## Section G. Neurological Conditions and Convulsive Disorders

#### Overview

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

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| Topic | Topic Name |
| 1 (old 25) | General Information on Neurological and Convulsive Disorders |
| 2 | Traumatic Brain Injury (TBI) |
| 3 | Secondary Conditions Associated with TBI |
| 4 | Peripheral Nerves |
| 5 (old 26) | Multiple Sclerosis (MS) |
| 6 | Amyotrophic Lateral Sclerosis (ALS) |
| 7 | Migraine Headaches |

#### 1. General Information on Neurological and Convulsive Disorders

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| **Introduction** | This topic contains general information about neurological and convulsive disorders, including   * considerations in service connection (SC) for neurological disorders * identifying epilepsy, and * evaluating progressive spinal muscular atrophy * . |

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| a. Considerations in SC for Neurological Disorders | See the table below for etiological considerations and manifestations involving specific neurological disorders. |

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| When ... | Then ... |
| considering questions of incurrence or aggravation in service | bear in mind the etiology and clinical course of each separate disease. |
| considering conditions of infectious origin | consider both the circumstances of infection and the incubation period. |
| determining aggravation for conditions such as multiple sclerosis, progressive muscular atrophy, and myasthenia gravis | be aware that increased symptomatology over a period of a few months may reflect natural progression of the disease. Base determinations on the developed medical evidence of record. |

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| b Identifying Epilepsy | Seizures must be witnessed *or* verified by a physician to warrant service connection (SC) for epilepsy. Verification may be by an electroencephalogram (EEG), which measures electrical activity in the brain.  A physician does not have to witness an actual seizure before a diagnosis of epilepsy can be accepted for evaluation purposes. Verification by a physician based upon factors other than observing an actual seizure is sufficient.  ***Reference***: For more information on   * identifying epilepsy, see [38 CFR 4.121](http://www.ecfr.gov/cgi-bin/text-idx?SID=f0aa74b3307a3ad4b8794ead73ecfa75&node=se38.1.4_1121&rgn=div8), and * psychomotor epilepsy, see [38 CFR 4.122](http://www.ecfr.gov/cgi-bin/text-idx?SID=f0aa74b3307a3ad4b8794ead73ecfa75&node=se38.1.4_1122&rgn=div8). |

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| c. Evaluating Progressive Spinal Muscular Atrophy | Progressive muscular atrophy, [38 CFR 4.124a, diagnostic code (DC) 8023](http://www.ecfr.gov/cgi-bin/text-idx?SID=f0aa74b3307a3ad4b8794ead73ecfa75&node=se38.1.4_1124a&rgn=div8), refers to progressive spinal muscular atrophy, which is a disease of the spinal cord.  Progressive muscular atrophy is subject to presumptive SC under [38 CFR 3.309(a)](http://www.ecfr.gov/cgi-bin/text-idx?SID=f0aa74b3307a3ad4b8794ead73ecfa75&node=se38.1.3_1309&rgn=div8) because it is an organic disease of the nervous system. |

**2.** **Traumatic Brain Injury**

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| Introduction | This topic contains information about traumatic brain injury (TBI), including   * definition of TBI * TBI events * external force for the purpose of TBI events * TBI residuals * determining the issues in TBI cases * SC of TBI residuals * evaluation of TBI residuals * multiple evaluations and pyramiding in TBI cases * opinion evidence and separate evaluations of TBI and a mental disorders * additional TBI signs or symptoms upon reevaluation. * TBI and special monthly compensation (SMC) * temporary total evaluations and TBI * training and signature requirements for TBI decisions |

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| a. Definition: TBI | The term ***traumatic brain injury (TBI)*** means the physical, cognitive and/or behavioral/emotional residual disability resulting from an event of external force causing an injury to the brain. |

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| b. TBI Events | The ***TBI event*** is a traumatically induced structural injury and/or physiological disruption of brain function resulting from an external force indicated by *at least one* of the following clinical signs immediately following the event   * any period of loss of consciousness or decreased consciousness * any loss of memory for events immediately before or after the injury * any alteration in mental state at the time of the injury (confusion, disorientation, slowed thinking, etc.) * neurological deficits, whether or not transient, or * intracranial lesion.   ***Notes***:   * The TBI event has two necessary components: the *external force* and the *identifiable acute manifestations* of brain injury immediately following the external force. Not all individuals exposed to an external force will have brain injury and therefore, they will not meet the criteria for having a TBI event. * The acute manifestations may resolve without chronic disability, or a chronic disability may result. * Although unconsciousness or reduced consciousness is common in TBI events, these are *not* required. Any one of the five signs will be sufficient. |

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| c. External Force for the Purpose of TBI Events | ***External force*** means any of the following events   * a foreign body (such as a bullet or shell fragment) penetrating the brain * the head being struck by an object (such as a fist, a hatch, or flying debris) * the head striking an object (such as the ground or a windshield) * the brain undergoing an acceleration/deceleration movement without direct external trauma to the head, * force generated from events such as a blast or explosion, or * other force yet to be defined.   ***Note***: TBI events may occur during combat or non-combat situations (such as a motor vehicle accident, fall, or personal assault). |

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| d. TBI Residuals | The resultant disabling effects of a TBI event beyond those that follow immediately from the acute injury to the brain are known as ***TBI residuals*** or ***TBI sequelae***.  The signs and symptoms of TBI residuals can be organized into the three main categories of physical, cognitive, and behavioral/emotional residuals for evaluation purposes. Examples of TBI residuals in each of the three categories may include, but are not limited to, those listed below. |

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| Physical | Cognitive | Behavioral/Emotional |
| Apraxia (inability to execute purposeful, previously learned motor tasks, despite physical ability and willingness) | Dementias (pre-senile Alzheimer’s type, dementia pugilistica, post traumatic dementia) | Depression |
| Aphasia (difficulty communicating orally and/or in writing) | Attention and concentration deficits | Agitation and irritability |
| Paresis (muscle weakness or incomplete paralysis) | Memory, processing, and learning impairment | Impulsivity |
| Plegia (paralysis or stroke) | Language deficiencies | Aggression |
| Dysphagia (difficulty swallowing) | Planning difficulties | Anxiety |
| Disorders of balance and coordination | Judgment and control difficulties | Posttraumatic stress disorder |
| Diseases of hormone deficiency | Reasoning and abstract thinking limitations |  |
| Parkinsonism | Self-awareness limitations |  |
| Nausea/vomiting |  |  |
| Headaches |  |  |
| Dizziness |  |  |
| Blurred vision |  |  |
| Seizure disorder |  |  |
| Sensory loss |  |  |
| Weakness |  |  |
| Sleep disturbance |  |  |

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| ***Note***: TBI residuals can resolve in a short period of time or can persist chronically or even permanently. Chronic TBI residuals may include some or all of the clinical signs that developed immediately during the TBI event. Others (such as seizures or spasticity) may have a delayed onset. |

