Today’s Topics

- Background on VA and VA disability programs
- VA disability claims process
- Differences between VA disability and other compensation programs
- VA hearing loss and tinnitus evaluation protocols
- Disability reports and opinions
- Questions & Answers
AUDIO is the second most common exam performed by VHA after general medical.

All Veterans:

<table>
<thead>
<tr>
<th>Specialty</th>
<th>C&amp;P Encounters*</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Medical</td>
<td>316,087</td>
</tr>
<tr>
<td>Auditory</td>
<td>106,801</td>
</tr>
<tr>
<td>All Specialties</td>
<td>689,931</td>
</tr>
</tbody>
</table>

OEF/OIF:

<table>
<thead>
<tr>
<th>Specialty</th>
<th>C&amp;P Encounters*</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Medical</td>
<td>52,582</td>
</tr>
<tr>
<td>Auditory</td>
<td>20,827</td>
</tr>
<tr>
<td>All Specialties</td>
<td>142,082</td>
</tr>
</tbody>
</table>

*Reported to 203450 stop code pair

DSS Clinic Stop Code Report (FY2008)
Auditory System Disabilities (FY2006)

- Hearing loss accounts for 5.4% of all disabilities and tinnitus accounts for 4.9% of all disabilities.

- Hearing loss and tinnitus accounted for over 90% of the auditory system disabilities (48.9% hearing loss and 43.5% tinnitus).

- In 2004-2006, there were 419,323 hearing loss decisions and 304,773 tinnitus decisions. Favorable decisions: 39.5% hearing loss and 58.6% tinnitus.
## Total Service Connected Veterans

### October 2008 (VBA)

<table>
<thead>
<tr>
<th>Diagnostic Code</th>
<th>Total Veterans Compensated (including 0% SC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>6100 (Series)</td>
<td>754,556</td>
</tr>
<tr>
<td>6260</td>
<td>619,826</td>
</tr>
<tr>
<td>Total</td>
<td>1,374,382</td>
</tr>
</tbody>
</table>
# Top 5 Individual Disabilities

October 2008 (VBA)

<table>
<thead>
<tr>
<th>Rank</th>
<th>Diagnostic Code</th>
<th>Disability Name</th>
<th>Total on Rolls</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>6100 Series</td>
<td>Impairment of Auditory Acuity</td>
<td>754,556</td>
</tr>
<tr>
<td>2</td>
<td>6260</td>
<td>Tinnitus</td>
<td>619,826</td>
</tr>
<tr>
<td>3</td>
<td>9411</td>
<td>Post-Traumatic Stress Disorder</td>
<td>151,297</td>
</tr>
<tr>
<td>4</td>
<td>7101</td>
<td>Hypertensive Vascular Disease (Essential Arterial Hypertension)</td>
<td>135,808</td>
</tr>
<tr>
<td>5</td>
<td>7805</td>
<td>Scars, Other</td>
<td>113,900</td>
</tr>
<tr>
<td>Diagnostic Code</td>
<td>Service Connected (including 0% SC)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------</td>
<td>-------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6100 (Series)</td>
<td>78,076</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6260</td>
<td>94,141</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>172,217</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

October 2008 (VBA)
# Top 5 Disabilities in OEF/OIF

October 2008 (VBA)

<table>
<thead>
<tr>
<th>Rank</th>
<th>Diagnostic Code</th>
<th>Disability Name</th>
<th>Total on Rolls</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>6260</td>
<td>Tinnitus</td>
<td>94,141</td>
</tr>
<tr>
<td>2</td>
<td>6100 Series</td>
<td>Impairment of Auditory Acuity</td>
<td>78,076</td>
</tr>
<tr>
<td>3</td>
<td>5237</td>
<td>Lumbosacral Or Cervical Strain</td>
<td>37,937</td>
</tr>
<tr>
<td>4</td>
<td>9411</td>
<td>Post-Traumatic Stress Disorder</td>
<td>28,116</td>
</tr>
<tr>
<td>5</td>
<td>5260</td>
<td>Limitation Of Flexion Of Leg</td>
<td>22,916</td>
</tr>
</tbody>
</table>
VA Definitions

- **Service connection**—disability incurred or aggravated in line of duty in the active military, naval, or air service (38 CFR 3.1).

- **Disability** represents as far as can practicably be determined the average impairment in earning capacity resulting from diseases and injuries in comparison to civil occupations (38 CFR 4.1).

- **Compensation**—Basic entitlement for disability incurred as the result of a personal injury or disease (including aggravation of a condition existing prior to service) in line of duty during active service (38 CFR 3.4).

- **Pension**—benefit paid to wartime veterans who have limited or no income, and who are age 65 or older, or, if under 65, who are permanently and totally disabled. Veterans who are more seriously disabled may qualify for other benefits (38 CFR 3.3).
VA Definitions

- **Functional impairment.** Basis of disability evaluations is the ability of the body as a whole, or of the psyche, or of a system or organ of the body to function under the ordinary conditions of daily life including employment (38 CFR 4.10).

- **Use of rating schedule.** The 1945 Schedule for Rating Disabilities will be used for evaluating the degree of disabilities in claims for disability compensation, disability and death pension, and in eligibility determinations. The provisions contained in the rating schedule will represent as far as can practicably be determined, the average impairment in earning capacity in civil occupations resulting from disability (38 CFR 3.21).
The 1945 Schedule forms the foundation of the VA Schedule for Rating Disabilities in effect today.

