United States General Accounting Office

GAO

Report to the Administrator of Veterans Affairs

December 1988

VETERANS' BENEFITS

Need to Update Medical Criteria Used in VA's Disability Rating Schedule

GAO/HRD-89-28

GAO
United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-233665

December 29, 1988

The Honorable Thomas K. Turnage
Administrator of Veterans Affairs

Dear Mr. Turnage:

Because of the important role that the Veterans Administration's rating schedule plays in determining veteran disabilities, we reviewed the medical criteria used in the schedule to determine whether they are accurate. This report shows that VA's medical criteria are outdated and need to be revised.

Also, this report contains recommendations to you. As you know, 31 U.S.C. 720 requires the head of a federal agency to prepare a written statement on actions taken on our recommendations to the Senate Committee on Governmental Affairs and the House Committee on Government Operations within 60 days of the date of the report and to the House and Senate Committees on Appropriations with the agency's first request for appropriations made over 60 days after the date of the report.

We are sending copies of the report to the Director, Office of Management and Budget; the Chairmen of the four above-mentioned committees; the Chairmen, House and Senate Committees on Veterans' Affairs; the Secretary of Defense; and other interested parties.

Sincerely yours,

Lawrence H. Thompson

Lawrence H. Thompson
Assistant Comptroller General

Executive Summary

Purpose

In fiscal year 1987, the Veterans Administration (VA) paid about $14.3 billion in disability benefits to about 3.8 million veterans and their survivors. VA uses its rating schedule as the official guide to assign disability ratings for thousands of veterans annually. Although VA has made periodic changes to the rating schedule, its last major revision to the rating schedule was in 1945. Because of the rating schedule's significance to veterans, GAO reviewed it to determine whether the medical criteria in the schedule are current enough for accurate and uniform disability decisions.

Background

The VA Administrator is required by federal law to adjust the rating schedule periodically to incorporate the results of medical advances and social and economic progress. The current VA rating schedule includes about 720 medical conditions resulting from disease or injury, and disability ratings are made on the basis of the degree of severity of the condition.

VA's disability programs are administered through 58 regional offices. Rating specialists at these offices generally request that a VA medical center examine a veteran and prepare a report on claimed impairments. A rating specialist then assigns a disability rating by converting the medical findings in the report to diagnostic codes and degrees of severity in the rating schedule.

GAO asked physicians from Jefferson Medical College, VA's Department of Medicine and Surgery, and the military services to analyze the schedule and determine whether the medical criteria in the rating schedule (the diagnosis and descriptions of degrees of severity) are sufficiently current. In addition, GAO administered a questionnaire to rating specialists, asking their views about the medical criteria for the rating schedule.

Results in Brief

VA cannot ensure that veterans are given accurate and uniform disability ratings because the rating schedule has not been adjusted to incorporate the results of many recent medical advances. Without current medical criteria, it is difficult for rating specialists to classify a disease or injury correctly. As a result, veterans may be assigned inconsistent ratings and some veterans may be undercompensated or overcompensated, depending on which rating specialist processes a disability claim.

Principal Findings

Physicians Suggest Improvements Are Needed to the Rating Schedule

Although VA has made some revisions to the rating schedule over the years, many medical advances have not been recognized in the schedule. In updating medical criteria, VA primarily reacts to proposed changes that originate from various sources, such as congressional staff and veterans' service organizations, rather than systematically reviewing the rating schedule. Since 1978, 10 of the 14 rating schedule sections have not been revised. The remaining four sections have been updated, but not comprehensively. (See pp. 13 and 14.)

At GAO's request, physicians from Jefferson Medical College, VA, and the military services analyzed the VA rating schedule. These physicians reported that substantial improvements are needed in the medical criteria. They identified examples of outdated terminology and ambiguous classifications. The physicians also identified medical conditions that should be added to the schedule. (See pp. 14 and 15.)

Rating Specialists Also Cite Need for Improved Medical Criteria

More than 50 percent of the rating specialists responding to a GAO questionnaire cited a need to improve medical criteria in the rating schedule. These rating specialists cited two principle concerns: (1) the rating schedule includes many diagnostic codes with minimal medical criteria for distinguishing between degrees of severity, and (2) many reports of medical examinations identify medical conditions that are not listed in the schedule. These inadequacies in the rating schedule's medical criteria can result in inconsistent ratings from one rating specialist to another.

Recommendations

To better ensure that the rating schedule serves as a practical tool in assigning uniform disability rates, GAO recommends that the VA Administrator

- prepare a plan for a comprehensive review of the rating schedule and, based on the results, revise medical criteria accordingly and
- implement a procedure for systematically reviewing the rating schedule to keep it updated.

Agency Comments

VA plans to implement GAO's recommendations to revise and systematically review the disability rating schedule.

The Department of Defense concurred with GAO's report findings and conclusions.

Contents

Abbreviations

GAO	General Accounting Office
VA	Veterans Administration

Introduction

The Veterans Administration (VA) pays billions of dollars to disabled veterans annually. VA determines the severity of a veteran's impairment(s) by converting medical findings on conditions to medical criteria (diagnoses and descriptions of degrees of severity) in VA's Schedule for Rating Disabilities (hereafter called the rating schedule). Because of the importance of the rating schedule in providing consistent and equitable benefits, we reviewed the schedule to see whether the medical criteria used are sufficiently current to ensure veterans are given accurate and uniform disability ratings.

VA Disability Programs

VA provides monthly cash benefits to disabled veterans of the U.S. Armed Forces and their survivors under its compensation and pension programs. Veterans are eligible for disability compensation benefits if they are partially or totally disabled by injury or disease incurred or aggravated during military service; these benefits are paid irrespective of any income earned by the veteran. Needy veterans are eligible for disability pension benefits if they are permanently and totally disabled by nonservice-connected impairments and served during a wartime period.[1]

The Congress legislates the amounts to be paid for disability compensation and pension benefits. In fiscal year 1987, VA paid (1) $10.5 billion in service-connected compensation benefits to 2.5 million veterans and their survivors and (2) $3.8 billion in nonservice pension benefits to 1.3 million veterans and their survivors.

Schedule for Rating Disabilities

Since early colonial days, various methods of rating disabilities have been used to award veterans benefits. The War Risk Insurance Act of 1917 created a rating schedule and provided the framework for today's compensation and pension programs for disabled veterans. The schedule was revised in 1921, 1925, 1933, and 1945; the 1945 rating schedule serves as the basis for current disability decisions.

Federal law (38 U.S.C. 355) states that the VA Administrator shall

> "adopt and apply a schedule of ratings of reductions in earning capacity from specific injuries or combination of injuries. The ratings shall be based, as far as practicable, upon the average impairments of earning capacity resulting from such injuries in civil occupations."

[1]The disability pension program automatically considers veterans totally disabled if they are 65 years of age or older and not working.

The VA Administrator shall "from time to time readjust this schedule of ratings in accordance with experience." Using this law, the VA Administrator is required to revise the rating schedule in light of medical advances in the treatment of disabilities and diseases, as well as social and economic progress.

According to VA officials, the Department of Veterans Benefits is responsible for revising the schedule when necessary. This responsibility is further delegated through the Director, Compensation and Pension Service, to the Chief of the Regulations Staff. Any proposed revision to the rating schedule must be approved by the Office of Management and Budget and published in the Federal Register for comment; the final ruling becomes the official policy for assigning disability ratings.

Each year, VA uses the rating schedule to assign disability rates for hundreds of thousands of veterans. The current rating schedule includes a listing of about 720 medical conditions (diagnostic codes) arranged by body system.

Each condition is described with medical criteria that are used to determine a disability rating, which is assigned according to the severity of the disease or injury. For example, the degree of severity for diagnostic code 7203 (stricture of the esophagus) is rated using the following criteria:

- permitting passage of liquids only, with marked impairment of good health (80 percent);
- severe, permitting liquids only (50 percent); and
- moderate (30 percent).

Eligible veterans are assigned disability ratings ranging from 0 to 100 percent, in increments of 10 percent. Effective December 1, 1987, monthly compensation benefits for veterans without dependents ranged from $71 to $1,411, as shown in table 1.1. Needy veterans without dependents who are assigned a 100-percent disability rating can receive monthly pension benefits up to $518. Veterans can receive additional compensation and pension benefits for dependents.

Table 1.1: VA Compensation Benefits for Veterans Without Dependents by Disability Rating

Disability rating (in percent)	Benefits	
	Monthly	Annually
10	$71	$852
20	133	1,596
30	202	2,424
40	289	3,468
50	410	4,920
60	516	6,192
70	652	7,824
80	754	9,048
90	849	10,188
100	1,411	16,932

Disability Determination Process

The Department of Veterans Benefits includes 58 regional offices, each with one or more rating boards; each board consists of a physician and two rating specialists (nonmedical). According to VA officials, the physician is primarily responsible for advising rating specialists on medical issues; the specialists generally request that VA medical center physicians examine a veteran and prepare a report on the impairments, if any. When a veteran applies for disability benefits, a rating specialist uses the veteran's service, medical, and personnel records for the time in service to help establish whether an impairment is service-connected or nonservice-connected.

After considering all available evidence, rating specialists convert the findings on medical conditions to diagnostic codes found in the rating schedule and select the appropriate degree of severity. If a veteran's impairments do not precisely fit diagnostic codes listed in the rating schedule, rating specialists assign a rating using a code assigned for similar symptoms; this is referred to as an analogous rating.

Objective, Scope, and Methodology

Our objective was to determine whether the medical criteria now used in VA's rating schedule reflect current medical advances and terminology so that rating specialists can make accurate and uniform disability decisions for veterans.

To evaluate the medical criteria, we relied extensively on the opinions and comments of physicians. During our preliminary audit work, we discussed the rating schedule with rating board physicians from two VA

regional offices. We then asked other physicians from VA's Department of Medicine and Surgery and the military services to (1) perform medical analyses of the medical criteria in VA's rating schedule and (2) identify outdated medical terminology, ambiguous or vaguely defined classifications, and medical conditions that are not listed in the rating schedule.

