## Section B. Conditions of the Organs of Special Sense

#### Overview

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| In this Section | This section contains the following topics: |

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| 11 | Specific Eye Conditions | 4-B-6 |
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| 13 | Exhibit 1: Examples of Rating Decisions for Diplopia | 4-B-22 |

#### 10. General Information About Eye Conditions

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| Introduction | This topic contains general information about eye conditions, including* measuring field of vision
* citing disease or injury in the diagnosis
* excluding congenital or developmental defects
* considering service connection for refractive errors
* reconciling inconsistent findings with refractive error
* establishing service connection for unusual developments, and
* considering visual acuity in a non-service-connected (NSC) eye.
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| a. Measuring Field of Vision | The examining medical facility retains discretion in the exact method used to test visual fields. However, they must use one of the following:* Goldmann Bowl kinetic perimetry
* automatic Perimetry (Humphrey Model 750, Octopus Model 101), or
* later versions of the Humphrey or Octopus machines with simulated Goldmann kinetic perimetry.

***Notes***: * If the specified automatic perimetry models are used, results must be reported with both the kinetic “Full Field” and kinetic “Numerical Values” printouts.
* If the reports do not include these printouts, the examination is insufficient for rating purposes and must be returned for corrective action.
* Veterans Benefits Management System-Rating (VBMS-R) allows use of the legacy eye calculator from within the application.
* The VBMS-R User Guide is embedded within the application and accessible by selecting “Help.”

***Reference***: For more information on visual field standards, see [38 CFR 4.77](http://www.benefits.va.gov/warms/docs/regs/38CFR/BOOKC/PART4/S4_77.DOC). |

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| b. Citing Disease or Injury in Diagnosis | Show the actual disease, injury, or other basic condition as the diagnosis, rather thana mere citation of impaired visual acuity, field of vision, or motor efficiency.***Note***: Actual pathology, other than refractive error, is required to support impairment of visual acuity. Impaired field of vision and impaired motor field function must be supported by actual appropriate pathology. |

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10. General Information About Eye Conditions, Continued

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| c. Excluding Congenital or Developmental Defects  | Defects of form or structure of the eye that are of congenital or developmental origin may *not* be considered as disabilities or SC on the basis of incurrence or aggravation beyond natural progress during service. The fact that a Veteran was supplied with glasses for correcting refractive error from any of the eye defects named above is not, in itself, considered indicative of aggravation by service that would warrant compensation.***Exception***: Malignant or pernicious myopia may be considered SC. |

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| d. Considering Service Connection for Refractive Errors | Refractive errors are * due to anomalies in the shape and conformation of the eye structures, and
* generally of congenital or developmental origin.

***Examples***: Astigmatism, myopia, hyperopia, and presbyopia.The effect of uncomplicated refractive errors must be *excluded* in considering impairment of vision from the standpoint of service connection and evaluation.***Exception***: Myopia may progress rapidly during the periods of service and lead to destructive changes, such as* changes in the choroid
* retinal hemorrhage, and
* retinal detachment.

***Notes***:* Children are usually hyperopic at birth and subsequently become less so, or they become emmetropic, or even myopic.
* In adults, refractive errors are generally stationary or change slowly until the stage of presbyopia, also a developmental condition.

***Reference***: For more information on considering service connection for refractive error of the eye, see [38 CFR 3.303(c)](http://www.benefits.va.gov/warms/docs/regs/38CFR/BOOKB/PART3/S3_303.DOC). |

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| e. Reconciling Inconsistent Findings with Refractive Error | When dealing with refractive error only, if the best corrected vision on any examination by the Department of Veterans Affairs (VA) is better than prior determinations, assume these prior determinations to be erroneous or at least as not representing best correction. |

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| f. Establishing Service Connection for Unusual Developments  | Long-established policy permits establishment of service connection for such unusual developments as choroidal degeneration, retinal hemorrhage or detachment, or rapid increase of myopia producing uncorrectable impairment of vision. Consider refractive error service-connected (SC) *only* under these unusual circumstances and when combined with uncorrectable residual visual impairment.***Note***: Irregular astigmatism may be due to corneal inflammation due to injury or operation. |

