


**Servicemembers' Group Life Insurance Traumatic Injury  
(TSGLI) Protection Program**  
YEAR-TEN REVIEW



# Table of Contents

1	Program Overview	1
2	Legislative and Regulatory History	2
2.1	Original Legislation and Regulation	2
2.2	Expansion of Losses	2
2.3	Legislation to Eliminate Theater Limitation for Retroactive Claims	2
2.4	Genitourinary Losses	2
3	Year-Ten Review Background	3
3.1	Pre-Review Study	3
3.2	Objectives	3
3.3	Focal Areas	3
3.4	Scope and Methodology	4
4	Loss Standards: Findings and Recommendations	5
4.1	Limb Salvage	5
4.2	Facial Reconstruction	6
4.3	Hospitalization/Loss of Activities of Daily Living	7
4.4	Burns	8
4.5	Amputation of Heel	10
5	Process: Findings and Recommendations	11
5.1	Clarify the Term "Direct Result"	11
5.2	Clarify the Application of the Benefit of the Doubt	11
5.3	Clarify the Appeals Process	12
5.4	Do Not Establish a Statute of Limitations for Filing Claims	13
5.5	Formalize TSGLI Training Protocol	14
5.6	Increase Use of Technology to Perform TSGLI Quality Reviews	14
5.7	Increase Access to TSGLI Program Data by Branches of Service	15
5.8	Increase Interaction between TSGLI Organizations	15
6	Forms: Findings and Recommendations	16
6.1	Require Supporting Evidence with the TSGLI Claim Form	16
6.2	Create a New TSGLI Appeal Form	17
6.3	Consolidate Hospitalization and Loss Sections of TSGLI Claim Form	17
6.4	Change Layout of Loss Standards on Part B of TSGLI Claim Form	18
6.5	Add Reserve/Guard/Active Duty Indicators on TSGLI Certification Worksheet	18
6.6	Add Code 13 to TSGLI Certification Worksheet	19
6.7	Include Information on Additional Insurance Benefits with TSGLI Letters	19
7	Exclusions: Finding and Recommendations	20
7.1	Misdemeanors	20



8	Traumatic Events: Findings and Recommendations	21
8.1	Complications From Surgery Resulting from a Traumatic Event	21
8.2	Non-Penetrating Blast Wave Impacts	21
8.3	Bites and Anaphylaxis	22
8.4	Heat Stroke and Frostbite	22
8.5	External Force	23
9	TSGLI Petition for Rulemaking	24
10	Appendices	25
10.1	Comparing Current TSGLI Loss Standards to Recommended Standards	25
10.2	Glossary	32
10.3	References	35
10.4	Contact Information	39

# 1. Program Overview

The Servicemembers' Group Life Insurance Traumatic Injury (TSGLI) protection program provides severely injured Servicemembers who suffer a loss as a direct result of a traumatic injury with short-term monetary assistance to lessen the economic burden on them and their families. The program is broadly modeled after commercial Accidental Death and Dismemberment (AD&D) insurance, specifically, the "dismemberment" portion of the coverage, while accounting for the unique needs of military personnel.

TSGLI provides payments ranging from \$25,000 to \$100,000 for a range of losses, including but not limited to:

- total and permanent loss of
  - sight (in one or both eyes),
  - hearing (in one or both ears), or
  - speech;
- loss of hand or foot by severance at or above the wrist or ankle;
- 2nd degree or worse burns, covering 20 percent of the body or 20 percent of the face; or
- the inability to perform a least two activities of daily living (ADL) due to a traumatic brain injury (TBI) or other traumatic injury (OTI).

TSGLI coverage is automatic upon entering service, as a rider to Servicemembers' Group Life Insurance (SGLI) coverage<sup>1</sup>. Servicemembers cannot decline TSGLI unless they also decline SGLI. Premiums for TSGLI are currently \$1.00 per month for those with full-time SGLI coverage

Although TSGLI pays benefits for traumatic injuries, it is not a compensation program, disability insurance program, an injury bonus or gratuity program. These programs, whether in the military, VA or civilian world have separate eligibility criteria from TSGLI.

As of November 30, 2017, TSGLI has paid 17,541 Servicemembers and Veterans over \$968 million in benefits, with an average benefit of \$55,215.

---

<sup>1</sup> The maximum SGLI coverage is \$400,000.

## 2. Legislative and Regulatory History

### 2.1 Original Legislation and Regulation

Public Law 109-13 created the TSGLI program on May 11, 2005. The legislation, codified in section 1980A of title 38, United States Code, took effect on December 1, 2005. A provision of the law extended retroactive coverage in certain circumstances. Such losses must result from injuries incurred on or after October 7, 2001, through and including November 30, 2005, in the theater of operations for Operations Iraqi or Enduring Freedom. VA published interim final regulations on December 22, 2005, allowing payments to begin during public comment (75 FR 75940). VA published the final rule on March 8, 2007 (72 FR 10362).

### 2.2 Expansion of Losses

Following the program's first year of operation, VA sought feedback on current and proposed loss standards from medical experts, advocacy groups, TSGLI Branch of Service (BOS) offices, and claimants. This input resulted in VA implementing new regulations through an interim final regulation effective November 26, 2008, which added and revised a number of TSGLI losses and definitions, including facial reconstruction, limb salvage, and additional amputations (73 FR 71926). VA published the final rule on June 4, 2009 (74 FR 26788).

### 2.3 Legislation to Eliminate Theater Limitation for Retroactive Claims

On October 13, 2010, Public Law 111-275 extended eligibility for retroactive TSGLI to Servicemembers who sustained qualifying losses from a traumatic injury during the period of October 7, 2001 to November 30, 2005, regardless of the geographic location of the injuries' occurrence. Prior to this time, claims during the retroactive period had to occur in the theater of operations for either Operations Enduring Freedom or Iraqi Freedom.

### 2.4 Genitourinary Losses

In 2011, VA's Insurance Service researched the increasing number of severe genitourinary injuries sustained by military personnel assigned to combat zones. After consulting with physicians from the National Naval Medical Center and Brooke Army Medical Center, VA published an interim final regulation adding genitourinary losses to TSGLI, effective December 2, 2011 (76 FR 75458). VA published the final rule on June 1, 2012 (77 FR 32397).

## 3. Year-Ten Review Background

### 3.1 Pre-Review Study

In late 2014, after ten years of operation, VA's Insurance Service staff performed a preliminary study to determine whether TSGLI was meeting its congressional intent and if the program required any changes. VA initiated the study as part of its ongoing oversight of the TSGLI program.

The TSGLI Pre-Year-Ten Review Study identified key areas for the full review. The summary findings were:

- TSGLI, overall, is meeting its goal of providing financial assistance to severely injured Servicemembers.
- The TSGLI definition of traumatic event closely mirrors the definition of "accident" in commercial AD&D plans.
- TSGLI exclusions mirror those in commercial AD&D plans, except where commercial plans would exclude events or injuries unique to military service.
- TSGLI losses, with the exception of Other Traumatic Injury (OTI) causing Activity of Daily Living (ADL) losses and Hospitalization losses, are consistent with losses covered by commercial AD&D plans or unique to military service.
- TSGLI provides a needed benefit even though other recovery benefits are now available through the military and VA.
- Areas warranting full review included OTI ADL and Hospitalization losses, including claimed physical limitations on OTI ADL benefits for single limb injuries, and qualifying hospital stays.

### 3.2 Objectives

The objectives of the TSGLI Year-Ten Review were to:

- Assess proposals for program improvements,
- Clarify complex eligibility standards to promote consistency in adjudication and improve the claims experience for Servicemembers,
- Identify administrative or operational enhancements, and
- Determine if the program is meeting its congressional intent.

### 3.3 Focal Areas

The focal areas for the Year-Ten Review were: Loss Standards, Process Changes, Form Changes, Exclusions, and the definition of Traumatic Events.