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| e. Determining the Issues in TBI Cases | A claim for SC for TBI may also be worded as a claim for “head injury,” or “concussion.” A claim document mentioning any of the above must be sympathetically read and understood as a claim for *all* identifiable TBI residuals that can be attributed to one or more TBI events.  A claim for “combat injuries,” assault, automobile accident, fall, or other injurious events may also raise the issue of a TBI if there was an injury to the head.  As recognized by [38 CFR 4.124a, DC 8045](http://www.ecfr.gov/cgi-bin/text-idx?SID=f0aa74b3307a3ad4b8794ead73ecfa75&node=se38.1.4_1124a&rgn=div8), the external force of a claimed TBI event may result not only in brain injury but also in physical or psychological disorders distinct from brain injury residuals. An explosion, for example, may cause burns, muscle injuries, orthopedic injuries including amputations, and posttraumatic stress disorder in addition to a brain injury. A TBI claim mentioning a specific traumatic event must be sympathetically read as a claim for SC for *all* disabling chronic residuals of the event.  ***Reference***: For more information on determining the issues, see M21-1 Part III, Subpart iv, 6.B. |

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| f. SC of TBI residuals | When signs and symptoms are identified as TBI residuals *and* associated with an in-service TBI event, [38 CFR 3.303](http://www.ecfr.gov/cgi-bin/text-idx?SID=f0aa74b3307a3ad4b8794ead73ecfa75&node=se38.1.3_1303&rgn=div8) allows for SC on a direct basis.  A medical opinion is necessary when the medical evidence of record *does not* show a clear-cut etiology for a sign or symptom claimed as a delayed effect. |

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| g. Evaluation of TBI Residuals | Evaluate SC TBI residuals under [38 CFR 4.124a, DC 8045](http://www.ecfr.gov/cgi-bin/text-idx?SID=f0aa74b3307a3ad4b8794ead73ecfa75&node=se38.1.4_1124a&rgn=div8).  In every case, one evaluation should be assigned using the highest level of impairment assigned to any facet contained in the table “Evaluation of Cognitive Impairment and Other Residuals of TBI not Otherwise Classified,” which has been incorporated into Veterans Benefits Management System – Rating (VBMS-R).  Additional evaluations may be appropriate to assign as provided in M21-1, Part III, Subpart iv, 4.G.2.h.  ***Note***: A medical classification of severity of the TBI *at the time of the acute trauma* from the TBI event ***has no bearing on evaluation for Department of Veterans Affairs (VA) compensation purposes***. It is not an evaluation factor and is not relevant to the application of the benefit of the doubt rule. Do not imply or state that initial severity classification was given weight in assigning a disability evaluation.  ***References***: For more information on   * evaluating secondary TBI-related conditions, see M21-1, Part III, Subpart iv.4.G.3, * required use of the Evaluation Builder and VBMS-R calculators, see M21-1, Part III, Subpart iv, 6.D.5.c, and * evaluating evidence, see M21-1, Part III, Subpart iv, 5. |

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| h. Multiple Evaluations and Pyramiding in TBI Cases | In addition to the evaluation for TBI manifestations under the table “Evaluation of Cognitive Impairment and Other Residuals of Residuals of TBI Not Otherwise Classified” in [38 CFR 4.124a, DC 8045](http://www.ecfr.gov/cgi-bin/text-idx?SID=061a0b481382fdc4ff5c1697742e7858&node=se38.1.4_1124a&rgn=div8) (and also incorporated into VBMS-R), manifestations of a comorbid mental, neurologic or other physical disorder can be separately evaluated under another DC if there is a distinct diagnosis – even if based on subjective symptoms – and no more than one evaluation is based on the same manifestation(s).  Follow the policy in the table below. |

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| If ... | Then ... |
| manifestations are clearly separable | assign a separate evaluation using each applicable DC. |
| the manifestations of two or more conditions cannot be clearly separated | assign a single evaluation under whichever set of criteria allows the better assessment of the overall impaired functioning due to both conditions. |

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| ***Examples***:   * Assign a separate evaluation under [38 CFR 4.124a, DC 8100](http://www.ecfr.gov/cgi-bin/text-idx?SID=f0aa74b3307a3ad4b8794ead73ecfa75&node=se38.1.4_1124a&rgn=div8) for a distinct comorbid diagnosis of migraine headaches as long as the manifestations do not overlap with those used to assign the evaluation of TBI under [38 CFR 4.124a, DC 8045](http://www.ecfr.gov/cgi-bin/text-idx?SID=061a0b481382fdc4ff5c1697742e7858&node=se38.1.4_1124a&rgn=div8). * Evaluate occasional subjective headaches as part of the TBI evaluation under [38 CFR 4.124a, DC 8045](http://www.ecfr.gov/cgi-bin/text-idx?SID=061a0b481382fdc4ff5c1697742e7858&node=se38.1.4_1124a&rgn=div8) rather than under a separate DC. Occasional subjective headaches are not a distinct comorbid diagnosis. * Assign a separate evaluation under [38 CFR 4.130, DC 9400](http://www.ecfr.gov/cgi-bin/text-idx?SID=58ecf49412cc9b2f5b9f58669425309d&mc=true&node=se38.1.4_1130&rgn=div8) for a distinct comorbid diagnosis of generalized anxiety disorder as long as the manifestations do not overlap with those used to assign the evaluation of TBI under [38 CFR 4.124a, DC 8045](http://www.ecfr.gov/cgi-bin/text-idx?SID=061a0b481382fdc4ff5c1697742e7858&node=se38.1.4_1124a&rgn=div8). * Evaluate subjective feelings of anxiety as part of the TBI evaluation under [38 CFR 4.124a, DC 8045](http://www.ecfr.gov/cgi-bin/text-idx?SID=061a0b481382fdc4ff5c1697742e7858&node=se38.1.4_1124a&rgn=div8) rather than under a separate DC. Subjective feelings of anxiety are not a distinct comorbid diagnosis.   ***Important***:   * If “major or mild neurocognitive disorder due to TBI,” is diagnosed, and the diagnosis is based on the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) criteria, evaluate the condition under [38 CFR 4.130, DC 9304](http://www.ecfr.gov/cgi-bin/text-idx?SID=58ecf49412cc9b2f5b9f58669425309d&mc=true&node=se38.1.4_1130&rgn=div8) as long as there is medical evidence that the manifestations supporting the diagnosis are clearly separable from the TBI. * Tinnitus is discussed in [38 CFR 4.124a, DC 8045](http://www.ecfr.gov/cgi-bin/text-idx?SID=f0aa74b3307a3ad4b8794ead73ecfa75&node=se38.1.4_1124a&rgn=div8) as both a physical disorder that can be evaluated under its DC, and as a subjective symptom. Evaluate tinnitus separately under [38 CFR 4.87, DC 6260](http://www.ecfr.gov/cgi-bin/text-idx?SID=58ecf49412cc9b2f5b9f58669425309d&mc=true&node=se38.1.4_187&rgn=div8) unless a higher overall evaluation is supported by including it with the subjective symptoms facet.   ***References***: For more information on   * the importance on examiner qualifications for TBI cases, see M21-1, Part III, Subpart iv, 3.D.2.g, and * pyramiding see * [38 CFR 4.14](http://www.ecfr.gov/cgi-bin/text-idx?SID=f0aa74b3307a3ad4b8794ead73ecfa75&node=se38.1.4_114&rgn=div8), and * [*Esteban v. Brown*, 6 Vet. App. 259 (1994).](http://vbaw.vba.va.gov/bl/21/advisory/CAVCDAD.htm#bme) |