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| g. Considering Visual Acuity in an NSC Eye | When visual impairment of only one eye is SC, either directly or by aggravation, consider the visual acuity of the nonservice-connected (NSC) eye to be 20/40, subject to the provisions of [38 CFR 3.383(a)](http://www.benefits.va.gov/warms/docs/regs/38CFR/BOOKB/PART3/S3_383.DOC).***Example 1*** (Direct incurrence)***Situation***:* Pre-service, a Veteran had visual acuity of 20/70 in the right eye and 20/20 in the left eye, with a history of bilateral inactive chorioretinitis.
* The Veteran developed a cataract in the left eye in service.
* Post-service, visual acuity was 20/70 in the right eye and 10/200 in the left eye.
* At the time of the rating determination, the left eye cataract was pre-operative.

***Result***:* The SC evaluation is 30 percent for the left eye cataract that was incurred in service, based on visual acuity of 10/200.
* Since the right eye is NSC, it is considered to have normal vision (20/40) for the purposes of this calculation.

***Example 2*** (Aggravation)***Situation***:* Pre-service, a Veteran had visual acuity of 20/50 in each eye due to scarring from an old injury.
* The Veteran’s left eye was re-injured in combat.
* Post-service, visual acuity was 20/50 in the right eye and 10/200 in the left eye.

***Result***:* The SC evaluation is 20 percent for left eye aggravation (30 percent for 10/200 (current left eye) minus 10 percent for 20/50 (left eye on entrance)).
* Since the Veteran’s right eye is NSC, it is considered to have normal vision (20/40) for the purposes of this calculation.

***References***: For more information on* evaluating visual acuity, see [38 CFR 4.75](http://www.benefits.va.gov/warms/docs/regs/38CFR/BOOKC/PART4/S4_75.DOC) and [38 CFR 4.79](http://www.benefits.va.gov/warms/docs/regs/38CFR/BOOKC/PART4/S4_79.DOC), diagnostic codes (DCs) 6063 through 6066, and
* determining in-service aggravation of pre-service disability, see
* [38 CFR 3.306](http://www.benefits.va.gov/warms/docs/regs/38CFR/BOOKB/PART3/S3_306.DOC), and
* M21-1MR, Part IV, Subpart ii, 2.B.5.
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#### 11. Specific Eye Conditions

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| Introduction | This topic contains information on specific eye conditions, including* considering amblyopia
* considering impairments of both visual acuity and visual field
* considering glaucoma
* considering diplopia, and
* evaluating diplopia together with impairment of visual acuity or visual field.
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| a. Considering Amblyopia | Ascertain the etiology of amblyopia in each individual case since a diagnosis may refer to either developmental or acquired causes of lost visual acuity. |

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| b. Considering Impairments of Both Visual Acuity and Visual Field | When there are impairments of both visual acuity and fields of vision* determine for each eye the percentage evaluation for visual acuity and for visual field loss (expressed as a level of visual acuity), and
* combine the evaluations under [38 CFR 4.25](http://www.benefits.va.gov/warms/docs/regs/38CFR/BOOKC/PART4/S4_25.DOC).

The combined evaluation for visual impairment can then be combined with any other disabilities that are present.***Example*** ***Situation***: * Corrected visual acuity is 20/40 in the right eye and 20/70 in the left eye, warranting a 10 percent evaluation.
* Visual field loss in right eye is remaining field 38 degrees (equivalent to visual acuity 20/70) and loss in left eye is remaining field 28 degrees (equivalent to visual acuity 20/100), warranting a 30 percent evaluation.

***Result***: Under [38 CFR 4.25](http://www.benefits.va.gov/warms/docs/regs/38CFR/BOOKC/PART4/S4_25.DOC), combine the 30-percent evaluation for visual field loss with the 10-percent evaluation for visual acuity, which results in a 40-percent combined evaluation for bilateral visual impairment. |