In November 1987, we asked physicians at the Jefferson Medical College, of Thomas Jefferson University, Philadelphia, to analyze VA's rating schedule (see app. I). We also interviewed 14 physicians from VA's Department of Medicine and Surgery who were referred to us by VA as representing their respective specialties. This department is VA's authority on medical issues. Lastly, we asked physicians from the military services to comment on the adequacy of the VA rating schedule since the military services use the schedule as a guide for assigning disability ratings to service members.

To determine whether rating specialists encounter problems converting findings on medical conditions to diagnostic codes in the rating schedule, we sent questionnaires to all 457 VA rating specialists as of September 30, 1987. Fifty-three of these specialists did not meet our study requirements because they had either not been on the rating board for at least 1 year or were not presently working on the board (for example, retired or on extended sick leave). Of the 404 specialists remaining, 383 (95 percent) responded (see apps. II and III).

We reviewed procedures followed by the military services when implementing the military disability programs and interviewed military service officials in Washington, D.C., and selected field locations. We interviewed Social Security Administration officials to determine what medical criteria they use for awarding social security disability benefits and how they update these criteria. We reviewed medical textbooks and spoke with the American Medical Association to identify its current criteria for rating impairments.

We reviewed (1) the 1945 and current VA rating schedules (as mentioned earlier, the 1945 schedule provided the basis for the current schedule), (2) VA policies and procedures for revising the rating schedule, (3) pertinent laws and regulations, (4) internal VA studies, and (5) records on amendments to the rating schedule since 1945. We also interviewed VA officials to discuss policies, procedures, and the results of our review.

We conducted our review from February 1987 to April 1988. It was done in accordance with generally accepted government auditing standards.

Need to Update Medical Criteria Used in VA's Disability Rating Schedule

Veterans may not receive accurate and uniform disability decisions because the medical criteria in the rating schedule are incomplete and outdated. It is inherently difficult to achieve uniform and accurate administration of this type of program; out-of-date rating schedules make it almost impossible. Federal law requires that the VA Administrator revise the rating schedule to reflect medical advances. Although the schedule includes some revisions, VA has not comprehensively updated the 1945 schedule to incorporate the results of medical advances and experience. This condition partly exists because VA does not systematically review the schedule to identify needed improvements. Physicians and VA rating specialists told us that improvements are needed in the schedule.

VA Has Not Ensured That Medical Criteria Are Current

The current rating schedule, developed in 1945, was published in 1946. It contains 14 sections; 1 has not been revised since 1964 and only 4 have been revised since 1978, as shown below.

- Dental and oral conditions, 1964;
- hemic and lymphatic systems, 1975;
- digestive system, 1976;
- genitourinary system, 1976;
- gynecological conditions, 1976;
- respiratory system, 1978;
- cardiovascular system, 1978;
- skin, 1978;
- systemic diseases, 1978;
- neurological and convulsive disorders, 1978;
- endocrine system, 1981;
- musculoskeletal system, 1986;
- organs of special sense, 1987; and
- mental disorders, 1988.

Even the four sections of the rating schedule that VA revised since 1978 did not represent a comprehensive update of medical criteria. For example, the 1988 mental disorder revision primarily brought VA's mental terminology into compliance with the terminology in the 1980 manual published by the American Psychiatric Association. VA did not, however, attempt to improve the specificity of definitions used to more correctly classify mental impairments by degrees of medical severity.

Before 1969, the VA Disability Policy Board, which consisted of eight medical and legal specialists, was responsible for revising the rating

schedule, including researching changes to reflect advances in medicine. According to VA officials, the board was disbanded around 1969. Currently, there are two nonmedical persons who are responsible for updating the rating schedule. These nonmedical persons told us they primarily react to proposed changes that originate from a variety of sources, including VA's experience with claims, enacted laws, veterans' service organizations, and congressional staff.

VA does not use a systematic process to review sections of the rating schedule in order to identify where updates of medical criteria are needed. VA officials stated that physicians in the Department of Medicine and Surgery are asked only to concur on proposed changes to the schedule that affect medical issues. The department, however, does not routinely send VA physicians copies of the rating schedule in order to solicit revisions in medical criteria.

Physicians View VA's Rating Schedule as Not Medically Current

VA has not performed a comprehensive update of the medical criteria in its disability rating schedule since 1945. We asked physicians from Jefferson Medical College, VA's Department of Medicine and Surgery, and the military services to analyze the schedule and to comment on the adequacy of medical criteria. The physicians concluded that substantial improvements were needed.

VA Physicians' Views

We asked 14 physicians in VA's central office to comment on the adequacy of medical criteria in the rating schedule. The VA physicians identified examples of (1) outdated terminology, (2) impairments that are not clearly defined, and (3) medical conditions that should be added to the rating schedule. The physicians stated that all sections of the rating schedule needed improved medical criteria, but some sections (for example, the hemic and lymphatic system and cardiovascular system) needed significant revisions.

Military Physicians' Views

The military services can discharge people who are considered "unfit for service" due to a disability. In 1949, the military services started using the VA rating schedule as a guide for assigning disability ratings. In September 1987, physicians from the Departments of the Army, Navy, and Air Force (1) provided us with comments on problems with the VA medical criteria, for example, the description of diagnoses that lack clarity and comprehension; and (2) suggested ways the schedule could be

updated to make it more useful, for example, by adding commonly diagnosed impairments that are not presently included in the schedule.

According to Army, Navy, and Air Force officials, even though VA retains primary responsibility for its schedule, these officials would like to provide input to any update of the VA schedule.

Jefferson Medical College Physicians' Views

Jefferson physicians reviewed the VA rating schedule to determine whether the medical criteria were current when compared with up-to-date terminology and practice. Jefferson physicians stated that the medical criteria do not (1) contain enough specific information, which is currently available in modern laboratory tests and examination procedures; (2) reflect current terminology; and (3) include specific diagnostic codes for each medical condition. Jefferson physicians concluded that major changes were necessary in many sections of the rating schedule and some sections contain ambiguities and vagueness of a magnitude that justifies the development of entirely new classifications. Without a major overhaul, they stated that inaccurate classifications of impairments are highly probable (see app. I).

The Jefferson physicians reported that ambiguous or vaguely defined classifications make it difficult to correctly classify a disease or injury. Improving the specificity of classifications through the use of appropriate diagnostic tests would decrease the need for interpretation by rating specialists, thereby improving reliability and validity when evaluating degree of severity.

These physicians also emphasized that when the terminology in the rating schedule is outdated, it does not match the current medical terminology used by examining physicians. Jefferson physicians emphasized that the need to translate current terminology into the older terminology in the rating schedule is a potential source of error in classification.

When the rating schedule does not list a separate diagnostic code for each medical condition, rating specialists must rely on analogous categories as the basis for assigning disability ratings. This is inherently less reliable than assigning ratings using a diagnostic code that specifically matches the medical findings of the examining physicians. Jefferson physicians reported that some medical conditions (and corresponding diagnostic codes) should be added to most of the sections in the schedule.

VA Rating Specialists Identify Rating Schedule Problems

According to VA officials, the rating schedule is designed to allow rating specialists a significant degree of judgment in classifying disabilities. This inherent judgment factor in the rating schedule, however, may prevent rating specialists from consistently giving accurate and uniform disability ratings to veterans.

We identified two areas where the judgment of the rating specialists may result in ratings that are particularly inconsistent. First, the rating schedule includes many diagnostic codes with minimal medical criteria (such as "severe" or "moderate") to distinguish between degrees of severity. For example, a veteran with a liver impairment can receive either a 30-percent rating for severe symptoms or a 20-percent rating for moderate symptoms. In these situations, the rating specialist must subjectively decide which degree of severity is supported by medical findings. Second, a medical examination may identify a medical condition that is not listed in the schedule. The rating specialist must then rate by analogy, as mentioned earlier, and select a diagnostic code that has symptoms similar to the identified medical condition.

Rating Specialists Responses to GAO Questionnaire

The rating specialists' skills at converting medical findings to diagnostic codes are critical to accurate ratings. In October 1987, we sent questionnaires to VA rating specialists to obtain their opinions about using VA physicians' reports of physical examinations and the rating schedule to determine veterans' disability ratings. We asked a series of questions about translating medical findings to diagnostic codes with degrees of severity. Of VA's 404 rating specialists, 383 (95 percent) responded to our questionnaire.

The difficulty in assigning ratings varied depending on which of the 14 sections was involved. Sixty-four percent of the rating specialists responded that neurological and convulsive disorders were difficult to rate, whereas only 6 percent responded that skin disorders were difficult to rate. The rating specialists cited two primary reasons for their difficulties: (1) medical criteria for disability percentages were not descriptive enough in the rating schedule to make judgments; (2) decisions had to be based on the patient's self-reported, unverified experiences.

We asked rating specialists whether they could support two or more rating percentages with the same medical evidence. Such situations, in our opinion, increase the risk of inconsistencies and lack of uniformity in rating decisions. Of the 383 specialists responding, 61 percent reported

it was "somewhat likely" or "very likely" for this situation to occur when rating mental disorders; 51 percent responded similarly for neurological and convulsive disorders. For all 14 sections, 22 percent responded that it was "somewhat likely" or "very likely" for this situation to occur.

To obtain information on the use of analogous codes, we asked rating specialists a series of questions concerning medical conditions that were not listed in the schedule. Rating specialists reported that a large number of disability cases now require rating by analogy, and the number has been increasing. We also identified 15 medical conditions not listed in the rating schedule and asked rating specialists to list the analogous codes they could use to rate the 15 conditions. Rating specialists reported that at least 10 different diagnostic codes could be used for each of the medical conditions.