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| i. Opinion Evidence and Separate Evaluations of TBI and Mental Disorder | Ensure that sufficiently clear and unequivocal *medical opinion evidence* exists in the claims folder whenever there is a question of whether TBI and a mental disorder are distinct and can be separately evaluated. Veterans Benefits Administration (VBA) decision makers are not qualified to make such determinations.  The opinion may be provided by either an examiner assessing the TBI or an examiner assessing the mental disorder as long as the individual offering the opinion is properly qualified.  If a medical provider cannot make the required determination without resorting to mere speculation, then careful consideration must be given to whether that statement can be accepted under [*Jones v. Shinseki*, 23 Vet. App. 382 (2010)](http://vbaw.vba.va.gov/bl/21/advisory/CAVCDAD.htm#bmj). |

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| j. Additional TBI Signs or Symptoms Upon Reevaluation | When considering a claim for reevaluation of TBI, do not automatically concede that a new sign, symptom or diagnosis is a residual of TBI simply because it is listed in M21-1, Part III, Subpart iv, 4.G.2.d or in the evaluation criteria.  If there is not competent evidence that the sign, symptom or diagnosis is associated with the SC TBI, obtain medical clarification. |

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| k. TBI and SMC | Brain injuries may be associated with loss of use of an extremity, sensory impairments, erectile dysfunction, need for regular aid and attendance (including need for protection from hazards of the daily living environment due to cognitive impairment), and being factually housebound or statutorily housebound.  Carefully consider eligibility for special monthly compensation (SMC) when evaluating TBI residuals. |

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| l. Temporary Total Evaluations and TBI | In cases of recently discharged Veterans, consider the applicability of a temporary 50 percent or 100 percent prestabilization evaluation under the provisions of [38 CFR 4.28](http://www.ecfr.gov/cgi-bin/text-idx?SID=f0aa74b3307a3ad4b8794ead73ecfa75&node=se38.1.4_128&rgn=div8).  Lengthy VA hospitalizations or surgeries with convalescence may also implicate consideration of eligibility for temporary total evaluation under [38 CFR 4.29](http://www.ecfr.gov/cgi-bin/text-idx?SID=f0aa74b3307a3ad4b8794ead73ecfa75&node=se38.1.4_129&rgn=div8) and [38 CFR 4.30](http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=15c58a6b52fdac4c03572c4e7534c186&mc=true&r=SECTION&n=se38.1.4_130). |

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| m. Training and Signature Requirements for TBI Decisions | All rating decisions that address TBI as an issue must *only* be worked/reviewed by a Rating Veterans Service Representative (RVSR) or Decision Review Officer (DRO) who has completed the required TBI Training Performance Support System module.  Rating decisions for TBI require two signatures until a decision maker has demonstrated an accuracy rate of 90 percent or greater based on a review of at least 10 TBI cases .  ***Reference***: For more information on two signature requirements in TBI rating decisions, see M21-1, Part III, Subpart iv, 6.D.7.c. |

**3. Secondary Conditions Associated with TBI**

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| **Introduction** | This topic contains information on secondary conditions associated with SC TBI including   * secondary SC under 38 CFR 3.310 * evaluating the initial severity of TBI * using the TBI initial severity table in 38 CFR 3.310 * evidence that may be relevant to the initial severity factors * registry for verifying blast injuries * determination of diagnosable conditions as secondary to TBI * considerations when establishing secondary SC * action when evidence shows a 38 CFR 3.310(d) condition, and * determining effective dates for secondary conditions. |

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| **a. Secondary SC under 38 CFR 3.310** | [38 CFR 3.310(d)](http://www.ecfr.gov/cgi-bin/text-idx?SID=f0aa74b3307a3ad4b8794ead73ecfa75&node=se38.1.3_1310&rgn=div8) was amended on December 17, 2013, to establish an association between TBI and certain illnesses.  In absence of clear evidence to the contrary, the following five diagnosable illnesses are held to be a secondary result of TBI   * Parkinsonism, including Parkinson’s disease, following moderate or severe TBI * unprovoked seizures, following moderate or severe TBI * dementias (presenile dementia of the Alzheimer’s type, frontotemporal dementia, and dementia with Lewy bodies), *if* the condition manifests within 15 years following moderate or severe TBI * depression, *if* the condition manifests within three years of moderate or severe TBI or within 12 months of mild TBI, or * diseases of hormone deficiency that result from hypothalamo-pituitary changes, *if* the condition manifests within 12 months of moderate or severe TBI.   Entitlement to secondary SC for these TBI-related conditions in [38 CFR 3.310(d)](http://www.ecfr.gov/cgi-bin/text-idx?SID=f0aa74b3307a3ad4b8794ead73ecfa75&node=se38.1.3_1310&rgn=div8) depends upon the initial severity of the TBI ***and*** the period of time between the injury and onset of the secondary illness.  ***Important***: There is no need to obtain a medical opinion to determine whether the above conditions are associated with TBI when there is a TBI of a qualifying degree of severity.  ***Notes***:   * Determine the initial severity level of the TBI based on the TBI symptoms at the time of the original injury, or shortly thereafter, rather than the current level of functioning. * Regional offices (ROs) must continue to follow guidance in M21-1 Part III, Subpart iv, 4.G.2 when evaluating residuals of TBI. *However*, ROs must follow guidance in this Topic when establishing secondary SC for claimants who have experienced a TBI in service and later develop one of the five diagnosable conditions listed in [38 CFR 3.310(d)](http://www.ecfr.gov/cgi-bin/text-idx?SID=f0aa74b3307a3ad4b8794ead73ecfa75&node=se38.1.3_1310&rgn=div8). |

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| b. Evaluating the Initial Severity of TBI | For purposes of determining the initial severity of the TBI, consider the factors from the table in [38 CFR 3.310(d)](http://www.ecfr.gov/cgi-bin/text-idx?SID=f0aa74b3307a3ad4b8794ead73ecfa75&node=se38.1.3_1310&rgn=div8). These are   * Structural imaging of the brain such as magnetic resonance imaging (MRIs) or positron emission tomography (PET) scans * loss of consciousness (LOC) * alteration of consciousness/mental state (AOC) including disorientation * post-traumatic amnesia (PTA) including any loss of memory * Glasgow Coma Scale (GCS) which provides a measurement of the degree of coma at or after 24 hours.   The table is reproduced below. |

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| Mild | Moderate | Severe |
| Normal structural imaging | Normal or abnormal structural imaging | Normal or abnormal structural imaging |
| LOC = 0-30 min | LOC >30 min and  < 24 hours | LOC > 24 hours |
| AOC = a moment up to 24 hours | AOC >24 hours. Severity based on other criteria | AOC >24 hours. Severity based on other criteria |
| PTA = 0-1 day | PTA >1 and <7 days | PTA > 7 days |
| CGS=13-15 | CGS=9-12 | CGS=3-8 |

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| ***Reference***: For more information on verifying in-service blast injuries, see M21-1, Part III, Subpart iv, 4.G.3.e. |

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| c. Using the TBI Initial Severity Table in 38 CFR 3.310 | The TBI does ***not*** need to meet *all* the criteria listed under a certain severity level in order to classify the TBI under that severity level.  If the Veteran’s TBI meets the criteria in more than one severity level, evaluate the TBI at the highest level in which a criterion is met.  Because “normal structural imaging,” “abnormal structural imaging” and “AOC greater than 24 hours” may be found at more than one severity level, evaluate severity based on other criteria in the table. If no other criteria are present, then determine the level of severity as follows   * If AOC is greater than 24 hours and no other criteria are present, determine the severity as moderate. * If structural imaging is noted as normal and no other criteria are present, determine the severity as mild. * If structural imaging is noted as abnormal and no other criteria are present, determine the severity as moderate.   If the level of severity cannot be determined based on the available evidence, then apply the provisions of [38 CFR 3.310 (a) and (b)](http://www.ecfr.gov/cgi-bin/text-idx?SID=f0aa74b3307a3ad4b8794ead73ecfa75&node=se38.1.3_1310&rgn=div8) and order a VA examination/medical opinion as necessary. |