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| c. Considering Glaucoma  | Glaucoma is recognized as an organic disease of the nervous system and is subject to presumptive service connection under [38 CFR 3.309(a)](http://www.benefits.va.gov/warms/docs/regs/38CFR/BOOKB/PART3/S3_309.DOC). Consider glaucoma, manifested to a compensable degree within one year of separation from an entitling period of service, to be SC on a presumptive basis unless there is * affirmative evidence to the contrary, or
* evidence that a recognized cause of the condition was incurred between the date of separation from service and the onset of the disability (that is, evidence of intercurrent cause).
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| d. Considering Diplopia | [38 CFR 4.78](http://www.benefits.va.gov/warms/docs/regs/38CFR/BOOKC/PART4/S4_78.DOC) requires use of Goldmann Bowl kinetic perimeter testing for examination of muscle function. However the Tangent Screen is sufficient for rating purposes if the following criteria are met:* The test must be performed at a distance of one meter with a 7.5 mm diameter round white test target to evaluate the central 30 degrees and/or a 3.75 mm diameter round white test target at a distance of one-half meter to evaluate beyond the central 30 degrees (up to 60 degrees).
* The light falling on the Tangent screen should be 7 foot candles.
* The output must be recorded on a Goldmann perimeter chart (recording sheet).

A diagnosis of diplopia that reflects the disease or injury that is the cause of the diplopia must be of record. When the affected field with diplopia extends beyond more than one quadrant or range of degrees, evaluate diplopia based on the quadrant and degree range that provides the higher (or highest) evaluation. When diplopia exists in two separate areas of the same eye, increase the equivalent visual acuity under diagnostic code 6090 to the next poorer level of visual acuity, but not to exceed 5/200.***Example*** ***Situation***: * The Veteran has an SC evaluation for diplopia.
* Diplopia in both eyes is in the 31 to 40 degree range of upward vision and in the 31 to 40 degree range of lateral vision.
* The diplopia in the upward vision is equivalent to visual acuity of 20/40, while the diplopia in the lateral vision is equivalent to visual acuity of 20/70.

***Result***: * Based on [38 CFR 4.78(b)(2) and (3)](http://www.benefits.va.gov/warms/docs/regs/38CFR/BOOKC/PART4/S4_78.DOC), the overall equivalent visual acuity for diplopia is 20/100, which is one step poorer than the diplopia (in this case, the lateral) that provides the higher evaluation.
* The overall evaluation for diplopia is, therefore, 10 percent, based on visual acuity of 20/100 for one eye and 20/40 for the other eye (diplopia is only taken into consideration for one eye).

***Note***: Diplopia that is occasional or that is correctable with corrective lenses is evaluated at zero percent. |

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| e. Evaluating Diplopia With Impairment of Visual Acuity or Loss of Visual Field | The table below shows the steps to take when assigning an evaluation to visual impairment when a claimant has both* diplopia, and
* a ratable impairment of visual acuity or loss of visual field in either eye.
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| Step | Action |
| 1 | Assign a level of visual acuity for diplopia for only one eye under diagnostic code (DC) 6090. |
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| If the visual acuity level assignable for diplopia is … | Then assign a level of corrected visual acuity for the poorer eye (or affected eye, if only one is SC) that is … |
| 20/70 or 20/100 | one step poorer than it would otherwise warrant, not to exceed 5/200. |
| 20/200 or 15/200 | two steps poorer than it would otherwise warrant, not to exceed 5/200. |
| 5/200 | three steps poorer than it would otherwise warrant, not to exceed 5/200. |

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| 3 | Determine the evaluation for visual impairment under DC 6065 or 6066 by using the* adjusted visual acuity of the poorer eye (or affected eye, if only one is SC), and
* corrected visual acuity for the better eye (or visual acuity of 20/40 for the other eye, if only one eye is service-connected).
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|  ***Reference***: For examples of rating decisions for diplopia, see M21-1MR, Part III, Subpart iv, 4.B.13. |

#### 12. Hearing Impairment

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| Introduction | This topic contains information about hearing impairment, including* determining impaired hearing as a disability
* reviewing claims for hearing loss and/or tinnitus
* considering the Duty Military Occupational Specialty (MOS) Noise Exposure Listing
* requesting audiometric examinations and medical opinions
* when a medical opinion is necessary to determine onset or etiology of tinnitus
* considering medical opinions in cases involving tinnitus
* handling changed criteria or testing methods
* applying past versions of hearing loss criteria
* reviewing for functional disturbances
* granting service connection for functional hearing impairment
* considering service connection for development of subsequent ear infection
* determining the need for a reexamination
* compensation payable for paired organs under 38 CFR 3.383, and
* using VBMS rating decision tools in hearing impairment claims.
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| a. Determining Impaired Hearing as a Disability | Per [38 CFR 3.385](http://www.benefits.va.gov/warms/docs/regs/38CFR/BOOKB/PART3/S3_385.DOC), impaired hearing is considered a disability for VA purposes when* the auditory threshold in any of the frequencies 500, 1000, 2000, 3000, 4000 Hertz is 40 decibels or greater
* the auditory thresholds for at least three of the frequencies 500, 1000, 2000, 3000, or 4000 Hertz are 26 decibels or greater, or
* speech recognition scores using the Maryland CNC Test are less than 94 percent.