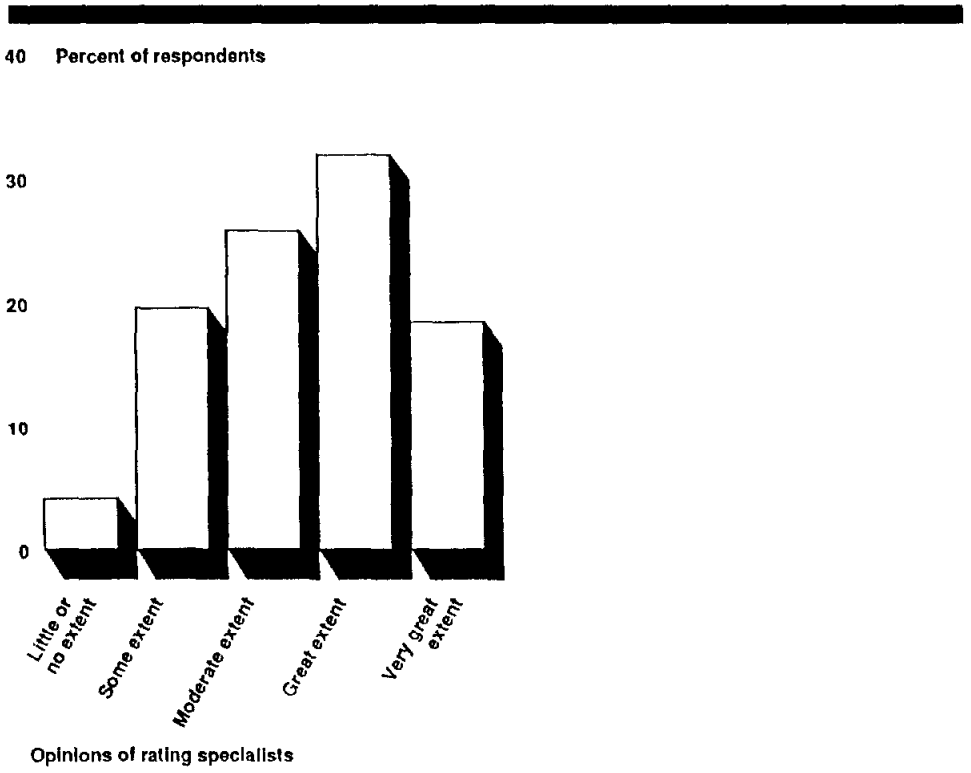
For 12 of the 15 medical conditions, rating specialists predominantly selected different impairments that used essentially the same range of disability percentages; in these instances, the veteran's benefits probably would not vary. But 3 of the 15 medical conditions had a higher likelihood of inconsistency and of inequitable treatment of veterans. For example, 60 percent of the respondents selected a diagnostic code for Crohn's disease with degrees of severity ranging from 10 to 100 percent; about 30 percent selected codes with degrees of severity ranging from 0 to 30 percent. Those impairments assigned a diagnostic code with a maximum 30-percent rating for degree of severity would entitle a veteran without dependents to receive up to $202 a month; a diagnostic code with the maximum 100-percent rating would entitle the same veteran to receive up to $1,411 a month.

We asked VA rating specialists whether the schedule needed changes. Of 383 responses, about 50 percent stated there was a great need to (1) quantify the rating schedule descriptions for the degrees of severity (see fig. 2.1) and (2) update diagnostic codes (along with appropriate guidelines) to take into account additional medical conditions (see fig. 2.2). About 45 percent stated there was a great need to update medical terminology (see fig. 2.3).

VA Internal Study

Because comparable medical conditions should be given comparable ratings, VA monitors the rating boards to determine whether ratings are reasonably consistent. In 1983, VA initiated an internal study that sampled the uniformity of rating board decisions. The sample included 13 cases

Figure 2.1: Extent to Which Descriptions for Degrees of Disability Need to Be Quantified



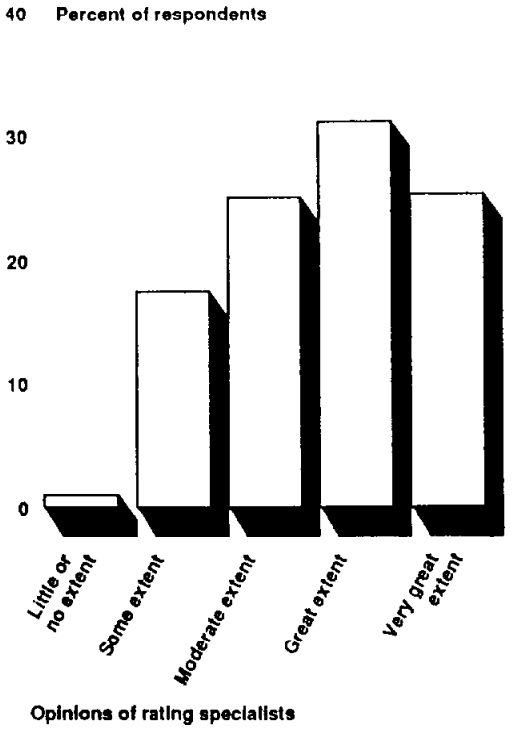
representing 23 separate impairments for which veterans had already been awarded VA disability compensation benefits. All relevant medical information necessary to deciding a rating was taken from the case files: Copies were then sent to rating boards at 56 of the 58 VA regional offices participating in the assessment.

At each location, one or more rating boards (or a combination of board members) assigned disability ratings using the medical information supplied. Although some of the disabilities were not rated by all participating regional offices, the study showed that, for the 23 impairments:

- 11 were assigned two different ratings;
- 6 were assigned three different ratings;
- 4 were assigned four different ratings; and
- 2 were assigned five different ratings.

Several veterans were assigned a wide range of disability ratings, which would result in significantly different monthly benefit payments. For example, one veteran with hypertensive heart disease was assigned five

Figure 2.2: Extent to Which Diagnostic Codes Are Needed for Additional Medical Conditions



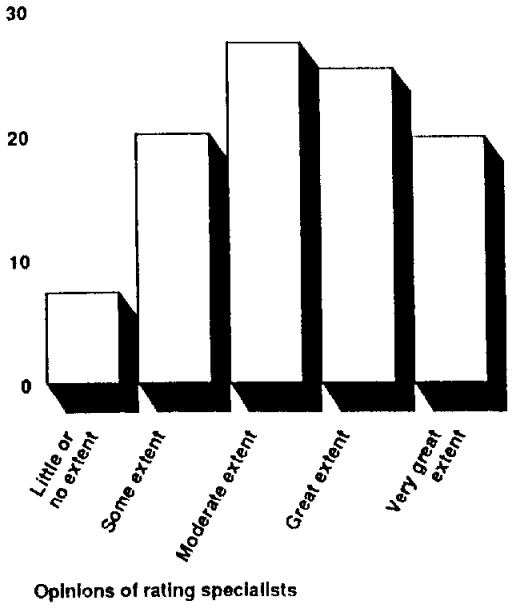
different ratings, ranging from 10 to 100 percent; 25 rating boards rated this veteran 30-percent disabled (for $202) and 21 boards rated him 60-percent disabled (for $516). In another instance, a veteran with post traumatic stress disorder was rated from 0- to 70-percent disabled. Sixteen boards rated him at 10 percent (for $71), 19 at 30 percent (for $202), and 13 at 50 percent (for $410).

This study demonstrated that veterans were given different ratings dependent on the subjective judgment of the rating specialists. This study concluded that the vagueness and generality of the rating schedule contributed to the lack of uniformity between rating boards in rating disabilities.

Conclusions

The VA rating schedule is a key factor in determining a veteran's claim for disability benefits; however veterans may not be awarded consistent and equitable disability benefits because the medical criteria in VA's rating schedule are neither complete nor current. Also, the military services

Figure 2.3: Extent to Which Medical Terminology Needs to Be Updated



use the VA rating schedule to make decisions for disabled military personnel. Although some sections of the rating schedule have been revised recently, the schedule has not been comprehensively updated since 1945. Medical experts and VA rating specialists told us that the rating schedule's medical criteria need to be updated.

VA does not systematically review the rating schedule to identify needed improvements. Without a clinically sound and up-to-date system of classifying impairments, rating specialists may not assign medically accurate or uniform ratings. Although some sections of the rating schedule may continue to require predominantly judgmental decisions by rating specialists, the medical criteria can be made more up-to-date and complete. This will reduce reliance on individual judgment, and contribute to more equitable decisions.

Recommendations to the Administrator of Veterans Affairs

To better ensure that the rating schedule serves as a practical tool in assigning uniform disability ratings to veterans, GAO recommends that the Administrator

- prepare a plan for a comprehensive review of the rating schedule and, using the results of the review, revise medical criteria accordingly and
- implement a procedure for systematically reviewing the rating schedule so as to keep it up-to-date in the future.

Agency Comments

We requested comments on a draft of this report from VA and the Department of Defense. Their comments are summarized below. Their written comments are presented in full in appendixes IV and V respectively.

VA Comments

VA agreed with our recommendation that it prepare a plan for a comprehensive review of the rating schedule and, using the results of the review, revise medical criteria accordingly. VA stated that in preparing such a plan it would perform a methodical review of the rating schedule by body system. However, the medical criteria will not be revised until the rating schedule changes have cleared the public notice and comment process.

VA also agreed with our recommendation that it implement a procedure for systematically reviewing the rating schedule to keep it up-to-date. VA stated that the comprehensive review established under the first recommendation will become a cyclical process.

Department of Defense Comments

The Department of Defense stated that it agreed with our conclusions and recommendations.