The Rating Schedule has approximately 700 diagnostic codes, organized under 15 body systems.

The main unit of measurement is impairment (extent of loss or loss of use of a body part or function).

For each code, the schedule provides evaluation criteria for assigning a percentage rating.

The criteria are primarily based on loss or loss of function of a body part or system, as verified by medical evidence (e.g. C&P exam).
Institute of Medicine

The presumed purpose of cash benefits in WC and VA disability compensation is to compensate for work disability (loss of earning capacity).

Operational basis of VA and WC programs of compensation is assessment of impairment.

- Programs use proxies (or predictors) of actual loss of wages, such as the extent of impairment, instead of actual loss of earnings.

- Impractical to directly measure actual loss of earnings for each individual.

A Modern View of Disability

- Traditional view—compensate for lost earnings.

- ICF and IOM models reflect a complex interaction between impairment and functioning of the individual.

- Include activity limitations and participation restrictions in the context of work and non-work disability (e.g., pain and suffering, distress, and effect on personal relationships), and quality of life.

IOM Concept of Loss of Earnings

- **Actual loss of earnings**—difference between actual earnings and potential earnings without injury.
- Prior to injury, wages increased over time from A to B, reflecting the worker's increasing responsibility, productivity, and skill, as well as inflation.
- Point B—worker suffers a work-related injury that permanently reduces earnings. Had the worker not been injured, earnings would have continued to grow along the line BC.
- Actual earnings dropped from B to D and continued at this zero earnings level until point E, when the worker returned to work at wage level F.
- Thereafter, actual earnings grew along the line F to G, but actual earnings never return to the potential earnings (line BC).
- **Wage loss**—potential earnings after the date of injury (BC) minus the actual earnings after the date of injury (BDEFG).
Disability Compensation

- Degree of disability, ranging from 0% to 100% in 10% increments.

- Monthly benefits in 2009 range from $123 for a 10% rating to $2,673 for a 100% rating (plus additional amounts for parents, spouses, and dependents of those with 30% ratings or higher). Additional special monthly compensation benefits may apply.

- VA policies are designed to benefit the veteran:
  - Deciding in favor of the veteran if there is reasonable doubt;
  - Assisting the veteran in gathering records and evidence;
  - Identifying conditions that might be compensable even if the veteran does not claim them;
  - Presumption of service connection for certain conditions.

- A disability rating also entitles a veteran to other benefits and services, such as vocational rehabilitation, employment services, and health care.

- The compensation is tax exempt, and the rates are, generally, adjusted annually by Congress.
- Average annual disability payment is $10,880 (FY2008)
VA disability compensation program was implemented soon after workers’ compensation programs were established by the state and federal governments.

Both programs compensate for disability (i.e., the consequences of injury), not for injury itself. In practice, degree of loss is often used as a proxy for degree of disability.

In both programs, disability is limited to economic loss, not to all physical, mental, social, and economic damages allowed under common law.

Generally, both programs use schedules based on the average loss of earning capacity of beneficiaries with similar impairments, rather than on the actual loss of earning capacity of each individual claimant.
Unique Aspects of VA Compensation

- VA compensates for injuries or illness incurred in or aggravated by military service and includes non-economic losses (e.g. special compensation).

- Bases ratings on pure tone average and speech recognition.

- VA payments may continue for life (compensation may change). WCP payments for partial permanent disability are usually time-limited. Total permanent disability may continue for life.

- There is no statute of limitations for VA claims.

- Presumption if hearing loss was noted within 12 months of discharge.

- VA compensation programs express lasting gratitude to veterans for their service, sacrifice, courage, and dedication that have secured the blessings of freedom and the greatness of the Nation.
Rating Hearing Loss

- Hearing loss disability is rated on basis of:
  - Best speech recognition performance (Maryland CNC) without hearing aids; and/or
  - Pure tone average (1000, 2000, 3000, and 4000 Hz)

- For VA purposes, impaired hearing is considered to be a disability when:
  - Auditory threshold in any of the frequencies 500, 1000, 2000, 3000, and 4000 Hz is 40 dB HL or greater; or
  - Auditory thresholds for at least three of these frequencies are 26 dB HL or greater; or
  - Speech recognition scores are less than 94%.

- Allows for exceptional patterns of hearing loss:
  - When threshold is 55 dB HL or greater at each frequency 1000-4000 Hz.
  - When threshold is 30 dB HL or less at 1000 Hz and 70 dB HL or more at 2000 Hz.

Note the concept of “low fence” similar to AAO/AMA criteria used by many WCP.
Most favorable hearing loss claims are adjudicated at 0% disability and most NIHL would be rated at 0%.

0% disability does not mean zero hearing loss.

Examples for asymmetric losses:
- Mild hearing loss with good speech recognition in the better ear and functional deafness in the poorer ear.
- Moderate to severe hearing loss with good speech recognition in the better ear and moderate to severe loss with fair speech recognition in the poorer ear.

Examples for symmetric losses:
- Moderate to profound loss with good speech recognition
- Moderate loss with fair speech recognition.
C&P disability examination requires diagnoses to prove whether or not a claimed disability actually exists and the functional effects of the disability on the veteran.