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| **d. Evidence That May be Relevant to the Initial Severity Factors** | Evidence that may be relevant in ascertaining the initial severity of TBI symptoms includes   * lay statements provided by the Veteran * lay statements from witnesses to the injury * history provided by the Veteran in medical reports to include VA exams, and   service treatment record (STR) findings at any time after the TBI.  ***Note***: The *evidence* that establishes the initial severity of the TBI does not necessarily have to be contemporaneous to the injury as long as it relates to the condition of TBI at or shortly after the time of the injury.  ***Example***: A Korean War Veteran submits a claim for SC for Parkinsonism secondary to his SC TBI. The Veteran’s discharge examination from 1954 mentions a history of TBI in service. However, it does not contain information sufficient to determine the level of severity of the initial TBI injury. The Veteran provides a statement that he experienced a loss of consciousness during the Battle of Chosin Reservoir. A review of prior VA examination reports reveals a history provided by the Veteran that he was told by fellow soldiers that he fell unconscious for almost an hour after two grenades exploded near him.  ***Analysis:*** Although service records do not reveal the specific level of TBI during service, the Veteran’s statement is credible, consistent with circumstances of his service, and therefore sufficient to determine that he experienced a moderate level of TBI during service. |

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| **e. Registry for Verifying Blast Injuries** | The U.S. Army Medical Research and Materiel Command Joint Trauma Analysis and Prevention of Injury in Combat (JTAPIC) has developed a registry of service members who were within 50 feet of a blast since mid-2010.  When existing Department of Defense (DOD) records, to include service treatment records, are not sufficient to verify exposure to a blast injury that occurred since mid-2010, Compensation Service (CS) will contact JTAPIC to determine if there is a record of exposure.  ***Important***: E-mail the CS Q&A Committee at [CO21Q&A@vba.va.gov](mailto:CO21Q&A@vba.va.gov) if exposure to an in-service blast injury from mid-2010 to the present cannot be verified. Include the following information in the email   * full name of Veteran * claim number and Social Security number (SSN) * branch of service * brief description of the blast injury * location * date of blast/injury, and * unit. |

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| **f. Determination of Diagnosable Conditions as Secondary to TBI** | Use the following table to determine secondary SC for conditions listed in [38 CFR 3.310(d)](http://www.ecfr.gov/cgi-bin/text-idx?SID=f0aa74b3307a3ad4b8794ead73ecfa75&node=se38.1.3_1310&rgn=div8). |

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| If there is a diagnosis of… | And the initial severity of the TBI was … | Then… |
| Parkinsonism, including Parkinson’s disease | moderate or severe | grant service connection. |
| unprovoked seizures, | moderate or severe | grant service connection. |
| dementia (presenile dementia of the Alzheimer type or post-traumatic dementia) | moderate or severe | grant service connection if dementia *manifested within 15 years* after the TBI. |
| depression | moderate or severe, mild, | grant service connection if depression *manifested within three years* after the TBI. |
| mild | grant service connection if depression *manifested within one year* after the TBI. |
| a disease of hormone deficiency that results from hypothalamo-pituitary changes (any condition in the endocrine system section of the rating schedule, [38 CFR 4.119, DCs 7900-7912](http://www.ecfr.gov/cgi-bin/text-idx?SID=4c6d208f5cda0391a07057c813d24e2f&mc=true&node=se38.1.4_1119&rgn=div8), or any condition evaluated analogous to one of those conditions), | moderate or severe | grant service connection if the condition *manifested within one year* after the TBI |

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| **g. Considerations When Establishing Secondary SC** | When evaluating TBI-related secondary conditions, avoid pyramiding when considering the initial TBI evaluation and symptoms that are now associated with the five secondary conditions. Also, consider Notes 1 and 2 under [38 CFR 4.124a, DC 8045](http://www.ecfr.gov/cgi-bin/text-idx?SID=061a0b481382fdc4ff5c1697742e7858&node=se38.1.4_1124a&rgn=div8), while ensuring that the claimant receives the highest overall evaluation under the provisions of [38 CFR 4.25](http://www.ecfr.gov/cgi-bin/text-idx?SID=2c083629815e61850d4f981fea53b185&node=se38.1.4_125&rgn=div8) (Combined Ratings Table).  Depending on the most advantageous combined evaluation, it is permissible to reduce an existing TBI evaluation as long as the overall evaluation of both TBI and the separate secondary SC condition is not reduced. Use the combinator tool in VBMS-R to determine the combined evaluation of TBI and the secondary SC condition. Thoroughly explain the decision narrative in the rating decision.  Consider symptoms which apply to both TBI and the secondary conditions as follows |

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| If ... | Then ... |
| the symptoms associated with one of the five conditions were also used to provide the highest level of evaluation for any facet under [38 CFR 4.124a, DC 8045](http://www.ecfr.gov/cgi-bin/text-idx?SID=061a0b481382fdc4ff5c1697742e7858&node=se38.1.4_1124a&rgn=div8) | * consider removing evaluation of the facet, and * use the next highest-evaluated facet as the evaluation for the TBI residuals, *as long as* the symptoms of that facet are not used to establish service connection for one of the five diagnosable conditions. |
| the same symptoms apply to both disabilities | * evaluate the evidence and determine whether the symptoms can be entirely associated with one disability versus the other disability, and * do not request an additional medical examination for this determination. If it is unclear, assume that the manifestations are not separable. |
| the same symptoms apply to both disabilities, and the symptoms are clearly associated with one disability versus the other disability | select the most advantageous option from the following   |  |  | | --- | --- | | 1 | * remove symptoms from the TBI facet * evaluate the TBI under the next highest-evaluated facet that does not contain those symptoms * grant secondary SC for the diagnosable condition, and * evaluate the secondary condition using those symptoms. | | 2 | * keep the symptoms under the TBI facet, and * do ***not*** grant secondary SC for the diagnosable condition, *but* * ensure the diagnosable condition is included with the description of the SC TBI disability in the rating decision. | | 3 | * keep the symptoms under the TBI facet * grant secondary SC for the diagnosable condition, and * evaluate based on the distinct symptoms. | |

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| ***Reference***: For more information on evaluating TBI residuals, see M21-1, Part III, Subpart iv, 4.G.2.g. |

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| **h. Action When Evidence Shows a 38 CFR 3.310(d) Condition** | Use the table below to determine how to proceed when evidence shows one of the five diagnosable conditions in [38 CFR 3.310(d)](http://www.ecfr.gov/cgi-bin/text-idx?SID=2c083629815e61850d4f981fea53b185&node=se38.1.3_1310&rgn=div8). |

