 3 facets for work or school, ADLs, and supervision for safety. We have determined that the effects on work or school are reflected in the disabling effects of all of the other facets and therefore work or school is not needed as a separate facet. The facets for ADLs and supervision for safety represent impairments that would be compensated by means of special monthly compensation (SMC), a special monthly monetary payment that is made under certain statutorily prescribed circumstances. SMC is provided to a veteran who is receiving disability compensation and who needs the regular assistance of another person in attending to the ordinary activities of daily living or to avoid the ordinary hazards of the daily environment. There are many residuals of TBI, including cognitive impairment, neurobehavioral effects, problems with visual spatial orientation, and impaired consciousness that may meet the criteria for entitlement to SMC, depending on their severity. If a veteran has such residuals of TBI, the veteran would be entitled to both SMC and disability compensation when the need for regular assistance of another person in attending to the ordinary activities of daily living or to avoid the ordinary hazards of the daily environment is present. However, the need for assistance with ADLs and the need for supervision with safety are impairments that in and of themselves qualify an individual for SMC regardless of their severity. If these impairments were considered in assigning a percentage disability rating and in determining entitlement to SMC, this would be compensating twice for the same manifestations of a disability, which would constitute pyramiding, and this is prohibited, per 38 CFR 4.14 (Avoidance of pyramiding).

Several commenters said that the criteria for consideration of SMC need to be explicitly delineated. This is not necessary, however, because the SMC regulations potentially apply in all cases and therefore need not be repeated in every rating schedule provision. We have, however, provided a direction under diagnostic code 8045 to consider SMC, and it states: ''Consider the need for special monthly compensation for such problems as loss of use of an extremity, certain sensory impairments, erectile dysfunction, the need for aid and attendance (including for protection from hazards or dangers incident to the daily environment due to cognitive impairment), being housebound, etc.'' This is similar to a reminder in the proposed regulation to consider SMC.

Another commenter said that we should add to the regulation a statement that raters must consider, in addition to SMC, total disability ratings, total disability ratings based on unemployability, total disability ratings for pension, and extra-schedular evaluations. As with the criteria for SMC, these special provisions potentially apply in all cases and therefore need not be repeated in every rating schedule provision. Moreover, unlike the SMC criteria, which are disability-specific and therefore relevant to the conditions listed in the TBI rule, the criteria for these ratings are not specific to any condition and therefore have no special applicability to TBI. We make no change based on this comment.

The 7 facets that have levels that we have called ''total,'' and the associated criteria, are: Under the memory, attention, concentration, executive functions facet, objective evidence on testing of severe impairment of memory, attention, concentration, or executive functions resulting in severe functional impairment; under the judgment facet, severely impaired judgment; for even routine and familiar decisions, usually unable to identify, understand, and weigh the alternatives, understand the consequences of choices, and make a reasonable decision, for example, unable to determine appropriate

clothing for current weather conditions or judge when to avoid dangerous situations or activities; under the orientation facet, consistently disoriented to two or more of the four aspects (person, time, place, situation) of orientation; under the motor activity facet, motor activity severely decreased due to apraxia; under the visual spatial orientation facet, severely impaired, may be unable to touch or name own body parts when asked by the examiner, identify the relative position in space of two different objects, or find the way from one room to another in a familiar environment; under the communication facet, complete inability to communicate either by spoken language, written language, or both, or to comprehend spoken language, written language, or both, unable to communicate basic needs; and under the new facet titled consciousness (discussed below), for persistently altered state of consciousness, such as vegetative state, minimally responsive state, coma.

One commenter said that guidelines should be extended to include individuals with persistent disturbances in consciousness (e.g., vegetative state, minimally conscious state). We agree with the commenter and have added a new facet for consciousness, with only a single severity level of ''total'' for persistently altered state of consciousness, such as vegetative state, minimally responsive state, or coma, since any level of disturbance of consciousness would be totally disabling and warrant a 100-percent evaluation.

Other Comments on the Proposed Cognitive Impairment Criteria

One commenter said that the regulation should include more specific guidelines to account for fluctuations in residuals. All claims are rated based on all of the evidence of record, which will include evidence of fluctuation in symptoms. In addition, the rating can be increased if the disability worsens in the future. We make no changes based on this comment.

One commenter said that we should clearly state that cognitive impairment refers strictly to mental function and not other aspects of the disability. That is unnecessary, since the clinician will determine which signs and symptoms are part of cognitive impairment and which are not. We make no change based on this comment.

One commenter suggested separating out some of the findings of facets that include more than one type of impairment, including the memory, attention, concentration facet and the speech and language disorders facet. The commenter felt the various elements of a single facet should be separately evaluated. We disagree, as this already complex regulation would become even more complex, to the point that raters would find it extremely difficult to use. In addition, the criteria in facets with multiple criteria are in related areas of functional impairment and not all criteria need to be met for a given level of evaluation. A 100-percent evaluation, for example, can be assigned in some cases where a facet encompasses multiple criteria even if only one of the impairments is assessed as total. We therefore make no change based on this comment.

The same commenter stated that apraxia is uncommon after TBI and that it is unclear how an intact motor and sensory system (a requirement for evaluating the motor activity facet) would be determined. Apraxia is widely reported to be a component of TBI. For example, the Veterans Health Initiative booklet titled ''Traumatic Brain Injury,'' a publication of the Veterans Health Administration, states on page 12 that apraxia is an effect of diffuse axonal injury of the brain, which is a common occurrence in TBI, and an article titled ''Dementia Due to Head Trauma'' by Julia Frank, MD, Director of Medical Student Education in Psychiatry, Associate Professor, Department of Psychiatry and Behavioral Sciences, George Washington University School of Medicine (available at *http://www.emedicine.com/med/topic3152.htm*), states that testing for aphasia and apraxia are important in head injury, along with evaluation of retention, short-term memory, and abstraction. Other types of motor disabilities such as weakness, paralysis, sensory loss, etc., would be separately evaluated under other diagnostic codes. A neurologic examination would be the basis of a determination as to whether or not the motor and sensory systems are intact. We make no change based on this comment.

Another commenter stated that apraxia is the inability to perform a skilled movement, despite the person's desire or intent and ''physical inability'' to perform the movement, and suggested that this distinction be included as a note. Presumably the commenter meant ''ability'' rather than ''inability'' to perform the desired movement. In both the proposed and final regulation, under the motor impairment facet, we indicate that apraxia is the inability to perform previously learned motor activities, despite normal motor function, and we believe this is a sufficient description for rating purposes.