Jefferson Medical College Clinical Review of the VA Disability Rating Schedule

Report to the

United States General Accounting Office

(Contract # 8130080)

A CLINICAL REVIEW OF THE

VETERANS ADMINISTRATION DISABILITY RATING SCHEDULE

February 1988

Jefferson Medical College
Thomas Jefferson University
Philadelphia, Pennsylvania

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CONTENTS

I. THE REVIEW PANEL

Clinical reviews of the current Veteran's Administration's Disability Rating Schedule were carried out by a selected group of Physicians on the faculty of Jefferson Medical College of Thomas Jefferson University. The project was managed by Jefferson's Center for Research in Medical Education and Health Care. A number of meetings were held (see below) and attended by GAO and Jefferson project staff to refine project goals, review project progress and initial drafts of this report. The U.S. General Accounting Office Staff provided valuable input throughout the course of the project. The clinical reviews, however, represent the professional judgment of the Jefferson project staff and consulting physicians, and do not represent an official opinion of the GAO or the United States Government.

Project Meetings

Date	Jefferson Medical College	GAO
12/8/87	D. Louis	W. Bricking
	P. Chodoff, M.D.	D. McCafferty
	J. Gonnella, M.D.	
	H. Weitz, M.D.	
1/11/88	D. Louis	R. Wychulis
	P. Chodoff, M.D.	W. Bricking
	H. Weitz, M.D.	D. McCafferty
2/11/88	D. Louis	R. Wychulis
	P. Chodoff, M.D.	W. Bricking
		D. McCafferty

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Professor of Medicine
Vice President and Dean
Jefferson Medical College

Peter Chodoff, M.D., M.P.H.
Professor of Anesthesiology
Assistant Dean
Jefferson Medical College

Physician Panel

Name and Title	Section(s) Reviewed
John J. Gartland, M.D. James Edwards Emeritus Professor of Orthopedic Surgery	The Musculoskeletal System
Thomas Behrendt, M.D. Professor of Ophthalmology Associate Professor of Family Medicine	The Organs of Special Sense - Vision
William A. Baltzell, M.D. Clinical Professor of Otolaryngology	The Organs of Special Sense - Hearing
Joseph F. Rodgers, M.D. Clinical Professor of Medicine Associate Dean	Systemic Diseases Non-pulmonary Tuberculosis, Inactive
Geno J. Merli, M.D. Clinical Associate Professor of Medicine Director, Division of Internal Medicine	The Respiratory System

Howard H. Weitz, M.D. Clinical Associate Professor of Medicine Division of Cardiology and Internal Medicine	The Cardiovascular System
Philip Nimoityn, M.D. Instructor of Medicine Division of Cardiology and Internal Medicine	The Cardiovascular System
Warren P. Goldburgh, M.D. Clinical Professor of Medicine	The Cardiovascular System
Joseph F. Majdan, M.D. Clinical Assistant Professor of Medicine	The Cardiovascular System
Steven P. Peikin, M.D. Associate Professor of Medicine	The Digestive System
Nancy Jermanovich, M.D. Assistant Professor of Medicine Division of Nephrology	The Genitourinary System
Richard A. Baker, M.D. Professor and Vice Chairman Obstetrics and Gynecology	Gynecological Conditions
Edward H. McGehee, M.D. Professor of Family Medicine	The Hemic and Lymphatic Systems
Young C. Kauh, M.D. Clinical Professor of Dermatology	The Skin
Paul C. Brucker, M.D. Alumni Professor and Chairman Department of Family Medicine	The Endocrine System
John M. Bertoni, M.D.,Ph.D. Associate Professor of Neurology	Neurological Conditions and Convulsive Disorders
Bryce Templeton, M.D. Professor of Psychiatry and Human Behavior	Mental Disorders
Anthony Farole, D.M.D. Assistant Professor of Otolaryngology (Oral Surgery)	Dental and Oral Conditions

II. BACKGROUND

Title 38, United States Code, Section 355 provides for the adoption by the Veteran's Administration (VA) of a Schedule for Rating Disabilities. This schedule serves as the official guide for classifying clinical findings and converting these findings into degrees of disability.

The rating schedule is a guide for evaluating disability resulting from all types of diseases and injuries sustained while serving in the military service. The disease or injury need not be the result of combat action. Disability is an administrative term that encompasses medical impairment and economic loss. Impairment is a functional loss due to alterations in the anatomic, pathologic or physiologic systems caused by disease or injury.

Use of this schedule in the adjudication of disability requires a complete medical examination. A lay rating specialist interprets the records of the treating facility and physician and then makes the disability determination. If consistent and fair decisions are to be made, the taxonomy must be up-to-date and consistently interpretable.

While some parts of the VA Rating schedule have been revised recently, the schedule has not undergone a complete update since 1945. The U.S. General Accounting Office (GAO), concerned with the equity of VA disability decisions, is conducting a review of the VA criteria for rating disabilities. In particular, the GAO wishes to determine whether or not the disability rating schedule reflects sufficient current medical knowledge and terminology to allow rating specialists to make equitable disability determinations.

III. GOALS OF THE REVIEW

The Center for Research in Medical Education and Health Care of Jefferson Medical College was asked to perform a clinical review of the VA rating schedule to determine the currency of medical knowledge and terminology contained therein.

The goal of the review was to identify common medical conditions not included in the schedule, outdated terminology, and ambiguity or clinical heterogeneity in the current classification, and to provide the GAO with sufficient examples of deficiencies in each body system section to document the need for a revised classification. This review was not intended to be an exhaustive analysis of every situation that might require improvement. Nor did the review address any economic issues inherent in disability rating.

Written guidelines for review were provided to the clinical panelists who were asked to address the following questions:

(1) Outdated terminology. Are there examples of terminology not currently used? Such examples could relate to diagnostic labels, tests, and/or procedures.

(2) Gaps in the classification. Are there medical conditions missing from the current rating schedule that should be added?

(3) Ambiguity/clinical heterogeneity in the classification. Are there categories in the current classification so ambiguously defined that it would be difficult to reliably assign individuals them? Are there individual categories in the current rating system that cover an inappropriately broad range of severity?

Can categories and ratings be more specifically defined to improve classification? Are there new diagnostic or prognostic tests that would improve the classification?

(4) Convalescent periods. For some conditions, the rating schedule specifies postoperative convalescent periods. Given current surgical techniques, are the specified periods appropriate?

IV. HIGHLIGHTS OF FINDINGS

Highlights of the clinical reviews are briefly summarized on the following pages.

The clinical reviewers are consistent in their call for improvement in the current VA disability rating schedule. There is a consensus among them that major changes are necessary in many sections of the schedule; and that some sections contain ambiguities and vagueness of a magnitude that justify the development of entirely new classifications rather than attempts aimed at patching or adjusting existing ones. Without a major overhaul, inaccurate classifications of impairment are highly probable.

Gaps in the Classification

Medical conditions missing from the rating schedule force the rating specialists to use "analogous" categories to classify individuals. This is inherently less reliable than assigning patients to categories that more closely match the medical problem documented by the examining physician. The impairment associated with an "analogous" condition may be different from that actually faced by the veteran. Unless these gaps are filled, there is significant risk that patients with these conditions will continue to be misclassified.

Most section reviewers noted gaps in the current classification system. In the Section on Organs of Special Sense - Vision, there is no means of rating a patient with macular scarring or degeneration who may retain close to 20/20 central vision, but perform so slowly that great difficulty would be encountered in performing tasks for which visual efficiency is required.

Examples of gaps in the Digestive System Section include "duodenitis" which can be debilitating even in the absence of an ulcer and, under gallbladder problems, "choledocholithiasis" and "common bile duct, stricture." The reviewer has recommended that a category be added to the Genitourinary System Section to classify "renal tubular disorders." Disability ratings should be developed to reflect both the degree of renal dysfunction and the extent of metabolic impairment.

"Glucose-6-phosphate dehydrogenase (G-6-PD) deficiency" is a disorder (hemic and lymphatic systems) that was not known when the classification was established. The deficiency destroys red cells (hemolysis) when an individual takes drugs such as anti-malarials, sulfonamides, maybe aspirin or many other commonly prescribed agents.

The reviewer of the Mental Disorders Section identified significant gaps in the current classification and recommended that the entire section be replaced by the classification system published by the American Psychiatric Association in Diagnostic and Statistical Manual of Mental Disorders (DSM-III, 1982 or DSM-IIIR, 1987).

Advances in treatment make revisions in the classification necessary. Prosthetic joint implants have been accompanied by problems that require changes in the rating schedule. The chronic postoperative infection and aseptic loosening that may follow prosthetic implantation are among the more recently recognized causes for impairment.

It was also recommended that a category for AIDS be added to the rating schedule.

Ambiguity and Clinical Heterogeneity

Ambiguous or vaguely defined categories make it difficult to reliably classify a disease or injury. Also, if the classification system includes clinically heterogeneous categories, individuals with different conditions or different levels of severity, will inappropriately end up in the same category.

A classification system that reflects current medical understanding of the causes and manifestations of disease could significantly improve this situation. Improving the specificity of category definitions through the use of appropriate diagnostic tests would decrease the need for interpretation, and thereby improve the reliability and validity of the classification and the evaluation of disabled veterans.

Problems of ambiguity and clinical heterogeneity in the current rating schedule were identified by all section reviewers. In the Endocrine System Section, for example, diabetes mellitus is listed as one condition. This very common disease

should be classified into two categories: "Type I (insulin dependent) diabetes mellitus" and "Type II (non-insulin dependent) diabetes mellitus." A new system should be developed for assessing the different impairments that result from Type I and Type II diabetes mellitus.

The reviewer of the Mental Disorders Section felt that the entire classification needed to be revised in to eliminate the ambiguities in the current rating schedule.

The reviewer of Systemic Diseases felt that this section should be eliminated, since most diseases included in the section can be more specifically classified based on etiology and the target organ(s) affected by the disease. Conditions such as beriberi, pellagra, scurvy, etc. would be more appropriately classified under avitaminosis.

For the Digestive System Section, it was recommended that the single category, "colitis, ulcerative" be split into two categories, "proctitis" and "global colitis" since the prognosis and degree of impairment usually differs between the two.