***Notes***: * Sensorineural hearing loss is considered an organic disease of the nervous system and is subject to presumptive service connection under [38 CFR 3.309(a)](http://www.benefits.va.gov/warms/docs/regs/38CFR/BOOKB/PART3/S3_309.DOC).

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|  (continued) | * Be careful in determining whether older audiometry results show a disability under [38 CFR 3.385](http://www.benefits.va.gov/warms/docs/regs/38CFR/BOOKB/PART3/S3_385.DOC). Results today may indicate a different level of impairment than in the past because of changed equipment standards.
* Audiometry results from before 1969 may have been in American Standards Association (ASA) units.
* Current testing will be to standards set by the International Standards Organization (ISO) /American National Standards Institute (ANSI).
* Test results should indicate the standard for the audiometry.
* Veterans Health Administration (VHA) examinations for compensation purposes routinely converted ISO/ANSI results to ASA units until the end of 1975 because the regulatory standard for evaluating hearing loss was not changed to require ISO/ANSI units until September 9, 1975.

***Important***: If you have older results that are in ASA units or the results date to a time when a ASA units may have been used, and you cannot determine what standard was used to obtain the readings, an audiologist opinion will be needed to interpret the results and convert any ASA test results to ISO/ANSI units. ***Reference***: For more information on: * applying past versions of hearing loss tables, see M21-1MR, Part III, Subpart iv, 4.B.12.h.
* obtaining medical opinions, see M21-1MR, Part III.Subpart iv.3.A.9.
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| b. Reviewing Claims for Hearing Loss and/or Tinnitus | Review each claim for hearing loss and/or tinnitus for* sufficient evidence of a current audiological disability (including lay evidence), and
* evidence documenting
* hearing loss and/or tinnitus in service, or
* an in-service event, injury, disease, or symptoms of a disease potentially related to an audiological disability.

If there is no documented evidence of an in-service disease, injury, or event with which the claimed condition could be associated, consider the Duty Military Occupational Specialty (MOS) Noise Exposure Listing to help determine the probability of the Veteran’s exposure to hazardous noise in service.Claims, particularly those from unrepresented claimants, must be read sympathetically. Although a claim for “hearing loss” denotes diminished hearing acuity, a lay claimant might interpret extraneous sounds (tinnitus) creating interference with normal hearing as “hearing loss.” References to “hearing impairment” and “hearing” are even more ambiguous. In cases where the claim is phrased as above but the claimant: 1) makes later contentions specifically about tinnitus, 2) submits evidence of tinnitus or 3) reports tinnitus at a hearing exam or if the examiner diagnoses tinnitus and associates that with the Veteran’s service or another service connected disability, treat the hearing-related claim to include a claim for tinnitus. Where service connection is established for tinnitus use the date of the hearing-related claim for effective date purposes. ***Note***: If tinnitus is not specifically claimed, do *not* address tinnitus in the rating decision unless service connection can be granted. ***Reference***: For more information on * considering the Duty MOS Noise Exposure Listing, see M21-1MR, Part III, Subpart iv, 4.B.12.c.
* sympathetic reading doctrine, see
* M21-1MR Part III, Subpart iv, 6.B and
* M21-1MR Part III, Subpart iv, 4.H.32.
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| c. Considering the Duty MOS Noise Exposure Listing | The Duty MOS Noise Exposure Listing, which has been reviewed and endorsed by each branch of service, is available at <http://vbaw.vba.va.gov/bl/21/rating/docs/dutymosnoise.xls>Based on the Veteran’s records, review each duty MOS, Air Force Specialty Code, rating, or duty assignment documented on the Duty MOS Noise Exposure Listing to determine the probability of exposure to hazardous noise. If the duty position is shown to have a “Highly Probable” or “Moderate” probability of hazardous noise exposure, concede exposure to hazardous noise for the purposes of establishing an event in service. ***Note***: * The Duty MOS Noise Exposure Listing is not an exclusive means of establishing a Veteran’s in-service noise exposure. Evaluate claims for service connection for hearing loss in light of the circumstances of the Veteran’s service and all available evidence, including treatment records and examination results.