One commenter said that the levels of functioning for neurobehavioral effects lack criteria for frequency and severity. It would make for an extremely complex regulation if we provided criteria for the frequency and severity of each possible individual neurobehavioral effect, and adding a method to combine such assessments into an overall evaluation would add to the complexity. Therefore, we have provided evaluation criteria for neurobehavioral effects based on the extent of interference with workplace interaction and social interaction, as discussed above. We also listed numerous examples of neurobehavioral effects at the 0 level, and indicated that any of the effects may range from slight to severe but that verbal and physical aggression are likely to have a more serious impact on workplace interaction and social interaction than some of the other effects.

One commenter disagreed with the statements in the preamble to the proposed rule that cognitive impairment is defined as decreased memory, attention, and executive functions of the brain and that primarily those who experienced a moderate or severe TBI would require evaluation under these criteria. The commenter felt that the need for cognitive assessment should be customized to each individual veteran's clinical signs and symptoms irrespective of the severity of the TBI in the immediate post-injury period and that all veterans with TBI should undergo cognitive evaluation for the claimed symptoms.

We agree in part with the commenter. The final rule does not provide different criteria depending on the original classification of TBI and does not limit evaluation under these criteria to veterans who experienced a moderate or severe TBI. Therefore, every veteran examined for residuals of TBI will be screened for cognitive impairment, regardless of the level of severity in the immediate post-injury period. Additional testing will then be conducted as indicated. However, we disagree that cognitive impairment is not defined as decreased memory, attention, and executive functions of the brain. The Veterans Health Initiative booklet titled ''Traumatic Brain Injury,'' referred to above, states on page 73 that the following symptoms have been seen as the most prominent cognitive sequelae following moderate to severe TBI: Attention and concentration problems, new learning and memory deficits, and executive control dysfunction.

Visual-Spatial Facet

One commenter suggested we add reading difficulty to the visual-spatial function facet (retitled visual spatial orientation). We believe that the communication (proposed as speech and language) facet adequately covers the issue of reading, via its criteria concerning the ability to communicate and to comprehend written language. Another commenter noted that the differential diagnosis of the visual-spatial function is not included. The differential diagnosis of a condition, which is often used clinically in arriving at a diagnosis, is not included because the purpose of the rating schedule is to provide criteria for determining the level of severity of a condition that has already been diagnosed by a clinician. Including a differential diagnosis in the rating schedule is neither necessary nor appropriate. We make no change based on this comment.

Another commenter stated that additional symptoms, such as loss of color vision and photosensitivity, should be included in the visual-spatial facet. As the preamble of the proposed regulation stated, our intent was to provide guidance for the evaluation of the most common, but not all possible, residuals of TBI. Visual-spatial orientation (the facet that was titled visual-spatial function in the proposed rule) refers to the relationship of objects in space to the body. Neither photosensitivity nor loss of color vision falls into this category. Since photosensitivity is a subjective symptom that is common after TBI, we have, however, included it as an example in the subjective symptoms facet at level 1. Vision screening is part of the TBI examination, and any signs or symptoms of visual problems found on screening require an examination by a vision specialist. If there are complaints of loss of color vision, special testing can be done to confirm the type and severity. It is therefore not a subjective symptom, as many aspects of vision impairment are not, but would be assessed under the direction in this rule to evaluate physical (including neurological) dysfunction under an appropriate diagnostic code. Visual impairment is one of the dysfunctions listed under this direction.

The same commenter said that the visual-spatial function facet should be reviewed by both neuro-opthalmology and low vision optometry experts, so that they can revise the facet as necessary to avoid inaccurate ratings for veterans who have significant impairments to their visual system. In practice, a vision specialist will examine any veteran with TBI who has vision complaints or in whom vision abnormalities are found or suspected on a screening examination. In addition, the vision specialists have the option of requesting additional special examinations when needed. However, the degree of specificity and complexity that neuro-opthalmology and low vision optometry experts might add to the facet would not necessarily assist in the disability evaluation process, because a fairly gross assessment of functional impairment allows raters to make an appropriate evaluation in the great majority of cases. Moreover, specific veterans may receive special examinations, where appropriate, as noted above. Finally, in exceptional cases where the schedular evaluations are found to be inadequate, an extra-schedular evaluation commensurate with the average earning capacity impairment may be assigned, based on such factors as marked interference with employment or frequent periods of hospitalization (see 38 CFR 3.321(b)). We make no change based on this comment.

Two commenters questioned how the judgment facet will be assessed, and they recommended more specific criteria. Judgment will be assessed by clinicians, as is routinely done during the course of examinations for mental disorders. We have added more specific information to the criteria in the judgment facet, indicating that judgment involves weighing the alternatives, understanding the consequences of choices, and making a reasonable decision.

One commenter suggested that the facet for supervision for safety should include not only the safety of the individual but also the safety of others. We have removed the supervision for safety facet because the need for supervision to protect the veteran from hazards in the environment would warrant SMC, as explained above. Verbal and physical aggressiveness would be evaluated under the subjective symptoms facet, and they are given as examples there.

One commenter said that the appropriate response in the social situations facet should include appropriate response in interpersonal relationships. The criteria in this facet, which we renamed social interaction, would encompass interpersonal relationships, as social situations include individual interaction and relationships as well as group interaction and relationships. We have revised the social situations facet, but we make no additional change based on this comment.

Cognitive Impairment Formula

Several commenters objected to the levels of evaluation for the facets and to the formula used to calculate the disability evaluation. One commenter said that using just 4 categories of impairment is too limited and that this limitation plus the lack of specificity could result in nearly all disability ratings for TBI being too low. Since, for most facets, percentage evaluations based on the table range from 0 to 100 percent, with levels of 10, 40, and 70 percent between them, the range of possible evaluations is broad and should be adequate for evaluating the severity of residuals. As stated above, an extra-schedular evaluation is available for exceptional cases in which the available evaluation criteria are not sufficient. Regarding the comment about lack of specificity, we have revised many of the criteria to make them more specific. Making them too specific, however, would disadvantage veterans because there is an extremely wide range of variability of the residuals of TBI, and leaving some flexibility in the criteria will allow evaluation based on a broad range of specific findings that may vary from veteran to veteran.