It was also suggested that "diseases of the trachea and bronchi" in the respiratory system section be classified under the general heading of "chronic obstructive pulmonary disease (COPD)," with sub-classifications of bronchitis, chronic and emphysema.

Reviewers cited examples of the need for increased specificity of definition throughout the rating schedule in order to achieve reliable assignment of severity levels. In the Respiratory System Section, the classification of asthma requires a complete revision to include specific criteria to define severity using pulmonary function tests, physical examination, arterial blood gases and symptoms.

There is only a single classification for "New growth, malignant, skin" in the current rating schedule, and the reviewer felt that a more detailed sub-classification should be developed based on the cells and tissues involved. The new classification should also reflect the extensive advances in knowledge of cutaneous malignancies. Impairments associated with various skin tumors can be significantly different from one another. The reviewer felt in addition, that radiation dermatitis should be added to the classification.

It was also suggested that the classification of "temporomandibular articulation, limited motion of" in the Section on Dental and Oral Conditions be revised to reflect the degree of limitation in motion rather than the current 1/4 inch to 1/2 inch because patients of different body sizes have different mouth openings. Comparing the degree of limitation to the patient's normal opening is more relevant than the absolute size of opening.

Specification of laboratory tests in the current classification is out of date and incomplete. For example, in the Endocrine System Section, the objective laboratory tests listed to evaluate hyperthyroidism are not complete. In 1988, many other thyroid function tests are usually performed to make a more precise diagnosis as to the etiology of thyrotoxicosis.

The reviewer of the Genitourinary System Section felt that a number of classifications for kidney disease were unacceptably ambiguous and should be modified to include the degree of renal dysfunction as measured by BUN and creatinine.

Outdated Terminology

The results of medical examination of veterans will be reported in current medical terminology. If the terminology in the rating schedule is outdated, it will not match the language used by examining physicians. The need to "translate" current terminology into rating schedule terminology is a potential source of errors in classification.

The clinical panel cited examples of outdated terminology throughout the current rating schedule. In the Cardiovascular System Section, the use of "auricular" to represent 'originating from the heart atrium,' should be replaced with the term "atrial."

The Neurological Conditions and Convulsive Disorders Section contains several terms no longer in use, such as "encephalitis, epidemic, chronic" and "paramyoclonus multiplex."

In the Digestive System Section, the term "gastritis, hypertrophic" should be changed by omitting the word "hypertrophic" since this is outdated terminology. The reviewer of Organs of Special Sense - Hearing felt that the term "otitis interna" is outdated and should be eliminated.

Outdated terminology was noted in the text as well as in classification titles. The term "nonprotein nitrogen," is obsolete and should be deleted from the Genitourinary System Section.

Convalescent Periods

In the current rating schedule a convalescent period has been specified for some surgical conditions. Modern surgical techniques have reduced the length of postoperative convalescent periods, making inappropriate those specified in the current rating schedule.

It was suggested by the reviewer that the six-month convalescent period allowed for "Ovaries, removal of both" be reduced. Similarly, while the 100% disability for one year following coronary artery bypass surgery may have been appropriate when first introduced, it is considered excessive in view of the current techniques for performing the procedure.

Other Reviewer Comments

Modern treatment has reduced the impairment associated with many diseases. While examples of this type of situation were identified by the clinical panel, modification of the rating schedule to accommodate the potential reduction in impairment is a policy issue beyond the scope of this review. Pernicious anemia, for example, is now better understood; and the missing vitamin is manufactured and available for therapy. There is little reason for impairment as a result of this disease. A failure to be injected with Vitamin B_{12}, as prescribed, is the chief reason for impairment. According to the physician who reviewed the section on the hemic and lymphatic systems: "Today, true pernicious anemia is one of the nicest diagnoses a practitioner can make."

On the preceding pages we have highlighted the recommendations made by the reviewing physicians. Detailed comments and suggestions on the current schedule are included in the individual section reviews which follow.

V. CONCLUSION

While the number of deficiencies noted by each of the reviewers differed, there was a strong consensus that major flaws exist in the medical classification(s) of the current rating schedule.

Diseases that could cause impairment, but are not included in the current rating system have been identified. A recommendation was made to revise the system to reflect current medical terminology. Numerous examples of ambiguity that could lead to misclassification were identified.

Understanding of the etiology of disease, the availability of more accurate and specific laboratory tests, and improved treatment methods make it feasible to develop a classification system that would provide greater accuracy in the assessment of impairment, allow more reliability in the classification of individual cases, and be easier and less costly to use.

The Veterans Administration Schedule for Rating Disabilities has significant implications for thousands of veterans. Non-medical issues, such as the level of disability corresponding to a specified medical impairment, were beyond the scope of our review. However, a clinically sound, modern system for classification of impairment is a necessary foundation for an equitable disability rating system.

The classification should include specific categories for all major causes of impairment. The category definitions should reflect current terminology and availability of modern laboratory and other diagnostic information. The category definitions should be as specific and precise as possible to assure uniform and consistent disability determination.

The current Veterans Administration Disability Rating Schedule clearly does not meet these criteria.

GAO Questionnaire for VA Rating Specialists

U. S. GENERAL ACCOUNTING OFFICE

REVIEW OF VETERANS ADMINISTRATION CRITERIA
FOR RATING DISABILITIES

The purpose of this questionnaire is to obtain information on your opinions and experiences as a Veterans Administration Rating Specialist. The questionnaire asks for your perspectives of VA Medical examination reports and the Schedule for Rating Disabilities.

Please respond to each of the following questions for fiscal year 1987 (October 1, 1986 - September 30, 1987), unless otherwise indicated.

Please provide your name and telephone number so that we may contact you if we need additional information.

Name: _____

Office
Phone No.: _____

Q1. What is your current job title?
(CHECK ONE.)

1. [ ] Non-medical Rating Specialist ---> (CONTINUE)
2. [ ] Medical Rating Specialist (Physician) ---> (STOP! PLEASE RETURN THIS QUESTIONNAIRE)
3. [ ] Other (PLEASE SPECIFY.) _____ ---> (STOP! PLEASE RETURN THIS QUESTIONNAIRE)

Q2. How many years of experience do you have as a rating specialist? (Please include your training period experience.)

_____ Years

Q3. For fiscal year 1987 (October 1, 1986 - September 30, 1987), please estimate the number of disability decisions you have made. (Do not include Confirm and Continue (C & C) decisions.)

To calculate this figure, consider the number of non-C&C decisions you made in a week multiplied by the number of weeks you worked in the fiscal year.

_____ Decisions

MEDICAL EXAMINATION REPORTS

04. Listed below are characteristics of a medical examination report. When determining a disability rating, how adequate or inadequate are each of the following characteristics in the VA medical examination reports that you receive?

(CHECK ONE FOR EACH CHARACTERISTIC.)

CHARACTERISTICS FOR RATING PURPOSES	Much More Than Adequate (1)	More Than Adequate (2)	Adequate (3)	Less Than Adequate (4)	Much Less Than Adequate (5)
1. Completeness of medical information					
2. Usefulness of medical information					
3. Understandability of medical information					
4. Other (PLEASE SPECIFY.) _____					

05. Overall, how adequate or inadequate are the VA medical examination reports that you have received in fiscal year 1987? (CHECK ONE.)

1. [ ] Much more than adequate
2. [ ] More than adequate
3. [ ] Adequate
4. [ ] Less than adequate
5. [ ] Much less than adequate

06. Consider the medical examination reports that you have received from the VA Medical Centers for fiscal year 1987. In general, what percent of the reports were incomplete, causing you to request additional medical information? (ENTER '0', IF NONE.)

_____ percent

SCHEDULE FOR RATING DISABILITIES

07. Listed below are body systems, conditions or disorders. In your experience when using the VA Schedule of Rating Disabilities and when examination evidence is complete, in general, how easy or difficult is assigning degrees of disability (severe, moderately severe, etc.) to each of the following?

(CHECK ONE FOR EACH BODY SYSTEM/CONDITION/DISORDER.)

BODY SYSTEM, CONDITION OR DISORDER	Very Easy (1)	Generally Easy (2)	Neither Easy Nor Difficult (3)	Generally Difficult (4)	Very Difficult (5)
1. Musculoskeletal (5000-5399)					
2. Organs of Special Sense (6000-6299)					
3. Systemic Diseases (6300-6399)					
4. Respiratory (6500-6899)					
5. Cardiovascular (7000-7199)					
6. Digestive (7200-7399)					
7. Genitourinary (7500-7599)					
8. Gynecological Conditions (7600-7699)					
9. Hemic and Lymphatic (7700-7799)					
10. Skin (7800-7899)					
11. Endocrine (7900-7999)					
12. Neurological and Convulsive Disorders (8000-8999)					
13. Mental Disorders (9200-9599)					
14. Dental and Oral Conditions (9900-9999)					

IF YOU CHECKED 'GENERALLY DIFFICULT' OR 'VERY DIFFICULT' FOR ANY PART OF QUESTION 7, CONTINUE TO QUESTION 08; OTHERWISE, GO TO QUESTION 09 ON PAGE 7.

08. For each body system, condition, or disorder that you checked 'generally difficult' or 'very difficult' in QUESTION 07, please indicate in the sections below for each: (1) the name of the body system, condition or disorder and (2) the extent, if any, each of the following was a reason for the level of difficulty for that body system. Please assume you have complete medical information.

(WE HAVE PROVIDED SPACE FOR 6 BODY SYSTEM RESPONSES. IF YOU HAD MORE THAN 6, PLEASE MAKE ADDITIONAL COPIES TO COMPLETE THIS QUESTION AND ATTACH THEM TO THE QUESTIONNAIRE.)

A. BODY SYSTEM: _____

(CHECK ONE FOR EACH REASON.)