### 3.4 Scope and Methodology

Initially, the review team examined claimant inquiries and elicited input from adjudicators of TSGLI claims. This information provided the starting point for the Pre-Review Study and Year-Ten Review. As part of that analysis, the team reviewed, among other items:

- Data from OTI ADL claims from the program’s inception to November 2014.
- Previously adjudicated claims (listed with their respective volumes):
  - OTI Hospitalization (over 600 claims),
  - OTI ADL (approximately 400 claims),
  - TBI ADL/Hospitalization (over 300 claims),
  - Facial Reconstruction (over 200 claims),
  - Burns (over 200 claims),
  - Limb Salvage (approximately 150 claims),
- Department of Defense Trauma Registry data on hospitalization days and TBI. *See Appendix 10.3 – References for a more detailed description of the data.*
- Commercial AD&D standards for TSGLI losses, “accident” definitions, and exclusions.
- Congressional and stakeholder inquiries, and other Federal programs supporting severely injured Servicemembers and Veterans.
- TSGLI legislative and regulatory history.
- Insurance case law.

In addition, the review team met with civilian, military, and VA medical experts in numerous areas, including TBI, oral/maxillofacial surgery, otolaryngology, burns, orthopedic and plastic surgery, and physical and rehabilitation medicine. *See Appendix 10.3 – References for a complete list of medical facilities.*

After obtaining this input, the team proposed procedural enhancements and revisions to standards for specific program losses. The team tested proposed standards against previously adjudicated claims to estimate the potential impact of program changes, as well as the ability to adjust standards. This analysis informed its final recommendations.

At the close of the review, VA sent all proposed recommendations to the Office of the Secretary of Defense and the branches of service for final review and feedback. The final recommendations in this report incorporate changes from this review. The Department of Defense, with these changes, concurs with the recommendations in the report.

## 4. Loss Standards: Findings and Recommendations

The loss standard recommendations seek to simplify and clarify TSGLI loss standards to promote consistency and equity in adjudication across the program, improve the experience for claimants, and better align payment criteria with the severity of injury.

The recommendations address the following areas:

1. Loss standards that appear vague or unclear.  
This category includes Limb Salvage, Facial Reconstruction and ADL/Hospitalization. Medical experts, claimants, and adjudicators indicated that the subjectivity of the standards led to confusion by claimants regarding eligibility and proved difficult to adjudicate.
2. Loss standards in which payments do not currently provide for gradations in severity raise questions regarding equity. For example, burn experts indicated that the existing standard, which provides an “all or nothing” benefit, did not adequately reflect varying burn severities.
3. Losses that VA should consider for possible addition to the current Schedule of Losses. This category includes the loss of heel. After VA added toes to Loss of Feet on the Schedule of Losses, questions arose as to whether the program should also cover the loss of the back of the foot.

### 4.1 Limb Salvage

Findings	Recommendation
Current standard is subjective and difficult to understand.	<ul style="list-style-type: none"> <li>• Revise the current standard to provide clear, objective criteria to support consistent adjudication.</li> <li>• Change current terminology from “Limb Salvage” to “Limb Reconstruction” to reflect current medical terminology and to clarify that TSGLI benefits are payable for surgical efforts to rebuild the limb to restore function.</li> <li>• Provide a tiered payment schedule for one or two of four of the following surgeries on a limb:               <ol style="list-style-type: none"> <li>1. Bone grafting</li> <li>2. Grafting/flap reconstruction</li> <li>3. Vascular reconstruction</li> <li>4. Nerve reconstruction</li> </ol> </li> </ul>



### Background

Medical experts explained that limb salvage patients generally experience multiple limb defects to muscle, tissue, bone, and neurovascular systems. As such, they suggested linking this loss standard to common surgical procedures for multiple body system defects in the limb. Using this proposed standard would eliminate the need to rely on the current, subjective standard that requires (1) proof that amputation was a viable medical alternative (which is difficult to prove) and (2) that multiple surgeries occurred.

### Impact

The proposed change in the standard is not expected to significantly alter the benefit, but rather create a clearer and more equitable standard that accounts for differing severity of injuries. Under the proposed graduated standard:

- Some previously ineligible claimants are expected to now satisfy the standard and receive payment at either the \$25,000 or \$50,000 level in cases where VA could not pay individuals previously.
- Some claimants who met the current standard are expected to:
  - Receive the same benefit as under the current standard,
  - Not meet the standard, or
  - Receive a \$25,000 payment instead of the \$50,000 maximum.
- The proposed criteria for limb reconstruction are clearer for claimants and adjudicators, which would support consistency in claims adjudication and better understanding by claimants of both the criteria and the decisions.

*See Appendix 10.1 on page 25 for the current and proposed Limb Salvage/Reconstruction standards.*

## 4.2 Facial Reconstruction

Findings	Recommendation
A substantive revision is not warranted because the current standard adequately addresses severe facial injuries.	<ul style="list-style-type: none"><li>• Maintain the current Facial Reconstruction standard.</li><li>• Add definitions for the terms “avulsion” and “discontinuity defect” to clarify that:<ol style="list-style-type: none"><li>1. An avulsion does not require a penetrating facial injury and can include a crush injury, and</li><li>2. A discontinuity defect requires bone or tissue to be missing from its normal bodily location to qualify for payment.</li></ol></li><li>• Clarify that loss of teeth alone does not meet the standard for Facial Reconstruction.</li></ul>
Background	
Medical experts indicated that the existing standard clearly indicates a severe facial injury.	

In addition, they confirmed that crush injuries, without the penetration of an external object through bone and tissue, can result in severe functional loss. However, they also indicated that not all crush injuries require surgical intervention. Defining the term “avulsion” will clarify that VA may pay for non-penetrating injuries that cause discontinuity defects.

**Impact**

The additional definitions for avulsion and discontinuity defect are expected to improve claimants’ understanding of the nature and severity of injuries that satisfy the standard.

*See Appendix 10.1 on page 26 for the current Facial Reconstruction standard with the proposed new definitions.*

### 4.3 Hospitalization/Loss of Activities of Daily Living (ADL)

Findings	Recommendation
<p>Overall, VA pays claims for OTI ADL in a manner consistent with congressional intent. While VA pays for single limb injuries under OTI ADL, these claimants generally have significant medical complications/procedures that support payment for OTI ADL.</p> <p>Claimants qualifying for a Part 1 loss often do not also qualify for a higher payment for a Part 2 OTI ADL scheduled loss. Thus, the evidence does not suggest that the TSGLI program is paying most Part 2 OTI ADL losses where the claimant is already eligible for payment under Part 1 of the Schedule of Losses.</p> <p>Replacing the current ADL standard with an installment hospitalization standard, while more objective than ADLs, would prevent many severely injured Servicemembers from receiving benefits.</p> <p>VA does not pay a hospitalization benefit under the current standard to claimants who briefly return home during their hospital stay as part of a treatment plan to determine how they can function at home.</p> <p>Treating facilities sometimes quickly move</p>	<ul style="list-style-type: none"> <li>• Maintain current TBI/OTI ADL and hospitalization standards.</li> <li>• Allow therapeutic trips outside of the hospital, which are part of the claimant’s treatment plan, without breaking the 15-day hospitalization period.</li> <li>• Clarify definition of inpatient hospitalization to specifically include acute care, inpatient rehabilitation, and skilled nursing facilities.</li> <li>• Add definitions of key terms, such as:             <ol style="list-style-type: none"> <li>1. Type of assistance (physical, verbal, and stand-by)</li> <li>2. The losses required for each TSGLI ADL (bathing, continence, dressing, eating, toileting, and transferring)</li> <li>3. Accommodating equipment</li> <li>4. Adaptive behavior</li> </ol> </li> </ul>

severely injured claimants from inpatient acute care facilities to acute rehabilitation and skilled nursing facilities.	
<b>Background</b>	
BOS offices deny OTI ADL claims at a higher rate than other losses, resulting in inquiries from stakeholders regarding their adjudication of these claims. Additionally, the subjective nature of OTI ADL claims makes adjudication complex. Therefore, VA robustly analyzed this issue.	
<b>Impact</b>	
A physician-approved, therapeutic pass to temporarily leave the facility would not break the required 15-consecutive days of inpatient hospitalization that would otherwise warrant a TSGLI benefit.	
VA would include inpatient rehabilitation and skilled nursing care in the consecutive inpatient hospitalization days.	
By defining key terms in the program, claimants will have a clearer understanding of the criteria for payments for loss of ADL.	