***Reference***: For more information on * considering the circumstances of the Veteran’s service, see [38 U.S.C. 1154(a) and (b)](http://law.cornell.edu/uscode/html/uscode38/usc_sec_38_00001154----000-.html),
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| d. Requesting Audiometric Examinations and Medical Opinions  | Where the question of service connection is at issue request an audiometric examination and/or opinion when necessary under [38 CFR 3.159(c)(4)](http://www.benefits.va.gov/warms/docs/regs/38CFR/BOOKB/PART3/S3_159.DOC). ***Notes***:* Competent evidence of a current diagnosis of symptoms could include records or lay evidence of difficulty hearing or tinnitus.
* Establishment of an event, injury or disease in service is fact specific. If there is no documentation of an in-service illness, injury or event involving the ears or hearing, the Duty MOS Noise Exposure listing will be considered.
* If noise exposure is conceded based on the duty MOS Noise Exposure Listing include the level of probability conceded, such as “highly probable” or “moderate,” in the information provided to the examiner in the body of the examination request.
* If noise exposure is not conceded but an examination and/or opinion are otherwise necessary based on another event, injury, disease provide the probable level of exposure to hazardous noise associated with the Veteran’s documented duty position in the examination request remarks.
* If the evidentiary threshold for finding a VA examination necessary under [38 CFR 3.159(c)(4)](http://www.benefits.va.gov/warms/docs/regs/38CFR/BOOKB/PART3/S3_159.DOC) has been met, a duty MOS consistent with a lower probability of hazardous noise exposure than “Highly Probable” or “Moderate” does not preclude a VA examination.
* Request a medical opinion regarding the significance of prior audiological findings if the evidence of record is unclear on any point.
* In *Noise and Military Service: Implications for Hearing Loss and Tinnitus* (2006), the National Academy of Sciences reported that a delay of many years in the onset of noise-induced hearing loss following an earlier noise exposure is extremely unlikely.

***References***: For more information on * when an exam is necessary under the duty to assist, see M21-1MR, Part I, 1.C.7
* use of the duty MOS to determine if there was in-service hazardous noise exposure, see M21-1MR, Part III, Subpart iv, 4.B.12.c, and
* medical opinions and the Hearing Loss and Tinnitus Disability Benefits Questionnaire (DBQ), see M21-1MR, Part III, Subpart iv, 3.A.9.i.
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| e. When a Medical Opinion is Necessary to Determine Onset or Etiology of Tinnitus  | A medical opinion is not required to establish direct service connection for claimed tinnitus if* service treatment records (STRs) document the original complaints and/or diagnosis of tinnitus
* there is current medical evidence of a diagnosis of tinnitus or the Veteran competently and credibly reports current tinnitus, and
* the Veteran claims continuity of tinnitus since service or there are records or other competent and credible evidence of continuity of tinnitus diagnosis or symptomatology.

***Exception***: An opinion may be necessary in the fact pattern above if evidence suggests a superseding post-service cause of current tinnitus. A tinnitus examination may also be necessary if:* the STRs do not document tinnitus but
* there is evidence establishing noise exposure or another in-service event, injury, or disease (for example ear infections, use of ototoxic medication, head injury, barotrauma or other tympanic trauma) that is medically accepted as a potential cause of tinnitus and
* there is a competent diagnosis or competent report of current tinnitus.