REASONS	Little or No Extent (1)		Some Extent (2)	Moderate Extent (3)	Great Extent (4)	Very Great Extent (5)
1. Rating specialist must make judgment based on patient's self-reported, unverified experiences						
2. Non-existent diagnostic codes						
3. The test procedures provided in the medical examination report did not match the tests required in the Schedule for Rating Disabilities						
4. The degrees of disability are not descriptive enough to make judgment						
5. Other (PLEASE SPECIFY.) _____						

B. BODY SYSTEM: _____

(CHECK ONE FOR EACH REASON.)

REASONS	Little or No Extent (1)		Some Extent (2)	Moderate Extent (3)	Great Extent (4)	Very Great Extent (5)
1. Rating specialist must make judgment based on patient's self-reported, unverified experiences						
2. Non-existent diagnostic codes						
3. The test procedures provided in the medical examination report did not match the tests required in the Schedule for Rating Disabilities						
4. The degrees of disability are not descriptive enough to make judgment						
5. Other (PLEASE SPECIFY.) _____						

C. BODY SYSTEM: _____

(CHECK ONE FOR EACH REASON.)

REASONS	Little or No Extent (1)		Some Extent (2)	Moderate Extent (3)	Great Extent (4)	Very Great Extent (5)
1. Rating specialist must make judgment based on patient's self-reported, unverified experiences						
2. Non-existent diagnostic codes						
3. The test procedures provided in the medical examination report did not match the tests required in the Schedule for Rating Disabilities						
4. The degrees of disability are not descriptive enough to make judgment						
5. Other (PLEASE SPECIFY.) _____						

D. BODY SYSTEM: _____

(CHECK ONE FOR EACH REASON.)

REASONS	Little or No Extent (1)	Some Extent (2)	Moderate Extent (3)	Great Extent (4)	Very Great Extent (5)
1. Rating specialist must make judgment based on patient's self-reported, unverified experiences					
2. Non-existent diagnostic codes					
3. The test procedures provided in the medical examination report did not match the tests required in the Schedule for Rating Disabilities					
4. The degrees of disability are not descriptive enough to make judgment					
5. Other (PLEASE SPECIFY.) _____					

E. BODY SYSTEM: _____

(CHECK ONE FOR EACH REASON.)

REASONS	Little or No Extent (1)	Some Extent (2)	Moderate Extent (3)	Great Extent (4)	Very Great Extent (5)
1. Rating specialist must make judgment based on patient's self-reported, unverified experiences					
2. Non-existent diagnostic codes					
3. The test procedures provided in the medical examination report did not match the tests required in the Schedule for Rating Disabilities					
4. The degrees of disability are not descriptive enough to make judgment					
5. Other (PLEASE SPECIFY.) _____					

F. BODY SYSTEM: _____

(CHECK ONE FOR EACH REASON.)

REASONS	Little or No Extent (1)		Some Extent (2)		Moderate Extent (3)		Great Extent (4)		Very Great Extent (5)
1. Rating specialist must make judgment based on patient's self-reported, unverified experiences									
2. Non-existent diagnostic codes									
3. The test procedures provided in the medical examination report did not match the tests required in the Schedule for Rating Disabilities									
4. The degrees of disability are not descriptive enough to make judgment									
5. Other (PLEASE SPECIFY.) _____									

09. Consider your use of the VA Schedule for Rating Disabilities to determine disability ratings. Overall, how easy or difficult for you is translating complete medical evidence to a diagnostic code with degrees of disability (severe, moderately severe, etc.)? (CHECK ONE.)

1. [ ] Very easy

2. [ ] Generally easy

3. [ ] Neither easy or difficult

4. [ ] Generally difficult

5. [ ] Very difficult

10. Consider the situation in which you are translating complete medical evidence to diagnostic codes with degrees of disability (severe, moderately severe, etc.). In your experience, how likely or unlikely will the situation occur that you could support two or more different ratings for the same medical condition?

(CHECK ONE FOR EACH BODY SYSTEM/CONDITION/DISORDER.)

BODY SYSTEM, CONDITION OR DISORDER	Very Unlikely (1)	Somewhat Unlikely (2)	As Likely As Not (3)	Somewhat Likely (4)	Very Likely (5)
1. Musculoskeletal (5000-5399)					
2. Organs of Special Sense (6000-6299)					
3. Systemic Diseases (6300-6399)					
4. Respiratory (6500-6899)					
5. Cardiovascular (7000-7199)					
6. Digestive (7200-7399)					
7. Genitourinary (7500-7599)					
8. Gynecological Conditions (7600-7699)					
9. Hemic and Lymphatic (7700-7799)					
10. Skin (7800-7899)					
11. Endocrine (7900-7999)					
12. Neurological and Convulsive Disorders (8000-8999)					
13. Mental Disorders (9200-9599)					
14. Dental and Oral Conditions (9900-9999)					

11. Consider the situation in which you are translating complete medical evidence to diagnostic codes with degrees of disability (severe, moderately severe, etc.). Overall, in your experience, how likely or unlikely will the situation occur that you could support two or more different ratings for the same medical condition? (CHECK ONE.)

1. [ ] Very unlikely

2. [ ] Somewhat unlikely

3. [ ] As likely as not

4. [ ] Somewhat likely

5. [ ] Very likely

12. Listed below are medical conditions that a rating specialist might need to review. Please (1) indicate whether or not you would use an analogous code-- because a diagnostic code was not in the Schedule for Rating Disabilties and (2) provide the diagonostic code(s) that you would use.

(IF YOU USE AN ANALOGOUS CODE, PLEASE PROVIDE THE '99' CODE AS DEFINED IN #27 OF THE 'GENERAL POLICY IN RATING' SECTION OF THE VA SCHEDULE FOR RATING DISABILITIES.)

MEDICAL CONDITION	(1) Would you use an Analogous Code? (CHECK ONE.) Yes (1)	No (2)	(2) Which diagnostic code(s) would you use?
1. Alzheimer's Disease			
2. Aseptic Necrosis of the hip			
3. Chondromalacia			
4. Crohn's Disease			
5. Chronic Obstructive Pulmonary Disease			
6. Guillain-Barre Syndrome			
7. Lymphoma			
8. Muscular Dystrophy			
9. Tension Vascular/Headaches			
10. Hypertrophic Cardiomyopathy			
11. Peripheral Vascular Disease			
12. Melanoma			
13. Syncope			
14. Colostomy			
15. Acquired Immune Deficiency Syndrome			

13. For Fiscal Year 1987, please estimate (1) the total number of cases that had at least one medical condition that you rated by analogy and (2) the total number of additional hours, if any, of research required to rate the medical condition for these cases. (ENTER '0', IF NONE.)

(1) _____ total number of cases

(2) _____ total number of hours

14. Based on your experiences, compared to fiscal year 1986, has the number of cases requiring rating by analogy in fiscal year 1987 decreased, increased, or remained the same? (CHECK ONE.)

1. [ ] Greatly decreased
2. [ ] Somewhat decreased
3. [ ] Remained the same
4. [ ] Somewhat increased
5. [ ] Greatly increased
6. [ ] Not applicable-- was not a rating specialist in FY 1986

15. In your experience, compared to fiscal year 1986, has the additional hours required to rate medical conditions by analogy in fiscal year 1987 decreased, increased or remained the same? (CHECK ONE.)

1. [ ] Greatly decreased
2. [ ] Somewhat decreased
3. [ ] Remained the same
4. [ ] Somewhat increased
5. [ ] Greatly increased
6. [ ] Not applicable-- was not a rating specialist in FY 1986

16. The VA Schedule for Rating Disabilities is the primary guidance used to assign disability ratings. Other than the Schedule for Rating Disabilities, what percent of the affected cases, if any, did you rely on other written VA Central Office policy guidance (M-21 instructions, VA regulations or decisions, etc.), to make a disability decision? (ENTER '0, IF NONE.)

_____ percent

17. Consider the current VA Schedule for Rating Disabiltiies. If changes could be made to this schedule, to what extent, if any, would the following changes be needed?

(CHECK ONE FOR EACH TYPE OF CHANGE.)

CHANGES NEEDED	Little or No Extent (1)	Some Extent (2)	Moderate Extent (3)	Great Extent (4)	Very Great Extent (5)
1. Quantify the descriptions (including incorporation of new diagnostic and testing techniques) for the degrees of disability					
2. Assign diagnostic codes, with appropriate guidelines, for additonal medical conditions					
3. Update medical terminology					
4. Other (PLEASE SPECIFY.) _____					

18. If you have any additional comments regarding the Schedule for Rating Disabilities or the questionnaire, please provide them in the space below.

VA Rating Specialists' Responses to GAO Questionnaire

In October 1987 we sent copies of the questionnaire reproduced in appendix II to all VA rating specialists. The responses summarized below are from individuals who met our criteria of 1 or more years' experience and are currently working as a rating specialist. Some rating specialists did not answer all questions because they did not have a valid basis for an estimate. Percentages, where used, may not add to 100 due to rounding.

I. Responses to Questionnaires

Number mailed	457
Number mailed meeting criteria	404
Number returned meeting criteria	383
Response rate for those meeting criteria	95%

II. Rating Specialists Experience

Range of years in position	1 to 25
Average years in position	9

III. Rating Specialist Workload

	Average	No. Of Respones
Number of decisions	1182	381

IV. Adequacy of Medical Examination Reports By Individual Characteristics (Percent of Rating Specialist responses)

Characteristics	Much More Than Adequate	More Than Adequate	Adequate	Less Than Adequate	Much Less Than Adequate	No. of Responses
Complete	.8	5.5	63.7	27.9	2.1	383
Useful	1.3	7.6	71	19.1	1.0	383
Understandable	.5	15.7	68.7	13.1	2.1	383

V. Overall Adequacy of Medical Examination Reports for Fiscal Year 1987. (Percent of Rating Specialist responses.)

	Much More Than Adequate	More Than Adequate	Adequate	Less Than Adequate	Much Less Than Adequate	No. of Responses
Overall	0.8	6.0	67.9	24.8	0.5	383

VI. Incomplete Medical Examination Reports Where Additional Information Was Requested

Total Responses	381
Number with the most frequent percent (1%)	94
Number represented by 5 percent or less	282
Number represented by 10 percent or less	338
Number represented by 25 percent or less	366

VII. The ease or difficulty with which degrees of disability are assigned to body systems, conditions, or disorders. (Percent of Rating Specialist responses.)