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| If ... | Then ... |
| one of the five diagnosable conditions in [38 CFR 3.310(d)](http://www.ecfr.gov/cgi-bin/text-idx?SID=2c083629815e61850d4f981fea53b185&node=se38.1.3_1310&rgn=div8) is identified in the evidence of record while processing a claim *unrelated* to SC TBI | a claim for that secondary condition ***must*** be invited. |
| evidence shows one of the five diagnosable conditions while evaluating a claim *related* to SC TBI | develop under normal claim processing procedures and make a determination on the secondary condition under the provisions of [38 CFR 3.310](http://www.ecfr.gov/cgi-bin/text-idx?SID=2c083629815e61850d4f981fea53b185&node=se38.1.3_1310&rgn=div8)(d). |

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| **i. Determining Effective Dates for Secondary Conditions** | The rule authorizing VA to establish the five secondary TBI-related conditions in [38 CFR 3.310](http://www.ecfr.gov/cgi-bin/text-idx?SID=2c083629815e61850d4f981fea53b185&node=se38.1.3_1310&rgn=div8) is effective, January 16, 2014.  This rule will be applied to all cases pending before VA on or after, January 16, 2014, and *does* constitute a liberalizing VA regulation under [38 U.S.C. 5110(g)](http://uscode.house.gov/view.xhtml?req=(title:38%20section:5110%20edition:prelim)%20OR%20(granuleid:USC-prelim-title38-section5110)&f=treesort&edition=prelim&num=0&jumpTo=true) and [38 CFR 3.114](http://www.ecfr.gov/cgi-bin/text-idx?SID=2c083629815e61850d4f981fea53b185&node=se38.1.3_1114&rgn=div8). Apply these principles when determining effective dates and retroactive benefits. |

#### 4. Peripheral Nerves

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| **Introduction** | This topic contains information on evaluating peripheral nerves, including   * considering the complete findings when evaluating incomplete paralysis * assigning level of incomplete paralysis * nerve branches of the lower extremities for which separate evaluations may be assigned * assigning separate evaluations for lower extremity peripheral nerves * determining individual nerves affected in the lower extremities when evaluating disabilities, and * electromyelogram (EMG)and other tests for peripheral nerve conditions. |

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| **Change Date** | June 15, 2015 |

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| a. Considering the Complete Findings When Evaluating Incomplete Paralysis | Evaluation Builder entries must be based upon the *complete findings*of the Disability Benefits Questionnaire (DBQ) and/or evidentiary record *and* must not be based solely upon the examiner’s assessment of the level of incomplete paralysis. See [*Moore v. Nicholson*, 21 Vet.App. 211 (2007)](http://vbaw.vba.va.gov/bl/21/advisory/CAVCDAD.htm#bmm).  The examiner’s clinical assessment of the extent of incomplete paralysis, as indicated on the DBQ, may be inconsistent with or appear to contradict the objective findings that are documented in other sections of the DBQ or other evidence of record.  ***Important***: The rating activity, not the examining medical professional, determines whether the overall evidentiary record shows the severity of the condition meets the criteria for a classification of mild, moderate, or severe.  ***Example 1***: An examiner assesses the peripheral nerve disability as “mild incomplete paralysis.” However, the DBQ shows muscle weakness, atrophy, and diminished reflexes, which are clearly demonstrative of more than mild incomplete paralysis. In this case, the complete evidentiary record shows the condition is more than mild under guidance contained in [38 CFR 4.124](http://www.ecfr.gov/cgi-bin/text-idx?SID=061a0b481382fdc4ff5c1697742e7858&node=se38.1.4_1124&rgn=div8) and therefore warrants a higher evaluation.  ***Example 2***: An examiner renders an assessment of “severe incomplete paralysis” when the objective test results are wholly sensory. Therefore the condition warrants an evaluation no higher than moderate incomplete paralysis under [38 CFR 4.124a](http://www.ecfr.gov/cgi-bin/text-idx?SID=061a0b481382fdc4ff5c1697742e7858&node=se38.1.4_1124a&rgn=div8).  ***Reference***: For more information on interpretation of examination reports see, [38 CFR 4.2](http://www.ecfr.gov/cgi-bin/text-idx?SID=061a0b481382fdc4ff5c1697742e7858&node=se38.1.4_12&rgn=div8). |

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| b Assigning Level of Incomplete Paralysis | The table below provides a general description of each level of incomplete paralysis of the upper and lower peripheral nerves. |

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| Degree of Incomplete Paralysis | Description |
| Mild | subjective symptoms or diminished sensation |
| Moderate | absence of sensation confirmed by objective findings |
| Severe | more than sensory findings are demonstrated, such as atrophy, weakness, and diminished reflexes. |

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| ***Notes***:   * Always consider the specific criteria in the [38 CFR 4.124a](http://www.ecfr.gov/cgi-bin/text-idx?SID=061a0b481382fdc4ff5c1697742e7858&node=se38.1.4_1124a&rgn=div8) DC at issue as well as the general guidance on neuritis and neuralgia under [38 CFR 4.123](http://www.ecfr.gov/cgi-bin/text-idx?SID=061a0b481382fdc4ff5c1697742e7858&node=se38.1.4_1123&rgn=div8) and [38 CFR 4.124](http://www.ecfr.gov/cgi-bin/text-idx?SID=061a0b481382fdc4ff5c1697742e7858&node=se38.1.4_1124&rgn=div8). * This guidance also applies to radiculopathy, which is evaluated under a peripheral nerve code. * Separate evaluations may not be assigned when evaluating an upper extremity peripheral nerve disability. See note under [38 CFR 4.124a, DC 8719](http://www.ecfr.gov/cgi-bin/text-idx?SID=061a0b481382fdc4ff5c1697742e7858&node=se38.1.4_1124a&rgn=div8). |

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| c. Nerve Branches of the Lower Extremities for Which Separate Evaluations May be Assigned | The following table lists the five nerve branches of the lower extremities for which separate evaluations may be assigned. See M21-1, Part III, Subpart iv, 4.G.4.d for rating guidance on assigning separate evaluations for nerve conditions of the lower extremities.  To assist in evaluating these nerves, the table below also includes any associated nerves in each branch, corresponding DCs under [38 CFR 4.124a](http://www.ecfr.gov/cgi-bin/text-idx?SID=993c22295f9daae770ddf81859d7bcab&mc=true&node=se38.1.4_1124a&rgn=div8), and the general functions covered by each nerve branch. |

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| Lower Extremity Nerve Branches | Function |
| ***Sciatic***   * sciatic nerve (DCs 8520, 8620, and 8720) * external popliteal nerve (common peroneal) (DCs 8521, 8621, and 8721) * musculocutaneous nerve (superficial peroneal) (DCs 8522, 8622, and 8722) * anterior tibial nerve (deep peroneal) (DCs 8523, 8623, 8723) * internal popliteal nerve (tibial) (DCs 8524, 8624, and 8724), and * posterior tibial nerve (DCs 8525, 8625, and 8725). | foot and leg sensory and motor function of the   * buttock * leg * knee * muscles below knee * lower leg * fibula * foot, muscles of foot, sole of foot, plantar flexion, and * toes. |
| ***Femoral***   * anterior crural nerve (femoral) (DCs 8526, 8626, and 8726) * internal saphenous nerve (DCs 8527, 8627, and 8727) | thigh and leg sensory and motor function of the   * quadriceps muscle, front of thigh * medial calf, and * medial malleolus. |
| ***Obturator*** (DCs 8528, 8628, and 8728) | Motor and sensory function of the   * hip and muscles of the hip, and * medial thigh. |
| ***External cutaneous nerve of thigh*** (DCs8529, 8629, and 8729) | Sensory function of the lateral thigh. |
| ***Illio-inguinal nerve*** (DCs 8530, 8630, and 8730) | Motor and sensory function of the   * lower abdominal wall * thigh * scrotum, and * labia majora. |