Another commenter said that the number of impaired facets should be weighted by the level of each facet, and the results combined by means of a specially designed combination table to calculate the additive disabling effects of TBI. We do not agree that this is necessary, and it would add greatly to the complexity of the regulation, without an obvious benefit. We make no change based on this comment.

Two commenters stated that not every facet includes every level between 0 and 4 (now 0 and total) but failed to notice that we pointed this out in the proposed regulation. The rationale is that not every facet warrants the entire gamut of evaluations, and we provided levels that we believe are most appropriate for each facet. One of these commenters recommended that a psychometrician examine the method of evaluation and that VA develop a plan to evaluate reliability and validity. This final rule reflects the input of medical professionals, some of whom contributed indirectly through research and public discussions about TBI and others who contributed directly by drafting or commenting on the rating criteria. Therefore, there is a scientific basis for the rule. Because the need for a new approach to TBI is both immediate and critical, we cannot delay further by submitting the criteria to a

psychometrician. However, VA will be paying close attention to the applications of this schedule in individual cases, and we will make any necessary revisions.

One commenter stated that the cognitive impairment table is unfair because a veteran requiring assistance with ADLs (formerly a facet) some of the time but less than half of the time could receive only a 10 percent evaluation. This comment is no longer pertinent since we have removed that facet. A similar comment we received to the effect that a veteran with only 3 facets of cognitive impairment could be unemployable but might only receive a 40-percent evaluation is also not pertinent now, since we have provided for a 100-percent evaluation for the most serious effects of these facets of TBI.

Neuropsychological Testing

Several commenters noted that we did not propose to require neuropsychological testing as part of every examination for TBI and did not provide guidance for the appropriate use of such testing. They felt such examinations are necessary.

We discussed this issue above in response to comments about specificity of the criteria and explained why we are leaving it to the discretion of the clinicians who examine veterans with TBI to determine when neuropsychological testing is needed. We make no change based on this comment.

Comorbid Mental Disorders

One commenter was concerned that mental health examiners who examine veterans with TBI may not be able to fully evaluate the veterans' physical problems related to TBI and wondered if we would have joint evaluations. We have developed and will issue updated Compensation and Pension Examination worksheets and computerized examination templates that will take into account the requirements of this regulation. These examination guidelines will include guidance, developed in association with the Veterans Health Administration's TBI experts, about who may conduct these examinations in order to ensure that all aspects of the veteran's disability are fully assessed.

One commenter stated that the rule should require VA to consider whether service connection is warranted for mental disorders secondary to service-connected TBI, while another commenter stated that VA rating officials should be careful not to attribute TBI signs and symptoms to a nonservice-connected mental disorder. There are several regulations that raters must apply in determining secondary service connection, and raters are very familiar with them and apply them daily. The applicable regulations need not be restated in this regulation as they apply in all cases.

Another commenter requested that we reinforce the fact that diagnosing or evaluating co-morbid mental disorders is difficult in someone with cognitive impairments. This information would be more appropriately conveyed to examiners and raters through training rather than through rating schedule regulations. VA has already carried out a number of TBI training initiatives and is planning even more extensive training in the near future, so that raters and clinicians will be well informed on the issues relating to the assessment of all aspects of TBI, including that of comorbid disorders. We make no change based on this comment.

We received 2 comments about proposed note number 1 under the cognitive impairment table, which required that a single evaluation be assigned 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) if the signs and symptoms of the mental disorder(s) and of cognitive impairment cannot be clearly separated. It also stated that if the signs and symptoms are clearly separable, VA would assign separate evaluations for the mental disorder(s) and for cognitive impairment.

One commenter said there should be more explanation for this determination because the criteria in the cognitive impairment table overlap with the criteria for evaluating mental disorders under 38 CFR 4.130, and because coexisting mental disorders may increase the TBI disability. According to the commenter, the note should state that if the signs and symptoms of a mental disorder and of cognitive impairment cannot be clearly separated, assign a single evaluation for whichever provides the better assessment and elevate that evaluation to the next higher evaluation. The second commenter said that this provision unfairly places the burden on the veteran and is inconsistent with the benefit of the doubt doctrine.

Regarding the first comment, the findings do overlap, and that is the reason the provision is needed. Pursuant to 38 CFR 4.14, Avoidance of pyramiding, VA is prohibited from evaluating the same impairments under different diagnoses, because to do so would effectively compensate the veteran twice for the same disability. Raters apply this regulation in numerous situations of overlapping symptoms, for example, when both mental and physical disorders are present, when more than one mental disorder or physical disorder (one service-connected and one not) is present, when there are two conditions affecting the same body system, with one service-connected and one not, etc. TBI is not unique in requiring the application of this regulation. Although the commenter stated that an evaluation encompassing both the effects of TBI and of a mental disorder should be elevated to the next higher level of evaluation than would be assigned based on whichever provides the better assessment (because the commenter felt that coexisting mental disorders may increase the TBI disability), we believe that the combined disabling effects of TBI and a mental disorder will be adequately taken into account by an evaluation that is based on ''the better assessment of overall impaired functioning due to both conditions,'' since such an assessment would include the extent of disabling effects due to both conditions. Regarding the second comment, the percentage evaluation is determined by the rater based on an assessment by the examiner, so there is no unique burden on the veteran in this situation. We make no change based on these comments.

Motor Impairment Evaluation

Two commenters expressed concern that there are no guidelines for selecting the appropriate code for evaluating such impairments of motor function as spastic hypertonia. We are planning to revise the neurologic section of the rating schedule to update it. One addition we plan is a rating formula for movement disorders, which would include such conditions as dystonia. We believe the neurologic rating schedule revisions will provide an adequate basis of evaluation for motor impairments of abnormal tone and spasticity. Until that regulation goes into effect, raters will use their judgment to evaluate such conditions analogously under the most appropriate diagnostic code in an individual case. We make no change based on this comment.