BODY SYSTEM, CONDITION OR DISORDER	Very Easy	Generally Easy	Neither Easy Nor Difficult	Generally Difficult	Very Difficult	No. Of Responses
1. Musculoskeletal	5.0	40.2	42.6	12.0	0.3	383
2. Organs of Special Sense	24.8	47.3	21.1	5.7	1.0	383
3. Systemic Diseases	2.6	21.4	57.2	17.0	1.8	383
4. Respiratory	3.4	44.9	44.1	7.3	0.3	383
5. Cardiovascular	3.9	39.9	45.4	10.2	0.5	383
6. Digestive	2.6	32.9	53.5	10.7	0.3	383
7. Genitourinary	1.8	30.3	56.1	11.5	0.3	383
8. Gynecological Conditions	2.3	19.3	47.3	25.6	5.5	383
9. Hemic and Lymphatic	1.3	18.3	59.5	20.1	0.8	383
10. Skin	5.7	49.1	39.4	5.7	0	383
11. Endocrine	2.1	23.2	54.8	18.5	1.3	383
12. Neurological and Convulsive Disorders	0.3	9.9	25.8	52.0	12.0	383
13. Mental Disorders	2.3	17.2	30.0	39.7	10.7	383
14. Dental and Oral Conditions	6.0	28.0	51.3	13.4	1.3	382

VIII. Reasons, by body system, condition, or disorder, why it might be difficult to assign degrees of disability. (Percent of Rating Specialist responses.)

BODY SYSTEM: Musculoskeletal

REASONS	Little or No Extent	Some Extent	Moderate Extent	Great Extent	Very Great Extent	No. of Responses
1. Rating specialist must make judgment based on patient's self-reported, unverified experiences	14.9	31.9	21.3	25.5	6.4	47
2. Non-existent diagnostic codes	17	34	27.7	14.9	6.4	47
3. The test procedures provided in the medical examination report did not match the tests required in the Schedule for Rating Disabilities	8.5	31.9	23.4	27.7	8.5	47
4. The degrees of disability are not descriptive enough to make judgment.	6.4	19.1	21.3	46.8	6.4	47

BODY SYSTEM: Organs of Special Sense

REASONS	Little or No Extent	Some Extent	Moderate Extent	Great Extent	Very Great Extent	No. of Responses
1. Rating specialist must make judgment based on patient's self-reported, unverified experiences	57.7	23.1	3.8	11.5	3.8	26
2. Non-existent diagnostic codes	53.8	26.9	15.4	3.8	0	26
3. The test procedures provided in the medical examination report did not match the tests required in the Schedule for Rating Disabilities	7.7	23.1	30.8	15.4	23.1	26
4. The degrees of disability are not descriptive enough to make judgment.	42.3	11.5	26.9	11.5	7.7	26

BODY SYSTEM: Systemic Diseases

REASONS	Little or No Extent	Some Extent	Moderate Extent	Great Extent	Very Great Extent	No. of Responses
1. Rating specialist must make judgment based on patient's self-reported, unverified experiences	11.1	37.5	31.9	16.7	2.8	72
2. Non-existent diagnostic codes	22.2	26.4	23.6	18.1	9.7	72
3. The test procedures provided in the medical examination report did not match the tests required in the Schedule for Rating Disabilities	20.8	34.7	23.6	15.3	5.6	72
4. The degrees of disability are not descriptive enough to make judgment.	13.9	29.2	20.8	27.8	8.3	72

BODY SYSTEM: Respiratory

REASONS	Little or No Extent	Some Extent	Moderate Extent	Great Extent	Very Great Extent	No. of Responses
1. Rating specialist must make judgment based on patient's self-reported, unverified experiences	10.3	27.6	34.5	27.6	0	29
2. Non-existent diagnostic codes	55.2	31	6.9	6.9	0	29
3. The test procedures provided in the medical examination report did not match the tests required in the Schedule for Rating Disabilities	24.1	24.1	24.1	20.7	6.9	29
4. The degrees of disability are not descriptive enough to make judgment.	10.3	37.9	24.1	17.2	10.3	29

BODY SYSTEM: Cardiovascular

REASONS	Little or No Extent	Some Extent	Moderate Extent	Great Extent	Very Great Extent	No. of Responses
1. Rating specialist must make judgment based on patient's self-reported, unverified experiences	14.6	26.8	17.1	31.7	9.8	41
2. Non-existent diagnostic codes	58.5	22	12.2	7.3	0	41
3. The test procedures provided in the medical examination report did not match the tests required in the Schedule for Rating Disabilities	26.8	24.4	19.5	22.0	7.3	41
4. The degrees of disability are not descriptive enough to make judgment.	7.3	29.3	24.4	29.3	9.8	41

BODY SYSTEM: Digestive

REASONS	Little or No Extent	Some Extent	Moderate Extent	Great Extent	Very Great Extent	No. of Responses
1. Rating specialist must make judgment based on patient's self-reported, unverified experiences	4.8	19	19	50	7.1	42
2. Non-existent diagnostic codes	45.2	38.1	11.9	4.8	0	42
3. The test procedures provided in the medical examination report did not match the tests required in the Schedule for Rating Disabilities	28.6	28.6	23.8	16.7	2.4	42
4. The degrees of disability are not descriptive enough to make judgment.	14.3	31.0	38.1	14.3	2.4	42

BODY SYSTEM: Genitourinary

REASONS	Little or No Extent	Some Extent	Moderate Extent	Great Extent	Very Great Extent	No. of Responses
1. Rating specialist must make judgment based on patient's self-reported, unverified experiences	15.6	22.2	33.3	26.7	2.2	45
2. Non-existent diagnostic codes	20	37.8	17.8	22.2	2.2	45
3. The test procedures provided in the medical examination report did not match the tests required in the Schedule for Rating Disabilities	15.6	28.9	24.4	24.4	6.7	45
4. The degrees of disability are not descriptive enough to make judgment.	20	28.9	31.1	11.1	8.9	45

BODY SYSTEM: Gynecological

REASONS	Little or No Extent	Some Extent	Moderate Extent	Great Extent	Very Great Extent	No. of Responses
1. Rating specialist must make judgment based on patient's self-reported, unverified experiences	24.4	31.9	29.4	10.9	3.4	119
2. Non-existent diagnostic codes	18.5	31.1	17.6	20.2	12.6	119
3. The test procedures provided in the medical examination report did not match the tests required in the Schedule for Rating Disabilities	30.3	24.4	24.4	16.8	4.2	119
4. The degrees of disability are not descriptive enough to make judgment.	15.1	27.7	18.5	32.8	5.9	119

BODY SYSTEM: Hemic and Lymphatic

REASONS	Little or No Extent	Some Extent	Moderate Extent	Great Extent	Very Great Extent	No. of Responses
1. Rating specialist must make judgment based on patient's self-reported, unverified experiences	22.5	33.7	27.5	12.5	3.8	80
2. Non-existent diagnostic codes	15.0	25.0	35.0	12.5	12.5	80
3. The test procedures provided in the medical examination report did not match the tests required in the Schedule for Rating Disabilities	20.0	28.7	31.3	15.0	5.0	80
4. The degrees of disability are not descriptive enough to make judgment.	8.8	40.0	23.7	20.0	7.5	80

BODY SYSTEM: Skin

REASONS	Little or No Extent	Some Extent	Moderate Extent	Great Extent	Very Great Extent	No. of Responses
1. Rating specialist must make judgment based on patient's self-reported, unverified experiences	27.3	31.8	13.6	18.2	9.1	22
2. Non-existent diagnostic codes	13.6	4.5	9.1	18.2	54.5	22
3. The test procedures provided in the medical examination report did not match the tests required in the Schedule for Rating Disabilities	22.7	4.5	27.3	31.8	13.6	22
4. The degrees of disability are not descriptive enough to make judgment.	4.5	18.2	18.2	36.4	22.7	22

BODY SYSTEM: Endocrine

REASONS	Little or No Extent	Some Extent	Moderate Extent	Great Extent	Very Great Extent	No. of Responses
1. Rating specialist must make judgment based on patient's self-reported, unverified experiences	14.5	35.5	35.5	10.5	3.9	76
2. Non-existent diagnostic codes	48.7	30.3	13.2	6.6	1.3	76
3. The test procedures provided in the medical examination report did not match the tests required in the Schedule for Rating Disabilities	14.5	26.3	25.0	25.0	9.2	76
4. The degrees of disability are not descriptive enough to make judgment.	3.9	28.9	31.6	27.6	7.9	76

BODY SYSTEM: Neurological and Convulsive Disorders

REASONS	Little or No Extent	Some Extent	Moderate Extent	Great Extent	Very Great Extent	No. of Responses
1. Rating specialist must make judgment based on patient's self-reported, unverified experiences	2.9	8.2	13.5	32.2	43.3	245
2. Non-existent diagnostic codes	47.8	24.1	18.0	7.8	2.4	245
3. The test procedures provided in the medical examination report did not match the tests required in the Schedule for Rating Disabilities	26.5	26.1	20.0	20.4	6.9	245
4. The degrees of disability are not descriptive enough to make judgment.	18.0	18.8	21.6	29.0	12.7	245

BODY SYSTEM: Mental Disorders

REASONS	Little or No Extent	Some Extent	Moderate Extent	Great Extent	Very Great Extent	No. of Responses
1. Rating specialist must make judgment based on patient's self-reported, unverified experiences	2.1	6.2	12.4	34.2	45.1	193
2. Non-existent diagnostic codes	77.7	14.0	6.2	1.6	0.5	193
3. The test procedures provided in the medical examination report did not match the tests required in the Schedule for Rating Disabilities	29.5	22.3	23.8	16.1	8.3	193
4. The degrees of disability are not descriptive enough to make judgment.	10.4	13.5	21.2	34.2	20.7	193

BODY SYSTEM: Dental and Oral Conditions

REASONS	Little or No Extent	Some Extent	Moderate Extent	Great Extent	Very Great Extent	No. of Responses
1. Rating specialist must make judgment based on patient's self-reported, unverified experiences	57.1	25.0	8.9	5.4	3.6	56
2. Non-existent diagnostic codes	23.2	28.6	14.3	23.2	10.7	56
3. The test procedures provided in the medical examination report did not match the tests required in the Schedule for Rating Disabilities	32.1	28.6	21.4	12.5	5.4	56
4. The degrees of disability are not descriptive enough to make judgment.	19.6	25.0	23.2	25.0	7.1	56

IX. Overall ease with which complete medical evidence can be translated to a diagnostic code with degrees of disability. (Percent of Rating Specialist responses.)