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| d. Assigning Separate Evaluations for Lower Extremity Peripheral Nerves | Unlike the upper extremities, separate evaluations of the lower extremities may be assigned for symptoms that are separate and distinct, do not overlap, and are attributed to different lower extremity nerves. This means that separate evaluations ***are*** warranted when symptoms arise from any of the five nerve branches listed in the table in M21-1, Part III, Subpart iv, 4.G.4.c.  If symptoms arise from within the same nerve branch of any of the five individual nerve branches in the lower extremity, assigning separate evaluations for those symptoms ***are not*** warranted as this would constitute pyramiding.  ***Example 1:*** ***Separate Evaluations Warranted***  A Veteran has severe incomplete paralysis of the *common peroneal nerve* and mild incomplete paralysis of the *femoral nerve*. Assign separate evaluations of 30 percent under [38 CFR 4.124a, DC 8521](http://www.ecfr.gov/cgi-bin/text-idx?SID=061a0b481382fdc4ff5c1697742e7858&node=se38.1.4_1124a&rgn=div8) and 10 percent under [38 CFR 4.124a, DC 8526](http://www.ecfr.gov/cgi-bin/text-idx?SID=061a0b481382fdc4ff5c1697742e7858&node=se38.1.4_1124a&rgn=div8).  ***Analysis***: The common peroneal nerve is part of the sciatic branch and the femoral nerve is part of the femoral branch. The functions for these branches are separate and distinct and therefore warrant separate evaluations.  ***Example 2: Separate Evaluations Not Warranted***  A Veteran has severe incomplete paralysis of the common peroneal nerve under DC 8521 and moderate incomplete paralysis of the tibial nerve under DC 8524. In this case, a single 30 percent evaluation is assigned under DC 8521.  ***Analysis***: Both of these nerves are part of the same sciatic branch, and therefore the functions associated with these nerves are not separate and distinct. The 30 percent evaluation shall be assigned under DC 8521 since it represents the predominant disability.  ***Note***: The amputation rule under [38 CFR 4.68](http://www.ecfr.gov/cgi-bin/text-idx?SID=061a0b481382fdc4ff5c1697742e7858&node=se38.1.4_168&rgn=div8) is ***not*** applied in evaluating peripheral nerves of the lower extremity as long as separate evaluations are warranted, as described above.  ***References***: For more information about   * separate evaluations and pyramiding, see M21-1, Part III, Subpart iv, 6.C.5.d, and * nerve branches of the lower extremities, see M21-1, Part III, Subpart iv, 4.G.4.c |

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| **e. Determining Individual Nerves Affected in the Lower Extremities When Evaluating Disabilities** | When evaluating peripheral nerve disabilities of the lower extremities, the rating activity must conduct a thorough review of the medical evidence of record to determine the individual nerve(s) affected.  VA examiners are required to select the individual nerves affected when completing DBQs. However, the examiner may not necessarily conduct a review of all previous clinical records or perform comprehensive tests to pinpoint the exact nerve and/or symptoms attributable to that nerve.  ***Important***: It is the responsibility of the rating activity, in accordance with [38 CFR 4.2](http://www.ecfr.gov/cgi-bin/text-idx?SID=993c22295f9daae770ddf81859d7bcab&mc=true&node=se38.1.4_12&rgn=div8), to interpret the DBQ along with the whole recorded history, and accurately identify and assess the current level of peripheral nerve disability. This includes identifying the appropriate nerve from a review of the evidence so that the appropriate evaluation can be assigned.  Follow the guidance in the table below when reviewing medical evidence pertaining to peripheral nerve disabilities of the lower extremity. |

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| **If the DBQ or equivalent…** | **And…** | **Then…** |
| indicates the specific nerve affected | there is no conflicting information | evaluate the specific nerve under the appropriate DC. |
| indicates the specific nerve affected | there is conflicting information on what nerve is affected, but the nerves identified are within the same nerve branch | evaluate the nerve that is most beneficial to the Veteran as long as the DC supports the symptoms. |
| indicates the specific nerve(s) affected | the identified nerves are in different nerve branches; however, the symptoms identified in the medical evidence are not clearly associated with an individual nerve | evaluate all symptoms shown in the medical evidence for the individual nerve(s) in the associated nerve branches. |
| does not specify the affected nerve(s) | there is no other evidence adequately documenting the affected nerve | seek clarification from the medical examiner. |

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| ***Note***: The nerve branches and general functions of the nerve branches are described in the table found in M21-1, Part III, Subpart iv, 4.G.4.c. |

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| f. EMG and Other Tests for Peripheral Nerve Conditions | Electromyelogram (EMG) test results are required for evaluations of peripheral nerve disabilities unless there is a previous EMG test of record *or* the record contains sufficient clinical evidence to determine the extent of paralysis in the peripheral nerve.  As noted in the Peripheral Nerves DBQ, EMG studies are usually rarely required to diagnose specific peripheral nerve conditions in the appropriate clinical setting and, if EMG studies are in the medical record and reflect the Veteran's current condition, repeat studies are not indicated.  ***Important***: Ultimately, it is the role of the rating activity to determine if the examination was sufficient to confirm the question and extent of peripheral nerve involvement.    ***Note***: Other clinical findings that may be sufficient to document a peripheral nerve disability include   * sensation to light touch testing, * deep tendon reflex testing, * certain signs for the median nerve, * trophic changes, * gait testing, * muscle strength testing, and * the presence of muscle atrophy. |

#### 5. Multiple Sclerosis

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| Introduction | This topic contains information about multiple sclerosis (MS), including   * the definition of ***multiple sclerosis*** * evaluating a residual MS disability 30 percent or more * example of evaluating residual MS disability 30 percent or more, and * presumptive SC for MS. |

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| Change Date | June 15, 2015 |

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| a. Definition: Multiple Sclerosis | ***Multiple sclerosis*** (MS) is a slowly progressive central nervous system disease, and is characterized by   * disseminated patches of demyelination in the brain and spinal cord which cause multiple and varied neurologic symptoms and signs, and * the occurrence of remissions and exacerbations in the symptoms. |

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| b. Evaluating a Residual MS Disability 30 Percent or More | In cases of multiple sclerosis   * evaluate each affected system or body part separately * show the DC for MS only once by listing it with the most severely affected function * code involvement of other manifestations thereafter under the DC assignable for the condition on which the evaluation is based, and * show the remaining conditions as secondary to multiple sclerosis.   ***Notes***:   * This is a change from the previous requirement to evaluate MS as a single disability when the combined degree was less than 100 percent. * If the combined evaluation for all disabilities due to MS is 20 percent or less, assign a 30 percent evaluation under [38 CFR 4.124a, DC 8018](http://www.ecfr.gov/cgi-bin/text-idx?SID=061a0b481382fdc4ff5c1697742e7858&node=se38.1.4_1124a&rgn=div8).   ***Important***: Readjudicate cases previously evaluated as a single disability as they are encountered under the procedure outlined above. |

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| c. Example of Evaluating Residual MS Disability 30 Percent or More | This exhibit contains an example of evaluating a residual MS disability 30 percent or more. |