Cumulative Effects

Two commenters stated that we should emphasize that the effects of multiple TBIs are cumulative, and one of them said that the number of episodes should be tracked. Although a veteran who has had multiple episodes of even mild TBI is more vulnerable to

persistent residuals, this is not relevant to the evaluation of TBI residuals, which is based on the extent of current disability, whether due to a single service-connected TBI or to multiple service-connected TBIs. If there were several in-service injuries, the examiner would consider their possible cumulative effect, consistent with sound medical principles. Thus, whether there was one or repeated instances of head trauma in service, raters evaluate residuals based on current functional impairment when provided with a diagnosis of TBI and findings the examiner attributes to TBI. Therefore, so long as a current disability can be medically linked to service, it will not matter whether the veteran suffered one head trauma or several lesser head traumas during service. It might be useful for other entities to track the number of TBI episodes for their particular purposes, such as taking precautions to prevent additional TBIs in a veteran who has already experienced one or more. However, it is generally not necessary for disability evaluation purposes. Therefore, we make no changes based on these comments.

Tools and Concepts for Assessing Disability

Various commenters recommended that we include specific assessment tools as part of our evaluation criteria. These included calls for the use of the American Speech-Language-Hearing Association's Functional Communication Measures to assess speech and language; the American Association on Intellectual and Developmental Disabilities' Supports Intensity Scale, to rate frequency, intensity, and type of support needed to engage in home living, community, lifelong learning, employment, health and safety, social activities, protection and advocacy, medical supports, and behavioral supports; and assessment tools on the Center for Outcome Measurement in Brain Injury Web site.

While all of these tools may be useful for clinical purposes, including them as part of the rating process would make the regulation prohibitively complex. Some commenters stated that even the proposed regulation, without those tools, was too complex and would be too time consuming to implement. One commenter said that the proposed regulation is unworkable due to its complexity, that it is difficult and burdensome, and that because of raters' productivity standards, employees might be pressured to take shortcuts on the case. Another said that the proposal will more than triple the work to rate a claim, and that there will be a long learning curve for raters. Some items assessed by the recommended tools, such as rating the type of support needed to engage in lifelong learning and rating medical and behavioral supports, go well beyond VA's statutory requirement to rate based on average impairment of earning capacity.

Also, the use of specific evaluative tests is the province of the medical specialist conducting the examination. So long as the examination report contains sufficient detail to rate the veteran's disability under the criteria in the regulation, it matters little which evaluative methods are used for the purposes of the rating schedule. For all these reasons, we make no change based on these comments.

Administration of Assessment

We received a number of comments about administering the regulation. Two of the commenters recommended that the rule be pilot tested in a large outcome study and be validated, standardized, etc. One felt that we should take into account time of day, familiarity with assessor, etc., and evaluate based on multiple sources. We discussed above the facts that multiple sources of information are considered in evaluating TBI and that the TBI regulations were developed based on multiple sources of information and in consultation with multiple TBI experts. Conducting the recommended studies would significantly delay the implementation of the regulation, which we believe should be expedited to the extent possible. However, VA regularly reviews the adequacy of the rating decisions issued by our regional offices, and if we encounter problems in the implementation of this regulation that can be fixed through subsequent revision of our regulations, then we will certainly take appropriate action in the future. We make no change based on these comments.

One commenter pointed out the need for training for examiners and the development of new examination templates with explicit instructions for each level of impairment. These are all planned but are not part of the regulation, and we make no change based on this comment.

Another commenter said that those proposing these ratings and regulations should be comprised of veterans suffering from TBI. This would be impractical since writing regulations is a highly technical undertaking that requires knowledge about the medical aspects of TBI, which are very complex, as well as knowledge about the legal aspects of regulations in general and rating schedule regulations in particular. This rulemaking was developed and written by medical and legal experts within VA who are knowledgeable about TBI in consultation with outside experts. In addition, Veterans, their caretakers, and the general public have had an opportunity to comment on the proposed regulation, and we are taking all comments into account. Therefore we make no change based on this comment.

Systematic Review of Regulation

Four commenters recommended that the TBI regulations be regularly reviewed and updated as medical information is updated. We agree that this is necessary and plan to do so.

Collaboration Among Various Groups of Experts

Several commenters recommended either more collaboration among civilian and military experts in TBI assessment and rehabilitation to ensure that veterans with TBI receive the highest quality of care or the establishment of an advisory committee to include experts in diagnosis and treatment, as well as vocational experts, who can provide a scientifically valid basis for the new regulation. Prior to developing the regulation, a series of conferences on TBI were held over a period of many months. The conferences included TBI experts from VA, the Department of Defense, and the non-governmental medical community. All aspects of TBI, including definition and diagnosis, disability assessment, treatment, family concerns, long-term care, testing methods, education and training, and research were thoroughly addressed. Those meetings provided extensive information on TBI that we carefully considered as we developed the regulations.

Another commenter recommended that VA form an employee workgroup to study and evaluate no fewer than 1,000 cases under the proposed regulation to determine whether the regulation is workable. This recommendation would be impractical to adopt because it would require us to delay implementing the regulation and would take substantial personnel time away from other duties, so we do not plan to adopt this recommendation. Once the regulation goes into effect, we will make adjustments to it if we find they are needed. However, we expect that with some training, which we are planning, raters will not find this regulation exceptionally difficult to apply.

Source of Information for Rating Determination

One commenter asked how a rater would obtain evidence to apply the cognitive impairment table and said that the veteran's recovery team should be queried, and another commenter asked who would be the source of information used to make the rating determination. As mentioned above, raters take into account all available medical evidence and other pertinent information. The report by the clinician who conducts the Compensation and Pension disability examination is a primary source of information. That clinician may incorporate into the examination report information received from individuals other than the veteran, including family members, caretakers, etc. Raters therefore receive an extensive amount of information to be used in making their determinations.

One of these commenters also recommended that we undertake health-service research to document the validity of the proposed rating constructs, inter-adjudicator reliability of the rating determinations and the actual versus predicted levels of disability. We have already addressed similar comments above and make no change in response to this comment.

Quality of Life (QOL)

One commenter said that disability ratings should reflect greater sensitivity to the potentially immense significance of any TBI-related impairment in terms of major loss in quality of life, regardless of how ''mild'' a symptom may appear to be on paper, and that VA should provide compensation for loss of QOL for all with TBI, including mild TBI. A second commenter also said that mild TBI should be compensated for QOL.

The current statutory requirement is that disability ratings be based on average impairment of earning capacity. However, VA has contracted for a study concerning issues related to quality of life in determining disability. We make no change based on these comments, pending the completion of that study and VA's review of the study and any recommendations made.

General Comments

One commenter expressed the hope that the use of this regulation will not be limited to soldiers with combat-related injuries. This regulation will apply to any veteran with residuals of a service-related TBI of any origin.