The purpose of the C&P exam is to provide very specific information in order to ensure a proper evaluation of the claimed disability rather than to provide medical treatment.

Medical exams are written for clinicians to understand, but C&P exams are written for rating specialists, lawyers, and judges to understand.
Exam Requirements

- Standard procedures are described in: *Handbook of Standard Procedures and Best Practices for Audiology C&P Examinations*

- Must be performed by licensed audiologist
- Calibrated audiometer (ANSI S3.6-2004)
- Sound-controlled room (ANSI S3.1-1999 R2008)
- Approved recording of speech materials:
  - *Speech Recognition and Identification Materials, Disc 2.0*
  - *Departments of Defense and Veterans Affairs Audiology Materials, Disc 1.0*
C&P Reports

- VBA Worksheet 1305 (AUDIO) includes:
  - Review of records
  - Pertinent history
  - Functional effects
  - Diagnostic and clinical tests (pure tone thresholds, pure tone average, and speech recognition scores)
  - Diagnosis
  - Opinion, if requested
Pertinent History

- Chief complaint.
- Effects of the condition on occupational functioning and daily activities.
- Pertinent service history.
- History of military, occupational, and recreational noise exposure.
- Pertinent family and social history; history of ear disease, head or ear trauma etc.
- Tinnitus
  - Is there a claim for tinnitus (verify from examination request i.e. 2507? (yes/no)
  - Is there a current complaint of tinnitus? (yes/no) If yes, answer the following questions whether or not the condition is claimed.
  - Date and circumstances of onset.
  - Whether it is unilateral or bilateral. Current complaints only.
  - Whether it is constant or recurrent (intermittent). Current complaints only.
  - If recurrent (intermittent), indicate the frequency and duration of tinnitus episodes. Current complaints only.
  - If there is a claim and no current complaint, the audiologist must:
    - State when veteran last experienced tinnitus.
    - Describe the tinnitus experienced at that time.
    - Describe intervening course between onset and last episode, e.g. how frequently in a year does a veteran experience tinnitus.
Medical Opinions

- Audiolists are the subject matter experts for hearing loss and tinnitus claims.
- Common types of opinions:
  - Diagnosis
  - Relationship between two conditions
  - Etiology (nexus)
  - Interpretation (e.g. foreign medical exams)
CAPRI provides two opinion formats (standard and non-standard).

Standard format prompts for required content.

Non-standard format is free text and allows you to paste text created in WORD.

Other entry methods must conform to opinion content requirements.
Compensation and Pension Record Interchange (CAPRI)

Information technology initiative to improve service to disabled veterans by promoting efficient communications between the Veterans Health Administration (VHA) and Veterans Benefits Administration (VBA).

- Online access to medical data enhances the timeliness of the benefits determination.
- Acts as a bridge between the VBA and VHA information systems.
- Provides VBA Rating Veteran Service Representatives and Decision Review Officers tools to build rating decision documentation through online access to medical data.
- Provides VHA Compensation and Pension (C&P) staff an easy, standardized way of recording C&P Examination reports using standardized templates.

Prompts do not exactly follow AUDIO Exam Template. Follow previous instructions.
Quality: Audiology and Speech Analysis and reporting (QUASAR)

- VistA-based management package for A&SP Services

- Does not contain a current AUDIO C&P exam template. Entry is free text.

- Follow previous instructions on completing an adequate exam in QUASAR.
Hensley v. Brown

- U.S. Court of Appeals ruled that 38 CFR 3.385 does not preclude service connection for a current hearing disability where hearing was within normal limits on audiometric testing at separation from service.

- When audiometric test results at a veteran's separation from service do not meet the regulatory requirements for establishing a "disability" at that time, he or she may nevertheless establish service connection for a current hearing disability by submitting evidence that the current disability is causally related to service.
In exams, the audiologist describes the degree of hearing loss in standard terms.

If hearing is normal by VA criteria (38 CFR 3.385), the audiologist should note that “hearing thresholds do not meet the criteria for disability under VA regulations”.

If requested to do so by VSC, review changes in hearing thresholds even when hearing is normal at separation. Examples of significant changes in hearing:

- Verified permanent threshold shift (HCP)
- Changes in hearing at any frequency greater than 25 dB
- Pattern of thresholds changes that suggest noise “notch”
- McBride and Williams (2001)
- Narrow (one frequency at deepest point) notches: at least 15 dB in depth
- Wide notches (more than one frequency at deepest point): at least 20 dB in depth with at least 10 dB recovery at the high end
VBA Guidance to rating specialists: If the SMRs show a threshold shift of 15 decibels or more in any frequency between 500 and 4,000 Hz, in-service decrease in hearing ability in that ear should be conceded. If the veteran currently meets VA criteria for a hearing loss under 38 C.F.R. § 3.385 or has submitted competent lay evidence of persistent or recurrent symptoms of hearing loss, a VA examination should be scheduled if the record does not contain sufficient competent medical evidence for VA to make a decision without providing an examination.
Martinak v. Nicholson

- United States Court of Appeals for veterans Claims ruled that the mere inclusion of objective test results in an audiological examination report does not satisfy the regulatory requirement in 38 CFR 4.10 and does not sufficiently account for the functional effects of disability on a person's ordinary activities.