*See Appendix 10.1 on page 27 for the current OTI ADL and Hospitalization standards with the proposed new definitions.*

#### 4.4 Burns

Findings	Recommendation
<p>The current standard does not distinguish between levels of severity in second degree burns or reflect current burn terminology, creating concerns regarding equity and aligning payment with severity of injury.</p> <p>There is currently no standardized objective measure for severity of inhalation burns.</p> <p>Electrical burn severity can vary widely, with severe electrical burns now paid under existing burn or OTI ADL standards.</p>	<ul style="list-style-type: none"> <li>• Retain criteria and payment for full thickness burns of 20% of the body at \$100,000.</li> <li>• Change burn payment standard to ensure: <ol style="list-style-type: none"> <li>1. Members who have partial thickness burns that do not cover 20 percent of the body or face, but who have grafting on body locations for which the American Burn Association (ABA) refers to Burn Centers, receive TSGLI benefits, and</li> <li>2. Distinguish payment between partial thickness burns with and without grafting due to the differing level of severity of the burns.</li> </ol> </li> <li>• Use full thickness and partial thickness terminology rather than degree of burns.</li> <li>• Do not add inhalation or electrical burns as a separate category under the burn standard.</li> </ul>

## Background

Medical experts agreed that full thickness burns (third degree) of 20 percent of the body are severe and VA should continue to cover them at the maximum benefit payable. However, these clinicians also agreed that not all second degree burn patients need significant rehabilitation or have functional impacts from their burns. These experts indicated VA should use additional criteria to identify the second degree burn patients who need additional treatment and rehabilitation. These medical experts also stated that the location of the burn and the need for grafting strongly suggests more severe burns resulting in additional rehabilitation, treatment, and complications.

Medical experts and research indicate that inhalation burns can result in severe injury, but most such burns occur in the upper airway above the glottis and heal quickly with minimal hospitalization. While bronchoscopy can visually inspect this damage to the lungs, many experts indicated that this procedure is not universally used and clinicians use their physical examinations to determine the severity. The ABA has not yet developed a standard measurement tool for inhalation burns at this time.

Medical experts indicated that injuries from electrical burn can vary widely and there is no objective measurement tool to determine their severity, unless the electrical burns result in external burns (measured as a percentage of total body surface area (TBSA)).

## Impact

VA does not expect the proposed change in the standard to significantly impact the benefit. Instead, the change will create a clearer and more equitable standard that accounts for differing severity of injuries. Under the proposed graduated standard, VA expects:

- Some previously ineligible claimants become eligible and receive either a \$50,000 or \$100,000 payment.
- Some claimants who met the current standard may:
  - Receive the same benefit as under the current standard,
  - Not meet the standard, or
  - Receive a \$50,000 payment instead of the \$100,000 maximum.

*See Appendix 10.1 on page 30 for the current and proposed Burn standard.*

## 4.5 Amputation of Heel

Findings	Recommendation
<p>Amputation of the heel occurs rarely because the difficulties in ambulation and rehabilitation prompt many patients to opt for amputation of the entire foot. Those who undergo heel amputation also undergo inpatient rehabilitation, which in most cases would already be covered under the TSGLI hospitalization standard or OTI ADL standard.</p>	<p>Maintain the current hand, foot, finger, and toe losses. Changing the standard to cover amputation of heel would likely have little-to-no impact on claimants, but would add needless complexity to the program.</p>
<p><b>Background</b></p>	
<p>Medical experts indicated that they have seen only a handful of cases during the last ten years where the Servicemember lost a heel and did not opt to have the entire foot amputated. The adaptive equipment with the loss of a heel is painful and difficult to use, and the rehabilitation outcomes are potentially worse than amputating the full foot and fitting a prosthesis. Due to significant difficulties in rehabilitation, medical experts indicated that patients who do not opt for full foot amputation would likely meet the OTI ADL standard for payment.</p>	
<p><b>Impact</b></p>	
<p>No impact. Servicemembers with loss of heel would continue to be eligible for TSGLI payments under the current OTI ADL or hospitalization standards.</p>	

## 5. Process: Findings and Recommendations

The process recommendations seek to improve efficiency and consistency in claims processing. Process recommendations fall into two categories:

1. Legal definitions and policy issues.  
Recommendations providing clearer guidance and promoting consistency in adjudication include: 5.1, 5.2, 5.3, and 5.4.
2. Process improvements.  
Recommendations improving overall administration of the program and promoting consistency of decisions include: 5.5, 5.6, 5.7, and 5.8.

### 5.1 Clarify the Term “Direct Result”

Findings	Recommendation
The standard for determining payment when both a traumatic injury and a preexisting illness or disease contribute to the scheduled loss is unclear.	<ul style="list-style-type: none"> <li>• Clarify the term “direct result” to include that members will be entitled to payment for a TSGLI loss as long as any preexisting condition did not substantially contribute to that loss.</li> <li>• This recommendation adopts the most liberal interpretation for payment supported by established case law.</li> </ul>
Background	
TSGLI claimants and adjudicators have indicated they need additional guidance to determine if the member is eligible for payment when both a traumatic event and an illness or disease played a role in causing a scheduled loss.	
Impact	
TSGLI claimants and adjudicators will be clearer as to whether a scheduled loss is a direct result of a traumatic event.	

### 5.2 Clarify the Application of the Benefit of the Doubt

Findings	Recommendation
The standard of evidence in the TSGLI program is unclear.	Clarify application of 38 USC 5107(b) to the TSGLI program to specify that when: <ol style="list-style-type: none"> <li>1. The evidence for and against the claim is approximately equal in weight, the adjudicator will give the benefit of the doubt to the claimant,</li> <li>2. The preponderance of the evidence weighs against the claim, the adjudicator will not invoke the benefit of the doubt.</li> </ol>

**Background**

38 USC 5107(b) establishes the general evidentiary standard for benefits decisions made by VA. This standard also applies to TSGLI, which falls under the purview of title 38. To ensure consistent application of this standard in TSGLI, we recommend clarifying this issue.

**Impact**

Evidentiary standards in TSGLI will be clearer and more consistent with other programs also under the purview of title 38.

### 5.3 Clarify the Appeals Process

<b>Findings</b>	<b>Recommendation</b>
<p>Claimants do not fully understand the tiered appeals process and the one-year appeal period.</p> <p>Title 38 and title 10 appeal processes use different standards of review.</p>	<ul style="list-style-type: none"> <li>• Clarify existing administrative appeals process to:               <ol style="list-style-type: none"> <li>1. Explain the three-tiered uniform service appeals process,</li> <li>2. Explain that the existing one-year limit on TSGLI appeals is not invoked when the claimant submits new and material evidence (38 CFR 3.156).<sup>2</sup></li> </ol> </li> <li>• Clarify that uniformed service appeal organizations must rely on 38 U.S.C. 1980A and 38 CFR 9.20 to adjudicate TSGLI appeals rather than the instituting authority for appeals organizations under title 10.</li> <li>• Require claimants to utilize the full three-tiered uniformed service appeals process prior to litigating in Federal district courts (38 USC 1975).</li> </ul>

---

<sup>2</sup> VA implemented this recommendation in March 2017 with updates to the TSGLI Procedures Guide.

**Background**

The current one-year appeal period in TSGLI may be confusing as to when to apply the one-year limit at each level of appeal and when to reopen the claim through the submission of new and material evidence (38 CFR 3.156).

In some cases, TSGLI claimants are litigating appeals in federal district courts without first utilizing the full three-tiered administrative appeal process. Changing this practice will benefit appellants and promote efficiency in both the program and the judicial system.

**Impact**

TSGLI appellants would better understand their rights and fully utilize the administrative appeals process prior to litigation.

Appellants would benefit by utilizing all levels of review and developing supporting evidence, while improving efficiency in the program and appeals process.

#### 5.4 Do Not Establish a Statute of Limitations for Filing Claims

<b>Findings</b>	<b>Recommendation</b>
Some injured Servicemembers and Veterans are unaware of the TSGLI program and do not apply for benefits until years after suffering their injuries.	Maintain current program rules that do not impose a statute of limitations for filing claims.
<b>Background</b>	
A small number of claims from Servicemembers and Veterans are received for injuries that occurred more than ten years ago. VA wants to ensure that all eligible claimants have the opportunity to apply for benefits to which they may be entitled.	
<b>Impact</b>	
Eligible claimants will continue to be able to file claims no matter when they decide to apply.	