Another commenter said that grouping cognitive impairment, the subjective symptoms cluster, and emotional/behavioral disorders under one diagnostic code would be unfair to claimants, who might otherwise receive 3 separate ratings. Our intent is that mental disorders associated with TBI will not be evaluated under diagnostic code 8045 but under the mental disorders section of the rating schedule (§ 4.130). The subjective symptoms have been incorporated in the final rule into the table now titled ''Evaluation Of Cognitive Impairment And Other Residuals Of TBI Not Otherwise Classified.'' A single evaluation will be assigned based on this table, but each of the facets in it will be considered.

We proposed to determine the evaluation level based on this table by adding the 3 highest evaluation levels and dividing that sum by 3 to determine the overall evaluation. However, we have revised this method to prevent the dilution of the severity level of the highest rated disability that would occur if less disabling problems were taken into account in the evaluation, as we proposed. Therefore, we have revised the method to base the evaluation on the highest level assigned for any facet. This level will determine the overall evaluation under the table of 0, 10, 40, 70, or 100 percent. This method of determining the evaluation is an efficient way to take into account the major and most severe disabling effects of TBI.

Another commenter stated that the proposal should encourage participation in vocational rehabilitation. The rating schedule, which is a guide to the evaluation of disabilities, is not the appropriate document in which to discuss the potential or need for vocational rehabilitation, and we make no change based on this comment.

One commenter urged VA to recognize the multidimensional and complex aspects of brain injury and points out that a variety of health problems, such as hypopituitarism, that do not exist immediately after TBI, become evident later. The commenter further said that the short and long-term impacts of TBI are still unknown. These are important points, and VA will make adjustments to the TBI regulation as necessary based on developing medical information about long-term and delayed residuals of TBI. The regulation does indicate that endocrine dysfunction is one of the possible physical residuals of TBI, and the rating schedule contains criteria for the evaluation of endocrine disabilities, including pituitary dysfunction, in the endocrine section of the rating schedule (38 CFR 4.119).

The same commenter urged VA to err on the side of providing more, rather than less, compensation to veterans for reported TBI-related impairments. Regulations (38 CFR 4.3, ''Resolution of reasonable doubt'' and 38 CFR 3.102, ''Reasonable doubt'') require VA to administer the law under a broad interpretation, consistent, however, with the facts shown in every case, and when there is a reasonable doubt regarding service origin, the degree of disability, or any other point, such doubt will be resolved in favor of the claimant. This is a guiding principle in all VA rating determinations. We also believe that the revisions to the proposed schedule, reflected in this final rule, will tend to result in awards of more, rather than less, compensation in individual cases.

Sua Sponte Reviews and Effective Date

We received several comments regarding the applicability date of the revised regulation and rating reviews under the new criteria. One commenter stated that VA should provide *sua sponte* reviews under the new criteria for all cases with service-connected TBI residuals. The commenter felt that the proposal would have required veterans to take affirmative action to request review, and many veterans will not know to do this or are too impaired to take such action. Additionally, the commenter stated that VA's undertaking review on its own initiative would result in an earlier effective date of any increase in compensation compared to review undertaken at a veteran's request.

The commenter also said that VA's proposal would create two classes of TBI ratings, some under the current criteria and some under the new criteria, which is inequitable. The commenter continued, if VA applies the new rating criteria to all TBI cases, they would all be rated uniformly under the same criteria.

A commenter stated that there should be a clause in the proposed regulation to direct raters not to reduce ratings under the new criteria. The commenter felt that no veterans who currently have service-connected TBI residuals should be adversely impacted by the rating criteria change.

A commenter stated that the proposed applicability of the revised rating criteria to all applications for benefits received by VA on or after the effective date of this rule is too restrictive and appears to violate 38 U.S.C. 5110 for claims pending on the date of enactment. Furthermore, given the nature of TBI, it is too burdensome to require veterans with TBI to request review. The commenter thought that claims filed on or after October 7, 2001, should be reviewed for readjudication

under the revised regulation. At a minimum, the commenter continued, veterans who currently have service-connected TBI should be notified of the change and offered a simple form to use if they wish to request review.

Another commenter stated that it is unfair to apply the old rating criteria to pending claims. It was suggested that the new criteria apply to claims and appeals pending on the date of publication of the new rule.

VA is applying this rating schedule change prospectively. It would be unfair to veterans to apply new criteria to examinations and medical evidence produced under prior guidance. As stated, we are revising our training and examination templates based on our new criteria. The applicability date and review guidance we are providing will allow veterans to be re-rated with new examinations that conform to the new criteria to ensure an adequate rating is provided. An effective date of a higher rating under the criteria would not be available prior to the effective date of the new criteria, as the new criteria did not exist prior to that date. It is unlikely that a veteran would receive a lower rating under the new criteria; however, consistent with 38 U.S.C. 1155, any review under the new criteria will not result in a reduction in a veteran's disability rating unless the veteran's disability is shown to have improved. We will provide outreach to ensure that all affected veterans are informed of the new criteria and the availability of re-rating under the new criteria. However, that is separate from what is included in the regulation. We are therefore making no changes based on these comments.

Additional Changes

In addition to adding the note defining ''instrumental activities of daily living,'' we made other changes in the notes under diagnostic code 8045. We revised proposed note (1), which directed how to evaluate when both cognitive impairment and one or more comorbid mental disorders are present, by expanding the instructions to include the situation when there is overlap of manifestations of the conditions evaluated under the table titled ''Evaluation Of Cognitive Impairment and Other Residuals Of TBI Not Otherwise Classified'' with not only a comorbid mental disorder but also with a neurologic or other physical disorder that can be separately evaluated under another diagnostic code. It states that if the manifestations of two or more conditions cannot be clearly separated, a single evaluation should be assigned under whichever set of diagnostic criteria allows the better assessment of overall impaired functioning due to both conditions, but if the manifestations are clearly separable, a separate evaluation should be assigned for each condition. This revision provides more comprehensive guidance to raters than the proposed note.

We have removed proposed note (2), which directed how to evaluate when both cognitive impairment and the symptoms cluster were present. This direction is no longer necessary since we have included cognitive impairment and subjective symptoms in the same rating table. We replaced proposed note (2) with new note (2), which states, for the sake of clarity, that symptoms listed at certain evaluation levels in the table are only examples and are not symptoms that must be present in order to assign a particular evaluation.