- The Court referred to Revised Disability Examination Worksheets, Fast Letter 07-10 instructing audiologists to describe effects on occupational functioning and daily activities.

- Unlike the rating schedule for hearing loss, extra-schedule provisions do not rely exclusively on objective test results to determine whether or not a referral for an extra-schedular rating is warranted.
FL 08-33: As a result of the Martinak v. Nicholson decision, the requirement for the audiologist to comment on the effects of the condition on occupational functioning and daily activities was reinstated. It replaces the requirement for the audiologist to comment on the situations of greatest difficulty (See AUDIO exam Worksheet, 10/10/2008 edition).

- Audiologists should relay the veteran's description of the effects of the condition on occupational functioning and daily activities.

- Audiologists should not offer an opinion of the effects of the condition on functioning, unless asked to do so by VSC. Do not describe how such effects relate to impairment (audiogram) or state that tinnitus is not disabling because it is “normally occurring” or does not meet clinical definition of disabling tinnitus (e.g. lasting less than 5 minutes less than once a week).

- Audiologists should not use handicap scales at this time as none have been standardized for use and the results might not be meaningful to rating specialists.

- NOTE: The term daily activities does not mean activities of daily living (ADL) such as eating, bathing, dressing, toileting, transferring, and continence) associated with physical impairments or instrumental activities of daily living (IADL) that reflect more complex life activities such as light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, medication management, and money management.
38 CRR Sec. 4.10 Functional impairment.

The basis of disability evaluations is the ability of the body as a whole, or of the psyche, or of a system or organ of the body to function under the ordinary conditions of daily life including employment. Whether the upper or lower extremities, the back or abdominal wall, the eyes or ears, or the cardiovascular, digestive, or other system, or psyche are affected, evaluations are based upon lack of usefulness, of these parts or systems, especially in self-support. This imposes upon the medical examiner the responsibility of furnishing, in addition to the etiological, anatomical, pathological, laboratory and prognostic data required for ordinary medical classification, full description of the effects of disability upon the person’s ordinary activity. In this connection, it will be remembered that a person may be too disabled to engage in employment although he or she is up and about and fairly comfortable at home or upon limited activity.
Functional Effects (CAPRI)

- Effects on usual occupational activities: If you select “no significant effects”, the impact list is disabled.
- If you select “significant effects” or “not employed”, then impact list is available (e.g. hearing difficulty).
- You can select one of the work-related activities or select “other”, and enter free text (recommended).
- Do not select ADL. These do not apply to Audiology.
VBA worksheet was changed because almost all people have a history of tinnitus. The pertinent question is whether or not there is *current complaint* of tinnitus.

The appropriate way to inquire about tinnitus is to ask about the current complaints without asking specifically about tinnitus or ringing in the ears.

**Audiologists should not use history forms or questionnaires that prompt for a history of tinnitus, ringing in the ears, or head noises.**

VBA feels that if a veteran has tinnitus that is disabling they will report it when asked about his/her current complaints. However, if tinnitus is a claimed condition or VBA specifically asks for information regarding tinnitus, then you MUST respond to the issues. Otherwise, the exam may be returned as incomplete or inadequate.
### Reporting Tinnitus

- Examiner must specifically inquire about tinnitus if it is a claimed condition, whether or not it is a current complaint.

- If there is a current complaint of tinnitus, the examiner must answer the additional tinnitus questions, whether or not the condition is claimed. The Regional Office will return any exam where the claimed condition was not addressed.

- There are four possible scenarios:
  1. Veteran claimed tinnitus and reports a current complaint of tinnitus
  2. Veteran claimed tinnitus and does not report a current complaint of tinnitus
  3. Veteran did not claim tinnitus and reports a current complaint of tinnitus
  4. Veteran did not claim tinnitus and does not report a current complaint of tinnitus.

- Why are audiologists asked to comment on a claimed condition that is not a current complaint?
  - Regulations do not define “recurrent tinnitus” and the fact that the tinnitus is not present now does not mean that the regulatory definition has not been met. Tinnitus might have disappeared a month ago, but it might reappear.
  - Since the regulation does not define disabling or “recurrent” tinnitus, VBA cannot ascribe any interpretation. If the tinnitus is (1) related to an event in service and (2) recurrent, it meets the regulatory definition. It is up the VHA examiners to provide the requested information about tinnitus on which the rating specialist can make a rating decision.
Reporting Tinnitus

a. Is there a claim for tinnitus (verify from 2507)? (yes/no)
b. Is there a current complaint of tinnitus (yes/no)? If yes answer the following questions whether or not the condition is claimed.

The examiner must specifically inquire about tinnitus if it is a claimed condition, whether or not is a current complaint. If there is a current complaint of tinnitus, the examiner must answer the additional tinnitus questions, whether or not the condition is claimed. The Regional Office will return any exam where the claimed condition was not addressed.
c. Date and circumstances of onset.
d. Whether it is unilateral or bilateral. Current complaints only.
e. Whether it is constant or recurrent (intermittent). Current complaints only.
f. If recurrent (intermittent), indicate the frequency and duration of tinnitus episodes. Current complaints only.
g. If there is a claim and no current complaint, the audiologist must:
   State when veteran last experienced tinnitus.
   Describe the tinnitus experienced at that time.
   Describe Intervening course between onset and last episode, e.g. how frequently in a year does the veteran experience tinnitus.
Examples

A. VETERAN FILED A CLAIM

- If the veteran filed a claim for tinnitus disability (on the 2507), and there is a current complaint of tinnitus, then answer YES to questions #6a and #6b and then answer the tinnitus questions (#6c-f). **NOTE: questions #6d-6f pertain only to current complaints of tinnitus.**
- If tinnitus is claimed and the veteran denies a current complaint of tinnitus, then answer YES to question #6a and NO to question #6b and answer questions #6c and 6g.