## 5.5 Formalize TSGLI Training Protocol

Findings	Recommendation
A formalized training protocol would support knowledge transfer.	Expand online training modules, legal and policy training. <sup>3</sup>
<b>Background</b>	
TSGLI claims adjudicators and appeal staff change as they rotate to new positions.. Robust training ensures accurate and comprehensive knowledge transfer during these transitions.	
<b>Impact</b>	
TSGLI claims adjudicators and appellate organizations will have consistent training supplemented by local training as needed.	

## 5.6 Increase Use of Technology to Perform TSGLI Quality Reviews

Findings	Recommendation
Quality reviews identify best practices and areas for improvement, but utilizing technology for remote reviews could expand sampling.	Enhance VA's quality reviews through both remote as well as on-site activities.
<b>Background</b>	
Quality reviews have helped improve the consistency of claims adjudication and identified best practices, as well as areas for improvement. Therefore, VA is exploring opportunities to leverage technology to review claims remotely as well as on-site at the TSGLI BOS offices.	
<b>Impact</b>	
Remote reviews will expand the number of cases checked, further improving the program.	

---

<sup>3</sup> VA implemented formalized training protocol in August 2016. VA will develop additional online training modules after implementation of any regulatory changes from the Year-Ten Review.

## 5.7 Increase Access to TSGLI Program Data by Branches of Service

Findings	Recommendation
Program stakeholders can better share information on key program metrics.	Increase access for TSGLI BOS offices to analytic data compiled by VA Insurance Service. <sup>4</sup>
<b>Background</b>	
VA analyzes TSGLI data monthly, quarterly, and annually.	
<b>Impact</b>	
Stakeholders have greater insight into program performance.	

## 5.8 Increase Interaction between TSGLI Program Organizations

Findings	Recommendation
More frequent contact, both by telephone and in-person, would afford adjudicators more opportunities to engage VA regarding the program.	Increase interaction between VA and the TSGLI BOS offices through additional conference calls and in-person meetings to ensure consistency of policy implementation across TSGLI.
<b>Background</b>	
In the early years of the TSGLI program, VA hosted monthly calls with TSGLI BOS offices as well as an annual, in-person meeting. As the program matured, the calls occurred quarterly and the annual in-person meeting was discontinued. Based on feedback at the TSGLI Year-Ten Review Kickoff Meeting in July 2015, calls resumed on a monthly basis and parties discussed plans for future in-person meetings, specifically for the end of the Year-Ten Review and also possibly biannually. Additionally, in January 2016, VA initiated new quarterly meetings of TSGLI medical professionals upon request from the BOS offices.	
<b>Impact</b>	
Adjudicators and oversight personnel will have additional opportunities to share information on best practices as well as challenges.	

---

<sup>4</sup> VA began providing quarterly and annual data to the TSGLI BOS offices at the end of 2015.

## 6. Forms: Findings and Recommendations

The following recommendations will improve TSGLI forms and the adequacy of evidence submitted with claims, simplify the claims process, and inform claimants of other VA Insurance benefits. TSGLI forms are one of the primary means to share program eligibility criteria and request evidence adequate to decide claims. The recommendations in this area fall into the following categories:

1. Improving the layout and design of the TSGLI claim form (SGLV 8600).  
See recommendations 6.3 and 6.4.
2. Ensuring all available evidence is considered in TSGLI claim adjudication.  
See recommendation 6.1.
3. Providing key information to claimants regarding the appeal process and other VA Insurance benefits.  
See recommendations 6.2 and 6.7.
4. Defining TSGLI claim form coding for improved data analysis/tracking.  
See recommendations 6.5 and 6.6.

### 6.1 Require Supporting Evidence with the TSGLI Claim Form

Findings	Recommendation
<p>The supporting statements from medical professionals on claim forms can be incomplete or appear inconsistent with underlying medical evidence of record.</p> <p>Medical professionals may not have the time to fully review TSGLI criteria before completing Part B of the TSGLI claim forms.</p>	<ul style="list-style-type: none"> <li>• Codify the current practice of requesting both the medical professional’s statement on Part B of the TSGLI claim form and his/her supporting evidence. This supporting evidence may include: medical treatment records, information provided by the claimant or others involved in his/her care, reports of examination by the signing medical professional, and/or lay statements.</li> <li>• Clarify that adjudicators must continue to consider and weigh the totality of medical and lay evidence when making decisions.</li> </ul>
<p><b>Background</b></p>	
<p>Since the first year of the TSGLI program, BOS offices have required supporting evidence in addition to the information provided on the claim forms. This requirement began after finding inconsistent information on the claim form and internal BOS systems. BOS offices receive supporting evidence from a range of sources, including medical professionals, family members, friends, and BOS systems.</p>	

**Impact**

Changes would codify the current practice of requiring supporting evidence with the TSGLI claim form. This recommendation would also promote consistency in weighing medical as well as lay evidence.

## 6.2 Create a New TSGLI Appeal Form

Findings	Recommendation
Claimants do not always clearly indicate the decision(s) they are contesting.	Create a new TSGLI appeal form to improve the process. <sup>5</sup>
<b>Background</b>	
Notices of appeals often do not clearly indicate the contested decisions, which can lead to additional correspondence and delays in processing.	
<b>Impact</b>	
Reduce the confusion in identifying contested decisions and the resulting processing delays.	

## 6.3 Consolidate Hospitalization with Loss Sections of TSGLI Claim Form

Findings	Recommendation
The separate hospitalization section on the TSGLI claim form can create confusion about whether the Servicemember is claiming this loss.	Remove the separate hospitalization section of TSGLI claim form on Part B (Medical Professional Statement) and merge with the existing loss section on Part B. <sup>6</sup>
<b>Background</b>	
Part B of the TSGLI claim form requires medical professionals to complete the hospitalization section, regardless of whether the member meets the TSGLI hospitalization standard. For all other TSGLI losses, the medical professional only completes the section if the member suffered the loss. This requirement can lead to confusion as to whether the claimant intended to apply for TSGLI benefits for hospitalization.	

---

<sup>5</sup> VA instructed the TSGLI BOS offices to begin using a standardized appeal form beginning January 1, 2017. The appeal form (SGLV 8600A) is available on the VA Insurance website.

<sup>6</sup> VA implemented this recommendation in late 2016.

**Impact**

TSGLI claimants will no longer receive letters disapproving the Hospitalization loss which they never intended to claim.

#### 6.4 Change Layout of Loss Standards on Part B of TSGLI Claim Form

<b>Findings</b>	<b>Recommendation</b>
Part B layout encourages completion of the TSGLI claim form by medical professionals before they review the loss standards.	Change the layout of Part B of the TSGLI claim form to place the TSGLI loss standards on the left side of the form and the check boxes to the right side for the medical professional to indicate whether the claimant meets the standard. <sup>7</sup>
<b>Background</b>	
Medical experts indicated that placing the check boxes on the left of the form and the explanation of the loss standards on the right was counterintuitive.	
<b>Impact</b>	
Easier for medical professionals to complete the TSGLI claim form.	

#### 6.5 Add Reserve/Guard/Active Duty Indicators on TSGLI Certification Worksheet

<b>Findings</b>	<b>Recommendation</b>
Servicemembers change status frequently and it can be unclear which TSGLI BOS office should process a TSGLI claim.	Add check boxes on TSGLI Certification Worksheet to indicate if the claimant was in Reserve, National Guard, or active duty status on the day of the traumatic event. <sup>8</sup>
<b>Background</b>	
Some BOS have separate TSGLI offices for active duty, Reserve, and Guard members.	
<b>Impact</b>	
This change ensures the appropriate office certifies the claim.	

<sup>7</sup> VA implemented this recommendation in late 2016.

<sup>8</sup> VA implemented this recommendation in early 2016.

## 6.6 Add Code 13 on TSGLI Certification Worksheet

Findings	Recommendation
TSGLI BOS offices do not evaluate losses that cannot be paid in combination with other losses because the issue is moot.	Add a new code 13 to the TSGLI Certification Worksheet for improved tracking of certain cases. Code 13 states that the “member’s loss was not evaluated because the loss cannot be combined with other losses paid.” <sup>9</sup>
<b>Background</b>	
Losses on Part I and Part II of the TSGLI Schedule of Losses cannot be combined. BOS offices approve and evaluate multiple losses on Part 1 of the TSGLI Schedule of Losses as they can be combined. They do not evaluate Part 2 losses that cannot be combined with Part 1 losses.	
<b>Impact</b>	
This data will allow for more robust analysis of the types of injuries suffered by claimants.	