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| ***Coded Conclusion:*** |  |
| 1. SC (KC PRES) |  |
| 8018-7512  40% from 12-10-81 | Multiple sclerosis with bladder dysfunction |
|  |  |
| 8521  10% from 12-10-81 | Weakness of right lower extremity secondary to multiple sclerosis |
|  |  |
| 8521  10% from 12-10-81 | Weakness of left lower extremity secondary to multiple sclerosis |
|  |  |
| 7523  0% from 12-10-81 | Impotency without penile deformity, secondary to multiple sclerosis |
|  |  |
| COMB: | 50% from 12-10-81 |
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| 43. Bilateral Factor of 1.9% added for diagnostic codes 8521 and 8521 |

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| K-1 | Entitled to special monthly compensation under 38 U.S.C. 1114, subsection (k) and 38 CFR 3.350(a) on account of loss of use of a creative organ from 12-10-81. |

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| ***Note***: SMC coding is 01-01-00-00-1. |

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| **d. Presumptive Service Connection for MS** | Presumptive service connection may be established for MS if the disease becomes manifest within 7 years from the date of separation.  ***Reference***: For more information on requirements for establishment of presumptive service connection, see [38 CFR 3.307(a)](http://www.ecfr.gov/cgi-bin/text-idx?SID=061a0b481382fdc4ff5c1697742e7858&node=se38.1.3_1307&rgn=div8) and [38 CFR 3.309](http://www.ecfr.gov/cgi-bin/text-idx?SID=039d52e6f928e64a4c69be720bd18f4e&mc=true&node=se38.1.3_1309&rgn=div8). |

**6. ALS**

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| **Introduction** | This topic contains information about ALS to include   * definition of ALS * establishing presumptive service connection for ALS * assigning a 100-percent minimum evaluation for ALS * evaluation guidelines for ALS, and * ALS and ancillary benefits |

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| **Change Date** | June 15, 2015 |

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| a. Definition of ALS | ***Amyotrophic lateral sclerosis*** (ALS), also called Lou Gehrig’s disease, is a neuromuscular disease that causes degeneration of nerve cells in the brain and spinal cord, resulting in muscle weakness, muscle atrophy, and spontaneous muscle activity. |

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| b. Establishing Presumptive SC for ALS | Effective September 23, 2008, [38 CFR 3.318](http://www.ecfr.gov/cgi-bin/text-idx?SID=061a0b481382fdc4ff5c1697742e7858&node=se38.1.3_1318&rgn=div8) established a presumption of SC for ALS for any Veteran who   * had active, continuous service of 90 days or more, and * develops the disease at any time after discharge from active service |

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| c. Assigning a 100 Percent Minimum Evaluation for ALS | ALS is evaluated under [38 CFR 4.124a, DC 8017](http://www.ecfr.gov/cgi-bin/text-idx?SID=f0aa74b3307a3ad4b8794ead73ecfa75&node=se38.1.4_1124a&rgn=div8).  Effective January 19, 2012, the diagnostic criteria for ALS was amended in [38 CFR 4.124a](http://www.ecfr.gov/cgi-bin/text-idx?SID=9848eb68e4a8ab1f8810e3e8a8acd53c&node=se38.1.4_1124a&rgn=div8) to provide a 100 percent evaluation for any Veteran with SC ALS. A diagnosis of ALS alone is sufficient to support an evaluation of 100 percent. A total disability evaluation is the minimum evaluation to be assigned for ALS because of the possibility of SMC and automatic entitlement to ancillary benefits.  ***Note***: This rule will be applied to all cases pending before VA on or after, January 19, 2012, and ***does*** constitute a liberalizing VA regulation under [38 U.S.C. 5110(g)](http://uscode.house.gov/view.xhtml?req=(title:38%20section:5110%20edition:prelim)%20OR%20(granuleid:USC-prelim-title38-section5110)&f=treesort&edition=prelim&num=0&jumpTo=true) and [38 CFR 3.114](http://www.ecfr.gov/cgi-bin/text-idx?SID=2c083629815e61850d4f981fea53b185&node=se38.1.3_1114&rgn=div8) for determination of effective dates and retroactive benefits. |

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| d. Evaluation Guidelines for ALS | Determine the proper evaluation for all complications of ALS prior to coding a single 100 percent evaluation under [38 CFR 4.124a, DC 8017](http://www.ecfr.gov/cgi-bin/text-idx?SID=f0aa74b3307a3ad4b8794ead73ecfa75&node=se38.1.4_1124a&rgn=div8). Refer to the table below for guidance. |

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| If ... | Then ... |
| there is no complication warranting a single 100 percent evaluation | * assign a 100 percent evaluation under [38 CFR 4.124a, DC 8017](http://www.ecfr.gov/cgi-bin/text-idx?SID=f0aa74b3307a3ad4b8794ead73ecfa75&node=se38.1.4_1124a&rgn=div8), and * include all compensable complications in the description of the diagnosis.   ***Example***: ALS with loss of use of the left foot and partial ninth cranial nerve paralysis. |
| a single 100 percent evaluation is warranted for a complication of ALS | * assign a 100 percent evaluation for that complication. * Use a hyphenated DC. * ***Example***: 8017-5110, loss of use of both feet. * separately evaluate additional complications. * Do not assign a separate evaluation under [38 CFR 4.124a, DC 8017](http://www.ecfr.gov/cgi-bin/text-idx?SID=f0aa74b3307a3ad4b8794ead73ecfa75&node=se38.1.4_1124a&rgn=div8) alone; this would be pyramiding under [38 CFR 4.14](http://www.ecfr.gov/cgi-bin/text-idx?SID=061a0b481382fdc4ff5c1697742e7858&node=se38.1.4_114&rgn=div8)***.***   ***Note***: A 100 percent evaluation for a complication of ALS satisfies the policy that all ALS grants will be assigned at least a 100 percent evaluation. |

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| e. ALS and Ancillary Benefits | Consider eligibility for SMC and/or other ancillary benefits in all ALS cases.   * Ensure the codesheet reflects all complications that can be separately evaluated. * Entitlement to SMC at the statutory housebound rate may be warranted when * ALS and complications are assigned one 100 percent evaluation under [38 CFR 4.124a, DC 8017](http://www.ecfr.gov/cgi-bin/text-idx?SID=061a0b481382fdc4ff5c1697742e7858&node=se38.1.4_1124a&rgn=div8) and the combined evaluation of other SC conditions totals 60 percent or higher, or * an ALS complication is evaluated as 100 percent disabling and the combined evaluation of other SC conditions, including additional separately-evaluated complications of ALS, total 60 percent or higher. * Entitlement to SMC, such as SMC K for loss of use of a foot, may still be warranted when one total disability evaluation is assigned for ALS and all complications under [38 CFR 4.124a, DC 8017](http://www.ecfr.gov/cgi-bin/text-idx?SID=f0aa74b3307a3ad4b8794ead73ecfa75&node=se38.1.4_1124a&rgn=div8). * Effective December 3, 2013, [38 C.F.R. 3.809d](http://www.ecfr.gov/cgi-bin/text-idx?SID=061a0b481382fdc4ff5c1697742e7858&node=se38.1.3_1809&rgn=div8) provides that SC ALS is a qualifying condition for the purpose of entitlement to specially adapted housing. * Effective February 25, 2015, [38 CFR 3.808](http://www.ecfr.gov/cgi-bin/text-idx?SID=061a0b481382fdc4ff5c1697742e7858&node=se38.1.3_1808&rgn=div8) provides that SC ALS is a qualifying condition for entitlement to a certificate of eligibility for automobile or other conveyance and adaptive equipment. The amendment applies to all applications pending before VA on, or received after, February 25, 2015.   ***References***: For more information on   * SMC, see M21-1 Part IV, Subpart ii, 2.H, * ancillary benefits, see M21-1 Part III, Subpart ii, 2.A.4 * specially adapted housing or special home adaptation grants, see M21-1 Part IX, Subpart i, 3 and * automobile allowance and adaptive equipment, see M21-1 Part IX, Subpart i, 2. |