B. VETERAN DID NOT FILE A CLAIM

- If tinnitus is not claimed, then inquire about the current complaints as part of the history without asking specifically about tinnitus or ringing in the ears.
- **NOTE: The guidance on proper inquiry applies only to the situation where tinnitus is not claimed. If the condition is claimed, then refer to the instructions for Question 6.**
- If veteran reports a current tinnitus complaint as part of the history, then answer NO to question #6a and YES to question #6b and answer the tinnitus questions (#6c-f). **NOTE: Questions #6d-6f pertain only to current complaints of tinnitus.**
- If the veteran does not report tinnitus as a current complaint during the history, then indicate that the veteran denied tinnitus as a current complaint in the medical history.
Tinnitus Changes in CAPRI

- Tinnitus questions are found under History. The history now includes radial button for current complaint of tinnitus.

- **Is there a current complaint of tinnitus Y/N.** If you select “no”, all tinnitus fields are disabled. If you select “yes”, indicate laterality and constant tinnitus Y/N. If you select “no” to constant, you must answer “yes” to intermittent. This enables the description of frequency and duration.

- Under Diagnosis, indicate if hearing loss is present. If “yes”, indicate if tinnitus is related to hearing loss. If “no”, indicate if tinnitus requires referral. If hearing loss is present and tinnitus not related to hearing loss, the referral box is enabled.

- The instructions indicate that whether or not tinnitus is claimed, a current complaint will trigger the remaining tinnitus questions.

- The changes did not include the other scenario where tinnitus is not a current complaint but is claimed. This change was evidently left out of programming and will have to be added later. In the meantime, please follow the previous instructions.

**NOTE:** Audiologist must also address the effects of tinnitus on occupational functioning and daily activities.
If tinnitus is associated with conditions other than hearing loss, indicate that the complaint of tinnitus requires referral to another provider (appropriate provider to be determined by VAMC C&P Director) for determination of etiology. For example, tinnitus can be associated with a variety of medical, neurological, and psychological conditions outside the scope of audiology.

The purpose of this question is to assist VBA in evaluating the nature of tinnitus and its association to hearing loss since hearing loss is the most common factor associated with tinnitus.

**Note: This requirement is under review.**
Non-organic Hearing Loss

- If you discover non-organic hearing loss that has already been adjudicated.

- Example: If you are treating the veteran (e.g. hearing aid) and you determined that hearing loss was exaggerated on the claim.

- You should not report this discrepancy to VSC. You of course make appropriate decisions on hearing aid candidacy based on your exam findings. Note: Audiology exams are performed by licensed audiologists and VBA accepts such exams as accurate measurements of organic hearing. This is not reversible error because VBA rated the claim based on the diagnosis of a qualified examiner.

- If the veteran returns for a claim and you discover that previous findings were in error, then you should comment on the discrepancy on your exam.
References

- Rating Job Aids: http://vbaw.vba.va.gov/bl/21/rating/rat00.htm
- AUDIO Worksheet: http://vbaw.vba.va.gov/bl/21/rating/Medical/exams/disexm05.htm
With malice toward none, with charity for all, with firmness in the right as God gives us to see the right, let us strive on to finish the work we are in, to bind up the nation's wounds, to care for him who shall have borne the battle and for his widow and his orphan, to do all which may achieve and cherish a just and lasting peace among ourselves and with all nations.

Abraham Lincoln, Second Inaugural Address, March 4, 1865
Supplemental Material
A. Review of Medical Records: Indicate whether the C-file was reviewed.
B. Medical History (Subjective Complaints):
   Comment on:
   - Chief complaint.
   - Effects of the condition on occupational functioning and daily activities.
   - Pertinent service history.
   - History of military, occupational, and recreational noise exposure.
   - Pertinent family and social history; history of ear disease, head or ear trauma etc.

Tinnitus
- Is there a claim for tinnitus (verify from examination request i.e. 2507? (yes/no)
- Is there a current complaint of tinnitus? (yes/no) If yes, answer the following questions whether or not the condition is claimed.
  - Date and circumstances of onset.
  - Whether it is unilateral or bilateral. Current complaints only.
  - Whether it is constant or recurrent (intermittent). Current complaints only.
  - If recurrent (intermittent), indicate the frequency and duration of tinnitus episodes. Current complaints only.
  - If there is a claim and no current complaint, the audiologist must:
    - State when veteran last experienced tinnitus.
    - Describe the tinnitus experienced at that time.
    - Describe intervening course between onset and last episode, e.g. how frequently in a year does a veteran experience tinnitus.