We also removed proposed note (3), which referred to the evaluation of subjective symptoms and cognitive impairment and is no longer pertinent. It directed that evaluation be made under the set of criteria that is most in accord with the residuals, whatever the original classification of the level of severity of the TBI. We replaced this with new note (3), concerning instrumental activities of daily living, as described above.

We made no change to the content of proposed note (4) concerning review of ratings for TBI made under the criteria effective before the effective date of this final regulation. However, we moved this content to new note (5).

We added new note (4), which states that the terms ''mild,'' ''moderate,'' and ''severe,'' which may appear in medical records, refer to a classification of TBI made at, or close to, the time of injury rather than to the current level of functioning and that this classification does not affect the rating assigned under diagnostic code 8045. This is a restatement of material in the proposed rule that was under diagnostic code 8045.

We edited language under diagnostic code 8045 and reorganized some of it for the sake of clarity and to comport with the revised evaluation criteria. For example, we removed all references to the proposed set of evaluation criteria for subjective symptoms clusters, which are no longer needed. To avoid confusion, we also added a statement that the evaluation assigned based on the ''Evaluation Of Cognitive Impairment And Other Residuals Of TBI Not Otherwise Classified'' table will be considered the evaluation for a single condition for purposes of combining with other disability evaluations.

VA appreciates the comments submitted in response to the proposed rule. Based on the rationale stated in the proposed rule and in this document, the proposed rule is adopted with the changes noted.

We are additionally adding updates to 38 CFR part 4, Appendices A, B, and C, to reflect changes to the TBI rating criteria made by this rulemaking. The appendices are tools for users of the Schedule for Rating Disabilities and do not contain substantive content regarding evaluation of disabilities. As such, we believe it is appropriate to include these updates in this final rule.

Benefits Costs

None of the changes to the proposed rule will alter the estimated costs provided in the previous Notice of Proposed Rulemaking.

Paperwork Reduction Act

This document contains no provisions constituting a collection of information under the Paperwork Reduction Act (44 U.S.C. 3501–3521).

Regulatory Flexibility Act

The Secretary hereby certifies that this final rule will not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act, 5 U.S.C. 601–612. This final rule would not affect any small entities. Only VA beneficiaries could be directly affected. Therefore, pursuant to 5 U.S.C. 605(b), this final rule is exempt from the initial and final regulatory flexibility analysis requirements of sections 603 and 604.

Executive Order 12866

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety, and other advantages; distributive impacts; and equity). The Executive Order classifies a ''significant regulatory action,'' requiring review by the Office of Management and Budget (OMB), as any regulatory action that is likely to result in a rule that may: (1) Have an annual effect on the economy of $100 million or more or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities; (2) create a serious inconsistency or otherwise interfere with an action taken or planned by another agency; (3) materially alter the budgetary impact of entitlements, grants, user fees, or loan

programs or the rights and obligations of recipients thereof; or (4) raise novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order.

The economic, interagency, budgetary, legal, and policy implications of this final rule have been examined and it has been determined to be a significant regulatory action under the Executive Order because it is likely to result in a rule that may raise novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order.

Unfunded Mandates

The Unfunded Mandates Reform Act of 1995 requires, at 2 U.S.C. 1532, that agencies prepare an assessment of anticipated costs and benefits before issuing any rule that may result in the expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of $100 million or more (adjusted annually for inflation) in any year. This final rule would have no such effect on State, local, and tribal governments, or on the private sector.

Catalog of Federal Domestic Assistance Numbers and Titles

The Catalog of Federal Domestic Assistance program numbers and titles for this final rule are 64.104, Pension for Non-Service-Connected Disability for Veterans, and 64.109, Veterans Compensation for Service-Connected Disability.

List of Subjects in 38 CFR Part 4

Disability benefits, Pensions, Veterans.

Approved: August 22, 2008.

James B. Peake,

Secretary of Veterans Affairs.

■ For the reasons set out in the preamble, 38 CFR part 4, subpart B, is amended as set forth below:

PART 4—SCHEDULE FOR RATING DISABILITIES

■ 1. The authority citation for part 4 continues to read as follows:

Authority: 38 U.S.C. 1155, unless otherwise noted.

Subpart B—Disability Ratings

■ 2. In § 4.124a, in the table titled ''Organic Diseases of the Central Nervous System,'' the entry for 8045 is revised in its entirety and a new table titled ''Evaluation of Cognitive Impairment And Other Residuals of TBI Not Otherwise Classified'' is added after the ''Organic Diseases of the Central Nervous System'' table, to read as follows:

§ 4.124a Schedule of ratings—neurological conditions and convulsive disorders.

* * * * *

ORGANIC DISEASES OF THE CENTRAL NERVOUS SYSTEM

	Rating
* * * * * * *	
8045 Residuals of traumatic brain injury (TBI):	
There are three main areas of dysfunction that may result from TBI and have profound effects on functioning: cognitive (which is common in varying degrees after TBI), emotional/behavioral, and physical. Each of these areas of dysfunction may require evaluation.	
Cognitive impairment is defined as decreased memory, concentration, attention, and executive functions of the brain. Executive functions are goal setting, speed of information processing, planning, organizing, prioritizing, self-monitoring, problem solving, judgment, decision making, spontaneity, and flexibility in changing actions when they are not productive. Not all of these brain functions may be affected in a given individual with cognitive impairment, and some functions may be affected more severely than others. In a given individual, symptoms may fluctuate in severity from day to day. Evaluate cognitive impairment under the table titled ''Evaluation of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified.''	
Subjective symptoms may be the only residual of TBI or may be associated with cognitive impairment or other areas of dysfunction. Evaluate subjective symptoms that are residuals of TBI, whether or not they are part of cognitive impairment, under the subjective symptoms facet in the table titled ''Evaluation of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified.'' However, separately evaluate any residual with a distinct diagnosis that may be evaluated under another diagnostic code, such as migraine headache or Meniere's disease, even if that diagnosis is based on subjective symptoms, rather than under the ''Evaluation of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified'' table.	
Evaluate emotional/behavioral dysfunction under § 4.130 (Schedule of ratings—mental disorders) when there is a diagnosis of a mental disorder. When there is no diagnosis of a mental disorder, evaluate emotional/behavioral symptoms under the criteria in the table titled ''Evaluation of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified.''	
Evaluate physical (including neurological) dysfunction based on the following list, under an appropriate diagnostic code: Motor and sensory dysfunction, including pain, of the extremities and face; visual impairment; hearing loss and tinnitus; loss of sense of smell and taste; seizures; gait, coordination, and balance problems; speech and other communication difficulties, including aphasia and related disorders, and dysarthria; neurogenic bladder; neurogenic bowel; cranial nerve dysfunctions; autonomic nerve dysfunctions; and endocrine dysfunctions.	
The preceding list of types of physical dysfunction does not encompass all possible residuals of TBI. For residuals not listed here that are reported on an examination, evaluate under the most appropriate diagnostic code. Evaluate each condition separately, as long as the same signs and symptoms are not used to support more than one evaluation, and combine under § 4.25 the evaluations for each separately rated condition. The evaluation assigned based on the ''Evaluation of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified'' table will be considered the evaluation for a single condition for purposes of combining with other disability evaluations.	
Consider the need for special monthly compensation for such problems as loss of use of an extremity, certain sensory impairments, erectile dysfunction, the need for aid and attendance (including for protection from hazards or dangers incident to the daily environment due to cognitive impairment), being housebound, etc.	