**7. Migraine Headaches**

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| **Introduction** | This topic contains information on migraine headaches, including   * evaluation criteria for migraine headaches * DC 8100 terminology: *prostrating* and *completely prostrating* * the role of medical evidence in establishing the fact of prostration * lay evidence of prostration from migraine headaches * DC 8100 terminology: *severe economic inadaptability* * DC 8100 terminology: *less frequent* and *very frequent* * frequency determinations: types of proof, and * headache journals. |

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| **Change Date** | June 15, 2015 |

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| a. Evaluation Criteria for Migraine Headaches | Migraine headaches are evaluated under the criteria of [38 CFR 4.124a, DC 8100](http://www.ecfr.gov/cgi-bin/text-idx?SID=061a0b481382fdc4ff5c1697742e7858&node=se38.1.4_1124a&rgn=div8). Evaluations depend primarily on the frequency of attacks and the degree to which symptoms are prostrating. The extent to which the headaches cause work impairment is also a factor and is considered for the 50 percent evaluation. |

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| b. DC 8100 Terminology: Prostrating and Completely Prostrating | ***Prostrating***, as used in [38 CFR 4.124a, DC 8100](http://www.ecfr.gov/cgi-bin/text-idx?SID=061a0b481382fdc4ff5c1697742e7858&node=se38.1.4_1124a&rgn=div8), means “causing extreme exhaustion, powerlessness, debilitation or incapacitation with substantial inability to engage in ordinary activities.”  ***Completely prostrating*** as used in [38 CFR 4.124a, DC 8100](http://www.ecfr.gov/cgi-bin/text-idx?SID=061a0b481382fdc4ff5c1697742e7858&node=se38.1.4_1124a&rgn=div8), means extreme exhaustion or powerlessness with *essentially total* inability to engage in ordinary activities. |

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| c. The Role of Medical Evidence in Establishing the Fact of Prostration | Although prostration is substantially defined by how the disabled individual subjectively feels and functions when having migraine headache symptoms, medical evidence is required to establish that the reported symptoms are due to the SC migraine headaches.  The following is an example of a medical statement that would ordinarily establish the fact of prostration if the medical report and the history provided by the claimant are both credible.  *The patient reports symptoms of severe head pain, blurred vision, nausea and vomiting, and being unable to tolerate light or noise, worsened by most activities including reading, writing, and engaging in conversations or physical activities. When experiencing these symptoms, the patient only sleeps or rests. The symptoms reported by the patient are consistent with the diagnosis of migraine headaches and the reported limitations are consistent with those seen in patients suffering from migraine headaches of similar clinical severity.*  ***Note***: Medical reports may not use the word “prostration.” However this is an adjudicative determination based on the extent to which the facts meet the definition of the term. |

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| d. Lay Evidence of Prostration from Migraine Headaches | A claimant’s own testimony regarding his or her symptoms *and* limitations when having those symptoms can establish prostration as long as the testimony is credible and symptoms are otherwise competently attributed to migraine headaches through medical evidence.  ***Example***: A claimant provides testimony that he/she 1) experiences severe headaches and vomiting when exposed to light; 2) does not engage in any activities when this occurs; and 3) must rest or sleep during these episodes. If there is medical evidence that the claimant’s description of symptoms are in fact symptoms of migraine headaches, a determination that the headaches cause prostration can be made.  ***Reference***: For more information on competency of lay testimony see   * M21-1, Part III, Subpart iv, 5, and * [*Espiritu v. Derwinski*](http://vbaw.vba.va.gov/bl/21/advisory/CAVCDAD.htm#bme)*,* 2 Vet. App. at 494. |

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| e. DC 8100 Terminology: Severe Economic Inadaptability | ***Severe economic inadaptability*** denotes a degree of substantial work impairment. It *does not* mean the individual is incapable of any substantially gainful employment. Evidence of work impairment includes, but is not necessarily limited to, the use of sick leave or unpaid absence.  ***Note***: In cases where migraine headaches meet the criterion of severe economic inadaptability and, additionally, the evidence shows that the claimant is incapable of substantially gainful employment due to the headaches, referral for consideration of an extraschedular award of a total evaluation based on individual unemployability is appropriate.  ***Reference***: For more information on severe economic inadaptability, see [*Pierce v. Principi*, 18 Vet.App 440 (2004)](http://vbaw.vba.va.gov/bl/21/advisory/CAVCDAD.htm#bmp). |

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| f. DC 8100 Terminology: Less Frequent and Very Frequent | [38 CFR 4.124a, DC 8100](http://www.ecfr.gov/cgi-bin/text-idx?SID=061a0b481382fdc4ff5c1697742e7858&node=se38.1.4_1124a&rgn=div8) does not define the terms ***less frequent*** for the 0 percent criterion or ***very frequent*** for the 50 percent criterion. However, the overall rating criteria structure for migraine headaches provides a basis for guidance.  As noted in [38 CFR 4.124a, DC 8100](http://www.ecfr.gov/cgi-bin/text-idx?SID=061a0b481382fdc4ff5c1697742e7858&node=se38.1.4_1124a&rgn=div8), the 10 percent evaluation specifies  average frequency (“averaging one in 2 months over the last several months”), which is half of what is required for a 30 percent evaluation (“on average once a month over the last several months”).  For definitions of the terms ***less frequent*** and ***very frequent***, refer to the table  below |

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| **Term** | **Evaluation Level** | **Definition** |
| ***less frequent*** | 0 percent | Duration of characteristic prostrating attacks, on average, are more than 2 months apart over the last several months. |
| ***very frequent*** | 50 percent | Duration of characteristic prostrating attacks, on average, are less than one month apart over the last several months. |

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| g. Frequency Determinations: Types of Proof | Frequency of migraine headache attacks or episodes is a factual determination. Analyze all evidence in the record bearing on the question.  Probative evidence may include   * medical progress notes * competent and credible lay evidence on how often the claimant experiences symptoms (as long as those symptoms have been competently identified as symptoms of migraine headaches) * contemporaneous notes (a headache journal) * prescription refills, and * witness statements.   ***Note***: The absence of treatment reports is not necessarily probative on the question of headache frequency as a claimant may not seek treatment for headaches during every episode.  ***Reference***: For more evidence on evaluating evidence, including competency and credibility, see M21-1, Part III, Subpart iv, 5. |

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| h. Headache Journals | Headache journals, which routinely and relatively contemporaneously record headache episodes, may be accepted as credible lay testimony regarding     * headache frequency * prostration, and * occupational impairment, (e.g., sick leave due to headaches).   ***Note:*** Headaches recorded on non-work days may be used to prove frequency and prostration. However, they will not generally be relevant to work availability, and performance or limitations, which are considerations in determining severe economic inadaptability. |