Audiology Exam Template, Version 10/10/2008
C. Physical Examination (Objective Findings):

1. Measure puretone thresholds in decibels at the indicated frequencies (air conduction):

<table>
<thead>
<tr>
<th></th>
<th>RIGHT EAR</th>
<th></th>
<th></th>
<th></th>
<th>LEFT EAR</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
<td>**</td>
<td>A</td>
<td>B</td>
<td>C</td>
</tr>
<tr>
<td>500</td>
<td>1000</td>
<td>2000</td>
<td>3000</td>
<td>4000</td>
<td>AVE</td>
<td>500</td>
<td>1000</td>
<td>2000</td>
<td>3000</td>
</tr>
</tbody>
</table>

*The puretone threshold at 500 Hz is not used in determining the evaluation but is used in determining whether or not a ratable hearing loss exists. Puretone thresholds should not exceed 105 decibels or the tolerance level.

**The average of B, C, D, and E.

2. Speech Recognition Score: Maryland CNC word list ____% right ear ____% left ear.

When only puretone results should be used to evaluate hearing loss, the examiner, who must be a state-licensed audiologist, should certify that language difficulties or other problems (specify what the problems are) make the combined use of puretone average and speech discrimination inappropriate.

Thresholds should not exceed 100 decibels or the tolerance level.

Audiology Exam Template, Version 10/10/2008
D. Diagnostic and Clinical Tests:
Report middle ear status, confirm type of loss, and indicate need for medical follow-up. In cases where there is poor inter-test reliability and/or positive Stenger test results, obtain and report estimates of hearing thresholds using a combination of behavioral testing, Stenger interference levels, and electrophysiological tests.
Include results of all diagnostic and clinical tests conducted in the examination report.

E. Diagnosis:
Summary of audiologic test results. Indicate type and degree of hearing loss for the frequency range from 500 to 4000 Hz. For type of loss, indicate whether it is normal, conductive, sensorineural, central, or mixed. For degree, indicate whether it is mild (26-40 HL), moderate (41-54 HL), moderately severe (55-69HL), severe (70-89 HL), or profound (90+HL).

[For VA purposes, impaired hearing is considered to be a disability when the auditory threshold in any of the frequencies 500, 1000, 2000, 3000, and 4000 Hz is 40 dB HL or greater; or when the auditory thresholds for at least three of these frequencies are 26 dB HL or greater; or when speech recognition scores are less than 94%.]

Note whether, based on audiologic results, medical follow-up is needed for an ear or hearing problem, and whether there is a problem that, if treated, might cause a change in hearing threshold levels.

If there is a current complaint of tinnitus, indicate whether or not tinnitus is as likely as not a symptom associated with the hearing loss, if hearing loss is present. If tinnitus is associated with conditions other than hearing loss indicate that the complaint of tinnitus requires referral to another provider (appropriate provider to be determined by VAMC C&P Director or other responsible person as with contractors) for determination of etiology.

Audiology Exam Template, Version 10/10/2008
Functional Effects

EXAMPLES OF FUNCTIONAL EFFECTS OF HEARING LOSS

Difficulty hearing at home or work
Difficulty hearing in groups or noisy or adverse listening situations
Difficulty hearing telephone, TV, movies, or radio
Isolation, sadness, or depression
Frustration, worry, or anxiety
Insecurity, irritability, fear, tenseness, nervousness, discontent, temperamental; or paranoia
Reduced social activity, avoidance of activities
Negative interpersonal relationships or family
Defensive strategies such as pretending that they heard what people said, avoiding telling people to repeat themselves, avoiding asking other people to help them with their hearing problem, or defensively talking too much to cover up the fact that they cannot hear well
Concerns about safety (e.g. hearing warning signs, instructions from doctor, making a serious mistake, not safe to be alone)
Decline in quality-of-life (emotional and social function, communication, cognitive function, and physical function)
Negative impact on household income or earning capacity, job opportunities, promotion, job advancement, or educational opportunities

EXAMPLES OF FUNCTIONAL EFFECTS OF TINNITUS

Persistent sleep disorders
Persistent despair, frustration, depression
Persistent annoyance, irritation, inability to relax
Persistent inability to concentrate
Persistent insecurity, fear, panic attacks, or worry
Reliance on medications, alcohol, or drugs
Suicidal ideations

NOTE: The effects listed above are examples only and are NOT intended to be used as checklists.
Levels of Medical Certainty

- Not incurred in or aggravated by military service (0% probability)

- Less likely as not incurred in or aggravated by military service (<50% probability)

- Standard of evidence: As likely as not incurred in or aggravated by military service (50/50 probability)

- More likely as not incurred in or aggravated by military service (>50% probability)

- Incurred in or aggravated by military service (100% probability)
Additional Reading


Auditory System Disabilities

- Auditory System includes hearing, tinnitus, ear disease, other senses
  - 11 hearing loss disability codes (6100-6110)
  - 9 ear disability codes (6200-6211)
  - 1 tinnitus disability code (6260)
  - 2 other sensory disability codes (smell and taste)

- In addition to current codes, older codes remain in the system as long as veterans with such ratings are alive and are not further evaluated:
  - 9 older hearing codes before 1956 (6250-6258) and 20 older hearing codes before 1999 (6277-6297). 77,725 veterans in FY2005.
  - 5 older ear codes (6199, 6261, 6262, 6263, 6299)

- All hearing loss and tinnitus rating criteria have been revised since 1990.