## 6.7 Include Information on Additional Insurance Programs with TSGLI Letters

Findings	Recommendation
TSGLI claimants are often unaware of the many other VA life insurance programs for which they may be eligible.	Provide information about other VA life insurance programs with all TSGLI decision letters. <sup>10</sup>
<b>Background</b>	
Regardless of whether TSGLI claimants receive payments, their injuries may limit their ability to obtain life insurance in the commercial market after separation. However, many SGLI members are unaware of the life insurance programs available to them after separation and the eligibility timelines.	
<b>Impact</b>	
TSGLI claimants will become more aware of other VA life insurance programs available after separation and how they may obtain the coverage.	

<sup>9</sup> VA implemented this recommendation in late 2015.

<sup>10</sup> VA implemented this recommendation in early 2016.

## 7. Exclusions: Findings and Recommendations

The TSGLI program currently excludes payment for losses incurred while committing felonies, mirroring many commercial AD&D exclusions. However, TSGLI does not exclude payment for losses incurred during the commission of misdemeanors. VA analyzed possible options to address this issue.

### 7.1 Misdemeanors

Findings	Recommendation
<p>Current felony exclusion does not bar payment in claims involving misdemeanors.</p> <p>Current felony exclusion does not specify if conviction is required.</p>	<ul style="list-style-type: none"> <li>• Retain existing felony exclusion standard.</li> <li>• Do not create a new misdemeanor exclusion.</li> <li>• Specify that conviction is not required to bar payment in claims involving felonies.</li> </ul>
<p><b>Background</b></p>	
<p>VA Insurance Service has concluded that attempting to modify the existing felony exclusion would add program complexity and would not reflect commercial AD&amp;D standards. Commercial AD&amp;D insurance generally utilizes felony exclusions. Given that TSGLI is intended to provide Servicemembers with a benefit comparable to that provided commercially, VA will not add a misdemeanor exclusion.</p> <p>Additionally, clarifying that conviction of a felony is not required to bar payment will continue to align this TSGLI exclusion with commercial AD&amp;D standards. Commercial AD&amp;D insurance makes such determinations on the “facts found” from the evidence of the event.</p>	
<p><b>Impact</b></p>	
<p>There is no impact to the program as VA is retaining the current felony exclusion.</p>	

## 8. Traumatic Events: Findings and Recommendations

The traumatic event recommendations seek to clarify the definition of the term “traumatic event,” a key eligibility criterion within the program.

### 8.1 Complications from Surgery Resulting From a Traumatic Event

Findings	Recommendation
Adjudicators may be unclear whether to exclude losses following surgeries necessitated by a traumatic event.	Clarify that the exclusion for losses due to surgical procedures does <b>not</b> exclude losses following surgery to treat injuries caused by traumatic event.
<b>Background</b>	
Losses from surgical procedures, when there is no precipitating traumatic event, are specifically excluded under TSGLI. Claimants and adjudicators may incorrectly conclude that any loss due to a surgical procedure is also excluded, even in cases where the surgery was required to treat injuries from a traumatic event.	
<b>Impact</b>	
This clarification would lead to consistent understanding by stakeholders that losses incurred when traumatic events require surgery may lead to payable losses.	

### 8.2 Non-Penetrating Blast Waves

Findings	Recommendation
Claimants may not understand that non-penetrating blast waves are traumatic events.	Clarify that VA considers a documented, non-penetrating blast wave to be an “external force” under the definition of “traumatic event.”
<b>Background</b>	
Many Servicemembers, while not visibly injured, develop TBI from the cumulative effects of concussive blast waves.	
<b>Impact</b>	
This clarification would lead to consistent understanding by stakeholders that losses occurring within two years of the last documented blast wave exposure may lead to payment.	



### 8.3 Bites and Anaphylaxis

Findings	Recommendation
<p>Claimants and adjudicators may be unclear whether bites/stings are considered traumatic events and if VA pays for losses resulting from anaphylactic shock brought on by a bite/sting.</p>	<ul style="list-style-type: none"> <li>• Clarify that VA considers bites and stings an “external force.”</li> <li>• Clarify that anaphylactic shock directly resulting from insect bites/stings or animal bites is not an illness or disease and VA may pay for any resulting loss regardless of the illness or disease exclusion.</li> </ul>
<b>Background</b>	
<p>Many insect bites/stings appear to be painless and harmless. However, they are traumatic events because injecting the venom/poison into the body requires external force. These bites can result in either anaphylactic shock or an illness/disease leading to a TSGLI loss. The BOS should not pay for a TSGLI loss if the bite results in an illness or disease (such as malaria). However, the BOS may pay a TSGLI benefit if the bite/sting results in anaphylactic shock.</p>	
<b>Impact</b>	
<p>This clarification would lead to consistent understanding by stakeholders that claimants who experience a loss due to anaphylactic shock from being bitten/stung by insects or other animals may receive a TSGLI benefit.</p>	

### 8.4 Heat Stroke and Frostbite

Findings	Recommendation
<p>Claimants may be unclear whether heat stroke and frostbite are traumatic events.</p>	<p>Clarify that heat stroke and frostbite are traumatic events and that VA may pay for any resulting loss regardless of the illness or disease exclusion.</p>
<b>Background</b>	
<p>Servicemembers may experience heat stroke and/or frostbite due to extreme weather conditions. These conditions could appear to be related to disease occurring because of environmental exposure. However, program criteria consider these situations to be traumatic events rather than an illness or disease.</p>	
<b>Impact</b>	
<p>This clarification would lead to consistent understanding by stakeholders that claimants who experience a loss due to heat stroke or frostbite may receive a TSGLI payment.</p>	

## 8.5 External Force Definition

<b>Findings</b>	<b>Recommendation</b>
Claimants may be unclear whether certain injuries are considered traumatic events in the TSGLI program.	Define the term “external force,” currently part of the definition of “traumatic event,” in order to: <ol style="list-style-type: none"><li data-bbox="691 436 1377 506">1. Clarify that traumatic events require impacts from outside the body, and</li><li data-bbox="691 516 1390 621">2. Explain that routine body motion involved in lifting, twisting, bending, pulling, or pushing is not a traumatic event.</li></ol>
<b>Background</b>	
Servicemembers have claimed ADL loss due to injuries occurring as a result of body motion without an external impact (e.g., back popping, rolling of ankle). TSGLI program policy has consistently been that these types of injuries do not qualify as a traumatic event.	
<b>Impact</b>	
This clarification would lead to consistent understanding by stakeholders of what constitutes a traumatic event.	



## 9. TSGLI Petition for Rulemaking

VA commenced a review of a petition for rulemaking requested under 5 U.S.C. 553. The petition requested VA to include explosive ordnance as a new exception to the exclusions for illness/disease under TSGLI. VA will respond to the petition during the formal regulatory submission process for the TSGLI Year-Ten Review recommendations.

# 10. Appendices

## 10.1 Comparing Current TSGLI Loss Standards to Recommended Standards

### *Limb Salvage*

Current Standard	Current Benefit Payment
<p>Limb Salvage of Arm or Leg: Salvage in place of amputation</p> <p>Limb Salvage is a series of operations designed to save an arm or leg with all of its associated parts rather than amputate it. For purposes of this section, a surgeon must certify that the option of amputation of the limb(s) was a medically justified alternative to salvage, and the patient chose to pursue salvage.</p>	<p>\$50,000 for each arm or leg</p>

Recommended Standard	Recommended Benefit Payment
<p>Limb Reconstruction of Arm or Leg, in Place of Amputation</p> <p>Undergoing at least <u>two</u> of the following four surgeries on a limb:</p> <ol style="list-style-type: none"> <li>1. Bone grafting to reestablish stability and enable mobility of the limb;</li> <li>2. Soft tissue grafting/flap reconstruction to reestablish stability and enable mobility of the limb;</li> <li>3. Vascular reconstruction to restore blood flow and support bone and tissue regeneration; or</li> <li>4. Nerve reconstruction to allow for motor and sensory restoration and muscle re-ervation.</li> </ol>	<p>\$50,000 for each arm or leg</p>
<p>Undergoing at least <u>one</u> of the four surgeries listed above on a limb:</p>	<p>\$25,000 for each arm or leg</p>

This proposal is not expected to substantially alter benefits when compared to the current standard.