ORGANIC DISEASES OF THE CENTRAL NERVOUS SYSTEM—Continued

Rating

Evaluation of Cognitive Impairment and Subjective Symptoms

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

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

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

Note (3): ''Instrumental activities of daily living'' refers to activities other than self-care that are needed for independent living, such as meal preparation, doing housework and other chores, shopping, traveling, doing laundry, being responsible for one's own medications, and using a telephone. These activities are distinguished from ''Activities of daily living,'' which refers to basic self-care and includes bathing or showering, dressing, eating, getting in or out of bed or a chair, and using the toilet.

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

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

* * * * * * *

EVALUATION OF COGNITIVE IMPAIRMENT AND OTHER RESIDUALS OF TBI NOT OTHERWISE CLASSIFIED

Facets of cognitive impairment and other residuals of TBI not otherwise classified	Level of impairment	Criteria
Memory, attention, concentration, executive functions.	0	No complaints of impairment of memory, attention, concentration, or executive functions.
	1	A complaint of mild loss of memory (such as having difficulty following a conversation, recalling recent conversations, remembering names of new acquaintances, or finding words, or often misplacing items), attention, concentration, or executive functions, but without objective evidence on testing.
	2	Objective evidence on testing of mild impairment of memory, attention, concentration, or executive functions resulting in mild functional impairment.
	3	Objective evidence on testing of moderate impairment of memory, attention, concentration, or executive functions resulting in moderate functional impairment.
	Total	Objective evidence on testing of severe impairment of memory, attention, concentration, or executive functions resulting in severe functional impairment.
Judgment	0	Normal.
	1	Mildly impaired judgment. For complex or unfamiliar decisions, occasionally unable to identify, understand, and weigh the alternatives, understand the consequences of choices, and make a reasonable decision.
	2	Moderately impaired judgment. For complex or unfamiliar decisions, usually unable to identify, understand, and weigh the alternatives, understand the consequences of choices, and make a reasonable decision, although has little difficulty with simple decisions.
	3	Moderately severely impaired judgment. For even routine and familiar decisions, occasionally unable to identify, understand, and weigh the alternatives, understand the consequences of choices, and make a reasonable decision.
	Total	Severely impaired judgment. For even routine and familiar decisions, usually unable to identify, understand, and weigh the alternatives, understand the consequences of choices, and make a reasonable decision. For example, unable to determine appropriate clothing for current weather conditions or judge when to avoid dangerous situations or activities.

EVALUATION OF COGNITIVE IMPAIRMENT AND OTHER RESIDUALS OF TBI NOT OTHERWISE CLASSIFIED—Continued

Facets of cognitive impairment and other residuals of TBI not otherwise classified	Level of impairment	Criteria
Social interaction	0	Social interaction is routinely appropriate.
	1	Social interaction is occasionally inappropriate.
	2	Social interaction is frequently inappropriate.
	3	Social interaction is inappropriate most or all of the time.
Orientation	0	Always oriented to person, time, place, and situation.
	1	Occasionally disoriented to one of the four aspects (person, time, place, situation) of orientation.
	2	Occasionally disoriented to two of the four aspects (person, time, place, situation) of orientation or often disoriented to one aspect of orientation.
	3	Often disoriented to two or more of the four aspects (person, time, place, situation) of orientation.
	Total	Consistently disoriented to two or more of the four aspects (person, time, place, situation) of orientation.
Motor activity (with intact motor and sensory system).	0	Motor activity normal.
	1	Motor activity normal most of the time, but mildly slowed at times due to apraxia (inability to perform previously learned motor activities, despite normal motor function).
	2	Motor activity mildly decreased or with moderate slowing due to apraxia.
	3	Motor activity moderately decreased due to apraxia.
	Total	Motor activity severely decreased due to apraxia.
Visual spatial orientation	0	Normal.
	1	Mildly impaired. Occasionally gets lost in unfamiliar surroundings, has difficulty reading maps or following directions. Is able to use assistive devices such as GPS (global positioning system).
	2	Moderately impaired. Usually gets lost in unfamiliar surroundings, has difficulty reading maps, following directions, and judging distance. Has difficulty using assistive devices such as GPS (global positioning system).
	3	Moderately severely impaired. Gets lost even in familiar surroundings, unable to use assistive devices such as GPS (global positioning system).
	Total	Severely impaired. May be unable to touch or name own body parts when asked by the examiner, identify the relative position in space of two different objects, or find the way from one room to another in a familiar environment.
Subjective symptoms	0	Subjective symptoms that do not interfere with work; instrumental activities of daily living; or work, family, or other close relationships. Examples are: mild or occasional headaches, mild anxiety.
	1	Three or more subjective symptoms that mildly interfere with work; instrumental activities of daily living; or work, family, or other close relationships. Examples of findings that might be seen at this level of impairment are: intermittent dizziness, daily mild to moderate headaches, tinnitus, frequent insomnia, hypersensitivity to sound, hypersensitivity to light.
	2	Three or more subjective symptoms that moderately interfere with work; instrumental activities of daily living; or work, family, or other close relationships. Examples of findings that might be seen at this level of impairment are: marked fatigability, blurred or double vision, headaches requiring rest periods during most days.
Neurobehavioral effects	0	One or more neurobehavioral effects that do not interfere with workplace interaction or social interaction. Examples of neurobehavioral effects are: Irritability, impulsivity, unpredictability, lack of motivation, verbal aggression, physical aggression, belligerence, apathy, lack of empathy, moodiness, lack of cooperation, inflexibility, and impaired awareness of disability. Any of these effects may range from slight to severe, although verbal and physical aggression are likely to have a more serious impact on workplace interaction and social interaction than some of the other effects.
	1	One or more neurobehavioral effects that occasionally interfere with workplace interaction, social interaction, or both but do not preclude them.
	2	One or more neurobehavioral effects that frequently interfere with workplace interaction, social interaction, or both but do not preclude them.
	3	One or more neurobehavioral effects that interfere with or preclude workplace interaction, social interaction, or both on most days or that occasionally require supervision for safety of self or others.
Communication	0	Able to communicate by spoken and written language (expressive communication), and to comprehend spoken and written language.
	1	Comprehension or expression, or both, of either spoken language or written language is only occasionally impaired. Can communicate complex ideas.
	2	Inability to communicate either by spoken language, written language, or both, more than occasionally but less than half of the time, or to comprehend spoken language, written language, or both, more than occasionally but less than half of the time. Can generally communicate complex ideas.
	3	Inability to communicate either by spoken language, written language, or both, at least half of the time but not all of the time, or to comprehend spoken language, written language, or both, at least half of the time but not all of the time. May rely on gestures or other alternative modes of communication. Able to communicate basic needs.
	Total	Complete inability to communicate either by spoken language, written language, or both, or to comprehend spoken language, written language, or both. Unable to communicate basic needs.