Note: All hearing loss disability codes (6100-6110) assigned after June 10, 1999 will be assigned 6100 code.
Although rating schedules have existed since 1917, the first official schedule for rating veterans was promulgated in 1921.

According to the 1921 Rating Schedule, “disability is considered to be a mental or physical condition which would cause to the average person an impairment of earning capacity in civil occupation.”

The authors had little information on the relationship between degree of disability and earnings on which to base the schedule.

- They represented the opinions of the physicians who had developed the schedules as to the effect of the various disabilities upon the earning capacity of the average person.

- Workers’ compensation programs and private disability insurance companies, but these were only a few years old and had accumulated little practical experience;

- Consulted leading medical experts in the United States and the schedules for rating veterans used in France, Canada, England, and Belgium.
The First Rating Schedule--1921

- Based on the idea that a **whole person** who suffers injury or illness with permanent effects loses a percentage of his or her capacity.
- Procedures were adopted for combining multiple rating percentages, that are still used today.
- For example, if a veteran has two disabilities rated 50 and 30 percent, the combined rating is 65 percent.
  - This is determined as follows: Highest rating is subtracted from 100 percent first, leaving the veteran with 50 percent residual capacity. The 50 percent remaining capacity is then reduced by the next highest rating, in this case, 30 percent (50 - (.3 x 50)), leaving him or her with 35 percent residual capacity and a combined rating of 65 percent (100 percent minus 35 percent).
  - After all disabilities have been considered and combined, the combined value is “then converted to the nearest number divisible by 10, and the combined values ending in 5 will be adjusted upward” (38 C.F.R. § 4.25(a)).
- So, in this example, the combined rating would be adjusted upward to 70 percent.
The 1921 schedule reflected then-prevailing practice of using degree of impairment of a body part or system as the measure of disability, because tools to measure the effect of impairment on a person’s ability to work did not exist.

Disability ratings provided in the 1921 schedule were not based on statistical or economic data regarding the effect of disability on earning capacities because such data were not available.

Tied the degree of disability to the extent that a body part was missing or unusable, not on how well the average person could function with impairments.

For example, percent disability caused by impairment of vision was based on degree of refractive error (e.g., 0 percent for 20/40 in both eyes, 100 percent for less than 10/200 in both eyes).

Impairment-based criteria still persist for many conditions, including hearing loss.
The 1925 Rating Schedule

- The 1925 Rating Schedule added “similar to the occupation of the injured man at the time of enlistment” to the original standard.

- Accordingly, the 1925 schedule included a method to adjust the ratings in accordance to the physical and mental demands of each claimant’s occupation.

- Under the 1925 schedule, two veterans with the same percentage of impairment would receive different amounts of compensation depending on their occupation.

  - For example, a lawyer and a carpenter who each lost a leg received different amounts of compensation for their injuries.

  - A lawyer was viewed as less affected because his profession was mostly sedentary, so he received less compensation than the carpenter, who needed mobility to work.

- Occupational table was developed by a panel of occupational specialists. They were assisted by experts who designed the California Schedule of Rating Permanent Disabilities, and other national and international sources.
The 1933 Rating Schedule

- The Rating Schedule was revised twice in 1933 and it is this second revision that is commonly called the 1933 Rating Schedule.

- The 1933 schedule had five broad groupings of conditions.

- The 1933 Rating Schedule returned to the original 1917 concept of average impairment of earning capacity without regard to occupation, but its ratings were derived from the 1925 schedule by using the midrange of the occupational ratings in the 1925 schedule.

- The 1933 schedule was the first to use diagnostic codes. There were seven “extensions” (revisions) to the 1933 schedule before it was superseded by the 1945 schedule.

- Beginning with the 1933 schedule, the combined rating is rounded to the nearest number divisible by 10 and ratings ending in 5 are rounded up.
Revisions to the 1945 Schedule

- The 1945 Rating Schedule became effective on April 1, 1946.

- Periodic changes were made in the Schedule.

- In 1989, the General Accounting Office (GAO)—now the Government Accountability Office—issued the report *Need to Update Medical Criteria Used in VA’s Disability Rating Schedule* based in part on a clinical review by a group of medical specialists on the faculty of Jefferson Medical College in Philadelphia.

- Reduce probability of inaccurate classifications of impairments, correct outdated, ambiguous, or missing classifications; revise evaluation criteria made obsolete by medical advances.

- In response to GAO, VA announced its intent to revise the 1945 Rating Schedule.
Revisions Since 1989

- VA considered the views of Veterans Health Administration clinicians, disability raters, medical specialty groups, and comments received in response to the proposed rules in the *Federal Register*.

- Revisions of nine body systems and the muscle injury part of the musculoskeletal system were made final and published in the *Federal Register* between 1994 and 1997. The hearing part of the special senses was finalized in 1999, and skin was finalized in 2002.

- Impairment of vision has been updated several times previously, but the digestive, orthopedic, and neurological body systems have not been comprehensively updated since 1945.
Changes in Auditory

- **February 27, 1952**—Examinations utilizing controlled speech reception replaced examinations recording impaired hearing in terms of number of feet at which ordinary conversational voice is heard (whispered voice test).

- Hearing examinations were based on pure tone audiometry, depending on availability of audiometers.