### Facial Reconstruction

Current Standard	Current Benefit Payment
Reconstructive surgery to correct traumatic avulsions of the face or jaw that cause discontinuity defects	
Jaw – Surgery to correct discontinuity loss of bone and tissue of the upper or lower jaw	\$75,000
Nose - Surgery to correct discontinuity loss of 50% or more of the cartilaginous nose	\$50,000
Lips - Surgery to correct discontinuity loss of 50% or more of the tissue of the upper or lower lip <ul style="list-style-type: none"> <li>○ For one lip</li> <li>○ For both lips</li> </ul>	\$50,000 \$75,000
Eyes - Surgery to correct discontinuity loss of 30% or more of the tissue of the periorbital <ul style="list-style-type: none"> <li>○ For each eye</li> </ul>	\$25,000
Facial Tissue - Surgery to correct discontinuity loss of the tissue in 50% or more of any of the following facial subunits: forehead, temple, zygomatic, mandibular, infraorbital, or chin. <ul style="list-style-type: none"> <li>○ For each facial subunit</li> </ul>	\$25,000

### Recommended Modifications

(The current standard criteria and benefit amounts will remain the same. VA will define key terms from the definition of Facial Reconstruction as follows:)

- Avulsion: a forcible detachment or tearing of bone and/or tissue due to a penetrating or crush injury.
- Discontinuity: an absence of bone and/or tissue from its normal bodily location, which interrupts the physical consistency of the face and impacts at least one of the following functions: mastication, swallowing, vision, speech, smell, or taste.

Additionally, each facial part will indicate the type of loss (bone and/or tissue) that is required for the discontinuity loss.

VA will also note that the loss of teeth alone does not meet the criteria for Facial Reconstruction.

This proposal is not expected to substantially alter benefits when compared to the current standard.

### *TBI/OTI ADL and Hospitalization*

Current Standards	Current Benefit Payment
<p>Traumatic Brain Injury resulting in inability to perform at least two Activities of Daily Living (ADL)</p> <ul style="list-style-type: none"> <li>• at 15th consecutive day of ADL loss</li> <li>• at 30th consecutive day of ADL loss</li> <li>• at 60th consecutive day of ADL loss</li> <li>• at 90th consecutive day of ADL loss</li> </ul>	<p>\$25,000            Additional \$25,000            Additional \$25,000            Additional \$25,000</p>
<p>Hospitalization due to traumatic brain injury at the 15th consecutive day of hospitalization. This payment replaces the first TBI ADL payment.</p>	<p>\$25,000</p>
<p>Other Traumatic Injury resulting in inability to perform at least two Activities of Daily Living (ADL)</p> <ul style="list-style-type: none"> <li>• at 30th consecutive day of ADL loss</li> <li>• at 60th consecutive day of ADL loss</li> <li>• at 90th consecutive day of ADL loss</li> <li>• at 120th consecutive day of ADL loss</li> </ul>	<p>\$25,000            Additional \$25,000            Additional \$25,000            Additional \$25,000</p>
<p>Hospitalization due to OTI at the 15th consecutive day of hospitalization. This payment replaces the first OTI ADL payment.</p>	<p>\$25,000</p>

Current Definition of Hospitalization
<p>The term “hospitalization” means an inpatient stay in a facility that:</p> <p><b>(A)(1)</b> Is accredited by the Joint Commission or its predecessor, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or accredited or approved by a program of the qualified governmental unit in which such institution is located if the Secretary of Health and Human Services has found that the accreditation or comparable approval standards of such qualified governmental unit are essentially equivalent to those of the Joint Commission or JCAHO;</p> <p><b>(2)</b> Used primarily to provide, by or under the supervision of physicians, to inpatients diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons;</p> <p><b>(3)</b> Requires every patient to be under the care and supervision of a physician; and</p> <p><b>(4)</b> Provides 24-hour nursing services rendered or supervised by a registered professional nurse and has a licensed practical nurse or registered nurse on duty at all times; or</p>

**(B)** Any Armed Forces medical facility that is authorized to provide inpatient and/or ambulatory care to eligible service members.

### **Recommended Modifications**

#### ADL Standards

The TBI/OTI ADL standard criteria, time periods, and benefit payment amounts would remain the same as the current standard. However, VA will add the following definitions:

- Types of Assistance
  - Physical: Hands-on assistance from another person to allow the member to perform the ADL. Without the hands-on assistance, the member would be unable to perform the ADL.
  - Stand-by: Someone within arm's reach of the member to allow them to perform the ADL, because their ability fluctuates. Without the stand-by assistance, the member would be unable to perform the ADL.
  - Verbal: Oral instructions to allow the member to perform the ADL. While the member may be able to physically perform the ADL, without instruction, they would not remember to perform the ADL due to cognitive impairment.
  
- Loss of ADL
  - Bathing: requires another person to wash more than one region of the body, either via tub/shower or sponge bath. Region of the body means the following areas in their entirety, head, back, front torso, genitalia, arms, or legs. If a member is able to give themselves a sponge bath, the member can bathe independently.
  - Continence: requires either 1) another person to manage the member's catheter or colostomy bag, if present or, 2) if the member does not have a catheter or colostomy bag, the inability of the member to partially or totally control bowel and bladder function. Simply having a catheter or colostomy bag does not meet the requirements for loss of continence.
  - Dressing: requires another person to obtain clothing from drawers/closets and put the appropriate clothing (dress for the correct season) on the member. Members who can obtain clothing and dress themselves, with the exception of tying their shoes, do not meet the requirements for loss of dressing as slip on shoes can be substituted.
  - Eating: requires either 1) another person to get food from the member's plate to their mouth (preparing or cutting food is not included) or 2) food/nutrition provided intravenously or by feeding tube. Members who are able to take liquid nourishment from a straw or cup do not meet the requirements for loss of eating.
  - Toileting: requires either 1) another person to assist the member getting on and off the toilet, getting clothes off or on before and after toileting, or providing

- cleaning/self-care after toileting, or 2) use of a bedpan or urinal.
- Transferring: requires assistance to move into or out of a bed or chair.

- Accommodating Equipment and Adaptive Behavior


- Accommodating equipment and adaptive behavior enable the member to perform the ADL independently. Once the member can use the equipment or behavior to perform the ADL, they no longer qualify for loss of ADL in the program.
- Accommodating Equipment: tools/supplies that enable injured members to perform ADLs without physical, stand-by, or verbal assistance, including, but not limited to:
  - Wheelchair
  - Walker/Cane
  - Reminder Apps
  - Velcro Clothing, Slip-On Shoes
  - Grabber/Reach Extender
  - Toilet Seat Raiser
  - Wash Basin
  - Shower Chair
  - Shower/Tub modifications (e.g. wheelchair access or no-step access, grab-bar/handle)
- Adaptive Behavior: Compensating skills that allow the member to perform the ADL without physical, stand-by, or verbal assistance.

### Hospitalization

VA proposes to modify the definition of “Hospitalization” to explicitly include inpatient acute care, inpatient rehabilitation, and skilled nursing facilities. Therefore, VA would add the following new definitions:

- Inpatient Acute Care Facility: A facility that provides care for a short duration (30 days or less) to treat a serious injury, an episode of illness/disease, or the residuals of surgery, and meets the criteria under (A)(1-4). This definition includes Armed Forces and Department of Veterans Affairs’ medical facilities that are authorized to provide short-duration care under supervision of physicians with available 24-hour nursing services.
- Inpatient Rehabilitation Facility: A healthcare institution that meets Federal criteria for Medicaid and Medicare reimbursement for inpatient rehabilitation, provides intensive rehabilitation to inpatients, and meets the criteria under (A)(1-4).
- Skilled Nursing Facility: A healthcare institution that meets Federal criteria for Medicaid and Medicare reimbursement for nursing care, providing skilled rehabilitative services and other related health services, and meets the criteria under (A)(1-4).