	Very Easy	Generally Easy	Neither Easy or Difficult	Generally Difficult	Very Difficult	No. Of Responses
Overall	2.1	32.6	52.0	13.1	0.3	383

X. The likelihood that two or more different ratings for the same medical condition could be supported when translating complete medical evidence to diagnostic codes with degrees of disability. (Percent of Rating Specialist responses.)

BODY SYSTEM, CONDITION OR DISORDER	Very Unlikely	Somewhat Unlikely	As Likely As Not	Somewhat Likely	Very Likely	No. Of Responses
1. Musculoskeletal	10.2	35.8	24.0	21.9	8.1	383
2. Organs of Special Sense	61.9	31.1	4.4	2.1	0.5	383
3. Systemic Diseases	13.1	39.2	33.2	12.0	2.6	383
4. Respiratory	12.8	42.6	27.7	14.4	2.6	383
5. Cardiovascular	12.8	41.8	24.3	17.2	3.9	383
6. Digestive	8.4	41.3	31.3	16.7	2.3	383
7. Genitourinary	14.1	48.3	26.4	10.2	1.0	383
8. Gynecological Conditions	21.4	42.8	23.5	10.7	1.6	383
9. Hemic and Lymphatic	12.3	42.3	31.1	12.3	2.1	383
10. Skin	17.8	46.5	22.5	11.5	1.8	383
11. Endocrine	9.9	39.2	30.5	18.0	2.3	383
12. Neurological & Convulsive Disorders	4.7	20.9	23.2	33.7	17.5	383
13. Mental Disorders	5.5	13.3	20.6	23.5	37.1	383
14. Dental and Oral Conditions	35.6	44.0	14.9	4.2	1.3	382

XI. The overall likelihood that two or more different ratings for the same medical condition could be supported when translating complete medical evidence to diagnostic codes with degrees of disability. (Percent of Rating Specialist responses.)

	Very Unlikely	Somewhat Unlikely	As Likely As Not	Somewhat Likely	Very Likely	No. Of Responses
Overall	6.3	40.7	31.1	18.8	3.1	383

XII. Results highlighting the differences of opinions on whether an analogous code should or should not be used and the number of analogous codes selected for the medical conditions not found in the Schedule for Rating Disabilities.

MEDICAL CONDITION	Would you use an Analogous Code? Yes %	No %	Total Yes/No Responses*	Number of different diagnostic codes used
1. Alzheimer's Disease	55.2	44.8	382	28
2. Aseptic Necrosis of the hip	81.7	18.3	383	22
3. Chondromalacia	64.2	35.8	383	16
4. Crohn's Disease	59.5	40.5	383	15
5. Chronic Obstructive	39.9	60.1	383	10
6. Guillain-Barre Syndrome	94.3	5.7	383	45
7. Lymphoma	78.3	21.7	383	12
8. Muscular Dystrophy	89.8	10.2	383	35
9. Tension Vascular Headaches	83.3	16.7	383	10
10. Hypertrophic Cardiomyopathy	86.9	13.1	381	16
11. Peripheral Vascular Disease	40.5	59.5	383	13
12. Melanoma	33.7	66.3	383	25
13. Syncope	92.0	8.0	322	34
14. Colostomy	37.7	62.3	382	12
15. Acquired Immune Deficiency Syndrome	25.1	74.9	383	12

*Does not always total 383 because some respondees believed some of the conditions were actully symptoms and therefore would not be rated.

XIII. The cases requiring analogous codes and the time required to rate them for Fiscal Year 87.

Cases	
Total Responses	366
Average Number of Cases Rated	435
Hours	
Total Responses	358
Average Number of Hours	49

XIV. Cases requiring analogous ratings for Fiscal Year 87 as compared to Fiscal Year 86. (Percent of Rating Specialist responses.)

	Greatly Decreased	Somewhat Decreased	Remained the same	Somewhat Increased	Greatly Increased	Not* Applicable	Total Responses
Percent of Responses	0.5	4.7	62.9	26.3	2.9	2.6	380

*Not a rating specialist for all of Fiscal Year 86.

XV. Hours required to rate medical conditions by analogy for Fiscal Year 87 as compared to Fiscal Year 86. (Percent of Rating Specialist responses.)

	Greatly Decreased	Somewhat Decreased	Remained the same	Somewhat Increased	Greatly Increased	Not* Applicable	Total Responses
Percent Of Responses	0.3	7.4	65.3	22.9	1.6	2.6	380

*Not a rating specialist for all of Fiscal Year 86.

XVI. Cases where reliance on VA Central Office policy other than the SRD was required.

Total responses	
Number with most frequent percent (5%)	69
Number represented by 10% or less	227
Number represented by 25% or less	312

XVII. Extent to which the following changes should be made to the Schedule for Rating Disabilities. (Percent of Rating Specialist responses.)

CHANGES NEEDED	Little or no Extent	Some Extent	Moderate Extent	Great Extent	Very Great Extent	Total Responses
1. Quantify the descriptions for the degrees of disability	4.2	19.6	25.8	31.9	18.5	383
2. Assign diagnostic codes, with appropriate guidelines, for additional medical conditions	1.0	17.5	25.1	31.1	25.3	383
3. Update medical terminology	7.3	20.1	27.4	25.3	19.8	383

Comments From the Veterans Administration

Veterans Administration

Office of the Administrator of Veterans Affairs

Washington DC 20420

NOV 1 1988

Mr. Lawrence H. Thompson
Assistant Comptroller General
Human Resources Division
U.S. General Accounting Office
Washington, DC 20548

Dear Mr. Thompson:

This responds to your request that the Veterans Administration (VA) review and comment on the General Accounting Office (GAO) September 20, 1988, draft report VETERANS BENEFITS: VA Needs to Update the Medical Criteria Used in Its Disability Rating Schedule. This report states that although the VA made periodic changes to the rating schedule, it has not undergone a major revision since 1945. GAO reviewed the schedule to determine whether the medical criteria in it are current enough for accurate and uniform disability decisions.

GAO concluded that VA cannot ensure that veterans are given accurate and uniform disability ratings because one of the principal requirements of the rating schedule--readjusting it to incorporate the results of medical advances--is not being met. The report states that, lacking current medical criteria, rating specialists find it difficult to correctly classify a disease or an injury. This may result in the assignment of inconsistent ratings and under- or overcompensation to veterans.

While we agree that improving the currency of the medical criteria will assist in rating board determinations, we do not expect it to have a significant impact on rating by analogy. As GAO states (page 21) concerning rating by analogy, "For 12 of the 15 medical conditions, rating specialists predominantly selected different impairments that used essentially the same range of disability percentages; in these instances, the veterans benefits probably would not vary." There is not a great disparity among the ratings determined by the various VA regional office rating specialists. Some variations in judgment may occur, but as the medical conditions fit the current schedule, that is how they are rated. From that aspect, the ratings are fairly consistent. The rating schedule is a guide for disability evaluation and is not designed to contain a separate diagnostic code and stratified symptom complex for every known disability.

To better ensure that the rating schedule serves as a practical tool in assigning uniform disability ratings to veterans, GAO recommends that I prepare a plan for a comprehensive review of the rating schedule and, using the results of the review, revise medical criteria accordingly.

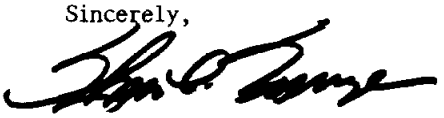
2.

We agree to prepare such a plan. We envision a methodical review of the rating schedule, by body system, using working groups composed of representatives from the Department of Veterans Benefits' Compensation and Pension Service and specialists from the Department of Medicine and Surgery. We will prepare a plan for the comprehensive rating schedule review but will not be able to revise the medical criteria until the proposed rating schedule changes have cleared the public notice and comment process.

GAO also recommends that I implement a procedure for systematically reviewing the rating schedule to keep it up-to-date.

We also concur in this recommendation. The comprehensive review established under the first recommendation will become a cyclical process. The first body system reviewed as part of the initial comprehensive plan will again be reviewed for additional changes once the entire rating schedule has undergone an initial review.

Sincerely,



THOMAS K. TURNAGE
Administrator

Comments From the Department of Defense

ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, D C 20301

HEALTH AFFAIRS

14 OCT 1988

Mr. Lawrence H. Thompson
Assistant Comptroller General
Human Resources Division
U.S. General Accounting Office
Washington, D.C. 20548

Dear Mr. Thompson:

This is the Department of Defense (DOD) response to the General Accounting Office (GAO) draft report, "VETERANS BENEFITS: VA Needs To Update The Medical Criteria Used In Its Disability Rating Schedule," dated September 20, 1988 (GAO Code 105323), OSD Case 7780.

The DoD has reviewed the report and concurs with the findings and conclusions. The Department appreciates the opportunity to comment on the report in draft form.

Sincerely,

for William Mayer, M.D.

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