***Notes***: * Under [*Jandreau v. Nicholson*](http://vbaw.vba.va.gov/bl/21/advisory/CAVCDAD.htm#bmj), 492 F.3d. 1372 (Fed. Cir. 2007), a lay person may provide a competent diagnosis of a condition when a lay person is competent to identify a medical condition. Tinnitus is medical condition that a lay person is competent to identify in himself/herself because the condition is defined by what the person experiences or perceives – namely subjective perception of sounds in his/her own ear(s) or head. Therefore, a layperson may establish the diagnosis of tinnitus at any point in time from service to present. However, consider credibility and weight of the evidence in deciding whether to accept lay testimony as proving tinnitus in service or presently.
* The Hearing Loss and Tinnitus DBQ tinnitus-only exam includes a number of options for examiner opinions on etiology. The examination may be conducted by an audiologist or non-audiologist clinician.
* Only ask the audiologist to offer an opinion about the association to hearing loss if hearing loss is concurrently claimed or already service-connected.
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| f. Considering Medical Opinions in Cases Involving Tinnitus  | Use the table below when considering an examiner’s medical opinion in a case involving tinnitus. |

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| If ... | Then ... |
| the examiner states tinnitus is a symptom of hearing loss | * evaluate tinnitus separately under diagnostic code 6260 if the hearing loss is determined to be SC and
* establish service connection for tinnitus on a direct, not secondary, basis.

***Note***: If the hearing loss is service connected, and the tinnitus is a symptom of the hearing loss, we concede that the hearing loss and tinnitus result from the same etiology. Therefore, service connection is warranted for tinnitus on a direct basis in these cases.  |
| * the examiner
* states tinnitus is not related to hearing loss, or
* is unable to determine the etiology within reasonable certainty, or
* there is no hearing loss
 | determine, based on all the evidence of record, whether or not the etiology of tinnitus requires further assessment by one of more additional examinations. ***Note***: The type and need for any additional examination(s) will depend on the Veteran’s claim as to the cause of tinnitus. ***Examples***:* If the Veteran claims tinnitus due to hearing loss, and the examiner says they are not related, no further action is needed.
* If Veteran claims tinnitus due to another condition (such as head injury, hypertension, etc., which would be outside the scope of the audiologist), it might be appropriate to request
* a general medical, ears/nose/throat (ENT), or other examination, and
* an opinion as to the causation of tinnitus.
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| If ... | Then ... |
| the examiner states that tinnitus is related to noise exposure or an event, injury, or illness in service | * evaluate all the evidence of record
* determine if the examiner’s opinion is consistent with the evidence, and

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| If … | Then … |
| the examiner’s opinion is consistent with the evidence or record | grant service connection on a direct basis. |
| * the examiner’s opinion is not consistent with the evidence of record, and
* the evidence VA provided to the examiner was incorrect or insufficient
 | * return the exam for clarification and
* provide the examiner with all necessary information.

***Note***: When the corrected exam is received, consider the opinion together with all other evidence of record to determine if service connection is warranted. |
| * the examiner’s opinion is not consistent with the evidence of record, and
* the information the Veteran provided to the examiner was also inconsistent with the record
 | consider the opinion together with all other evidence of record to determine whether service connection is warranted. |

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| ***References***: For more information on * when to use lay evidence, see
* M21-1MR, Part III, Subpart iv, 5.9.b
* [*Buchanan v. Nicholson*](http://vbaw.vba.va.gov/bl/21/Advisory/CAVCDAD.htm#bmb), 451 F.3d 1331 (Fed. Cir. 2006), and
* [*Jandreau v. Nicholson*](http://vbaw.vba.va.gov/bl/21/Advisory/CAVCDAD.htm#bmj), 492 F.3d 1372 (Fed.Cir. 2007).
* weighing evidence, see
* M21-1MR, Part III, Subpart iv, 5.12
* [*Coburn v. Nicholson*](http://vbaw.vba.va.gov/bl/21/Advisory/CAVCDAD.htm#bmc), 19 Vet. App. 427 (2006)
* [*Kowalski v. Nicholson*](http://vbaw.vba.va.gov/bl/21/Advisory/CAVCDAD.htm#bmk), 19 Vet.App. 171 (2005), and
* [*Reonal v. Brown*](http://vbaw.vba.va.gov/bl/21/Advisory/CAVCDAD.htm#bmr), 5 Vet. App. 548 (1993).
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| g. Handling Changed Criteria or Testing Methods | If there is a change in evaluation criteria (including a required change in testing methods) and applying the current facts to the changed criteria would support a lower evaluation ***but there has not been an improvement in the degree of hearing loss (or tinnitus),*** the existing evaluation ***may not be reduced***. ***Reference***: For more information on preservation of disability ratings, see [38 CFR 3.951(a)](http://www.benefits.va.gov/warms/docs/regs/38CFR/BOOKB/PART3/S3_950.DOC). |

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| h. Applying Past Versions of Hearing Loss Criteria | In some cases it may be necessary to consider past legal criteria for evaluating hearing loss. Such cases may include:* unresolved pending claims and
* claims where a past decision denying service connection – or establishing an evaluation – for hearing loss must be revised due to clear and unmistakable error.