In the Schedule of Losses, the hospitalization losses for TBI and OTI would explain that hospital passes that are part of the medical treatment plan do not break the 15-day hospitalization period.


This proposal is not expected to substantially alter benefits when compared to the current standard.

## Burns

Current Standard	Current Benefit Payment
Second degree or worse burns to at least 20 percent of the body including the face or, at least 20 percent of the face	\$100,000

Recommended Standard	Recommended Benefit Payment
Full-thickness burns to at least 20 percent of the body, including the face, or at least 20 percent of the face	\$100,000
Partial-thickness burns requiring grafting on the: <ul style="list-style-type: none"> <li>○ Face</li> <li>○ Hands</li> <li>○ Feet</li> <li>○ Genitalia</li> <li>○ Perineum, or</li> <li>○ Major joints (ankles, knees, hips, wrists, elbows, shoulders, or spine)</li> </ul>	\$100,000
Partial-thickness burns to at least 20 percent of the body (including the face) without grafting, or at least 20 percent of the face without grafting	\$50,000

Recommended New Definitions
<p>VA would add the following new definitions to the burn standard:</p> <ul style="list-style-type: none"> <li>• <b>Grafting:</b> A surgical procedure that involves removing tissue from one area of the body and moving it, or transplanting it, to a different area of the body, or using tissue from a donor or synthetic source and transplanting it to another person.</li> <li>• <b>Full-thickness burns:</b> Also called third- and fourth-degree burns, these burns extend through all layers of the skin, and can extend through muscle and bone.</li> <li>• <b>Partial-thickness burns:</b> Also called second degree burns, these burns can involve the top layer of skin (epidermis) combined with the upper layers of skin (dermis) and extend significantly into the skin.</li> <li>• <b>Genitalia:</b> The external female or male reproductive organs. The external female genitalia include the structures that are part of the vulva/pudendum. The external male genitalia include the penis, urethra, and scrotum.</li> <li>• <b>Perineum:</b> The surface area between the thighs bounded by the scrotum and the anus in males, and the posterior vulva junction and the anus in females.</li> <li>• <b>Major joints:</b> Joints are the area where two bones are attached, permitting body parts to</li> </ul>



move. The major joints of the body are the ankles, knees, hips, wrists, elbows, shoulders, and spine.

This proposal is not expected to substantially alter benefits when compared to the current standard.

## 10.2 Glossary

Accidental Death and Dismemberment Insurance (AD&D):	The legislative history of TSGLI shows it was based on this type of commercial insurance. AD&D typically provides a benefit to an insured policyholder should he/she die or experience loss of a limb or other body part due to an accident.
Activities of Daily Living (ADL):	Bathing, continence, dressing, eating, toileting, and transferring. These ADL are key criteria for benefit payment under the TSGLI program for TBI and other injuries not listed on Part 1 of the TSGLI Schedule of Losses. These ADL loss criteria are based on the Katz Scale for basic function, rather than executive functioning (e.g., inability to drive, perform certain complex tasks). The law specifically requires these ADL for the purpose of paying TBI benefits under TSGLI.
Department of Defense (DoD):	The Department of Defense is a key partner in the TSGLI program. Most TSGLI Branch of Service (BOS) offices are within DoD. By law, these offices decide whether a claimant is eligible for a TSGLI benefit and for how much.
Department of Defense Trauma Registry (DoDTR):	The centralized data repository for trauma injuries within DoD.
Other Traumatic Injury (OTI):	A category of TSGLI payment requiring loss of ADL. Created by DoD and VA at the inception of the program to provide a benefit to injured Servicemembers who had long recovery periods but were not already covered on the TSGLI Schedule of Losses.

Traumatic Brain Injury (TBI):

The signature injury of the recent conflicts in Iraq and Afghanistan. By law, TBI is a category of TSGLI payment requiring loss of ADL. TBI is a traumatically induced structural injury and/or physiological disruption of brain function resulting from an external force, indicated by certain clinical signs involving consciousness, memory, neurological deficits, or intracranial lesions.

TSGLI Appeal Form:

TSGLI claimants use this form (SGLV 8600A) to contest or disagree with decisions by their branches of service. The form is available on VA's Insurance website at [www.benefits.va.gov/insurance](http://www.benefits.va.gov/insurance).

TSGLI Branch of Service (BOS) Offices:

Offices created by all branches of service covered by Servicemembers' Group Life Insurance to adjudicate TSGLI claims. Servicemembers file claims with their specific branch of service, which adjudicates the claims, provides the decisions to the program's insurer for payment or record of denial, and sends decision letters to claimants.

TSGLI Certification Worksheet:


TSGLI BOS offices use this form to document their claims decisions. BOS offices send the worksheets with the TSGLI Claim Forms (SGLV 8600) to the program's insurer as it provides information needed to pay the claim or record the denial, and to maintain all data.

TSGLI Claim Form:

Injured Servicemembers use this form (SGLV 8600) in applying for TSGLI benefits with their branch of service. It is available on VA's Insurance website at [www.benefits.va.gov/insurance](http://www.benefits.va.gov/insurance).

TSGLI Procedures Guide:

The TSGLI program manual maintained by VA. It provides the TSGLI BOS offices, claimants, and the public with information on the requirements and procedures of the program. It is available on VA's Insurance website at [www.benefits.va.gov/insurance](http://www.benefits.va.gov/insurance).



TSGLI Schedule of Losses:

The listing of payment categories for the TSGLI program. It is available on VA's Insurance website at [www.benefits.va.gov/insurance](http://www.benefits.va.gov/insurance).

VA Insurance Service:

The organization within VA that is responsible for oversight of the TSGLI program.

## 10.3 References

### *Personal Interviews*

Staff at the following facilities/programs provided detailed information and input through in-person and telephone interviews:

- Center for Translational Injury Research, Houston, TX
- Combat Casualty Care Research Program, Fort Detrick, MD
- DoD Brain Injury Research Center, Fort Detrick, MD
- George Washington University Medical Center, Washington, DC
- Johns Hopkins University Medical Center, Baltimore, MD
- Moss Rehabilitation Research Institute, Elkins Park, PA
- Navy Medical Center, San Diego, CA, Project Care Conference 2016
- San Antonio Military Medical Center, San Antonio, TX
- Temple University Hospital, Philadelphia, PA
- University of Pennsylvania Hospital, Philadelphia, PA
- United States Army Institute of Surgical Research, San Antonio, TX
- VA Amputation System of Care, VA Medical Center, Richmond, VA
- VA Medical Center, Bay Pines, FL
- VA Polytrauma Center, Tampa, FL
- VA Toxic Embedded Fragment Surveillance Center, Baltimore, MD
- VA War-Related Illness and Injury Study Center, East Orange, NJ
- VHA Central Office, Washington, DC
- Walter Reed National Military Medical Center, Washington, DC

### *Literature*

- “Application of the Mangled Extremity Severity Score in a Combat Setting” *Military Medicine*, (172, 7:777, 2007). LTC Robert M. Rush, Jr., USA.
- Armed Forces Institute of Regenerative Medicine, publicly available research and reports at [www.afirm.mil](http://www.afirm.mil).
- “Blast Injuries” *New England Journal of Medicine*, (352, 1335-1342, 2005). Ralph G. DePalma, M.D.; David G. Burris, M.D.; Howard R. Champion, F.R.C.S.; and Michael J. Hodgson, M.D., M.P.H.
- “Blast Injury” *Military Medicine*, (176, 3:276, 2011). CAPT David S. Plurad, MC USN
- “Burn Center Referral Criteria,” American Burn Association, Chicago, IL.
- “Cardiomyopathy Induced by Sinus Tachycardia in Combat Wounded: A Case Study” *Military Medicine* (179, 9:e1062, 2014). LCDR Michael Kavanaugh, MC USN; LCDR Jonathan McDivitt, MC USN; LCDR Andrew Philip, MC USN; LCDR Jerald W. Froehner, MC USN; CDR John Rotruck, MC USN; Maj Brian Hemann, MC USA; Mark Haigney, MD; COL John Atwood, MC USA; and LCDR Joel Anthony Nations, MC USN.