EVALUATION OF COGNITIVE IMPAIRMENT AND OTHER RESIDUALS OF TBI NOT OTHERWISE CLASSIFIED—Continued

Facets of cognitive impairment and other residuals of TBI not otherwise classified	Level of impairment	Criteria
Consciousness	Total	Persistently altered state of consciousness, such as vegetative state, minimally responsive state, coma.

* * * * *

■ 3. In Appendix A to Part 4, § 4.124a, add diagnostic code 8045 in numerical order to the table to read as follows:

Appendix A to Part 4—Table of Amendments and Effective Dates Since 1946

* * * * *

Sec.	Diagnostic code No.	
*	*	*
4.124a	8045	Criterion and evaluation October 23, 2008.
*	*	*

* * * * *

■ 4. In Appendix B to Part 4, diagnostic code 8045 is revised to read as follows:

Appendix B to Part 4—Numerical Index of Disabilities

* * * * *

Diagnostic code No.	
*	*
8045	Residuals of traumatic brain injury (TBI).
*	*

* * * * *

■ 5. In Appendix C to Part 4 under the heading for ''Brain'' remove ''Disease due to trauma'' and its diagnostic code ''8045''; and add in alphabetical order a new heading ''Traumatic brain injury residuals'' and its diagnostic code ''8045''.

[FR Doc. E8–22083 Filed 9–22–08; 8:45 am]

BILLING CODE 8320–01–P

DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 4

RIN 2900–AM55

Schedule for Rating Disabilities; Evaluation of Scars

AGENCY: Department of Veterans Affairs.

ACTION: Final rule.

SUMMARY: This document amends the Department of Veterans Affairs (VA) Schedule for Rating Disabilities by revising that portion of the Schedule that addresses the Skin, so that it more clearly reflects our policies concerning the evaluation of scars.

DATES: *Effective Date:* This amendment is effective October 23, 2008.

Applicability Date: This amendment shall apply to all applications for benefits received by VA on or after October 23, 2008. A veteran whom VA rated before such date under diagnostic codes 7800, 7801, 7802, 7803, 7804, or 7805 of 38 CFR 4.118 may request review under these clarified criteria, irrespective of whether his or her disability has worsened since the last review. The effective date of any award, or any increase in disability compensation, based on this amendment will not be earlier than the effective date of this rule, but will otherwise be assigned under the current regulations regarding effective dates, 38 CFR 3.400, etc.

FOR FURTHER INFORMATION CONTACT: Maya Ferrandino, Regulations Staff (211D), Compensation and Pension Service, Veterans Benefits Administration, Department of Veterans Affairs, 810 Vermont Avenue, NW., Washington, DC 20420, (727) 319–5847. (This is not a toll-free number.)

SUPPLEMENTARY INFORMATION: On January 3, 2008, VA published in the **Federal Register** (73 FR 428) a proposal to amend those portions of the Schedule for Rating Disabilities that address the Skin, 38 CFR 4.118, by revising the guidelines for the evaluation of scars. Interested persons were invited to submit written comments on or before February 4, 2008. We received comments from the National Organization of Veterans' Advocates, Inc. (NOVA), and Disabled American Veterans (DAV).

NOVA's Comment

NOVA addressed a proposed change to a note in diagnostic code 7801 that would consider the trunk as one area of the body. Currently, the note in diagnostic code 7801 directs that scars on widely separated areas, as on two or more extremities or on anterior and posterior surfaces of extremities or trunk, will be separately rated. We proposed to revise this note to clarify that if multiple scars are present, VA will assign a separate evaluation for each affected extremity based on the total area of the qualifying scars on that extremity, and assign a separate evaluation for the trunk based on the total area of the qualifying scars on the trunk. Qualifying scars under diagnostic code 7801 are deep scars that are not located on the head, face, or neck.

NOVA is concerned that the proposed change will not adequately compensate veterans for scars of the trunk. NOVA stated the rationale for the change of ensuring that the area of all deep scars of the trunk are taken into account was inadequate considering that the anterior and posterior surfaces of the trunk may be the largest separate and distinct areas of the body.

Second, NOVA stated that a scar can cross over into more than one separate area of the body. In the proposed rule, we stated that such a scar would be treated as two separate scars to ensure that the ratings reflect the disability to each distinct area of the body.

Third, NOVA stated the proposed change would potentially result in a lower evaluation for a veteran with one scar that covers both the anterior and posterior trunk. NOVA offers the following example: A veteran has one 30 inch scar that wraps around his anterior and posterior trunk, with 15 square inches on the anterior side and 15 square inches on his posterior side. Under the current diagnostic code, this scar would be rated separately at 20 percent and 20 percent, for a combined evaluation of 40 percent. Under the proposed change, the veteran would be