The document linked [here](http://vacoappbva1/lsadocs/CitatorRegulation/4-85-b.pdf) contains all versions of hearing loss evaluation tables from Extension 8-B of the 1945 Schedule for Rating Disabilities to the amendment of 38 CFR 4.85(b), effective 6/10/99. ***References***: For more information on * applying the law when criteria changes during a pending claim, see [VAOPGRPREC 3-2000](http://www.va.gov/ogc/docs/2000/prc03-2000.doc), and
* standards for old audiometry, see M21-1MR Part III, Subpart iv, 4.B.12.a.
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| i. Reviewing for Functional Disturbances | If, following an examination at an audiology clinic, a drastic reduction in rating for a hearing impairment is in order, thoroughly review the claims folder for evidence of a psychiatric disease entity, which might be manifested in part by a nonorganic hearing impairment. |

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| j. Granting Service Connection for Functional Hearing Impairment | Determine entitlement to service connection for a psychiatric disability, manifested in part by a hearing impairment, by the usual regulations pertaining to the grant of service connection. It is anticipated the psychiatric disorder will be identifiable by manifestations other than those relating to hearing complaints alone. Base the rating either on the organic hearing loss or the psychiatric disorder, but not both in combination.***Reference***: For more information on evaluating psychiatric disorders, see [38 CFR 4.126](http://www.benefits.va.gov/warms/docs/38CFR/BOOKC/PART4/S4_126.DOC). |

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| k. Considering Service Connection for Development of Subsequent Ear Infection | If the disease of one ear, such as chronic catarrhal otitis media or otosclerosis, is held as the result of service, the subsequent development of similar pathology in the other ear must be held due to the same cause if* the time element is not manifestly excessive, a few years at most, and
* there has been no intercurrent infection to cause the additional disability.

***Note***: If there is continuous SC infection of the upper respiratory tract, the time cited for the purpose of service connecting infection of the second ear should be extended indefinitely. |

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| l. Determining the Need for Reexamination | Use the table below to determine whether reexamination is necessary.***Note***: A single examination is often sufficient to meet the qualifying conditions of permanence under [38 CFR 3.327](http://www.benefits.va.gov/warms/docs/regs/38CFR/BOOKB/PART3/S3_327.DOC). |

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| If … | Then … |
| the extent of hearing loss in an individual claim has been satisfactorily established by an examination | do not routinely schedule reexamination. |

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|  (continued) |

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| --- | --- |
| If … | Then … |
| the Veteran has hearing loss evaluated 100 percent under diagnostic code 6100 with a numeric designation of XI & XI  | * permanency can be conceded, and
* Special Monthly Compensation (SMC) granted unless extenuating circumstances are present.

***Note***: If hearing loss is functional, such as psychogenic, schedule at least one future examination to ensure that permanency is established before granting SMC. |
| there is evidence that the hearing loss is likely to improve materially in the future  | * schedule a reexamination, and
* include justification for such reexamination in the *Reasons for Decision* section of the rating decision.
 |
| the Veteran has had middle ear surgery  | * consider that hearing acuity will have reached a stable level one year after surgery, and
* schedule reexamination for one year after such surgery under [38 CFR 3.327](http://www.benefits.va.gov/warms/docs/regs/38CFR/BOOKB/PART3/S3_327.DOC).
 |

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| m. Compensation Payable for Paired Organs Under 38 CFR 3.383 | Even if only one ear is SC, compensation may be payable under [38 CFR 3.383](http://www.benefits.va.gov/warms/docs/regs/38CFR/BOOKB/PART3/S3_383.DOC) for the other ear, as if SC, if the Veteran’s hearing impairment* is compensable to a degree of 10 or more in the SC ear, and
* meets the provisions of [38 CFR 3.385](http://www.benefits.va.gov/warms/docs/regs/38CFR/BOOKB/PART3/S3_385.DOC) in the non-SC ear.