- **March 23, 1956**—all examinations will include controlled speech testing and calibrated audiometry, and when indicated, Galvanic Skin Response (GSR) procedures.

- **September 22, 1978**—Galvanic Skin Response (GSR) procedure is no longer used.

- **October 22, 1987**—Average pure tone decibel loss at 1000, 2000, 3000, and 4000 Hz, rather than the previously used frequencies of 500, 1000, and 2000 Hz. Maryland CNC word lists, rather than the previously used W-22 word lists.
Changes in Auditory

June 10, 1999—Major revision of the hearing impairment section (38 CFR 4.85 and 4.86):

- Exams by a state-licensed audiologist
- Evaluating veterans with either of two exceptional patterns of hearing impairment:
  - PTA of 55 dB HL or greater
  - Precipitous high-frequency hearing losses.
Changes in Tinnitus

- **March 10, 1976**—Diagnostic code 6260, tinnitus, assigned an evaluation criterion and rating of 10 percent (previously 0%).

- **May 11, 1999**—Changed the criteria from “persistent as a symptom of head injury, concussion, or acoustic trauma” to a 10% evaluation for “recurrent tinnitus” due to any condition. Tinnitus may be combined with ratings for hearing loss, otitis media and peripheral vestibular disorders.

- **May 14, 2003**—Criteria clarified that only a single rating for tinnitus may be assigned regardless of which ear or where in the head the tinnitus was perceived.
The Peculiar History of Tinnitus Compensation

- Part of rating schedule since 1925. The current rating schedule (1945) is a variant of the 1925 schedule.
- **1976**--received its own clinical criteria for determining disability and was rated at 10%. Prior to 1976, tinnitus had its own disability code but was rated at 0%.
- Tinnitus also listed under head trauma. Purely subjective complaints such as tinnitus, headache, dizziness, insomnia, etc., recognized as symptomatic of brain trauma, were rated at 10% and no more under dementia due to head trauma (9304).
- Compensable if associated with head injury, concussion, or hearing loss. Because it remained a subjective condition, the 10% limitation on disability was continued.
- **1999**--criterion was changed to allow tinnitus to be compensated if related to any condition.
- **2003**--changed to clarify that a single award for recurrent tinnitus would be assigned whether it was perceived in one or both ears.
- Tinnitus still remains under cerebral arteriosclerosis. Purely subjective complaints such as headache, dizziness, tinnitus, insomnia and irritability, recognized as symptomatic of cerebral arteriosclerosis are rated 10 percent and no more under vascular dementia (9305).
Subjective Symptoms of TBI

- In 2008, VA completely revised the evaluation of TBI, including tinnitus (DC 8045)
- Three main areas of dysfunction that may result from TBI and have profound effects on functioning: cognitive, emotional/behavioral, and physical.
- Subjective symptoms may be the only residual of TBI or may be associated with cognitive impairment or other areas of dysfunction. These subjective conditions, including tinnitus not otherwise explained, will be evaluated using a new evaluation system “Evaluation of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified."
- Levels of impairment:
  - 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.
Evaluating TBI Symptoms

- "Evaluation of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified" contains 10 facets of TBI related to cognitive impairment and subjective symptoms.

- 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."

- Subjective symptoms (e.g. tinnitus) include three levels of impairment (0-2).

- The overall percentage evaluation based on the level of the highest facet as follows: 0 = 0%; 1 = 10%; 2 = 40%.

- **Example:** For three or more subjective symptoms (e.g. tinnitus, headaches, and dizziness) with mild effect on daily activities, 10% would be assigned (same as tinnitus associated with other conditions).

- Same three conditions with moderate effect on daily activities would be rated at 40%. In other words, the schedule allows higher ratings for truly disabling tinnitus related to TBI. It also allows for combining other cognitive, judgment, social, orientation, visual, motor, neurobehavioral, and communication symptoms in a way not previously allowed under regulations.

- Tinnitus handicap scales or other instruments can be used by the examiner in making a determination of effect of TBI on ordinary activities.
<table>
<thead>
<tr>
<th>Coverage</th>
<th>VA</th>
<th>WC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compensation for hearing loss</td>
<td>Y</td>
<td>All but one state</td>
</tr>
<tr>
<td>Waiting period</td>
<td>N</td>
<td>9 states</td>
</tr>
<tr>
<td>Statute of Limitations</td>
<td>N</td>
<td>90 days up to 5 years</td>
</tr>
<tr>
<td>Formula</td>
<td>Speech recognition and/or PTA1234</td>
<td>ME, AMA, AAO-59/79</td>
</tr>
<tr>
<td>Age adjustments</td>
<td>N</td>
<td>15 states</td>
</tr>
<tr>
<td>Tinnitus</td>
<td>Y</td>
<td>27 states</td>
</tr>
<tr>
<td>Time limited</td>
<td>N</td>
<td>Y (PPD)</td>
</tr>
<tr>
<td>Minimum exposure</td>
<td>N</td>
<td>Some states</td>
</tr>
<tr>
<td>Medical benefits</td>
<td>Y</td>
<td>Most states</td>
</tr>
<tr>
<td>Vocational benefits</td>
<td>Y</td>
<td>Most states</td>
</tr>
<tr>
<td>Presumption</td>
<td>Y</td>
<td>N</td>
</tr>
</tbody>
</table>