- “Characteristics of Maxillofacial Injuries and Safety of In-Theater Facial Fracture Repair in Severe Combat Trauma” *Military Medicine*, (180, 3:315, 2015). LCDR Matthew W. Keller, MC USN; Peggy P. Han, MPH; Michael R. Galarneau, MS; CDR Curtis W. Gaball, MC USN.
- “Computed Tomography of Craniofacial Trauma at a Combat Support Hospital in Afghanistan,” *Military Medicine*, (170, 3:206, 2005). MAJ John D. Statler, MC USAR; MAJ Carl G. Tempel, DC USA; COL H. Theodore Harcke, MC ARNG.
- “Considerations for the Head-Injured Air-Evacuated Patient: A Case Report of Frontal Sinus Fracture and Review of the Literature,” *Military Medicine*, (170, 7:577, 2005). LTC Eric Helling, MC USA; 2LT Alex J. McKinlay, MSC USA.
- DoD Blast Injury Research Program website, [www.blastinjuryresearch.amedd.army.mil](http://www.blastinjuryresearch.amedd.army.mil).
- “Ethnicity, Insurgency, and Civil War,” *American Political Science Review*, (97,01:75, 2003). Fearon, J. D., & Laitin, D. D.
- “Explosions and Human Health: Long-Term Effects of Blast Injury,” *Prehospital and Disaster Medicine* (27(4), 385-391, 2012. Sarah E. Finlay, FCEM; Michelle Earby, FCEM; David J. Baker, FRCA; and Virginia S.G. Murray, FRCP.
- “For Combat Wounded: Extremity Trauma Therapies from the USAISR,” *Military Medicine*, (176, 6:660, 2011). David I. Devore, PhD; Thomas J. Walters, PhD; Robert J. Christy, PhD; Christopher R. Rathbone, PhD, Joseph R. Hsu, MD; David G. Baer, PhD; and Joseph C. Wenke, PhD.
- “International State of the Science Meeting on Blast Injury Dosimetry – Summary Materials,” DoD Blast Injury Research Program Coordinating Office, Fort Detrick, Maryland, June 8-9, 2010.
- Long-Term Consequences of TBI, *Institute of Medicine, Gulf War and Health* (Vol. 7, 2008). Committee on Gulf War and Health.
- Long-Term Effects of Blast Exposures, *Institute of Medicine, Gulf War and Health* (Vol. 9, 2014). Committee on Gulf War and Health.
- “Medical Costs of War in 2035: Long-Term Care Challenges for Veterans of Iraq and Afghanistan,” *Military Medicine*, (177, 11:1235, 2012). James Geiling, MD; Joseph M. Rosen, MD; and Ryan D. Edwards, PhD.
- “The Military Extremity Trauma Amputation/Limb Salvage (METALS) Study Outcomes of Amputation Versus Limb Salvage Following Major Lower-Extremity Trauma,” *Bone Joint Surg Am*, 2013 Jan 16; 95 (2): 138 -145. COL (Ret) William C. Doukas, MD; COL (Ret) Roman A. Hayda, MD; H. Michael Frisch, MD; COL Romney C. Andersen, MD; CDR Michael T. Mazurek, MD; COL James R. Ficke, MD; CDR John J. Keeling, MD; COL Paul F. Pasquina, MD; Harold J. Wain, PhD; Anthony R. Carlini, MS; and Ellen J. MacKenzie, PhD.
- “Minimally Invasive Shortening Humeral Osteotomy to Salvage a Through-Elbow Amputation,” *Military Medicine*, (175, 9:693, 2010). CPT Michael J. Beltran , MC USA; LTC Kevin L. Kirk , MC USA; LTC Joseph R. Hsu, MC USA; Skeletal Trauma Research Consortium (STReC).
- National Burn Repository 2014, American Burn Association Chicago, IL.



- “Partial Foot Amputations in the Combat Wounded,” *Journal of Surgical Orthopaedic Advances*, (20, No. 1, Spring 2011) LTC Kevin L. Kirk, DO; Maj Evan M. Jones, MD; MAJ Benjamin Kyle Potter, MD; Maj Patrick M. Osborn, MD; and COL James R. Ficke, MD.
- “Pituitary Dysfunction after Blast Traumatic Brain Injury: The UK BIOSAP Study,” *Annals of Neurology* (74, 527-536, 2013). David Baxter, MD; David J. Sharp, MD, PhD; Claire Feeney, MD; Debbie Papadopoulou, BSc, RN; Timothy E. Ham, MD; Sagar Jilka, BSc, MRes; Peter J. Hellyer, BSc, MRes; Maneesh C. Patel, BSc, MD; Alexander N. Bennett, MD, PhD; Alan Mistlin, MD; Emer McGilloway, MD; Mark Midwinter, MD; and Anthony P. Goldstone, MD, PhD.
- “Posttraumatic Epilepsy in Operation Enduring Freedom/Operation Iraqi Freedom Veterans,” *Military Medicine* (179, 5:492, 2014). Leo L. K. Chen, MD; Christine B. Baca, MD, MSHS; Jessica Choe, MD; James W. Chen, MD, PhD; Miriam E. Ayad, MPH; and Eric M. Cheng, MD, MS.
- “Posttraumatic Stress Symptoms in OIF/OEF Service Members with Blast-related and Non-blast-related Mild TBI,” *NeuroRehabilitation* (26, 223-231, 2010). Jan E. Kennedy, Felix O. Leal, Jeffrey D. Lewis, Maren A. Cullen, and Ricardo R. Amador.
- “Pulmonary Injury Risk Assessment for Short-Duration Blasts,” *The Journal of Trauma, Injury, Infection, and Critical Care* (65: 604–615 2008). Cameron R. Bass, PhD; Karin A. Rafaels, BS; and Robert S. Salzar, PhD.
- “Retrospective Analysis of Long-Term Outcomes After Combat Injury: A Hidden Cost of War,” *Circulation* (132, 2126-2133, 2015). Ian J. Stewart, MD; Jonathan A. Sosnov, MD; Jeffrey T. Howard, PhD; Jean A. Orman, ScD; Raymond Fang, MD; Benjamin D. Morrow, MD; David H. Zonies, MD; Mary Bollinger, PhD; Caroline Tuman, RN; Brett A. Freedman, MD; and Kevin K. Chung, MD.
- “Shotgun Injury to the Arm: A Staged Protocol for Upper Limb Salvage,” *Military Medicine*, (175, 3:206, 2010). Darabos Nikica, MD, PhD; Cesarec Marijan, MD; Grgurovic Denis, MD; Rutic Zeljko, MD; Darabos Anela, MD; and Kenneth Egol, MD, PhD.
- “Simultaneous Revascularization and Coverage of a Complex Volar Hand Blast Injury: Case Report Using a Contralateral Radial Forearm Flow-through Flap,” *Military Medicine*, (173, 8:801, 2008). Navanjan S. Grewal, MD; LCDR Anand R. Kumar, MC USN; SSgt Christina K. Onsgard, USAF WF; and CDR Bruce J. Taylor, MC USN.
- “Subjective Sleep Disturbance in Veterans Receiving Care in the Veterans Affairs Polytrauma System Following Blast-Related Mild Traumatic Brain Injury,” *Military Medicine*, (178, 9:951, 2013). L. Farrell-Carnahan, L. Franke, C. Graham, and S. McNamee.
- “TBI May Be Independent Risk Factor for Stroke,” *Neurology* (81(1), 33-39, 2013). James F. Burke, MD, MS; Jessica L. Stulc, MD, MPH; Lesli E. Skolarus, MD, MS; Erika D. Sears, MD, MS; Darin B. Zahuranec, MD, MS; and Lewis Be. Morgenstern, MD.
- “Traumatic Brain Injury-Related Hypopituitarism: A Review and Recommendations for Screening Combat Veterans,” *Military Medicine* (175, 8:574, 2010). CPT(P) Arthur F. Guerrero, MC USA; and MAJ Abel Alfonso, MC USA.
- VA War-Related Illness and Injury Study Center website, [www.warrelatedillness.va.gov](http://www.warrelatedillness.va.gov)



*External Data Source*

- DoD Trauma Registry



## 10.4 Contact Information

Direct questions concerning this report to Karen Naccarelli, Chief, Program Administration and Oversight Staff, Department of Veterans Affairs Insurance Center, 5000 Wissahickon Avenue Philadelphia, PA, 19144, telephone: (215) 381-3290, email address: karen.naccarelli@va.gov.