***Reference***: For more information on compensation payable for paired SC and non-SC organs, see* M21-1MR, Part III, Subpart iv, 6.B.4, and
* M21-1MR, Part IV, Subpart ii, 2.K.66.
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| n. Using VBMS Rating Decision Tools in Hearing Impairment Claims | VBMS-R includes embedded calculators for hearing loss and tinnitus and ear diseases to help Rating Veterans Service Representatives (RVSRs) and Decision Review Officers (DROs) assign correct evaluations and generate required narrative explanation. The calculator output is placed in the rating narrative. ***Note***: The VBMS-R User Guide is embedded within the application and accessible by selecting “Help.” ***References***: For more information on VBMS, see the [VBMS Resources page](http://vbaw.vba.va.gov/VBMS/resources.asp).  |

#### 13. Exhibit 1: Examples of Rating Decisions for Diplopia

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| Introduction | This exhibit contains three examples of rating decisions for diplopia. |

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| Change Date | August 3, 2011 |

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| a. Example 1 | ***Situation***: The Veteran filed an original claim for bilateral impairment of visual acuity on June 1, 2009. VA examination reveals the best distant vision obtainable after correction is 20/200 (6/60) in the right eye and 20/70 (6/21) in the left eye. Diplopia secondary to thyroid myopathy has been diagnosed and is within 24 degrees in the upward quadrant. Diplopia within 24 degrees in the upward quadrant is ratable as 20/70 (6/21) under DC 6090.***Rationale***: Because the evaluation for diplopia is 20/70, evaluate visual acuity in the poorer eye (right) as 15/200 per [38 CFR 4.78](http://www.benefits.va.gov/warms/docs/regs/38CFR/BOOKC/PART4/S4_78.DOC), one step poorer than it would otherwise warrant.  |

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| --- | --- |
| *Coded Conclusion:* |  |
| 1. SC (VE INC) |  |
| 6066 | Visual impairment secondary to thyroid myopathy, bilateral, with diplopia |
| 40% from 06/01/2009 |  |

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| b. Example 2 | ***Situation***: The same facts as in Example 1, except the diplopia exists within 24 degrees in the downward quadrant. Diplopia within 24 degrees in the downward quadrant is ratable as 15/200 (4.5/60) under DC 6090. ***Rationale***: Because the evaluation for diplopia is 15/200, evaluate visual acuity in the poorer eye (right) as 10/200 per [38 CFR 4.78](http://www.benefits.va.gov/warms/docs/regs/38CFR/BOOKC/PART4/S4_78.DOC), two steps poorer than it would otherwise warrant.  |

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| *Coded Conclusion:* |  |
| 1. SC (VE INC) |  |
| 6066 | Visual impairment secondary to thyroid myopathy, bilateral, with diplopia |
| 50% from 06/01/2009 |  |

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| c. Example 3 | ***Situation***: The Veteran is service connected for impairment of the visual field in the right eye secondary to trauma. The average contraction of the visual field is to 50 degrees, and is ratable equivalent to 20/50 (6/15) at 10 percent. Diplopia has been diagnosed secondary to trauma and exists within 20 degrees in the central area. Diplopia within 20 degrees in the central area is ratable as 5/200 (1.5/60). ***Rationale***: Since the evaluation for diplopia is 5/200, evaluate the visual field impairment in the SC eye (right) as 20/200 per [38 CFR 4.78](http://www.benefits.va.gov/warms/docs/regs/38CFR/BOOKC/PART4/S4_78.DOC), three steps poorer than it would otherwise warrant. ***Result***: Assign a 20-percent evaluation under diagnostic code 6090-6066 for diplopia with impairment of the visual field, right eye. Do not assign a separate 10 percent evaluation for contraction of the visual field. |

|  |  |
| --- | --- |
| *Coded Conclusion:* |  |
| 1. SC (VE INC) |  |
| 6090-6066 | Diplopia secondary to trauma, with impairment of visual field, right eye |
| 20% from 06/01/2009 |  |